

Provider and Payer Advisory Task Force Meeting #2

Date: March 27, 2026, 9:00 a.m. – 12:00 p.m.

Minnesota Humanities Center, Library

Meeting Summary and Key Themes

Meeting Overview: The Provider and Payer Advisory Task Force (PPATF) convened for its second meeting to continue supporting the work of the Center for Health Care Affordability (CHCA). The meeting focused on three main goals: reviewing results from a member survey, reflecting on recent discussion by the Health Care Affordability Advisory Task Force (HCAATF), and gathering input on two topics that may shape future recommendations: value-based payment and insurance benefit design. Members also discussed how these topics fit into the broader roadmap for developing recommendations by June 2026.

Welcome and Agenda Review: Alex Caldwell, Director of the Center for Health Care Affordability, welcomed members attending in person and online and reviewed the meeting agenda and goals. Members were reminded that this stage of the process is meant to help lay the groundwork for future policy development and recommendations.

Survey Results: Julie Sonier of Mathematica reviewed the results of a survey completed by task force members after the January meeting. Members agreed that administrative burden is a significant source of cost and frustration in health care. Examples discussed included prior authorization, disconnected data systems, and limited ability for systems to share information. At the same time, members noted that reducing administrative burden alone will not solve affordability challenges. They also pointed to workforce pressures, productivity challenges, and the need for better data systems as important issues affecting the cost of care.

Members also identified several topics for potential future discussion. These included prescription drugs, pharmacy spending, price transparency for consumers and providers, price differences across providers and care settings, fraud and abuse, the rise of private equity firms, and opportunities to improve care coordination. Some members also encouraged the group to think more broadly about the role of technology, including better data sharing, updated administrative systems, artificial intelligence, remote patient monitoring (a way of monitoring patients with chronic conditions on an ongoing basis outside of a clinical setting), and care provided in the home.

Several members said it is important to look at affordability across the full health care system, not only the commercial market. In particular, they discussed concerns about the long-term stability of Medicaid and the risk that underfunding in public programs can shift costs into other parts of the system. Members also emphasized the patient perspective, including how deductibles, copayments, and other out-of-pocket costs can make it harder for people to get needed care.

Recap of the Health Care Affordability Advisory Task Force: Alex Caldwell provided a summary of the February HCAATF meeting. Members responded to themes from that discussion, including administrative burden, the role of intermediaries in the health care system, high and variable prices, and the need for both short-term and long-term solutions. Members generally supported taking both practical and broader system-level approaches to affordability.

During the discussion, members noted that while prior authorization creates real burden, some form of oversight for high-cost services will still be needed unless larger system changes occur. Others said that innovations introduced in siloes by different payers can add more complexity because providers must understand and work with each payer separately on their unique approach. Members also raised concerns about private equity, recent state and federal activity related to prescription drug pricing, and the need to give consumers information they can more easily understand and use. Throughout the discussion, members emphasized that health care affordability must be viewed as part of the larger health care system, where changes in one area can affect many others.

Some members encouraged the task force to consider bold ideas in areas where the state may have a clearer opportunity to directly help residents with affordability. Others emphasized the importance of clear public communication, noting that support for recommendations may depend on how well the issues and tradeoffs are explained.

Value-Based Payment: Julie Sonier gave an overview of value-based payment and explained how it differs from traditional payment approaches. She also shared examples from Minnesota and other states. In discussion, members generally agreed that value-based payment remains an important strategy to consider because it can support prevention, care coordination, and new ways of delivering care. Some members shared examples from Minnesota where these approaches have shown promise, especially in primary care and rural settings.

At the same time, members described many challenges that can make value-based payment hard to implement. These included difficulties with data sharing, payment design, quality measurement, patient engagement, variation in approaches across payers, and implementing these arrangements at a meaningful scale (especially for rural providers with low numbers of patients). Some members also questioned whether wide use of these approaches is realistic in the near term, especially given current financial pressures on providers. Some members suggested that strengthening primary care may be one of the more practical paths forward.

A major theme in this discussion was the need to keep patients at the center. Members noted that even if value-based payment lowers costs in the system overall, those savings may not result in lower out-of-pocket costs for patients. Workforce shortages, especially in primary care, were also identified as an important challenge for any strategy that depends on more coordinated and preventive care.

Insurance Benefit Design: Julie Sonier also introduced the topic of insurance benefit design and reviewed several possible approaches. These included designs intended to make primary care easier to access, guide patients toward higher-value care, or create incentives around certain services. Minnesota and California examples were also discussed.

Member views on benefit design were more mixed. Some saw real potential for these approaches to help reduce barriers to primary care and encourage use of higher-value services. Members also noted examples of promising strategies involving provider networks and

prescription drug benefits. At the same time, many members raised concerns about the limits of benefit design. They noted that these approaches can sometimes add complexity for patients, especially when provider networks change or are hard to understand. Members also discussed the need for better information on quality, especially for specialty care, and questioned whether benefit design can reduce underlying costs or mainly shifts costs from one place to another. Some members also questioned how practical these approaches would be for smaller employers.

End-of-life care was also discussed, especially the role of advance care planning. Members noted that this topic matters both for cost and for making sure care reflects patient preferences. More broadly, some participants said the task force should stay focused on ideas most directly tied to lowering health care spending, while others felt benefit design should remain part of the conversation because it affects what patients pay and how they seek care. Several members said they would benefit from more background information before drawing conclusions about how benefit design should fit into future recommendations.

Closing and Next Steps: Alex Caldwell closed the meeting by encouraging members to keep the broader Minnesota policy and market context in mind, including work happening in other agencies and related efforts. Members also discussed the importance of being clear about the task force's focus: whether the main goal is reducing cost barriers for people seeking care, slowing growth in overall health care spending, or both.

The meeting also included a request for nominations for PPATF co-chairs. The next PPATF meeting is scheduled for June 11, 2026, and the next HCAATF meeting is scheduled for April 21, 2026. Members were invited to contact the Center with additional questions or comments.

ABOUT THE CENTER FOR HEALTH CARE AFFORDABILITY

The Minnesota Center for Health Care Affordability at the Minnesota Department of Health is committed to making health care more affordable for all Minnesotans.

The Center identifies cost drivers, provides transparent research, and advances solutions that stabilize health care spending so that Minnesotans can afford the high-quality care they need.

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