Appraising a Health Insurance Exchange for Minnesota

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KEY POINTS

- An exchange would function as a new market for health insurance that helps correct problems related to certain tax inequities and insurance market distortions caused by the tax code and federal insurance regulations.
- By transferring health plan purchasing decisions from employers to consumers (employees), an exchange delivers a number of advantages over traditional employer-based health plans. Advantages include more choice and variety when selecting a health plan, greater price transparency, portability, coordinated funding for dual-income couples, and more competition among health plans.
- An exchange also can extend valuable tax advantages to new types of employer-sponsored health plan arrangements, as well as to people without access to employer-sponsored plans.
- Establishing an exchange is not without risk. An overly ambitious exchange could result in costlier health plans that price more people out of the market. To avoid additional risk, an exchange must not be allowed to manage competition among health plans and the sale of health plans must not be prohibited outside the exchange.

Introduction

In 2007, Minnesota's legislature and governor's office convened two separate groups charged with finding solutions to the cost, access, and quality problems ailing our health care system. Among the many ideas considered, a statewide health insurance exchange attracted favorable and bipartisan interest. An exchange is a state government reform whose objective is to correct problems created by the federal government—including certain tax inequities and insurance market distortions caused by the federal tax code's preference for employer-sponsored group health plans.

An exchange would function as a new marketplace where people with limited or no access to tax-advantaged employer-sponsored group health plans—people who disproportionately are low-income—could buy their own health plan with pre-tax dollars. Employer groups could also use an exchange as their health plan and give their employees the opportunity to choose and own their own health plan. In this way, an exchange would improve dysfunctional health plan markets by spurring more competition and innovation, expanding the variety of health plans available to consumers, increasing the portability of health plans, promoting price and quality transparency, and encouraging people to be more engaged in their health care decisions.

There are, however, serious risks to the state establishing an exchange. A poorly designed exchange could result in costlier health plans that would price even more low-income families out of the market. The fact is, most health care market reforms fail to live up to their expectations; therefore, any attempt even to tweak the market should be taken with extreme caution. That said, if an exchange can extend tax advantages and improve health plan markets, it deserves a close look.

This report reviews the possible advantages and the pitfalls of an exchange. The first section starts by defining the exchange concept. The following section outlines how an exchange can help solve or at least mitigate a number of problems ailing our health care system. An exchange can, however, encounter significant pitfalls if designed poorly, and the next section discusses these. The report concludes by answering some objections from both the left and the right.

What is a Health Insurance Exchange?

In its most basic form, a health insurance exchange is a marketplace (or store) for buying and selling a variety of competing health plans. It would function more like the New York Stock Exchange (NYSE) than a Target store. While Target inventories products and actively markets those products, the NYSE connects buyers and sellers of stocks directly with one another and is generally neutral to the actual stock traded. Similarly, an exchange would connect buyers and sellers of health plans without showing preference for one health plan over another.

The primary function of any health insurance exchange is to aggregate and process health plan payments. The process is thus: Individual consumers, their employers, and/or the government pay into the exchange, the exchange aggregates the payments for the consumer, the consumer directs the exchange to buy a health plan, and, finally, the exchange processes the payment to the health plan. These health plans would be individually-owned health plans versus traditional employer-sponsored group health plans.

Beyond the basic functions of aggregating and processing health plan payments, there are a number of possible structural variations to an exchange, based on the following:

- people or groups eligible to participate
- powers to set benefits, co-pays, deductibles, loss ratios, and prices
- financing arrangements
- corporate structure
- board of directors selection and composition
- risk pooling arrangements
- risk equalization payment system features
- federal health insurance regulation adherence
- participation mandates for individuals and health plans
- group plan availability
- add-on services

Advantages to Be Gained

There are two key advantages to a health insurance exchange and at least two lesser advantages worth mentioning. First, an exchange helps improve the function and competitiveness of health plan markets. Second, an exchange helps extend the tax code's generous exemption of employer-paid health insurance premiums. Less key, but potentially very important, an exchange creates the opportunity both to reform Medicaid and to reform insurance market regulations.

Improving health plan markets. Today, health care markets are inefficient and inattentive to consumers because most consumers, as a result of current tax incentives, rely on their employers for their health plan coverage.[1] An exchange helps put consumers in control of their health plan decisions, which forces health care markets to attend to consumer needs, not employer needs.

Nearly all employers that offer a health insurance plan offer a *defined benefit health plan*, which is a

health plan chosen, defined, and paid for mostly by the employer, not the employee. Because employers call the shots, the actual consumer (the employee) plays only a secondary role in shaping the health care market. Thus, unlike almost any other market for goods or services, health care markets are not driven by consumer input. Without a strong connection to consumers, the price and quality of health plans remains largely unaccountable because employers can absorb cost increases through salary reductions.

In place of a *defined benefit health plan*, an exchange creates the opportunity for employers to offer their employees a *defined contribution health plan*. In defined contribution health plans, employees receive from their employers pre-tax cash contributions that can be used freely to pay for health care expenses. An exchange acts as a central place where employers can make that defined contribution, which employees can then apply to their own health plan choices regardless of their employers.

By helping employers move from offering a defined benefit health plan to offering a defined contribution health plan, an exchange helps correct a number of very specific health care market problems caused by traditional defined-benefit health plans.

- ***An exchange expands the choice of available health plans.*** Most employers offer only one health plan.[2] This lack of choice limits value-enhancing competition among health plan companies and undermines their ability to know what employees want and need in a health plan. Ideally, an exchange would offer the full range of health plans now offered in the individual market.
- ***An exchange makes the true cost of health care transparent.*** Few people actually know how much their employers pay for their health plan or that the costs of the plans are almost entirely offset by reduced wages. A defined contribution health plan makes the employer-paid portion crystal clear, which gives consumers the information they need to make more informed purchasing decisions.
- ***An exchange forces health plans to pay more attention to cost and quality.*** Employers, able to fund health plan cost increases through salary reductions, do not exert nearly enough pressure on health plans to keep costs down and quality up. With newfound control over their health care budgets and the freedom to choose their health plans, employees have incentives to economize and monitor quality. They will exert more pressure on health plans than their employers ever did.
- ***An exchange gives consumers the freedom to define their own benefits.*** For some consumers a quality chiropractor might be a godsend, and they will demand generous chiropractic benefits. Other, more cost-conscious consumers might wish to limit their benefits with plans that, for example, place higher co-pays on brand-name prescription drugs. In an exchange, individual consumers decide what their health plans cover. To realize this freedom fully, current insurance coverage mandates in Minnesota would have to be repealed.
- ***An exchange makes health plans more portable from job to job.*** Because health plans are tied to employment, losing a job usually means losing health care coverage, which can be especially disastrous if the job loss is the result of sickness. An exchange moves people to individual market policies that they can maintain by paying out of pocket if they lose employer funding. It's much easier to continue affording individual market premiums in the event of a job loss, especially a job loss resulting from illness, because individual market policies guarantee that illness or an increased health risk cannot raise insurance premiums upon annual renewal.[3]
- ***An exchange enables dual-income couples and people with two jobs to coordinate funding from their multiple employers.*** Having multiple jobs often means choosing

the most generous health plan from one job and forgoing the other. If each employer were to make a defined cash contribution to an exchange, the funds could be combined (aggregated) and applied to one plan.

- ***An exchange allows consumers to choose health plans that fit their conscience.*** As the science, technology, and policy of health care advances, more and more matters of conscience are entering the equation. Embryonic stem cell research, genetic testing, contraception, abortion, organ sales, and assisted suicide could all find themselves part of a health plan, whether explicitly within the benefits set or more implicitly through research or other funding grants. In an exchange, consumers can follow their consciences and choose health plans aligned with their convictions.[4]

Extending tax advantages. An exchange can help extend tax advantages available to people through the tax code's exemption on employer paid health plan premiums in two ways. First, an exchange provides employers that sponsor health plans a new defined contribution health plan alternative with the same tax advantages as a defined benefit health plan. Second, for employers that do not sponsor a health plan, an exchange encourages them to establish cafeteria plans that employees can use to pay health plan premiums with pre-tax dollars.

Until recently, there was no clear answer to whether an employer could sponsor a defined contribution health plan and receive the same tax advantages as a defined benefit health plan. To stay on the safe side of the law, employers have long sponsored defined benefits. However, over the past decade the Internal Revenue Service (IRS) has issued guidance on a number of tax issues that confirmed employers may indeed sponsor defined contribution health plans. One of the major developments took place in 2002 when the IRS endorsed the use of Health Reimbursement Arrangements (HRA).[5] An HRA is a financial account owned and funded by employers that employees can use to pay for medical expenses. Importantly, the IRS confirmed in 2002 that employees can use the account to pay individual health plan premiums. More recently, in August 2007, the IRS confirmed that a cafeteria plan can be used to pay individual health plan premiums. But questions remain over how to coordinate premium payments from an HRA and a cafeteria plan.

A health insurance exchange offers an alternative to an HRA-style defined contribution plan that can provide an easier solution for some employers, especially small employers. First, an exchange does not carry the same questions over intermingled funding from HRAs and cafeteria plans because the exchange is only used to pay health plan premiums. Second, an exchange is also free from many federal regulations because it functions only as a processor of payments and does not maintain a fund balance that would otherwise be subject to federal regulations. Admittedly, even the exchange's tax status is not fully clear because the IRS has yet to specifically endorse the arrangement. With employers already funding health plan premiums through the Massachusetts Connector, the nation's first state-sponsored exchange, tax lawyers have already requested clarification on this issue.

Employees who work for employers that do not offer health benefits must buy their own health plans, and, in general, do not receive tax exemptions for their monthly premiums. Yet there is, in fact, a process for people to get the tax exemption when they buy their own plans, and an exchange can help more people benefit from it. Employees without access to employer-sponsored group health plans can still exempt individual health plan premiums if their employers agree to pay the premiums through a cafeteria plan.[6] In a cafeteria plan, employees choose to allocate a portion of their pre-tax salaries to the plan to pay for certain health- or child-care expenses. The plan—i.e., the employer—then pays those expenses.

However, only a minority of employers—34 percent nationally—offer cafeteria plans.[7] Without

a human resources department or an employee benefits consultant, many small employers are not even aware that cafeteria plans exist. Awareness may also be limited because cafeteria plans are not widely advertised.[8] Further, many employers do not offer cafeteria plans due to the perceived cost and administrative burden.

An exchange can both increase awareness and ease the administrative burden of cafeteria plans and thereby encourage employers to offer them to their employees. Through advertising and the news generated from the creation of an exchange, awareness about cafeteria plans and their tax advantages will rise. More importantly, by acting as a central point for choosing and paying health plans, an exchange removes the administrative burden of selecting and paying multiple health plans. To encourage further the use of cafeteria plans, an exchange might also offer an add-on service to assist employers in the process of setting up their cafeteria plans.

Reforming Medicaid. While not a necessary component to an exchange, most exchange proposals either include or envision the application of a subsidy program within exchanges.[9] Minnesota's current Medicaid program channels eligible enrollees into a one-size-fits-all managed care health plan. On top of being inflexible, Medicaid crowds out private coverage, pays providers below-cost reimbursement rates, and interrupts the continuity of care for enrollees when they enter or leave the program. All of these problems could be resolved or mitigated if Medicaid were reformed into a program that subsidizes private coverage.[10] As a payment aggregator, an exchange could easily administer a public subsidy program giving low-income people the power to pay private health plan premiums from an aggregated pool of government, employer, and individual funds.

Reforming insurance regulations. An exchange creates an opportunity to reform dysfunctional insurance regulations. When establishing an exchange, the state will want to rethink the way it regulates both the individual and the small group markets and may wish to develop new regulations that authorize a hybrid market that combines the best features of the individual market (portability, choice, and guaranteed renewability) with the best features of the small group market (its tax advantages and lack of individual underwriting). In fact, federal regulations may require these new regulations, to some degree, in order for the exchange to process defined contributions from employers.

Currently, Minnesota's small group market tends to attract a disproportionate number of unhealthy, high-risk, and high-cost individuals. This is because federal regulations force group health plans to accept every small employer group that seeks coverage, regardless of the group's health risk. Furthermore, the market does not spread the cost of high-risk employees equitably. Because health plans charge employers higher premiums based on their total risk and because employers must distribute the higher premium equally among its employees, employees that happen to work for higher-risk employer groups pay higher premiums than similarly situated employees in lower-risk groups.

In contrast, Minnesota's less regulated individual market allows health plans to charge higher premiums for higher risks and even to exclude people with risks deemed too high. Minnesota's high risk pool picks up the higher risks and funds these risks more equitably. Consequently, Minnesota's average annual individual health plan premium sits $189 *below* the national average, while Minnesota's average small group health plan premium sits $156 *above* the national average.[11] Thus, the individual market trades a more equitable insurance product, with guaranteed access and less premium variation, for lower premiums.

An exchange gives Minnesota a chance to take a fresh look at how it regulates the small group and individual insurance markets. Reforming how the state regulates insurance could help mitigate risk selection problems found in the small group market and the inequities found in both markets. These

decisions will be the most difficult part of the process in establishing an exchange, because they present tough tradeoffs. Moreover, it's often hard to predict how new insurance market regulations will impact the market. The wrong choices could exacerbate risk selection problems and raise premiums, which is exactly what happened in some states that modified their insurance market regulations in the 1990s.[12]

Pitfalls to Be Avoided

While a Health Insurance Exchange might appear to offer a path to more affordable high quality health plans, most ambitious health care reforms fail with great gusto. As noted, there are a number of possible variations to an exchange. Some of these variations would transform an exchange into a much more ambitious market-wide reform and increase the risk (and scope) of failure. Of these variations, there are two critical pitfalls to avoid: First, an exchange must not be allowed to *manage competition*; second, the sale of health plans must not be prohibited outside the exchange.

Pitfall #1: Giving the exchange the power to manage competition.

The more ambitious variations introduce a new role for an exchange in the marketplace. Instead of just aggregating and processing pre-tax premium payments, an exchange would begin actively managing competition among the health plans it offers. For example, the Health Care Transformation Task Force, one of the two groups established by the legislature and the governor, recommends limiting the number of health plans offered in an exchange, reasoning that too many health plans might be too confusing for consumers. An exchange also might standardize the benefits that a health plan can offer in an effort to help consumers compare the plans on price and quality measures. In doing so, this type of exchange embodies a style of health care reform called *managed competition*.

As originally conceived by Stanford University professor Alain Enthoven, managed competition is a vital component to an exchange. However, he did not necessarily envision a single state-sponsored exchange. To Enthoven, exchanges "could be private or public, for-profit or nonprofit organizations, electronic or traditional."[13] Notably, once the advantages of exchanges become known, he predicts that they would become entrepreneurial ventures competing against one another.[14]

It would be one thing for a single exchange to manage competition in a field of competing exchanges, but quite another to manage competition as a single state-sponsored exchange. Without competing exchanges, a single state-sponsored exchange that manages competition would essentially be a new and less accountable state insurance regulator. To manage competition, an exchange might pursue the following approaches: set premium caps; set minimum loss ratios; limit co-pays, co-insurance, and deductibles; establish standards for health plan and provider quality; define minimum and standardized benefits packages; or require special payments to health plans to equalize their risks.

Proponents of managed competition believe this sort of active management will protect consumers and enhance competition between health plans. Loss ratio minimums, premium caps, and limits on out-of-pocket costs intend to protect consumers from the supposed avarice of health plans, even the so-called nonprofits. But attempts to plan a market centrally in the interests of consumers never work. Caps on prices lead to shortages; limits on out-of-pocket costs lead to overuse and costlier premiums. Vigorous competition—one company trying to best another by delivering a superior product—remains the most effective consumer protection policy.

Interestingly (and oxymoronically), proponents of managed competition believe that it will also invigorate competition. By requiring health plans to offer standardized benefit sets, proponents believe consumers will be better equipped to shop because shoppers comparing the price of standardized benefits will be comparing apples to

apples; this will, in theory, force health plans to compete more actively on price (and maybe even on quality, if reliable measures ever become available). The presumption here is that without focused competition over price, current health plans operate inefficiently with high administrative costs.

Yet focusing competition on the price of a few benefit designs does not guarantee lower prices or increase the overall competitiveness of the health plan market. Setting standardized benefits is little different than restricting car manufacturers to producing a four-door sedan based on one standard design and then forcing them to compete on how efficiently they can produce that one car, even if some consumers might have opted for a less expensive design.

Health plans currently compete to offer innovative benefit designs, a practice that should be encouraged, not restricted. Not everyone shares the same risk tolerance, health habits, health conditions, or preferences for various medical treatments, like alternative medicine. Moreover, certain design elements, like higher co-insurance levels or linking cost sharing with healthy behaviors, can affect the price of a plan significantly, and, of course, not everyone has the same health care budget. Tailoring benefit designs to meet these various preferences is an important competitive element that managed competition as envisioned by some people would inhibit.

At best, an exchange that manages competition would become yet another third-party decision maker that cuts health care consumers out of the process in the same way that employers and government health programs do now. At worst, it would implement an array of well-intentioned regulations ostensibly to protect consumers and, in the process, drive up premiums and damage Minnesota's health plan market. These consequences are serious and demand a clear and muscular prohibition against the power of an exchange to manage competition.

Pitfall #2: Prohibiting the sale of individual and small group health plans outside the exchange. An early draft of the Health Care Transformation Task Force report—one of the groups charged by the legislature and the governor to find solutions—recommends collapsing the individual and small group markets into one statewide exchange, making the exchange the only entry point into the insurance market.[15] This recommendation presents serious problems. As the only entry point to the insurance market, any authority given to the exchange will govern the entire individual and small group market, and the success of the market will depend on the success of the exchange.[16] Even if the exchange is not given the power to regulate or manage competition, collapsing the whole market into the exchange certainly paves the way to that. In the future, it will be all too tempting for lawmakers to surrender politically difficult decisions to the exchange.

Moreover, without any competitive forces, the exchange will likely devolve into a sluggish and expensive bureaucracy. The freedom to buy health plans outside the exchange—either directly, through a broker, or even through another exchange—is a competitive force essential to keeping the exchange responsive to customers.[17]

Objections

Because the exchange attracts bipartisan support, it's no surprise that objections spring from both the left and the right. Most objections have some legitimacy and are therefore worth considering.

- **Objection #1: Every exchange is a form of managed competition that constrains health care markets and reduces competition.** People who know the history of health care reform know that President Clinton's 1993 health care initiative drew from Professor Alain Enthoven's managed competition ideas and was itself labeled managed competition. Knowing that history, it's not hard to understand why some conservatives might

react strongly, even viscerally, against the idea. (It should be noted that Enthoven quickly disavowed and disassociated himself from the Clinton proposal.)[18] However, the exchange proposed here, and similarly proposed by the conservative Heritage Foundation, would not adopt the managed competition elements first proposed by Enthoven.[19] That said, even if the exchange starts out modestly and is given limits, conservatives should worry that it might, in the future, be empowered to manage competition.

- **Objection #2: Even a modest exchange will be used to pave the way to a government-run health care system and should be avoided at all costs.** While this might seem a tad conspiratorial, there is no question that many people on the left would like to use the exchange, as just discussed, to manage how health plans compete. After all, that was the original intent. And it's true that some Minnesota policy makers propose an even more ambitious exchange with broader authority to control Minnesota's health care market by making it responsible for defining quality, measuring risk, and even setting how doctors get paid. With these responsibilities, an exchange would be responsible for orchestrating Minnesota's entire health care system and thus would, in any practical sense, become a government-run system.

  But do these proposals to strengthen governments hand in health care mean we should avoid an exchange altogether? People must understand that there is also a substantial risk of moving toward a government-run system if we do nothing. Right now, the status quo in health care is frustrating, to say the least, and public moods are shifting. Five more years of double-digit cost increases, and the public may be willing to accept a much stronger government role. Health savings accounts already demonstrate how medical care consumerism can bring down costs without sacrificing quality; it's worth giving an exchange the same chance to show how health plan consumerism can do likewise.

- **Objection #3: By moving more people into the individual market, an exchange increases the number of people eligible for the state's subsidized high-risk pool.** This is true, but this result is far more equitable than the present situation where employees who happen to work for employer groups with high health risks end up paying higher insurance rates than similarly situated people working for employers with low risks.

- **Objection #4: An exchange will encourage employers to drop or reduce the health care benefits they fund and increase the financial burden on employees.** As long as the tax code allows employers to exempt the cost of employer-sponsored plans from payroll taxes, few employers will completely drop health benefits. Under the right circumstances, an exchange would encourage broader employee participation. Some employees find employer-sponsored health plans unaffordable and refuse them because the employer offers only a benefit-rich plan and pays only a small portion of the expensive premium. If this employer were to make defined contributions to an exchange, more employees would take up insurance because they would have a lower-cost option.[20]

  It's true that some employers may begin reducing the portion of health benefits they pay directly, but overall this result should be positive. For employers that start paying a defined contribution—a set dollar amount each month—employer funding will no longer be tied to the actual cost of health benefits and thus annual inflationary adjustments to their funding may not keep pace with more rapidly inflating health care costs and employees will need to pay a greater share to maintain the same benefit level. While some people worry that an increased employee share will become too burdensome, employees

already pay this share through reduced salaries—they just don't realize it.[21] As long as employees receive the tax exemption on their share, not much changes. The fact is, the higher the employees' share, the better the health plan market will function, because employees are more attentive to the cost and quality of their health plans. As already noted, employers do not exert enough pressure on health plans to keep their costs down and quality up.

- **Objection #5: An exchange accomplishes nothing that is not already done privately.** Insurance brokers already assist individuals and small employers with finding the right health plans and setting up cafeteria plans. Web sites, such as eHealthInsurance.com, already help organize information to help shoppers compare and buy health plans. But no one, at least in Minnesota, has set up an arrangement where multiple employers and employees can aggregate funding in a way that allows employees to take maximum advantage of the tax code and that grants employees in group plans access to a wide variety of health plans.

- **Objection #6: If an exchange is such a good idea, an entrepreneur would have already created it.** Without state authorization, an exchange would be risky venture for an entrepreneur. Certain interpretations of federal health insurance regulations apply the law's small group market regulations to individual market health plans if an employer pays any part of the premium, even if the premium gets paid through a cafeteria plan.[22] If true, then an exchange would need to follow small group market regulations even though the health plans would be individually owned. Most states would need to pass laws that set out and authorize this new combination of small group regulation on individually owned plans.

  Even if state authorization is unnecessary, there are more reasons an entrepreneur might take a pass. First, investing in a market as dysfunctional as most states' individual and small group markets would represent quite a risk in itself. Second, this risk multiplies when you consider the likelihood that future state reforms might radically alter the market's landscape. Third, most individual and small group markets are quite small, which makes bringing an exchange to a profitable scale challenging.

  These points present a common theme: Both federal and state laws etch a great deal of uncertainty into the future success of an exchange. Because states exert some control over uncertainties, they may be best situated to establish an exchange.

Conclusion

If the state government is best situated to open an exchange, then policymakers must remain mindful that the government, in opening one, is stepping into the private market. An exchange is not a traditional public good or public service that justifies government involvement; it is fundamentally a private service connecting private citizens with private health plan companies. This sort of market intrusion would not be tolerated in other industries. The proposal would be pilloried as market planning. Yet an exchange can be justified as a tool to help counteract federal intrusions.

Policymakers must take care that this step into the private market does not become a leap. Indeed, as a tool to reduce the overall influence of the government on health care markets, an exchange should not be justified as a tool to embark on other initiatives related to issues like quality measurement, risk selection, benefit design, and provider payments. If allowed to take on these responsibilities, an exchange will begin looking and functioning more and more like the state's health care central planning agency, setting Minnesota's health care market on a course toward less innovation, longer waits, frequent shortages, wasteful surpluses, fewer choices, poor customer

service, and, of course, rationing. To avoid this result, an exchange needs clear limits and boundaries.

These warnings notwithstanding, a strictly bounded exchange can deliver positive results. Federal tax laws and group health plan regulations exert enormous influence on how Minnesotans purchase their health plans. The result is less choice, higher costs, less flexibility, reduced competitiveness, lower quality, less accountability, and less portability. An exchange can reduce that federal influence. Ideally, the federal government would take action and de-link tax benefits from employer-paid health care. This would eliminate the need for an exchange. The idea is gaining traction among federal policymakers, but considering that the problem has been well understood for decades, Minnesotans should not expect quick reform. Rather, Minnesota should move forward with an exchange, the most feasible opportunity to reduce federal distortions on Minnesota's health plan market.

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Notes

[1] *See* Peter Nelson, *A Primer on How Employment-Based Health Benefits (and the Tax Code) Distort the Health Care Market*, Center of the American Experiment, November 2007, available at http://www.americanexperiment.org/publications/2007/200711nelson.php.

[2] The Kaiser Family Foundation and Health Research and Educational Trust, *Employee Health Benefits 2007 Annual Survey*, available at http://www.kff.org/insurance/7672/ (accessed March 20, 2008) .

[3] According to research by economists Mark Pauly and Rob Lieberthal, at the time people desperately need coverage—when they become ill—people tend to have more trouble maintaining employer-based group coverage than people with individual market coverage. They attribute this to the fact that most individual policies guarantee that a recent illness or an increased health risk will not be a factor when setting the price of annual renewals. Mark Pauly and Rob Lieberthal, *How Risky is Individual Health Insurance?*, U.S. Department of Health and Human Services, May 2007, available at http://aspe.hhs.gov/daltcp/reports/2007/howrisky.htm (accessed March 20, 2008).

[4] *See* Connie Marshner, "The Health Insurance Exchange: Enabling Freedom of Conscience in Health Care," *The Heritage Foundation WebMemo*, No. 1377, March 1, 2007; and Robert E. Moffit, Jennifer A. Marshall, and Grace V. Smith, "Patients' Freedom of Conscience: The Case for Values-Driven Health Care Plans," *The Heritage Foundation Backgrounder*, No. 1933, May 12, 2006.

[5] Internal Revenue Service Notice 2002-45, Internal Revenue Bulletin 2002-28, pp. 93-6, July 15, 2002.

[6] Internal Revenue Service, *Employee Benefits—Cafeteria Plans; Proposed Rule*, 72 Fed. Reg. 43938, August 6, 2007, available at http://edocket.access.gpo.gov/2007/pdf/E7-14827.pdf (accessed March 24, 2008) (confirming that cafeteria plans may be used to pay individual accident and health insurance premiums).

[7] According to MetLife surveys, only 34 percent of employers offer cafeteria plans and the offer rate among small employers (2-49 employees) is a much lower 22 percent. MetLife, *Fifth Annual Study of Employee Benefits Trends*, 2007.

[8] Trent D. Bryson, "The Benefits of Cafeteria Plans," Entrepreneur.com, Sept. 14, 2005, at http://www.entrepreneur.com/humanresources/compensationandbenefits/article79978.html (accessed on March 14, 2008) (reporting that cafeteria plans are not widely advertised because the plans do not generate significant profits).

[9] For instance, the Massachusetts Connector includes partial subsidies for those under 300 percent of the federal poverty guideline and a full subsidy for those under 100 percent. Also, in 2007, Gov. Tim Pawlenty proposed Healthy Connections, which would have subsidized a private health plan through an exchange. Minnesota Office of the Governor, "Healthy Connections: Health Care Reform to Lower Costs, Improve Quality, and Increase Access to Coverage," news release, January 11, 2007, available at http://www.governor.state.mn.us/mediacenter/pressreleases/2007/PROD007915.html (accessed March 14, 2008).

[10] A subsidy program would look very different from Medicaid managed care. Enrollees would choose from a variety of health plans; employers would have less incentive to drop coverage completely; providers would be paid at market, not Medicaid rates; and people would be able to continue seeing their preferred doctor when their Medicaid eligibility status changed.

[11] America's Health Insurance Plans, *Individual Health Insurance Survey 2006-2007*, December 2007, available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf (accessed March 17, 2008); America's Health Insurance Plans, *Small Group Health Insurance in 2006*, September 2006, available at http://www.ahipresearch.org/pdfs/FINALSmallGroupPaper.pdf (accessed March 18, 2008).

[12] Kentucky offers the most striking example of insurance market collapse, while results in other states have been mixed and open to debate. *See* Conrad F. Meier, *Destroying Insurance Markets: How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States* (2005); and Len M. Nichols, "State Regulation: What Have We Learned So Far?, *Journal of Health Politics, Policy, and Law*, Vol. 25, No. 1 (February 2000): 175-96.

[13] Economic & Social Research Institute, *Covering America: Real Remedies for Covering America*, Vol. 1 p. 158 (June 2001) available at http://www.esresearch.org/RWJ11PDF/full_document.pdf (accessed March 18, 2008).

[14] Id. at 159.

[15] Minnesota Health Care Transformation Task Force, *Principles, Issues, and Recommendations*, Draft Version 5.1, Nov. 26, 2007 available at http://health.state.mn.us/divs/hpsc/hep/transform/novdocuments/healthcaretransformprinciplesissuesrecommendationsv51.pdf (accessed March 19, 2008).

[16] Michael Tanner of the Cato Institute, arguing against the exchange concept, asserts an exchange would act as a monopsony buyer of health insurance. Michael Tanner, "Reforming Health Care in Kansas," Testimony before the Kansas House Insurance and Financial Institutions Committee, February 13, 2007. But if it were the sole entry point to health insurance products, an Exchange would really be a monopoly supplier of payment processing services, not a monopsony purchaser of health insurance, because individuals would still maintain the power to choose the health insurance they purchase within the Exchange.

[17] For some states, an exchange acting as the only entry point might make some sense. In the 1990s, states implemented a range of insurance regulation reforms which caused some markets to collapse. A single exchange offers a chance to revive these defunct markets, which is exactly what the highly publicized Massachusetts reforms intend to accomplish. Minnesota, fortunately, is not a state with a defunct insurance market in need of a revival.

[18] Kant Patel and Mark E. Rushefsky, *Health Care Politics and Policy in America*, p. 276 (1999 2nd Ed.).

[19] Stuart Butler, *Evolving Beyond Traditional Employer-Sponsored Health Insurance*, The Brookings Institution Discussion Paper 2007-06, May 2007; and Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," The Heritage Foundation Web Memo No. 1230, October 5, 2006.

[20] This scenario would likely have upfront costs for the employer, because more employees would accept the benefit. Employers could reduce the contribution to compensate for the expansion, but benefit reductions are a tough sell, especially to unionized employees.

[21] *See* Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *The American Economic Review*, Vol. 84, No. 3 (June 1994): 622-41.

[22] Terry Humo, *Employer's Guide to the Health Insurance Portability and Accountability Act*, pp. 77-78 (Thompson Publishing June 2007); and Department of Health and Human Services, Program Memorandum 00-02 (June 2000).

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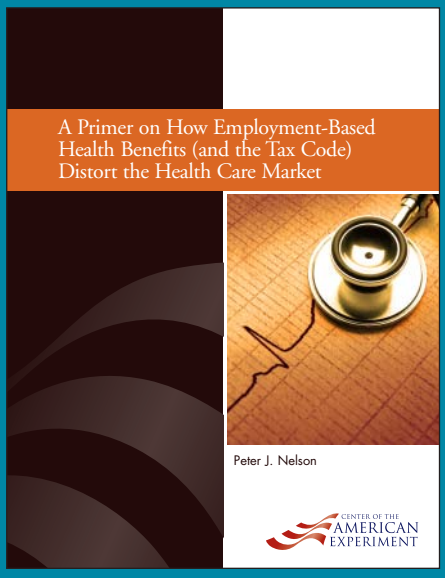

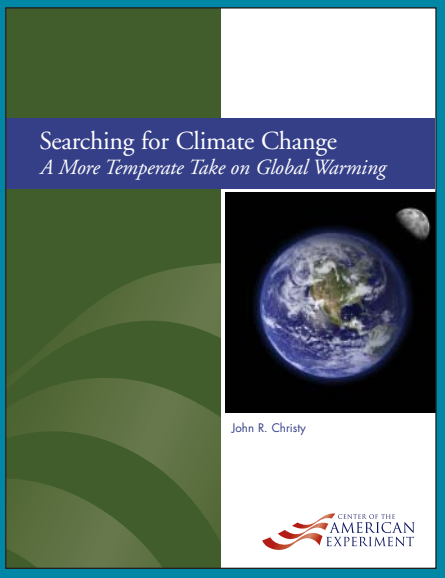

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