LAKEBRIDGE

INSTITUTE

TECHNICAL REPORT

Provincial Rules, American States

The Government Cost of Canadian-Style Health Coverage in the United States

Key finding. If each US state adopted the public-coverage rules of the Canadian province it most resembles, US government health spending would rise by an expected $806.7 billion a year in 2020 dollars, about $2,454 per person. Under the sensitivity checks the estimate ranges from about $725 billion to $1,064 billion.

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Executive summary

This report estimates how much more US governments would spend on health care if each state financed care the way a comparable Canadian province does. The central estimate is **$806.7 billion a year** in 2020 dollars, or **$2,454 per person**, on top of what Medicare and Medicaid already pay. In 90% of 10,000 simulated assignments of states to provinces, the figure falls between **$792.2 billion and $822.3 billion**.

Question. Canada has no single national health plan. Each of its ten provinces runs its own public system, and they differ in how much of each type of care the government pays for. The report asks what US government spending would be if every state applied the public-coverage rules of the province it most resembles, using the state's own spending as it stands.

Approach.

- **Cost model.** For each state and each type of care (hospital, physician, drugs, nursing homes and six others), the province's government share is applied to the state's own 2020 spending. Provider administrative costs are cut to the Canadian level, which removes 14.4% of hospital, physician, nursing-home and home-health spending. The result, minus current Medicare and Medicaid spending, is the extra government cost.
- **Matching.** States are matched to provinces in four ways of increasing detail: every state under one province's rules (Part 1 bounds), the closest province by population (Part 2), the closest province on four demographic and economic factors (Part 3), and a probabilistic assignment over ten factors (Part 4).
- **Probabilistic assignment.** Each state receives a chance of adopting each province's system and a small chance of keeping its own system, based on its appetite for change. The expected cost and its range come from these chances and a 10,000-run simulation.
- **Sensitivity.** Four checks vary the size of the administrative savings, the data year, the price level and the amount of care people use once covered.

Key findings.

1. **The extra government cost is about $807 billion a year.** That is $2,454 per person in 2020 dollars, with a simulated 90% range of $792.2 billion to $822.3 billion.
2. **The change is mainly a shift in who pays.** Government's share of personal health spending rises from 39.9% to 71.4%. Total spending falls by $344.6 billion because of lower administrative costs, and employers, households and private insurers pay about $1.15 trillion less.
3. **The matching method barely moves the national total.** Population matching gives $816.5 billion, four-factor matching $817.4 billion and probabilistic matching $806.7 billion. The province rules set the outer bounds: $753.0 billion if every state used New Brunswick's rules and $912.4 billion under Newfoundland and Labrador's.
4. **Assumptions move it more.** Halving the administrative savings raises the cost to $960.3 billion. Adding the Congressional Budget Office's estimate of increased use of care (7%) raises it to $956.7 billion. Using 2019 data lowers it to $724.7 billion in 2020 dollars, and restating it in 2025 prices raises it to $909.4 billion. Across all checks the estimate runs from about $725 billion to $1,064 billion.

5. **The cost per person varies fourfold by state.** It is highest where spending is high and government pays a small share today, such as South Dakota ($5,242) and Alaska ($5,159). It is lowest where government already pays about half, such as New Mexico ($1,311) and Arkansas ($1,517).
6. **Manitoba is the most common model.** It is the most likely match for 14 states, Nova Scotia for 10, and Ontario and Quebec for 8 each. Ontario's rules account for the largest share of the expected cost, $242.1 billion, because Ontario is the likeliest match for California, Texas, New York and Illinois.

Scope. The estimate is an accounting projection of how financing would shift at 2020 prices and volumes. It is not a cost estimate of any bill, and it does not model a transition period, tax design or provider responses beyond the sensitivity checks. Federal programs for specific populations (the Veterans Health Administration, military health care and the Indian Health Service) stay in place outside the change, as Canada's comparable federal programs sit outside its provincial plans; their spending is the same before and after, so it does not enter the extra cost. Medicare and Medicaid are folded into the provincial system rather than kept alongside it; keeping both programs as they are and applying the provincial rules to everyone else's spending would cost about $1.11 trillion a year instead (Section 4.4).

The model at a glance

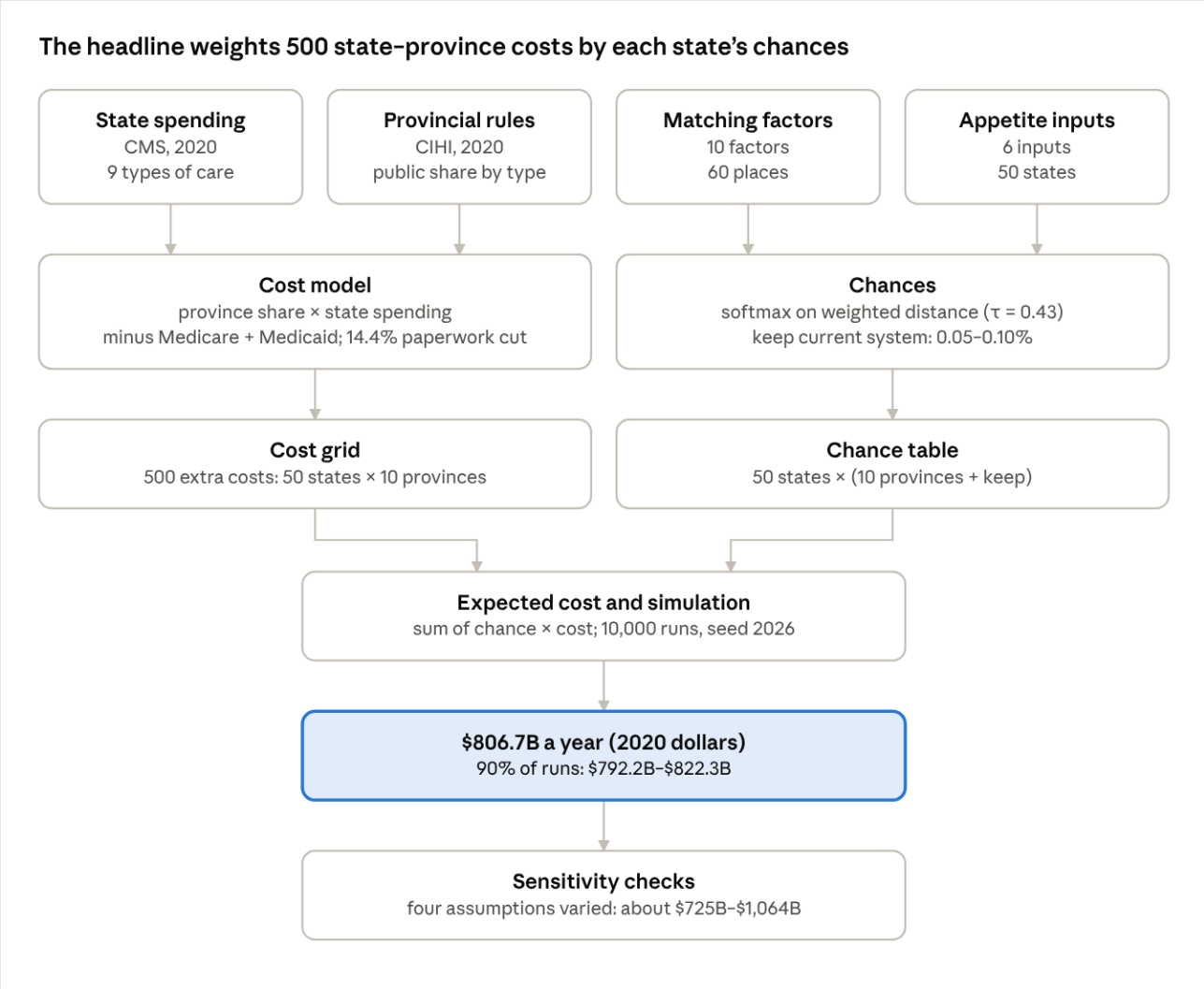


Figure 1 · How the estimate is built

Two strands meet in the expected cost. On the left, spending and provincial rules give an extra cost for every state–province pair; on the right, ten matching factors and six appetite inputs give each state's chances. Sections 4 and 6 describe each box.

1. Premise and research question

The report asks one question: if each US state adopted the public-financing rules of a comparable Canadian province, holding its own prices and use of care fixed, how much more would government spend?

1.1 Why Canada, and why province by province

Canada is the comparison most often made in US debates about public health coverage, but "the Canadian system" is ten provincial systems. Federal law sets common conditions for hospital and physician care, and each province decides how far public coverage reaches beyond that. The differences are large. Ontario's government pays 84.5% of hospital spending while the other provinces pay 91–95%. Quebec's government pays 18.3% of dental, vision and other professional care, against 2–9% elsewhere. Newfoundland and Labrador's pays 80.7% of nursing-home and residential care, against 52–73% elsewhere. A single national average would blur choices that matter for cost.

US states differ just as much on the other side of the ledger. In 2020, personal health spending ran from about $7,500 per person (Utah) to $14,000 (New York). Medicare and Medicaid paid 25.1% of it in South Dakota and 50.5% in New Mexico. The same provincial rules therefore cost very different amounts in different states, and a projection has to be built state by state.

1.2 Why match states to comparable provinces

A province's public share reflects its population, economy and politics as well as its policy choices. Applying Alberta's rules to Vermont, or Prince Edward Island's to California, would pair systems with populations they were not designed for. The report therefore matches each state to the province or provinces it most resembles. Because no matching method is uniquely right, it uses four of increasing detail and reports how much the answer depends on the choice.

1.3 What is being estimated

The quantity of interest is the **extra government cost**: government spending on personal health care under the province's rules, minus what Medicare and Medicaid spend in the state today. It combines federal and state governments; how the cost would be split between them, and how it would be financed, is outside the scope. The estimate is in 2020 US dollars, the latest year of state-level spending data, and covers the 50 states (the District of Columbia is excluded).

Medicare and Medicaid are not kept as separate programs on top of the provincial rules. The province's government share applies to all personal health spending in the state, including care for people now covered by Medicare and Medicaid, and today's Medicare and Medicaid spending is then subtracted. Their current spending is part of what the provincial system replaces. Section 4.4 explains what that implies and prices the alternative of keeping both programs as they are.

The analysis answers four sub-questions:

1. **Size:** what is the national extra government cost?

2. **Robustness to matching:** how much does it change with the method used to pair states and provinces?
3. **Distribution:** how does the cost per person vary across states, and why?
4. **Robustness to assumptions:** how much does it change with the size of administrative savings, the data year, the price level and the amount of care used?

1.4 How this differs from Medicare for All estimates

Published estimates of Medicare for All price a hypothetical US program that would cover nearly all care, including prescription drugs, dental, vision and often long-term care, with little or no cost sharing. This report prices something narrower and real: the public-financing rules that Canada's provinces actually operate, under which most drug, dental and long-term care spending stays with households, employers and private insurers. Its estimate is therefore lower than Medicare for All estimates, and the two should not be read as competing estimates of the same policy. The question here is what the Canadian model, as it exists, would cost if US states adopted it.

2. How Canada's provinces pay for care

Provincial governments pay almost all hospital and physician costs, but only a quarter to a third of drug costs and very little dental or vision care. That pattern, and the differences between provinces within it, drive every result in this report.

2.1 The common core and the provincial margin

The Canada Health Act (R.S.C. 1985, c. C-6) sets the conditions a province must meet to receive its full federal health transfer. Its definition of insured health services covers hospital, physician and surgical-dental services provided to insured persons. Provincial plans must cover medically necessary services in those categories, without user charges (Library of Parliament, 2019).

Everything beyond that core is a provincial choice: prescription drugs outside hospital, dental and vision care, home care, and long-term residential care. Provinces cover these through their own programs, with income tests, age limits, deductibles and copayments that differ from one province to the next. Much of this care is paid privately, through employer insurance or out of pocket.

2.2 Measuring each province's rules

The report measures each province's rules directly from spending, using the Canadian Institute for Health Information's National Health Expenditure Trends 2025 data tables:

- **Series D1:** total health spending by use of funds, by province, in millions of current dollars (tables D.1.x.1.a).
- **Series D4:** provincial government health spending by use of funds, same layout (tables D.4.x.1.a).

For each province and type of care, the government share is D4 ÷ D1. The share counts the provincial government sector only, consistent with the US side, where federal direct programs outside Medicare and Medicaid are also left out. "Home and other health" combines CIHI's home and community care with the rest of its other health spending.

2.3 Provincial government share by type of care, 2020

Province	Hospitals	Doctors	Nursing homes & residential	Drugs	Home & other health	Dental, vision, other prof.
Ontario	84.5%	97.1%	59.7%	35.9%	68.5%	6.6%
Quebec	95.2%	96.1%	72.8%	24.9%	72.2%	18.3%
British Columbia	94.5%	96.7%	64.8%	26.8%	69.4%	4.5%
Alberta	93.7%	95.1%	52.1%	36.3%	71.7%	8.7%
Manitoba	93.0%	96.4%	68.9%	30.9%	55.8%	4.3%
Saskatchewan	91.3%	98.0%	57.3%	30.4%	66.3%	6.7%
Nova Scotia	92.1%	96.2%	59.8%	27.2%	66.3%	3.1%

Province	Hospitals	Doctors	Nursing homes & residential	Drugs	Home & other health	Dental, vision, other prof.
New Brunswick	91.6%	96.4%	56.4%	24.0%	68.6%	1.9%
Newfoundland and Labrador	92.9%	98.1%	80.7%	25.8%	87.6%	3.8%
Prince Edward Island	93.5%	98.6%	62.9%	25.4%	70.4%	3.5%

Source: CIHI National Health Expenditure Trends 2025, Series D1 and D4, 2020; shares computed from the dollar tables. The same calculation for 2019 is used in Section 8.

2.4 What the table implies for the US

- **The core is nearly uniform.** Physician shares run 95.1–98.6% and hospital shares 91.3–95.2%, except Ontario at 84.5%. In 2020, hospital and physician care made up 61.9% of US personal health spending (37.8% and 24.1%), so this core decides most of the cost.
- **The margin varies widely.** Nursing-home shares run 52.1–80.7%, drug shares 24.0–36.3%, home and other health 55.8–87.6%, and dental, vision and other professional care 1.9–18.3%. These differences separate the cheapest provincial rules (New Brunswick, Ontario) from the most generous (Quebec, Newfoundland and Labrador).
- **No province pays for everything.** Even under the most generous rules, a large part of drug, dental and long-term care spending stays private. This is the main difference between the provincial model and US single-payer proposals that cover nearly all care with no cost sharing.
- **2020 was unusual.** Public shares rose in 2020 in most provinces, most of all for hospitals (Ontario 83.0% → 84.5%, British Columbia 92.4% → 94.5%). Section 8 tests the 2019 shares.

3. Data

Every input comes from the agency that produced it. Cost inputs are for 2020, the latest year of US state-level spending data; matching inputs are the most recent available, 2021–2026.

3.1 Cost inputs

Input	Used for	Source	Year
Personal health spending by state of residence, nine types of care	Spending the province's shares are applied to	CMS, Health Expenditures by State of Residence, 1991–2020 (released August 2022): US_AGGREGATE20	2020 (2019 in Section 8)
Medicare and Medicaid spending by state	Government spending today	CMS, same release: MEDICARE_AGGREGATE20 and MEDICAID_AGGREGATE20	2020 (2019)
State population	Per-person figures	CMS, same release: US_POPULATION20 (328.8 million, 50 states)	2020 (2019)
Provincial government share by type of care	Each province's rules	CIHI, National Health Expenditure Trends 2025, Series D1 and D4	2020 (2019)
Administrative cost, US vs Canada	Paperwork savings	Himmelstein, Campbell & Woolhandler, *Annals of Internal Medicine* (2020), 2017 data	2017

The nine CMS types of care are hospital care; physician and clinical services; other professional services; dental services; prescription drugs and other non-durable products; home health care; durable medical products; nursing home care; and other health, residential and personal care. Together they are personal health care: $3,347.6 billion across the 50 states in 2020.

3.2 Matching inputs

Factor	States	Provinces
Population	Census Bureau, SCPRC-EST2025-18+POP, July 1, 2025	Statistics Canada Table 17-10-0009-01, July 1, 2026
Share aged 65+	Census Bureau sc-est2025-agesex-civ (65+) ÷ resident population, 2025	Statistics Canada population estimates by age, July 1, 2025
Rural share	Census Bureau, State-level Urban and Rural Information for the 2020 Census	Statistics Canada, 2021 Census, population outside population centres
GDP per person, % of own country	BEA SAGDP1 2025 ÷ 2025 population	Table 36-10-0221-01 (2024 GDP) ÷ Table 17-10-0009-01 (2024 population)
Population density	Population ÷ Census Bureau land area	Population ÷ 2021 Census Profile land area (98-401-X2021001)
Life expectancy	CDC/NCHS US State Life Tables, 2022	Tables 13-10-0114-01 and 13-10-0140-01 (PEI), 2021–2023
Born abroad	ACS 2024 1-year, Table DP02, foreign-born share	2021 Census Profile: immigrants plus non-permanent residents
Unemployment	BLS LAUS, 2024 annual average	Table 14-10-0327-01, 2024

Factor	States	Provinces
Political lean	2024 Republican presidential share minus 49.8% (FEC)	2025 Conservative federal share minus 41.3% (Elections Canada)
Turnout	UF Election Lab (M. McDonald), 2024 VEP turnout, v0.4	Elections Canada, 2025, ballots ÷ registered electors
Single-payer support (appetite only)	Estimated from KFF's September 2026 poll by party, applied to each state's 2024 vote	Not used

The full table of values for all 60 places is in the project data file "Part 4 Data - Matching Factors".

3.3 Definitions that differ between the countries

- **Rural:** Canada counts places of 1,000 or more people as urban; the US needs 5,000 people or 2,000 homes. US rural shares run slightly higher as a result.
- **Born abroad:** the provincial figure adds non-permanent residents to immigrants so that it matches the US foreign-born definition.
- **Unemployment:** Canada's definition runs about 1 point higher than the US definition would for the same labor market.
- **Turnout:** the US denominator is the voting-eligible population; Canada's is registered electors.
- **Income and politics:** GDP per person and political lean are measured relative to each country's own average, so the comparison is "rich for its country" and "right-leaning for its country."

Where definitions differ, the Part 4 matching compares each place both on the raw value and relative to its own national average (Section 6).

3.4 Checks on the data

- **CMS file against the figures first used.** The first runs used KFF's republication of the CMS data. The original CMS file matches it to within $17 million for every state and type of care. Medicare and Medicaid spending matches to within $4 per person, and the national extra cost differs by about $0.04 billion under every province's rules.
- **Primary sources against secondary copies.** Eleven matching inputs were first taken from secondary compilations. All were re-pulled from the producing agency. Eight matched exactly. Three changed and were re-run: state GDP per person (up to 4.4 points), state turnout (national 63.88% → 64.30%) and province GDP per person (up to 0.6 points). The national estimate moved by $0.1 billion (Section 9).
- **Provincial shares.** Recomputing the 2020 shares from the CIHI dollar tables reproduces every published share exactly.

4. The cost model

The model applies a province's government share for each type of care to a state's own spending on that care, after cutting provider administrative costs to the Canadian level. The extra government cost is the result minus what Medicare and Medicaid spend in the state today.

4.1 Formula

For state *s* under province *p*:

$$G_{s,p} = \Sigma_k \, \sigma_p[c(k)] \times S_{s,k} \times (1 - a \times 1[k \in A]), \text{ summed over the nine types of care } k$$

$$\text{Extra}_{s,p} = G_{s,p} - (\text{Medicare}_s + \text{Medicaid}_s)$$

where $S_{s,k}$ is the state's 2020 spending on type of care *k*; σ is the province's government share for the CIHI category c(k) that *k* maps to; *a* = 0.144 is the paperwork cut; and A is the set of provider types it applies to (hospital, physician and clinical, nursing home, home health). Prices and the amount of care used are held at each state's 2020 levels.

4.2 Mapping US types of care to provincial categories

CMS type of care	Share of US spending, 2020	CIHI category used	Paperwork cut applied
Hospital care	37.8%	Hospitals	Yes
Physician and clinical services	24.1%	Physicians	Yes
Prescription drugs and non-durables	12.9%	Drugs	No
Other health, residential and personal care	6.2%	Other institutions	No
Nursing home care	5.9%	Other institutions	Yes
Dental services	4.2%	Other professionals	No
Home health care	3.7%	Other health spending	Yes
Other professional services	3.5%	Other professionals	No
Durable medical products	1.6%	Other health spending	No

4.3 Paperwork savings

Himmelstein, Campbell and Woolhandler (2020) estimate that administration takes 25.6% of US provider spending and 13.1% of Canadian, using 2017 data. If non-administrative costs stay the same and administration falls to the Canadian share, provider spending falls by:

$$1 - (1 - 0.256) \div (1 - 0.131) = 0.144$$

The 14.4% cut is applied to the four provider types the study covers. It lowers total US spending by $344.6 billion and is the same under every province's rules. Insurer overhead is not part of personal health care spending, so savings from simpler insurance are outside these figures. Section 8 tests a cut of half this size.

4.4 Government spending today

Current government spending is Medicare plus Medicaid, federal and state shares combined: $1,337.2 billion in 2020, or 39.9% of personal health spending. Other public programs (the Veterans Health Administration, military health care, the Indian Health Service, and smaller federal, state and local programs) are assumed to stay in place, unchanged. The VA, military health care and the Indian Health Service serve specific populations under service and treaty obligations, and a state adopting provincial rules would not change them. Canada likewise keeps care for its armed forces, some veterans' benefits, and health benefits for First Nations and Inuit in federal programs outside the provincial plans, and the provincial shares used here exclude that federal spending. Because these programs pay the same before and after, they drop out of the extra cost. They are also left out of the government shares reported here (39.9% today, 71.4% after); counting them would raise both.

Because the provincial share applies to all spending, Medicare and Medicaid are absorbed into the provincial system rather than kept beside it. For most types of care the provincial share is higher than the share Medicare and Medicaid pay today, so public spending rises. For three it is lower: other professional services (Medicare and Medicaid pay 31.7% today; provinces pay 2–18%), dental services (10.7% today; lower under every province's rules except Quebec's) and prescription drugs (33.8% today; lower under every province's rules except Ontario's and Alberta's). In those categories the model implies less public spending than Medicare and Medicaid provide now, so it does not guarantee that every service those programs cover today stays publicly paid.

The alternative design keeps Medicare and Medicaid exactly as they are, after the same paperwork cut, and applies the provincial shares only to the spending they do not pay. With the same Part 4 chances it costs about $1,114 billion a year, or $3,389 per person: about $307 billion more than the main estimate. It is reported as a different policy design, not as a sensitivity check, and has not been run through the simulation.

4.5 Worked example: Ohio under Ontario's rules

Type of care	2020 spending ($B)	After paperwork cut ($B)	Ontario's government share	Government pays ($B)
Hospital care	48.89	41.85	84.5%	35.38
Physician and clinical	29.35	25.13	97.1%	24.40
Drugs and non-durables	13.34	13.34	35.9%	4.79
Nursing home care	9.09	7.78	59.7%	4.65

Type of care	2020 spending ($B)	After paperwork cut ($B)	Ontario's government share	Government pays ($B)
Other residential and personal care	8.16	8.16	59.7%	4.88
Dental services	4.37	4.37	6.6%	0.29
Home health care	3.96	3.39	68.5%	2.32
Other professional services	3.51	3.51	6.6%	0.23
Durable medical products	1.85	1.85	68.5%	1.27
Total	**122.52**	**109.38**	**71.5%**	**78.21**

Medicare and Medicaid pay $51.54 billion in Ohio today (42.1% of spending). The extra government cost is $78.21 billion − $51.54 billion = **$26.67 billion**, or $2,281 for each of Ohio's 11.69 million residents.

4.6 The cost grid

The same calculation for every state under every province gives a grid of 500 state-by-province costs. Every matching method in Sections 5 and 6 reads its costs from this grid; the methods differ only in which province, or which mix of provinces, each state is assigned. Across all ten provinces, the same state's extra cost varies by 13–44%, typically about 21%. Section 9 describes how the grid was checked against the published results.

5. Matching states to provinces: Parts 1–3

Three deterministic methods each give every state one province. They bracket the answer and show how much the choice of province matters before uncertainty is modeled in Part 4.

5.1 Part 1: one province's rules for every state

Part 1 first applied each province's rules to the five states closest to it in population. That view is useful province by province, but it is not a national total: it covers 29 states, some more than once. Across those groups the extra cost ran from about $2,180 per person (Alberta's states) to $4,850 (Newfoundland and Labrador's). The large provinces' states land at $2,180–2,780 and the small provinces' at $3,050–4,850, mainly because the smallest states have high spending and low current government shares.

The national bounds come from applying one province's rules to all 50 states. They run from $753.0 billion under New Brunswick's rules and $756.8 billion under Ontario's, to $903.3 billion under Quebec's and $912.4 billion under Newfoundland and Labrador's (Figure 2). Every matched estimate in this report has to fall between these bounds, and all of them sit near the middle.

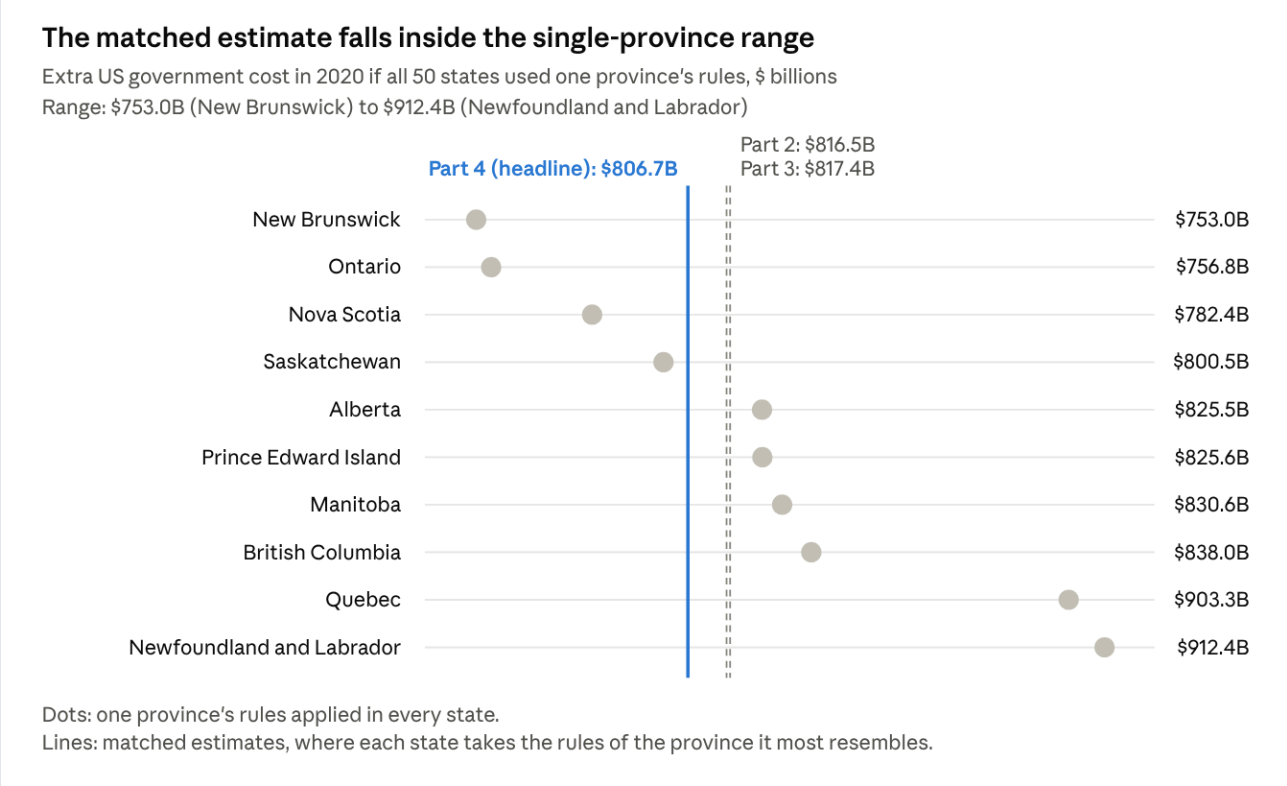


Figure 2 · National extra cost under each province's rules · State x Province Cost Grid and Parts 2–4 results, 2020 dollars

The headline sits $53.7 billion above the lowest bound and $105.7 billion below the highest. The three matching methods differ from one another by at most $10.7 billion, while the single-province bounds are $159.4 billion apart, so the choice of matching method matters far less than the spread between provinces.

5.2 Part 2: closest province by population

Each state is assigned the province nearest to it in population (Statistics Canada July 1, 2026 estimates; Census Bureau July 1, 2025 estimates). Saskatchewan and Prince Edward Island are never the nearest, so their rules are not used.

Province	States	People	Government pays now	Extra government cost	Per person
Ontario	6	135.2M	41.1%	$303.6B	$2,250
Quebec	8	75.6M	38.8%	$205.1B	$2,710
British Columbia	9	55.3M	39.0%	$149.2B	$2,700
Manitoba	12	27.0M	39.4%	$67.1B	$2,490
Alberta	7	29.1M	41.3%	$66.1B	$2,270
New Brunswick	3	2.4M	28.6%	$10.9B	$4,560
Nova Scotia	3	3.1M	38.2%	$9.2B	$2,950
Newfoundland and Labrador	2	1.2M	32.7%	$5.2B	$4,350
United States	**50**	**328.8M**	**39.9%**	**$816.5B**	**$2,480**

Population alone is a crude match. Ontario, at 16.3 million, has no state within 3 million people, and Prince Edward Island, at 183,000, is less than a third the size of Wyoming.

5.3 Part 3: closest province on four factors

Part 3 matches on population (log scale), share aged 65 and older, rural share, and GDP per person relative to the country's average. Each factor is standardized across all 60 places (z-scores with the population standard deviation), and the match score is the straight-line distance:

> $d_{s,p} = \sqrt{[\ \Sigma\ (z_s - z_p)^2\ ]}$, summed over the four factors

Each state takes the province with the smallest *d*. Scores under 1 indicate a close match and over 2 a loose one.

Province	States	People	Government pays now	Extra government cost	Per person
Ontario	9	132.0M	39.2%	$299.6B	$2,270
Quebec	9	85.0M	41.4%	$217.1B	$2,550
Alberta	3	30.3M	40.5%	$85.5B	$2,820
Manitoba	8	34.5M	41.7%	$78.6B	$2,280
British Columbia	6	21.7M	37.9%	$67.2B	$3,100
Nova Scotia	8	17.1M	39.1%	$41.0B	$2,400
Saskatchewan	4	4.4M	32.1%	$17.0B	$3,840
New Brunswick	3	3.8M	39.2%	$11.3B	$3,010
United States	**50**	**328.8M**	**39.9%**	**$817.4B**	**$2,490**

- **National total:** $817.4 billion, within $1 billion of Part 2 despite assigning many states differently.
- **Close calls:** 11 states are within 0.1 of their runner-up province. Moving all 11 to the runner-up gives $822.0 billion.
- **Province by province:** applying each province's rules to its five closest states on these factors gives $2,440 (Manitoba) to $3,820 (Prince Edward Island) per person. That range is narrower than Part 1's, because matching on age, rural share and income pairs provinces with more similar states.

5.4 Why a single assignment is not enough

The deterministic methods agree on the national total but disagree on individual states. Twenty-nine states have a different most likely province in Part 4 than their Part 3 match. Many states sit almost equally close to two or three provinces, and a rule that gives each state exactly one province turns a near-tie into an all-or-nothing choice. Part 4 replaces that choice with chances.

6. Probabilistic assignment: Part 4

Part 4 gives each state a chance of adopting each province's system, based on how similar they are on ten factors, and a small chance of keeping its current system, based on its appetite for change. The expected cost is the chance-weighted average of the cost grid; a 10,000-run simulation gives its range.

6.1 Similarity on ten factors

The ten factors are population, population density, share aged 65 and older, rural share, GDP per person, political lean, life expectancy, share born abroad, unemployment and turnout. Population and density are compared on a log scale, so the comparison is between ratios. GDP per person and political lean are already measured against each country's own average.

Four factors are measured on definitions that differ between the countries (Section 3.3) or sit at different national levels: life expectancy, born abroad, unemployment and turnout. Each enters twice at half weight: once as the raw value, and once as the gap from the place's own national average. A Florida-like state is thus compared with provinces both on its share born abroad (23.1%) and on how far that is above the US average of 14.8%.

Reference value	Canada	United States
Life expectancy (years)	81.43 (2021–2023)	77.5 (2022)
Born abroad (%)	25.6 (2021)	14.8 (2024)
Unemployment (%)	6.3 (2024)	4.0 (2024)
Turnout (%)	69.0 (registered electors, 2025)	64.30 (eligible voters, 2024)
Right-party vote share (%)	41.3 (Conservative, 2025)	49.8 (Republican, 2024)

Every term is standardized across all 60 places (z-scores, population standard deviation), and the distance between state *s* and province *p* is:

$$d_{s,p} = \sqrt{\left[\Sigma\, w \times (z_s - z_p)^2 \right]},\ \text{summed over all terms, with weight } w = 1 \text{ or } \tfrac{1}{2}$$

The weights add to 10, so each of the ten factors counts equally. Geography is deliberately left out: a state is not matched to a province because they share a border.

6.2 From distances to chances

Each state's distances are turned into chances with a softmax on how much farther each province is than the closest one:

$$P(p \mid s) = \exp[-(d_{s,p} - d_{s,\min}) \div \tau] \div \Sigma \exp[-(d_{s,q} - d_{s,\min}) \div \tau],\ \text{summed over all ten provinces } q;\ \tau = 0.43$$

The sharpness $\tau = 0.43$ gives the closest province about a 50% chance in a typical state, ranging from 25.5% (Colorado) to 91% (North Dakota). Two alternative settings test the choice: a sharper $\tau = 0.215$, which concentrates the chance on the closest province, and a flatter $\tau = 0.86$, which spreads it more evenly. These are chances given that the state switches; Section 6.3 adds the chance of not switching.

6.3 The chance of keeping the current system

A state may choose not to adopt any provincial model. Part 4 gives every state a small chance of keeping its current system, scaled by an appetite index built from six inputs, each standardized across the 50 states:

Input	Pushes toward switching when	Assumed reasoning
Politics	support for single-payer is higher and the state leans less Republican	The two are averaged into one input, because they move together exactly
Unemployment	higher	More people without job-based coverage
Life expectancy	lower	Worse population health
Share aged 65+	higher	More people already on public coverage
Rural share	higher	Thinner private provider and insurance markets
Share born abroad	higher	More residents familiar with public systems

The directions are modeling assumptions, not measured effects. Single-payer support by state is not polled, so it is estimated from KFF's September 2026 poll by party (84% of Democrats, 72% of independents and 34% of Republicans in favor; 66% overall), applied to each state's 2024 Republican presidential share *T* and calibrated to the national figure:

> $\text{Support}_s = 84 \times (1 - T_s) + 34 \times T_s + 6.9$

The six inputs are averaged with equal weight and rescaled so the least inclined state scores 0 and the most inclined 100. The chance of keeping the current system is:

> $k_s = 0.1\% \times (1 - \tfrac{1}{2} \times A_s \div 100)$

This gives 0.100% for Utah (appetite 0) and 0.050% for Maine (appetite 100). The chance is kept small on purpose: it represents a holdout, not a forecast of state politics, and it lowers the expected national cost by only about $0.5 billion.

6.4 Expected cost and simulation

The probability that state *s* adopts province *p* is $P(p \mid s)(1 - k_s)$, and keeping the current system adds no cost. The expected national extra cost is computed exactly:

> $E[C] = \Sigma_s \, \Sigma_p \, P(p \mid s) \times (1 - k_s) \times \text{Extra}_{s,p}$

To see the spread around that expectation, each of 10,000 simulated runs draws, independently for every state, either one province or "keep current system" from these probabilities, and adds up the costs. The runs use a fixed random seed (2026), so they can be reproduced exactly. The 5th and 95th percentiles of the 10,000 national totals give the middle 90% range.

6.5 Tests of the design

- **Sharpness:** the sharper setting gives $803.0 billion and the flatter $812.1 billion, against $806.7 billion in the main setting.
- **Dropping factors:** without population density the expected cost is $816.7 billion; without political lean, $814.5 billion; with only Part 3's four factors, $819.1 billion. Density and lean pull many states toward Manitoba, Nova Scotia and Saskatchewan, whose rules cost less than Quebec's.
- **Most likely province only:** giving every state its single most likely province costs $804.2 billion.
- **Politics counted once:** single-payer support and political lean were first entered as two inputs to the appetite score. Because they move together exactly (correlation −1.0), politics was being counted twice; merging them changed the national cost by $0.01 billion.

7. Results

The expected extra government cost is $806.7 billion a year in 2020 dollars, $2,454 per person, with 90% of simulated runs between $792.2 billion and $822.3 billion.

7.1 National estimate

Estimate	Expected extra cost	Middle 90% of runs	Lowest / highest run
Part 4, main setting (headline)	**$806.7B**	**$792.2B – $822.3B**	$713.1B / $849.3B
Part 4, sharper chances (τ = 0.215)	$803.0B	$791.7B – $815.2B	$704.7B / $834.2B
Part 4, flatter chances (τ = 0.86)	$812.1B	$794.9B – $830.4B	$719.3B / $855.0B
Part 4, most likely province only	$804.2B	—	—
Part 3, four-factor match	$817.4B	—	—
Part 3, close calls moved to runner-up	$822.0B	—	—
Part 2, population match	$816.5B	—	—

- **The matched estimates agree within about $18 billion**, or 2%, from $804.2 billion to $822.0 billion.
- **The simulated average** over the 10,000 runs is $806.5 billion, within $0.2 billion of the exact expectation.
- **The lowest runs** are the rare ones in which a large state keeps its current system. In the lowest run ($713.1 billion), California kept its current system. About 341 state-level "keep" draws are expected per 10,000 runs (337 occurred).

7.2 Who pays, before and after

Payer	2020 today	Under the provincial rules (expected)	Change
Government (Medicare + Medicaid today)	$1,337.2B (39.9%)	$2,143.9B (71.4%)	+$806.7B
Everyone else (employers, households, private insurance, other programs)	$2,010.4B (60.1%)	$859.2B (28.6%)	−$1,151.3B
Total personal health spending	**$3,347.6B**	**$3,003.0B**	**−$344.6B**

The extra government cost is smaller than the drop in private spending, because the paperwork savings lower total spending. In effect, $1.15 trillion of premiums, out-of-pocket payments and other private spending is replaced by $807 billion of additional government spending. Spending by the VA, military health care and the Indian Health Service is in the "everyone else" row in both columns and does not change.

7.3 Which provincial models the states follow

Province	Most likely model for (states)	Expected number of states	Expected population covered	Expected extra cost under its rules
Ontario	8	6.8	103.4M	$242.1B
British Columbia	3	5.8	51.7M	$135.4B
Manitoba	14	11.5	55.0M	$129.5B
Quebec	8	5.9	37.5M	$107.6B
Nova Scotia	10	9.0	40.2M	$92.5B
Saskatchewan	5	5.7	14.0M	$37.5B
Alberta	0	1.2	12.9M	$30.7B
New Brunswick	2	3.8	12.9M	$28.5B
Prince Edward Island	0	0.3	1.0M	$2.5B
Newfoundland and Labrador	0	0.0	0.1M	$0.3B
Total	**50**	**50.0**	**328.8M**	**$806.7B**

- **Manitoba** is the most likely model for 14 states, mostly in the South and the interior, from Oklahoma and Kansas (73% each) down to Kentucky (36%).
- **Ontario** carries the most cost because it is the likeliest model for the most populous states: California (86%), New Jersey (76%), New York (60%), Illinois (59%) and Texas (50%).
- **Newfoundland and Labrador** is the least likely model in 44 states. It is an outlier on several factors at once: the highest unemployment (10.0%), the oldest population (25.2% aged 65+), the lowest share born abroad (3.9%) and very low density.
- **Alberta** is never the most likely model. Its strong right lean relative to Canada matches only the most right-leaning states, which sit closer to Saskatchewan on the other factors.

7.4 Variation across states

The expected extra cost per person varies fourfold, from $1,311 in New Mexico to $5,242 in South Dakota; the median state is at $2,612. Two numbers explain almost all of the variation: how much a state spends per person, and how much of that Medicare and Medicaid already pay. A linear fit across the 50 states gives:

> Extra per person ≈ 3,996 + 290.6 × spending per person ($000) − 111.8 × government share today (%), $R^2 = 0.956$

Each additional $1,000 of spending per person adds about $291 of extra cost, and each point of current government share removes about $112. Which province a state follows matters far less than these two facts about the state.

- **Highest per person:** South Dakota ($5,242), Alaska ($5,159), Wyoming ($4,182), North Dakota ($3,762), New Hampshire ($3,714), Massachusetts ($3,701). These states spend heavily and Medicare and Medicaid pay 25–37% today.
- **Lowest per person:** New Mexico ($1,311), Arkansas ($1,517), Mississippi ($1,798), South Carolina ($1,825), Arizona ($1,834), Louisiana ($1,843). Medicare and Medicaid already pay 42–51% in these states.
- **Largest in total:** California ($85.9B), Texas ($60.8B), New York ($56.1B) and Florida ($49.9B) together account for 31% of the national cost; the ten largest states account for 52%.

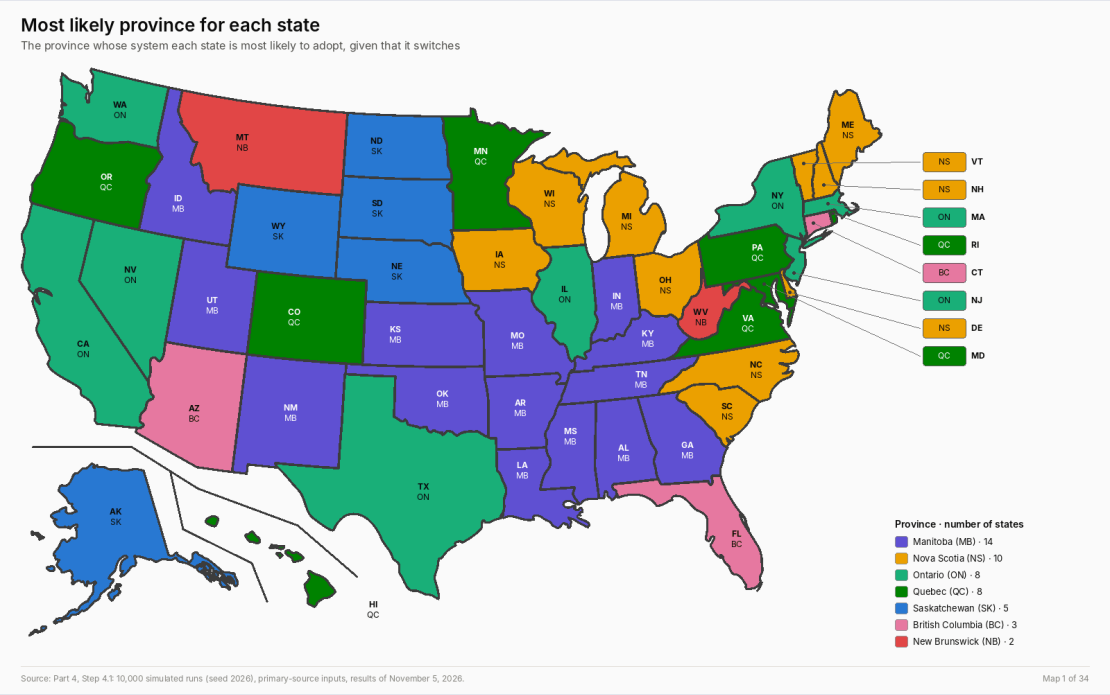
7.5 How uncertain each state is

The spread of a state's cost across runs depends on how evenly its chances are split between provinces with different rules. For New Mexico, the middle 90% of runs spans 32% of its expected cost; for Alaska, 2%. Most of the national uncertainty comes from the large states with split chances, such as Florida (British Columbia 46%, Ontario 43%) and New York (Ontario 60%, British Columbia 28%).

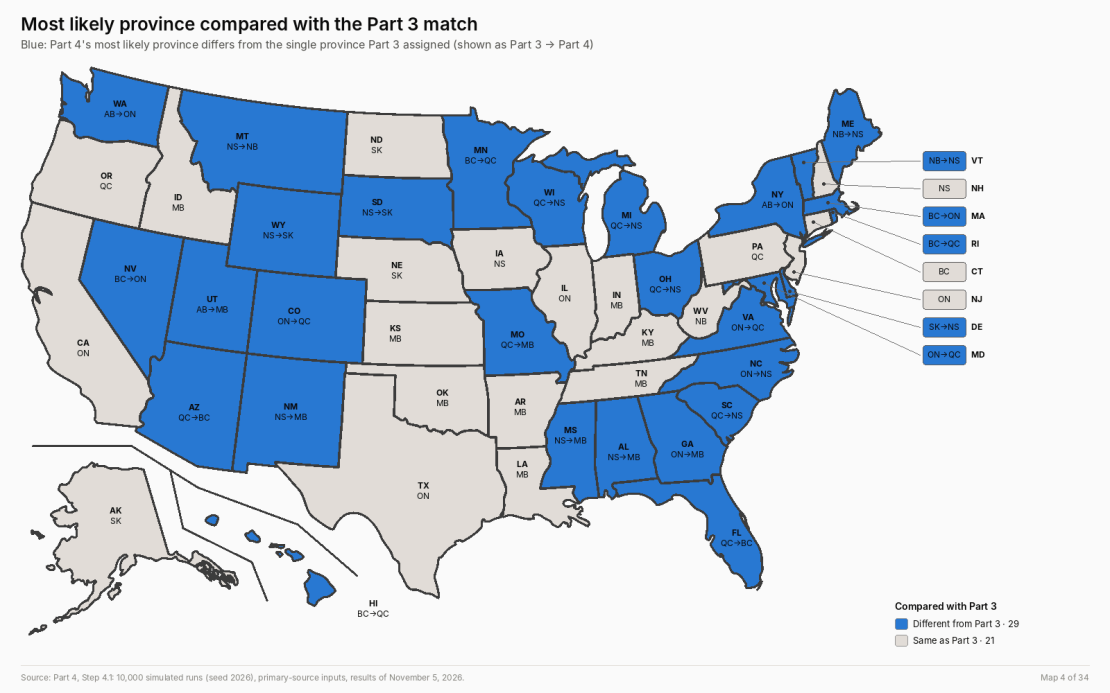
7.6 Key maps

The eight maps below carry the main results; the remaining 26 are in Appendix B. All maps use the November 5, 2026 results.

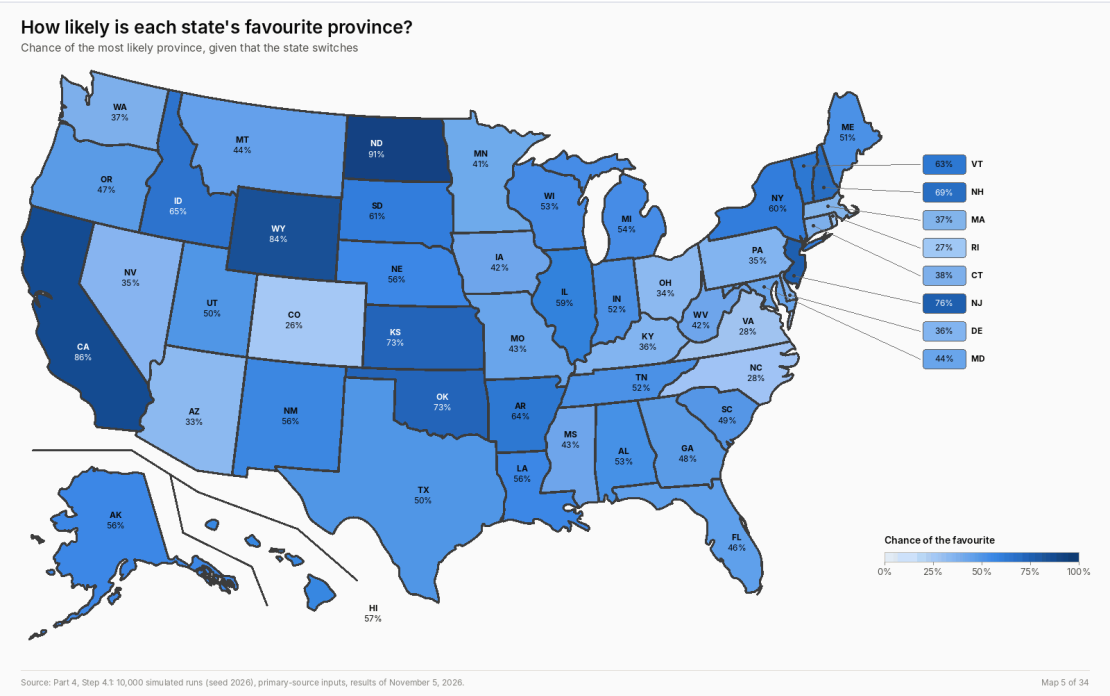
Map 1. Most likely province for each state. Manitoba in 14 states, Nova Scotia 10, Ontario 8, Quebec 8, Saskatchewan 5, British Columbia 3, New Brunswick 2.



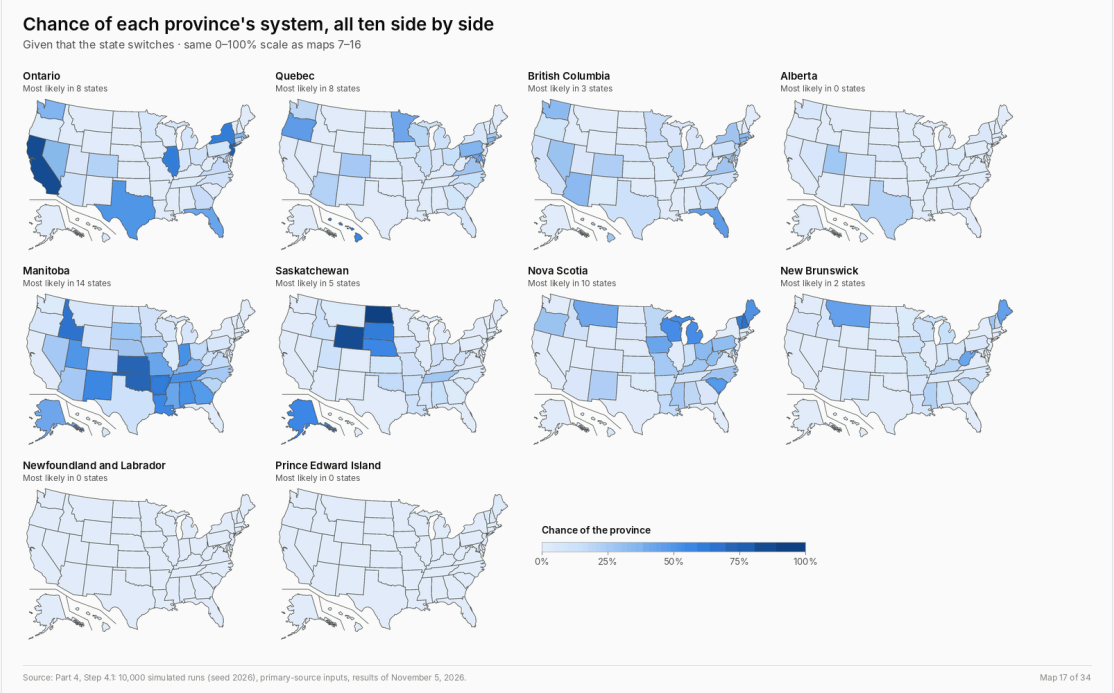
Map 4. Most likely province compared with the Part 3 match. 29 states differ.



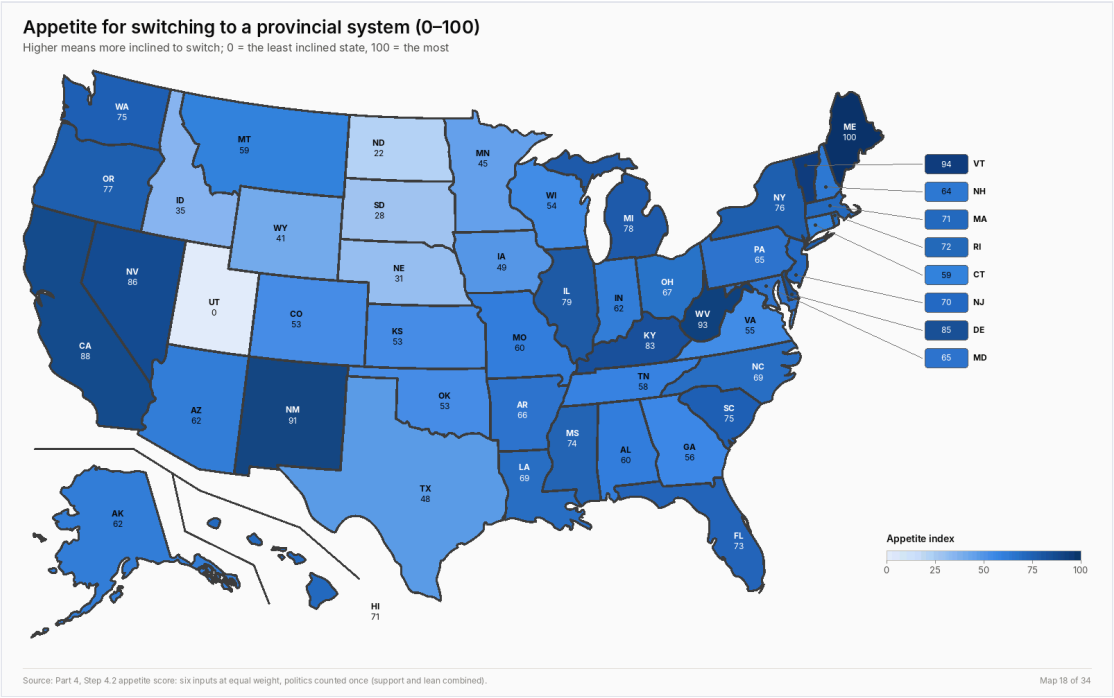
Map 5. Chance of the favourite province. From 25.5% in Colorado to 91% in North Dakota.



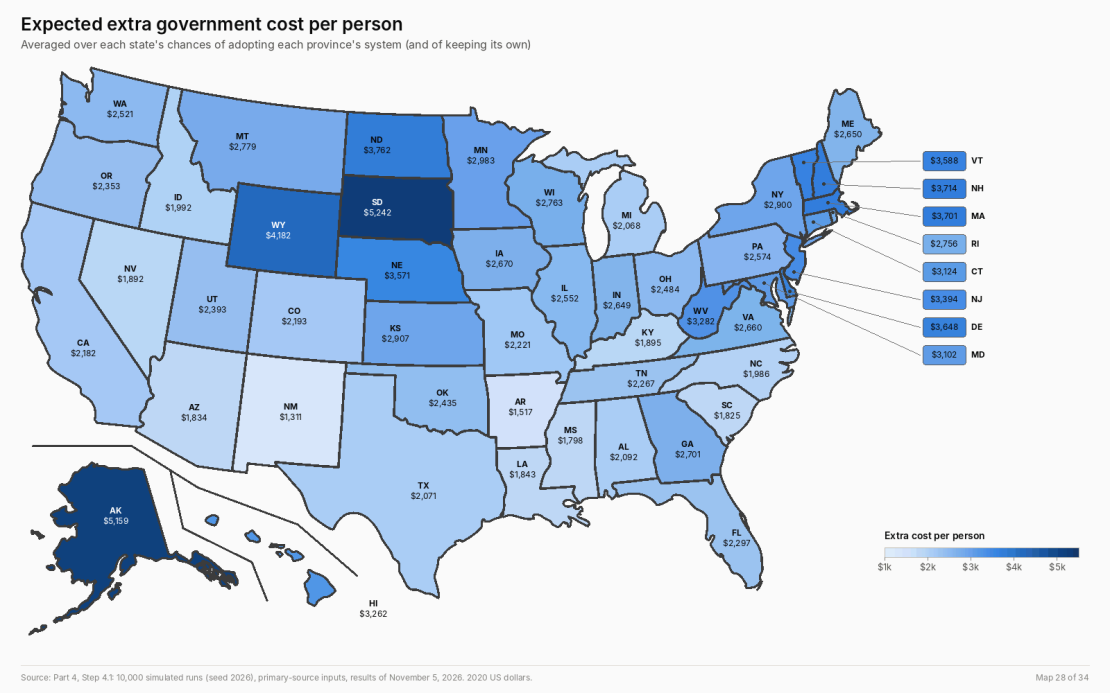
Map 17. Chance of each province, all ten side by side. Manitoba and Nova Scotia spread widest; Newfoundland and Labrador and Prince Edward Island barely register.



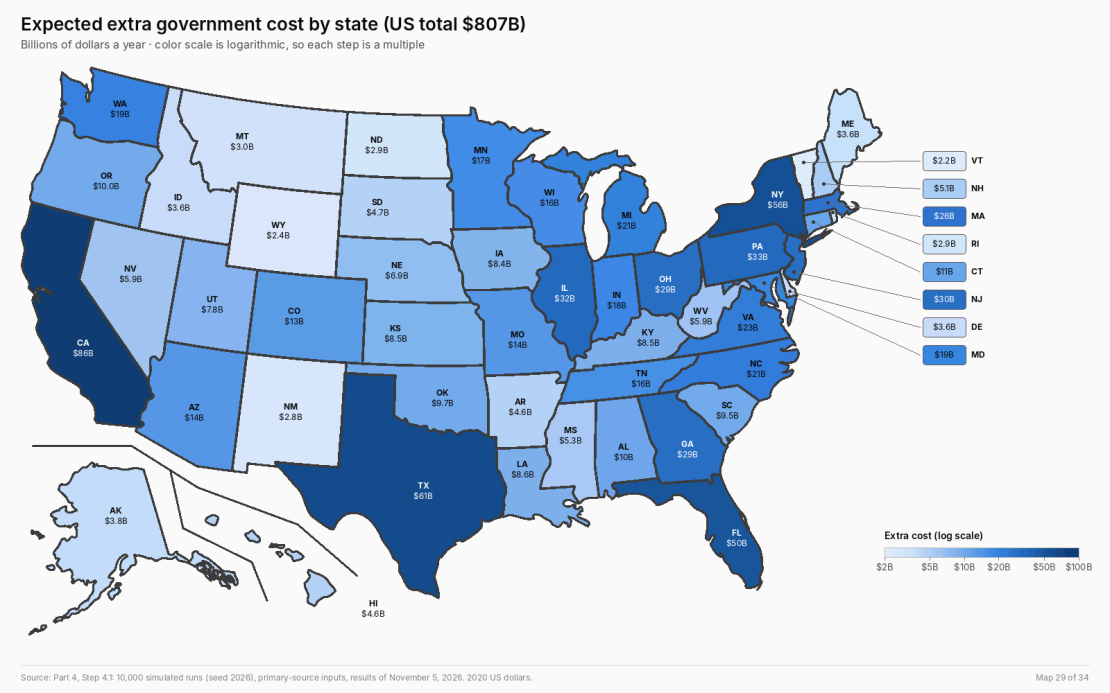
Map 18. Appetite for switching (0–100). Maine 100, Vermont 94, West Virginia 93; Utah 0, North Dakota 22.



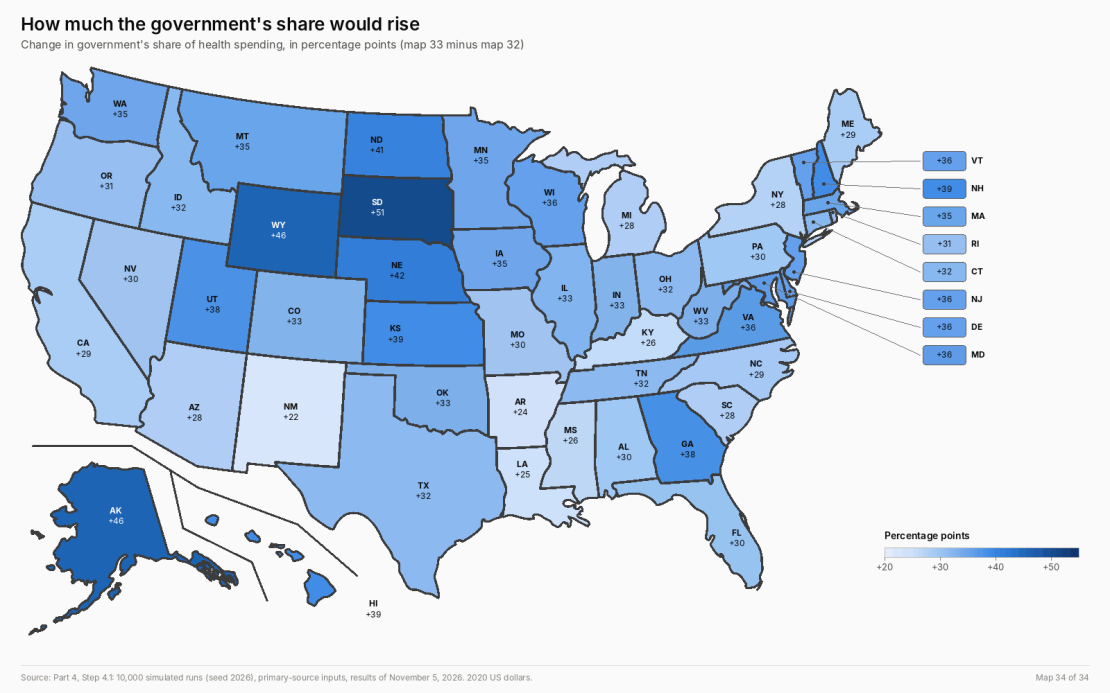
Map 28. Expected extra government cost per person. From $1,311 in New Mexico to $5,242 in South Dakota.



Map 29. Expected extra government cost by state. California $86B, Texas $61B, New York $56B, Florida $50B.



Map 34. Rise in government's share of health spending. From +22 points in New Mexico to +51 in South Dakota.



8. Sensitivity analysis

Four checks each change one assumption and hold everything else at the main setting. They move the estimate far more than the matching method does: from about $725 billion to $1,064 billion.

8.1 Summary

Check	Part 4 expected	Middle 90% of runs	Per person	Change	Part 3	Part 2
Main setting (2020, 2020 dollars)	**$806.7B**	$792.2B – $822.3B	$2,454	—	$817.4B	$816.5B
Half the paperwork savings (7.2% cut)	$960.3B	$944.5B – $977.1B	$2,921	+$153.6B (+19%)	$971.1B	$970.0B
2019 data, in 2020 dollars	$724.7B	$710.2B – $741.1B	$2,212	−$82.0B (−10%)	$741.4B	$735.6B
2025 prices	$909.4B	$893.0B – $926.9B	$2,766	+$102.7B (+13%)	$921.4B	$920.4B
More use of care: low end (1.9%)	$854.0B	$839.4B – $869.6B	$2,597	+$47.3B (+6%)	$864.8B	$863.9B
More use of care: main (CBO, 7%)	**$956.7B**	$941.2B – $973.4B	$2,910	+$150.0B (+19%)	$968.2B	$967.3B
More use of care: median of studies (8.0%)	$978.9B	$963.3B – $995.8B	$2,978	+$172.2B (+21%)	$990.5B	$989.6B
More use of care: highest (12%)	$1,063.9B	$1,047.5B – $1,081.4B	$3,236	+$257.2B (+32%)	$1,075.9B	$1,074.9B

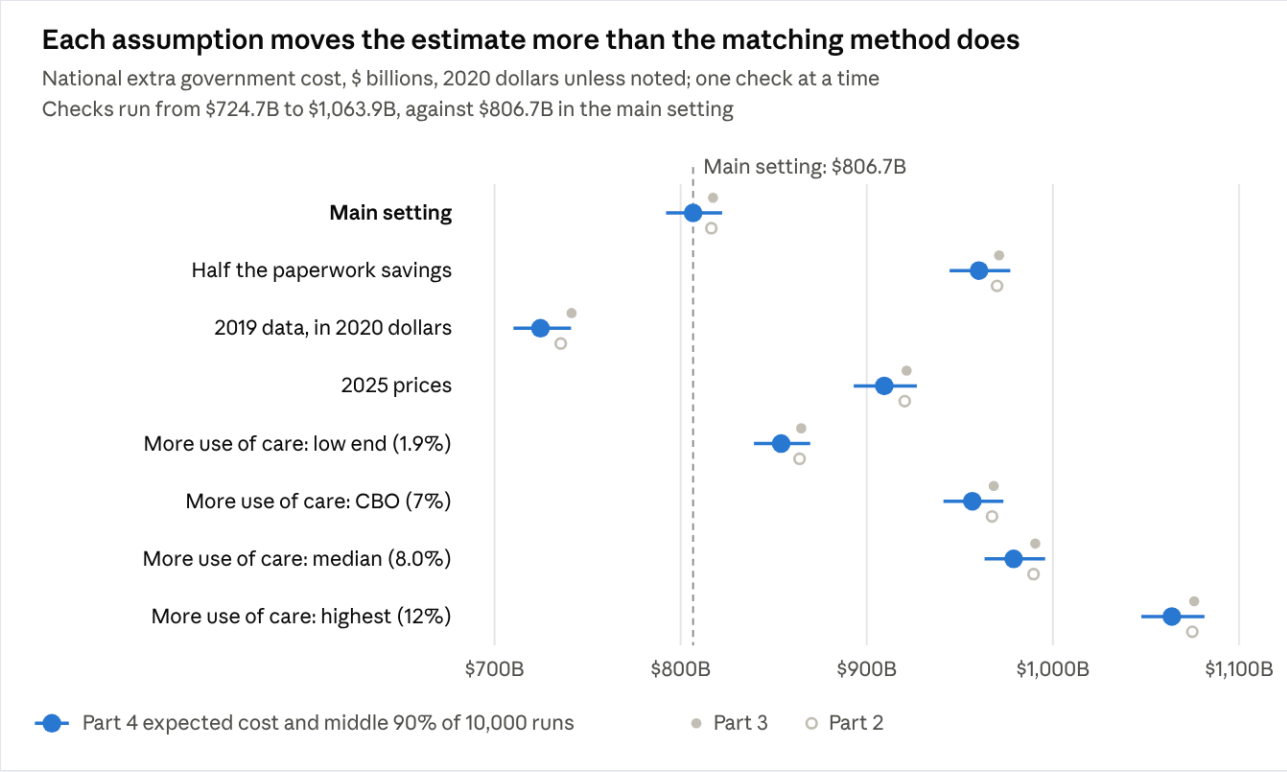


Figure 3 · Sensitivity checks, one at a time · Sensitivity Checks - Results (project data)

- **What matters most:** the size of the paperwork savings and the amount of extra care used, about $150 billion each at their main settings; then the price level, about $100 billion; then the data year, about –$80 billion.
- **What matters least:** the matching method. In every check, Parts 2, 3 and 4 stay within about $17 billion of each other.
- **Method:** the checks reuse the same Part 4 chances and the same 10,000 simulated runs, so their ranges are directly comparable. They were run one at a time and not combined.

8.2 Smaller paperwork savings

The main setting assumes US provider administration falls all the way to the Canadian share. Halving the cut to 7.2% lowers paperwork savings from $344.6 billion to $172.3 billion and raises the extra cost to $960.3 billion. Almost all of the lost savings, $153.6 billion of $172.3 billion, comes back as government cost, because provincial governments pay 85–99% of hospital and physician care.

8.3 The 2019 data year

The main estimate uses 2020, a pandemic year. Re-running every state with CMS 2019 spending and every province with its 2019 CIHI shares gives $709.6 billion in 2019 dollars ($2,166 per person), or $724.7 billion in 2020 dollars, 10% below the main setting. Before the restatement in 2020 dollars, the $97.1 billion gap splits into two parts:

- **US spending, about −$80 billion:** 2019 US spending with 2020 provincial shares gives $726.7 billion in 2019 dollars. Between 2019 and 2020, total personal health spending rose 5.8% while Medicare and Medicaid rose 3.3%; spending by everyone else rose 7.4%. The model expects the provincial rules to pay for most of that faster-growing remainder.
- **Provincial shares, about −$18 billion:** 2020 US spending with 2019 provincial shares gives $788.6 billion. Provincial governments' shares rose in 2020, most of all for hospitals.

The two parts add to about $98 billion, close to the gap. Restating the 2019 result in 2020 dollars adds back $15.1 billion, which leaves the net $82.0 billion. Both effects point the same way, so the 2020 main estimate is likely somewhat inflated by the pandemic year.

8.4 Today's dollars

The main estimate is restated in 2025 prices with the Bureau of Economic Analysis price index for personal consumption expenditures on health (FRED series DHLTRG3A086NBEA, 2017 = 100): 105.442 in 2020 and 118.864 in 2025, a 12.7% rise. This index covers health goods as well as services, matching the model's mix of spending. The result is $909.4 billion ($2,766 per person); the services-only index would give $917.5 billion. The conversion adjusts prices only. It does not add growth in population or in the amount of care used since 2020, which would require state spending data for 2025.

8.5 More use of care once covered

When care becomes free or cheaper at the point of use, people use more of it. The main setting holds use fixed. This check adds the increase in care actually provided, as estimated by five published US studies, applies it to spending after the paperwork cut, and lets government pay its provincial share of the extra care.

Study	What it found or assumed	Increase in care used	Part 4 result
Gaffney, Himmelstein, Woolhandler & Kahn, *Health Affairs* (2021)	Review of past coverage expansions: ambulatory visits +7–10%, hospital use +0–3%	1.9% (low ends); 2.9% (midpoints)	$854.0B; $878.8B
Congressional Budget Office, Working Paper 2020-08, Option 4	Care supplied +7% (demand +12%; the rest unmet), with payment rates above Medicare's, no cost sharing for medical services and long-term care unchanged	7.0%	$956.7B
RAND, Liu & Eibner (2019)	Half of new demand unmet: total spending $3.89T with the limit vs $4.20T without, against $3.82T under current law (care delivered derived from these totals)	8.0%	$978.9B
Mercatus Center, Blahous (2018)	Added demand of $435B in 2022 against $3,859B projected personal health spending	11.3%	$1,048.3B
PERI, Pollin et al. (2018)	High-end assumption: overall use +12%	12.0%	$1,063.9B

- **Main estimate: CBO, 7%.** CBO's Option 4 is the closest match to this model: no cost sharing for medical services, payment rates above Medicare's (this model keeps prices at state levels), and no new long-term-care benefit. It is also the only nonpartisan government estimate in the set.

- **Low end:** Gaffney et al.'s lower bounds (ambulatory +7%, hospital +0%) applied to physician and other professional services and hospital care, with other care unchanged. This equals 1.9% of all spending.
- **Median: 8.0%**, the middle of the five studies, with Gaffney et al. at their midpoints. With five estimates the median is RAND's figure.
- **Not included:** the Urban Institute's 2019 single-payer estimates, whose published summary gives the overall change in spending but no separate figure for increased use.
- **Caveat:** these studies model Medicare for All, which covers more than Canada's provinces do (drugs, dental, vision and often long-term care) with little or no cost sharing. Under provincial rules much of drug and dental spending stays private, so use would likely rise less, and these figures lean high. Applying one percentage to every type of care partly offsets this, since government pays only 2–36% of drug and dental care.

8.6 Reading the range

The one-at-a-time checks give a range of about $725 billion to $1,064 billion around the $806.7 billion main estimate. The main setting sits toward the low end of that range, because it assumes the full administrative savings and no increase in the use of care. The checks were not combined; a scenario that combined smaller savings with more use, in 2025 prices, would lie above the top of the range.

9. Validation and reproducibility

Every step of the analysis has been rebuilt in code and checked against the published results, and every input has been confirmed against its primary source. The checks below are what a reader would need to reproduce the estimate.

9.1 Reproduction tests

The original analysis code was not kept, so each step was rebuilt and tested against the published figures before any input was changed.

Step	Test	Result
Provincial shares	Recompute the 2020 shares from CIHI D1 and D4 dollar tables	All published shares reproduced exactly
Cost grid	Recompute 500 state-by-province costs	Every cell within $0.001B
Published state results	148 state-by-province figures from Parts 1–3	Government spending and extra cost within $0.05B; per person within $6
Part 2 and Part 3 totals	Recompute national totals from the published groupings	$816.5B and $818.9B (original inputs), exact
Part 3 match	Recompute match scores on the original inputs	Scores within 0.04; same closest province for 48 of 50 states (Tennessee and Indiana were within 0.01 of a tie and tipped the other way)
Appetite index	Recompute on the original inputs	45 of 50 states exact, the rest within 1 point
Part 4 chances	Recompute 500 state-by-province chances	Every chance within 0.9 percentage points
Part 4 expected cost	Recompute on the original inputs	$806.9B vs $806.8B published
Part 4 design tests	Drop density, drop lean, Part 3 factors only	$816.9B, $814.6B, $818.9B vs $816.8B, $814.5B, $818.7B published
Simulation	Compare simulated frequencies and average with exact chances	Average within $0.2B of the exact expectation

9.2 Effect of moving every input to its primary source

After the reproduction tests passed, the three matching inputs that changed on primary-source checking (state GDP per person, state turnout and province GDP per person) were swapped in and Parts 3 and 4 re-run.

- **Part 3:** $818.9 billion → $817.4 billion. Iowa, Delaware and South Dakota change province; all three were close calls.
- **Part 4:** $806.8 billion → $806.7 billion. Only Rhode Island's most likely province changes, from Nova Scotia to Quebec, a near-tie. No province chance moves by more than 9 points, and no state's expected cost per person by more than $11.

9.3 Reproducing the estimate

- **Data:** every input table is held in the project as CSV: the CMS 2019–2020 extract, the state spending inputs, the matching factors, the 500-cell cost grid and the 50-state results.
- **Code:** Python 3 with numpy, pandas, scipy and Pillow, documented in three project files: "Part 4 Code - Rebuilt Scripts" (cost grid, matching, appetite score, simulation), "Sensitivity Checks - Code" and "Part 4 Code - Map Drawing".
- **Random seed:** 2026 (numpy default_rng), 10,000 runs. The expected cost does not depend on the seed; only the simulated range does.
- **Order of operations:** build the cost grid; compute the matching factors' z-scores; compute distances and chances; compute the appetite index and keep chances; compute the expected cost; run the simulation; run the sensitivity checks.

10. Limitations

The estimate is a transparent accounting projection, and its limits follow from that design. The most important are listed first.

10.1 What the model holds fixed

1. **Prices and payment rates.** Each state keeps its 2020 prices. Provinces pay hospitals mostly through global budgets and physicians through negotiated fee schedules, and a US state adopting provincial rules might change what it pays providers. That could lower costs (lower rates) or raise them (rates set to keep providers in the system). Neither is modeled.
2. **The amount of care used.** The main setting holds use fixed. Section 8.5 shows that published estimates of increased use add $47–257 billion.
3. **Provider supply.** The model assumes the care demanded is delivered. CBO and RAND both find that part of the added demand under universal coverage would go unmet, which would hold spending down but lengthen waits.
4. **The public–private split itself.** The provincial shares are applied as they are measured in Canada. They reflect Canadian prices, use and population health as well as policy, and applying them to US spending assumes the same split would hold at US prices.

10.2 What the model leaves out

5. **Other public programs.** The Veterans Health Administration, military health care, the Indian Health Service and smaller public programs are assumed to stay as they are, as their Canadian counterparts sit outside the provincial plans. A broader reform that folded them into the new system would offset part of the new cost with their current spending, and the extra cost would be lower, most in Alaska, the Dakotas and Montana.
6. **Insurer overhead.** Savings from replacing private insurance administration are not counted, because insurer overhead is outside personal health care spending. Including them would lower total spending further, though not necessarily the government's share.
7. **Transition and financing.** The analysis does not model a transition period, the split of costs between federal and state governments, the taxes or premiums that would finance the shift, or effects on wages and employment.
8. **The District of Columbia and the territories** are not included.

10.3 Data and definitions

9. **Different data years.** Spending and provincial shares are for 2020, a pandemic year; the 2019 check (Section 8.3) suggests 2020 inflates the estimate by about 10%. Matching factors are from 2021–2026.
10. **Definitions that differ between countries.** Rural, born abroad, unemployment and turnout are measured differently in the US and Canada (Section 3.3). The Part 4 matching compares each place against its own national average as well as on raw values, but the adjustment is approximate.

11. **Category mapping.** The nine US types of care map onto six CIHI categories. Dental and other professional services share one provincial share, as do home health and durable products, and nursing homes and other residential care.
12. **Estimated single-payer support.** No state-by-state polling exists. Support is estimated from a national poll by party and enters only the appetite score, which changes the national cost by less than $1 billion.

10.4 What the matching represents

13. **A modeling device, not a political forecast.** The chances describe which provincial model a state most resembles, not what its legislature would choose. The ten factors are weighted equally by assumption, and geography is excluded on purpose. Section 6.5 shows that dropping factors or changing the sharpness moves the national cost by at most about $12 billion.
14. **Use-of-care estimates from a different policy.** The studies in Section 8.5 model Medicare for All, which covers more than Canada's provinces do, so they likely overstate the increase in use under provincial rules.

11. Conclusion

If each US state financed health care the way its most similar Canadian province does, US government health spending would rise by about $807 billion a year in 2020 dollars, or $2,454 per person. Government's share of personal health spending would rise from 40% to 71%, total spending would fall by $345 billion through lower administrative costs, and employers, households and private insurers would pay about $1.15 trillion less.

The four research questions have clear answers:

1. **Size.** The central estimate is $806.7 billion, with a simulated 90% range of $792.2 billion to $822.3 billion.
2. **Robustness to matching.** The matched estimates agree within about 2%, from $804.2 billion to $822.0 billion, whichever method pairs states with provinces. The provincial rules themselves set wider bounds, from $753.0 billion (New Brunswick) to $912.4 billion (Newfoundland and Labrador), and the matched estimates sit in the middle.
3. **Distribution.** The cost per person ranges fourfold across states, from $1,311 in New Mexico to $5,242 in South Dakota. A state's own spending level and the share Medicare and Medicaid already pay explain 96% of that variation; which province it follows matters much less.
4. **Robustness to assumptions.** The estimate is far more sensitive to assumptions than to matching. One-at-a-time checks give about $725 billion to $1,064 billion. The two assumptions that matter most are how much administrative cost a US system would actually save and how much more care people would use once covered; each moves the estimate by about $150 billion at its central setting.

One feature of the provincial model stands out. No province pays for everything: even under the most generous rules, a large part of drug, dental and long-term care spending stays with households, employers and private insurers, and 28.6% of US spending would remain non-governmental. The provincial model is therefore a distinct and narrower design than single-payer proposals that cover nearly all care with no cost sharing, and estimates of one should not be read as estimates of the other.

Further work that would sharpen the estimate:

- re-running with state spending for a recent year once it is available, rather than restating 2020 in today's prices;
- pricing a broader reform that also folds the Veterans Health Administration, military health care and the Indian Health Service into the new system;
- modeling provider payment rates and supply explicitly, rather than holding prices and use fixed;
- combining the sensitivity checks into joint low and high scenarios;
- splitting the extra cost between federal and state governments and examining how it would be financed.

Appendix A. Results for all 50 states

States are listed by population, largest first. Province chances are given that the state switches; the expected extra cost includes each state's small chance of keeping its current system. Costs are in 2020 dollars.

State	Most likely province	Second most likely	Part 3 match	Expected extra cost	Per person	Middle 90% of runs	Government share now → after
California	Ontario (86%)	British Columbia (11%)	Ontario	$85.9B	$2,182	$84.4B – $94.9B	42.9% → 71.6%
Texas	Ontario (50%)	Alberta (22%)	Ontario	$60.8B	$2,071	$58.4B – $63.7B	38.7% → 70.5%
Florida	British Columbia (46%)	Ontario (43%)	Quebec	$49.9B	$2,297	$47.8B – $54.8B	39.8% → 70.2%
New York	Ontario (60%)	British Columbia (28%)	Alberta	$56.1B	$2,900	$52.9B – $66.3B	42.3% → 69.9%
Pennsylvania	Quebec (35%)	Nova Scotia (31%)	Quebec	$32.9B	$2,574	$29.1B – $36.3B	42.4% → 71.9%
Illinois	Ontario (59%)	British Columbia (20%)	Ontario	$32.1B	$2,552	$30.5B – $36.5B	38.5% → 71.0%
Ohio	Nova Scotia (34%)	Manitoba (17%)	Quebec	$29.0B	$2,484	$26.7B – $32.6B	42.1% → 73.7%
Georgia	Manitoba (48%)	Ontario (16%)	Ontario	$28.9B	$2,701	$27.4B – $30.8B	33.9% → 72.3%
North Carolina	Nova Scotia (28%)	Manitoba (26%)	Ontario	$21.1B	$1,986	$19.3B – $23.2B	40.4% → 69.7%
Michigan	Nova Scotia (54%)	New Brunswick (14%)	Quebec	$20.6B	$2,068	$19.4B – $23.7B	42.4% → 70.5%
New Jersey	Ontario (76%)	British Columbia (20%)	Ontario	$30.1B	$3,394	$29.6B – $31.7B	34.3% → 70.0%
Virginia	Quebec (28%)	British Columbia (28%)	Ontario	$22.9B	$2,660	$21.0B – $24.4B	36.0% → 72.4%
Washington	Ontario (37%)	British Columbia (32%)	Alberta	$19.4B	$2,521	$17.9B – $21.6B	37.4% → 72.0%
Arizona	British Columbia (33%)	Manitoba (25%)	Quebec	$13.6B	$1,834	$12.1B – $14.9B	43.8% → 72.0%
Tennessee	Manitoba (52%)	Saskatchewan (27%)	Manitoba	$15.6B	$2,267	$14.7B – $16.0B	39.8% → 71.4%
Massachusetts	Ontario (37%)	British Columbia (34%)	British Columbia	$25.5B	$3,701	$23.4B – $28.0B	37.2% → 72.4%
Indiana	Manitoba (52%)	Nova Scotia (14%)	Manitoba	$17.9B	$2,649	$16.5B – $19.6B	40.0% → 72.9%
Missouri	Manitoba (43%)	Nova Scotia (27%)	Quebec	$13.7B	$2,221	$12.5B – $15.2B	41.6% → 71.4%
Maryland	Quebec (44%)	British Columbia (28%)	Ontario	$18.8B	$3,102	$17.0B – $19.9B	37.4% → 73.7%
Colorado	Quebec (26%)	British Columbia (23%)	Ontario	$12.7B	$2,193	$11.6B – $14.0B	38.3% → 71.2%
Wisconsin	Nova Scotia (53%)	Quebec (19%)	Quebec	$16.1B	$2,763	$15.2B – $17.8B	37.8% → 73.5%

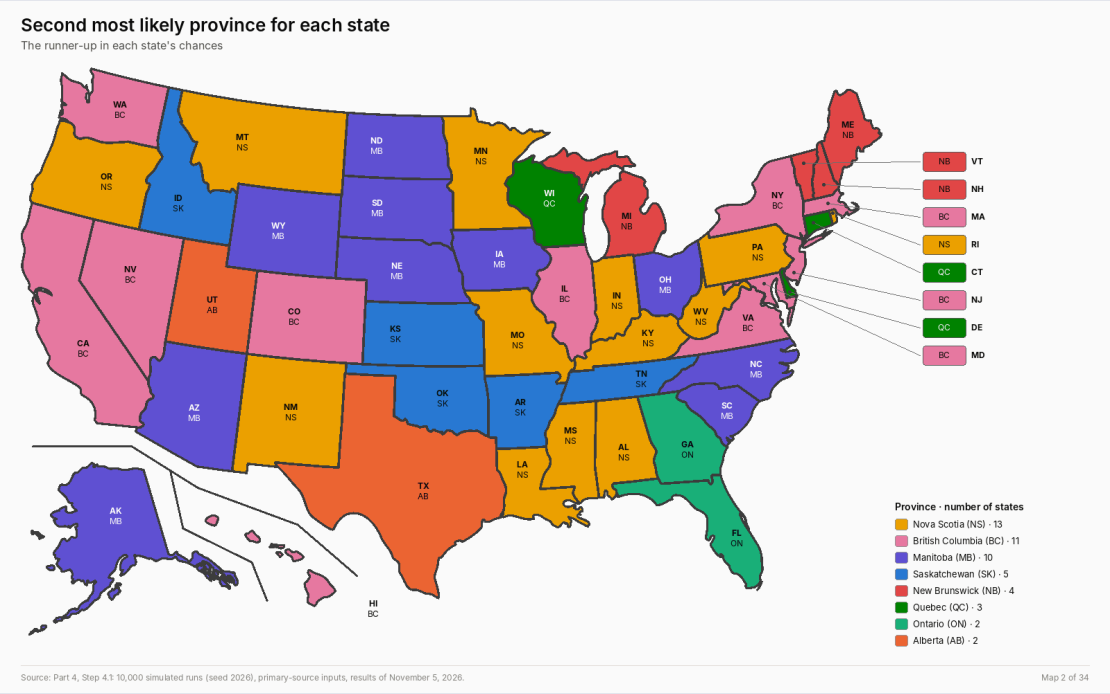
State	Most likely province	Second most likely	Part 3 match	Expected extra cost	Per person	Middle 90% of runs	Government share now → after
Minnesota	Quebec (41%)	Nova Scotia (19%)	British Columbia	$16.9B	$2,983	$14.8B – $18.3B	38.2% → 73.1%
South Carolina	Nova Scotia (49%)	Manitoba (20%)	Quebec	$9.5B	$1,825	$9.0B – $10.8B	42.0% → 69.9%
Alabama	Manitoba (53%)	Nova Scotia (18%)	Nova Scotia	$10.3B	$2,092	$9.5B – $10.6B	40.5% → 70.0%
Louisiana	Manitoba (56%)	Nova Scotia (17%)	Manitoba	$8.6B	$1,843	$7.6B – $8.8B	46.5% → 71.4%
Kentucky	Manitoba (36%)	Nova Scotia (27%)	Manitoba	$8.5B	$1,895	$7.8B – $9.0B	46.0% → 72.0%
Oregon	Quebec (47%)	Nova Scotia (29%)	Quebec	$10.0B	$2,353	$8.6B – $10.9B	42.3% → 72.9%
Oklahoma	Manitoba (73%)	Saskatchewan (17%)	Manitoba	$9.7B	$2,435	$9.3B – $9.8B	38.7% → 72.0%
Connecticut	British Columbia (38%)	Quebec (35%)	British Columbia	$11.1B	$3,124	$10.0B – $12.0B	38.9% → 70.9%
Utah	Manitoba (50%)	Alberta (27%)	Alberta	$7.8B	$2,393	$7.5B – $7.9B	30.3% → 68.5%
Nevada	Ontario (35%)	British Columbia (29%)	British Columbia	$5.9B	$1,892	$5.7B – $6.2B	40.1% → 69.8%
Iowa	Nova Scotia (42%)	Manitoba (22%)	Nova Scotia	$8.4B	$2,670	$7.9B – $9.5B	36.9% → 71.8%
Arkansas	Manitoba (64%)	Saskatchewan (13%)	Manitoba	$4.6B	$1,517	$4.1B – $4.7B	47.4% → 71.0%
Kansas	Manitoba (73%)	Saskatchewan (8%)	Manitoba	$8.5B	$2,907	$8.1B – $8.6B	34.3% → 73.1%
Mississippi	Manitoba (43%)	Nova Scotia (26%)	Nova Scotia	$5.3B	$1,798	$4.9B – $5.6B	44.6% → 71.0%
New Mexico	Manitoba (56%)	Nova Scotia (23%)	Nova Scotia	$2.8B	$1,311	$2.4B – $3.3B	50.5% → 72.7%
Idaho	Manitoba (65%)	Saskatchewan (13%)	Manitoba	$3.6B	$1,992	$3.4B – $3.7B	39.7% → 71.6%
Nebraska	Saskatchewan (56%)	Manitoba (28%)	Saskatchewan	$6.9B	$3,571	$6.8B – $7.1B	30.5% → 72.0%
West Virginia	New Brunswick (42%)	Nova Scotia (31%)	New Brunswick	$5.9B	$3,282	$5.7B – $6.2B	38.7% → 72.1%
Hawaii	Quebec (57%)	British Columbia (27%)	British Columbia	$4.6B	$3,262	$4.3B – $4.7B	32.8% → 71.8%
New Hampshire	Nova Scotia (69%)	New Brunswick (18%)	Nova Scotia	$5.1B	$3,714	$4.9B – $5.7B	31.8% → 70.6%
Maine	Nova Scotia (51%)	New Brunswick (45%)	New Brunswick	$3.6B	$2,650	$3.5B – $3.6B	41.1% → 69.8%
Montana	New Brunswick (44%)	Nova Scotia (42%)	Nova Scotia	$3.0B	$2,779	$2.9B – $3.2B	37.9% → 72.9%
Rhode Island	Quebec (27%)	Nova Scotia (25%)	British Columbia	$2.9B	$2,756	$2.7B – $3.2B	40.1% → 70.8%
Delaware	Nova Scotia (36%)	Quebec (21%)	Saskatchewan	$3.6B	$3,648	$3.4B – $3.9B	36.6% → 72.5%
South Dakota	Saskatchewan (61%)	Manitoba (30%)	Nova Scotia	$4.7B	$5,242	$4.6B – $4.8B	25.1% → 75.7%

State	Most likely province	Second most likely	Part 3 match	Expected extra cost	Per person	Middle 90% of runs	Government share now → after
North Dakota	Saskatchewan (91%)	Manitoba (7%)	Saskatchewan	$2.9B	$3,762	$2.9B – $3.0B	30.8% → 71.4%
Alaska	Saskatchewan (56%)	Manitoba (41%)	Saskatchewan	$3.8B	$5,159	$3.7B – $3.8B	30.5% → 76.5%
Vermont	Nova Scotia (63%)	New Brunswick (29%)	New Brunswick	$2.2B	$3,588	$2.2B – $2.4B	36.7% → 72.4%
Wyoming	Saskatchewan (84%)	Manitoba (11%)	Nova Scotia	$2.4B	$4,182	$2.4B – $2.5B	27.6% → 73.7%

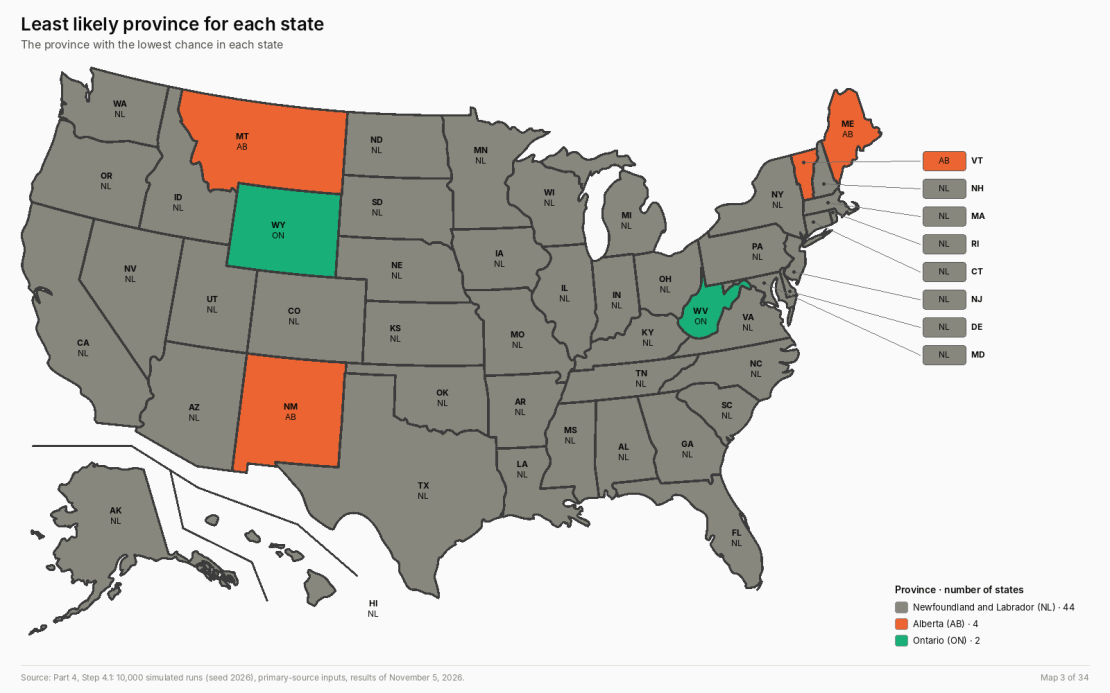
Appendix B. Remaining maps

These 26 maps complete the set of 34; maps 1, 4, 5, 17, 18, 28, 29 and 34 are in Section 7.6. Province chances are given that the state switches, and costs are in 2020 dollars.

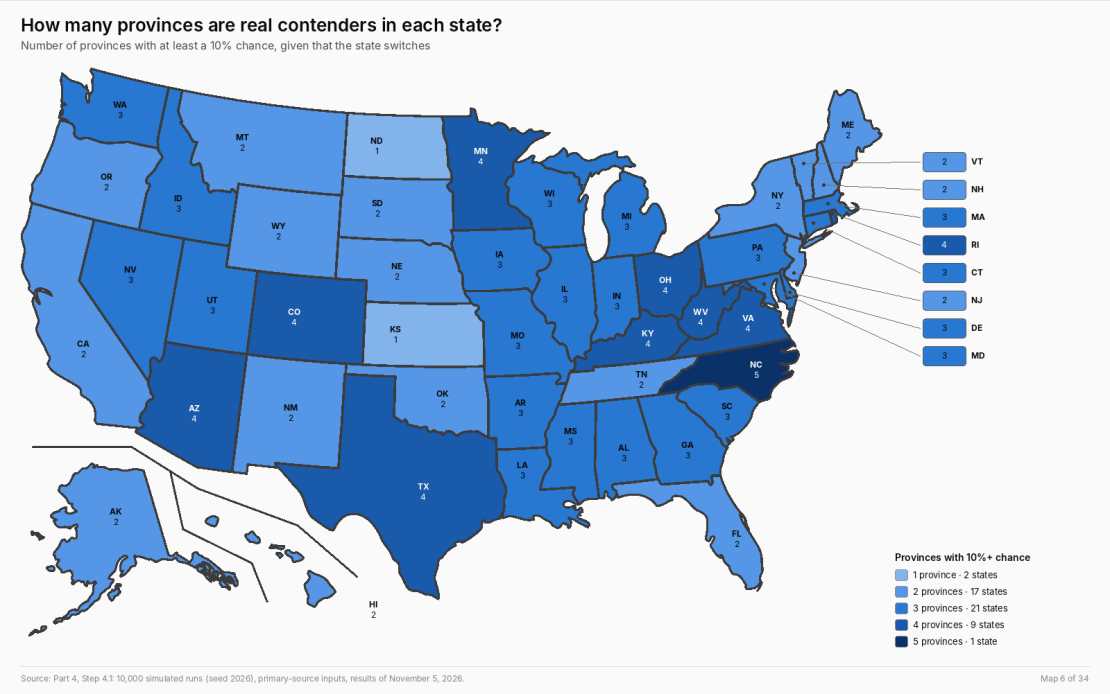
Map 2. Second most likely province. Nova Scotia is the runner-up in 13 states, British Columbia in 11 and Manitoba in 10.



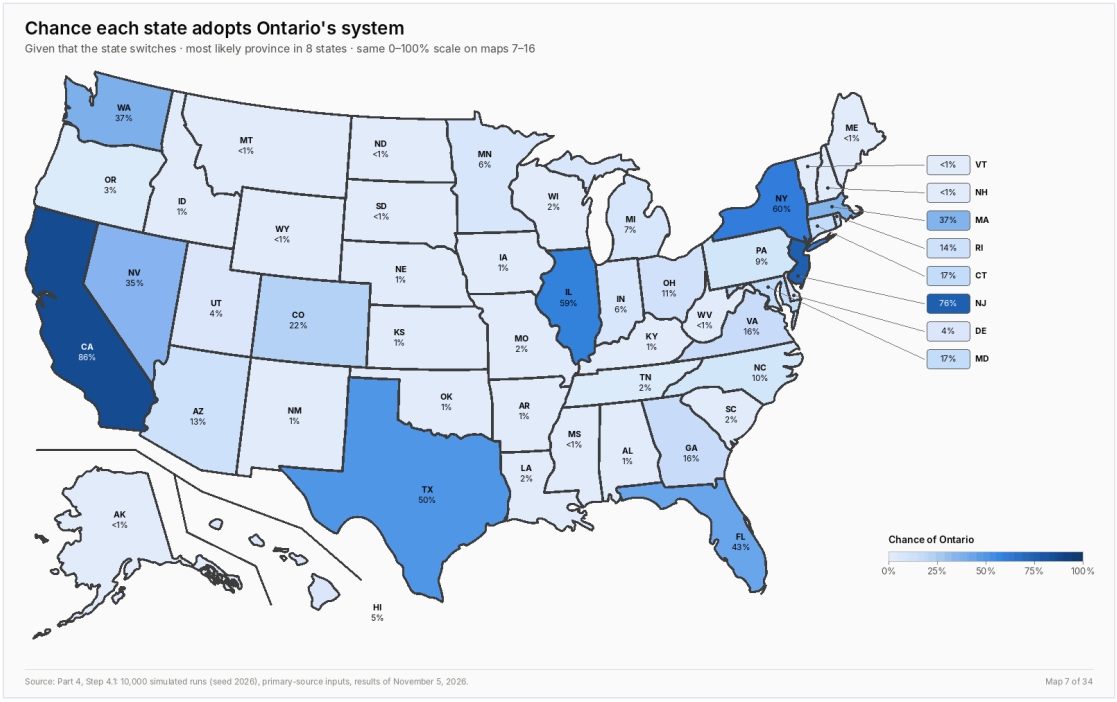
Map 3. Least likely province. Newfoundland and Labrador in 44 states, Alberta in 4 and Ontario in 2.



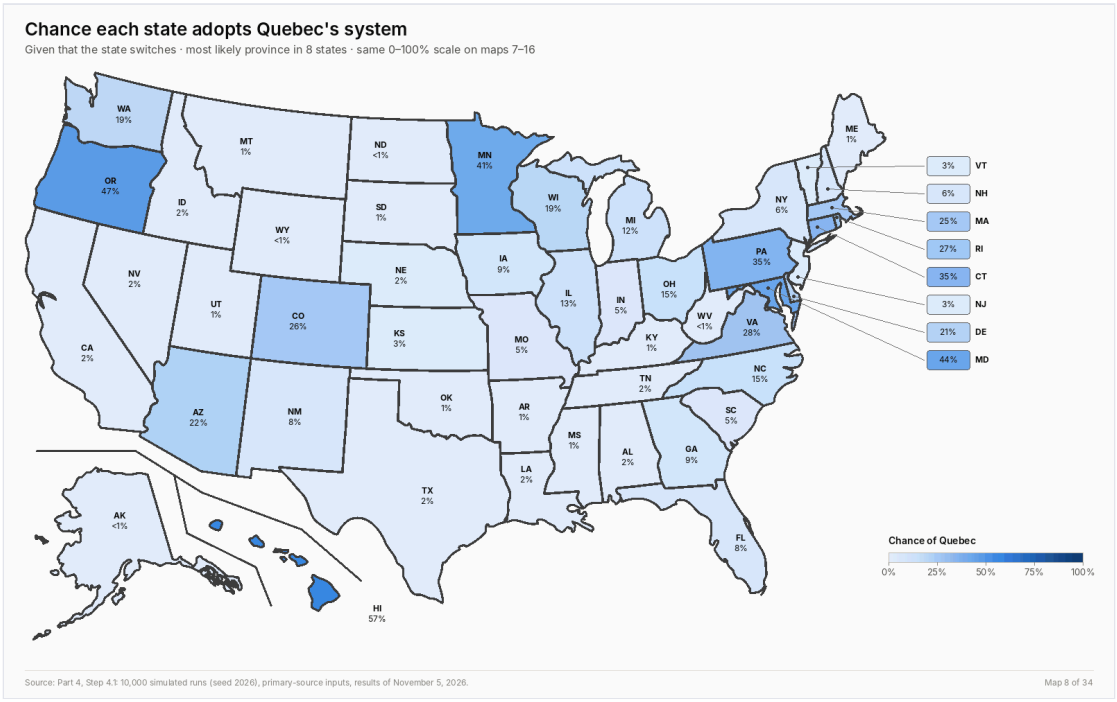
Map 6. Provinces with at least a 10% chance. Three in 21 states, two in 17, four in 9, five in North Carolina, and one in Kansas and North Dakota.



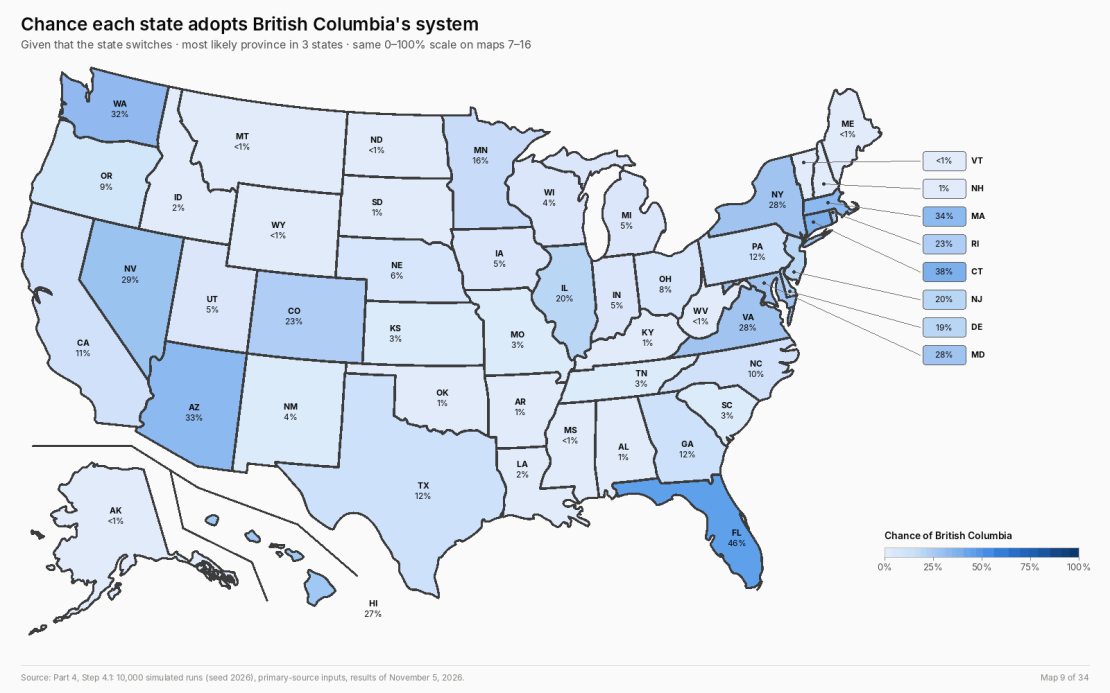
Map 7. Chance of Ontario's system. Most likely in 8 states; highest California 86%, New Jersey 76%, New York 60%, Illinois 59%.



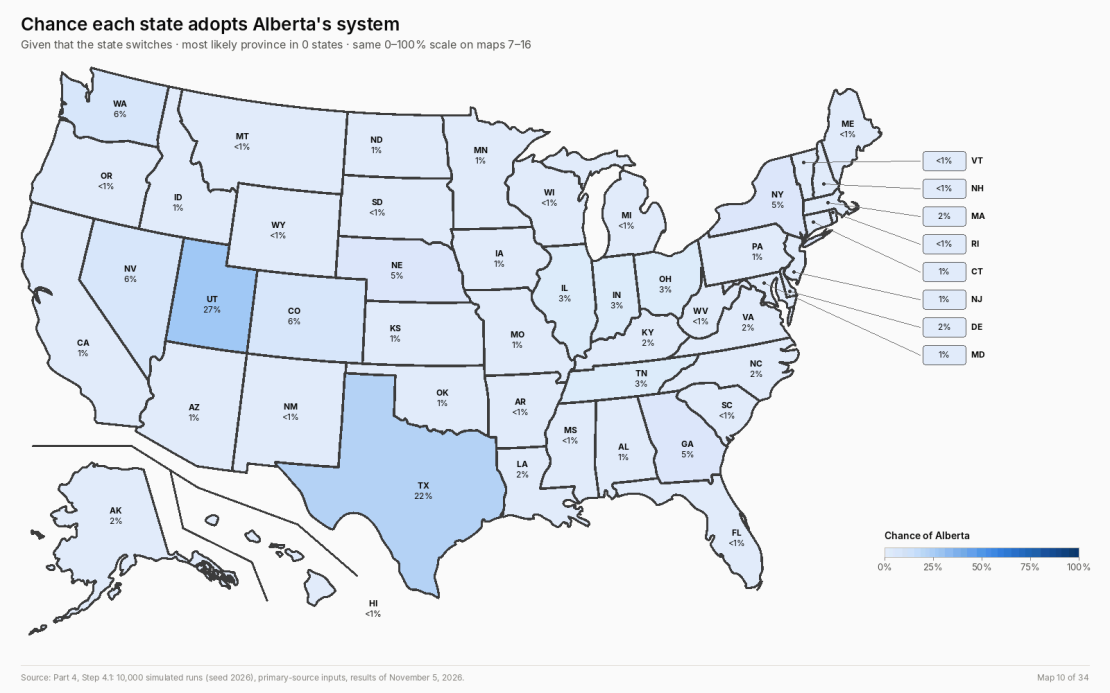
Map 8. Chance of Quebec's system. Most likely in 8 states; highest Hawaii 57%, Oregon 47%, Maryland 44%, Minnesota 41%.



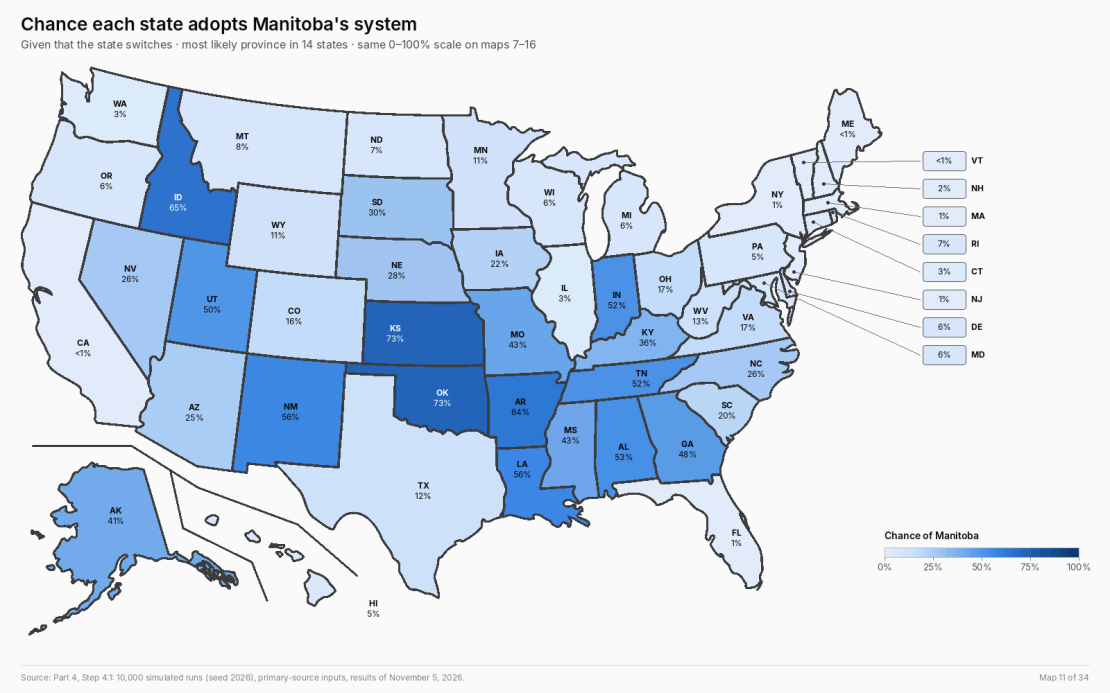
Map 9. Chance of British Columbia's system. Most likely in 3 states; highest Florida 46%, Connecticut 38%, Massachusetts 34%, Arizona 33%.



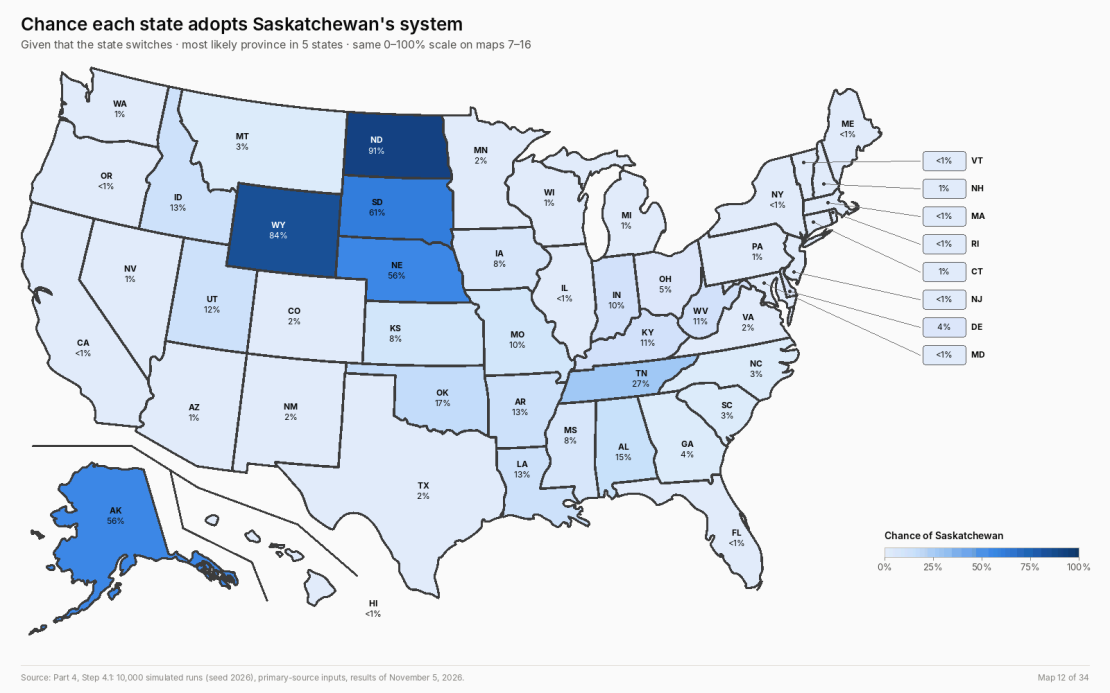
Map 10. Chance of Alberta's system. Most likely nowhere; 10% or more only in Utah (27%) and Texas (22%).



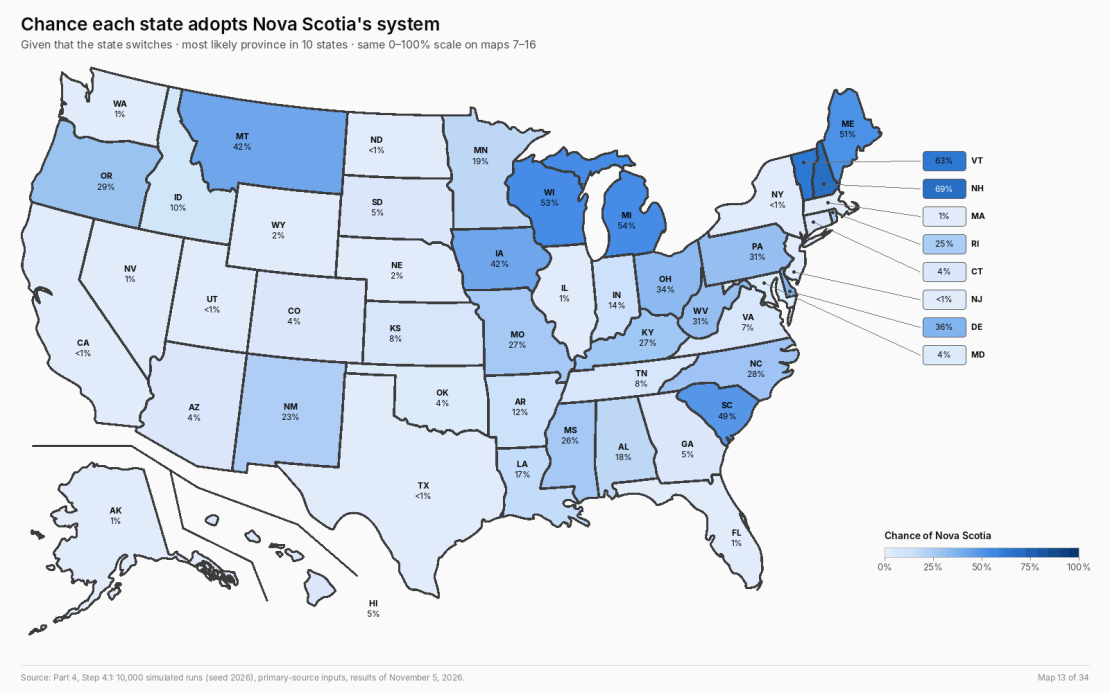
Map 11. Chance of Manitoba's system. Most likely in 14 states; highest Oklahoma 73%, Kansas 73%, Idaho 65%, Arkansas 64%.



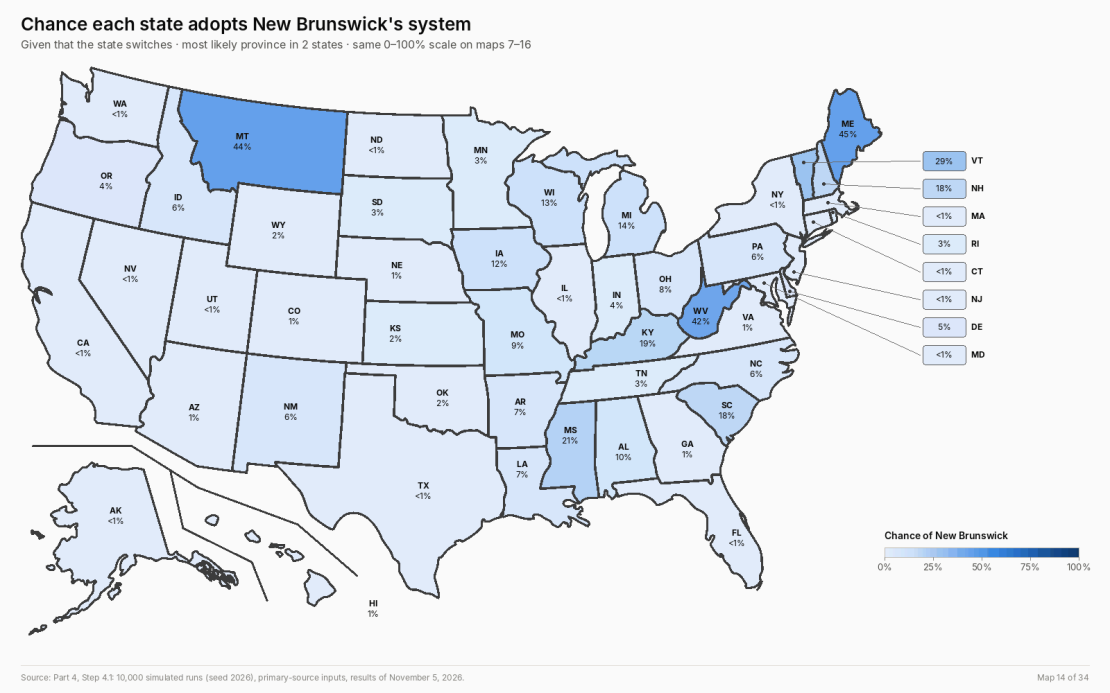
Map 12. Chance of Saskatchewan's system. Most likely in 5 states; highest North Dakota 91%, Wyoming 84%, South Dakota 61%, Alaska 56%.



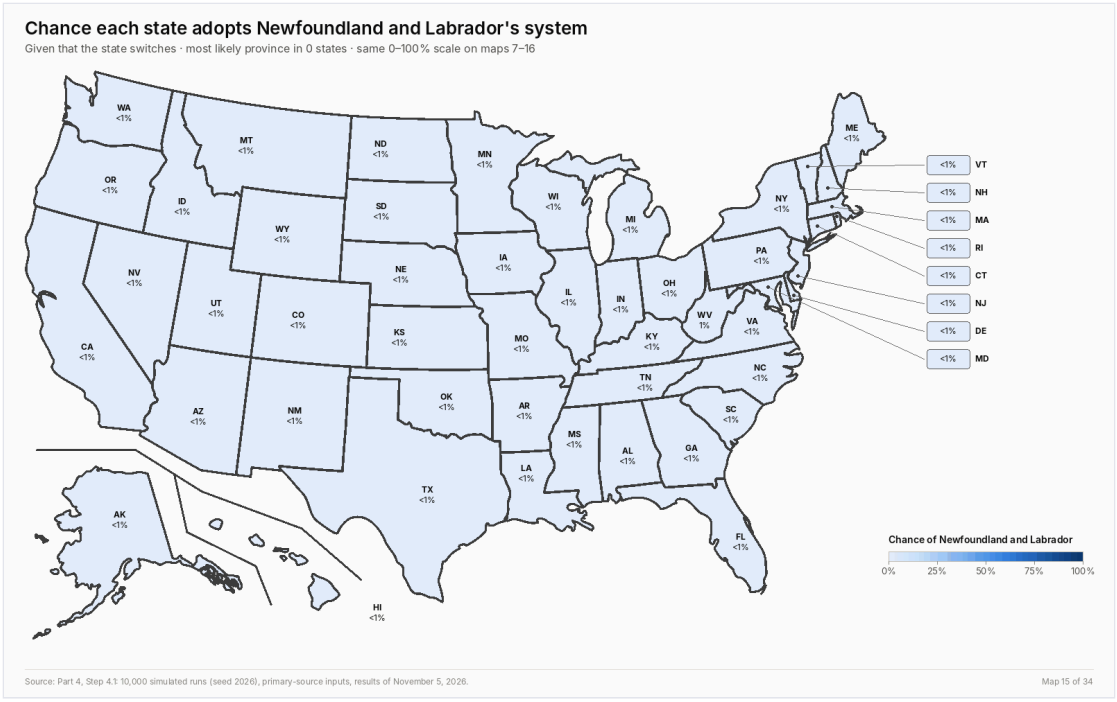
Map 13. Chance of Nova Scotia's system. Most likely in 10 states; highest New Hampshire 69%, Vermont 63%, Michigan 54%, Wisconsin 53%.



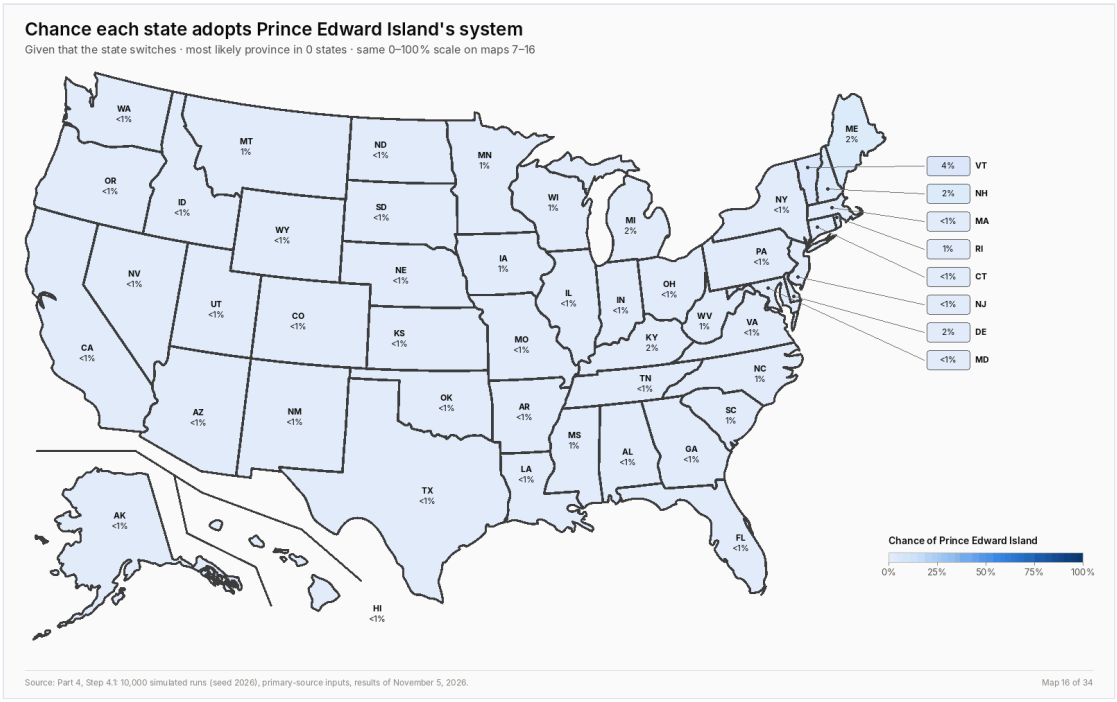
Map 14. Chance of New Brunswick's system. Most likely in 2 states; highest Maine 45%, Montana 44%, West Virginia 42%.



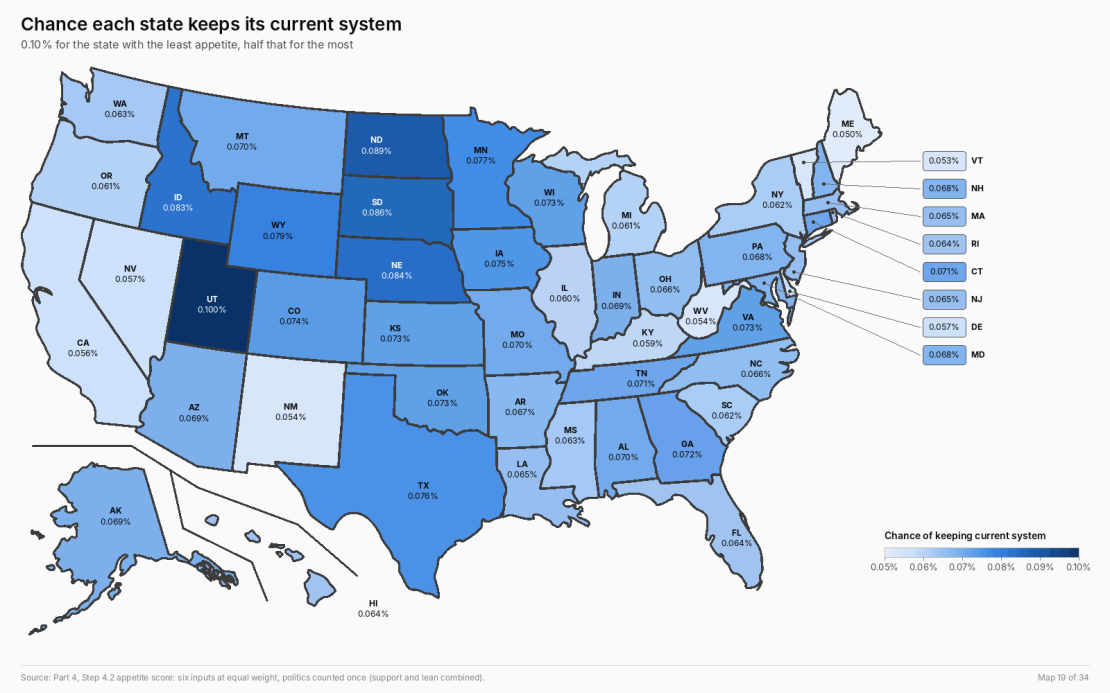
Map 15. Chance of Newfoundland and Labrador's system. Under 2% everywhere; highest West Virginia at 1.3%.



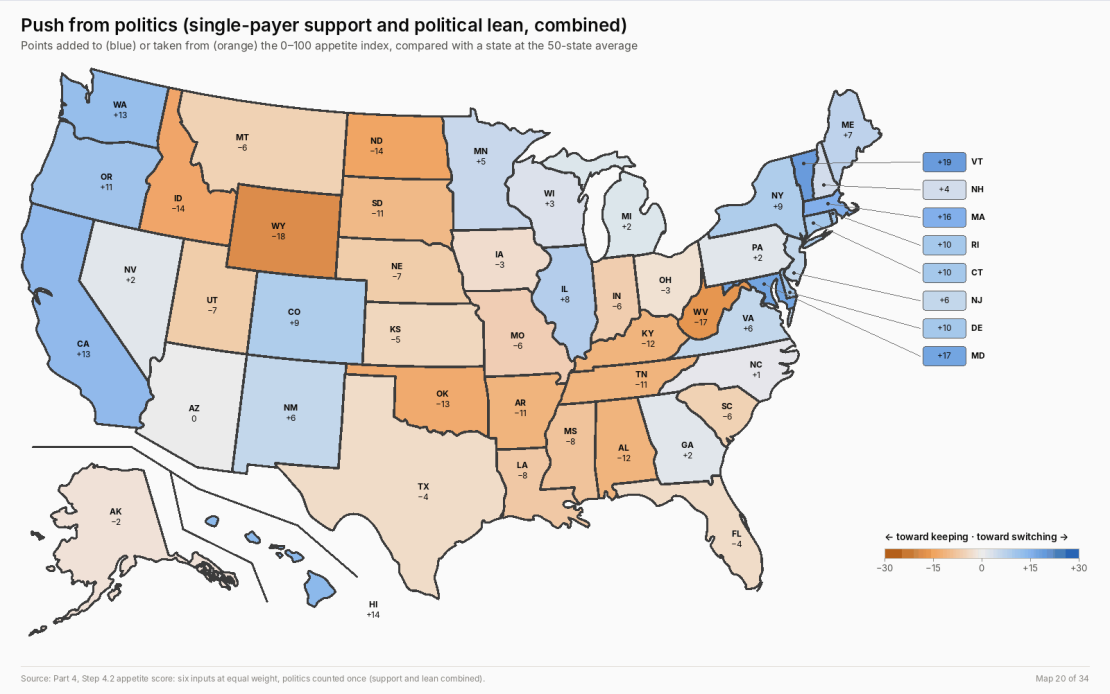
Map 16. Chance of Prince Edward Island's system. Under 5% everywhere; highest Vermont at 4.3%.



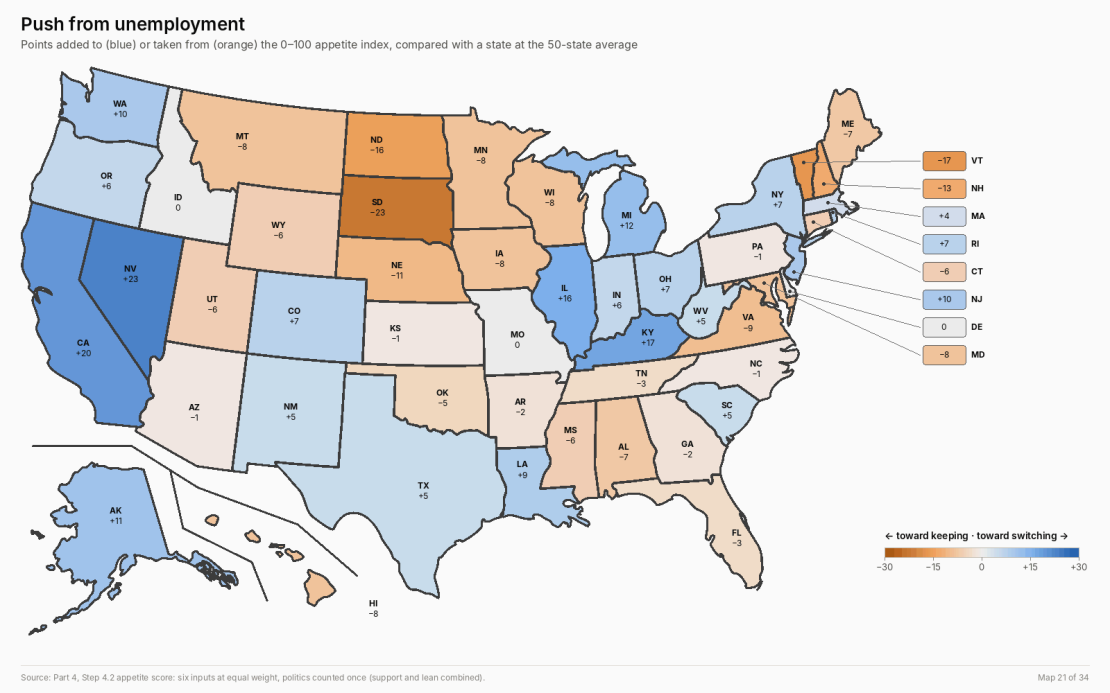
Map 19. Chance of keeping the current system. From 0.050% in Maine to 0.100% in Utah.



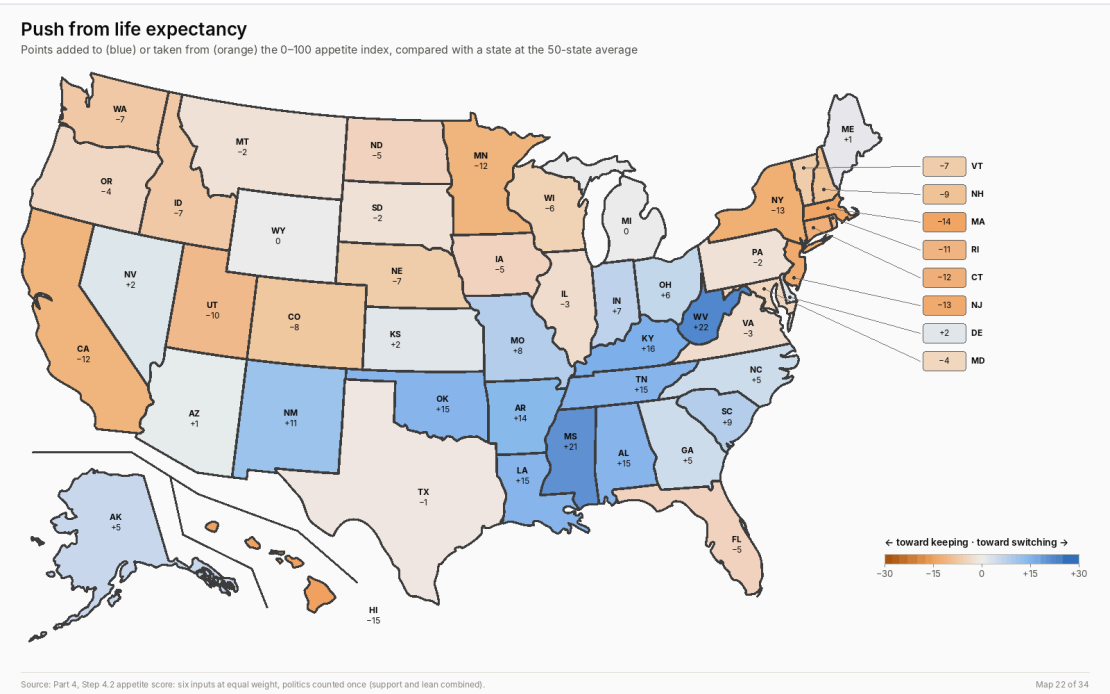
Map 20. Push from politics. Single-payer support and political lean combined: Wyoming −18 to Vermont +19 points on the appetite index.



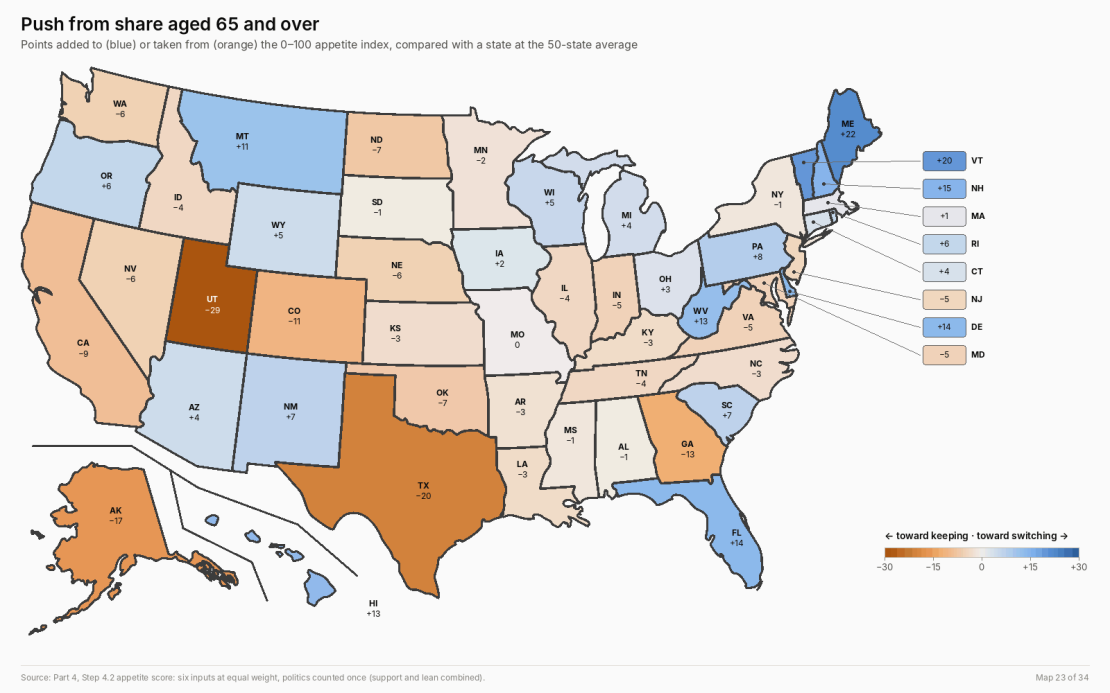
Map 21. Push from unemployment. South Dakota −23 to Nevada +23 points.



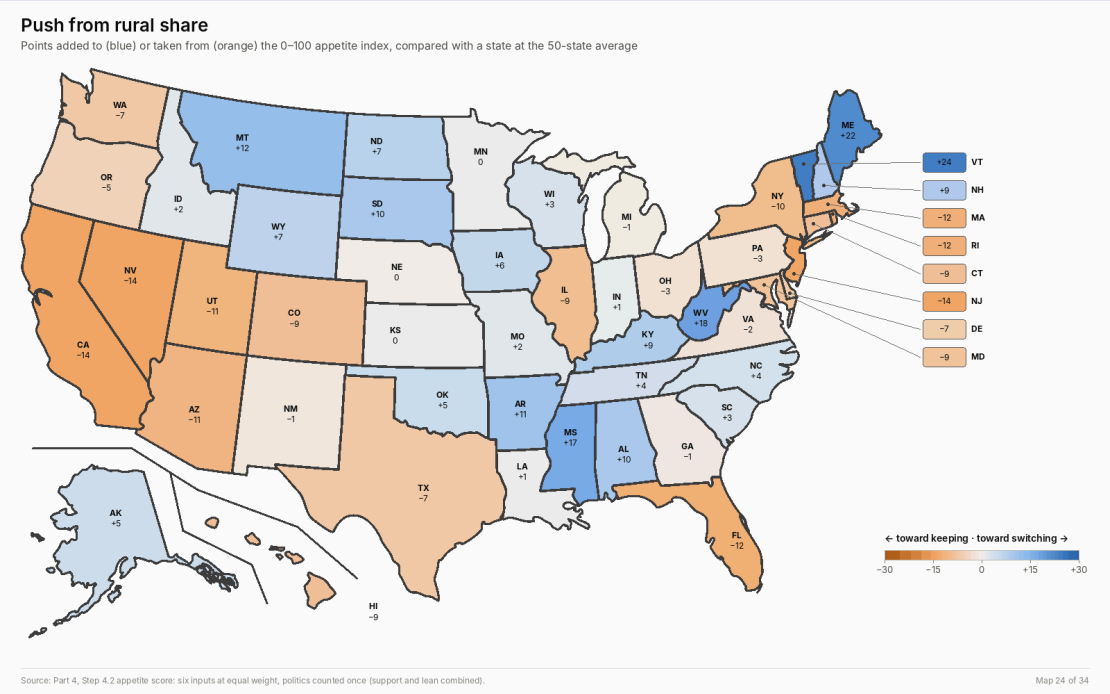
Map 22. Push from life expectancy. Hawaii −15 to West Virginia +22 points.



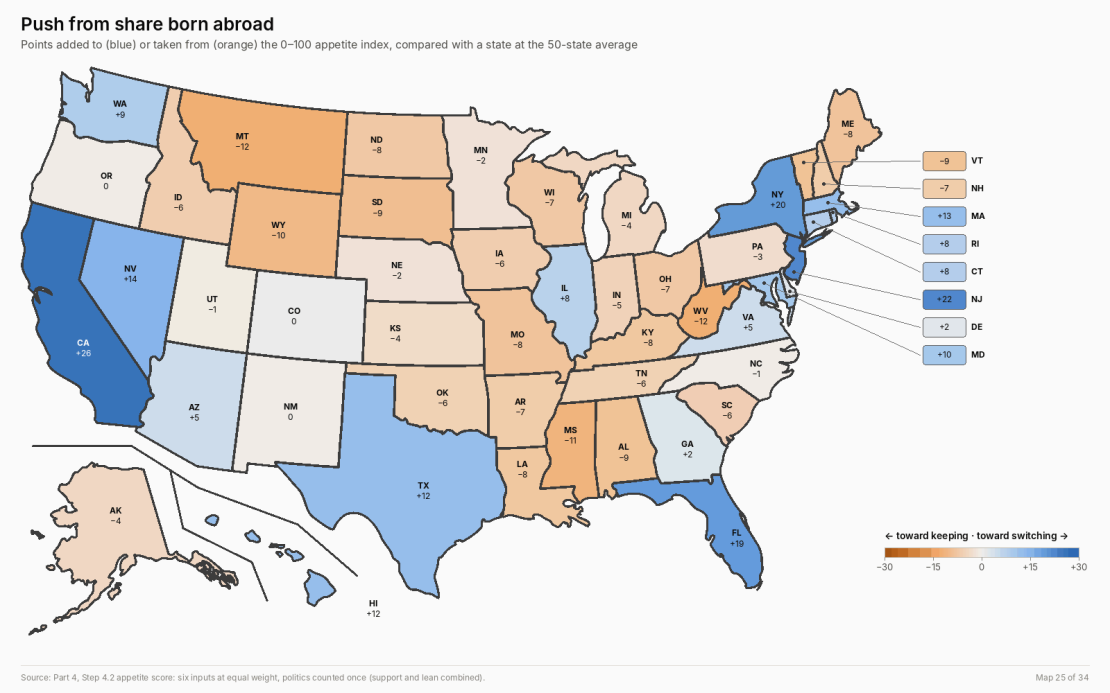
Map 23. Push from share aged 65 and over. Utah −29 to Maine +22 points.



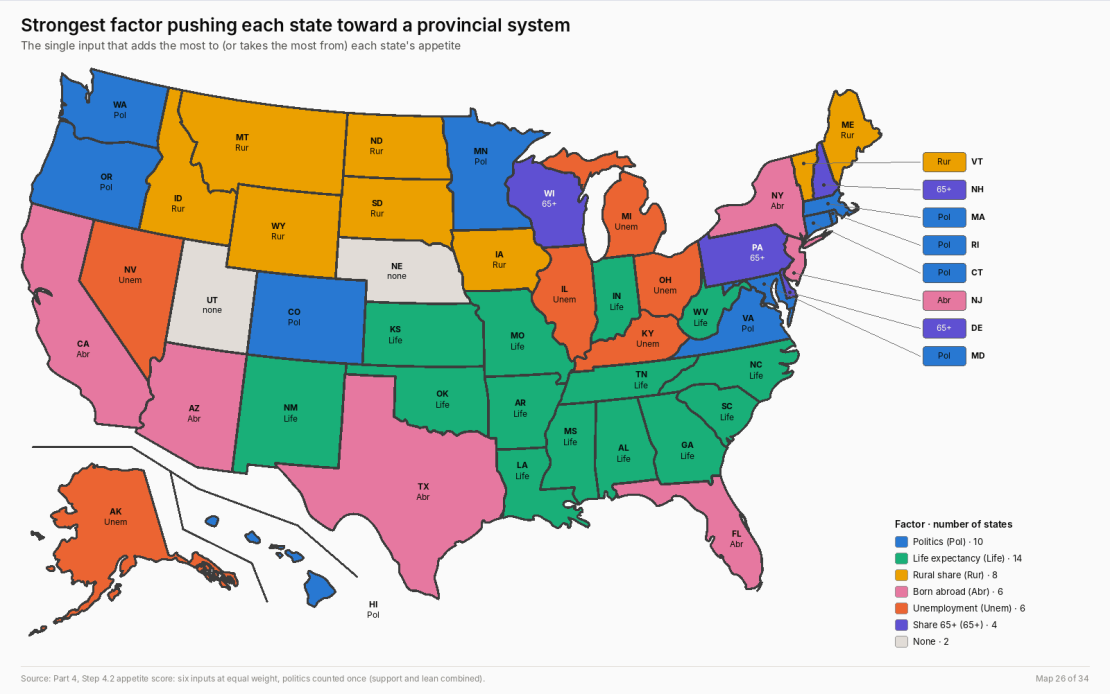
Map 24. Push from rural share. California −14 to Vermont +24 points.



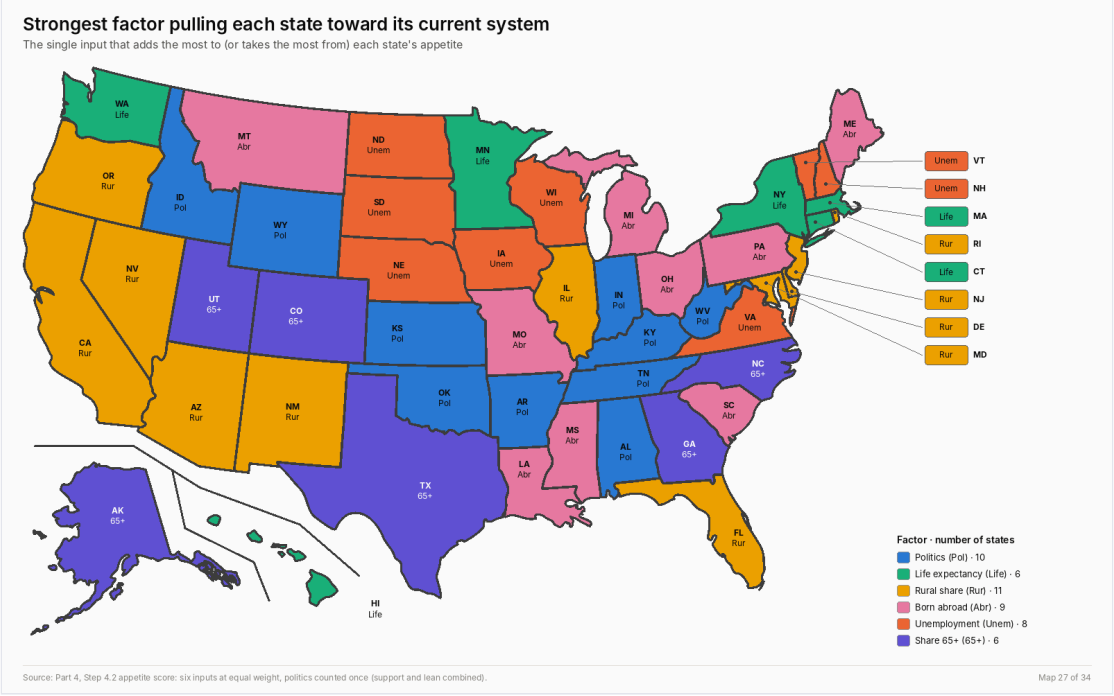
Map 25. Push from share born abroad. Montana −12 to California +26 points.



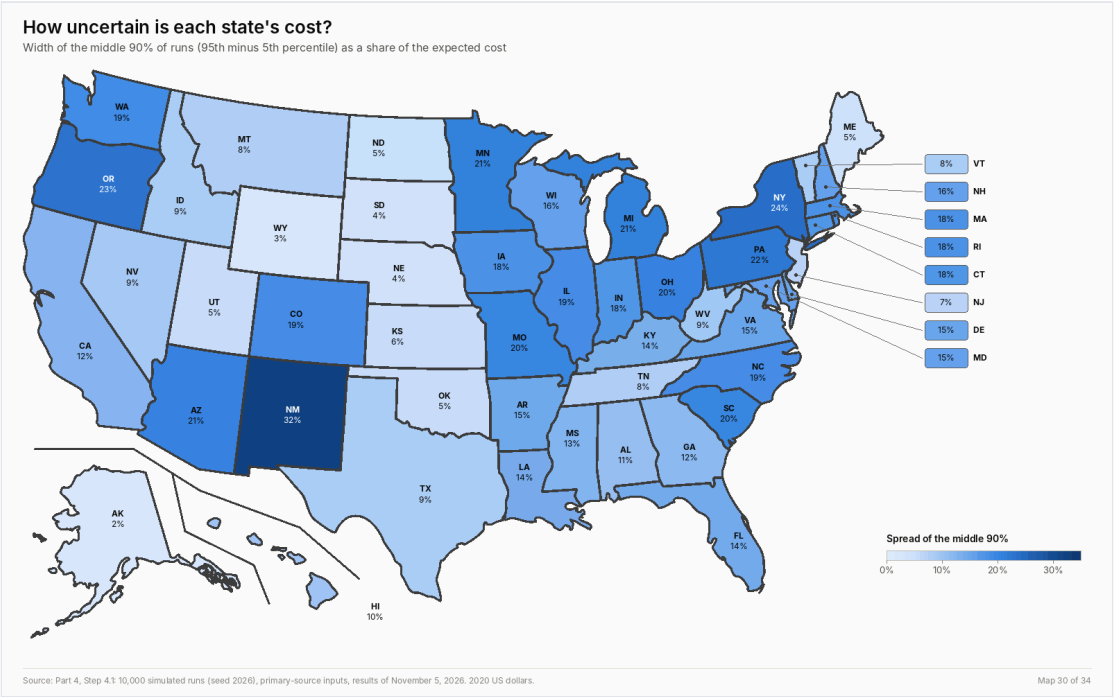
Map 26. Strongest push toward switching. Life expectancy in 14 states, politics 10, rural share 8, born abroad 6, unemployment 6, share 65+ 4; none in Utah and Nebraska.



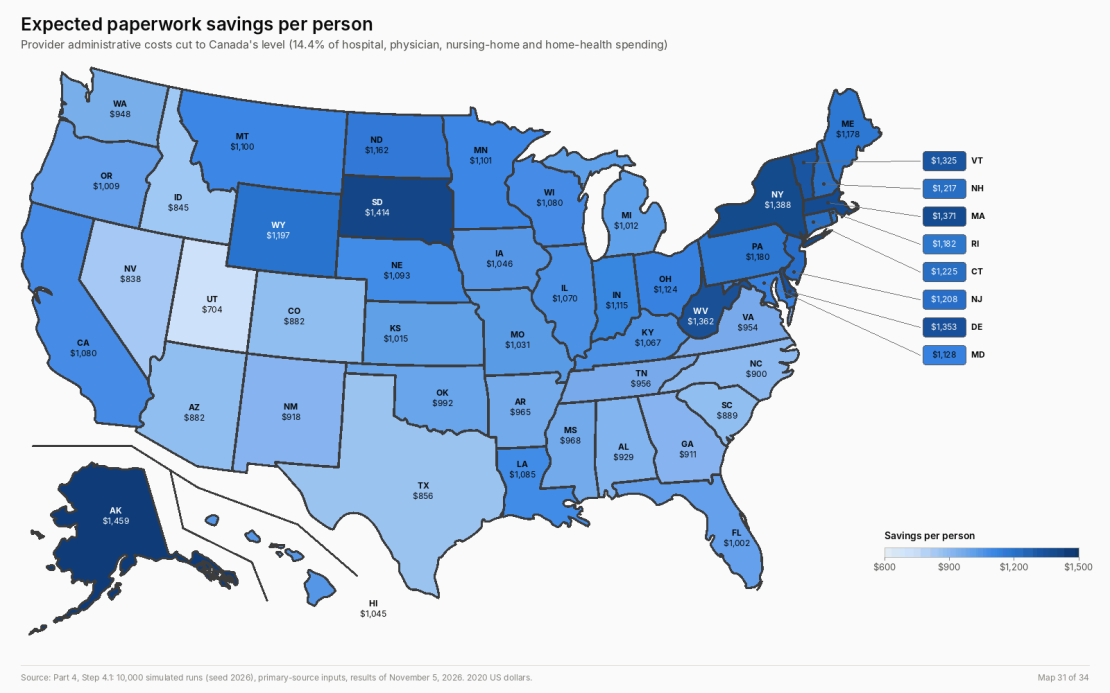
Map 27. Strongest pull toward keeping. Rural share in 11 states, politics 10, born abroad 9, unemployment 8, share 65+ 6, life expectancy 6.



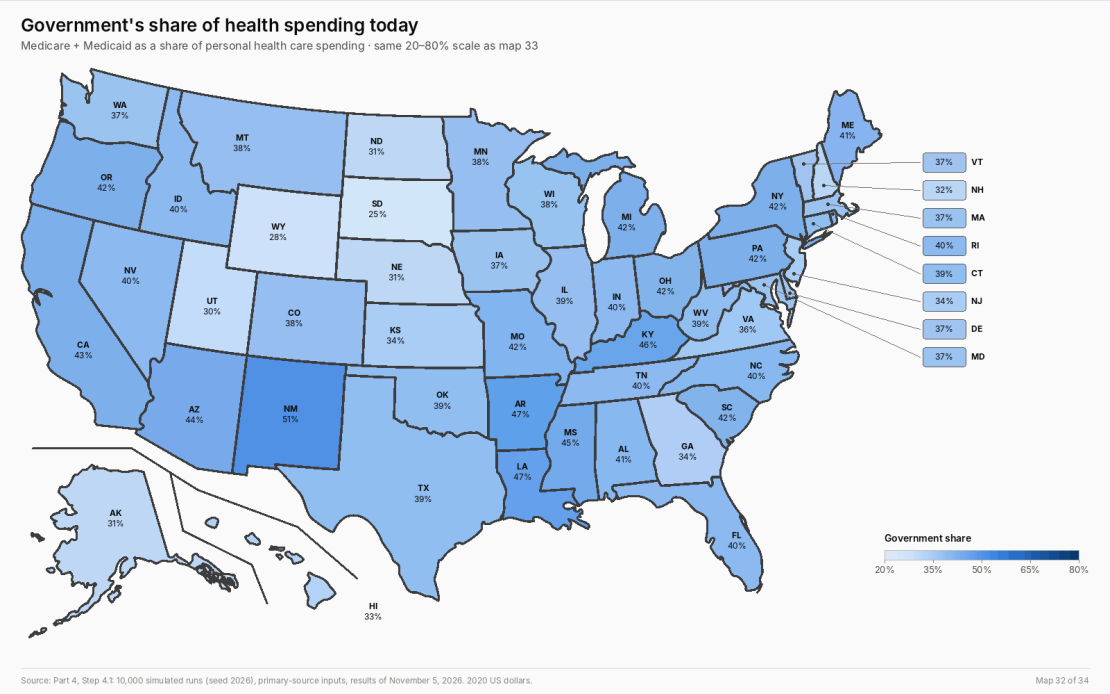
Map 30. How uncertain each state's cost is. The middle 90% of runs spans 32% of the expected cost in New Mexico and 2% in Alaska.



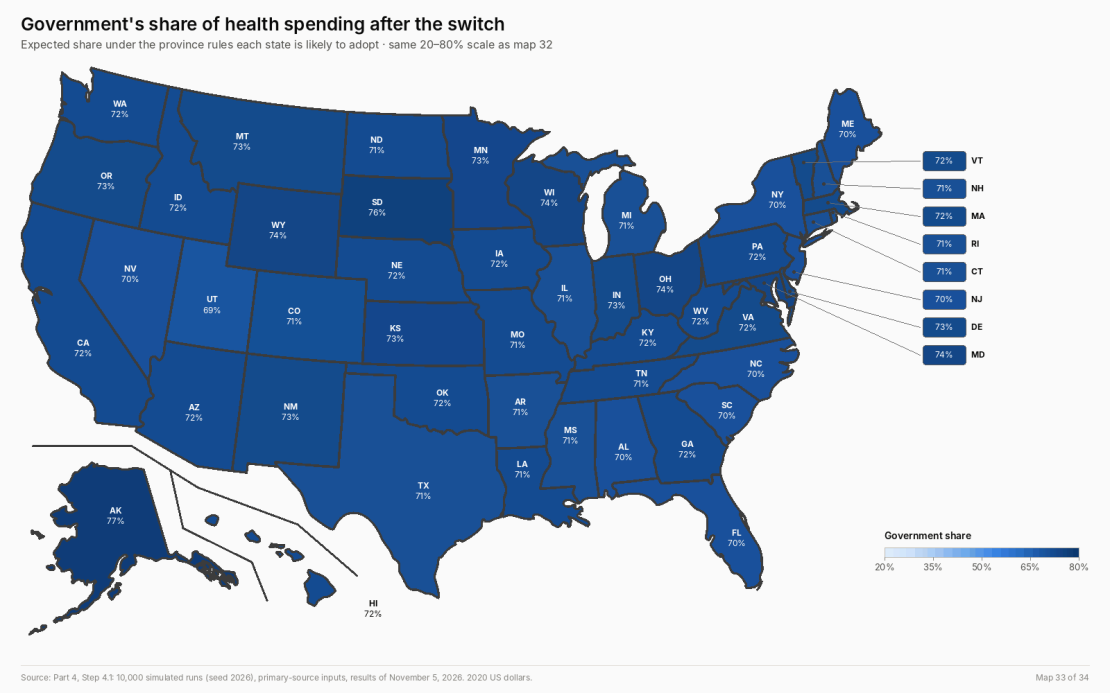
Map 31. Paperwork savings per person. From $704 in Utah to $1,459 in Alaska.



Map 32. Government's share of health spending today. From 25% in South Dakota to 51% in New Mexico.



Map 33. Government's share after the switch. From 69% in Utah to 77% in Alaska, on the same 20–80% scale as map 32.



Sources

Spending and coverage data

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Analysis files (held with the project data): Part 1–4 results and data tables, "Data - Primary Source Extracts", "Sensitivity Checks - Results", and the code files listed in Section 9.3.