The Minnesota healthcare exchange is not a marketplace. It is not, as some have called it, a “one-stop-shopping” place for health insurance or “Travelocity.” The MN Exchange, being built under DFL Governor Mark Dayton’s executive order, and now advancing through legislation, has been called the “Minnesota Insurance Marketplace.”

The U.S. Department of Health & Human Services is also promoting this deceptive term. Its website now calls the Exchange the “Health Insurance Marketplace.” (healthcare.gov)

Nothing could be further from the truth.

For example, although the Minnesota bill (HF5/SF1) is called the “Minnesota Insurance Marketplace Act,” the legislation states, “The Minnesota Insurance Marketplace is a state agency for purposes of the Minnesota Government Data Practices Act...”

The bill also defines “Minnesota Insurance Marketplace” as “a state health benefit exchange as described in section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), and further defined through amendments to the act and regulations issued under the act.” The PPACA is often referred to as “Obamacare.”

The Minnesota insurance “marketplace” is actually a government agency, or as some Minnesota legislators have called it, a “super agency.” It will not only limit available coverage to federally approved plans, it will also involve itself in medical care, such as “health improvement” and “care coordination.” It will be expensive – estimated to cost $60 million a year. The fiscal note detailing services and staff, is 47 pages long.

As further evidence of Exchanges not being marketplaces, HF5 requires the following:

- A dedicated state fund with designated appropriations, and an annual report to the state legislature.
- “[E]xercise all powers reasonable necessary to implement and administer the requirements of this chapter and the Affordable Care Act, Public Law 111-148.”
- A board of seven members, including the Commissioner of Human Services, appointed by the Governor and confirmed by the Minnesota Senate.
Data-sharing agreements between the Exchange and “federal and state agencies and other entities,” with sharing of private data on individuals, employees or employers in the Exchange.

Consultations and agreements with Minnesota Departments of Administration, Commerce, Health, Human Services, and the MN Office of Enterprise Technology.

Publication in the State Registry of all Exchange proposed and final policies and procedures without requirements to address public comments or hold a public hearing if people are opposed.

A compensation plan for Exchange director and managerial staff that must be submitted to the Minnesota Commissioner of Management and Budget and approved by the state Legislative Coordinating Commission.

Appeals of Exchange board decisions conducted under the state “Administrative Procedures Act” (Chapter 14), which governs state government agencies.

Ability to administer eligibility for other state government “health care and public assistance programs,” such as food stamps, Section 8 housing, WIC, etc.

All Exchanges are federal. The state-based exchanges are developed under the PPACA. They are federally controlled agencies that maintain IT superstructures – 24/7 cyber connections between state and federal agencies to implement Obamacare. As noted in the USA Today article (12/6/12), the state Exchanges will be connected to the federal government using a Federal Data Services Hub. This vast, centralized data system will create a "privacy nightmare."

Thus, unlike the true marketplace which exists today, where private buyers offer products and compete for private sellers, the Exchange is set up by the state legislature—a clear indication of its governmental nature—controlled by the federal government, will be directed by a board of political appointees, and must comply with the federal PPACA law and regulations. More than 13,000 federal regulations have been issued with more to come.

The exchanges have been called the heart of health care reform -- the centerpiece of the federal law. As stated by Robert Laszewski, president of Health Policy and Strategy Associates (HealthDay, Sept 2012):

“The ACA cannot be implemented without an insurance exchange in each state. It’s a go or it’s a no-go. It’s that simple.”

States are not required to set up Exchanges. This would be unconstitutional federal commandeering of states. Instead, it’s voluntary at an estimated cost of $4 million to $300 million per year in operating costs. The PPACA allows HHS to set up a Federal Exchange for states that refuse to set up or fund a state Exchange, but Congress did not fund it and the U.S. House has refused subsequent funding requests. Furthermore, no state needs to connect with it if, and when, it is set up.

The Exchange, whether state or federally funded, is not a marketplace. It will implement Obamacare state by state. The Exchange will monitor individual and employee insurance status and enforce the IRS mandates to purchase health insurance. States should refuse to cooperate, capitulate, or comply with the federal takeover of health care.