Health Care Affordability Advisory Task Force

December 16, 2025

Today's Objectives

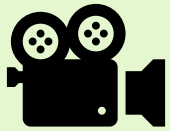
- Finalize shared values and principles
- Review and refine a framework for understanding excess health care spending and opportunities to address it
- Build a shared foundation and understanding of state strategies to improve health care affordability
- Identify Minnesota-specific considerations for priorities and policy options
- Begin to identify priorities for future task force focus

Today's Agenda

- Updates from Center for Health Care Affordability– **CHCA**
- Finalize values and principles – **CHCA**
- Post-October meeting survey review – **Mathematica**
- Charting a path forward: scope of the challenge and state policy approaches – **Mathematica**
- *Break*
- Digging deeper: small group discussion and reaction – **Mathematica**
- Closing and next steps – **CHCA**

Housekeeping

- Slides and recording of meeting will be available on the Center's website
- Bathrooms are outside the room at the end of the hallway
- Please remain on mute when not speaking
- Tech problems? Please try logging back in, or email Health.Affordability@state.mn.us



This meeting is being recorded.

Closed captioning is available.

Updates from Center for Health Care Affordability

Alex Caldwell | Director, Center for Health Care Affordability

Updates from the Center

- Task force leadership roles
- Summary of Community Conversation November 20, 2025
- Provider and Payer Advisory Task Force kickoff on January 22, 2026

Values and Principles

Alex Caldwell | Director, Center for Health Care Affordability

Values: Core Beliefs and Priorities about How We Do the Work

Evidence and innovation

- Recognize and affirm that change is possible, and that both incremental and larger-scale reforms should be considered
- Build on Minnesota's strengths, seek examples of approaches that have worked elsewhere, and innovate to find new solutions
- Understand evidence and data to inform priorities and recommendations, while recognizing the importance of innovation that may not yet have an evidence base

Values, Continued

Equity and inclusion

- Engage and listen to all perspectives, while centering Minnesotans' individual experiences
- Consider equity and address disparities in cost burden, access, and quality

Integrity and collaboration

- Collaborate to solve problems across multiple sectors
- Conduct our work transparently

Principles: How We Act on Our Values and What Success Looks Like

Implementable impact

- Ensure that systemwide savings translate to improved affordability for Minnesotans and employers
- At the same time, the task force must address total cost. It is not sufficient to just shift costs around between different stakeholders
- Solutions should be clear about the roles of different stakeholders (individuals, employers, health care providers, health insurers, suppliers, and government) to achieve desired outcomes
- Recognize that there will be difficulties and tradeoffs with any decision, but ultimately the benefits should outweigh the costs of any action

Principles, Continued

Consider the full system

- Success may require investment in approaches that may not produce results in the short term, such as prevention of chronic disease and other "upstream" strategies
- Solutions must consider the fact that the health care landscape is changing rapidly and account for these changes to the degree possible (examples include impacts of federal policy changes, AI, and climate change)
- Solutions should consider both short-term and long-term effects, as well as potential unintended effects

Group Discussion

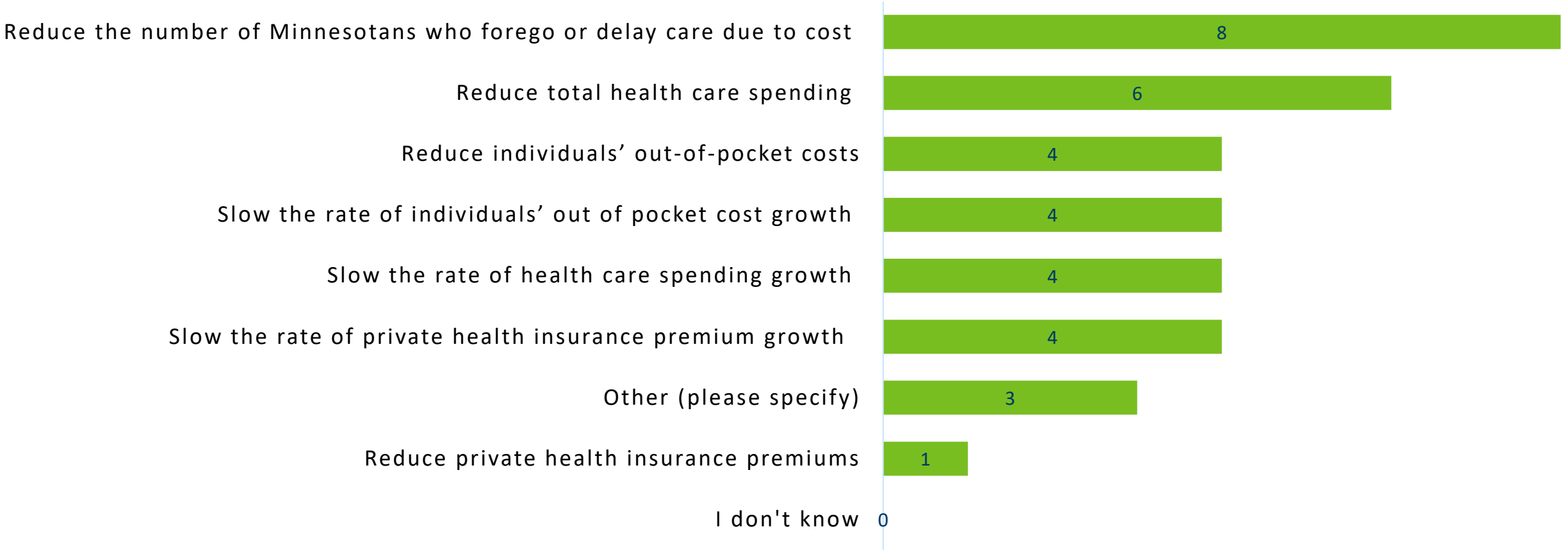
- What questions or comments to you have?
- Are we comfortable moving ahead with these working versions?

Post-October Meeting Survey Review

Julie Sonier | Mathematica

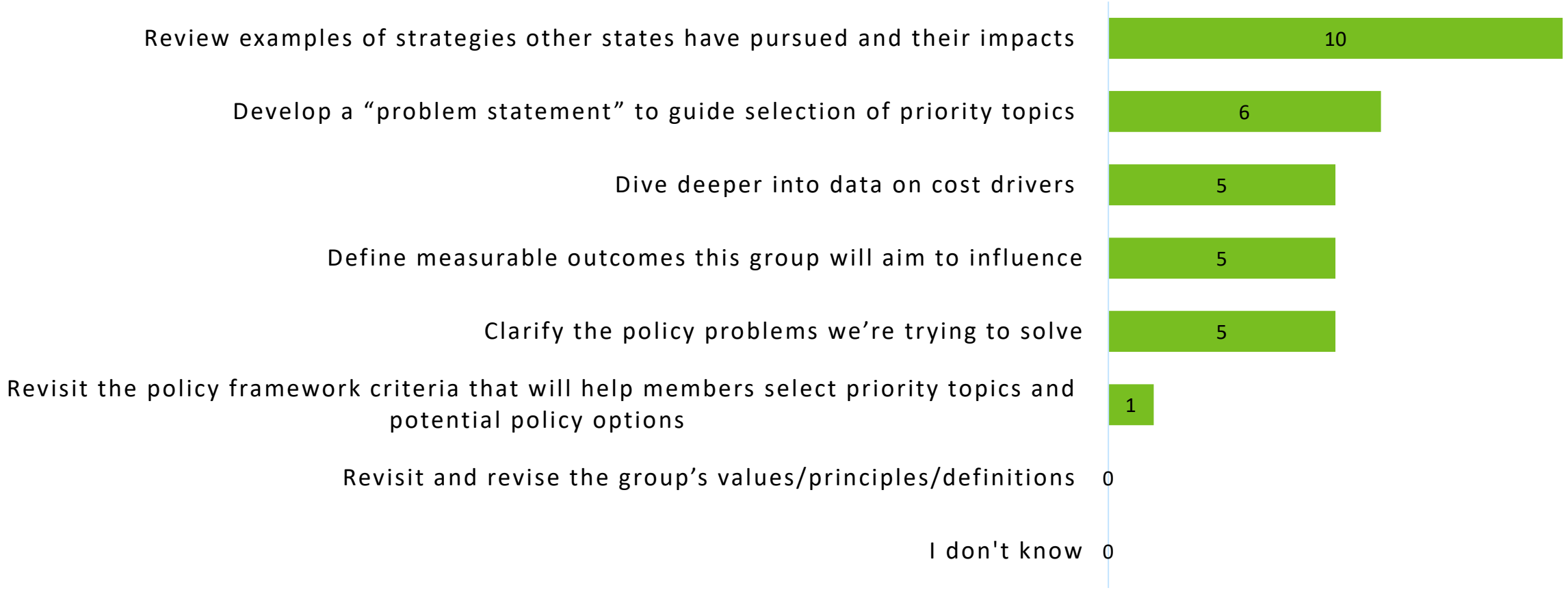
Summary of Member Survey: Defining Success

The following metrics may help define success for the Center and therefore this task force. Which do you feel matter most? (select up to 3)



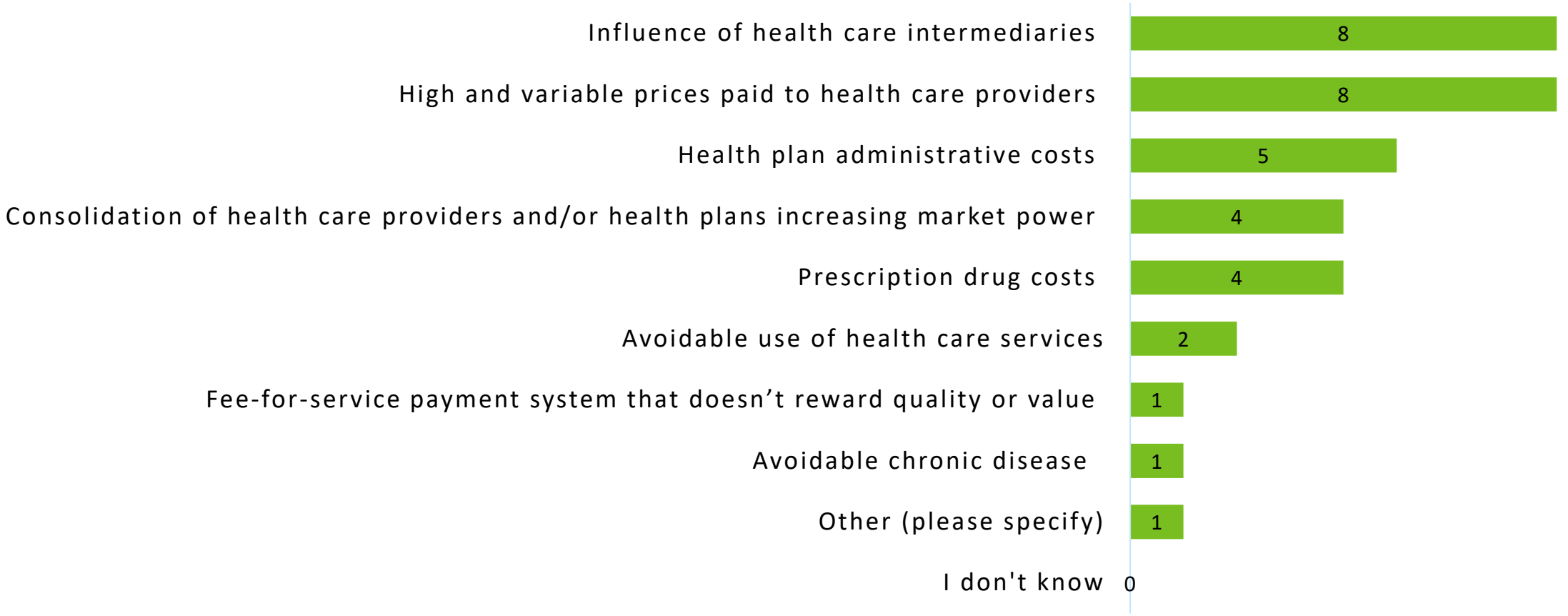
Summary of Member Survey: Activity Prioritization

In your opinion, which of the following activities should we prioritize in the next 12 meetings to help the task force focus on specific affordability challenges? (select up to 3)



Summary of Member Survey: Spending Drivers

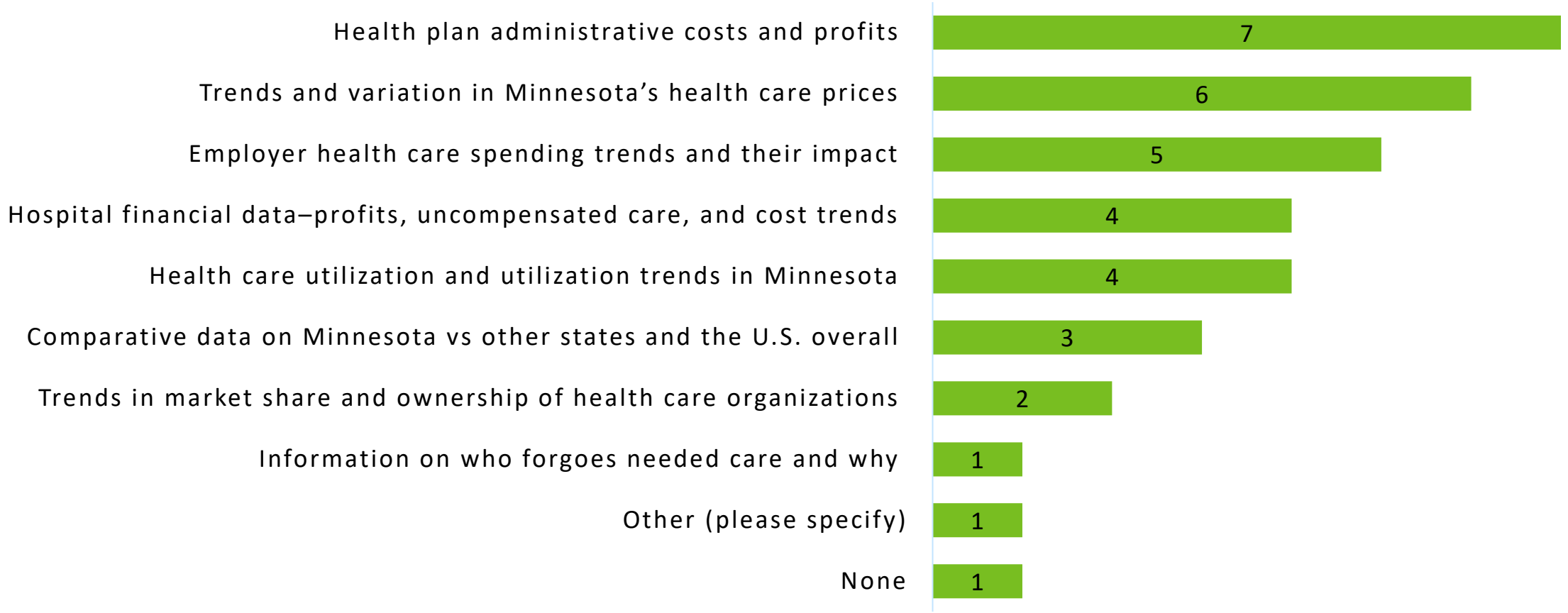
The following topics have come up in task force conversations in the first two meetings. Based on what you know today, which of the following health care spending drivers would you say is most important for the task force to tackle, either by getting more data and/or developing policy recommendations? (select up to 3)



MEMBER SELECTIONS

Summary of Member Survey: Additional Data Needs

What kinds of additional data do you think the task force needs in order to refine a problem statement and/or begin prioritizing topics for 2026? (select up to 3)



Group Discussion

- For those of you who did not have a chance to complete the survey is there anything that you would like to share?
- Do you have anything to add about key takeaways from the summarized survey results?

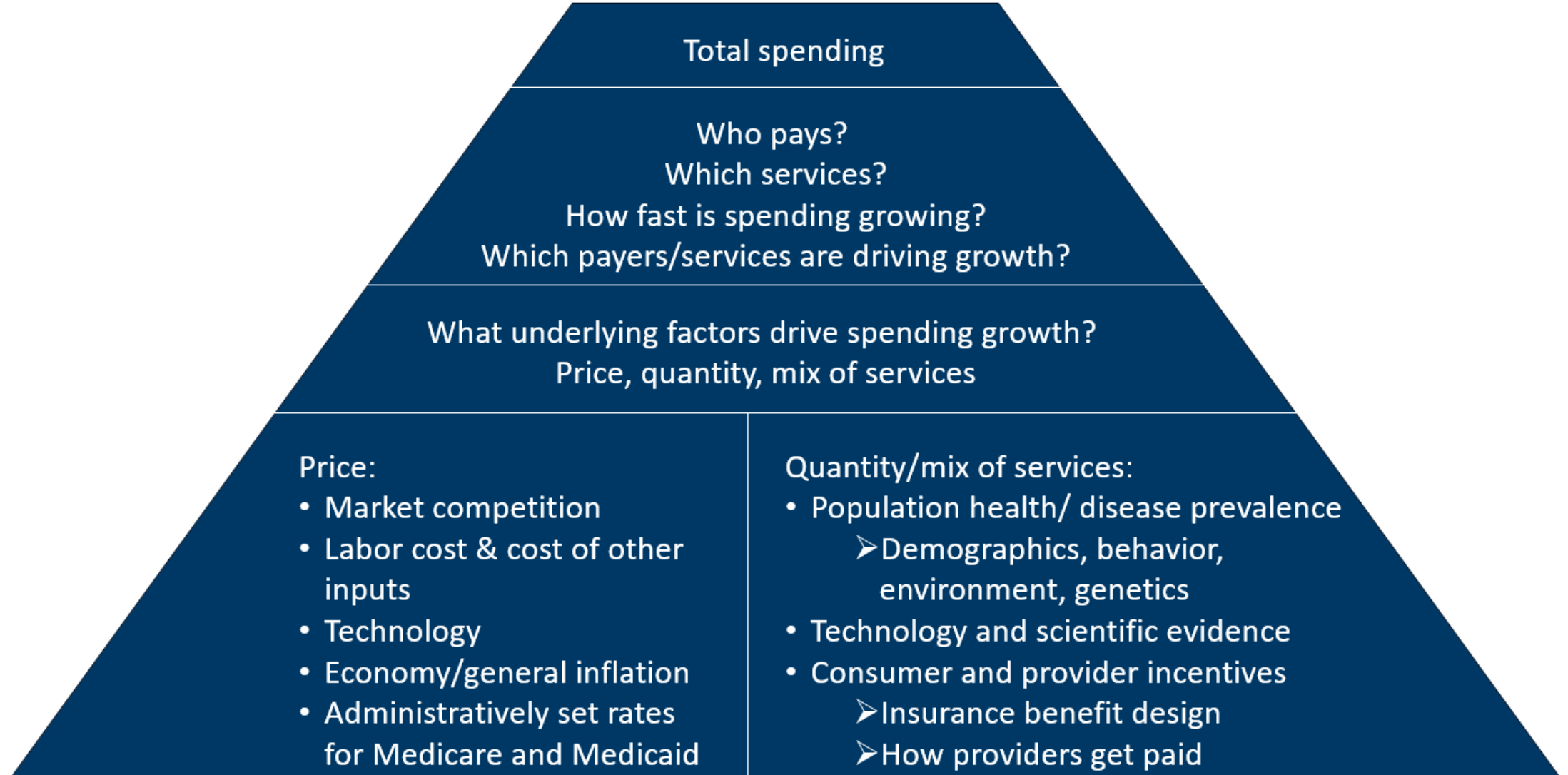
Charting a Path Forward: Scope of the Challenge and State Policy Approaches

Julie Sonier | Mathematica

Overview of This Section

- Establish a framework for understanding the scope of the challenge
- Outline 10 potential state-level strategies to address the challenges
  - Strategies are described in the *Commonwealth Brief: State Strategies for Slowing Health Care Cost Growth in the Commercial Market*
  - Identify Minnesota-specific considerations for each strategy
- Highlight examples where other states have implemented policies to address issues associated with affordability

A Reminder: Health Care Spending Drivers



Framework for Identifying the Scope of the Challenge

Failure of Care Delivery
- Ineffective or harmful care
- Lack of adherence to evidence-based practices
- Poor preventive care

Failure of Care Coordination
- Disjointed care
- Inadequate communication
- Avoidable complications or hospital readmissions

Overtreatment or Low-Value Care
- Low-value testing, treatments, or procedures
- Prolonged duration of services

Pricing Failure
- Variability and inflation in pricing of medications and services
- Provider consolidation and market power

Fraud and Abuse
- Fraudulent billing or other improper claims
- Cost of administrative processes to catch and prevent fraud

Administrative Complexity
- Inefficient administrative processes
- Excessive overhead costs and processes

Source: Adapted from Shrank et al., 2019, *JAMA*

Group Discussion

- What questions do you have?
- What jumped out at you as most important?
- Do you have suggestions for refining this framework to make it more useful for the task force?

Strategy #1: Implement a Health Care Cost Growth Target

Description: Establish a target, or benchmark, for per capita health care cost growth; measure performance against that target; hold entities accountable for meeting the target; and implement cost growth mitigation strategies to attain it

- **1990s cost-growth limits**: Minnesota created the Health Care Commission (1992) and enacted statewide spending growth limits (1994–1998) aiming to cut overall cost growth by 10% per year
- **Outcomes**: Spending growth slowed in the mid-1990s, but this was likely attributable to broader market and economic factors; no enforcement actions were taken, and the cost-growth limit program expired after 1998

Strategy #1: State Examples

Massachusetts – Health care cost growth benchmark

- **Success**: Early years (2013-2017) kept spending growth near/below the cost growth benchmark
- **Challenges**: Recent spending growth has far exceeded the target with few consequences
- **Unique feature**: Longest running cost growth benchmark program

MASSACHUSETTS HEALTH POLICY COMMISSION

Oregon – Health care cost growth target

- **Success**: Transparent reporting and first wave of entities required to adhere to a plan for improvement if they exceed the target
- **Challenges**: Statewide cost growth still exceeding the 3.4% target for both reporting years (2021-2022 and 2022-2023)
- **Unique feature**: Formal "reasonableness" test before requiring improvement plans

OREGON HEALTH AUTHORITY

HEALTH CARE COST GROWTH TARGET

Strategy #2: Promote Adoption of Population-Based Provider Payment

Description: Encourage or require increased adoption of advanced alternative payment methodologies, particularly those that move provider payment toward meaningful risk sharing

- Minnesota's Integrated Health Partnership (IHP) model implements an Accountable Care Organization (ACO) model for the Medicaid program
- Minnesota has strong infrastructure for common quality measurement across payers, which supports population-based payment

Strategy #2: State Examples

Maryland – Hospital global budgets/Total Cost of Care model

- **Success**: Global hospital budgets – a fixed amount of money a hospital gets for the whole year – generated savings and quality gains
- **Challenges**: Constant recalibration needed to avoid cutting necessary care and shifting costs to other parts of the system
- **Unique feature**: All-payer hospital global budgets

health services cost review commission

Vermont – All-payer Accountable Care Organization model

- **Success**: Development of a system which created broader alignment around improvement priorities and some utilization/quality improvements
- **Challenges**: Mixed results on overall spending and uneven participation
- **Unique feature**: Single ACO structure across all major payers

VERMONT

Strategy #3: Cap Provider Payment Rates or Rate Increases

Description: Set a limit on prices paid or restrict provider price increases in state-regulated markets

- No current experience related to capping provider payment rates or rate increases

Strategy #3: State Examples

Rhode Island – Affordability standards

- **Success**: Hospital price growth cap reduced commercial prices and premiums
- **Challenges**: More employers are choosing self-insured plans, and some hospitals, particularly safety-net providers, are feeling financial strain under the state's limits on hospital price growth
- **Unique feature**: Price growth caps enforced through insurer rate review that are tied to explicit affordability standards set by Rhode Island's Office of the Health Insurance Commissioner

Oregon - State employee/teacher hospital price cap

- **Success**: Setting a clear cap on hospital prices lowered what the state paid for hospital services
- **Challenges**: The policy applied only to a small set of purchasers, and some worried it could affect patient access or complicate contract negotiations
- **Unique feature**: A single price cap—tied to a fixed percentage of Medicare rates—used only for public employee and teacher plans

Strategy #4: Contain Growth in Prescription Drug Prices

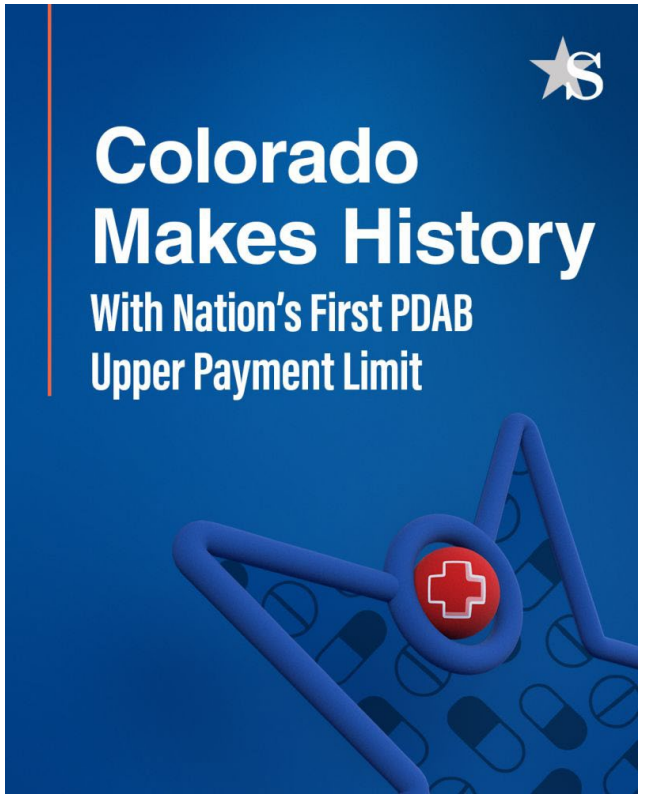
Description: Establish prescription drug affordability boards (PDABs), upper payment limits, international reference pricing, or penalties for “excessive” prices

- Minnesota established a PDAB in 2023 that has authority to review pricing and affordability for specific drugs and create upper payment limits (UPLs) – a rule that sets the highest amount the state or insurers are allowed to pay for a prescription drug – across all payers

Strategy #4: State Example

Colorado – PDAB

- **Success**: First state to set a maximum price (upper payment limit) for a prescription drug, starting in 2027
- **Challenges**: Strong industry opposition and likely litigation
- **Unique feature**: The price limit applies to most insurers and purchasers across the state; not just public programs like Medicaid, the state employee health plan, and other government-run coverage



Strategy #5: Improve Oversight of Provider Consolidation

Description: Reinforce states' ability to review and disapprove mergers and prohibit anticompetitive contracting terms to counter the impact of health care consolidation on provider prices

- Minnesota's Attorney General and MDH have pre-transaction review authority which requires health entities to provide advance notice (60 days) prior to engaging in a merger, sale, asset purchase, new venture, or other transaction concerning a health care entity

Strategy #5: State Examples

Oregon - Health Care Market Oversight (HCMO)

- **Success**: Pre-transaction review has increased transparency and conditioned deals
- **Challenges**: Resource-intensive review and industry pushback
- **Unique feature**: Integration with Oregon's cost-growth target program

Massachusetts - Cost & Market Impact Reviews (CMIRs)

- **Success**: Reviews have helped stop or reshape large health care mergers or expansions that could have raised costs
- **Challenges**: No direct power to block deals; relies on public disclosure and transparency
- **Unique feature**: Public, analytic reports and a "cooling-off" period

Strategy #6: Strengthen Health Insurance Rate Review

Description: Use the insurance rate review process as a lever for health care cost containment

- State regulators review and approve rates in the fully-insured commercial market

Strategy #6: State Examples

Oregon - Division of Financial Regulation

- **Success**: The state's review process lowered some insurers' requested rate increases by about one percentage point
- **Challenges**: Rate review alone can't fully offset medical cost trends
- **Unique feature**: Highly public process with hearings and plain-language decisions

Rhode Island – Rate review with affordability standards

- **Success**: Rate review tied to affordability standards has limited premiums and admin growth
- **Challenges**: Complex to administer and limited to fully insured market
- **Unique feature**: Explicit hospital price-growth caps embedded in rate review

Strategy #7: Adopt Advanced Benefit Designs

Description: Promote strategies that encourage consumers to choose lower-cost providers, such as reference-based benefit design and “smart shopper” programs

- State employee health plan uses the Minnesota Advantage Health Plan with clinic “cost levels” (tiered networks) and some value-based insurance design features

Strategy #7: State Examples

California – Public employee plan reference-based benefits

- **Success**: Setting standard prices the state employee health plan (CalPERS) would pay for certain procedures helped lower prices and resulted in cost savings for the plan
- **Challenges**: Requires strong member education and protects against surprise bills
- **Unique feature**: Uses specific price caps for selected procedures within one of the state's largest public employee health plans

Strategy #8: Promote Use of Community Paramedicine

Description: Enable emergency medical service providers to provide a range of services to patients without transport to an emergency department (ED) to reduce unnecessary emergency and inpatient care

- Community Paramedic credential
  - First in nation to establish this credential which allows for Medicaid coverage and reimbursement
  - Has enabled targeted home visits and chronic care support for underserved communities

Strategy #8: State Example

Colorado – Community Integrated Paramedicine Pilots

- **Success**: Community Integrated Health Care (CIHC) has demonstrated reductions in avoidable ED transports and chronic condition support in several regional pilots
- **Challenges**: Uneven payer participation and limited long-term reimbursement mechanisms
- **Unique feature**: Colorado allows multiple mobile integrated health provider types (not just paramedics), creating highly flexible models

COLORADO
Department of Public Health & Environment

Strategy #9: Improve Behavioral Health Crisis Systems

Description: Expand behavioral health crisis services to reduce use of more costly ED and inpatient services, and leverage multipayer support for these programs

- Minnesota counties provide access to mobile crisis intervention services through a unified "988 system" (access to these services is a county responsibility in state law)

Strategy #9: State Example

Arizona – "Crisis Now" System

- **Success**: Comprehensive crisis system reduced reliance on emergency departments and jails
- **Challenges**: Maintaining funding and consistent capacity statewide
- **Unique feature**: "No wrong door" drop-off centers for law enforcement

CRISIS NOW
Transforming Crisis Services

NASMHPD

Strategy #10: Reduce Administrative Waste

Description: Address product choices and administrative processes that contribute to waste by, for example, streamlining plan choices, health care utilization review, and billing functions

- MDH's Health Economics Program reports each year on how health plans spend money on administration, and the Legislature recently asked MDH to expand this work to include administrative spending by health care organizations
- MDH leads the Administrative Uniformity Committee (AUC), which works to simplify and standardize administrative processes across the health care system

Strategy #10: State Examples

Washington – Prior Authorization Standardization

- **Success**: Early improvements in prior authorization turnaround times and reduced provider burden under new uniform PA standards
- **Challenges**: Slow payer system upgrades and variation in provider readiness
- **Unique feature**: Requires fully standardized electronic prior authorization (ePA) and automatic approvals for clean (complete and error free) claims

Washington State Health Care Authority
Report to the Legislature

Texas – Statewide Prior Authorization "Gold Carding" Law

- **Success**: High-performing clinicians exempted from prior authorization for many services, significantly reducing admin burden
- **Challenges**: Persistent coding issues and lack of transparency around what criteria are needed to be awarded a gold card, narrowing the number of eligible physicians
- **Unique feature**: Mandatory gold-carding for any provider with great than or equal to 90% approval rate for a service

TDI Texas Department of Insurance

Mapping State Strategies to What Part of the Challenge They Address

Strategy	Care delivery	Care coordination	Overtreatment or low-value care	Pricing	Fraud and abuse	Administrative complexity
Cost growth target	X	X	X	X		X
Population-based provider payment	X	X	X	X		
Cap payment rates/rate increases				X		
Prescription drug price growth				X		
Provider consolidation oversight				X		
Rate review				X		
Benefit designs	X			X		
Community paramedicine	X	X				
Behavioral health crisis system enhancement	X	X				
Administrative waste						X

Mapping State Strategies to Task Force Survey Results

Strategy	Care delivery	Care coordination	Overtreatment or low-value care	Pricing	Fraud and abuse	Administrative complexity
Cost growth target	X	X	X	X		X
Population-based provider payment	X	X	X	X		
Cap payment rates/rate increases				X		
Prescription drug price growth				X		
Provider consolidation oversight				X		
Rate review				X		
Benefit designs	X			X		
Community paramedicine	X	X				
Behavioral health crisis system enhancement	X	X				
Administrative waste						X

High and variable prices paid to health care providers; market power; rx drug costs

Health plan administrative costs

Influence of health care intermediaries ?

Mapping State Strategies to Implementation and Potential Impact (2022 Commonwealth Fund)

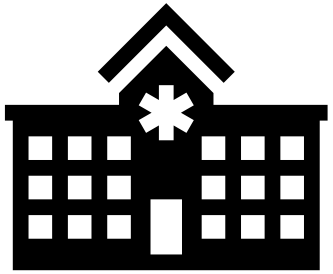
Strategy	Resources required	Potential Magnitude of Impact	Political Difficulty
Cost growth target	High	High	Medium
Population-based provider payment	High	High	Medium
Cap payment rates/rate increases	Medium	High	High
Prescription drug price growth	Medium to high	High	High
Provider consolidation oversight	Medium to high	Unknown	High
Rate review	Medium to high	Unknown	Medium
Benefit designs	Low to medium	Moderate	Low to medium
Community paramedicine	Low	Moderate	Low to medium
Behavioral health crisis system enhancement	Low	Moderate	Low
Administrative waste	Low	Unknown	Variable

Source: Adapted from Hwang et al., 2022, *The Commonwealth Fund*

Additional Strategies to Think About

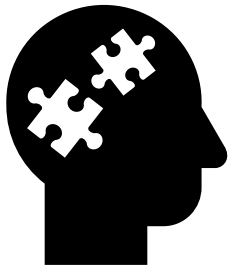
Invest in prevention of avoidable chronic disease

Address health-related social needs



Integrate primary and behavioral health care

Mitigate private-equity-driven price and utilization pressures



Group Discussion

- Which state policy approaches would you like to know more about and why?
- What clarifying questions do you need answered to be able to go into a small group discussion about focus areas for the task force?

Digging Deeper: Small Group Discussion and Reaction

Julie Sonier | Mathematica

Small Group Discussion

- Based on the discussion today and in prior meetings, what is emerging as most important for the task force to learn more about in future discussions? Why?
- What ideas and examples from other states do you find most relevant and promising? What concerns do you have about any of these approaches?
- Are there ideas that aren't part of the Commonwealth Fund framework that you believe are important to consider as potential priorities?
- What Minnesota-specific considerations will be important as we think about how to move forward?

Next Steps

What: Health Care Affordability Advisory Task Force Meeting

When: February 25, 9-11:30am

Where: Location details forthcoming (with hybrid option)

Stay tuned for:

- Provider and Payer Advisory Task Force kickoff January 22, 2026, 9am-12pm

Thank You!

Center for Health Care Affordability

Health.Affordability@state.mn.us

Sources

- Hwang, A., Lischko, A. M., Betlach, T., & Bailit, M. H. (2022, February). *State strategies for slowing health care cost growth in the commercial market.* The Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_ib.pdf

- Institute of Medicine (US) Roundtable on Evidence-Based Medicine, Yong, P. L., Saunders, R. S., & Olsen, L. (Eds.). (2010). The Healthcare Imperative: Lowering Costs and Improving Outcomes. National Academies Press (US). https://doi.org/10.17226/12750

- Shrank, W. H., Rogstad, T. L., & Parekh, N. (2019). *Waste in the US health care system: Estimated costs and potential for savings. JAMA, 322*(15), 1501–1509. https://doi.org/10.1001/jama.2019.13978