The Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals

Final Report

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About KNG Health Consulting, LLC

KNG Health Consulting, LLC, is a health economics and policy consulting company assisting clients across all sectors of the healthcare industry. The company's work focuses on two main practice areas: Healthcare Reform and Payment Innovation; and Evaluation and Health Economics. In the HRPI practice, KNG Health's experts work with our clients to estimate the effects of a wide-range of healthcare reform and payment innovation policies, ranging from modeling innovative state and federal proposals to reduce health insurance premiums to facilitating learning systems for providers on alternative payment models. In the EHE practice, KNG Health's experts conduct studies on the efficiency, effectiveness, and value of medical interventions using big and small data, applying careful research designs, and translating findings into actionable results.

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Executive Summary

Key Findings

- We used a micro-simulation model to estimate the effects of the Medicare-X Choice Act[1] on health insurance coverage and healthcare spending. Medicare-X Choice would make a public health insurance plan fully available on the health exchanges beginning in 2024 and reimburse providers using Medicare rates.
- We project public plan enrollment of 40.7 million in 2024, with approximately 90 percent of enrollees coming from individuals currently insured on the non-group market or through employer-sponsored insurance (ESI).
- Of the 29.0 million currently uninsured, Medicare-X Choice would result in 5.5 million gaining coverage. By comparison, additional support of the Affordable Care Act would result in 9.1 million uninsured persons gaining coverage.
- Nationally, healthcare spending would be reduced by $1.2 trillion (7%) over the 10-year period from 2024 to 2033, with spending for hospital services being cut by $774 billion -accounting for almost two-thirds of the total spending reduction.
- The Medicare-X Choice reductions in healthcare spending and increases in coverage would be financed through reductions in provider payments, given that Medicare rates are significantly less than payments by commercial payers.
- Medicare-X Choice would compound financial stresses already faced by the nation's hospitals, potentially impacting access to care and provider quality. MedPAC estimates Medicare hospital margins will be -11 percent in 2018. Moreover, the Congressional Budget Office has projected that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law.
- While Medicare-X Choice would increase insurance coverage, the gains are modest relative to what could likely be achieved through strengthening existing components of the Affordable Care Act.

Access to affordable health care coverage continues to be a major public concern. While many Americans have gained coverage since the enactment of the Affordable Care Act (ACA) through, for example, health insurance marketplaces and state Medicaid expansions, approximately 27 million non-elderly individuals living in the U.S. remained uninsured in 2017, up slightly from 2016.[2] In 2017, Members of the 115th Congress introduced eight legislative proposals to expand public health insurance coverage. Seven of the eight proposals would make Medicare or a Medicare-like public plan option available to a larger population than currently has access to Medicare or other public insurance. The other proposal (Medicare-for-All) would create a single-payer healthcare system.

In this study, we model the effects of the Medicare-X Choice Act on coverage and healthcare spending. Although not as expansive as Medicare-for-All, Medicare-X Choice would allow any

[1] S. 1970. 115th Congress. 2017. Accessed at https://www.congress.gov/115/bills/s1970/BILLS-115s1970is.pdf.
[2] Key Facts about the Uninsured Population. Kaiser Family Foundation. Accessed at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population.

individual to voluntarily enroll in a public plan offered on each health exchange. As a result, the Medicare-X Choice public plan's reach would be broader than Medicare "buy-in" proposals that only allow certain age groups (e.g., age 55-64) to purchase Medicare. Under Medicare X-Choice, the public plan would reimburse providers using Medicare rates, which are significantly less than commercial rates and, for hospitals, fall below the cost of providing care.[3] We assess the impact of Medicare-X Choice on coverage and healthcare spending by projecting the take-up of the new public plans among the uninsured and those with commercial health insurance.

Methods. We used the KNG Health Reform Model (KNG-HRM) to estimate individual and family insurance coverage decisions. The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choices. The model is based on data from the 2017 U.S. Census Bureau's American Community Survey (ACS), which is a large national survey of households. In the model, individuals consider several coverage options, maximizing utility for their family or "health insurance unit (HIU)." For the non-group market and those uninsured at baseline, changes from the status quo policy trigger a dynamic, iterative process with HIUs selecting new coverage choices and premiums being recalculated until a new equilibrium is reached. For this study, we expanded the KNG-HRM to incorporate coverage decisions of individuals on employer-sponsored insurance (ESI). For individuals receiving coverage through their employer, we used baseline premiums for ESI (updated over time for cost inflation) and assumptions on employer-covered share of premiums to model the decision to stay on ESI or select an alternative coverage option. Each individual's utility is a function of healthcare consumption; out-of-pocket spending including premiums, cost-sharing reduction (CSR) subsidies and tax credits; and variance in out-of-pocket spending (to capture the value of insurance to mitigate risk of unexpectedly high healthcare expenditures). We do not model competition among health plans and, instead, assume that the availability of plans would be unaffected by the introduction of a public plan on the exchanges.

We estimated healthcare utilization based on an individual's demographics and imputed health status, including general health, presence of select chronic conditions, physical function, and cost-sharing requirements. We convert healthcare utilization into total and out-of-pocket spending by multiplying use rates by prices. Commercial insurer prices were obtained from publicly-available data from the Health Care Cost Institute (HCCI). We developed comparable Medicare prices using studies from the Congressional Budget Office (CBO) and other sources that compare commercial provider payment rates to Medicare rates.

Key Findings. We find that national enrollment in the public plan would be 40.7 million in 2024 and would increase slightly to 42.3 million by 2033 (Table ES1). Under Medicare-X Choice, the number of uninsured and the commercially insured on the non-group market would fall by 5.5 and 12.6 million in 2024, respectively, while enrollment in employer-sponsored insurance would fall by 22.6 million. About ninety percent of the enrollment in the public plans would comprise individuals who were either covered under ESI or on a commercial non-group plan in the

[3] June 2018 Data Book. Medicare Payment Advisory Commission. Chart 6-19. Accessed at https://bit.ly/2EMwQ2Y.

baseline. While most of the enrollment in the public plan comes from those previously with ESI, the public plan take-up rate is highest (67%) among those with commercial non-group insurance.

Table ES1. Change in Insurance Coverage Status in 2024 and 2033

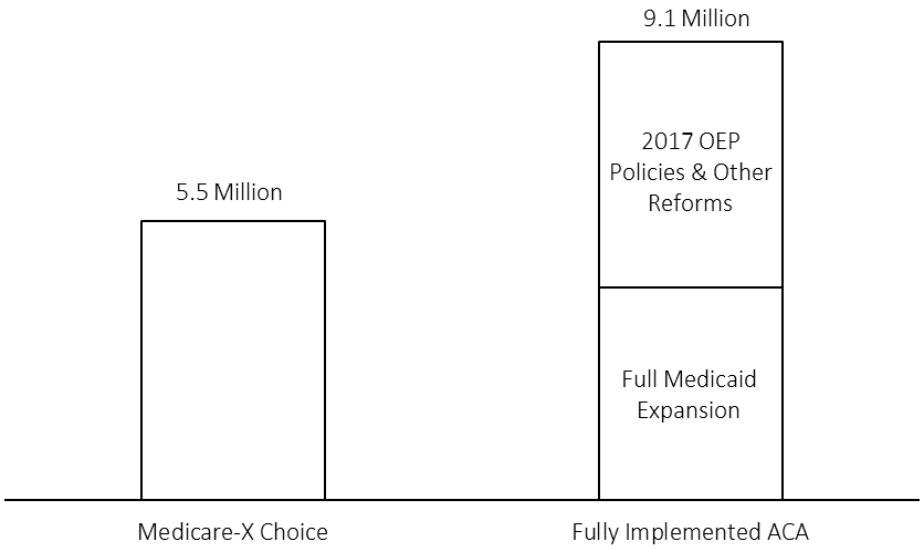
			Change in Coverage under Medicare-X Choice			
Source of Coverage	Baseline		Coverage Change		Percent Change	
	2024	2033	2024	2033	2024	2033
Employer	152.7 M	154.9 M	-22.6 M	-21.4 M	-15%	-14%
Non-Group	21.1 M	21.3 M	-12.6 M	-14.0 M	-60%	-66%
Uninsured	29.0 M	31.2 M	-5.5 M	-6.9 M	-19%	-22%
Public			40.7 M	42.3 M	n/a	n/a

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: n/a = Not Applicable. Components may not sum to totals because of rounding.

We compare estimated reductions in the number of uninsured under Medicare-X Choice in 2024 to the impact of a fully-implemented ACA (Figure ES1). Specifically, we update estimates reported by the Urban Institute on insurance coverage in 2019 and the impact of Medicaid expansion in non-expansion states and insurance coverage policies in effect during the 2018 Open Enrollment Period (OEP) as compared to the 2017 OEP. [4,5] We used estimates directly from the Urban Institute studies but updated for projected population growth between 2019 and 2024. We find that a fully implemented ACA would result in a reduction of 9.1 million in the uninsured, while Medicare-X Choice would result in a reduction of 5.5 million.

[4] Buettgens M. The Implications of Medicaid Expansion in the Remaining States: 2018 Update. The Urban Institute. Accessed at https://urbn.is/2QnkqGg.
[5] Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. The Urban Institute. Accessed at https://urbn.is/2G07k8E.

Figure ES1. Reductions in Number of Uninsured under Medicare-X Choice and Fully Implemented ACA



Source: KNG Health analysis of the KNG-Health Reform Model and data from the Urban Institute.

We estimate considerable reductions in healthcare spending of 7 percent under Medicare-X Choice over the 10-year period from 2024 to 2033 (Table ES2). Spending on individuals who are uninsured in the baseline is projected to increase by 9 percent in 2024, however, increased spending on the uninsured would be more than offset by spending reductions among those who are enrolling in the public plan but previously insured through private insurance. While hospital-based services represent 47 percent of total baseline healthcare spending, these services would account for roughly 67 percent of the reduction in total spending. Overall, we estimate that hospitals would experience a 10-percent reduction in payments among the relevant population.

Table ES2. Spending by Type of Service in Baseline and Under Medicare-X Choice

			Change in Spending by Service (1-Year and 10-Year)			
Type of Service	Baseline		Dollars		Percent	
	2024	2024-33	2024	2024-33	2024	2024-33
Hospitalizations	$260 B	$3,103 B	-$30 B	-$370 B	-11%	-12%
Hospital Outpatient Visits	$135 B	$1,594 B	-$13 B	-$163 B	-10%	-10%
Emergency Department	$84 B	$1,013 B	-$9 B	-$117 B	-11%	-12%
Other Hospital	$141 B	$1,682 B	-$10 B	-$124 B	-7%	-7%
Physician Visits	$90 B	$1,073 B	-$6 B	-$86 B	-7%	-8%
Prescription Drugs	$263 B	$3,125 B	$1 B	$7 B	0%	0%
Other Non-Hospital	$352 B	$4,199 B	-$24 B	-$309 B	-7%	-7%
Total	**$1,325 B**	**$15,789 B**	**-$92 B**	**-$1,161 B**	**-7%**	**-7%**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

Conclusions. Medicare-X Choice would result in significant changes in the health insurance landscape, with 36.5 million[6] people leaving private coverage for the new government-run public option, and 5.5 million individuals without insurance gaining coverage. While we estimate material reductions in the number of uninsured, most of those choosing coverage under a public plan would come from those currently covered under a commercial non-group plan or ESI. We estimate reductions in total healthcare spending due to reduced payments to providers, given the large differences in prices between Medicare and commercial insurers. For hospitals and other providers, the introduction of Medicare-X Choice would reduce revenue without commensurate reductions in costs. Although the increase in the number of insured individuals would increase revenue from the formerly uninsured, higher spending from this group would not be enough to offset the lost revenue from shifts between private and public insurance coverage.

For hospitals, the introduction of a public plan that reimburses providers using Medicare rates would compound financial stresses already faced by the sector, potentially impacting access to care and provider quality. CBO projects that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law.[7] Given that Medicare pays hospitals below their costs (e.g., the Medicare Payment Advisory Commission estimates that Medicare inpatient margins will be -11 percent in 2018), Medicare-X Choice would be expected to increase the number of hospitals with negative margins.[8] While hospitals may attempt to shift some costs to commercial insurers, the ability to do this under a public plan may be limited because of the study's projected significant take-up by those in the non-group market. Policymakers should have a clear understanding of potential effects on patient access, provider payment, the commercial insurance market, and ESI (desired as well as unintended) when considering proposals to expand Medicare coverage.

[6] The 36.5 million represents movement out of the private insurance market and does not account for the 1.5 million uninsured moving into the private insurance market (see Table 2 within main report). The net change in private insurance coverage is a reduction in 35.2 million (22.6 million reduction in employer coverage plus 12.6 million reduction in non-group coverage - Table ES1).

[7] Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios. Congressional Budget Office. September 2016. Accessed at https://www.cbo.gov/publication/51919.

[8] Report to Congress - Medicare Payment Policy. Medicare Payment Advisory Commission (MedPAC). March 2018. Accessed at https://bit.ly/2Hr3Srn.

I. Introduction

Access to affordable health care coverage continues to be a major public concern. While many Americans have gained coverage since the enactment of the Affordable Care Act (ACA) through, for example, health insurance marketplaces and state Medicaid expansions, approximately 27 million non-elderly individuals living in the U.S. remain uninsured in 2017, up slightly from 2016.[9] The impact of the ACA on the uninsured differs across states with rates of uninsured ranging from 4 percent in the District of Columbia to 20 percent in Texas.[10] The reasons for this variation include: some states' declining to expand Medicaid, variation in exchange plans' premium levels, and the effectiveness of individual incentives to purchase coverage, such as the individual mandate (when it was in effect) and subsidies.

In 2017, members of the 115th Congress introduced eight legislative proposals intended to expand public health insurance coverage. Seven of the eight proposals would make Medicare or a public plan option available to a larger population than currently has access to Medicare or other public insurance (hereafter, collectively referred to as "Medicare expansion proposals"). Generally, the Medicare expansion proposals can be grouped into three types:

1. Single-payer health insurance program (Medicare-For-All: S. 1804; H.R. 676);
2. Public plan option (e.g., Medicare-X Choice Act: S. 1970; H.R. 4094);
3. Medicare buy-in option for older adults (The Medicare at 55 Act: S. 1742; Medicare Buy-In and Health Care Stabilization Act: H.R. 3748).

While the scope of each plan differs, a key similarity is that providers would be paid using Medicare rates, which are significantly less than commercial rates and, for hospitals, fall below the cost of providing care.[11] Thus, the impact of these proposals on healthcare providers is uncertain. On the one hand, expanding public insurance options could increase insurance coverage and reduce hospitals' and health systems' charity and uncompensated care costs. On the other hand, hospitals may see reductions in revenue to the extent that the policies crowd out private health insurance. Such concerns are intensified by long-term projections that show Medicare payments to hospitals dropping steeply relative to private payers over time.[12] To the extent the Medicare expansion policies negatively impact hospital and other provider revenues, the policies may not have their desired effects, due to reduced patient access or other unintended consequences.

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[9] Key Facts about the Uninsured Population. Kaiser Family Foundation. Accessed at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population.

[10] Health Insurance Coverage of Nonelderly 0-64. Kaiser Family Foundation. Accessed at https://www.kff.org/other/state-indicator/nonelderly-0-64.

[11] June 2018 Data Book. Medicare Payment Advisory Commission (MedPAC). Chart 6-19. Accessed at https://bit.ly/2EMwQ2Y.

[12] John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare & Medicaid Services. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf.

In this study, we model the effects of the Medicare-X Choice Act on coverage and healthcare spending. Although not as expansive as Medicare-for-All, Medicare-X Choice would allow any individual (other than those eligible for Medicare) to voluntarily enroll in a public plan offered on each health exchange. As a result, Medicare-X Choice's reach would be broader than other Medicare "buy-in" proposals that only allow certain age groups (e.g., age 55-64) to purchase Medicare. We assess the impact of Medicare-X Choice on coverage and healthcare spending by projecting the take-up of the new public plans among the uninsured and those with commercial health insurance.

II. Approach Overview

We modeled the effects of Medicare-X Choice by estimating insurance coverage changes due to the introduction of the new public plan, characterizing the utilization of healthcare services for those individuals whose health insurance status changes, and then estimating the effects on healthcare spending. We used the KNG Health Reform Model (KNG-HRM) to estimate individual and family insurance coverage decisions. We extended the model to incorporate healthcare utilization estimates based on individual health status and estimates of prices for healthcare services by payer. We provide an overview of our approach in the sections below (see Appendix for further detail).

a. Overview of KNG Health Reform Model (KNG-HRM)

The KNG-HRM is a microsimulation model that uses a parameterized utility function to determine individual insurance coverage choice. The model is based on data from the U.S. Census Bureau's American Community Survey (ACS), with significant inputs from the U.S. Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS), the U.S. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), and other sources.[13,14,15] In our model, individuals consider several coverage decisions, maximizing utility for their "health insurance unit (HIU)." For non-group and public plans, changes from status quo policy result in a dynamic, iterative process with HIUs selecting new coverage choices and premiums being recalculated until a new equilibrium is reached. An individual's utility is a function of healthcare consumption; out-of-pocket spending including premiums, cost-sharing reduction (CSR) subsidies and tax credits; and variance in out-of-pocket spending (to capture the value of insurance to mitigate risk of unexpectedly high healthcare expenditures). The utility model is based on the RAND COMPARE model.[16] Similar to RAND, we

[13] American Community Survey. US Census Bureau. Accessed at https://www.census.gov/programs-surveys/acs/
[14] Medical Expenditure Panel Survey. Agency for Healthcare Research and Quality. Accessed at https://meps.ahrq.gov/mepsweb.
[15] Behavioral Risk Factor Surveillance System. US Center for Disease Control and Prevention. Accessed at https://www.cdc.gov/brfss/index.html.
[16] C. Eibner and J. Liu, Options to Expand Health Insurance Enrollment in the Individual Market (The Commonwealth Fund, October 2017). Accessed at https://www.commonwealthfund.org/publications/fund-reports/2017/oct/options-expand-health-insurance-enrollment-individual-market.

include a calibration factor that varies with, for example, income group and by college student status (defined as individuals between 18 and 35 years old and in school). These factors are set so that insurance coverage take-up in the baseline period approximates empirical patterns under status quo policy.

Chronic Conditions and Health Status. We imputed general health status, smoking status, and the presence of eight chronic conditions for each ACS respondent, based on age, race, sex, state of residence, education, and disability status. The included chronic conditions were obesity, diabetes, asthma, skin cancer, other cancer, heart attack, angina, and stroke. Incidence rates for the chronic conditions were estimated in the BRFSS using a series of logistic regression models. We then applied the regression coefficients from the BRFSS to the ACS. Our approach accounted for two-way correlations across condition categories.

Healthcare Utilization. We estimate healthcare utilization and spending for each individual in the ACS, based on an individual's demographics and imputed health status, including general health, presence of select chronic conditions, and disabilities. We estimate a series of zero inflated Poisson (ZIP) regressions using the MEPS with healthcare use as the dependent variable (number of prescription medications, hospital discharges, outpatient department physician visits, office-based physician visits, and emergency room visits). We include age, race, gender, geographic region, household size, perceived health status, smoking status, chronic condition indicators, and disability indicators as explanatory variables. We then evaluate the regression model estimated in MEPS for each respondent in the ACS using factors in the ACS or imputed to the ACS (see online Appendix at www.knghealth.com). When imputing utilization in the ACS, we apply adjustments to replicate the two-way correlations in utilization across service categories that are empirically observed in the MEPS.

Healthcare Prices. We convert healthcare utilization into spending by multiplying use rates by prices. Commercial insurer prices were obtained from publicly available data from the Health Care Cost Institute (HCCI). We developed comparable Medicare prices using studies from the Congressional Budget Office (CBO) and other sources that compare commercial provider payment rates to Medicare (See Appendix). In addition, we allow both commercial and Medicare prices to vary geographically. For commercial prices, we use the HCCI Healthy Marketplace Index (HMI) to develop a commercial price index by geographic area and imputed an index value for geographic areas not included in the HMI. To account for geographic and provider variation in Medicare prices, we use the input price and policy adjustments under the Medicare fee schedules (e.g., wage index, indirect medical education, and geographic practice cost index).

Because of scheduled productivity adjustments under current law, Medicare payment rates are expected to fall relative to other payers. We incorporate these expected changes when projecting future prices based on estimates from the CMS Office of the Actuary.[17]

Uninsured Prices. There is limited data available on prices paid by uninsured populations. People without health insurance coverage are often billed charges, but then receive discounts through charity care programs. Following analyses of the AHA Annual Survey data for hospital services and estimates in the literature, we assume that the uninsured pay rates comparable to Medicare for hospital services and rates comparable to commercial payers for other services.[18,19]

Premiums. Coverage decisions are made to maximize utility for the HIU. When new policies or events upset the status quo equilibrium, individuals change their coverage category, leading to shifts in the average healthiness of local risk pools. The model dynamically adjusts non-group and public plan premiums to account for these shifts, prompting all individuals to reevaluate their coverage decisions. When a new equilibrium is reached, we observe coverage decisions and premiums. In the baseline, we establish premiums for only one plan in each state, with the plan assumed to be at the silver-metal level. Total premiums are calculated based on the expected plan liability in the rating area and inflated to account for administrative costs. Family premiums are assigned using the Marketplace age- and tobacco-rating rules. The model does not dynamically estimate employer premiums.

Projections. We use information on demographic trends from the U.S. Census Bureau, which reports population projections by combinations of single year of age, sex, race, Hispanic status, and native status.[20] We also adjust health spending and income in future years, relying on CBO's projections of CPI-M and CPI-U, respectively.

b. Modeling Medicare-X Choice

The introduction of new public plans such as Medicare-X Choice fits naturally into our KNG-HRM framework. We assess each individual's eligibility based on factors already known in the model – marketplace eligibility, documentation status, and incarceration status. For eligible individuals, we add an additional coverage option to their choices, and they make decisions to maximize utility as usual. Elements of program design such as benefit generosity, premiums (net of subsidies), and cost sharing impact the utility from any choice.

Assumptions Affecting Changes in Insurance Coverage Type. For purpose of modeling the effects of Medicare-X Choice, we assume no impact for those currently enrolled in Medicaid or

[17] John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare & Medicaid Services. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2018TRAlternativeScenario.pdf.

[18] Melnick and Fonkych. Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices? Health Affairs. 2008. Accessed at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.w116.

[19] Gruber and Rodriguez, How Much Uncompensated Care Do Doctors Provide? Journal of Health Economics. 2007. Accessed at https://economics.mit.edu/files/6423.

[20] 2017 National Population Projections Datasets. U.S. Census Bureau. Accessed at https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html.

Medicare. That is, we assume no change in enrollment in those programs between the baseline and after introduction of Medicare-X Choice. For individuals currently enrolled in ESI, we do allow movement from employer coverage to other options (public plan, non-group, or uninsured). However, we impose some limitations on this movement. First, we apply the public plan eligibility criteria and prevent ineligible individuals on ESI to move onto a public plan. Second, we do not allow ESI policyholders to move off employer coverage while non-policyholders in their health insurance unit remain on employer coverage. Third, consistent with ACA requirements, individuals on ACA-compliant and affordable employer coverage are not eligible for premium or cost-sharing subsidies for non-group or public plans. However, individuals on employer coverage are eligible for employer subsidies and benefit from paying ESI premiums with pre-tax dollars. We include these employer subsidies and ESI tax benefits in our choice model. While we allow movement from employer coverage to other options at the individual level, in other respects we treat the ESI market as static. We do not adjust ESI premiums based on changing risk pools as some individuals choose other options. Moreover, we do not model firm behavior, holding constant firms' decisions regarding ESI offer, ESI premium subsidies, and compensation levels. Therefore, our findings do not reflect potential impacts of Medicare-X Choice on ESI premiums or availability of employer coverage.

Changes in Utilization of Services and Healthcare Spending. Changes in the distribution of health insurance coverage after the introduction of an expanded Medicare program drive estimated changes in total utilization of healthcare services over the study period. For the uninsured, the Oregon Health Insurance Experiment provides an estimate on the change in utilization as individuals move from being uninsured to Medicaid, which we used to predict changes in utilization rates for uninsured populations moving onto a public plan.[21] We assume no change in utilization rates for privately insured populations moving onto the public plan. We also assume no change in utilization rates over time. Finally, healthcare spending changes because of the different prices paid to providers by the uninsured, under the public plan, and commercial insurance.

Drug Prices. Under the Medicare-X Choice Act, the Department of Health and Human Services Secretary would have authority to negotiate drug prices.[22] In prior analyses, the Congressional Budget Office has expressed skepticism that granting authority for the Secretary to negotiate drug prices in Medicare would yield savings, unless Medicare used a restrictive formulary or some other mechanism to create bargaining leverage with drug companies.[23] We assume that drug prices paid by commercial plans and the government under Medicare-X Choice would be comparable. Therefore, we used our estimate of commercial drug prices for drug prices under the public plan.

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[21] Finkelstein A, Taubman S, Wright B, et al. The Oregon Health Insurance Experiment: Evidence from the First Year. Quarterly Journal of Economics. 2012. Accessed at https://www.nber.org/papers/w17190.

[22] The proposal also provides the Secretary the authority to negotiate drug prices under Medicare Part D. However, individuals eligible for Medicare Part A and B are not eligible for the Medicare-X Choice plan; we assume no direct impact of Medicare Part D drug prices on drug prices for the public plans.

[23] Cubanski, J. and Neuman, T. Searching for Savings in Medicare Drug Price Negotiations. Kaiser Family Foundation. April 2018. Issue Brief. Accessed at http://files.kff.org/attachment/issue-brief-searching-for-savings-in-medicare-drug-price-negotiations

Reinsurance. The Medicare-X Choice Act allows for the development of a reinsurance mechanism to reduce premiums, although the Medicare-X Choice Act does not specify features of the reinsurance proposal. During its initial years, the ACA established a reinsurance program from 2014 to 2016. In the last year (2016 - the least generous) the program covered 50 percent of claims costs exceeding $90,000 and capped at $250,000. The American Academy of Actuaries estimated that this would reduce net claims by 4 to 6 percent.[24] Under the ACA, the reinsurance program was funded, at least in part, by a fee on all health plans and third-party administrators (to access self-insured plans). However, the reinsurance program directed funds to plans on the exchanges. Under Medicare-X Choice, the reinsurance program may be funded by fees on those health plans that would benefit. Thus, the fees could be expected to offset the impact of the reinsurance program on premiums. Because of uncertainty regarding the source of the fees, we assumed that premiums for non-public plans in the non-group market would be reduced by half of what the American Academy of Actuaries estimated the impact of the 2016 ACA Reinsurance program would have on net claims (2.5%).

c. Estimating the Coverage Impact of a Fully Implemented ACA

Though the ACA provided enhanced Federal Funds to support states in expanding their Medicaid program, fourteen states have continued to opt out of the Medicaid coverage expansion. In a 2018 report, the Urban Institute estimated that if these states expanded Medicaid coverage to all adults with incomes below 138 percent of the Federal Poverty Level, the number of uninsured would reduce by 4.1 million in 2019.[25] In a separate report, the Urban Institute estimated the effects on insurance coverage from recent policy changes, such as repeal of the individual mandate, defunding the cost-sharing reduction payments, and reduced Federal investment in advertising and enrollment assistance.[26] This analysis found that moving from insurance coverage policies in effect during the 2017 Open Enrollment Period (OEP) to policies in effect during the 2018 OEP would result in 4.7 million additional uninsured people in 2019. These findings suggest that under a fully implemented ACA scenario, where all states adopted the Medicaid expansion and the Federal government reverted to 2017 OEP policies, there would be 8.8 million fewer uninsured people in 2019. Our own model suggests that the number of uninsured will increase by 4.1 percent between 2019 and 2024 under current law. This suggests that a fully implemented ACA would increase insurance coverage by 9.1 million in 2024.

[24] American Academy of Actuaries. Drivers of 2016 Health Insurance Premium Changes. August 2015. Issue Brief.
[25] Buettgens M. The Implications of Medicaid Expansion in the Remaining States: 2018 Update. The Urban Institute. Accessed at https://urbn.is/2QnkqGg.
[26] Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. The Urban Institute. Accessed at https://urbn.is/2G07k8E.

III. Key Findings

Changes in Insurance Coverage. We estimate that by 2024 approximately 173.8 million individuals will be insured through either an employer or a plan in the non-group market with another 29.0 million uninsured in the baseline. By 2033 without any changes in policy, the number of individuals in ESI and non-group would grow by 2.4 million and the uninsured would grow by 2.2 million (Table 1). Under Medicare-X Choice, we estimate that public plan participation would be 40.7 million in 2024 and 42.3 million in 2033.

Table 1. Change in Insurance Coverage Status – 2024 and 2033

			Change in Coverage under Medicare-X Choice			
Source of Coverage	Baseline		Coverage Change		Percent Change	
	2024	2033	2024	2033	2024	2033
Employer	152.7 M	154.9 M	-22.6 M	-21.4 M	-15%	-14%
Non-Group	21.1 M	21.3 M	-12.6 M	-14.0 M	-60%	-66%
Uninsured	29.0 M	31.2 M	-5.5 M	-6.9 M	-19%	-22%
Public			40.7 M	42.3 M	n/a	n/a

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: n/a = Not Applicable. Components may not sum to totals because of rounding.

We estimate that take-up of the public plan, on a percentage basis, is high among those currently on commercial non-group coverage and, while smaller, significant among the uninsured and those on ESI in the baseline. Under the Medicare-X Choice plan, the uninsured and the commercially insured on the non-group market would fall by a net reduction of 5.5 and 12.6 million in 2024, respectively (Table 1). These reductions reflect a take-up of the public plan of:

- 22.3 million from the employer market (15 percent of the employer market);
- 14.2 million from the non-group market (67 percent of the non-group market); and
- 4.2 million uninsured (14 percent of all uninsured)

Overall, we estimate a reduction in the uninsured of 5.5 million with the introduction of the Medicare-X Choice plan, with 4.2 million gaining coverage under the public plan and 1.5 million gaining non-group coverage (Table 2). Thus, under Medicare-X Choice, there would be 23.5 uninsured individuals in 2024 and 24.3 uninsured individuals in 2033. We observe some differences in take-up rates across states among the uninsured, those in a commercial non-group plan, and those on ESI at baseline (Appendix Table A2).

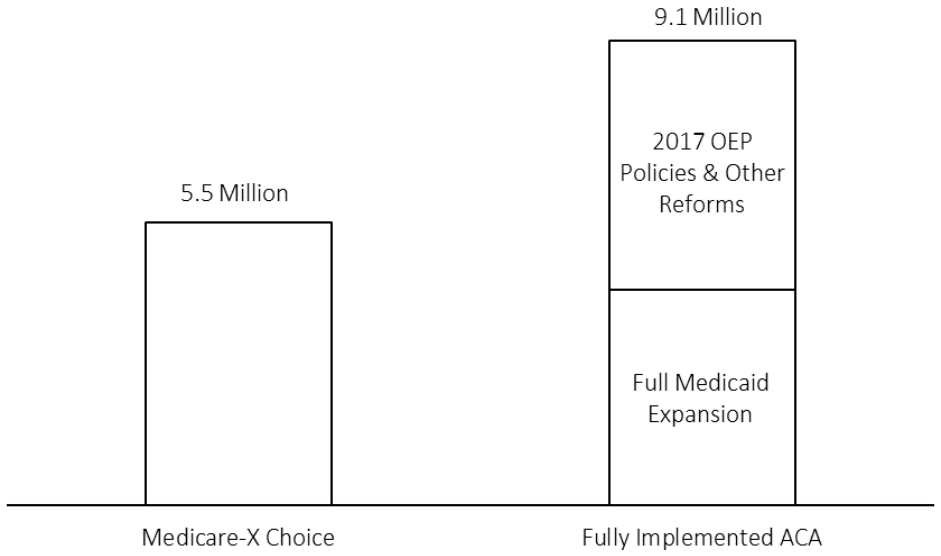
Table 2. Take-up of Public Plan among the Uninsured, Commercially Insured Individuals on the Non-Group Market, and ESI in 2024

		Coverage Levels	
Baseline Coverage	Post Coverage	Baseline	Medicare-X Choice
Employer	Employer	152.7 M	130.1 M
	Non-Group		0.2 M
	Public		22.3 M
	Uninsured		0.1 M
Non-Group	Non-Group	21.1 M	6.8 M
	Public		14.2 M
	Uninsured		0.1 M
Uninsured	Uninsured	29.0 M	23.3 M
	Public		4.2 M
	Non-Group		1.5 M

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Components may not sum to totals because of rounding.

We compare estimated reductions in the number of uninsured under Medicare-X Choice in 2024 to the impact of a fully implemented ACA (Figure 1). We find that a fully implemented ACA would result in 9.1 million fewer uninsured individuals, compared with 5.5 million fewer uninsured individuals under Medicare-X Choice. Under a fully implemented ACA, ESI enrollment would fall by approximately 1 percent. By comparison, we project a 15-percent decline in ESI under Medicare-X Choice. This difference in ESI crowd-out may reflect ACA design elements that specifically target the uninsured population, while being minimally disruptive to the existing private insurance market.

Figure 1. Reductions in Number of Uninsured under Medicare-X Choice and Fully Implemented ACA



Source: KNG Health analysis of the KNG-Health Reform Model and data from the Urban Institute.

Changes in Healthcare Spending. In our baseline, we estimate total healthcare spending of $1.3 trillion in 2024 among those with ESI coverage, non-group coverage, or among those individuals who are uninsured (Table 3). We project this to grow to $1.9 trillion by 2033 due to population changes and price inflation. Under Medicare-X Choice, spending would fall by $1.2 trillion over the ten-year period. The spending reductions occur among populations who previously had private coverage and are the result of lower prices under the public plan. For those who previously had ESI and non-group coverage, spending would fall by 4 percent and 29 percent, respectively. The larger non-group spending impact is driven by both higher per-person spending and higher take-up rates among that population. Among those uninsured in the baseline, we estimate spending would increase by 9 percent, which is driven by higher service utilization rates for those gaining insurance coverage. This increase in spending for the originally uninsured partially offsets the reduction in spending among the other groups.

Table 3. Spending by Original Source of Coverage in Baseline and Under Medicare-X Choice

Original Source of Coverage	Baseline		Impact	
	2024	2024-2033	2024	2024-2033
Employer	$1,026 B	$12,153 B	-$40 B	-$474 B
Non-Group	$222 B	$2,698 B	-$59 B	-$775 B
Uninsured	$77 B	$938 B	$7 B	$88 B
Total	**$1,325 B**	**$15,789 B**	**-$92 B**	**-$1,161 B**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

Effects on spending by category of service. While hospital-based services (e.g., hospitalizations, hospital outpatient visits, emergency department visits, and other hospital services) represent 47 percent of total baseline healthcare spending, these services would account for 67 percent of the reduction in total healthcare spending. In total, under Medicare-X Choice, hospitals would experience a $774 billion reduction in payments for the studied population between 2024 and 2033. These reductions translate into a 10-percent reduction in payments to hospitals. Spending would fall for all types of healthcare services with the exception of prescription drugs, which would increase slightly. The pattern in drug spending is driven by two factors. First, we assumed that prescription drug prices are constant across Medicare, commercially insured, and uninsured populations. Second, we assumed that prescription drug use would increase for the uninsured as they gain coverage under the Medicare-X Choice proposal.

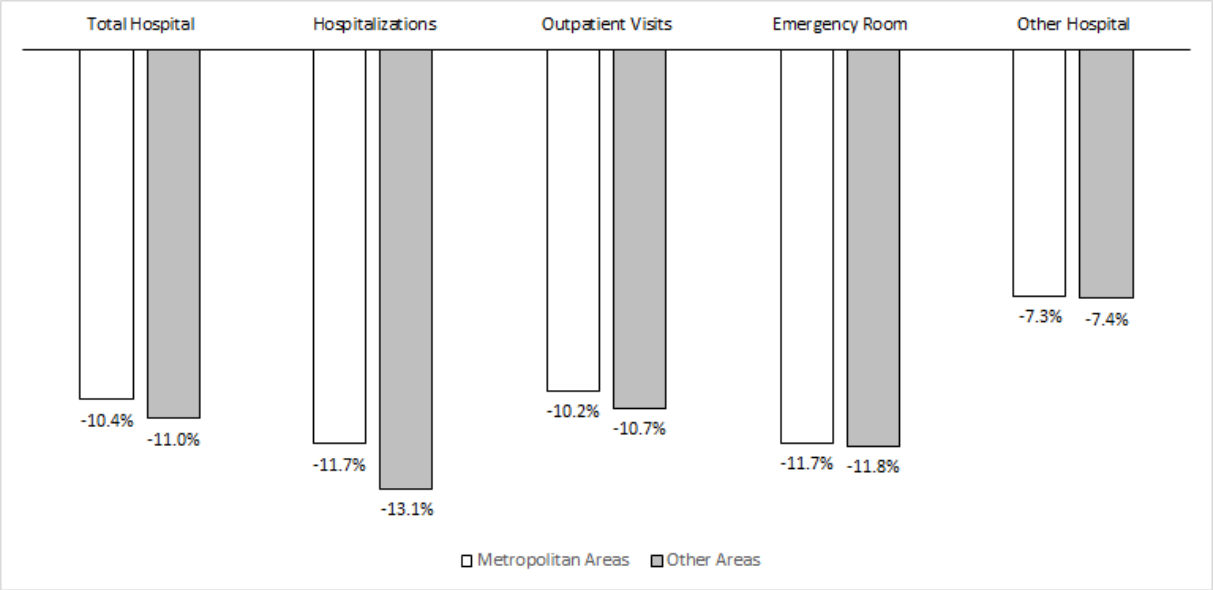
Table 4. Spending by Type of Service in Baseline and Under Medicare-X Choice

Type of Service	Baseline		Change in Spending by Service (1-Year and 10-Year)			
			Dollars		Percent	
	2024	2024-2033	2024	2024-2033	2024	2024-2033
Hospital	$620 B	$7,392	-$62 B	-$774 B	-10%	-10%
Hospitalizations	$260 B	$3,103 B	-$30 B	-$370 B	-11%	-12%
Hospital Outpatient Visits	$135 B	$1,594 B	-$13 B	-$163 B	-10%	-10%
Emergency Department	$84 B	$1,013 B	-$9 B	-$117 B	-11%	-12%
Other Hospital	$141 B	$1,682 B	-$10 B	-$124 B	-7%	-7%
Non-Hospital	$705 B	$8,397	-$30 B	-$388 B	-4%	-5%
Physician Visits	$90 B	$1,073 B	-$6 B	-$86 B	-7%	-8%
Prescription Drugs	$263 B	$3,125 B	$1 B	$7 B	0%	0%
Other Non-Hospital	$352 B	$4,199 B	-$24 B	-$309 B	-7%	-7%
Total	**$1,325 B**	**$15,789 B**	**-$92 B**	**-$1,161 B**	**-7%**	**-7%**

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE). Components may not sum to totals because of rounding.

Effects on spending by location type. Medicare-X Choice would produce larger relative impacts to hospital spending in non-metropolitan areas (outside metropolitan areas, mixed areas) than in metropolitan areas. Figure 2 illustrates these differential relative impacts. Since 81 percent of baseline hospital spending occurs in metropolitan areas, Medicare-X Choice would produce larger absolute impacts to hospital spending in metropolitan areas than non-metropolitan areas.

Figure 2. Differences in Spending Impacts between Metropolitan Areas and Other Areas under Medicare-X Choice



Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Spending excludes populations covered by public coverage (e.g., Medicaid, TRICARE)

IV. Conclusions

In this study, we model the effects of the Medicare-X Choice Act, which would introduce a public plan on the health insurance exchange markets. We estimated the effects on insurance coverage and healthcare spending using the KNG-Health Reform Model and after incorporating geographic variation in both healthcare utilization and prices. We estimate that public plan participation would be 40.7 million in 2024, which would include 36.5 million who were previously insured in private plans. Medicare-X Choice reduces the number of uninsured by 5.5 million, 4.2 million of whom would gain coverage in the new public option, and 1.5 million who would gain non-group coverage. The public plan take-up rates are the highest among those previously covered on the non-group market and are projected to be 67 percent. We estimate a 7-percent reduction ($1.2 trillion) in overall healthcare spending for the studied populations, but a 9-percent increase ($88 billion) in spending for those who would otherwise be uninsured. Reductions in spending are predominantly driven by a shift from private to public coverage and the lower Medicare provider payment rates that would apply. Hospital-based services would be disproportionately affected by the policy and would experience a 10-percent reduction in payments among the relevant population.

For hospitals, the introduction of a public plan that reimburses providers using Medicare rates would compound financial stresses they are already facing, potentially impacting access to care and provider quality. CBO projects that between 40 and 50 percent of hospitals could have negative margins by 2025 under current law.[27] Given that Medicare already pays hospitals below their costs (e.g., the Medicare Payment Advisory Commission estimates that Medicare hospital margins will be -11 percent in 2018), Medicare-X Choice would be expected to increase the number of hospitals with negative margins. While hospitals may attempt to shift some costs to commercial insurers, the ability to do this under a public plan may be limited because of the potentially significant take-up by those in the non-group market. Policymakers should have a clear understanding of potential effects on patient access, provider payment, the commercial insurance market, and ESI (desired as well as unintended) when considering proposals to expand Medicare coverage.

[27] Projecting Hospitals' Profit Margins Under Several Illustrative Scenarios. Congressional Budget Office. September 2016. Accessed at https://www.cbo.gov/publication/51919.

V. Appendix

a. Sensitivity Analysis and Limitations

Our findings are dependent on several key assumptions but are particularly sensitive to assumptions on price and utilization levels under the public plan option. Within our model, significant take-up in the public plan option is driven by lower premiums and lower out-of-pockets costs relative to private insurance, which is a result of lower prices paid to providers under the public option. However, for some categories of services, the risk-adjusted Medicare-to-commercial price ratio is unknown. Lastly, while we assume that utilization for previously-insured public plan enrollees does not change, utilization could conceivably change for this population and such trends could also affect price levels. In particular, we might expect utilization under Medicare-X Choice to be higher than under commercial plans, because commercial insurers use utilization review, narrow networks, and other tools to control healthcare use and the public plan may not. Conversely, significantly lower prices could reduce provider participation, which might hinder access to care and decrease utilization under Medicare-X Choice. In addition, the Medicare-X Choice proposal would allow Medicare prices to increase by up to 25 percent in rural areas. Table A1 illustrates how assumptions related to price levels and utilization affect public plan take-up within our model.

Table A1. Sensitivity of Medicare-X Choice 2024 Coverage Impacts to Price and Utilization Assumptions

	Midpoint Scenario	25% Lower Public Plan Prices	25% Higher Public Plan Prices	25% Higher Public Utilization
Employer	-22.6 M	-24.5 M	-21.3 M	-22.8 M
Non-Group	-12.6 M	-12.6 M	-11.8 M	-11.9 M
Uninsured	-5.5 M	-6.5 M	-4.6 M	-5.3 M
Public	40.7 M	43.5 M	37.8 M	40.0 M

Source: KNG Health analysis of public plan options using the KNG-Health Reform Model.
Note: Components may not sum to totals because of rounding.

Prior studies on the impact of the introduction of a public plan show a range of estimates. In November 2013, the CBO reported its estimates of the impact of adding a public plan to the health insurance exchanges.[28] The public plan considered by CBO was similar to the public plan under Medicare-X Choice: (1) the public plan would have to charge premiums that fully covered its costs, including administrative expenses; and (2) the payment rates to providers would be based on Medicare rates. CBO estimated that the number of uninsured would fall by 2 million and ESI coverage would fall by about the same amount. In 2018, researchers from the Urban Institute proposed the "Healthy America Program."[29] Under this proposal, there would be a new

[28] Add a "Public Plan" to the Health Insurance Exchanges. Congressional Budget Office. Accessed at https://www.cbo.gov/budget-options/2013/44890.
[29] Linda J. Blumberg, John Holahan, Stephen Zuckerman. The Healthy America Program. The Urban Institute. Accessed at https://www.urban.org/sites/default/files/publication/98432/2001826_2018.05.11_healthy_america_final_9.pdf.

national public plan option, enhanced premium and cost-sharing subsidies, and tax penalties for remaining uninsured. The authors characterize the proposal as more comprehensive than Medicare-X Choice. Under the Healthy America Program, the ESI population is estimated to fall by 18 million, non-group coverage by 14 million, and the uninsured by 16 million.

Like the Urban Institute, we estimate a significantly larger effect of a public plan on the uninsured and ESI than CBO. Our estimates of reductions in non-group coverage are comparable to the Urban Institute (-13 M vs. -13 M). However, we project greater fall off of ESI coverage (-18 M vs -23 M) and smaller reductions in the number of uninsured (-16 M vs. -6 M). The differences in the impact on the uninsured can be explained, at least in part, by the tax penalties and enhanced premium and cost sharing subsidies in the Healthy America Program. The reason for our higher estimate of ESI crowd out from a public plan is less clear. The Urban Institute estimates ESI premiums dynamically. To the extent a public plan reduces ESI premiums because of a healthier risk pool, Urban's model would make ESI more attractive to consumers than in our model. Our results indicate that take-up of the public plan for those on ESI in the baseline is sensitive to the public plan prices paid to providers. The differential between commercial and Medicare prices used by the Urban Institute is unclear.

Our analysis has several limitations. We do not consider the diversity of plan design in the non-group market, instead imposing homogenous plan designs within each market representative of typical marketplace plan features in the status quo. We do not model competition among health plans and, in fact, model a single, representative plan for each state. The introduction of a public plan in each market, as under Medicare-X Choice, could create competitive pressures and lower premiums for commercial plans. As a result, these plans may look more attractive to consumers than our model would suggest. In addition, we made a series of simplifying assumptions to assess the effects of a public plan on ESI coverage. First, we held ESI premiums fixed at baseline levels (only updating for medical inflation). In practice, ESI premiums may change with introduction of a public plan, making ESI more or less attractive as compared to the baseline. Second, we do not model non-economic considerations that could reduce ESI drop-off, such as behavioral inertia or a cultural preference for employer coverage over public coverage. As noted above, we assume no impact on use of healthcare services from take-up of the public plan by those previously insured on the non-group market or ESI. In assessing geographic differences in the relationship between commercial and Medicare prices, we relied on data populated for select areas. For many areas (particularly small markets), the relationship is imputed, by taking the nearest area for which we have data or, in areas without nearby data, a broader regional average.

b. Additional Study Methods

Price Assumptions. Medicare payment rates are generally lower than those set by commercial payers. This suggests that populations moving from commercial to public plans that use Medicare fee schedules would likely reduce provider reimbursement. Consequently, our model must incorporate price differentials between Medicare and commercial plans. To estimate the

magnitude of this differential, we reviewed studies that compared Medicare and commercial prices for the same set of services. In 2017 and 2018, the Congressional Budget Office (CBO) released two studies comparing prices for commercial and Medicare hospital admissions and physician care. In their analysis of hospitals using data from the Health Care Cost Institute (HCCI), CBO found that commercial insurers paid 89 percent more than Medicare for inpatient hospitalizations.[30] The findings were similar for both medical and surgical admissions.

CBO also found that commercial insurers paid more than Medicare for physician services but did not report an overall average difference.[31] We used the service taxonomy provided by the HCCI to classify the twenty physician services analyzed by CBO into four physician service categories: office visits, surgical services, radiology services, and other professional services.[32] Within a service category, we computed an unweighted average commercial-to-Medicare payment ratio for all reported services in the category. Next, we linked these average ratios to commercial per-capita spending amounts from the HCCI. We then computed an overall mean commercial-to-Medicare payment ratio by computing the average commercial-to-Medicare payment ratios across the four service categories, weighted by the per-capita spending amount in each service category. This calculation resulted in an overall commercial-to-Medicare ratio of 1.49 for physician services.

Table A2. Calculation of Overall Physician Commercial-to-Medicare Payment Ratio

Service Category	Commercial Per Capita Spending	Mean Commercial-to-Medicare Payment Ratio
Office Visits	$385.91	1.12
Surgical Services	$280.63	1.70
Radiology Services	$133.58	2.17
Other Professional Services	$523.26	1.47
Weighted Mean Commercial-to-Medicare Ratio		1.49

Sources: Maeda 2017; Health Care Cost Institute Annual Report
Categories: Office Visits: 99203, 99213, 99214; Surgical services: 17311, 19081, 27130, 27447, 29881, 45385, 47562, 58558, 66984; Radiology services: 70553, 74183, 77418, 78815; Other Professional: 92928, 93000, 93458, 99232

CBO has not released an analysis comparing differences in commercial and Medicare payment rates for outpatient hospital services. In a 2017 Report to Congress, the Medicare Payment

[30] An Analysis of Private-Sector Prices for Hospital Admissions. Congressional Budget Office. 2017. Accessed at https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf.
[31] An Analysis of Private-Sector Prices for Physicians' Services: Working Paper 2018-01. Congressional Budget Office. 2018. Accessed at https://www.cbo.gov/publication/53441.
[32] HCCI Professional Service Categories – CPT Procedure Codes. Health Care Cost Institute. 2016. Accessed at https://www.healthcostinstitute.org/research/research-resources.

Advisory Commission (MedPAC) stated that commercial rates "are often far more than 50 percent above Medicare rates."[33] A 2010 study from the Center for Studying Health System Change found that private insurer rates for hospital outpatient services were between 134 percent and 266 percent of Medicare rates across eight studied markets.[34] This is consistent with public filing reports from California insurers which showed commercial outpatient rates that were 200 percent more than Medicare.[33] We will assume that the inpatient commercial-to-Medicare payment ratio estimated by CBO (1.89) is also applicable in the outpatient setting, which is on the lower end of the range reported in published research.

[33] Report to the Congress: Medicare Payment Policy Chapter 3. Medicare Payment Advisory Commission. 2017. Accessed at http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch3.pdf.

[34] Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. Center for Studying Health System Change. 2010. Available at http://www.hschange.org/CONTENT/1162/.

c. Additional Results

Table A3. State-level Coverage Impacts in 2024

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024			Impact 2024			
	Employer	Non-Group	Uninsured	Employer	Non-Group	Uninsured	Public
AK	0.3 M	0.0 M	0.1 M	0.0 M	0.0 M	0.0 M	0.1 M
AL	2.1 M	0.3 M	0.5 M	-0.3 M	-0.1 M	-0.1 M	0.5 M
AR	1.2 M	0.2 M	0.2 M	-0.2 M	-0.1 M	0.0 M	0.3 M
AZ	3.1 M	0.4 M	0.7 M	-0.5 M	-0.3 M	-0.1 M	0.9 M
CA	17.9 M	2.9 M	2.9 M	-2.5 M	-1.7 M	-0.5 M	4.8 M
CO	2.6 M	0.4 M	0.4 M	-0.4 M	-0.2 M	-0.1 M	0.7 M
CT	1.8 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.4 M
DC	0.3 M	0.1 M	0.0 M	0.0 M	0.0 M	0.0 M	0.1 M
DE	0.5 M	0.0 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
FL	8.3 M	2.1 M	2.9 M	-1.1 M	-1.4 M	-0.6 M	3.1 M
GA	4.8 M	0.7 M	1.4 M	-0.8 M	-0.4 M	-0.2 M	1.4 M
HI	0.8 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IA	1.6 M	0.2 M	0.1 M	-0.2 M	-0.1 M	0.0 M	0.3 M
ID	0.7 M	0.2 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IL	6.6 M	0.8 M	0.9 M	-1.0 M	-0.5 M	-0.2 M	1.7 M
IN	3.3 M	0.4 M	0.5 M	-0.5 M	-0.2 M	-0.1 M	0.8 M
KS	1.5 M	0.2 M	0.2 M	-0.2 M	-0.1 M	0.0 M	0.4 M
KY	1.9 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.4 M
LA	1.9 M	0.3 M	0.4 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
MA	3.6 M	0.4 M	0.2 M	-0.6 M	-0.3 M	0.0 M	0.9 M
MD	3.2 M	0.3 M	0.4 M	-0.6 M	-0.2 M	-0.1 M	0.9 M
ME	0.6 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
MI	4.8 M	0.5 M	0.5 M	-0.7 M	-0.4 M	-0.1 M	1.1 M
MN	3.1 M	0.3 M	0.2 M	-0.5 M	-0.3 M	-0.1 M	0.9 M
MO	2.9 M	0.4 M	0.5 M	-0.4 M	-0.3 M	-0.1 M	0.8 M
MS	1.2 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
MT	0.4 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NC	4.6 M	0.8 M	1.2 M	-0.7 M	-0.5 M	-0.2 M	1.4 M
ND	0.4 M	0.1 M	0.0 M	-0.1 M	0.0 M	0.0 M	0.1 M
NE	1.0 M	0.1 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.3 M
NH	0.7 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NJ	4.9 M	0.5 M	0.7 M	-0.7 M	-0.3 M	-0.2 M	1.2 M
NM	0.7 M	0.1 M	0.2 M	-0.1 M	0.0 M	0.0 M	0.2 M
NV	1.5 M	0.2 M	0.4 M	-0.2 M	-0.1 M	0.0 M	0.3 M
NY	9.0 M	1.2 M	1.1 M	-1.3 M	-0.5 M	-0.2 M	2.0 M
OH	5.7 M	0.5 M	0.7 M	-0.8 M	-0.3 M	-0.1 M	1.2 M
OK	1.5 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
OR	1.9 M	0.3 M	0.3 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
PA	6.3 M	0.7 M	0.7 M	-0.9 M	-0.5 M	-0.1 M	1.5 M
RI	0.5 M	0.1 M	0.0 M	-0.1 M	0.0 M	0.0 M	0.1 M
SC	2.1 M	0.3 M	0.6 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
SD	0.4 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.1 M
TN	3.1 M	0.4 M	0.6 M	-0.5 M	-0.3 M	-0.2 M	0.9 M
TX	13.3 M	1.8 M	5.3 M	-2.0 M	-1.0 M	-1.0 M	4.0 M
UT	2.0 M	0.3 M	0.3 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
VA	4.2 M	0.6 M	0.7 M	-0.6 M	-0.4 M	-0.1 M	1.1 M
VT	0.3 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M
WA	3.6 M	0.4 M	0.5 M	-0.6 M	-0.3 M	-0.1 M	0.9 M
WI	3.1 M	0.3 M	0.3 M	-0.4 M	-0.1 M	-0.1 M	0.6 M
WV	0.7 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
WY	0.3 M	0.0 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
US	**152.7 M**	**21.1 M**	**29.0 M**	**-22.6 M**	**-12.6 M**	**-5.5 M**	**40.7 M**

Table A4. State-level Coverage Impacts in 2033

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024			Impact 2024			
	Employer	Non-Group	Uninsured	Employer	Non-Group	Uninsured	Public
AK	0.3 M	0.0 M	0.1 M	0.0 M	0.0 M	0.0 M	0.1 M
AL	2.1 M	0.3 M	0.5 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
AR	1.2 M	0.2 M	0.3 M	-0.2 M	-0.1 M	0.0 M	0.3 M
AZ	3.4 M	0.4 M	0.8 M	-0.5 M	-0.3 M	-0.2 M	1.0 M
CA	18.0 M	2.9 M	3.2 M	-2.3 M	-2.0 M	-0.6 M	4.9 M
CO	2.5 M	0.4 M	0.4 M	-0.4 M	-0.2 M	-0.1 M	0.7 M
CT	1.8 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.5 M
DC	0.4 M	0.1 M	0.0 M	0.0 M	0.0 M	0.0 M	0.1 M
DE	0.5 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
FL	8.6 M	2.2 M	3.1 M	-1.1 M	-1.5 M	-0.7 M	3.4 M
GA	4.9 M	0.7 M	1.5 M	-0.7 M	-0.4 M	-0.3 M	1.5 M
HI	0.9 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IA	1.5 M	0.2 M	0.1 M	-0.2 M	-0.1 M	0.0 M	0.3 M
ID	0.7 M	0.2 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.2 M
IL	6.7 M	0.8 M	1.0 M	-0.9 M	-0.5 M	-0.2 M	1.7 M
IN	3.3 M	0.4 M	0.6 M	-0.4 M	-0.2 M	-0.1 M	0.8 M
KS	1.5 M	0.2 M	0.3 M	-0.2 M	-0.1 M	0.0 M	0.4 M
KY	1.9 M	0.2 M	0.2 M	-0.3 M	-0.1 M	0.0 M	0.4 M
LA	1.9 M	0.3 M	0.4 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
MA	3.6 M	0.4 M	0.2 M	-0.5 M	-0.3 M	0.0 M	0.8 M
MD	3.3 M	0.3 M	0.4 M	-0.6 M	-0.3 M	-0.1 M	0.9 M
ME	0.6 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
MI	4.8 M	0.5 M	0.5 M	-0.6 M	-0.3 M	-0.1 M	1.1 M
MN	3.1 M	0.3 M	0.3 M	-0.4 M	-0.2 M	-0.1 M	0.8 M
MO	2.9 M	0.4 M	0.5 M	-0.4 M	-0.3 M	-0.1 M	0.8 M
MS	1.1 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
MT	0.4 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.1 M
NC	4.9 M	0.8 M	1.3 M	-0.7 M	-0.5 M	-0.3 M	1.5 M
ND	0.4 M	0.1 M	0.0 M	-0.1 M	0.0 M	0.0 M	0.1 M
NE	1.0 M	0.1 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.3 M
NH	0.7 M	0.1 M	0.1 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NJ	5.1 M	0.5 M	0.8 M	-0.7 M	-0.3 M	-0.2 M	1.2 M
NM	0.8 M	0.1 M	0.2 M	-0.1 M	-0.1 M	0.0 M	0.2 M
NV	1.6 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
NY	8.6 M	1.2 M	1.2 M	-1.2 M	-0.7 M	-0.2 M	2.1 M
OH	5.6 M	0.5 M	0.7 M	-0.7 M	-0.3 M	-0.2 M	1.2 M
OK	1.6 M	0.2 M	0.4 M	-0.2 M	-0.1 M	-0.1 M	0.4 M
OR	1.9 M	0.3 M	0.3 M	-0.3 M	-0.2 M	-0.1 M	0.5 M
PA	6.2 M	0.7 M	0.7 M	-0.8 M	-0.5 M	-0.2 M	1.5 M
RI	0.5 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
SC	2.1 M	0.3 M	0.6 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
SD	0.4 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
TN	3.2 M	0.4 M	0.7 M	-0.5 M	-0.3 M	-0.2 M	1.0 M
TX	14.2 M	1.9 M	5.9 M	-2.0 M	-1.2 M	-1.4 M	4.6 M
UT	2.2 M	0.3 M	0.4 M	-0.3 M	-0.2 M	-0.1 M	0.6 M
VA	4.3 M	0.6 M	0.8 M	-0.6 M	-0.4 M	-0.2 M	1.1 M
VT	0.3 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M	0.0 M
WA	3.7 M	0.5 M	0.5 M	-0.5 M	-0.3 M	-0.1 M	0.9 M
WI	3.0 M	0.3 M	0.3 M	-0.4 M	-0.2 M	-0.1 M	0.7 M
WV	0.7 M	0.1 M	0.1 M	-0.1 M	0.0 M	0.0 M	0.1 M
WY	0.3 M	0.0 M	0.1 M	0.0 M	0.0 M	0.0 M	0.1 M
US	**154.9 M**	**21.3 M**	**31.2 M**	**-21.4 M**	**-14.0 M**	**-6.9 M**	**42.3 M**

Table A5. State-level Spending Impacts by Original Source of Coverage in 2024

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024				Impact 2024			
	Employer	Non-Group	Uninsured	Total	Employer	Non-Group	Uninsured	Total
AK	2.2 B	0.3 B	0.2 B	2.7 B	-0.1 B	-0.1 B	0.0 B	-0.2 B
AL	14.1 B	3.9 B	1.4 B	19.4 B	-0.5 B	-0.7 B	0.2 B	-1.0 B
AR	6.8 B	1.7 B	0.6 B	9.2 B	-0.2 B	-0.3 B	0.0 B	-0.4 B
AZ	17.7 B	3.6 B	1.7 B	22.9 B	-0.8 B	-0.9 B	0.1 B	-1.5 B
CA	115.2 B	29.1 B	6.8 B	151.1 B	-6.3 B	-9.1 B	0.8 B	-14.5 B
CO	15.4 B	3.5 B	1.0 B	19.8 B	-0.8 B	-0.9 B	0.1 B	-1.7 B
CT	12.5 B	2.1 B	0.5 B	15.1 B	-0.4 B	-0.4 B	0.0 B	-0.8 B
DC	2.5 B	0.5 B	0.1 B	3.0 B	-0.1 B	-0.1 B	0.0 B	-0.1 B
DE	3.2 B	0.4 B	0.1 B	3.7 B	-0.1 B	-0.1 B	0.0 B	-0.2 B
FL	58.0 B	23.7 B	7.7 B	89.4 B	-2.2 B	-7.3 B	0.6 B	-8.9 B
GA	29.7 B	7.0 B	3.7 B	40.3 B	-1.2 B	-1.8 B	0.3 B	-2.8 B
HI	4.6 B	0.6 B	0.1 B	5.4 B	-0.3 B	-0.2 B	0.0 B	-0.5 B
IA	9.7 B	1.6 B	0.3 B	11.7 B	-0.3 B	-0.2 B	0.0 B	-0.4 B
ID	4.5 B	2.0 B	0.5 B	7.0 B	-0.2 B	-0.7 B	0.0 B	-0.8 B
IL	44.4 B	7.7 B	2.5 B	54.6 B	-1.5 B	-2.0 B	0.2 B	-3.3 B
IN	25.0 B	4.1 B	1.5 B	30.5 B	-0.9 B	-1.3 B	0.2 B	-2.1 B
KS	8.9 B	2.0 B	0.6 B	11.6 B	-0.3 B	-0.5 B	0.1 B	-0.8 B
KY	13.0 B	2.1 B	0.6 B	15.8 B	-0.4 B	-0.4 B	0.1 B	-0.8 B
LA	11.9 B	2.7 B	1.1 B	15.7 B	-0.4 B	-0.5 B	0.1 B	-0.8 B
MA	23.4 B	3.7 B	0.5 B	27.6 B	-0.7 B	-0.7 B	0.0 B	-1.3 B
MD	17.4 B	2.4 B	1.0 B	20.8 B	-0.4 B	-0.3 B	0.1 B	-0.7 B
ME	5.2 B	1.3 B	0.3 B	6.8 B	-0.1 B	-0.3 B	0.1 B	-0.4 B
MI	33.0 B	5.2 B	1.3 B	39.5 B	-0.8 B	-1.2 B	0.1 B	-2.0 B
MN	18.3 B	2.6 B	0.6 B	21.6 B	-0.7 B	-0.7 B	0.1 B	-1.3 B
MO	20.3 B	4.9 B	1.5 B	26.7 B	-0.6 B	-1.3 B	0.1 B	-1.8 B
MS	7.8 B	2.6 B	1.0 B	11.5 B	-0.2 B	-0.7 B	0.1 B	-0.8 B
MT	2.9 B	1.0 B	0.2 B	4.1 B	-0.1 B	-0.3 B	0.0 B	-0.4 B
NC	32.9 B	9.1 B	3.2 B	45.1 B	-1.3 B	-2.8 B	0.3 B	-3.8 B
ND	2.5 B	0.6 B	0.1 B	3.2 B	-0.1 B	-0.1 B	0.0 B	-0.1 B
NE	6.9 B	1.5 B	0.4 B	8.8 B	-0.2 B	-0.4 B	0.0 B	-0.6 B
NH	5.0 B	0.7 B	0.2 B	5.9 B	-0.1 B	-0.2 B	0.0 B	-0.3 B
NJ	35.8 B	5.9 B	2.0 B	43.7 B	-1.3 B	-1.8 B	0.2 B	-2.9 B
NM	5.2 B	1.1 B	0.4 B	6.7 B	-0.2 B	-0.3 B	0.0 B	-0.5 B
NV	9.0 B	1.4 B	0.9 B	11.2 B	-0.4 B	-0.4 B	0.1 B	-0.7 B
NY	69.5 B	12.5 B	3.0 B	85.0 B	-2.1 B	-2.6 B	0.4 B	-4.3 B
OH	40.7 B	5.8 B	1.8 B	48.4 B	-1.3 B	-1.4 B	0.2 B	-2.5 B
OK	10.0 B	2.6 B	1.3 B	14.0 B	-0.3 B	-0.5 B	0.2 B	-0.7 B
OR	12.5 B	3.2 B	0.7 B	16.4 B	-0.6 B	-1.0 B	0.1 B	-1.5 B
PA	44.1 B	9.1 B	1.9 B	55.1 B	-1.4 B	-2.3 B	0.2 B	-3.4 B
RI	2.9 B	0.5 B	0.1 B	3.5 B	-0.1 B	-0.1 B	0.0 B	-0.1 B
SC	13.6 B	3.7 B	1.6 B	18.9 B	-0.6 B	-1.1 B	0.1 B	-1.5 B
SD	3.0 B	0.8 B	0.1 B	3.9 B	-0.1 B	-0.2 B	0.0 B	-0.3 B
TN	19.2 B	4.7 B	1.8 B	25.7 B	-0.7 B	-1.3 B	0.2 B	-1.8 B
TX	93.8 B	18.9 B	14.7 B	127.5 B	-4.6 B	-5.6 B	1.3 B	-8.9 B
UT	11.0 B	2.4 B	0.7 B	14.1 B	-0.5 B	-0.6 B	0.1 B	-1.1 B
VA	27.6 B	6.0 B	2.1 B	35.8 B	-1.1 B	-1.8 B	0.2 B	-2.6 B
VT	2.1 B	0.3 B	0.1 B	2.5 B	-0.1 B	0.0 B	0.0 B	-0.1 B
WA	22.7 B	4.1 B	1.1 B	27.8 B	-1.0 B	-1.2 B	0.1 B	-2.1 B
WI	20.6 B	3.3 B	0.8 B	24.6 B	-0.7 B	-0.6 B	0.1 B	-1.2 B
WV	6.1 B	0.9 B	0.3 B	7.4 B	-0.2 B	-0.1 B	0.1 B	-0.2 B
WY	1.6 B	0.3 B	0.1 B	2.1 B	-0.1 B	-0.1 B	0.0 B	-0.2 B
US	**1,025.8 B**	**221.9 B**	**77.0 B**	**1,324.7 B**	**-39.8 B**	**-59.4 B**	**7.3 B**	**-91.9 B**

Table A6. State-level Spending Impacts by Original Source of Coverage in 2024-2033

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Baseline 2024-2033				Impact 2024-2033			
	Employer	Non-Group	Uninsured	Total	Employer	Non-Group	Uninsured	Total
AK	26.4 B	3.9 B	2.2 B	32.5 B	-1.5 B	-1.8 B	0.4 B	-2.9 B
AL	164.4 B	46.9 B	16.7 B	228.1 B	-5.7 B	-12.1 B	1.7 B	-16.1 B
AR	79.8 B	20.3 B	7.7 B	107.7 B	-2.0 B	-3.3 B	0.5 B	-4.7 B
AZ	218.5 B	44.5 B	21.1 B	284.1 B	-9.9 B	-11.4 B	1.6 B	-19.7 B
CA	1,367.0 B	354.2 B	82.7 B	1,804.0 B	-73.8 B	-119.7 B	9.3 B	-184.2 B
CO	177.4 B	40.9 B	11.3 B	229.6 B	-9.7 B	-12.6 B	1.1 B	-21.1 B
CT	146.9 B	25.2 B	6.6 B	178.8 B	-4.5 B	-5.9 B	0.6 B	-9.8 B
DC	29.8 B	6.1 B	0.8 B	36.7 B	-0.8 B	-1.2 B	0.1 B	-2.0 B
DE	37.2 B	5.0 B	1.5 B	43.7 B	-1.5 B	-1.1 B	0.1 B	-2.5 B
FL	696.2 B	294.2 B	94.5 B	1,084.8 B	-26.9 B	-94.2 B	7.7 B	-113.5 B
GA	352.2 B	85.6 B	44.8 B	482.7 B	-15.0 B	-24.3 B	3.7 B	-35.6 B
HI	60.1 B	8.3 B	1.6 B	70.0 B	-3.3 B	-3.1 B	0.1 B	-6.3 B
IA	111.5 B	18.7 B	3.8 B	134.0 B	-3.1 B	-3.2 B	0.3 B	-5.9 B
ID	53.0 B	23.8 B	5.6 B	82.3 B	-2.2 B	-7.8 B	0.5 B	-9.6 B
IL	528.4 B	94.9 B	30.7 B	653.9 B	-17.6 B	-25.2 B	2.6 B	-40.2 B
IN	291.2 B	49.1 B	17.3 B	357.5 B	-10.0 B	-16.5 B	1.9 B	-24.6 B
KS	104.6 B	23.9 B	7.7 B	136.2 B	-3.9 B	-6.2 B	0.6 B	-9.5 B
KY	151.2 B	24.7 B	7.4 B	183.4 B	-4.8 B	-5.7 B	0.6 B	-10.0 B
LA	139.5 B	31.5 B	13.0 B	184.0 B	-4.4 B	-6.5 B	0.9 B	-9.9 B
MA	274.8 B	44.8 B	5.8 B	325.4 B	-7.8 B	-8.6 B	0.6 B	-15.8 B
MD	207.8 B	29.4 B	12.4 B	249.6 B	-5.7 B	-4.4 B	0.9 B	-9.2 B
ME	59.8 B	15.1 B	3.5 B	78.4 B	-1.6 B	-3.7 B	0.6 B	-4.7 B
MI	384.4 B	61.8 B	15.8 B	461.9 B	-9.6 B	-14.5 B	1.5 B	-22.6 B
MN	214.8 B	31.3 B	7.3 B	253.4 B	-8.1 B	-7.9 B	0.9 B	-15.1 B
MO	236.6 B	57.0 B	17.9 B	311.6 B	-6.9 B	-15.8 B	1.6 B	-21.1 B
MS	92.1 B	30.6 B	12.4 B	135.1 B	-3.0 B	-9.3 B	1.1 B	-11.1 B
MT	33.2 B	11.8 B	2.2 B	47.2 B	-1.3 B	-4.1 B	0.3 B	-5.1 B
NC	399.3 B	112.8 B	39.4 B	551.6 B	-15.8 B	-36.1 B	3.3 B	-48.6 B
ND	29.4 B	6.6 B	1.3 B	37.3 B	-0.9 B	-1.2 B	0.2 B	-1.9 B
NE	80.2 B	17.9 B	5.4 B	103.4 B	-2.9 B	-4.9 B	0.5 B	-7.3 B
NH	57.3 B	8.6 B	2.2 B	68.1 B	-1.7 B	-2.6 B	0.3 B	-4.1 B
NJ	429.3 B	73.9 B	25.2 B	528.3 B	-15.5 B	-21.9 B	2.7 B	-34.7 B
NM	63.9 B	14.3 B	5.5 B	83.6 B	-2.4 B	-4.6 B	0.5 B	-6.4 B
NV	110.0 B	17.5 B	10.7 B	138.2 B	-4.6 B	-4.6 B	0.7 B	-8.5 B
NY	797.0 B	149.5 B	35.6 B	982.2 B	-24.8 B	-36.3 B	4.2 B	-56.8 B
OH	473.9 B	68.7 B	21.2 B	563.8 B	-15.5 B	-18.7 B	2.2 B	-32.0 B
OK	118.1 B	31.1 B	15.7 B	164.9 B	-3.8 B	-7.0 B	1.9 B	-9.0 B
OR	147.2 B	38.8 B	8.4 B	194.4 B	-6.5 B	-12.8 B	0.9 B	-18.4 B
PA	513.8 B	107.7 B	22.4 B	643.9 B	-15.8 B	-31.6 B	2.3 B	-45.2 B
RI	33.6 B	6.6 B	1.5 B	41.7 B	-1.0 B	-0.9 B	0.2 B	-1.7 B
SC	160.3 B	43.6 B	18.6 B	222.4 B	-6.6 B	-12.8 B	1.6 B	-17.8 B
SD	34.6 B	8.9 B	1.7 B	45.2 B	-1.3 B	-2.5 B	0.2 B	-3.7 B
TN	230.6 B	57.7 B	21.9 B	310.2 B	-8.5 B	-16.0 B	1.9 B	-22.6 B
TX	1,147.5 B	239.7 B	183.6 B	1,570.9 B	-58.0 B	-73.9 B	15.7 B	-116.2 B
UT	137.9 B	29.8 B	9.6 B	177.3 B	-6.8 B	-7.7 B	0.8 B	-13.7 B
VA	328.2 B	73.0 B	25.2 B	426.5 B	-12.5 B	-22.3 B	2.1 B	-32.7 B
VT	24.2 B	3.9 B	0.8 B	28.8 B	-0.6 B	-0.6 B	0.1 B	-1.0 B
WA	269.9 B	50.9 B	12.9 B	333.7 B	-12.5 B	-15.4 B	1.2 B	-26.8 B
WI	238.9 B	38.8 B	9.0 B	286.7 B	-8.1 B	-8.2 B	1.1 B	-15.1 B
WV	70.9 B	10.2 B	3.9 B	85.0 B	-2.2 B	-1.2 B	1.0 B	-2.4 B
WY	18.6 B	3.7 B	1.8 B	24.1 B	-0.9 B	-1.1 B	0.2 B	-1.9 B
US	**12,153 B**	**2,698.0 B**	**937.9 B**	**15,789 B**	**-473.8 B**	**-775.0 B**	**87.6 B**	**-1,161.2 B**

Table A7. State-level Spending Impacts by Service Category

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	Hospital Spending				Non-Hospital Spending			
	2024		2024-2033		2024		2024-2033	
	Baseline	Impact	Baseline	Impact	Baseline	Impact	Baseline	Impact
AK	1.4 B	-0.1 B	17.1 B	-1.8 B	1.3 B	-0.1 B	15.3 B	-0.8 B
AL	8.4 B	-0.7 B	98.5 B	-10.9 B	11.0 B	-0.4 B	129.6 B	-5.8 B
AR	3.5 B	-0.2 B	41.8 B	-2.6 B	5.6 B	-0.1 B	66.0 B	-1.3 B
AZ	10.4 B	-1.0 B	129.0 B	-12.9 B	12.5 B	-0.4 B	155.1 B	-6.0 B
CA	78.4 B	-10.4 B	937.7 B	-130.6 B	72.7 B	-5.0 B	866.2 B	-64.4 B
CO	9.4 B	-1.2 B	109.6 B	-14.6 B	10.4 B	-0.6 B	120.1 B	-7.5 B
CT	7.0 B	-0.5 B	83.2 B	-6.0 B	8.1 B	-0.3 B	95.6 B	-3.7 B
DC	1.6 B	-0.1 B	19.0 B	-1.4 B	1.5 B	-0.1 B	17.7 B	-0.8 B
DE	1.6 B	-0.1 B	19.4 B	-1.6 B	2.1 B	-0.1 B	24.3 B	-1.0 B
FL	41.3 B	-6.4 B	501.1 B	-80.1 B	48.1 B	-3.1 B	583.8 B	-39.9 B
GA	17.0 B	-1.6 B	204.0 B	-21.0 B	23.3 B	-0.8 B	278.7 B	-10.6 B
HI	2.8 B	-0.3 B	36.5 B	-4.3 B	2.6 B	-0.2 B	33.5 B	-2.2 B
IA	5.1 B	-0.3 B	58.2 B	-3.8 B	6.6 B	-0.2 B	75.8 B	-2.7 B
ID	3.4 B	-0.6 B	39.8 B	-7.3 B	3.6 B	-0.3 B	42.5 B	-3.8 B
IL	25.5 B	-2.2 B	305.6 B	-26.5 B	29.1 B	-1.1 B	348.3 B	-14.2 B
IN	14.7 B	-1.5 B	171.5 B	-16.9 B	15.9 B	-0.6 B	186.0 B	-7.6 B
KS	5.2 B	-0.5 B	61.2 B	-6.4 B	6.4 B	-0.3 B	75.0 B	-3.2 B
KY	6.9 B	-0.5 B	80.1 B	-6.4 B	8.9 B	-0.3 B	103.3 B	-3.2 B
LA	6.6 B	-0.5 B	77.3 B	-5.7 B	9.1 B	-0.2 B	106.7 B	-3.1 B
MA	12.8 B	-0.9 B	151.2 B	-10.5 B	14.8 B	-0.6 B	174.2 B	-8.0 B
MD	8.2 B	-0.4 B	98.5 B	-5.1 B	12.6 B	-0.2 B	151.1 B	-3.3 B
ME	3.4 B	-0.2 B	39.4 B	-3.1 B	3.4 B	-0.1 B	39.0 B	-1.6 B
MI	18.2 B	-1.3 B	212.7 B	-15.3 B	21.3 B	-0.6 B	249.2 B	-7.8 B
MN	9.6 B	-0.8 B	112.7 B	-9.4 B	12.0 B	-0.6 B	140.7 B	-6.6 B
MO	12.5 B	-1.2 B	145.9 B	-13.8 B	14.2 B	-0.5 B	165.6 B	-6.3 B
MS	5.2 B	-0.5 B	61.2 B	-7.2 B	6.3 B	-0.2 B	73.9 B	-2.9 B
MT	2.1 B	-0.3 B	24.6 B	-3.9 B	2.0 B	-0.2 B	22.6 B	-1.8 B
NC	20.4 B	-2.5 B	249.8 B	-30.9 B	24.7 B	-1.2 B	301.8 B	-15.5 B
ND	1.5 B	-0.1 B	17.5 B	-1.3 B	1.7 B	-0.1 B	19.8 B	-0.8 B
NE	4.1 B	-0.4 B	47.7 B	-4.8 B	4.7 B	-0.2 B	55.7 B	-2.7 B
NH	2.7 B	-0.2 B	31.0 B	-2.5 B	3.2 B	-0.1 B	37.1 B	-1.5 B
NJ	21.2 B	-1.9 B	256.7 B	-21.9 B	22.5 B	-0.9 B	271.7 B	-10.7 B
NM	3.5 B	-0.3 B	42.9 B	-4.7 B	3.3 B	-0.2 B	40.7 B	-2.3 B
NV	5.4 B	-0.4 B	66.0 B	-5.4 B	5.9 B	-0.2 B	72.2 B	-2.1 B
NY	41.7 B	-2.9 B	483.2 B	-38.3 B	43.3 B	-1.6 B	498.9 B	-22.3 B
OH	23.0 B	-1.7 B	268.6 B	-21.0 B	25.3 B	-0.7 B	295.2 B	-9.2 B
OK	6.0 B	-0.4 B	71.4 B	-5.5 B	7.9 B	-0.2 B	93.6 B	-2.1 B
OR	8.0 B	-1.0 B	94.7 B	-12.8 B	8.4 B	-0.6 B	99.8 B	-7.1 B
PA	26.5 B	-2.5 B	309.2 B	-32.3 B	28.7 B	-1.2 B	334.7 B	-16.0 B
RI	1.5 B	-0.1 B	17.3 B	-1.1 B	2.1 B	-0.1 B	24.4 B	-0.7 B
SC	8.1 B	-1.0 B	95.1 B	-11.6 B	10.8 B	-0.5 B	127.3 B	-5.7 B
SD	2.0 B	-0.2 B	23.0 B	-2.5 B	1.9 B	-0.1 B	22.2 B	-1.3 B
TN	10.4 B	-1.1 B	126.1 B	-13.9 B	15.3 B	-0.5 B	184.0 B	-7.1 B
TX	58.8 B	-5.6 B	724.8 B	-71.7 B	68.7 B	-1.9 B	846.1 B	-26.2 B
UT	6.8 B	-0.8 B	85.4 B	-9.5 B	7.3 B	-0.4 B	91.9 B	-4.8 B
VA	16.1 B	-1.8 B	192.2 B	-21.9 B	19.7 B	-0.9 B	234.3 B	-11.5 B
VT	1.3 B	-0.1 B	14.5 B	-0.7 B	1.2 B	0.0 B	14.4 B	-0.4 B
WA	13.3 B	-1.4 B	160.3 B	-17.8 B	14.5 B	-0.7 B	173.4 B	-9.8 B
WI	10.9 B	-0.8 B	127.2 B	-9.3 B	13.7 B	-0.5 B	159.5 B	-6.6 B
WV	3.4 B	-0.1 B	39.4 B	-1.5 B	4.0 B	-0.1 B	45.6 B	-0.7 B
WY	0.9 B	-0.1 B	10.9 B	-1.2 B	1.1 B	0.0 B	13.2 B	-0.4 B
US	**619.7 B**	**-62.0 B**	**7,391.6 B**	**-773.6 B**	**705.0 B**	**-29.9 B**	**8,397.2 B**	**-387.6 B**

Table A8. State-level Take-up of Medicare-X Choice in 2024 by Baseline Coverage

Source: Analysis of Medicare-X Choice using the KNG-Health Reform Model.

State	ESI	Non-Group	Uninsured
AK	13%	78%	41%
AL	15%	50%	8%
AR	15%	72%	12%
AZ	16%	70%	15%
CA	14%	65%	12%
CO	16%	63%	13%
CT	15%	67%	12%
DC	11%	49%	7%
DE	17%	74%	14%
FL	14%	73%	17%
GA	15%	70%	11%
HI	14%	82%	16%
IA	14%	38%	7%
ID	14%	74%	15%
IL	15%	73%	14%
IN	14%	75%	17%
KS	15%	69%	13%
KY	15%	65%	12%
LA	15%	67%	10%
MA	16%	74%	15%
MD	18%	75%	21%
ME	13%	55%	9%
MI	14%	74%	13%
MN	16%	84%	41%
MO	14%	75%	17%
MS	14%	77%	17%
MT	15%	77%	30%
NC	15%	72%	14%
ND	15%	44%	13%
NE	14%	75%	24%
NH	15%	82%	27%
NJ	15%	70%	17%
NM	13%	55%	6%
NV	14%	64%	11%
NY	14%	52%	9%
OH	14%	59%	12%
OK	14%	55%	10%
OR	15%	71%	15%
PA	14%	68%	15%
RI	17%	40%	7%
SC	14%	75%	17%
SD	16%	78%	15%
TN	15%	78%	24%
TX	15%	67%	16%
UT	15%	63%	13%
VA	15%	67%	14%
VT	12%	35%	3%
WA	15%	66%	10%
WI	14%	47%	10%
WV	14%	24%	3%
WY	18%	72%	17%