Wyoming Liberty Group

Liberty Brief

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The Five Step Plan to Achieve National Health Care Reform

by Regina Meena

Executive Summary

Americans know we cannot continue to operate our health care system as we do currently. The uncontrollable costs prove government-run health programs fail to deliver on their promises and that Americans suffer under a suppressed health insurance market that has limited our options. Year after year, we tweak and alter our current system hoping that results finally turn positive. The fundamental reason we have not made progress toward achieving affordable health care or insurance is the lack of a systematic process to guide reform efforts.

This paper identifies that process. This sequence is a series of five essential steps, combined in a manner that leverages free-market principles necessary to reform our health care system.

Step 1. **Limit** Federal and State government involvement in health care

Step 2. **Return** health insurance to the private market and individual

Step 3. **Reform** the structure and funding of Medicare, Medicaid and CHIP

Step 4. **Perpetuate** the free-market solutions

Step 5. **Secure** and protect health care reforms

The five steps deliver true reforms that correct mistakes made when we entangled health insurance with employment, and health care with entitlements. It is time to sever our tethered -elephant mindset by curtailing employer and government involvement in health care and put individuals back into control over their health care decisions.

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INTRODUCTION

Although most agree that health care reform is long overdue, how best to achieve it is a point of contention. Some believe expanding government-run health programs is the key. Others believe we should focus on creating affordable health insurance through free market solutions that deliver competition and put the individual back in control of their health care decisions.

This paper details a five step plan that leverages free market principles to return health insurance to the private indemnity market where other insurance products function. Leveraging the free-market would trigger health insurance reforms that create an undistorted market, driven by consumer demand. True demand creates competition that produces quality and price controls as people determine where to spend their money. When consumers choose between affordable, viable coverage options and health care services, pressure is lifted from government-run health programs as people join a stable, national risk pool. Freed from constant pressure, government programs can chisel away at entitlement spending, return flexibility to state governments and ensure the American taxpayers keep more of their hard-earned money.

THE FIVE STEP PLAN—A SEQUENCE

The United States Supreme Court will rule in *Florida v. Department of Health and Human Services* regarding the constitutionality of the Patient Protection and Accountable Care Act (PPACA) in late spring or summer of 2012. Whether one favors the entire act, specific provisions of it or desires it be struck down altogether, most agree the PPACA will not emerge from this battle unmodified.

It is during this precious moment in time, when American health care as we know it has been upended, that we are presented with a golden opportunity to reform our health care system into one that delivers positive health outcomes and lessens its dependence on federal funds. Tackling health care reform is not a new idea. We stab at it every year. This piecemeal approach has not delivered the results hoped for. Wyoming Liberty Group's Five Step Plan addresses all of the essential problems (government involvement, employer mingling, public funding, over-regulation and a misunderstanding of the economics of health care) in one sequential process. The sequence clarifies the relationship between each step, distinguishes between free-market and essential government functions and identifies state and federal steps needed to set the process in motion. If followed sequentially, the Five Step Plan provides the most feasible and principled approach to health care reform.

STEP 1: LIMIT FEDERAL AND STATE GOVERNMENT INVOLVEMENT IN HEALTH CARE

In the book, *Two Days That Ruined Your Health Care*, William Carter Waters details two events that fundamentally changed America's health care system for the worse. The first was the day Congress passed the McCarran-Ferguson Act, entangling a private indemnity product—health insurance—with employment. The second day was the day President Lyndon Johnson signed Titles 18 and 19 of the Social Security Act, creating the health benefit programs known as Medicare and Medicaid. This act entangled health insurance with social welfare entitlement programs.

It is fair to say there was a third day that ruined health care. On March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act (PPACA), which brought together social welfare entitlement programs and state reserved powers to regulate the business of insurance under one umbrella. The primary purpose of this was to establish socialized health care by expanding government run health programs, notably Medicaid. America has experimented with socialized health since 1955, when the Indian Health Service (IHS) was established. This and other programs provide 57 years of data that show these programs do not yield positive results. In fact, the data proves that: IHS, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) do not improve people's health, improve access to care, create affordable insurance or lower the cost of health care. These programs have failed. We must begin anew by redirecting economic resources to the free-market and away from federal programs and funding.

While programs such as Medicaid are built on direct government subsidies, indirect subsidies for health care have also contributed myriad problems. Unfortunately, many of these indirect subsidies and legal methods have been incorrectly embraced as free market reform. For example, Health Savings Accounts (HSAs) are supported by many physician groups and various sectors of our health care industry as a "Silver Bullet" public policy solution, but are ultimately a fallacy. (See **Appendix 1** for a brief discussion of HSAs.)

Public Policy Steps to Take for Step 1:

State Level:

a. Do not pass legislation enacting Medicaid expansion programs. Wyoming is not an expansion state. Our Medicaid program covers people at or below 100% of the federal poverty level (FPL) and the Categorically Needy at 133% of FPL. This is one reason Wyoming has not suffered the fiscal crises seen in other states. Medicaid expansion programs result in a state and federal takeover of the private insurance market for citizens with incomes up to 200% FPL or beyond. The cost of this to the private market is no more evident than in the loss of child-only plans that occurred in Wyoming when HHS implemented the Children's Health Insurance Program. Costs remain exorbitant despite services provided to the most healthy, steadily numbered segment of our population.

b. Do not pass legislation approving the set-up of a PPACA exchange or acceptance of federal grants stipulating the set-up of an exchange. "Level One and Level Two" grants obligate the state to set up an exchange and expand Medicaid, revamp rate review laws and secure federal control over the "business of insurance."

c. Ratify a Health Care Freedom Amendment (HCFA) to protect the individual right to health care freedom. Wyoming's HCFA will provide strong protection of individual liberty from encroachment by government. Specifically, the amendment leverages use of the Ninth and Tenth Amendments combined with federal enforcement of the Bill of Rights to ensure the HCFA paints a line that government cannot cross. It also requires state government to formulate policies that respect health care freedom by securing the fundamental right to make health care decisions. Individuals are put back in control of their health care choices. Every state should secure and define this separating line.

Federal Level:

a. Do not appropriate additional funding to Health and Human Services (HHS) for implementation of any PPACA provision. States will not add to their Maintenance of Effort (MOE) requirement without federal matching funds.

b. Do not appropriate additional funding for any Medicare, Medicaid or CHIP expansion initiatives promoted through the HHS Waiver Demonstration Project programs. These waivers require states to amend their Medicaid State Plan and grow socialized health programs at taxpayer expense, which continue to deliver poor results.

c. Resist the pressure to mandate the use of HSAs as a matter of public policy. Instead, consider tax reforms that return fairness to individuals along with more of their income.

STEP 2: RETURN HEALTH INSURANCE TO THE PRIVATE MARKET AND INDIVIDUAL CONTROL

During the wage and price controls enacted during World War II, employers unable to pay and recruit employees began offering health insurance as a benefit in lieu of pay. Then, in 1945, Congress passed the McCarran-Ferguson Act which effectively removed health insurance from the private indemnity market and placed it with employers. Specifically, the act 1) partially exempts insurance companies from anti-trust laws that apply to most businesses, 2) allows for the state regulation of the "business of insurance," 3) allows states to establish mandatory licensing requirements, and 4) preserves certain state laws of insurance.

After 67 years, and the results of McCarran-Ferguson are: 1) employer-based health plans that exclude millions of people and lack portability, 2) unfair federal tax laws exempting employer-based coverage from taxes that everyone else pays, 3) health insurance industry protectionism, 4) inferior plans loaded with service mandates that do not meet needs, 5) unaffordable insurance premiums and limited options, 6) loss of consumer control over health care choices and spending, and finally 7) small risk pools confined within state borders.

Removing health insurance from the private indemnity market and entangling it with employment was a mistake. We can correct this. Insurance licensing laws prevent individual purchasers from joining insurance pools with residents of other states due to different regulatory schemes and mandates.

Although the federal government has proven reluctant to allow the sale and purchase of health insurance in the interstate market, many states have considered opening their own borders. Georgia lead the way in 2011 by passing a simple law, now codified at GA. CODE ANN., § 33-29A-30 *et. seq.* This law allows for any insurer licensed to sell health insurance in Georgia to sell individual health insurance policies its parent or affiliate is authorized to sell in other states to Georgians. These policies are governed by the law of other states, and thus bypass the regulations placed on Georgia policies.

Wyoming recently considered this approach for both the individual and small group market during the 2012 Budget Session. House Bill 119 aimed to allow Wyoming health insurance companies to sell health insurance from other states, regulated by that second state. This is exactly how auto, property, life and supplemental health insurance products currently function for citizens, and one reason why they remain affordable and part of a national risk pool. HB 119 garnered 13 sponsors, passed the Wyoming House with and overwhelming 56-1 vote (with 3 excused), but died in the Senate Labor Committee. The bill will likely return next year. (See **Appendix 2** for a copy of this bill.)

Competition between state regulators would eliminate unwanted, costly regulations and retain only those consumers find valuable, which means states can retain premium tax revenue and bring about both essential regulation and citizen valued regulation as the consumer is put back into control over product design. As witnessed with other insurance products, consumers value and demand strong consumer protections. These already exist. Consumers also benefit from "choice-of-law" clauses where the insurance company can decide the state law that will be used to resolve a dispute. This is a necessary procedure to reconcile the differences between the laws of different states and is used in contracts to settle tort lawsuits and family lawsuits. The clauses frequently govern auto, property, life and supplemental health policies. Thus, these policies remain affordable and useful to consumers.

In summary, a large portion of our current health care problems are the result of small risk pools confined to state borders that cause a lack of affordable health insurance, which in turn creates a lack of insurance coverage. No government-run health program can fix this.

Public Policy Steps to Take for Step 2:

State Level-

a. Pass "Georgia-style" legislation to allow health insurers with a business in Wyoming to sell policies here that they sell in other states. Because states have the power to regulate the" business of insurance," any state can pass a law stipulating that meeting the regulatory requirement of any other state will satisfy its own regulations without relying upon compacts and federal approval. Overregulation can be solved when regulators themselves are forced to compete.

b. Grow the private insurance market in all 50 states. The current problem with high-cost health care is due to a lack of affordable health insurance caused by a lack of competition. Opening health insurance to a national risk pool will create consumer -driven plans with services we want and need as we enter into the national insurance risk pool, one state at a time. By returning health insurance to the private indemnity market, individuals are put back in charge of their health care.

Continued on Next Page

Federal Level-

a. Commission an actuarial study that allows Americans to visualize what health insurance would look like as it functions in the free market with all the other indemnity products (auto, property, life, supplemental health, etc.). In other words, show people that the solution to our current health care crisis is to simply return health insurance to the private indemnity market and what we can expect as a result. The following list details basic actuarial principles the model should address:

    - Use the existing auto insurance model as the basis for comparison, because this is how health insurance needs to operate in a national risk pool.
    - Demonstrate at what point (be it the number of months, the size of the risk pool or number of competitors) the cost curve starts to bend downward. It may start immediately.
    - Demonstrate what the market demographics would look like when risk is assessed to costs through a national pool. The study may need to use ranges versus specific numbers.
    - Demonstrate how properly assessing risk will result in fair pricing that drives incentives for people to purchase a now-useful and valued product.
    - Demonstrate the economic ripple effects on health care costs when the market shifts to individual purchase (control) and away from employer and government control. This would also show the effects of having health care providers price competitively.
    - Most importantly, include the current Medicaid, CHIP and Medicare populations above 100% FPL. They are included in the auto insurance market and will need to join a national health insurance risk pool.

    The results of this actuarial study, which are likely to be very favorable, will deter the "tethered elephant" mindset on how health insurance should work. When baby elephants are trained, they are tethered to a stake in the ground using a very thick rope. As the elephant matures, it becomes accustomed to roaming within the diameter defined by the length of the rope. When the rope is removed, it takes some time before the elephant understands it can move beyond that perimeter. This mindset has severely limited our options. Employer-provided health insurance is our tether. The actuarial model will help citizens understand what is possible beyond employer provided and government run health care. Without this study, we continue to look at how the market currently functions instead of how it should function.

STEP 3: REFORM THE STRUCTURE AND FUNDING OF MEDICAID, MEDICARE AND CHIP

Affordable health insurance is a precursor to reforming government-run health programs. It is critical to establish the private market within a national risk pool before beginning state and federal reforms to entitlement programs. Nationwide competition creates low-cost insurance options. Without these options, people have nowhere to go. We simply cannot continue segregating low income people into poorly run government health programs that produce poor results. We should instead allow populations served in government health programs to join the private market, as they currently do by purchasing auto and other insurance products.

To facilitate the transition of people into the free market, states must have the flexibility to appropriately manage the Medicare, Medicaid and CHIP programs. This is key to backing our way out of government control over health care.

Public Policy Steps to Take for Step 3:

State Level-

a. States must push for changes to all federal programs that will allow them to roll back income eligibility requirements to 100% FPL. This will allow states to transition current enrollees into affordable health insurance created by nationwide competition, leaving only the most vulnerable citizens to receive health care through government-run programs. Reform would also allow states to provide that help through block grants or tax credits. A model by the Health Care Compact Alliance (www.healthcarecompact.org) delivers a straightforward funding matrix that states can count on, and use to plan in advance for population fluctuations. (See **Appendix 3** for a table of base level funding under the Compact.)

Federal Level-

a. Institute means-testing for Medicare participants.

b. Eliminate the Maintenance of Effort (MOE) requirement for entitlement programs.

c. Adopt the Health Care Compact funding matrix already supported by a number of states.

d. Eliminate subsidies to all but our most vulnerable citizens.

STEP 4: PERPETUATE FREE-MARKET SOLUTIONS

Once the individual right to health care freedom is protected, government health care services are transitioned back into the free market and government-run health programs are redesigned to benefit our most vulnerable citizens, we can begin leveraging the power of free markets to capitalize on the benefits the American health care industry offers.

These reforms would allow for innovation in medical treatments and enable competition between all segments of the health care delivery system. This will bend the cost curve downward, and can be accomplished by removing burdensome regulations, which are easily identified by their failure to produce the results detailed in their enabling legislation. Deregulation in federal Food and Drug guidelines—which burden health care choice and innovation with red tape—as well as state medical professional licensing laws could create valued products and services. This would also create competition between medical providers and industries, just as prior reforms would create competition within the insurance market. This competition ensures industries profit by lowering fraud, waste and abuse and this, in turn, translates into low cost health care options. Finally, the economics of health care begin to fall into place.

Public Policy Steps to Take for Step 4:

State Level-

a. Identify regulations that inhibit competition or otherwise suppress free-market innovations and correct them. Significant time and resources must be spent culling current laws.

b. Consider implementing Medical Freedom Zones, legally recognized geographic areas where health care professionals may provide service and conduct research governed by professional associations and private contracts. Different types of freedom zones exist around the world, including the Dubai International Financial Centre, which is governed by British common law to resolve financial market issues. Regulatory overload has diminished the performance of many sections in the US economy, and freedom zones can serve as limited experiments to show the positive impact of deregulation.

Federal Level-

a. Identify FDA, HHS, IRS provisions, licensing laws and regulations that inhibit states' power to regulate their health care and insurance industries and repeal or amend them. Specifically, look at tax credits for employers and consider if they should be shifted directly to the consumer.

b. Identify coercive funding programs and amend. Follow through by letting Americans keep more of their paychecks and states more of the money now collected through federal taxes.

STEP 5: SECURE AND PROTECT HEALTH CARE REFORMS

The final step in achieving true health care reform is to identify remaining problem areas, or areas needing stronger legal remedies, and resolve them. Once the free market has cleared the way by solving market related issues, we will be able to identify the true cost drivers in American health care. Reforming these cost-drivers would restore faith in the health care industry's ability to deliver consumer-driven services and products. In turn, they can depend on a familiar cycle where free markets respond to needs and create solutions to consumer problems. Finally, we will restore free-market health care that will deliver cost controls that government-run health programs simply cannot.

Public Policy Steps to Take for Step 5:

State Level-

a. Identify remaining high cost health care areas not benefiting from current free-market reforms and resolve through tort reforms, safeguards for "choice-of-law" provisions and protection of arbitration and alternative dispute resolution provisions in contracts.

Federal Level-

a. Continue repealing federal laws, regulations and programs that redistribute wealth .

b. Continue spending cuts that halt government growth.

CONCLUSION

When the free market works to solve problems, there is no distortion in the market. True markets yield true solutions. This Five Step Plan for National Health Care Reform leverages these markets to achieve true health care reform by combining them in a sequential process that puts consumers back in control of their health care decisions, returns health insurance to the private indemnity market, eliminates employer involvement and reduces the role of government in everyday life.

Federal socialized health care programs have been in operation since 1955. They do not improve health, increase access to care, create affordable insurance or lower the cost of health care. The simple fact is that they have failed on every account. It is time to remove the tether and think differently about how to resolve our current health care woes. We need to untangle private indemnity products designed to protect us from catastrophic financial loss from government and employers and return these products to the free market. Returning health insurance to the free market prevents socialized health care. Preventing socialized health care puts us on the road to health care freedom.

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APPENDIX 1

A Brief Analysis of Health Savings Accounts

Health Savings Accounts (HSAs) have garnered a great deal of support as a free market option for national health reform. However, HSAs are not actually a free market reform. HSAs were established in 2003 as yet another tax shelter under the Internal Revenue Code. Millions of Americans currently contribute to one. This, by any definition, is a sizeable market. To date, results tell us how well these accounts are doing:

1. HSAs do not control costs. They also have no effect on the 10% of the population that accounts for 70%-80% of health care spending.
2. HSAs do not increase access to care or reduce the number of uninsured.
3. HSAs are combined with high deductible health plans, leading to rationing of care based on ability to pay for high out-of-pocket costs. They shift costs from the insurers to the patient.
4. HSAs do not create affordable health insurance premiums.
5. HSAs create another layer of administrative costs such as servicing fees paid to the financial institutions to manage the accounts paid for by the patient and further reduce the money that can be spent on direct care.
6. HSAs deplete funds from the insurance risk pool and general economy as people without health care costs are unable to use their money. The money removed from the economy is replaced by increased premiums, additional fees, cuts in coverage and the like, ensuring our current cycle.
7. HSAs are of no use to lower income people who lack the ability to contribute to their accounts or purchase insurance with high premiums.
8. HSAs are another unfair tax break for people with high incomes, employers and those with ongoing health care costs.
9. HSAs do not allow people to be responsible for their own health care since the IRS determines which medical expenses are qualified for tax free reimbursement.
10. HSAs do not address portability issues as employees lose employer contributions. They are still tied to employment.
11. HSAs actually perpetuate the current cycle of high health care and insurance costs as providers justify their pricing to pull money from private accounts set aside for exclusive use. Providers no longer need to compete with other industries for consumer money.

HSAs have not delivered on their promises. They do not address the fundamental problems with our current health care system: small risk pools confined to state borders and a service delivery system that removes consumer control over their spending choices. HSAs end up functioning as a subsidy for health care providers. Subsidies can't deliver on their promise to make a product affordable—at least not permanently, because they address only the supply side. They distort the market as they seek to create greater demand by keeping costs down artificially. However, insurers continue to increase prices, requiring more subsidies for a program that could not stand on its own in the first place. In the long run, this is unsustainable. The performance of HSAs does not support their use in sound public policy, and they should not be mandated as an insurance replacement.

APPENDIX 2

Interstate Insurance Sales Law

The following bill, House Bill 119, was introduced during the 2012 Wyoming Budget Session. It is modeled on a bill ratified in Georgia in 2011, now codified at GA. CODE ANN., § 33-29A-30 *et. seq.* Unlike the Georgia law, this bill would allow for insurance companies to sell out-of-state insurance policies for both individual policies and small group policies, which are currently restricted from coverage pools that extend across state lines. Although tailored for Wyoming, this bill would work as a starting point for any state wishing to open its borders to effective insurance pools, competitive mandates, and interstate cooperation. Unless the federal government acts to free the sale of insurance across interstate lines, this bill is integral to implementing Step 2 of the Five Step Plan.

HOUSE BILL NO. HB0119

Health insurance-sale of out-of-state policies.

Sponsored by: Representative(s) Buchanan, Edmonds, Esquibel, K., Hunt, Kasperik, Kroeker, Lubnau, Peasley, Pedersen and Zwonitzer, Dn. and Senator(s) Anderson, Nutting and Ross

A BILL

for

AN ACT relating to health insurance; authorizing Wyoming insurers to offer individual and small employer health insurance policies in Wyoming that have been approved for issuance in other states; providing minimum standards for out-of-state policies; prescribing notice requirements; granting rulemaking authority; preempting conflicting laws; providing definitions; and providing for an effective date.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-18-301 through 26-18-307 are created to read:

ARTICLE 3

SALE OF OUT-OF-STATE HEALTH INSURANCE POLICIES

26-18-301. Definitions.

(a) As used in this article:

(i) "Health insurance," "health benefit plan" and "health benefit policy" mean a health benefit plan as defined by W.S. 26-1-102(a)(xxxii);

(ii) "High deductible health plan" means health insurance plans sold or maintained under the applicable provisions of section 223 of the Internal Revenue Code;

(iii) "Small employer" means small employer as defined by W.S. 26-19-302(a)(xxii);

(iv) "Small employer health insurance policy" is any policy defined by W.S. 26-19-303(a).

26-18-302. Sale of health insurance policies approved in other states.

(a) The insurance commissioner shall approve for sale in Wyoming any individual or small employer health insurance policy or high deductible health plan that is currently approved for issuance in another state where the insurer or the insurer's affiliate or subsidiary is authorized to transact insurance, subject to the following:

(i) The insurer or the insurer's affiliate or subsidiary filing and issuing the policy in Wyoming is also authorized to transact insurance in this state pursuant to title 26, chapter 3 of the Wyoming statutes;

(ii) The policy meets the requirements of this article;

(iii) Any authorized insurer may offer an individual or small employer insurance policy with benefits equivalent to those in any policy approved for sale in Wyoming under this article, provided that the offered policy meets the requirements of this article.

26-18-303. Financial requirements; continuing compliance.

(a) Any insurer selling a health insurance policy pursuant to this article and any policy approved pursuant to this article shall satisfy actuarial standards of the National Association of Insurance Commissioners, the requirements of this act and any regulations of the department implementing this act.

(b) The commissioner shall determine whether an insurer satisfies the requirements of this article and shall expeditiously approve policies and plans that comply with this article. The commissioner shall have the authority to determine whether a health insurance policy or plan sold pursuant to this article continues to satisfy the requirements of this article in the same manner as for other policies under this code. The commissioner shall have the authority to require an insurer to participate in the Wyoming health insurance pool and to make other payments required of insurers under this code.

(c) Any policy sold pursuant to this article shall be protected under the Wyoming Life and Health Guaranty Association Act under Chapter 42 of this title.

26-18-304. Disclaimers required.

(a) Each written application for a policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

> The benefits of this policy may primarily be governed by the laws of a state other than Wyoming. All of the laws applicable to policies filed in this state may not apply to this policy. Any purchase of individual health insurance should be considered carefully since future medical conditions may make it impossible to qualify for another individual health insurance policy.

(b) Each policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

> The benefits of this policy may be governed primarily by the laws of a state other than Wyoming. The benefits covered may be different

from other policies you can purchase in this state. Consult your insurance agent or insurer to determine which health benefits are covered under this policy.

(c) If a benefit under the out-of-state policy or a similarly named benefit is defined differently under Wyoming statutes and regulations than it is in the other state, the policy shall contain a side-by-side chart that compares Wyoming's and the other state's respective definitions.

26-18-305. Rules and regulations.

(a) The commissioner shall adopt rules and regulations necessary to implement this article, including the issuance of standard forms for the disclosure of benefits.

(b) Any dispute resolution mechanism or provision for notice and hearing in this code shall apply to insurers issuing and delivering policies pursuant to this article.

26-18-306. Conflict with other code provisions.

If the provisions of this article conflict with any other provision of this code, the provisions of this article shall control.

26-18-307. Authorization date.

No policy shall be issued or delivered for issuance in this state pursuant to this article before July 1, 2012.

Section 2. This act is effective July 1, 2012.

(END)

APPENDIX 3

Base Level Funding Under the Health Care Compact

The Health Care Compact (www.healthcarecompact.org) is a state-based initiative to have the federal government turn over control of health care regulation (with the exception of military health care) to compacting states, and allot funding in the form of block grants. A compact is a legal agreement between states that has the power of federal law when it is approved by Congress. As of this publication, six states have ratified the Compact: Utah, Texas, Oklahoma, Missouri, Indiana, and Georgia.

The following table is from the Health Care Compact, and lists the base level funding each state would receive if the Compact takes effect. Restructuring Medicaid, Medicare, and CHIP in this fashion is an important part of Step 3 of the Five Step Plan.

The following table lists estimated Member State Base Funding Level for each State:

STATE	MEMBER STATE BASE FUNDING LEVEL	STATE	MEMBER STATE BASE FUNDING LEVEL
Alabama	$13,880,000,000	Montana	$2,330,000,000
Alaska	$1,438,000,000	Nebraska	$4,144,000,000
Arizona	$16,266,000,000	Nevada	$3,991,000,000
Arkansas	$8,727,000,000	New Hampshire	$2,920,000,000
California	$109,102,000,000	New Jersey	$25,579,000,000
Colorado	$8,907,000,000	New Mexico	$6,010,000,000
Connecticut	$12,174,000,000	New York	$78,319,000,000
Delaware	$2,336,000,000	North Carolina	$24,644,000,000
Florida	$58,876,000,000	North Dakota	$1,657,000,000
Georgia	$21,556,000,000	Ohio	$35,043,000,000
Hawaii	$3,081,000,000	Oklahoma	$10,344,000,000
Idaho	$2,988,000,000	Oregon	$9,149,000,000
Illinois	$40,048,000,000	Pennsylvania	$47,448,000,000
Indiana	$16,785,000,000	Rhode Island	$4,316,000,000
Iowa	$8,453,000,000	South Carolina	$11,144,000,000
Kansas	$6,985,000,000	South Dakota	$1,922,000,000
Kentucky	$13,836,000,000	Tennessee	$21,840,000,000
Louisiana	$15,957,000,000	Texas	$60,434,000,000
Maine	$3,540,000,000	Utah	$4,102,000,000
Maryland	$13,994,000,000	Vermont	$1,966,000,000
Massachusetts	$29,085,000,000	Virginia	$15,301,000,000
Michigan	$29,466,000,000	Washington	$15,497,000,000
Minnesota	$13,348,000,000	West Virginia	$6,372,000,000
Mississippi	$9,648,000,000	Wisconsin	$21,888,000,000
Missouri	$18,669,000,000	Wyoming	$1,104,000,000

This table is not intended to be included in the compact language itself, but rather as a reference for each State to include in the definition of Member State Base Funding Level.

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