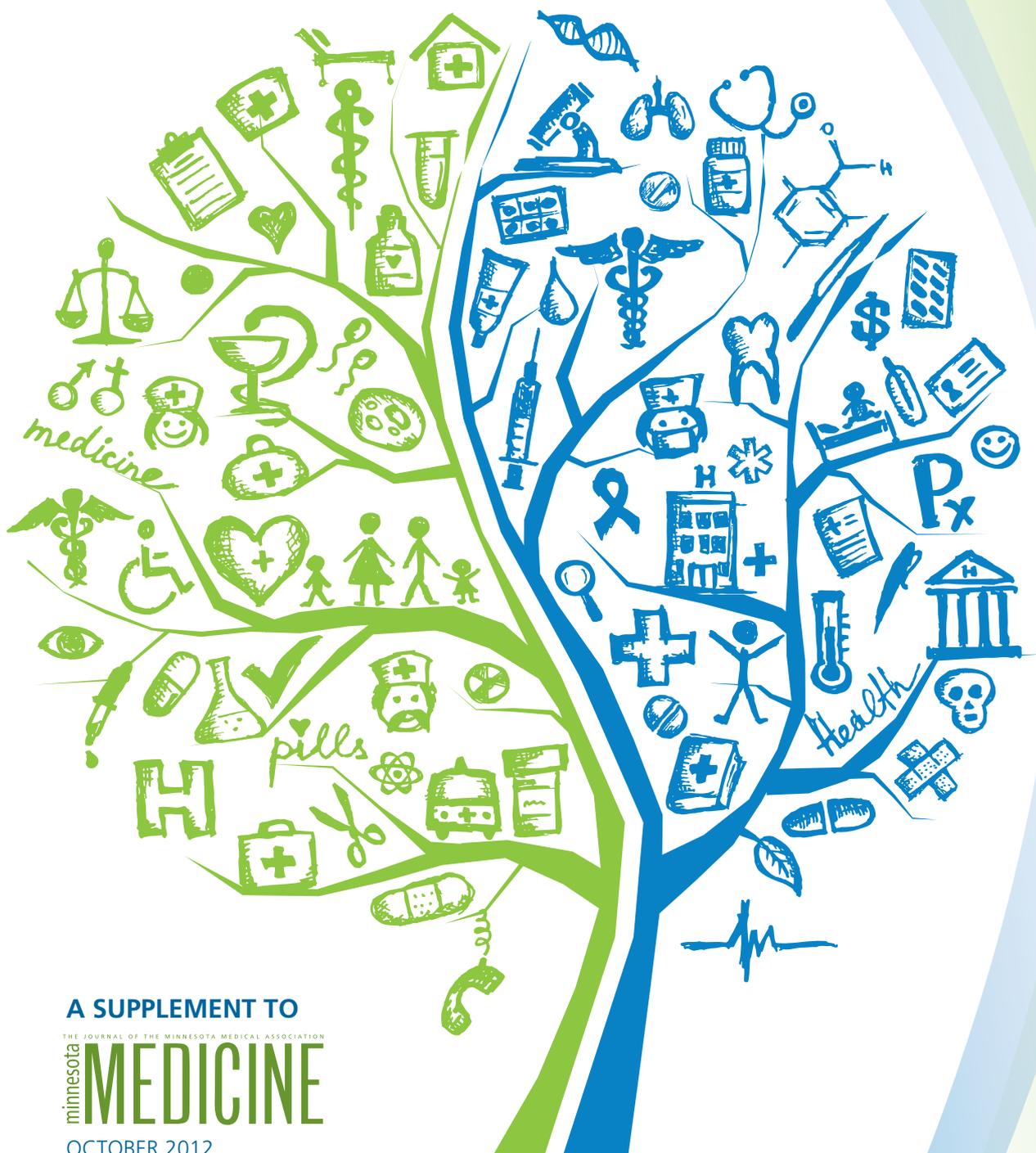




MINNESOTA
MEDICAL
ASSOCIATION

A LOOK INSIDE

Minnesota's health insurance exchange



A SUPPLEMENT TO

THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

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MEDICINE

OCTOBER 2012

A LOOK INSIDE
**Minnesota's
health
insurance
exchange**

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A Minnesota solution

Minnesotans are modestly proud. That may sound somewhat contradictory, but it's true. We like to do stuff on our own but generally keep quiet about it.

This holds true for our efforts regarding health care reform. Well before Congress debated the topic, we rolled up our sleeves and initiated efforts at the state level to transform public health; increase health care coverage and make it more affordable; promote chronic care management; reform payment and improve quality; encourage administrative efficiency; and contain costs. We passed our own health care reform legislation two years before the Affordable Care Act (ACA) became law.

So it just makes sense that when faced with the choice of creating our own health insurance exchange or using one run by the federal government, we would build our own version.

"We don't like the feds doing things on our behalf," said Manny Munson-Regala, deputy exchange director for the Minnesota Department of Commerce, at a panel discussion on the ACA the MMA held this past summer. "They tend to steal our best ideas, and we like to think that they don't do so well with them." The MMA agrees.

We prefer to lead rather than be led. We want to provide our patients with what's best for them, and we feel we understand their unique needs better than Washington does.

And, we're not talking about just a few patients. The exchange is expected to be used by a large number of Minnesotans, roughly one in five, so it's important that we get this right.

As we move toward a Minnesota-made health insurance exchange, many issues will arise. This publication takes a closer look at those issues—how the exchange will affect Minnesota physicians in general; its relationship to the Statewide Quality Reporting and Measurement System and the state's Provider Peer Grouping initiative; and the standards to be applied to qualified health plans and the future of the MinnesotaCare program.

We also examine what has happened in the states that have gone before us in creating their own exchanges and highlight the work of three of our members who are volunteering hours of their time to ensure the physician's voice is heard as we develop our exchange.

There is plenty to sort out. We hope this special issue sheds light on this sometimes murky topic.

A handwritten signature in black ink, appearing to read 'Dave Thorson'.

DAVE THORSON, M.D.
CHAIR, BOARD OF TRUSTEES

The purpose of an insurance exchange

(continued from previous page)

assistance for individuals with annual incomes between 133 percent and 400 percent of poverty

- Determining eligibility for Medical Assistance
- Determining eligibility for small business premium tax credits (for employers with 25 or fewer employees with average wages below \$50,000)
- Determining whether an individual meets the insurance mandate exemptions (e.g., certain religious groups, prisoners, those with incomes below tax filing limit, etc.)
- Providing enrollment information to employers
- Establishing a program that connects potential enrollees with an individual or organization that can help them understand and use the exchange.

Qualified health plans

To participate in the exchange, a plan offered by an insurer must be certified as a QHP to ensure that it meets quality and value standards, and other state-specified requirements.

Although federal regulations establish some minimum requirements for QHP certification, states have additional latitude.

Among the minimum federal standards for QHP certification are providing coverage for "essential health benefits," state insurance licensure and nondiscrimination against applicants. Of particular interest to physicians is a requirement for "network adequacy," ensuring that the plan has a network sufficient in the number and types of providers to ensure that all services are accessible without unreasonable delay.

Minnesota has existing network adequacy requirements but only for HMOs. HMO enrollees must be able to access primary care and mental health services within 30 miles or 30 minutes and specialty care within 60 miles or 60 minutes. This is likely to be the standard applied to QHPs in Minnesota's exchange.

Federal rules also require an exchange to develop and implement quality rating and enrollee satisfaction survey systems by 2016, and insurers are also required to report information on health care quality and outcomes. Minnesota is currently working to define the quality measurement system it will use in its exchange.

MINNESOTA METRICS

1.2 million Number of Minnesotans expected to use the state-run exchange. (One out of every five residents.)

MINNESOTA METRICS

\$500 Amount the average Minnesota family is expected to save in health costs by purchasing insurance through the exchange.

MINNESOTA METRICS

7.5 Percentage of small employers (50 employees or fewer) that are expected to save on premiums costs by using the exchange to purchase coverage for their employees. (Employers with fewer than 25 employees are expected to save even more.)

At a minimum, all participating insurers will need to use national measures such as the Healthcare Effectiveness Data and Information Set and patient experience ratings from the Consumer Assessment of Healthcare Providers and Systems survey. Additionally, Minnesota is expected to use hospital and clinic metrics from the Minnesota Statewide Quality Reporting and Measurement System and the Provider Peer Grouping initiative to provide consumers with information on hospital and physician clinic quality and cost performance.

The ACA further requires that every state include in its exchange two multi-state plans (MSPs). These plans, which must be licensed in each state in which they operate, will be administered by and overseen by the federal Office of Person-

nel Management (OPM), which administers the Federal Employee Health Benefits Program (FEHBP). The OPM must administer MSPs separately from the FEHBP and must contract with both a nonprofit insurer and one that does not provide abortion coverage. The OPM will negotiate premiums, set rates, establish medical loss ratios and profit margins as well as certify and decertify plans and make sure they have adequate networks of providers. Any QHP certification standards established by the state, however, will not apply to the MSPs, making aggressive state purchasing actions somewhat limited. +

The impact on MinnesotaCare

When the exchange becomes operational in 2014, new insurance premium tax credits will be available to individuals under the age of 65 with an annual income between 133 percent and 400 percent of the federal poverty guidelines (approximately \$11,170 to \$44,680 in 2012). Some of the persons who will be eligible for the new tax credits are currently enrolled in the state's MinnesotaCare program.

Currently, MinnesotaCare is available to families with incomes up to 275 percent of poverty and to adults without children with incomes between 75 percent and 250 percent of poverty. The ACA requires the state to continue to provide coverage to children from families currently enrolled in MinnesotaCare until October 1, 2019. But Minnesota will need to decide whether to continue MinnesotaCare coverage for adults.

Some of the adults enrolled in MinnesotaCare may be eligible for Medicaid in 2014 should Minnesota choose to expand Medicaid eligibility to those with incomes up to 133 percent of poverty.

The ACA allows states to create a basic health plan (BHP) for individuals with incomes between 133 percent and 200 percent of poverty. The state is working to analyze the fiscal impact of the BHP options, and the topic is expected to be an issue of significant debate during the 2013 legislative session. Physicians will be interested in the discussion because the question of how to finance a BHP could raise new interest in the provider tax, which currently helps fund MinnesotaCare and is scheduled to be phased out by 2019.

A NEW STANDARD FOR INSURANCE COVERAGE

Essential health benefits

The ACA dictates that, with few exceptions, individuals have “qualifying coverage” for health insurance. This can come in the form of either a public program (e.g., Medicare or Medicaid), an employer-sponsored plan, a “young invincible” plan (catastrophic coverage for those younger than 30 years of age without other insurance), or through one of four essential health benefit set plans (bronze, silver, gold or platinum).

The EHB provision establishes new standards for covered services that are designed to reduce the variability and to ensure the adequacy of insurance coverage. Beginning in 2014, all non-grandfathered insurance plans sold in the individual and small employer group markets — those sold through an exchange and outside of the exchange — must provide coverage for the following essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including dental and vision care.

The cost-sharing features will determine the level of actuarial value of the plan — bronze at 60 percent actuarial value (meaning the policyholder would be responsible for 40 percent of the costs of all covered benefits), silver at 70 percent, gold at 80 and platinum at 90.

States must select a benchmark plan that reflects services offered by a typical employer plan. If a state doesn't select a plan, the default EHB set plan will be the small group plan with the highest enrollment in the state (in Minnesota, a HealthPartners plan).

States can select from four benchmark plans:

- The largest plan by enrollment in any of the largest three small-group insurance plans
- Any of the largest three state employee health benefit plans by enrollment
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment
- The largest insured commercial non-Medicaid Health Maintenance Organization operating in the state.

Minnesota's Access Work Group (a subcommittee of the Governor's Health Care Reform Task Force) analyzed the differences in covered services among the various benchmark plan options in Minnesota and concluded that the three options governed by state law had only modest differences among them and all provide coverage for state-mandated benefits; the FEHBP program, however, does not include coverage for all of Minnesota's mandated benefits, and the state would have to pay for the cost of such benefits that are not part of the EHB set.

As this report went to press, the state was waiting for further federal guidance on EHB selection details. A final choice must be made by September 30, 2012, and would apply to coverage starting in 2014-2015.

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Minnesota's progress

A detailed timeline tracking the beginning of the exchange to its launch.

MARCH 2010

Affordable Care Act (ACA) signed into law.

AUGUST 2010

Gov. Tim Pawlenty signs Executive Order 10-12 directing that no applications or requests for grant funding for programs and demonstration projects deriving from the ACA be submitted unless otherwise required by law, or approved by the office of the governor. Minnesota becomes one of only two states that does not apply for an initial exchange planning grant.

MINNESOTA METRICS

700,000 Number of Minnesotans expected to use the exchange to sign up for Medicaid, 120,000 of whom will be newly covered.

FEBRUARY 2011

Shortly after Gov. Mark Dayton assumes office, Minnesota applies for and receives a \$1 million grant from the federal government to fund the initial stages of planning an exchange.

MINNESOTA METRICS

\$1 billion+ Amount Minnesota families are expected to save because of the exchange.

JUNE 2011

A Request for Proposals is issued by the Commerce Department for prototypes to evaluate technical options and costs for a Minnesota exchange.

AUGUST 2011

Minnesota receives a \$4.2 million grant to move planning to the design and development stage.

SEPTEMBER 2011

Formation of a broad-based Health Insurance Exchange Advisory Task Force to advise the state on the design and development of a Minnesota exchange is announced. Republican legislators are invited to serve on the task force but decline the offer.

JANUARY 2012

The Advisory Task Force approves recommendations for the basis of a Minnesota exchange.

OCTOBER 2011

Dayton signs Executive Order 11-30 establishing a Health Care Reform Task Force, which has as one of its responsibilities consultation with the state on the design and development of a Minnesota-made exchange.

FEBRUARY 2012

Minnesota receives a \$23 million grant for the design and development of the exchange.



NOVEMBER 2011

The first four technical work groups of the Exchange Advisory Task Force are formed: Governance; Finance; Adverse Selection and Encouraging Market Competition/Value; and Navigators and Agents/Brokers.

FEBRUARY 2012

Additional technical work groups are initiated. They are: Individual Eligibility; IT and Operations; Measurement and Reporting; Outreach, Communications and Marketing; Plan Certification; and Small Employers and Employees.

DECEMBER 2011

Sample modules from vendors seeking to build the IT infrastructure for the exchange are made available to the public. Feedback is documented and used in the evaluation of vendors' proposals.

Filling in the blanks

Although much work has taken place in terms of building a Minnesota exchange, many questions remain.

How will it be structured and governed?

The Health Insurance Exchange Advisory Task Force, a 15-member group appointed by the governor, recommended this past January that the exchange should be a non-taxable entity subject to public accountability (i.e., Legislative Auditor review) and that it should have a 15- to 20-member board with a majority of participants representing consumers or small businesses. In addition, the task force recommended that it should be structured to ensure operational flexibility in terms of decision-making (i.e., not subject to state rulemaking and state procurement processes). Plus, a rigorous conflict-of-interest policy should be applied to ensure board members cannot benefit financially from contracting with the exchange or gain unfair advantage over competitors. At this time, however, no action has been

taken on the recommendations and the actual structure remains unclear.

How will it be financed?

The Commerce Department recently projected that it will cost between \$35 million and \$54 million per year to run the exchange by 2016. By January 1, 2015, Minnesota and other states need to fully finance the cost of their exchanges. Financing options include assessing fees on participating health insurance providers, appropriating state funds to the exchange, or allowing for other public or private funding sources.

In January, the Health Insurance Exchange Advisory Task Force recommended that ongoing financing (federal financing is available only through 2014) should reflect those directly served by the exchange (e.g., plans selling in the exchange and consumers purchasing through the exchange) and those who benefit more broadly (e.g., employers, providers). It also recommended that financing mechanisms should not disproportionately burden one group or sector, and should be proportionate to benefit received. In addition, financing should be implemented by July 2013 (three months before enrollment

will begin) to ensure adequate reserves by 2015.

How do we ensure it will be fair?

To help ensure that the cost of insurance coverage offered through the exchange is not higher than the cost of coverage offered outside the exchange (i.e., to guard against sicker individuals who incur higher health care costs from using the exchange disproportionately), the task force recommended that insurance market rules and regulations should be the same within the exchange as outside of it.

What will it be called?

Market research conducted earlier this year shows that the word "exchange" is not popular with consumers. When given a choice of five names, Minnesota consumers and small business owners preferred "Minnesota Health Choices."

What about brokers?

The role of insurance brokers, many of whom see an exchange as a direct challenge to their historic role of assisting individuals and employers in purchasing health care insurance, is still to be determined. +

MAY 2012

Minnesota meets with the U.S. Department of Health and Human Services for a design review to assess progress on IT and operational functions of an exchange.

JANUARY 2013

Minnesota must achieve certification on the design and development of a Minnesota-made exchange or a federal health insurance exchange will be imposed on Minnesota.

JANUARY 1, 2014

ACA deadline for exchange operation.

AUGUST 2012

Minnesota applies for an additional \$42.5 million to support exchange implementation.

OCTOBER 2013

Enrollment in the exchange is scheduled to begin for individuals and small employers as part of the open-enrollment process.

NOVEMBER 2012

Minnesota must submit an application to the U.S. Department of Health and Human Services on plans to operate a state-based exchange.

Source: Minnesota Department of Commerce

MINNESOTA'S EFFORTS

Moving forward amid controversy

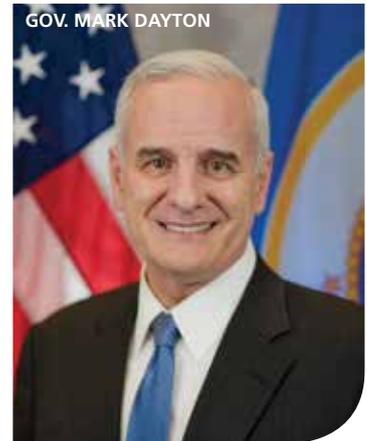
Nobody said it would be easy. As with the macro-debate over health care reform, the micro-debate over creating a state-run health insurance exchange has its supporters and naysayers.

Following opposition to the development of an insurance exchange by the Pawlenty administration, Gov. Mark Dayton changed course in early 2011 with an application for and subsequent receipt of federal planning dollars. As the state shifted from planning to implementation, input from the community and support from the Legislature was a logical next step.

To begin that work, the Department of Commerce — the state agency originally responsible for leading exchange development — convened the Health Insurance Exchange Advisory Task Force

in late 2011 with the goal of advancing recommendations for consideration by the 2012 Legislature. (In mid-September, Dayton switched accountability for the exchange to the Department of Minnesota, Management and Budget.) Given the deadlines imposed by the ACA, it was hoped that Minnesota lawmakers would pass legislation defining the structure and operational foundation for Minnesota's exchange.

However, in March, a bill supporting the creation of an exchange went down in defeat in the Senate's Health and Human Services Committee. A handful of



GOV. MARK DAYTON



SEN. DAVID HANN

MMA members play role in creating exchange

For Marilyn Peitso, M.D., it took a personal experience to drive home the benefit of a health insurance exchange.

As a physician, she certainly understood the concept—make it easier for more people to access health insurance in a competitive marketplace. But after

watching her 26-year-old daughter shop for insurance for the first time, she really began to understand the need for such an entity.

"I learned firsthand how helpful an exchange could be for someone looking for coverage," she says.

The St. Cloud-based pediatrician is one of three MMA members taking an active role in the development of the online tool.

Peitso is a member of the Plan Certification Work Group, whose mission is to

provide technical assistance and information on the options related to developing Minnesota's criteria for certifying qualified health plans. It is just one of many working parts in the complex process of launching a state-run health insurance exchange in 2014.

Peitso began her involvement with the exchange informally back in May 2011, when she served on a group that provided feedback on the informational needs and process flows for the exchange's infrastructure. This past May, she joined the

influential senators and representatives spoke out against the exchange, balking at the expense and the need for it in the first place.

Many of those opponents expected the ACA to be deemed unconstitutional by the Supreme Court. When that did not happen, they turned their attention to the upcoming elections, hoping that afterward there will be enough votes in Congress to repeal it.

This past June, Sen. David Hann (R-Eden Prairie), chair of the committee that voted down the Dayton-supported legislation, told the *St. Paul Pioneer Press*: “People do not want [the ACA] law.” Without the Legislature in session until January, he pointed out, “there’s no possible way we can pass a health exchange [bill] between now and January.”

Despite the resistance, the governor and his appointed state leaders have pressed on. Dayton reconfirmed his intent to build a Minnesota exchange this past July, shortly after the Supreme Court made its ruling. In a letter to Kathleen Sebelius, U.S. Secretary of Health and Human Services, he wrote: “We are excited by this opportunity to design our own exchange, which will best meet the needs of Minnesotans. It will empower individuals, families and businesses to make

the most informed decisions about their health coverage. It will require health care insurers and providers to compete for their business.”

Since then, a \$41 million contract with Maximus, Inc., an IT vendor, has been let. In addition, a market research firm is conducting focus groups and the state is putting pieces in place so that it can meet

the federal government’s next deadline — November 2012 — at which time the state must file its intent to run its own exchange. By October 2013, the exchange website must be ready to handle open enrollment.

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How states have responded

Although each state has the same deadline for creating an exchange, not all are making the same progress.

About a third of the states have passed legislation and received federal grants to establish an exchange. Another third, including Minnesota, have received federal establishment grants but have passed no legislation. And the final third have made no significant progress in acquiring grants or enacting legislation. Two states in particular — Louisiana and Arkansas — have decided they will not create their own exchanges.

Massachusetts and Utah have been vanguards on the exchange front, creating their own before the ACA became law (see page 11). Both states are in the process of updating their exchanges to meet federal rules.

The governors of Rhode Island, New York and Indiana launched their exchange efforts by executive order after legislation failed. Others, including several Republican governors, have vociferously opposed state exchanges. For example, the governors of New Mexico and New Jersey have vetoed state exchange legislation, and Florida and Kansas are among states that returned grant money to avoid federal involvement.

more formal Plan Certification Work Group.

Mayo Clinic’s Kurt Hoppe, M.D., is a member of the Measurement and Reporting Work Group. He and other members of the group are exploring options for reporting cost, quality and satisfaction information for health insurers, benefit plans and providers through the exchange.

“The task of making information useful for consumers is formidable,” Hoppe says. “Consumers are often bewildered by the vast amount of available information but likely do not have the experience or

skills to navigate successfully through all of the decision points.”

Ensuring that consumers have access to useful information is one of the reasons Hoppe says he joined the work group. He is also interested in providing a

physician’s perspective and ensuring that the work group’s input is relevant to both patients and providers, can be acted upon

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Moving forward amid controversy

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More than a political act

Minnesota's efforts have been led by more than just politicians.

In September 2011, Dayton established a 15-member Health Insurance Exchange Advisory Task Force, which has been meeting monthly since November. Among that group of 15 is MMA member Roger Kathol, M.D.

Kathol, who also serves as co-chair for the task force's Adverse Selection Work Group, is one of three MMA members actively involved in the exchange. Marilyn Peitso, M.D., serves on the Plan Certification Subgroup, and Kurt Hoppe, M.D., is a member of the Measurement and Reporting Work Group.

Ten technical work groups support the overall task force:

- Governance
- Finance

- Adverse Selection and Encouraging Market Competition/Value
- Navigators and Agents/Brokers
- Tribal Consultation
- IT and Operations
- Individual Eligibility
- Small Employers and Employees
- Measurement and Reporting
- Outreach, Communications and Marketing.

These groups have many decisions to make and challenges to overcome before a Minnesota exchange is launched. But Kathol remains confident that the end-product will be best for the state: "Minnesota," he points out, "is one of the national leaders in setting up health services for its citizens." +

MINNESOTA METRICS

300,000 Number of uninsured Minnesotans expected to gain coverage through the exchange by 2016.

MINNESOTA METRICS

200,000 Number of small business employees expected to access coverage through the exchange.

MMA members play role in creating exchange

(continued from previous page)

and fairly assesses care processes and outcomes, and preserves the physician-patient relationship.

Peitso is concerned about "network adequacy" issues. In other words, ensuring that plans have a provider network sufficient to ensure that all services are accessible without unreasonable delay. In particular, she wants networks to include an adequate number of specialty providers for mental health and pediatric specialties.

"Physicians need to be at the table" as networks are defined, she says.

When it comes to MMA member involvement, Roger Kathol, M.D., is perhaps the most active. He has served on the exchange task force, a 15-member body that is advising the administration on the exchange's development, since its inception in September 2011. He also serves as co-chair of the Adverse Selection Work Group, which is meeting to ensure the exchange is not saddled with supporting only the needs of high-risk, high-cost

populations and thereby increasing the cost of available coverage.

With a background in business, administration and clinical work, Kathol not only represents physicians but also small businesses and behavioral health specialists.

He is focused on service delivery. "Physicians need to be thinking about and involved in decisions about how population-based, patient-centered care delivery can be fairly paid as reform activities are instituted," he says.

To follow the exchange development process more closely, sign up for the weekly updates issued by the state: <http://mn.gov/commerce/insurance/topics/medical/exchange/Exchange-Email-Listserv/>. +

For more information

MINNESOTA

[Health Reform Minnesota](#)

Home of Minnesota's health care reform activities
<http://mn.gov/health-reform/topics/exchange/>

FEDERAL

[HealthCare.Gov](#)

A website managed by the U.S. Department of Health and Human Services
www.healthcare.gov/law/features/choices/exchanges/index.html

THE EXCHANGE SPECTRUM

Learning from Massachusetts and Utah

As Minnesota creates its own state-run health insurance exchange, it has two working examples to study.

Both Massachusetts and Utah have operated exchanges for at least three years. Each state set out to make it easier for the public to compare and purchase insurance but ended up with different tools for doing so.

Massachusetts' Health Connector is geared more toward individuals while Utah's Health Exchange is designed more for small business. The former is used by some 220,000 people while the latter serves around 2,200 enrollees, according to 2011 figures.

Because they both launched before the Affordable Care Act of 2010 dictated their creation, each started from scratch without guidance.

The Massachusetts model

Massachusetts launched its Health Connector as part of a comprehensive health care reform effort in 2006. At the time, Massachusetts' rate of uninsured citizens was at 10.6 percent. Three years later, that rate declined to 4.4 percent. Today, it's 1.9 percent.

The Connector is really two things: a subsidized program called Commonwealth Care for individuals with annual incomes below 300 percent of the federal poverty level; and an unsubsidized program called Commonwealth Choice. The latter option also includes a program called Business Express for businesses with up to 50 employees.

Consumers can use the Connector to compare prices of standard tiered plans, thus the comparison to online travel shopping sites such as Orbitz and Expedia. It is known as an "active purchaser" model, which only works with selected qualified health plans.

Currently, eight health insurance carriers take part in the Commonwealth Choice program, six of which are nonprofit, Massachusetts-based companies.

To get a sense of how the Connector works, visit www.mahealthconnector.org. You can punch in a Boston zip code (for example, 02215, Fenway Park's zip) and take it for a test run.

The Utah model

Utah's Health Exchange, which launched in 2009, is much smaller than Massachusetts' Connector. It is run by the Office of Consumer Health Services on a relatively small budget (less than \$1 million a year) and with two employees; Massachusetts' Connector has a budget of \$30 million and a staff of nearly 50 employees.

Shortly after it launched, 13 businesses (with 50 employees or fewer) with a total of 161 employees participated in the Exchange. A year later, the numbers had increased to 811 employees and 1,370 dependents. Although relatively small, Utah's Exchange did increase options for small businesses and their employees. By 2010, they had nearly 150 plans to choose from. This is because Utah uses a "clearinghouse" model. It includes all insurance products that meet modest criteria.



MASSACHUSETTS' HEALTH CONNECTOR:
www.mahealthconnector.org



UTAH'S HEALTH EXCHANGE:
www.exchange.utah.gov

In Utah, employers decide how much they want to contribute to the cost of insurance. Employees then shop for a plan, be it a high-deductible plan or otherwise, knowing how much their employer will be contributing to the total premium.

Although the Exchange focuses on small businesses, families and individuals who do not have access to insurance through their employer can use it to buy directly from five health insurance providers including Humana and UnitedHealthcare. The website also allows families and individuals to do side-by-side comparisons.

You will find the Utah Health Exchange at www.exchange.utah.gov. +

What does MMA do for you and your clinic?

Take a look.

Advocacy Supporting the profession Strategic partnerships Leadership Career Center Focused for Success Health care reform Supreme Court ruling event MMA Foundation Provider peer grouping oversight MemberAdvantage Issue briefs Repeal of Provider Tax Day at the Capitol Legislative tool kits Minnesota Medicine Amicus briefs Annual Meeting County Medical Societies Insurance contract reviews Access to Legislative leaders Strength Practice insurance District Dialogues Office products/surgical supplies Young Physician Section Health IT programs MEDPAC Engagement Connected Board of Trustees MMA website Action Alerts Physician Advocate Regulatory advocacy Special reports Capitol Rounds Personal insurance Established in 1853 Electronic credentialing Influence Media voice Joint sponsorships 10,300 members strong Practice management support House of Delegates MMA Rounds AMA Delegation Health plan advocacy Resident-Fellow Section Committees Advocacy tips Legal advocacy Newborn screening Physician Finder Physician well-being programs Task forces Dementia webinar Medical School Section HIT webinar Online CME Lobbying CME programs News and information Discounted products/services CG-CAHPs webinar Accreditation Quality-improvement webinars Networking POLST information MMA News Now Insights Annual Report



“I used to pay my dues and wonder what the MMA did — now I know. They’re like an insurance plan. When you really need them, it’s great to know they are there for you.”

*Steven Meister, M.D., Affiliated
Community Medical Centers – Marshall*

“The MMA is one of the groups that is listened to by members of the Legislature.”

*Rep. Paul Thissen, minority leader,
Minnesota House of Representatives.*

Put MMA to work for you by joining or renewing your membership. For membership information, go to www.mnmed.org/imadoctor, or call 612-362-3747.



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