



Health Care Affordability Advisory Task Force

May 14, 2026

Today's Objectives

- Review the task force's role and direction
- Continue defining policy directions for the non-value added spending and high and variable prices recommendation areas
- Provide an overview of insurance benefit design and value-based payments as ways to make care more affordable in Minnesota
- Present potential recommendations for insurance benefit design and value-based payment and elicit task force feedback and preferences for further exploration

Today's Agenda

- Re-grounding: Role, Direction, and the Path Ahead – **CHCA**
- Defining Recommended Policy Directions – **Mathematica**
- *Break*
- Insurance Benefit Design – **Mathematica**
- Value-Based Payments – **Mathematica**
- Closing and Next Steps – **CHCA**

Re-grounding: Role, Direction, and the Path Ahead

Alex Caldwell | Director, Center for Health Care Affordability



Purpose of the Center for Health Care Affordability

To conduct targeted analysis of the drivers of health care spending, engage with the public, and convene advisory bodies, all in an effort to identify and advance strategies that improve health care affordability.

HCAATF Advisory Task Force Objectives

- Analyze spending trends: Review and understand cost growth trends reported by MDH to advise the Center and to inform the Minnesota legislature and the public on the impact of rising health care costs
- Explore cost drivers: Advise MDH on additional data or analyses needed to understand cost growth drivers and identify potential strategies for slowing cost growth
- **Evaluate strategic options: Advise MDH on potential affordability strategies to pursue, providing guidance on benefits and trade-offs**
- **Recommend actionable solutions: Develop and recommend evidence-based strategies to slow cost growth and improve affordability, ensuring that access, quality, and equity are not compromised. Recommendations will be shared with the Center and with the Commissioner of Health**
- Support public engagement and transparency: Support the Center's public reporting and engagement efforts, including the Center's annual reporting and at least one public hearing per year
- Advise the Center on evaluating impact: Provide input on how the Center could measure the impact of potential cost growth reduction strategies over time

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

Implementable impact

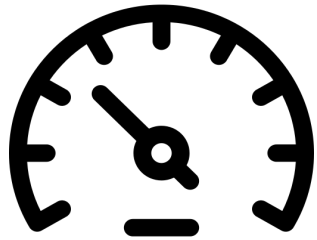
- Ensure that systemwide savings translate to improved affordability for Minnesotans
- At the same time, the task force must address total cost. It is not sufficient to just shift costs around between different stakeholders
- Solutions should be clear about the roles of different stakeholders (individuals, 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

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

Additional Considerations for Future Work

- The task force's role is to **identify actionable recommendations**, including building momentum and support for promising policy approaches that have worked in other states, as well as original ideas tailored to Minnesota
- The goal is not to duplicate existing work, but to **add value by bringing broad stakeholder support and input to strategies** that can improve health care spending outcomes
- There is a need and potential to balance longer-term transformation and shorter-term change

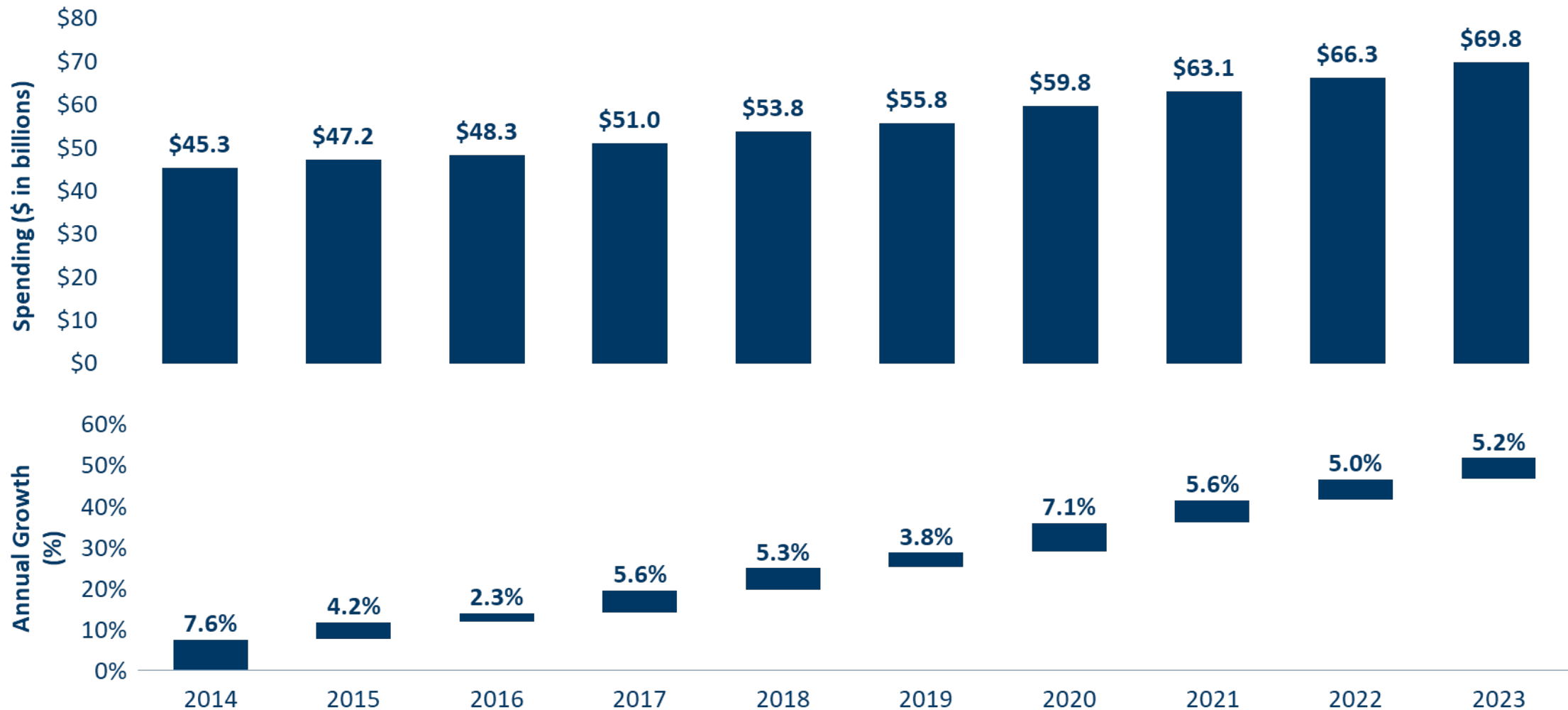


Minnesota's health care spending will **grow at a slower, more sustainable rate**

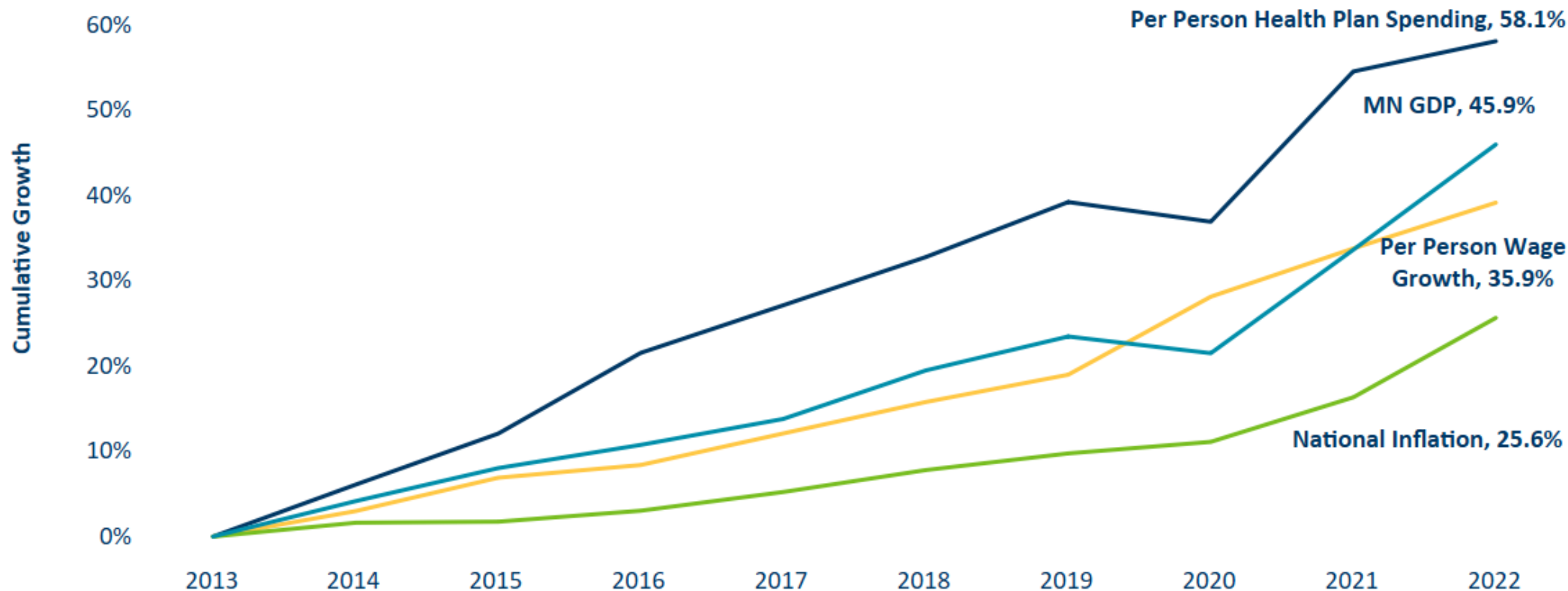


Fewer Minnesotans will report **foregoing or delaying needed care due to cost**

Estimates of MN Health Care Spending, 2023



Cumulative Growth in Key Minnesota Health Care Cost and Economic Indicators

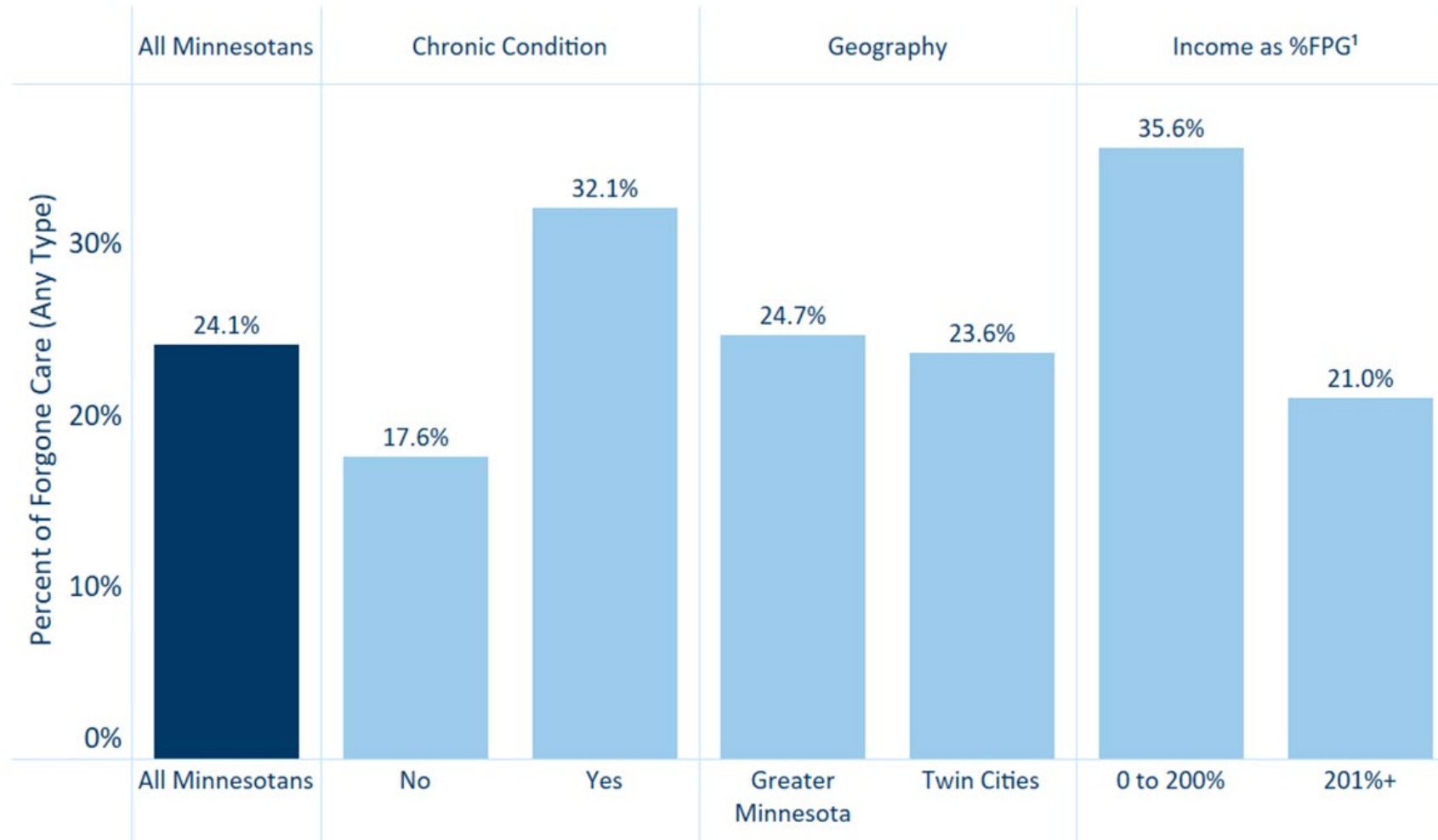


Health care spending is Minnesota fully-insured commercial spending per person and does not include enrollee out-of-pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

Fully-insured commercial market only.

Sources: MDH, Health Economics Program analysis of annual medical-only reports from health plan companies; Gross State Product (MN GDP) from U.S. Department of Commerce, Bureau of Economic Analysis; Consumer Price Index (All Urban Consumers (CPI-U), U.S. City Average), as of October 2, 2024; per person wage growth from Minnesota Department of Employment and Economic Development as of October 2, 2024.

Any Forgone Care Due to Cost by Chronic Conditions, Geography, and Income, 2025

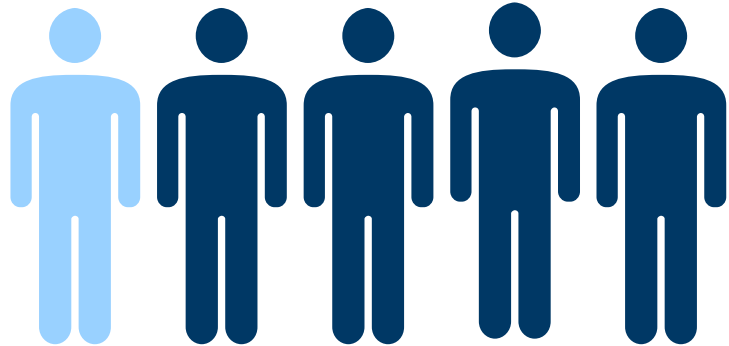


Source: Minnesota Health Access Survey, 2025

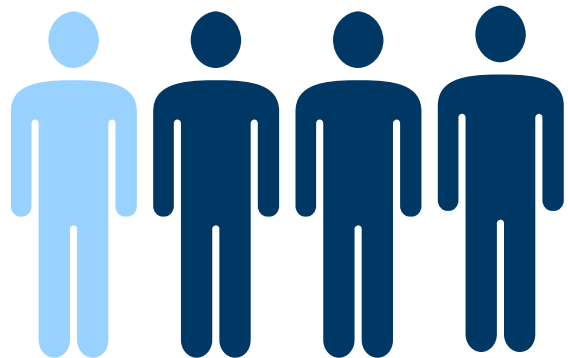
¹ Indicates statistically significant difference (95%) level from all Minnesotans within year. [Federal Poverty Guidelines \(https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines\)](https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines)

www.health.state.mn.us/health/economics

Even With Private Health Insurance, Minnesotans Worry about Affording Care



1 in 5 Minnesotans with private insurance aren't confident they could pay their deductible if there was a major medical event.



1 in 4 Minnesotans with private insurance weren't satisfied with their level of insurance to protect them against high medical bills.

Roadmap to Recommendations: Round 1

Task forces are nearing the end of round 1

Sept. 2025 – Jan. 2026

1. Understand the Charge

2. Review the Landscape

3. Prioritize within topic areas

4. Define the policy directions

5. Refine and finalize policy directions

April – May 2026

June 2026

Ongoing advisory input into Center's research, stakeholder engagement, and communications

- What additional questions do you have about the task force's role and/or direction?



Defining Recommended Policy Directions

Julie Sonier | Mathematica

Purpose of the Discussion

- Develop a clearer understanding of what the task force would need to grapple with should it move forward with a priority recommendation area
 - What questions need to be answered?
 - What policy directions appear the most promising?

Priority Recommendation Areas

- Non-Value-Added Spending
 - Increase **ownership transparency** of health care entities
 - Study and regulate **PBMs and pharmaceutical drug prices**
- High and Variable Prices
 - Strengthen **market oversight** to promote competitive markets
 - Strengthen health **insurance regulation**
 - Regulate **commercial prices** and price growth

Ownership Transparency (1/2)

Why this matters for affordability:

- Private equity firms are increasingly purchasing physician practices, skilled nursing homes, and other health care entities nationwide
- **Investor and corporate ownership can affect incentives around prices, staffing, service mix, and operational decisions that affect cost**
- Research suggests that when these investors have more influence in the system, spending goes up (and there are more negative health outcomes)
- **MN's market concentration is primarily the result of non-profit hospital consolidation;** however, there is a risk that private equity firms penetrate the market and increase their ownership share

Current context:

- Minnesota legislators have been working on the **Health Care Accountability Act** for several years, which would:
 - Ban non-clinician ownership in professional medical firms,
 - Enhance transparency reporting, and
 - Restrict corporate interference in medical judgment
- But scale of private equity investment in Minnesota health care entities is unknown and not required to be reported under current law

Ownership Transparency (2/2)

What the task force would need to learn

- How does private equity manifest in Minnesota, and **is it a measurable problem today?**
- **Which factors matter most** to improving affordability: ownership, management control, real estate control, etc ?
- Whether the primary gap is **transparency, need for regulation, or both?**

What pursuing this area could look like:

- **Clarify which ownership or control arrangements matter most:** Identify which structures are most important from an affordability standpoint, such as private equity, REITs, MSOs, parent entities, management arrangements, or changes in controls
- **Define when ownership structures should be reported and/or trigger additional scrutiny:** Consider what kinds of ownership arrangements or ownership changes should be visible to the state and when they should prompt closer review
- **Recommend how transparency should be used:** Weigh whether ownership transparency is mainly intended to improve public visibility, strengthen regulatory intelligence, inform transaction review, or support additional safeguards

PBMs and Drug Prices (1/2)

Why this matters for affordability:

- Prescription drugs represent a **significant driver** of health care spending in Minnesota
- Prescription drug spending is shaped by manufacturers, PBMs, pharmacies, insurers, and benefit design
- **PBM and other intermediary arrangements** – such as rebates and fees – can obscure net drug spending

Current context:

- Minnesota already has a **prescription drug price transparency framework**. MDH collects and publishes data on high-priced new drugs, large price increases, and certain drugs of substantial public interest
- Minnesota has also established a **Prescription Drug Affordability Board** and already regulates PBMs
- Congress recently enacted laws regulating PBMs
- Proposals in other states would go further on PBMs, including **banning spread pricing and imposing stronger fiduciary-style duties**, suggesting the conversation has shifted from transparency alone toward stronger PBM regulation

PBMs and Drug Prices (2/2)

What the task force would need to learn

- Whether the main concern is **pharmacy access, patient cost-sharing, PBM conduct, manufacturer prices**, or all of the above?
- **Where the largest information gaps are:** PBM practices generally, rebates, spreads, specialty pharmacy, pharmacy closures, or health plan net spending on drugs?
- Which **levers** are available and **which parts of the pharmacy supply chain do they affect?**
- **Given recent federal action on PBMs**, what additional steps should Minnesota consider to make drugs more affordable?

What pursuing this area could look like:

- **Clarify the primary affordability concern:** Identify whether the task force is most concerned about pharmacy reimbursement, patient out-of-pocket costs, PBM practices, manufacturer prices, or the interaction among them
- **Define where greater scrutiny is most needed:** Consider which parts of the drug supply chain most warrant attention, such as rebates, spread pricing, specialty pharmacy practices, reimbursement methods, or pricing of high-cost drugs
- **Recommend the general policy direction:** Weigh whether the priority should be transparency, regulation of PBM business practices, broader drug affordability tools, or a combination

Market Oversight (1/2)

Why this matters for affordability:

- Changes in ownership, consolidation, and market structure can **increase the leverage** that providers or other health care entities have to demand higher prices
- Those effects may show up as **higher commercial prices, faster premium growth, fewer lower-cost options for purchasers (i.e. employers) and patients**, and less pressure on the system to control costs
- Stronger oversight can help the state identify transactions or market changes that may **undermine affordability** before those effects become entrenched

Current context:

- Minnesota already has a health care transaction law in **Chapter 145D** that requires notice and disclosure for certain health care entity transactions
 - For covered transactions, the Attorney General, in consultation with MDH, reviews **potential effects on affordability**, access, health care options, and the workforce, and considers public input
 - The law is being used in active transaction reviews, but it is still a **review-and-enforcement model**, not a system where the state directly approves or denies every deal above a designated threshold

Market Oversight (2/2)

What the task force would need to learn

- Which market changes **matter most for affordability**: horizontal consolidation (like mergers and acquisitions), vertical integration (like large systems buying clinics or other entities), clinic or service closures, or other changes?
- Whether **transaction thresholds** miss smaller or serial transactions that still reshape markets?
- What data, staffing, and authority do agencies already have and need for meaningful review?
- **How to balance affordability with other considerations, like access and quality?**
- What state or federal policies already exist and how do they impact potential approaches to oversight?

What pursuing this area could look like:

- **Define when market changes should trigger additional scrutiny**: Consider what kinds of transactions or arrangements may warrant closer review based on likely effects on prices, access, competition, or local market power
- **Recommend what effective oversight should focus on**: Weigh whether the priority is better notice and visibility, stronger review of high-risk transactions, or clearer follow-up when market changes appear to increase prices

Health Insurance Regulation (1/2)

Why this matters for affordability:

- **Health insurance premiums** are one of the clearest ways that consumers, employers, and public purchasers experience rising health care costs
- When provider prices, prescription drug spending, utilization, or administrative costs rise, those pressures are passed on to consumers and employers through premiums
- Health insurance regulation – and specifically rate review – is one of the state’s most **direct tools to ensure that premium increases are justified**, make the drivers of those increases more visible, and, depending on the policy design, create stronger pressure for insurers to manage costs on behalf of members

Current context:

- Minnesota already reviews and approves individual and fully-insured group insurance rates.
- The current framework is centered on whether filed rates are **reasonable and actuarially justified**, rather than on a broader affordability standard
- Even after review, affordability pressure remains high: approved **2026 rates increased an average of 21.5% in the individual market and 14.2% in the small-group market**

Health Insurance Regulation (2/2)

What the task force would need to learn

- Which kinds of health insurance plans are within state regulatory scope?
- **What is driving premium growth: prices, utilization, administrative costs, or a mix?**
- Which tools do regulators have and what additional tools would be effective?
- **Which outcome matters most: lower premiums, slower growth, or transparency?**

What pursuing this area could look like:

- **Clarify the goal of stronger insurance regulation:** Identify whether the priority is smaller premium increases, stronger insurer accountability, better visibility into cost drivers, or some combination
- **Define what affordability-focused health insurance regulation should examine:** Consider which parts of rate filings most warrant closer scrutiny, such as trend assumptions, administrative costs, margins, and the extent to which insurers are managing underlying costs
- **Recommend how ambitious the policy direction should be:** Weigh whether health insurance regulation should remain primarily a technical actuarial process or become a more explicit affordability tool

Commercial Prices (1/2)

Why this matters for affordability:

- **Commercial prices are often much higher than Medicare and Medicaid prices** and can vary widely across providers or within a given health system for the same service, without corresponding differences in quality
- Those higher prices result in **higher premiums, higher employer health care costs, and higher out-of-pocket spending** for people with commercial coverage

Current context:

- Minnesota already has strong analytic infrastructure for this issue through the **Minnesota All Payer Claims Database** and related MDH health economics data resources
- Minnesota policymakers have begun **exploring more direct price controls**, including bills to require or expand reference-based pricing health plans

Commercial Prices (2/2)

What the task force would need to learn

- Where are price **levels** highest, where is price **growth** fastest, and where do prices **vary** most for the same or similar services?
- To what extent are differences tied to **market concentration, contracting dynamics, site-of-service differences, service mix, or possible cross-subsidization across commercial and public markets?**
- **What does the evidence suggest** about approaches such as price transparency, cost growth benchmarks, prospective review, reference pricing, or direct price limits, including impact on affordability, tradeoffs and implementation challenges?

What pursuing this area could look like:

- **Clarify the core affordability problem:** Identify whether the task force is most concerned about high commercial price levels, rapid price growth, large price differences for the same service, or some combination.
- **Define which policy approaches deserve closer consideration:** Consider when options such as public reporting, price growth guardrails, prospective review, reference pricing, or same-service same-price approaches may be most appropriate.
- **Recommend a starting point for further policy development:** Weigh whether this area calls first for better visibility and benchmarking, targeted guardrails for high-price or high-growth actors, or more direct price standards.

- What additional questions do you have about the task force's role and/or direction?
- What questions would you like to ask the Provider and Payer Task Force about these issues?
- Are there other considerations we haven't listed that we should take into account as we plan how to move forward?



Break

Insurance Benefit Design

Julie Sonier | Mathematica

Insurance Benefit Design: Definition

- **Insurance Benefit Design**: a health plan's covered benefits, member cost-sharing, and access rules, which in turn affects affordability, utilization, and equity
- Key levers:
 - Enrollee cost sharing
 - Deductibles
 - Copayments/coinsurance
 - Out-of-pocket maximums
 - Network structure
 - Referrals
 - Tiering

Cost Sharing Effects on Utilization

- Research shows that higher cost-sharing:
 - Reduces overall utilization
 - Reduces both high- and low-value care
 - Can create barriers to chronic disease management
 - Can cause people to avoid or delay care, especially people with low incomes
- As a result, policymakers have explored targeted approaches (e.g., value-based insurance design) to better align cost-sharing with clinical value

Benefit Design Strategies

- Value Based Insurance Design (VBID): a benefit approach that aligns patients' out-of-pocket costs with the clinical value of services by **lowering cost-sharing for high-value care** and, in some cases, increasing it for low-value care
- Primary care first designs: **Make primary care very low-cost (or free)** to the patient to encourage early, continuous, and preventive care
- Reference-based benefit design: A benefit design approach where the insurer sets a maximum payment amount for a service (the “reference price”). If a patient chooses a provider that charges more than that amount, **the patient pays the difference**
- Site-of-care optimization: A strategy that **steers care to lower-cost settings** when clinically appropriate (e.g., outpatient surgery center instead of hospital outpatient department)

Value-based insurance design (VBID): Connecticut Health Enhancement Program

Policy Summary

- **Lowers or eliminates member cost sharing** for targeted preventive care, chronic-condition visits, maintenance medications, and diabetes supplies
- Requires age-appropriate preventive screenings and chronic-condition education
- Nonparticipants or members removed for noncompliance face a premium surcharge and exposure to deductibles

Successes

- NASHP reports 98% compliance among enrolled members in years when compliance was measured
- **Higher use of targeted services**, better medication adherence, and lower emergency department use in the first two years
- **Spending effects were inconclusive** in the first two years of evaluation

Known challenges and limitations

- Program administration requires claims-based compliance tracking, member notices, waiver handling, and third-party administrative support.

Primary care first designs: Colorado Option standardized plans

Policy Summary

- Applies in Colorado's individual and small-group markets and uses the **same copays, deductibles, and out-of-pocket limits across insurers within each metal** (Bronze, Silver, or Gold) tier, so plans are easier for consumers to compare
- Provides **\$0 primary care and mental health visits**, plus \$0 prenatal/postnatal care and some diabetes supplies

Successes

- Enrollees had **15% lower out-of-pocket costs** than non-Colorado Option enrollees

Known challenges and limitations

- Room to grow in the small-group market
- Employers and brokers expressed **interest in more plan design options**, including HSA-compatible options
- Public sources reviewed did not identify clear evidence on whether the policy **increased primary care use specifically**

Reference-Based Benefit Design: CalPERS Surgical Procedure Model

Policy Summary

- Plan sets a reference price for specific services
- Members receive **standard coverage at designated facilities meeting price and quality criteria**
- Members choosing **higher-priced facilities** may pay the amount above the reference price
- Used for joint replacement, arthroscopy, cataract surgery, and colonoscopy

Successes

- Use of lower-priced facilities for joint replacement **increased from 48% to 63%**
- Average price charged to CalPERS for joint replacement **declined 26.3%** in the year after implementation

Known challenges and limitations

- Best suited to **non-emergency, shoppable services with meaningful price variation** and enough lower-priced capacity
- Requires price and quality analytics, facility designation, member education, and exceptions policies
- **Broader savings may be modest** and must be weighed against plan complexity and member financial risk

Minnesota Example: State Employee Group Insurance Plan (SEGIP) Value-Based Insurance Design Approach

Policy Summary

- Clinic systems are tiered based on total cost of care; member cost sharing varies by tier to encourage use of lower-cost providers
- Reduced or eliminated cost-sharing for certain high-value medications (e.g., chronic conditions such as diabetes, hypertension)
- Incentives to improve medication adherence and chronic disease management

Successes

- Encourages choosing lower-cost providers - about 90 percent of SEGIP's membership is enrolled in cost levels 1 and 2
- Incentivizes providers to lower prices or enter risk-sharing arrangements to remain in a tier with lower cost sharing

Known challenges and limitations

- Both tiering and VBID add to administrative complexity

Insurance Benefit Design: Key Considerations

- Potential impact on affordability:
 - Lower use of avoidable or low-value care
 - Shift care towards better-value providers
 - May or may not be lower cost because value is a component of both price and quality
- Risks to consumers:
 - Consumers may experience confusion, access barriers, or higher out of pocket exposure if a preferred provider is not designated high-value
- Key Question:
 - Can consumers and providers access and understand the information they need to choose high-value care at the point when decisions need to be made?

PPATF Feedback: Insurance Benefit Design

- Members saw potential in benefit design, especially for encouraging use of primary care, steering patients to lower-cost settings, and creating incentives to choose higher-value care
- At the same time, many felt this area has limits and may be hard to influence at the state level
- There are concerns about the added administrative complexity individualized benefit packages create, confusing choices for patients and providers on what is covered, and the risk of shifting costs to other parts of the system rather than reducing overall spending

Recommendations: Insurance Benefit Design

1. Develop and assess options to expand the use of benefit designs that **reduce or eliminate cost-sharing** for high-value primary care and other high-value services
2. Assess options to encourage benefit designs that **steer care to lower-cost, clinically appropriate sites of care** without creating barriers to needed treatment
3. Develop and evaluate options for **reference-based benefit design** or similar approaches for shoppable services where there is meaningful price variation and adequate consumer protections
4. Analyze options to **simplify benefit design for consumers**, including clearer cost-sharing structures, more predictable out-of-pocket exposure, and improved decision support

Questions: Insurance Benefit Design

- Do you have any clarifying questions?
- Do you have any questions that should be raised with the Provider and Payer Task Force?



Value-Based Payment

Julie Sonier | Mathematica

- **Fee-for-service:** Providers (doctors, hospitals) are paid for each individual service they deliver
- **Value-Based Payment (VBP):** A broad approach to paying for health care that rewards quality and cost control, rather than volume
 - **Types of value-based payment models:**
 - **Population-based payment:** A provider or health system receives a fixed payment to care for a group of people over a period of time
 - **Global budgets:** A type of population-based payment where a provider (often a hospital system) gets a fixed total budget to cover all care for a defined population
 - **Shared savings:** A payment model where providers can share in the savings if they keep costs below a target while maintaining quality

What is Value-based Payment Trying to Solve?

Problem 1: Volume Incentives

- Providers are paid more when they provide a higher volume of services

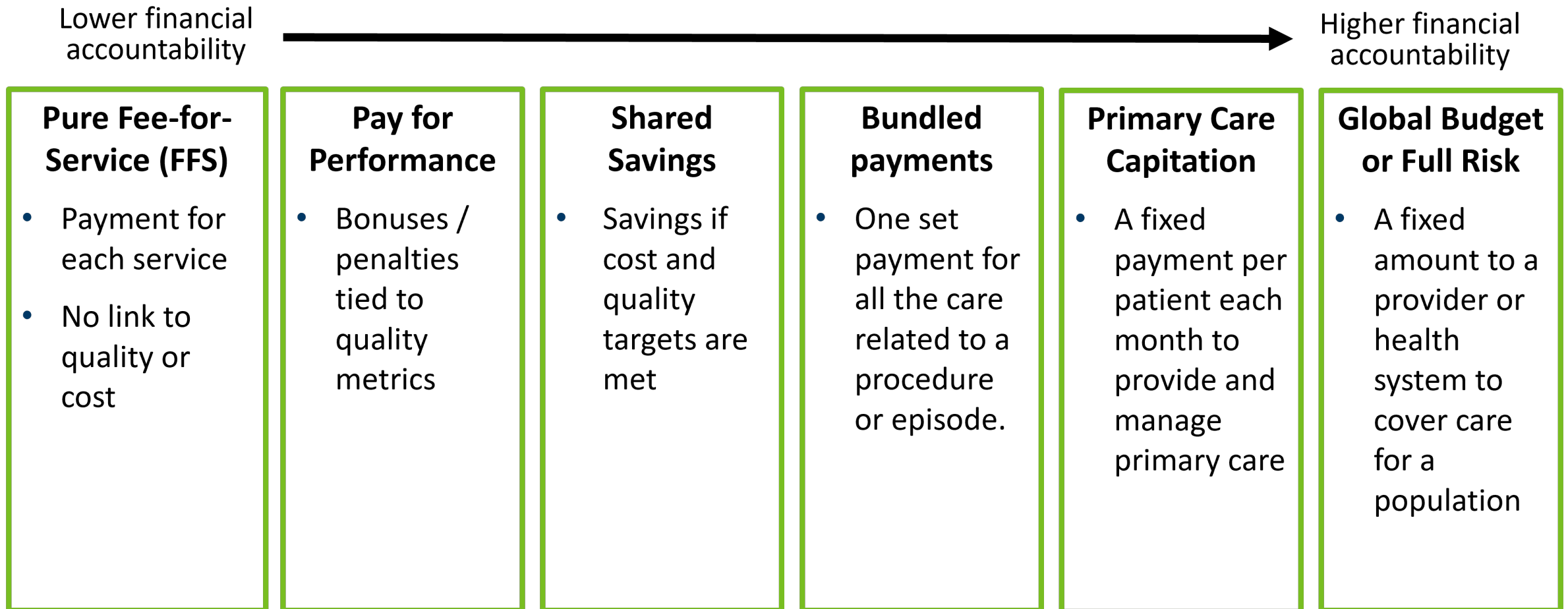
Problem 2: Fragmented care

- No one entity is responsible or accountable for avoidable emergency use, readmissions, duplicative tests (low-value care), chronic condition management or appropriate care transitions

Problem 3: Uneven focus on equity

- Traditional payment often does not reward closing gaps in access, outcomes, or patient experience

Value-Based Payment as a continuum



Elements of a Successful Value-based Payment Strategy

- **Financial incentives**: Tie provider payment to performance on cost, quality, and equity, using tools like upside/downside risk, prospective payment, and larger or more direct incentives to strengthen behavior change
- **Nonfinancial incentives**: Encourage participation by giving providers more flexibility to deliver appropriate care and by strengthening mission, professionalism, and reputation for high-quality, affordable care
- **Measurement**: Establish a common set of priority measures related to quality, safety, equity, and cost and track provider performance on those measures so payment and accountability can be tied to results over time. A centralized source for data collection reduces burden and fragmentation in reporting
- **Public reporting**: Publish performance results so patients, purchasers, and others can compare providers and plans, creating pressure to improve

Strengths and Challenges of Value-Based Payment

Strengths

- Greater flexibility in care delivery
- Incentives for prevention and coordination
- Budget predictability
- Explicitly considers quality and value
- Can also have incentives around reducing disparities
- Some evidence of savings in population-based payment models

Challenges

- Savings can be modest and uneven
- Administrative burden and complexity (e.g., quality measurement/reporting, payment reconciliation)
- Potential for increased market concentration
- Concerns about patient mix and risk adjustment
- Generating critical mass across payers

Global Budgets: Maryland Total Cost of Care

Policy Summary

- Set **hospital global budgets across payers**, giving hospitals predictable annual revenue rather than payment tied only to service volume
- The later Total Cost of Care Model **made the state accountable for Medicare total cost** and added hospital, care redesign, and primary care components

Successes

- Independent evaluation found a **16.2% reduction in hospital admissions** during 2019 to 2022
- The **model reduced total Medicare spending**, including non-claims payments, by \$689 million from 2019 to 2021, and reduced disparities on several quality measures

Known challenges and limitations

- **Earlier reforms focused mainly on hospitals**, limiting the state's leverage over spending and quality outside the hospital
- The primary care component showed some operational gains, but its savings were not large or certain enough to offset program costs in the evaluation period

Mixed Approach: Oregon Medicaid Coordinated Care Organizations

Policy Summary

- Oregon Medicaid **coordinated care organizations (CCOs)** are locally governed entities responsible for access and quality across physical, behavioral, and oral health care
- **CCOs receive capitation and can earn incentive payments above the capitation rate** based on performance on selected quality measures

Successes

- **CCOs generally improved performance in most categories** from 2022 to 2023
- Preventive dental/oral health services for young children rose above pre-pandemic levels; behavioral health measures mostly improved

Known challenges and limitations

- A 2024 Oregon Health Authority study called for more involvement of Oregon Medicaid members, community-based organizations, and providers in the metrics and scoring process
- Ongoing refinement needed: Oregon's quality improvement program study identified governance and program-design changes, especially to strengthen equity and transparency

Mixed Approach: Vermont Statewide All-Payer Accountable Care Organization model

Policy Summary

- Vermont tested a state-specific **all-payer accountable care organization (ACO) model** across Medicare, Medicaid, and commercial payers
- The state was accountable for **participation, financial, and population health targets**, with payment intended to reward value and quality rather than volume

Successes

- **Reduced gross (6.6 percent per person per year) and net (6.3 percent per person per year) Medicare spending** for ACO-attributed beneficiaries from 2018 to 2022
- Evaluators also reported **reduced hospital utilization** and improved understanding and acceptance of value-based care among providers

Known challenges and limitations

- Scaling was limited by incomplete participation across all three payer ACO initiatives and variation in payment mechanisms
- Financial constraints, **administrative burden**, access to timely data, and rural specialty access limitations were documented barriers

Minnesota VBP Example: Medicaid Integrated Health Partnership (IHP) Model

Policy Summary

- Launched in 2013 as Minnesota Medicaid's accountable care model with voluntary participation for provider organizations
- **Population-based payment tied to total cost of care** for attributed Medicaid beneficiaries
- DHS sets the total cost of care target and providers share in savings if spending is below the target and quality thresholds are met
- **Flexibility to invest in care coordination, primary care, and non-traditional services**

Successes

- **Program scale has grown from six provider groups at launch to 25 IHP partnerships**; DHS currently reports more than **530,000 Minnesotans served**
- **SHADAC reports nearly \$546 million in total IHP savings** through 2022, with IHPs evaluated on cost, quality, utilization, and equity domains
- The model created a Medicaid-specific pathway for provider-led accountability while allowing local flexibility in care coordination and equity strategies

Known challenges and limitations

Track 1 is non-risk bearing, so provider financial accountability varies across participating organizations

PPATF Feedback: Value-Based Payment

- General agreement that this approach could **help make care more affordable** by supporting prevention, better coordination, and more flexibility in how care is delivered
- Progress has been slower and harder than expected
- Key challenges include limited access to timely information at the point of care, as well as timely performance measurement, primary care staffing shortages, implementation capacity for rural and small providers, and variation in quality measures and incentives across payers
- Uncertainty about whether patients see direct savings, even when the system saves money
- Future discussion should focus on what it would take to make this approach work better in practice, especially through stronger primary care and better collaboration across the system

Recommendations: Value-Based Payment

1. Assess options to increase **adoption of value-based payment** arrangements in Minnesota's commercial market, with particular attention to barriers facing purchasers, plans, and providers
2. Develop and evaluate options to **reduce administrative burden for providers within value-based payment models**, especially for smaller, independent, rural, and safety-net providers

Questions: Value-Based Payment

- Do you have any clarifying questions?
- Do you have any questions that should be raised with the Provider and Payer Advisory Task Force?



Discussion: Insurance Benefit Design and Value-based Payments

- MDH Comments
- Task Force Co-Chair Comments
- Task Force Discussion



- What additional information do you need to continue defining policy directions?





What: Health Care
Affordability Advisory Task
Force Meeting

When: June 24th, 9 am to 12
pm

Where: Wilder Foundation,
Auditorium A



Stay tuned for:

- Virtual Community Conversation with Advocates on May 20, 1 – 2:15 pm
- Provider and Payer Advisory Task Force meeting on June 11th, 9am-12pm

Thank You!

Center for Health Care Affordability

Health.Affordability@state.mn.us

References

- Berkeley Center for Health Technology. (n.d.). *Reference pricing for joint replacement*. University of California, Berkeley. <https://bcht.berkeley.edu/reference-pricing-joint-replacement>
- Butler, J. (2023). *Improving insurance access, affordability, and equity: Updates on the Colorado Option*. National Academy for State Health Policy. <https://nashp.org/improving-insurance-access-affordability-and-equity-updates-on-the-colorado-option/>
- Centers for Medicare & Medicaid Services. (n.d.). *Maryland Total Cost of Care Model*. <https://www.cms.gov/priorities/innovation/innovation-models/md-tccm>
- Centers for Medicare & Medicaid Services. (2024). *Evaluation of the Maryland Total Cost of Care Model: Progress report*. <https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt>
- Connect for Health Colorado. (n.d.). *What are Colorado Option plans?* <https://connectforhealthco.com/faq/what-are-colorado-option-plans/>
- Hirth, R. A., Cliff, E. Q., Gibson, T. B., McKellar, M. R., & Fendrick, A. M. (2016). Connecticut's value-based insurance plan increased the use of targeted services and medication adherence and produced savings. *Health Affairs*, 35(4), 637-646. <https://doi.org/10.1377/hlthaff.2015.1371>
- Hwang, A., et al. (2022). *Health care cost growth: Strategy 7 -- Benefit design*. Commonwealth Fund. https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_07_benefit.pdf
- Lewis, C., Horstman, C., Blumenthal, D., & Abrams, M. K. (2023, February 10). *Value-based care: What it is, and why it's needed*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed>
- McDonald, T. M., White, C., Claxton, G., & Whaley, C. M. (2022). Clinic price reductions in a tiered total cost benefit design. *The American Journal of Managed Care*, 28(2), e57-e64. <https://pmc.ncbi.nlm.nih.gov/articles/PMC9940713/>
- New Hampshire Department of Administrative Services. (n.d.). *Cost savings programs*. <https://www.das.nh.gov/riskmanagement/active/medical-benefits/cost-savings-programs.aspx>

References Cont.

- NORC at the University of Chicago. (n.d.). *Evaluation of the Vermont All-Payer Accountable Care Organization Model*. <https://www.norc.org/research/projects/vermont-all-payer-aco-model-evaluation.html>
- Oregon Health Authority. (2023). *2023 CCO metrics annual report*. <https://www.oregon.gov/oha/HPA/DSI/QHOCMeetingDocuments/2023-CCO-Metrics-Annual-Report.pdf>
- Oregon Health Authority. (2024). *Quality Incentive Program study findings report*. <https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/QIP-Evaluation-Report.pdf>
- Pohl, R. V., Steiner, A., Davadi, M. L., Nester, K., Faunce, L., Farid, M., & Gordon, B. (2026, January 16). *Analysis of the Colorado Option, pursuant to § 10-16-1310, C.R.S.* Mathematica. <https://www.mathematica.org/publications/analysis-of-the-colorado-option>
- Robinson, J. C., Brown, T. T., Whaley, C., & Finlayson, E. (2015). Association of reference payment for colonoscopy with consumer choices, insurer spending, and procedural complications. *JAMA Internal Medicine*, 175(11), 1783-1789. <https://doi.org/10.1001/jamainternmed.2015.4588>
- Ryan, A. M. (2026, January 23). *Value-based payment and managed care will not solve the affordability crisis*. *Health Affairs Forefront*. <https://www.healthaffairs.org/content/forefront/value-based-payment-and-managed-care-not-solve-affordability-crisis>
- Song, Z., Ji, Y., Safran, D. G., & Chernew, M. E. (2019). Health care spending, utilization, and quality 8 years into global payment. *The New England Journal of Medicine*, 381(3), 252-263. <https://doi.org/10.1056/NEJMsa1813621>
- Veltri, V. (2023, October 6). *State employee plans and value-based insurance design: Connecticut and Minnesota*. National Academy for State Health Policy.
- White, C., & Eguchi, M. (2014, October 1). *Reference pricing: A small piece of the health care price and quality puzzle* (Research Brief No. 18). National Institute for Health Care Reform. <https://www.mathematica.org/publications/reference-pricing-a-small-piece-of-the-health-care-price-and-quality-puzzle>