



SINGLE PAYER 101

WHAT IS SINGLE PAYER?

Single payer refers to a way of financing health care, which includes both the collection of money for health care and reimbursement of providers for health care costs. In a single payer system, both the collection of funds and the reimbursement are the responsibility of one entity: the government. The government collects funds from individuals and businesses, mainly in the form of taxes, and the government reimburses providers for health care services delivered to individuals enrolled in the public health insurance program.

In the United States, there are multiple payers, not a single payer. The collection of money for health care is a joint responsibility of the private insurance industry, which collects premiums and other payments from individuals and businesses, and the government, which collects taxes from individuals and businesses. Similarly, reimbursement responsibilities fall on both the private insurance industry, which reimburses providers for health care services delivered to privately insured individuals, and the government, which reimburses providers for health care services delivered to publicly insured individuals (e.g. people enrolled in Medicare, Medicaid, S-CHIP, or the VA).

Denmark, Sweden, and Canada are example of countries with single payer financing of health care. There is also a single payer system in America: the Medicare program, which is the health insurance program for almost every American aged 65 and over. A provider taking care of a Medicare patient has only one entity to bill: the government. In contrast, a provider has multiple entities to bill when dealing with privately insured individuals due to the large number of private insurance companies in America.

Importantly, the term “single payer” is different from “socialized medicine” and “universal health care.” **Socialized medicine refers to a system like the National Health Service of the U.K., in which the mechanisms of delivery of health care are owned by the government.** That is, the government owns the health care facilities and physicians work for the government. In contrast, the mechanisms of delivery of health care in a single payer system are not necessarily owned by the government. Physicians can be either in private practice or public practice, and hospitals can be both publicly or privately owned. In Canada, for example, physicians are predominantly in private practice, while hospitals are both public and private. As another example, American physicians and hospitals that take care of Medicare patients are usually private. **Single payer does not specify a health care delivery mechanism; it specifies a health care financing mechanism.**

The term “universal health care”, in a general sense, refers to providing every citizen of a country with health insurance. Although universal health care connotes a national public insurance program to some people, there are in reality a variety of ways of achieving universal health care, some of which are predominantly public, and others of which use a mixture of public and private elements. Single payer is one way of achieving universal health care, but other ways include the multi-payer systems of Germany and Japan.

FEATURES OF SINGLE PAYER SYSTEMS

Single payer systems are heterogeneous; Canada’s system is different from Sweden’s system, which is different from U.S. Medicare, and so on. The well-known Proposal of the Physicians’ Working Group for Single Payer National Health Insurance illustrates one way single payer might look in the United States. The following discussion is based on the details of this proposal.¹

Eligibility and Benefits:

Every resident of the United States would be enrolled in a public insurance system (the National Health Insurance or “NHI” program). Coverage would include all necessary medical care, including mental health, long-term illness, dental services, and prescription drugs. Coverage decisions would be determined by a national board of experts and community representatives; unnecessary or ineffective interventions would not be covered. Patients would not be billed for medical care covered under the NHI program; rather, all costs for covered services would be paid by the NHI program.

Private insurance that covers services covered by the NHI program would be forbidden, although private insurance would be available to insure patients for services not covered under the NHI program.

Financing:

The program would be funded by combining current sources of government health spending (Medicare, Medicaid, etc.) into a single fund with modest new taxes, such as a small payroll tax or earmarked income taxes. While taxes will increase for individual citizens, the increase will be offset by reductions in premiums and out-of-pocket spending. Employees may also receive higher wages from employers, who will no longer have to pay as much for health benefits as part of employee compensation (i.e. instead of paying employees in health benefits, employers will pay higher wages).

Hospitals:

Hospitals would receive a global budget from the NHI program, which means that they would receive a lump sum to cover all operating expenses every month. Hospitals would need to find a way to stay within their global budget while still providing all necessary medical care.

The global budget for the hospital would not cover “capital expenditures” (e.g. facility expansions, purchasing new equipment). Such expenditures would be funded by the NHI program separately from the global budget. Approval for capital expenditures would be based on community needs to prevent over-concentration of technology and facilities in one area.

Physicians:

Physicians would remain in private practice or continue to work for private hospitals. In terms of reimbursement, physicians could choose one of three ways of being reimbursed:

- *Fee-for-service*: A national fee schedule will be negotiated each year between the NHI program and provider organizations (e.g. medical associations).
- *Salary at health care facility*: Physicians who work for hospitals and other health care facilities would receive an annual salary.
- *Salary within a capitated group*: A group practice or nonprofit HMO that employs physicians would receive payments from the NHI to pay their physicians. These payments would be capitated – that is, a payment would be made every month for each patient enrolled with a physician to cover the cost of taking care of patients.

Medications and supplies:

An expert panel would create and maintain a national formulary of prescription drugs covered under the NHI program. Prices for drugs and supplies would be negotiated with the NHI program, which would get a good price from manufacturers due to its bulk purchasing power.

THE ARGUMENT FOR SINGLE PAYER

The argument for universal health care is both similar to and different from the argument for single payer as the *specific mechanism* for achieving universal health care. Both arguments include the moral travesty of allowing millions to suffer because they lack health insurance, the economic losses associated with lower productivity due to uninsurance, and the cultural dissonance created when there is not health care for all in a country that purports to believe in equality and equal opportunity.²

In this primer, the argument for single payer will focus on its advantages over methods of achieving universal health care that retain the current system of employer-based insurance and for-profit health insurance companies (employer mandates, individual mandates, expansions of Medicaid, tax credits, etc.). Note that a discussion of single payer vs. multi-payer systems like Germany and Japan, while extremely important, is far beyond the scope of this text. Suffice it to say that many of the advantages of single payer systems are retained by these other systems, and that both single payer and non-single payer universal health care systems have distinct advantages over the other.

The argument for single payer can be broken down into two parts: philosophical and economic.

The philosophical argument for single payer

The U.S. health care system is driven largely by market forces, which are predicated on the profit motive. The theory behind the U.S. system is that private health insurance companies seeking to maximize profit will compete with each other, thus driving down costs.

How well does this theory work in practice? From 2000-2004, profits for the top 17 U.S. health insurance companies rose 114%; in contrast, the profits of companies in the S&P 500 (an index of 500 commonly owned stocks) rose 5% during the same period.³ Simultaneously, the number of uninsured individuals grew by six million people, and health insurance premiums rose 60%.^{3,4} Contrary to popular belief, the newly uninsured were overwhelmingly native citizens, not immigrants.⁵

This situation – private insurance companies making record profits while health insurance premiums and the number of uninsured skyrocket – suggests that insurance companies have an incentive to price people out of health care to maximize profit. The methods by which private health insurance companies achieve this include denial of insurance to people with pre-existing conditions, heavy utilization review, and “cherry-picking” (selectively insuring the healthy and charging higher premiums for the less healthy).²

Whether this is an acceptable situation depends foremost on how valuable society believes it is to have equitable, universal health care access. The free market in health care may deliver a good health insurance product to those who can afford it, but it is not designed to distribute health insurance equally or universally. Private health insurance companies seeking to maximize profit have no incentive to insure everyone, as this would require them to insure patients with high health care costs.

If society believes that equality and universality are important features of a health care system, then the current system is necessarily unacceptable. A single payer system would be a far better alternative.

The economic argument for single payer

The economic argument for single payer is twofold. First, single payer will save money by reducing administrative costs. Second, and more importantly, single payer greatly facilitates cost control because of its centralized administration.

Administrative simplification

The complexity of the American health care system has been the subject of much criticism. As the prominent Brookings Institute economist Henry Aaron wrote, “Like many other observers, I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that

differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird.”⁶

Although administrative costs are commonly discussed, there is much confusion as to exactly what they are. The following figure illustrates the nature of some of the functions that induce administrative costs in the U.S. health care system.⁷

Exhibit 1
Administrative Costs. By Function And Sector Of The U.S. Health Care System

Function/ component	Health insurance	Hospitals	Nursing homes	Physicians	Firms	Consumers/ individuals
Transaction - related	Claims processing	Admitting, billing	Admitting, billing	Billing	Tracking employee hires/ terminations	Submitting claims
Benefits management	Statistical analyses, quality assistance, plan design	Management information systems	Management information systems	Management information systems	Internal analyses	Tracking expenses eligible for reimbursement
Selling and marketing	Underwriting, risk/ premiums, advertising	Strategic planning, advertising	Strategic planning	Advertising	Flexible benefit programs	Search costs
Regulatory/ compliance	Premium taxes, reserve requirements	Waste management	Discharge planning	Licensing requirements	Filing summary plan descriptions, COBRA obligations	Mandated benefit laws

^a COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, which includes provisions for continuation of coverage when an employee leaves a firm.

A 2003 New England Journal of Medicine study calculated the administrative costs involved with insurance overhead, employers’ costs to manage health care benefits, hospital administration (e.g. billing), administrative costs of practitioners (e.g. billing), and administrative costs of long-term care facilities. The study estimated that in 1999, as much as \$294.3 billion was used for administrative costs, representing 31.0% of health care expenditures in America. In contrast, in Canada’s single payer system, administrative costs represented 16.7% of health care expenditures.⁸ A few caveats must be applied here:

- The authors themselves acknowledge the imprecision of their estimate and the methodological problems involved with studying administrative costs.⁸ In addition, one study argued that the \$294.3 billion amount is an overestimate of at least \$50 billion based on methodological issues.⁶ The actual number of \$294.3 billion should not be taken too literally; the more important point is that the administrative costs in America are very high.
- Administrative costs are not bad in and of themselves. Some administrative costs, such as quality improvement or utilization review, may improve quality. Others, such as marketing, advertising, or complex billing due to the plethora of private payers in America, are much more questionable in their usefulness.⁸ **The goal is**

to reduce administrative costs that are wasteful, not to reduce administrative costs in general.

- Comparisons of administrative costs are somewhat difficult to interpret, because different health care systems perform different functions. For instance, Canada's health care system does not cover outpatient prescription drugs for the most part, while the opposite is true for most American private insurers, Medicaid, the VA, and, as of 2006, Medicare. Such differences are the basis for the common argument from single payer opponents that comparing the administrative costs of the U.S. and Canada is like "comparing apples and oranges." Although no one claims that the cost of administering a drug plan accounts for more than a small percentage of the difference in administrative costs between American and Canada, it is worth remembering that a simple comparison of administrative costs in two countries is most useful when the specific functions each country's system performs are identical.
- Finally, it should be kept in mind that if the United States adopts a single payer system, the administrative functions the system performs will clearly be different from those of Canada's.⁶ No two health care systems are identical.

Even with all these caveats in mind, there is little doubt that the administrative costs in America are higher than that in Canada. More importantly, much evidence also suggests that a large portion of administrative costs in the U.S. go to functions that likely do not improve patient care. In support of this notion, a 2005 study showed that in California, private insurers devote 20-22% of their spending to "billing and insurance-related functions" (BIR). While the definition and measurement of BIR is potentially controversial, one conclusion that can be comfortably drawn from the study is that physicians, hospitals, and insurers devote a large amount of money to handling claims and hiring administrative staff to deal with billing.⁹ These costs, along with costs like marketing and advertising, are among the administrative costs that would be saved by switching to a single-payer system. The specific amount saved would vary according to the design and functions of the new system.

Cost control mechanisms

To slow the rate of health care expenditure growth, a health care system needs to be able to address the major drivers of health care inflation. In general, administrative costs are not thought to be a major cause of health care inflation.¹⁰⁻¹² While these costs represent a large expenditure, reducing administrative costs in a single payer system without instituting other cost control mechanisms would do little to slow the growth of health care costs overall.

The strongest economic argument for single payer is that it can control costs in a coordinated fashion because of the centralized nature of its administration. In contrast, because of the non-centralized administration of the U.S. health care system, effective cost controls are difficult to institute. For example, Medicare has been more successful at controlling costs than private insurers in recent years, but these cost controls have had little effect on overall health care costs because private insurers

have not instituted the same cost controls as Medicare¹⁰⁻¹². In essence, when a health care system has multiple payers who all play by different rules, it is extraordinarily difficult to institute systemic cost controls. When a health care system has a single payer and only one set of rules, cost controls can apply to the entire system.

To illustrate this point, consider one of the major drivers of health care inflation: the diffusion of new medical technology.¹¹ Overall, technological innovation has improved health care outcomes for patients, but it has done so at the cost of rapidly increasing health expenditures. Furthermore, not every technological innovation is cost-effective, nor is every technological innovation necessarily an improvement over previous technologies.¹¹

In many other industrialized countries, including countries with single payer systems, there are nationally coordinated attempts to assess the cost-effectiveness of health technologies; the results of these evidence-based assessments are made into national policy. The same cannot be said of the United States. While there are various attempts at evidence-based assessment of health technology in America, the results of these assessments often do not substantially affect the practice of medicine. One reason is that specialists and manufacturers of technology have a disproportionate impact on whether a health insurance company covers new technologies, potentially blunting the effects of any evidence-based reports.¹¹ A more important reason is that in the non-centralized U.S. health care system, the effect of any report will necessarily be limited by how much a given payer decides to use the findings to make decisions about what services to cover.¹¹ For example, even if Medicare decides not to cover a technology deemed ineffective by its internal health technology assessment studies, the government has little power to influence whether private insurance companies cover that particular technology. In a single payer system, the government could theoretically use evidence-based assessment of technology to determine what is covered throughout the system, thus minimizing the use of ineffective technologies.

As another example of the power of single payer systems to control costs because of its centralized administration, consider cost controls such as global budgeting for hospitals and supply limitations (e.g. preventing the purchase of too many MRIs in an area that is already oversaturated with MRIs). These measures are known to be some of the strongest cost controls available to policy makers. Indeed, other countries have been able to successfully institute such controls, slow down the rate of health care expenditure inflation, and still provide high-quality coverage to its citizens.¹² However, the U.S. experience with such controls is limited. This can partly be attributed to politics, but it can also be partly attributed to the impracticality of attempting to institute such controls when there is not one centralized entity overseeing the system.

Other cost controls

There are a variety of other economic advantages of single payer systems in terms of cost control. First, single payer systems can get better prices for goods and services because of their bulk purchasing power. One study compared the price of a defined group of medications in different countries. The price of these medications in Canada,

which uses its purchasing power to negotiate with drug companies, was 60% of the cost of the medications in America.¹²

Second, because billing is done by one entity, single payer systems facilitate the collection of massive databases that can be used to study and potentially improve practice patterns. The databases can also be used to screen for fraudulent billing by providers, as has been done in Taiwan's new single-payer system.¹⁴

A caveat about cost controls in single payer systems

It is important to note that all cost control mechanisms have potential disadvantages and that none of these cost controls discussed above are intrinsic to single payer systems. That is, any given single payer system would not necessarily have global budgeting for hospitals, limitations on technology, etc. The important point is that a single payer system enables the *option* of instituting these cost controls, whereas that option is not available to policymakers in the current fragmented U.S. health care system.

Another important point is that decisions about cost controls in a single payer system will involve a good deal of public debate, as they do in Canada. For example, the public will have influence over what is and what is not covered in the single payer system; if there is a public outcry for technology even though it means paying more for health care, then the system will adapt to these demands. In the current system, as discussed above, coverage decisions by private insurance companies are dominated by special interests, and consumers play a very minor role.¹¹ A system in which decision makers are directly accountable to the public is more likely to be more responsive to public opinion than the current system, in which decision makers (i.e. private insurance company executives) are not directly accountable to the public.

In summary, perhaps the strongest economic argument for single payer is that it gives policymakers the option of controlling costs. Whether they elect to use this option will be influenced by a democratic process that incorporates the needs of the American public.

ADVANTAGES OF SINGLE PAYER TO VARIOUS GROUPS OF PEOPLE

The benefits of single payer are numerous, but they do not accrue to all sectors of society. Clearly, private health insurance companies do not stand to gain from a single payer system, as their role would be dramatically minimized. Furthermore, the pharmaceutical industry does not stand to gain from a single payer system because of the potential for price controls and bulk purchasing.

For most Americans, though, single payer would represent a clear improvement over the current system:

Advantages to patients

- **Improved health.** The most prominent benefit of single payer is that patients will be able to access health care with minimal financial barriers. This improved access will increase health by increasing preventive/primary care and allowing patients to afford their treatment regimens.
- **Free choice of provider.** Patients will have free choice to choose their doctor. In the current system, not every provider accepts every form of health insurance, and the existence of managed care preferred provider networks is an impediment to free choice of providers.
- **Portability of coverage.** In the current system, insurance status is linked to employment. In a single payer system, a person can go from job to job without experiencing interruptions in health insurance coverage. De-linking insurance status with employment will also increase the number of small businesses, as there are many people who refrain from starting their own businesses because they are afraid to lose their health insurance (the "job lock" phenomenon).¹⁵

Advantages to physicians

- **Restoration of clinical autonomy:** The United States arguably has some of the most intrusive regulation of physician behavior of any industrialized country.¹⁶ This regulation comes mainly through private insurance companies, particularly managed care companies that require pre-approval for interventions and institute heavy utilization reviews. In a single payer system, physicians will be relieved from the burden of these regulations, increasing their clinical autonomy.
- **Lower malpractice premiums:** Currently, a significant portion of malpractice jury awards are devoted to future medical costs for the patient. Under a single payer system, this percentage would decrease, as the government would pay for these future medical costs.⁸ In addition, a single payer system may be able to decrease medical errors and therefore the number of malpractice suits by increasing continuity of care. That is, patients would not shuttle from doctor to doctor because they change insurance companies or their insurance company alters its preferred provider network.
- **Improved patient care.** Physicians will be able to make clinical decisions based on best practices, as the influence of a patient's financial circumstances will be decreased. Physicians will also enjoy increased compliance by patients, who will be able to afford the medications and interventions prescribed to them.
- **Simplified billing.** Since physicians will have only one entity to bill, billing will be greatly simplified. Physicians will save money on overhead because they will not have to hire as many administrative staff to deal with billing.

Advantages to businesses

- **Decreased health care costs.** In 2005, the average employer-based health insurance premium for a family of four was \$10,880, while the premium was \$4,024 for an individual.¹⁷ Under a single payer system, businesses will no longer be required to cover the vast majority of health insurance premiums for their employees. Depending on the specific proposal, businesses might be required to fund the new health care system through a payroll tax, but for most businesses,

such a payroll tax is likely to cost less than providing health insurance for employees.

- **Equal playing field.** The businesses that stand to lose money in a single payer system are those that do not currently provide health insurance. Workers in such businesses either enroll in Medicaid, which is taxpayer-funded, or they become uninsured and receive uncompensated care, which is predominantly financed by taxpayer money. Moreover, businesses that do not provide health insurance gain an advantage over businesses that do provide health insurance. Single payer would eliminate this advantage, thus leveling the playing field for businesses.
- **Improved global competitiveness.** The relief of the health care burden on businesses will help stimulate the economy and improve the global competitiveness of U.S. businesses. Currently, U.S. businesses are at a competitive disadvantage to foreign companies, which have lower health care costs and therefore lower prices on their products.¹⁸

THE POTENTIAL DISADVANTAGES OF SINGLE PAYER

The vitality of any public program lies in its funding levels, and the biggest potential disadvantage to a single payer system is the threat of underfunding. There are several ways in which this might occur:

- **Underfunding by a hostile government:** a government that favors privatization might take measures to undermine the public system. In America, the strength of private special interests makes this possibility especially worrisome.
- **Mismanagement:** an inept or corrupt government could misallocate funds in a single payer system, taking away money from vital services and decreasing quality.
- **Recession:** public systems rely on tax dollars, which decrease during recessions.

Another potential disadvantage of single payer relates to one of its strengths: the ability to control costs. As noted above, all cost control mechanisms have downsides, and overly aggressive cost control could result in decreases in quality. For instance, inappropriately strict limits on the diffusion of technology might stifle positive innovation in technology. Along with underfunding, this can be avoided through prudent management of the health care system, but it remains a potential concern.

The transition from the current system to a single payer would undoubtedly be very difficult. Thousands of people who work for private insurance companies would need to be shifted to other sectors of the economy. Even though these individuals could be trained to work in the new public system, they would still experience a significant change in their lives. Because of these considerations, most single payer advocates and policy analysts believe that any transition to a single payer system would necessarily be gradual, taking place over the course of many years.

Finally, there are some important tradeoffs that Americans will have to make in a single payer system. The first is that technology-hungry Americans will have to accept limits on ineffective, questionable, or medically unnecessary interventions that would not be

covered by the single payer system. Such interventions could be likely be covered by supplemental private insurance, as is the case in other countries with single payer. The second major tradeoff is that Americans will have to accept less choice in insurance plans. Some Americans want to choose the health insurance plan that is tailored to their individual needs, but a single payer system would give everyone the same insurance plan. The last major tradeoff is that Americans will have to accept more government control and less private control of the health care system. Neither the government nor the private insurance industry can currently claim great popularity with Americans, and the question is which entity Americans will trust more to manage the health care system.

CONCLUSION

This primer has endeavored to articulate the nature and advantages of a single payer system. Solutions that achieve universal health care through mechanisms that build on the current system of for-profit employer-based insurance, while potentially beneficial, do not achieve the philosophical purity, administrative simplification, or cost control potential that a single payer system achieves.

Single payer, however, has significant potential disadvantages that must be addressed. Although many of the disadvantages can be avoided through proper management of the system (e.g. funding the system at a very high level and insuring adequate capacity), others represent true tradeoffs that the American public must debate in its mind. The time for such debates is now. In the current system, insurance companies have a financial incentive to avoid insuring the people who need it the most, which means that more and more Americans suffer every year. It is only a matter of time before some type of reform takes place, and single payer should be a reform option that should be seriously considered.

Contact:
Flávio Casoy
AMSA Jack Rutledge Fellow
1902 Association Drive
Reston, VA 20191
jrf@amsa.org
(703) 620-6600 x256

Written by Kao-Ping Chua
AMSA Jack Rutledge Fellow 2005-2006
Updated by Flávio Casoy
AMSA Jack Rutledge Fellow 2007-2008

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