

A Decisionmaker's Guide to Competing Health Evidence

Single Payer Savings and Benefits: What the Estimates Measure, Where They Disagree, and What to Watch

The United States spent \$5.3 trillion on health care in 2024 and still left 27.5 million people uninsured. Single payer is the most sweeping proposal for changing that — and this summer it generated two headlines that seem to contradict each other: \$1 trillion in annual savings, and \$47 trillion in federal costs over a decade. Both numbers are defensible. Neither answers the same question. Here is what the evidence actually shows, where it runs out, and how to read the claims you will encounter.

1. Why This Matters Right Now

The United States spent **\$5.3 trillion on health care in 2024**, 18 percent of the economy, and still left **about 27.5 million people uninsured** and tens of millions more with coverage that doesn't protect them from large bills. Single payer, in which one public program replaces private insurance for everyone, is the most sweeping proposal for changing that. The Medicare for All Act is its current legislative form, and most of the estimates in this guide score either that bill or earlier versions of it. The core questions are older than the bill: would single payer cost more or less than what we have, who would pay, and would people live longer? Those sound like one question. They aren't, and much of the disagreement comes from treating them as if they were.

The debate reopened this summer. On July 24, Yale researchers posted a **preprint**, a paper that hasn't yet been peer reviewed, projecting that the Medicare for All Act would cut national health spending, the total everyone in the country pays for care, by \$1.04 trillion a year and prevent 114,000 deaths. It traveled fast. The Senate sponsor of the **Medicare for All Act** said it **"confirms what we have known for years."** A month later the American Action Forum published a **competing analysis** finding instead that the bill would cost the federal government \$47 trillion over ten years. Candidates in several 2026 primaries have run in support of the policy, while 2025 coverage roll-backs have put the uninsured number back on an upward path. Hill staff will be asked which trillion-dollar figure to believe. This guide is about how to answer that.

AT A GLANCE

- **What it does:** The Medicare for All Act, the leading single-payer bill, would replace private insurance, Medicaid, and existing Medicare with one federally financed program covering everyone with no premiums, deductibles, or copays.
- **How big it is:** The bill would reorganize how essentially all of the **\$5.3 trillion** the country spends on health care each year gets paid.
- **What's at stake:** Whether the country spends more or less in total, how much cost shifts onto the federal budget, and whether universal coverage saves lives.
- **What the evidence shows:** Total national spending (what everyone combined pays) could fall or rise modestly depending on what the program pays doctors and hospitals; federal spending (the share paid by the U.S. government through taxes) would rise by trillions under every serious estimate; and coverage improves health but the size of the effect on deaths is contested.

AT A GLANCE

Who's Saying What

This map describes public positions of major stakeholders. It does not endorse or evaluate them.

Proponents

- **The Yale research team** projects **\$1.04 trillion in annual savings and 114,174 deaths prevented**, calls its estimates conservative, and says the barrier to universal coverage is how resources are allocated, not whether they exist. The analysis was produced **in response to a request** from a House member.
- **Congressional sponsors of the Medicare for All Act** say the study **confirms** that single payer saves money and lives.
- **Physicians for a National Health Program** **supports the bill** and has long argued that simpler administration and negotiated prices would fund comprehensive coverage.

Opponents

- **The Partnership for America's Health Care Future**, a coalition of hospital, insurer, and drug industry groups, argues that paying all providers at Medicare rates **would threaten hospital finances and access**, and favors building on existing coverage instead.
- **The American Action Forum**, a center-right policy institute, finds a **\$47.4 trillion federal cost** over 2027 to 2036 and argues the Yale estimate confuses national spending with the federal budget and ignores how hospitals would respond. AAF has also

published its own **market-based alternative**, which it projects would cover all U.S. citizens at no added federal cost by funding health savings accounts and a high-deductible plan as the floor benefit; it would leave about 10 million non-citizens uninsured.

- **Editorial boards and commentators on the right** have called the proposal **costly and unworkable** and have questioned the preprint's independence, noting the senior author's prior advisory role to the bill's Senate sponsor.

Independent analysts

- **The Congressional Budget Office** hasn't scored the current bill. Its **2020 analysis of five illustrative designs** found national spending could fall \$0.7 trillion or rise \$0.3 trillion in 2030, while the federal government's share of that spending would rise \$1.5 to \$3.0 trillion under every option, because premiums and other private payments would become taxes.
- **The Urban Institute** **modeled an enhanced single-payer plan in 2019** and found national spending would rise about \$720 billion in the first year while federal spending would rise \$34 trillion over a decade. **The Mercatus Center** **estimated in 2018** a \$32.6 trillion federal cost over ten years, while noting national spending could fall about \$2 trillion if the bill's payment rates held.

2. Why Do Smart People Disagree?

Start with what nobody disputes. The United States spends more per person than any peer country. Roughly **27.5 million people are uninsured**, and nearly a quarter of working-age adults with coverage are **underinsured**, meaning their deductibles and out-of-pocket costs are high enough relative to income that most of them report skipping care. A single-payer system with automatic enrollment would cover essentially everyone; even the most critical estimates concede that. Consolidating billing into one payer would save real money on paperwork; the critics concede that too. And every serious model, from Yale to CBO to AAF, agrees that the single largest lever is what the program pays hospitals and doctors.

The fight is over which question you're asking. "Would single payer save money?" has at least four honest answers, because there are at least four different totals you could mean. Total national spending, everything everyone pays, is one. Federal spending is another, and it rises by trillions in every estimate, including the favorable ones, because premiums and employer contributions become taxes. What a given household pays, all in, is a third. Whether a dollar cut from a hospital's revenue is a saving to the country or just a transfer from the hospital to the taxpayer is a fourth. The Yale preprint answers the first question. Its loudest critics answer the second. Both can be right about their own question and wrong about what the other one is saying.

THE QUESTIONS BEHIND THE DEBATE

 The Question Being Asked	 What It Measures	 Who Tends to Ask It
Does total national health spending go up or down?	Change in what everyone combined spends on health care	Academic modelers, single-payer advocates
How much moves onto the federal budget?	New federal outlays, and the taxes or debt needed to cover them	CBO, budget analysts, opponents
What does a household pay, all in?	Premiums plus out-of-pocket costs plus new taxes, by income	Advocates, distributional analysts
Are lower prices savings or transfers?	Provider and drug revenue lost vs. real resources freed up	Hospitals, physicians, health economists
What happens to demand and supply?	How much more care people use when it's free; whether doctors and hospitals can absorb it	CBO, microsimulation modelers, provider groups
How many deaths does coverage prevent?	The causal effect of insurance on mortality, not just the correlation	Epidemiologists, health services researchers

The disagreement is less about whether single payer could cut national spending than about whether that's the number that matters, and whether the assumptions that produce it would survive contact with hospitals, patients, and Congress.

3. What Does the Evidence Show?

The answer depends on which total you're asking about. On national spending, the honest range runs from a large decrease to a modest increase. On federal spending, every estimate points the same direction: up, by trillions. On deaths, coverage saves lives, but the number depends on assumptions the evidence can't yet pin down.

How the estimates are built

Every single-payer cost estimate, favorable or not, is an accounting exercise built on the same four levers: what the program pays providers, what it pays for drugs, how much administrative cost disappears, and how much more care people use when it's free at the point of service. The estimates differ because the levers are set differently, not because anyone has found new data. Mercatus [showed this](#) in 2018 without meaning to: paying all providers at Medicare rates, as the bill specified, cut national spending by about 2 percent, but the same paper's [alternative estimate](#), which held payment rates at today's national average, turned that into a \$290 billion increase. One assumption flipped the sign.

Evidence on national spending

CBO's [2020 analysis](#) remains the anchor, not because CBO is reliably right (its ACA projections [overshot marketplace enrollment and undershot Medicaid](#), though it did better than most forecasters), but because it's nonpartisan and shows how each design choice moves the estimate. Across five designs, national spending in 2030 ranged from \$0.7 trillion lower to \$0.3 trillion higher than current law. Lower provider payments and administrative savings drove the decreases; more use of care, especially if long-term care was covered, drove the increases. Urban's [enhanced option](#), which paid hospitals closer to their costs and covered long-term care, raised national spending by about \$720 billion in its first year. The Yale preprint's \$1.04 trillion decrease sits outside that range, and the reason is visible in its assumptions.



What we know:

- A single-payer system with automatic enrollment would cover essentially everyone; no serious estimate disputes this.
- Federal spending would rise by trillions per year under every published estimate, favorable or unfavorable.
- Provider payment rates are the single largest driver of every cost estimate, and no estimate has good evidence on how providers would respond to Medicare rates nationwide.
- Gaining insurance reduces deaths; three natural experiments and one randomized study agree on direction.



What we don't know:

- Whether national spending would fall by \$1 trillion, fall by \$700 billion, or rise, because that depends on payment rates and use of care that no one can observe in advance.
- How much administrative saving is achievable once a national program has to do the work insurers do now, including reviewing claims and catching fraud.
- How much excess mortality comes from being underinsured, since no direct estimate exists.
- Whether hospitals paid Medicare rates for everyone would cut costs, cut services, close, or merge.

Payment rates are the assumption everything else rests on. MedPAC, the commission that advises Congress on Medicare payment, [reports](#) that hospitals lost about 12 cents on every dollar of Medicare business in 2024 while earning a 6.5 percent margin across all payers. Commercial insurers are covering the gap. That's the number hospitals cite when they say Medicare rates for everyone would close doors. The same report complicates the story. Hospitals MedPAC classifies as relatively efficient lost only about a penny on the dollar, for-profit hospitals were slightly positive, and the loss would have been about half as large had one-time 340B payments been counted. Whether Medicare rates are "below cost" depends on whose costs, and on whether current costs reflect what care has to cost or what commercial revenue has allowed it to cost. Nobody has good evidence on how hospitals would respond to losing that revenue nationwide, because it's never happened.

Administrative savings are real and contested in size. Medicare's main programs run about [2.3 percent overhead](#) against 7 to 14 percent in private insurance, but as FREOPP argues, Medicare's ratio looks good partly because elderly enrollees spend so much per person that the same fixed costs look smaller. On the other side, [Himmelstein and colleagues](#), who co-founded Physicians for a National Health Program, estimated in 2020 that administration consumed 34 percent of U.S. health spending against 17 percent in Canada, a gap that includes billing costs inside hospitals and clinics that the Yale model leaves out. Unfortunately, the preprint's \$286 billion figure cites the FREOPP paper, which argues against the comparison it's being used to support.

The two weakest inputs are the ones critics have focused on. The \$286 billion fraud reduction extrapolates an 8 percent figure from a [2003 paper on Taiwan](#) whose subject was overall spending growth after universal coverage, not fraud detection. The \$378 billion drug saving applies a 51 percent cut, based on what other rich countries pay, across all pharmaceutical spending. The authors' own sensitivity analysis is instructive: drop the fraud saving and use the smaller discount the VA negotiates, and net savings fall to \$663 billion. That figure is closer to CBO's most favorable design.

Evidence on the federal budget

Here the estimates agree. CBO: federal spending rises \$1.5 to \$3.0 trillion in 2030 under every design. Urban: \$34 trillion over a decade. Mercatus: \$32.6 trillion. AAF this summer: [\\$47.4 trillion](#) over 2027 to 2036 before new revenue. These aren't contradictions of the national-spending estimates. Premiums, employer contributions, state Medicaid spending, and out-of-pocket costs stop being private or state spending and become federal spending. A system can cost the country less in total and the Treasury far more at the same time. Which of those facts matters more is a values question, not an empirical one.

Evidence on lives saved

The preprint's mortality estimate has three parts, and they don't rest on the same evidence. The 33,232 deaths attributed to being uninsured assume the uninsured die at 1.4 times the rate of the insured, a figure from a [2009 observational study](#). That study has always been contested; a [reanalysis the same year](#) that adjusted for more differences between the groups found no significant effect. The better evidence

comes from natural experiments since then, where researchers compare places that expanded coverage with similar places that didn't. Massachusetts reform was associated with a **2.9 percent drop in deaths**, about one death prevented per 830 adults gaining coverage. Medicaid expansion cut deaths among low-income adults in their late 50s and early 60s by **9.4 percent**. A randomized experiment, in which the IRS sent letters nudging uninsured taxpayers to enroll, found that **coverage reduced deaths** among middle-aged adults. Applied to 27.5 million uninsured, the Massachusetts ratio yields a number in the same range as the preprint's. That component is defensible.

The 29,631 deaths attributed to being underinsured rest on a mortality ratio of 1.25 that the authors estimated by splitting the difference, because no direct evidence exists. It's a reasonable guess. It isn't evidence. And the 51,311 deaths from reversing 2025 coverage rollbacks are a projection about other policies, not a finding about single payer; 45 percent of the headline number belongs to a different argument.

The Oregon experiment, the only randomized test of Medicaid itself, **found no significant improvement** in blood pressure, cholesterol, or diabetes control over two years, though it was too small to detect deaths. It did find large improvements in financial protection and depression. Coverage reliably does those things. Its effect on death is real but smaller and slower than advocates' arithmetic often implies.

4. Risks and Unknowns

If Congress sets payment rates above Medicare's, watch the savings shrink or vanish. Every favorable estimate assumes the program pays hospitals and physicians at or near current Medicare rates. Mercatus **showed** that holding rates at today's average turns a national saving into a national cost. Hospitals are the most effective lobby in health care, and they have never accepted an across-the-board cut of this size. The rates written into a bill and the rates a program ends up paying may not be the same number.

If payment rates hold, watch what hospitals do. MedPAC's **data** show nonprofit hospitals losing 13 cents on the dollar for Medicare patients while for-profits roughly break even. Losing commercial revenue could push hospitals toward the cost structure of the efficient ones, or toward closing service lines, merging, and shedding staff. Both have happened in response to smaller shocks. Rural and safety-net hospitals, which already run thin margins, have the least room to adjust.

If care becomes free at the point of service, watch demand outrun supply. CBO **projects** that use of care would rise under every design and that the supply of care would not keep pace, producing delays and forgone care under the lower-payment options. CBO's "lower" rates were **only 13 percent below today's average for hospitals and 7 percent for physicians**, far gentler than Medicare rates, and congestion still rose. The Yale model adds \$198 billion for new use by the uninsured and underinsured but doesn't model any response among the already-insured who'd lose their deductibles. Whether that response is small, as Oregon's results might suggest, or large, as opponents assume, is the biggest empirical unknown.

If administrative savings arrive, watch who loses a job. PERI, whose analysis supports single payer, **estimated** that up to 1.8 million insurance and billing jobs would become redundant. The bill funds transition assistance. Displacement on that scale still concentrates in specific regions and kinds of workers, and it's the one cost of single payer that its own supporters have quantified most carefully.

If the federal ledger grows by trillions, watch the tax design. The financing question isn't whether taxes rise; every estimate says they do. It's whether the new taxes cost a given household more or less than the premiums and deductibles they replace, and the answer differs sharply by income. Vermont's **Green Mountain Care** collapsed in 2014 when the state priced the required payroll and income taxes and concluded they'd shock the economy, even though its own modeling said the system would save money overall. A national program would face the same arithmetic with more zeros.

If the estimates keep getting cited, watch which number travels. The \$1 trillion figure is a national spending estimate. The \$47 trillion figure is a federal spending estimate. The 114,000 figure is 55 percent single payer and 45 percent reversing other policies. Each is defensible on its own terms and misleading when swapped for another. The most likely failure in this debate isn't a bad model. It's a good number used to answer a question it wasn't built for.

5. How to Read the Evidence Yourself

1. **Which total is this number about?** National health spending, federal spending, and household spending move in different directions under the same policy. Before reacting to any dollar figure, find out which one it's measuring. A study can be accurate about one and silent about the others.
2. **What did the model assume about payment rates?** This one assumption drives most of the difference between estimates. If the paper pays providers at Medicare rates, ask what happens at 110 or 120 percent. If it doesn't say, the estimate has a wide margin of error the authors haven't shown you.
3. **Is a saving a real saving or a transfer?** Cutting a hospital's revenue by \$100 billion is a saving to whoever was paying and a loss to the hospital. It only frees up real resources if the hospital was spending that money on something the country didn't need. Ask whether the study distinguishes lower prices from lower costs.
4. **Would this outcome happen without the policy?** The 51,311 deaths from 2025 coverage rollbacks would be prevented by any policy that reversed those rollbacks, not just single payer. The benefit of covering the uninsured would flow from any coverage expansion. Ask what part of the claimed effect is specific to the reform being scored and what part comes from things it happens to include.
5. **How was the mortality estimate built?** A ratio from a 2009 survey study applied to a 2024 population is a different kind of evidence than a comparison of states that did and didn't expand Medicaid, which is different again from a randomized trial. All three can be informative. They shouldn't be reported with the same confidence, and a number the authors estimated by splitting the difference shouldn't be reported as a finding.

6. The Bottom Line

The evidence settles less than either side says. It does settle a few things. Single payer would cover nearly everyone. Federal spending would rise by trillions per year under any design. Coverage reduces deaths. Administrative costs would fall by a meaningful amount, though how much depends on what a national program has to do that insurers do now. The evidence doesn't settle whether national spending would fall by a trillion dollars, fall by less, or rise, because that hinges on payment rates and patient behavior that no study can observe before the fact.

The tradeoff no design can eliminate is this: the savings come from paying doctors, hospitals, and drug companies less, and the people who receive that money will respond. Set rates low enough to save a trillion dollars and you're betting on how thousands of hospitals and **more than a million physicians** adjust to losing commercial revenue. Set them high enough to keep providers whole and the savings disappear. Every estimate in this guide, from Yale's to AAF's, is a different bet on that response. None of them knows.

The evidence that insurance improves health and financial security is much stronger than the evidence about what any particular reform would cost. That asymmetry should shape how decisionmakers read claims on both sides. A projection that single payer saves \$1 trillion and a projection that it costs \$47 trillion are both accounting exercises built on assumptions the authors chose. The underlying findings, that coverage helps people and that the U.S. pays far more than peer countries for care, don't depend on those choices. Be more skeptical of the confident number than of the evidence beneath it.

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