

# Health Care Affordability Advisory Task Force Meeting #6

**Date:** May 14, 2026, 1:00 p.m. – 4:00 p.m.

**Amherst Wilder Foundation, Auditorium A**

## Meeting Summary and Key Themes

Alex Caldwell, Director of the Center for Health Care Affordability, welcomed task force members and other participants attending in person and online. She introduced the co-chairs of the Provider and Payer Advisory Task Force, Ghita Worcester and Joel Beiswenger, who joined the meeting to listen to the discussion. The meeting focused on four goals: reviewing the task force role and direction, continuing to define priority policy areas, and discussing insurance benefit design and value-based payment as possible ways to improve health care affordability in Minnesota.

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

Task force co-chairs and MDH staff reviewed the role of the task force. They clarified that the task force advises the Center for Health Care Affordability but is not a separate legislative task force. Members discussed how their work can help the Center become a trusted long-term source of information, public input, and policy ideas.

Members noted that many health care affordability problems have existed for decades. Because the Center cannot analyze and develop potential recommended solutions to every issue at once, members said it will be important to choose areas where the Center can make useful progress.

Members also discussed the Center's long-term goals. These goals are to reduce the number of Minnesotans who delay or skip needed care because of cost and to slow the growth of total health care spending in Minnesota. Members said the task force should keep both goals in mind when setting priorities.

Several members emphasized that affordability is closely tied to access. They said Minnesotans should be able to get the care they need, at the right time, without facing costs they cannot afford. Members also asked for more information about which cost drivers make up the largest share of spending and which are growing the fastest.

## Defining Recommended Policy Directions

Julie Sonier of Mathematica reviewed the five priority areas that came out of the April meeting.

- Increase ownership transparency of health care entities
- Study and regulate pharmacy benefit managers (PBMs) and pharmaceutical drug prices
- Strengthen market oversight to promote competitive markets

- Strengthen health insurance regulation
- Regulate commercial prices and price growth

Julie explained the goal of this discussion was to provide some more information and context around each of the five issues to help ensure all task force members are working with a base of information on what each topic entails and the types of issues the task force would need to learn about to develop specific recommendations.

Members asked what it means to prioritize a recommendation area. MDH explained that task force priorities will be reflected in a letter from the task force describing recommended topics for future work to be submitted to MDH this summer. These recommendations will help guide future Center research, development of proposed policies, and stakeholder engagement.

In preparing materials for this meeting, MDH used language that was simplified as compared to what HCAATF members reviewed in their previous meeting. Members raised concerns about how this was done in a few cases, noting that some topics were presented more narrowly as compared to their initial broader scope and that some language shifted from describing a problem to prematurely identifying a solution. They asked MDH to revisit the wording before these topics are shared with the PPTF for its June meeting.

Members discussed healthcare ownership transparency in detail. They asked that the Center broaden this recommendation area to include private equity and other ownership issues, such as nonprofit consolidation, vertical integration, real estate ownership, and management arrangements. Members also discussed the difference between problems affecting Minnesotans currently and steps that could help prevent future problems.

Members also discussed pharmacy benefit managers and drug prices. Some members noted that state and federal policy work is already happening in this area, which might suggest the HCAATF and the Center focus capacity on other topics. Others said that this activity has not necessarily changed the experience for purchasers, pharmacies, or consumers and that additional policy actions are needed. Members also pointed to specialty drugs, including GLP-1 medications and high-cost cell and gene therapies, as growing concerns for future spending.

The discussion also included commercial prices and reference-based pricing. Reference-based pricing sets a maximum amount a plan will pay for a service. Some members said this approach may appeal to self-funded employers. Others raised concerns that patients could be left to manage extra costs if protections are not in place. Members also discussed whether the Center should explore affordability standards, such as defining a percentage of household income that would be considered affordable.

Members will have the opportunity to provide additional feedback and questions about each of the five prioritized recommendation areas following the meeting. Questions will be brought to the Provider and Payer Advisory Task Force for discussion.

## Insurance Benefit Design

Julie defined insurance benefit design as the services a health plan covers, how much people pay out of pocket, and the rules people must follow to get care. She explained that higher out-of-pocket costs can reduce both needed care and less useful care. This can make it harder for people to manage chronic conditions or get care early.

The presentation reviewed several possible approaches. These included lowering cost-sharing for high-value care, making primary care very low cost or free, steering people to lower-cost care settings when appropriate, and using reference-based benefit design for services that people can plan ahead for.

Examples included Connecticut's Health Enhancement Program, Colorado Option standardized plans, the CalPERS reference-based benefit design model, and Minnesota's State Employee Group Insurance Program (SEGIP).

Members discussed whether the state has enough ability to influence benefit design. They noted limits related to federal programs, self-insured employer plans, Medicaid, and employer preferences for flexibility. Some members suggested that public purchasing and pooling may offer ways to provide options without directly trying to regulate all employer health plans.

Members discussed SEGIP as one example that could offer lessons for other groups, such as schools, cities, counties, small employers, or other public-sector groups. Members also encouraged the Center to think broadly about new approaches, including telehealth-first designs, plans that make prices easier to see before care, state coverage options, and alternatives to employer-sponsored insurance.

## Value-Based Payment

Julie defined value-based payment as a way to pay for health care that rewards quality and cost control, rather than paying only based on the number of services provided. She described different types of models, including shared savings, bundled payments, population-based payments, and global budgets.

Examples included Maryland's Total Cost of Care model, Oregon Medicaid coordinated care organizations, Vermont's all-payer accountable care organization model, and Minnesota's Medicaid Integrated Health Partnership model.

The presentation explained that value-based payment is meant to address some problems in fee-for-service payment. Fee-for-service payment compensates providers for each service they deliver. This can reward higher volume, even when better coordination or prevention may be more useful.

Members discussed how value-based payment is different from managed care. A key point was who benefits when savings are achieved. In value-based payment, providers share in savings. In managed care, health plans benefit from savings. Members raised concerns that savings may not always reach patients through lower premiums or lower out-of-pocket costs.

Members said evidence on value-based payment is mixed. Some members said bundled payments may have stronger evidence in certain situations. Others noted that broader models, such as global budgets or full-risk arrangements, can raise hard questions about what happens if providers do not succeed financially. This concern is especially important in rural areas, where the loss of a provider could threaten access to care.

Members also discussed quality measures and administrative burden. They suggested asking the Provider and Payer Advisory Task Force why past efforts to use more common quality measures did not solve the problem of fragmented reporting. Members said any future work on

value-based payment should consider the burden on smaller, independent, rural, and safety-net providers.

## Closing and next steps

Alex closed the meeting by thanking members for their discussion and noting that their feedback would help MDH and the co-chairs refine the task force's priority areas before the HCAATF submits its letter outlining recommended focus areas for future work to MDH this summer. Members will have additional opportunities to provide feedback and raise questions about the topics discussed. MDH will bring relevant questions from this task force to the Provider and Payer Advisory Task Force, including questions about ownership structures, drug spending, benefit design, value-based payment, and quality measure reporting.

The next Provider and Payer Advisory Task Force meeting is scheduled for June 11, 2026. The next Health Care Affordability Advisory Task Force meeting is scheduled for June 24, 2026. The Center also held a virtual Community Conversation with consumer and patient advocates on May 20, 2026.

## 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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5/20/2026

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