

Health Insurance Exchange Study

Minnesota Department of Health

February, 2008



Division of Health Policy
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882
(651) 201-3550
www.health.state.mn.us

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Introduction

The 2007 Legislature required a report on the possibility of establishing a health insurance exchange that would provide individuals with greater access, choice, portability, and affordability of health insurance products.¹ Specifically, the report must evaluate, identify options, and present recommendations in the following areas:

- Whether a health insurance exchange would provide individuals with greater access, choice, portability, and affordability of health insurance coverage;
- The duties and powers of the exchange;
- The use of the exchange to receive and process employee premiums on a pre-tax basis through Section 125 plans;
- Eligibility criteria that enrollees and health plan companies must meet to participate in the exchange;
- The types of health plans to be offered through the exchange, and the extent to which these plans should be available for purchase only through the exchange;
- Loss ratio requirements for health plans offered through the exchange;
- The extent to which the operation of the exchange will lower the cost of health care coverage;
- Estimates of administrative costs of operating the exchange, and methods for funding these administrative costs; and
- Other topics relevant to the design and operation of the exchange if its establishment is recommended.

The idea of states' establishing health insurance exchanges (sometimes also called "connectors") to promote better functioning of health insurance markets has received a great deal of attention from policymakers in the past few years. In 2006, Massachusetts enacted a comprehensive set of health care reforms that included a requirement for individuals to obtain health insurance coverage, a requirement that employers establish "Section 125" plans to enable employees to pay for health insurance with pre-tax dollars, and the creation of a health insurance exchange to make it easier for individuals and employers to navigate the market. Since then, several other states – including Minnesota – have considered proposals to establish a health insurance exchange.² In addition, a private industry association in Connecticut has operated a similar model since 1995.

What is a health insurance exchange?

The basic idea of a health insurance exchange is similar to the concept of a stock exchange or farmers market – an exchange serves as a market clearinghouse, but not as a regulator or purchaser.³ It functions as a single place where people can go to find out about their health insurance options, and improves market competition among health plans by providing more complete and understandable access to information about the products and pricing available in the market.

In combination with other health care market reforms, an exchange could provide additional benefits. For example, the concept of a health insurance exchange was originally promoted as a way to facilitate "defined

¹ 2007 Minnesota Laws Chapter 147, Article 19, sec. 3, subd. 6.

² Other states that have formally considered or enacted some version of a health insurance exchange include Washington, Colorado, and Kansas.

³ Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs* v 25 no. 6, November/December 2006, p. 1580-1590.

contribution” approaches to health insurance benefits⁴; as explained in more detail later in this report, Minnesota would likely need to change some of its laws related to issuance and premium rating of health insurance coverage in order to make this feasible. Used in this way, an exchange could improve portability of coverage and choice of plans. It could also provide an avenue for people who are usually not eligible for employer plans (such as part-time employees) to gain access to limited employer contributions toward health insurance, and could even allow people with multiple jobs to combine contributions from more than one employer. If the State decides to require employers to offer Section 125 plans,⁵ the exchange would reduce administrative burden on employers by providing a single place for employers to remit money withheld from employees’ paychecks for health insurance coverage (see Text Box on Section 125 plans), and could also serve as a source of education and technical assistance to employers.

The Health Care Transformation Task Force and the Legislative Commission on Health Care Access are considering comprehensive health care reforms in Minnesota to improve health care access, contain cost, and improve quality. The Health Care Transformation Task Force has proposed, and the Legislative Commission on Health Care Access is considering, a health insurance exchange to (1) improve market functioning and (2) facilitate the implementation of other reforms (such as insurance market reforms, an individual responsibility to purchase coverage, and a requirement that employers offer Section 125 plans).

The next section of this report describes research that the Minnesota Department of Health conducted in order to answer the questions posed by the Legislature, and the final section describes the study recommendations.

⁴ Robert E. Moffit, “The Rationale for a Statewide Health Insurance Exchange,” Web Memo published by the Heritage Foundation, October 2006. A defined contribution approach is one in which an employer provides a set allowance toward health insurance premiums, and employees pay the difference between that amount and the cost of the policy they choose to purchase.

⁵ Throughout this report, references to a requirement that employers establish Section 125 plans mean a requirement that employers establish “premium only” plans that allow employees to pay for health insurance with pre-tax dollars. Although employers could choose to offer additional nontaxable benefits through Section 125 plans, such as Flexible Spending Accounts that can be used to pay for health care expenses not covered by insurance, they would not be required to do so.

Using Section 125 Plans to Purchase Health Insurance

What is a Section 125 plan?

The term “Section 125 plan” refers to section 125 of the United States Internal Revenue Code; Section 125 plans are also referred to as “cafeteria plans.” This section of the tax code establishes rules for employers that offer employees a choice between taxable and nontaxable benefits (including, but not limited to, health insurance coverage). As envisioned in Governor Pawlenty’s 2007 “Healthy Connections” proposal, employers with more than 10 employees would have been required to establish a “premium only” plan that would have allowed employees to choose to have part of their salary withheld to purchase health insurance coverage in the individual market. Employers could choose to establish Section 125 plans that offer other nontaxable benefits as well, but would not be required to do so. Under a Section 125 plan, employers are not required to contribute to the cost of health insurance.

Impact on Employers

For employers, there are financial benefits to establishing a Section 125 plan. For example, employers do not pay Medicare, Social Security, or unemployment insurance taxes on the amounts that employees choose to have withheld from their paychecks on a pre-tax basis. It is inexpensive for an employer to set up a Section 125 plan,¹ and so if even only a few employees choose to take advantage of the ability to buy health insurance with pretax dollars, the employer can realize a net financial gain.

Impact on Individuals

Individuals who buy health insurance through a Section 125 plan benefit from the ability to pay for coverage with pre-tax earnings. Depending on their income, the amount of money that individuals can save by paying for health insurance this way is about 30 to 50% of the cost of health insurance.² Because of interactions with other parts of the tax code (particularly the Earned Income Tax Credit), the estimated savings are highest for people with relatively low incomes.

When individuals choose to reduce their taxable salary and receive pre-tax benefits instead, there can be an impact on their future Social Security benefits. Although the size of the impact varies depending on individual circumstances, the reduction in future Social Security benefits was small – ranging from about \$4 per month to \$26 per month – in examples provided to the Legislature in 2007 by the Minnesota Department of Revenue.³

Impact on State Revenues

When individuals reduce their taxable income by shifting part of their compensation from after-tax to pre-tax benefits, both the state and federal governments experience a loss of tax revenue. Because federal income tax rates are much higher than the state’s rates, about 80% of the revenue impact would be on the federal government. In other words, for every dollar of revenue that the state would lose, the federal government would lose \$4; this compares very favorably to the current 50/50 split between the state and federal government for the Medicaid program.

¹In Massachusetts, the Commonwealth Health Insurance Connector Authority provides an online tool that employers can use to set up a Section 125 plan.

²Estimates provided by Paul Wilson, Minnesota Department of Revenue, February 2007.

³Memo to Representative Thomas Huntley, Chair, Health Care and Human Services Finance Committee, from Paul Wilson, February 12, 2007.

Research Conducted for This Study

In conducting this study, MDH contracted with Mathematica Policy Research, Inc., for modeling and analysis of a variety of options related to the scope and operation of a health insurance exchange, and their interaction with other potential policy changes to improve access to private health insurance coverage. On behalf of MDH, Mathematica modeled the impact of several policy options (individually and in combination):

- Guaranteed issue and removal of health status as a rating factor in the small group and individual insurance markets;
- An individual responsibility to obtain health insurance coverage;
- Merging the small group and individual health insurance markets; and
- Requiring firms with more than 10 employees to offer a Section 125 plan to enable pre-tax payment of health insurance premiums.

Mathematica's analysis estimates the impact of these options on public and private insurance coverage in Minnesota, as well as the impact on the cost of coverage, and any costs to the state (revenue losses as well as direct costs resulting from changes in public insurance program enrollment). The Mathematica study also includes an analysis of the legal and operational issues associated with establishing a health insurance exchange and requiring employers to offer Section 125 plans. This report includes preliminary results of this modeling analysis. Other analyses, including other combinations of policy options and sensitivity analyses, are ongoing and will be available at a later date.

In addition, MDH contracted with the health policy consulting firm Burns & Associates to conduct focus groups with small employers and insurance brokers to identify their concerns related to offering health insurance, the cost of coverage, and potential proposals to establish a health insurance exchange, establish an individual responsibility to obtain health insurance coverage, and/or require employers to offer Section 125 plans.

For small employers, focus groups were conducted with employers that currently offer health insurance coverage, and with those that do not. Major findings from the focus groups included the following:

- There are large differences in the level of knowledge about health insurance benefits between employers that offer coverage and those that do not. Employers that offer health insurance had a higher awareness of Section 125 plans;⁶
- Small business owners are concerned that the exchange would be too bureaucratic, particularly if it is run directly by the State;
- Cost and administrative burden were cited as the main reasons why some small businesses do not offer health insurance. Small business owners that do not offer coverage were attracted to the idea that an exchange could reduce the administrative burden associated with offering insurance, but were more concerned about the high cost of coverage;

⁶ However, the research suggests that there is some degree of misunderstanding about Section 125 plans even among employers that offer coverage. Many employers noted that they "replaced" their section 125 plan when they switched to a Health Savings Account (HSA) option; this suggests that there may be confusion about the ability for employees to pay for premiums using a Section 125 plan. (Another popular type of Section 125 plan is a "Flexible Spending Account," or FSA, which allows employees to set aside money tax-free for health care expenses not covered by insurance. Employers offering HSAs would likely not offer FSAs as well, but could still offer a Section 125 plan for employees to pay for their share of premiums on a pre-tax basis.)

- Employers that offer coverage are frustrated by high costs as well, and particularly by the volatility in premiums that can occur if just one person in the group has high claims;
- The small business owners who participated in the focus groups were not supportive of requiring employers to offer Section 125 plans or requiring individuals to obtain coverage (partly because of concern that this would create additional administrative burdens for employers);
- Small business owners also recommended many other strategies to reform health care, including making costs more transparent in the market, promoting prevention of disease, making the system more efficient through the use of information technology, reducing waste and overutilization, and reducing health plan administrative costs.

Insurance agents who participated in focus groups (which were held separately from the small business owner focus groups) were generally not supportive of a health insurance exchange, because of concern about unnecessary government involvement in private markets. The participants in these focus groups also did not support requiring employers to offer Section 125 plans or establishing an individual responsibility to obtain health insurance coverage.

Options and Recommendations

The discussion below addresses each of the issues in the legislative charge to perform this study. Although each issue is addressed separately, it is important to recognize that many of the decisions about these issues are interdependent, and are also dependent on other policy decisions such as whether to enact comprehensive insurance market reforms.

1. Whether a health insurance exchange would provide individuals with greater access, choice, portability, and affordability of health insurance coverage

As noted above, a health insurance exchange by itself does not directly influence the availability and affordability of health insurance plans. Rather, it facilitates better market functioning, and could be an effective tool to improve access, choice, portability, and affordability of health insurance coverage in combination with other reforms.

In recent years, rising health insurance premiums have led employers to search for ways to contain costs, including ways to engage employees to consider cost when making decisions about health insurance coverage and how they use health care services. Some employers have dropped coverage altogether.⁷ A health insurance exchange could enable some employers to shift to a “defined contribution” model of employee health insurance benefits; for some, this could be an alternative to dropping coverage entirely. For employees, this type of model would increase choice and portability of coverage. In combination with a requirement that employers offer Section 125 plans, it would improve affordability for people who do not currently have the option of paying for health insurance with pre-tax dollars. This impact on affordability would also affect MinnesotaCare enrollees, who could be given the ability to make premium payments with pre-tax dollars; in addition, savings of 30 to 50% of premium associated with pre-tax payment of premiums (see Text Box on using Section 125 plans to purchase health insurance) could enable some current MinnesotaCare enrollees to shift to private coverage, particularly those at the higher end of the income eligibility scale.

⁷ For example, 23% of small employers (3 to 199 employees) that did not offer health insurance in one large national survey reported that they had offered coverage in the last five years (Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2007 Annual Survey, Exhibit 2.9).

A health insurance exchange is an essential element of a package of insurance market reforms that has been recommended by the Health Care Transformation Task Force. The Legislative Commission on Health Care Access has also recommended the creation of a health insurance exchange as part of its health reform proposal.

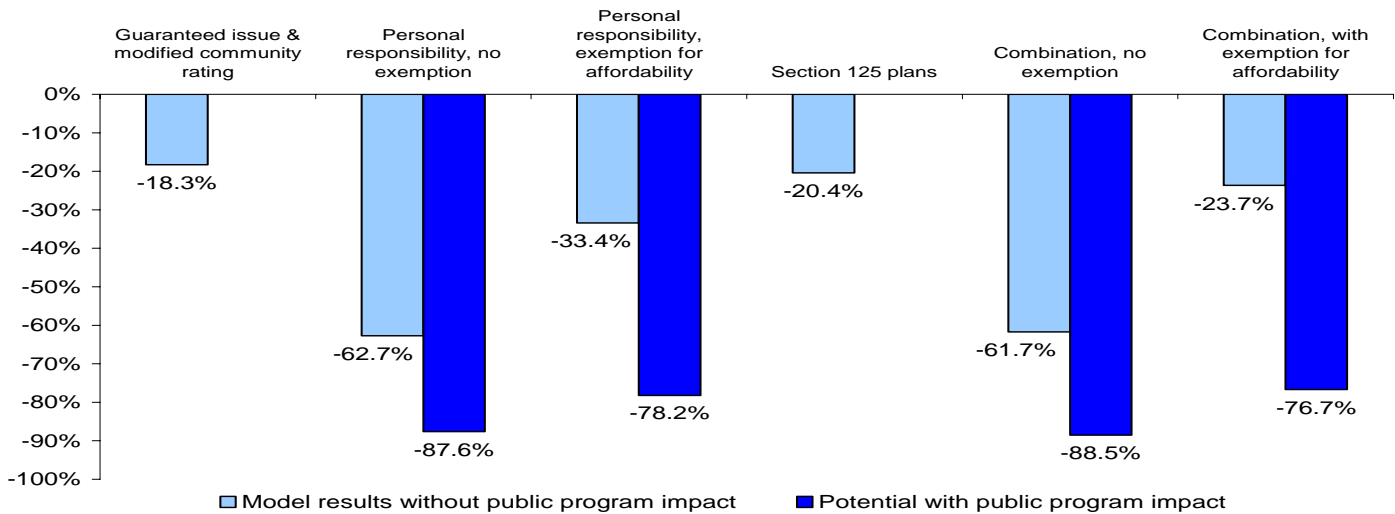
The Transformation Task Force proposed establishing guaranteed issue in the individual market, changing the rules of insurance rating to eliminate health status as a factor in determining premiums (but price differences based on health behaviors, such as smoking, would still be allowed), combining the individual and small group insurance markets, creating an expectation that individuals obtain and maintain a minimum level of health insurance coverage, requiring employers with more than 10 employees to establish Section 125 plans, and subsidizing the cost of coverage for people who cannot obtain “affordable” coverage.

In the Task Force recommendations, the definition of “affordability” varies based on income. The Task Force proposed a sliding scale to determine eligibility for premium subsidies. Families with incomes at or below 300% of federal poverty guidelines (\$61,950 for a family of four in 2007) would not be expected to pay more than 7% of gross income (\$4,337) for health insurance coverage, while families with income at 400% of federal poverty guidelines (\$82,600 for a family of four in 2007), would not pay more than 10% of gross income for health insurance (\$8,260).

Figure 1 summarizes the preliminary estimates from the Mathematica modeling in terms of the potential reduction in the number of uninsured Minnesotans. As shown in the figure, for example, instituting guaranteed issue and modified community rating in the small group and individual health insurance markets is estimated to result in about 18% fewer people uninsured in 2009 compared to baseline projections. Similarly, a personal responsibility to obtain health insurance coverage is estimated to result in about a 63% reduction in the number of uninsured, and potentially up to 88% if all the uninsured that are potentially eligible for public programs actually enroll.⁸ Including an exemption from the personal responsibility requirement for people who cannot obtain affordable coverage would have a smaller impact (up to 78% reduction in the number of uninsured, if all of the uninsured who are potentially eligible for public programs enroll). Establishing a requirement that employers with more than 10 employees offer a Section 125 plan is expected to result in an approximate 20% reduction in the number of uninsured. Finally, the two sets of bars at the far right side of Figure 1 show the estimated impact of these policy options in combination (with and without an affordability exemption from the personal responsibility requirement).

⁸ For the policy options that include a personal responsibility element, these preliminary model results do not yet include shifts from the uninsured into public programs.

Figure 1
Estimated Reduction in Number of Uninsured, 2009



Source: Preliminary estimates from Mathematica Policy Research as of January 31, 2008.

2. The duties and powers of the exchange

The proposed exchange would have the following responsibilities:

- Provide education, outreach, and technical assistance for individuals and employers related to health insurance options and the advantages of paying for health insurance through a Section 125 plan;
- Provide education, outreach, and technical assistance for employers establishing Section 125 plans;
- Develop state of the art tools for helping consumers navigate the market, such as tools that compare available health insurance options based on factors that the consumer chooses (e.g., premium, deductible, cost sharing, provider network, or covered benefits);
- Provide online, telephone, written, and in-person assistance to consumers and employers purchasing health insurance through the exchange;
- Provide information and enrollment assistance to people who may be eligible for MinnesotaCare or Medical Assistance;
- Act as a “payment aggregator” for funds withheld from employee paychecks and transmit payments to health plans. This function would reduce burden on employers who might otherwise have to send payments to many different health plans on behalf of their employees who purchase individual coverage through a Section 125 plan. Instead, the exchange would send the employer a bill for the aggregate amount of premiums owed by employees who are purchasing coverage through a Section 125 plan and the exchange would be responsible for making payments to health plans on behalf of enrollees.

The exchange could be given responsibilities related to other health care reform initiatives as well. For example, if a system of premium subsidies based on affordability is enacted, the exchange could administer the determination of eligibility for premium subsidies, collect subsidy payments from the state, and remit payments (enrollee premiums plus subsidies) to health plans. Depending on the effective date of the subsidy availability, this function could be phased in over time (in other words, the exchange would not necessarily need to perform this function when it first becomes operational). The exchange could also serve as the entity responsible for implementing health care payment system reforms.⁹

⁹ This proposal is one of the Health Care Transformation Task Force’s recommendations to the Governor and the Legislature.

After initial start-up costs, the exchange should be expected to become self-sustaining. It would need the power to establish assessments on premiums to fund the cost of administering the exchange.

3. The use of the exchange to receive and process employee premiums on a pre-tax basis through Section 125 plans

As noted above, the exchange can reduce the administrative burden on employers that is associated with establishing and operating Section 125 plans. The exchange could act as a “payment aggregator” for funds withheld from employee paychecks by helping employers keep track of how much money to withhold from each employee’s paycheck based on which health plan the employee has chosen to buy and serving as a single place for employers to remit money withheld from employee paychecks for the purchase of health insurance (instead of employers’ having to send payments to many different health plans).

As explained in more detail in the Text Box on Section 125 plans, pre-tax payment of health insurance premiums will have a financial impact on both employers and employees. The cost to employers of setting up a Section 125 plan is minimal, and employers will save money because the amounts that employees choose to have withheld from their paychecks to pay for health insurance will not be subject to payroll taxes. For employees who cannot currently pay for health insurance with pre-tax dollars, the ability to do so can effectively reduce their health insurance premiums by 30 to 50 percent. For some people who choose to buy insurance with pre-tax dollars, there may be a reduction in future Social Security income but this cost is likely to be very small compared to the benefit of buying insurance with pre-tax income.

4. Eligibility criteria that enrollees and health plan companies must meet to participate in the exchange

In general, all individuals living in Minnesota and small employers (with 50 or fewer employees) located in Minnesota should be eligible to participate in the exchange. Other individuals who should be eligible to participate include individuals who (1) do not live in Minnesota but are dependents of another individual who is eligible to participate in the exchange, or (2) do not live in Minnesota but who work for a Minnesota employer that is required to offer a Section 125 plan.

There is no particular reason to limit the number of health plan companies that participate in the exchange, as long as they are licensed to operate in Minnesota.

5. The types of health plans to be offered through the exchange, and the extent to which these plans should be available for purchase only through the exchange

In considering the issues related to sales inside vs. outside of the exchange, the most important issue is that if a health insurance product is sold both inside and outside of the exchange, its price should be identical in both places. The focus group research conducted for this study highlighted concerns about whether the exchange would limit choice of products in the marketplace, and also concerns about employers being forced to use the exchange.

One of the simplest ways to address these concerns is to allow for sales both inside and outside of the exchange, and to require health plans to make all of their individual/small group products available for purchase through

the exchange at the same price as they are sold outside of the exchange.¹⁰ This option ensures that people who want to buy coverage through the exchange do not have limited choices, while addressing the concerns of employers that do not want to be forced to purchase coverage only through the exchange.

One disadvantage of this option is that it becomes more difficult for the exchange to help consumers sift through their available options to make good choices about the health insurance coverage that is best for them. For example, in Massachusetts the Health Insurance Connector limits the number of plans sold inside the Connector and ranks them as gold, silver, or bronze based on their prices and benefit sets. Both the limited number of plans and the ranking system make the consumer's task of choosing a plan easier. Despite the fact that the proposed Minnesota exchange would not limit the number of products available, it should still be feasible for the exchange to rank available products based on their prices and benefit sets.

6. Loss ratio requirements for health plans offered through the exchange

Generally speaking, a loss ratio is the amount of money that a health carrier pays out in claims as a percentage of total premiums in a given year.¹¹ (The remaining money that is not paid out in claims is either administrative cost or profit.) Current Minnesota law establishes minimum loss ratio requirements for health insurance carriers that sell coverage to small employer groups and individuals, with different requirements depending on the type of health carrier and market share. The current requirements are summarized in Table 1.

Table 1
Minimum Loss Ratio Requirements

| | <u>Small employer</u> | <u>Individual</u> |
|--|-----------------------|-------------------|
| HMOs and nonprofit health service plan corporations | | |
| Market share of 3% or more | 82% | 72% |
| Less than 3% market share | 71% to 75%* | 68% |
| Insurance companies | | |
| Market share of 10% or more | 82% | 72% |
| Less than 10% market share | 60% | 60% |

*71% minimum loss ratio for small employer groups with fewer than 10 employees, and 75% minimum for small employer groups with 10 or more employees

Market share is measured by the health carrier's share of the total annual MCHA assessment.

Source: Minnesota Statutes Section 62A.021

¹⁰ The Health Care Transformation Task Force recommended that price differentials based on whether a health plan was purchased through an insurance agent or directly from a health plan company be allowed; this could be implemented for sales both inside and outside of the exchange.

¹¹ Calculation of loss ratios is described more specifically in the Minnesota Department of Commerce's annual reports on loss ratio experience in the individual and small employer health plan markets.

For the small group and individual markets as a whole, loss ratios in recent years have been well above the minimum levels set in statute. In 2006, the aggregate loss ratios were 87% and 93% in the small group and individual markets, respectively.¹² Particularly for the individual market, where the costs of underwriting and marketing policies are high, recent loss ratios suggest that carriers are likely losing money on these policies; some carriers reported loss ratios higher than 100%.

Establishing a health insurance exchange would reduce some health plan administrative costs, such as costs for marketing and premium billing. In combination with other market reforms it is likely that administrative costs could be reduced by even more. For example, underwriting costs would be reduced by guaranteed issue, modified community rating, and a personal responsibility requirement.

Because this study recommends allowing the sale of all insurance products inside and outside the exchange and not limiting product choice, it is not necessary to establish special loss ratio requirements for products sold in the exchange. If a decision is made to merge the small group and individual markets, then it will be necessary to consider what an appropriate minimum loss ratio for this merged market would be. The small group market in Minnesota currently includes an estimated 440,000 enrollees, and is twice the size of the individual market (220,000 enrollees).¹³ Given the reduction in overhead costs that would be associated with the insurance market reforms described above and the fact that the small group market would represent a large share of the merged market, it seems reasonable to set an expectation in the merged market that minimum loss ratios should be at least as high as the current standards for the small group market.

7. The extent to which the operation of the exchange will lower the cost of health care insurance coverage

By itself, the operation of the exchange would likely have only a minimal impact on the cost of health insurance coverage. To the degree that it increases competition among health carriers and reduces the costs of marketing, it could reduce health insurance premiums. This effect would likely be small because most (over 90%) of the cost of health insurance is due to medical expenses; in addition, a large share of administrative expense (such as claims processing) is unlikely to be affected much by greater competition among health plans for market share.

In combination with other reforms, however, there could be significant impacts on the cost of coverage. For example, greater use of Section 125 plans would substantially improve the affordability of coverage for individuals (although it would not necessarily affect the total premium, individuals could realize a 30 to 50% savings by paying for insurance with pre-tax dollars).

To significantly lower the overall cost of coverage, however, other changes that more directly affect the prices and utilization of health care services are necessary. The Health Care Transformation Task Force has recently proposed a number of strategies aimed at reducing health care costs and reducing future cost growth. These include aggressive health improvement strategies to reduce rates of preventable chronic disease, increased focus on improving health care quality and system efficiency, and fundamental reforms to the health care payment system that create incentives to reduce cost and improve quality.

¹² Minnesota Department of Commerce, "Report of 2006 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations, and Health Maintenance Organizations," June 2007.

¹³ Minnesota Department of Health, Health Economics Program, online Health Care Markets Chartbook Section 4, Small Group and Individual Health Insurance Markets, <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html>, updated July 2007.

8. Estimates of the administrative costs of operating the exchange, and methods for funding these administrative costs

Regardless of whether the exchange is established as a public, public-private, or private entity (see the discussion of governance below), it is likely that one of the most efficient ways to operate the exchange would be to set up contracts with vendors that already have the infrastructure to handle financial transactions and administrative tasks associated with operating the exchange.

The start-up and ongoing operational costs of the exchange will vary depending on what other health insurance reforms are enacted. For example, if the state establishes an individual responsibility to maintain a minimum level of health insurance coverage, significant outreach will be necessary to make people aware of it and the exchange would be a logical place to assign responsibility for this public awareness campaign.

One rough guide that can be used to estimate the likely cost of operating the exchange is to compare it to the initial budget of the Massachusetts Health Insurance Connector. The Massachusetts Connector was given a startup budget of \$25 million, and authority to fund ongoing expenses through an assessment on premiums of products sold through the Connector. It is important to point out that some of the Connector's expenses replace expenses that would otherwise be incurred by insurance companies – for example, insurance companies' cost of billing and collecting premiums would be lower because the exchange would aggregate premiums from employers and individuals and remit them to health plans. The Connector's expenses also include fees paid to insurance brokers that would otherwise have been paid by health plans.

In its first year, the Connector incurred \$20.9 million in expenses. The experience of Minnesota's health insurance exchange, as proposed here, would likely be different than that of the Massachusetts Connector, because it would have a different set of responsibilities. Governor Pawlenty's 2008-2009 budget proposal estimated that the first-year cost of operating the exchange would be approximately \$9 million, and this continues to be a reasonable estimate of the start-up cost for the basic responsibilities of the exchange as described in Section 2 of this report. Adding other responsibilities, such as administration of a subsidy program or implementation of payment reform, would require additional funding.

The initial expenses associated with establishing the exchange would need to be funded by an appropriation, but the exchange should be expected to become self-sustaining over time. Because the exchange is expected to benefit the entire market (and because of the importance of having prices be identical inside and outside of the exchange), it should be funded through an assessment on all small group and individual health insurance plans sold in Minnesota. Total premium volume in these two markets was just over \$2 billion in 2006, which means that if the exchange incurs expenses of \$10 million per year the assessment as a percentage of premium would be 0.5%.

9. Other topics relevant to the design and operation of the exchange if its establishment is recommended

This section of the report addresses two other topics that are relevant to the creation of a health insurance exchange and broader insurance market reform. These topics are (1) governance of the exchange, and (2) interaction with federal requirements.

Governance: A health insurance exchange could be established as a public entity (i.e., a new state agency or as part of an existing agency), a public-private entity, or a privately-owned entity.

- Placing the exchange inside of an existing state agency such as the Department of Employee Relations (which operates the state employee insurance program as well as a small purchasing pool for public employers) might have the advantage of lower startup costs and lower ongoing operating expenses (due to lower salaries for state employees compared to the private sector). The state would also directly control the policy and operational decisions made by the exchange. However, the necessary infrastructure to establish and operate an exchange does not currently exist in state government, and so the difference in start-up costs compared to another type of governance would not necessarily be large. In addition, given the recommendation above that participation in the exchange be voluntary (i.e., insurance can be purchased outside the exchange), the concerns of small employers about government involvement could limit participation in the exchange if it is viewed to be part of state government.
- Creating a public-private entity with public oversight – such as a nonprofit with a board that includes representatives from both the public and private sectors – to establish and operate the exchange would have the advantage of public accountability and the ability to run the exchange more like a business. It would likely be viewed more favorably by potential exchange participants, and would be responsive to both public and private concerns.
- A private entity¹⁴ to run the exchange would likely be the option viewed most favorably by small businesses that are its potential customers; however, such an entity would not be directly accountable to policymakers. This is a particular concern in relation to the exchange’s proposed responsibility to determine eligibility for subsidies, since some degree of public oversight would be necessary if the exchange is expected to fulfill public goals as well as private ones.

Of these options, creating a public-private entity to run the exchange is the best choice, because the entity would be responsive to both public and private concerns, have the ability to run like a private business, and would likely be viewed more favorably by potential customers than a public agency.

The board of the exchange should include the commissioners of Health, Commerce, and Human Services, as well as other people with knowledge and experience in areas related to health insurance.

Federal Requirements: As noted earlier, an exchange could increase choice and portability of coverage if it is able to serve as a vehicle through which employers could implement a “defined contribution” approach to health insurance coverage. Such a model could also increase access to employer-subsidized coverage for people who frequently are not eligible for health benefits, such as part-time or temporary employees. In the focus group research performed for this study, such an option was appealing to many employers.

However, changes to Minnesota law would likely be necessary to avoid conflict with federal laws and regulations that establish nondiscrimination requirements for employer group health plans.

Specifically, the Health Insurance Portability and Accountability Act (HIPAA) requires that “group health plans” may not restrict access or vary health insurance premiums based on health factors.

¹⁴ One other proposal that has been advanced would be to establish multiple exchanges. Because the purpose of an exchange is to provide a comprehensive source of information to consumers and employers, it would be most efficient to establish a single exchange rather than duplicate this function across multiple exchanges.

Because current Minnesota law allows individuals to be denied coverage and charged a higher premium based on their health status for coverage in the nongroup health insurance market, employers could be in violation of federal law *even if they do not contribute to coverage*.

In order for a “defined contribution” type model to be feasible in Minnesota, the legal analysis in the Mathematica study recommends that the state change its insurance market rules to require guaranteed issue and to remove health status as a rating factor in the individual market. The experience of other states that have implemented these reforms suggests that unless an individual responsibility to maintain a minimum level of health insurance coverage is also enacted, guaranteed issue and rating reforms alone could have severe negative consequences on the affordability of coverage (and, as a result, on the number of people covered).

Strategies that could expand individuals’ ability to purchase health insurance coverage through a Section 125 plan, while avoiding federal compliance problems and minimizing adverse effects on insurance markets, should be examined. For example, short of sweeping changes to the individual insurance market, the state could require that health plans sell coverage on a guaranteed issue basis and without regard to health status¹⁵ during an employer’s annual open enrollment period for its Section 125 plan, and also when an individual experiences other “qualifying events” for coverage (e.g., a change in jobs or family status).

The definition of dependent coverage in Minnesota law is also potentially in conflict with federal requirements. Effective January 2008, Minnesota law defines a “dependent” for purposes of health insurance coverage to include unmarried children under the age of 25.¹⁶ This definition is inconsistent with the definition of “dependent” for purposes of who is eligible to pay for health insurance through a Section 125 plan, which requires that the person also be considered a dependent for tax purposes. Conflicts such as this do not necessarily preclude the state from establishing a requirement that employers adopt Section 125 plans, but they do mean that there will need to be extensive efforts to educate employers about how to establish and operate these plans in compliance with federal requirements.

¹⁵ There could still be limitations on pre-existing conditions, as allowed by state and federal law.

¹⁶ Minnesota Statutes, Section 62L.02