Summary: Health Care Affordability Advisory Task Force Meeting | June 24, 2026

Date: 06/24/2026

Location: Amherst Wilder Foundation, Auditorium A

Meeting Summary and Key Themes

Alex Caldwell, Director of the Center for Health Care Affordability, welcomed Health Care Affordability Advisory Task Force members and other participants attending in person and online. The meeting marked an important step before the task force co-chairs finalize a written statement of initial health care affordability priorities for the Commissioner of Health.

The meeting focused on three goals: (1) sharing feedback from the Provider and Payer Advisory Task Force (PPATF) and consumer advocates, (2) discussing how the Center might develop shared goals for making health care more affordable, and (3) reviewing priority topic areas that will guide future research and policy work.

Where We've Been and Where We're Going

Task force co-chairs Matthew Anderson and Sheila Kiscaden described the work to date as organized brainstorming that has helped identify where Minnesota should begin deeper research and analysis. They emphasized that the task force is not yet recommending final policy solutions; instead, the written statement is meant to identify priority areas where the Center and MDH should begin research, analysis, public and stakeholder engagement, and policy development.

Members discussed the need to keep future work flexible enough to respond to new ideas, research findings, and changes in state government. Several members noted that Minnesota's health care system is highly connected and that state policy tools can affect only some parts of the system, so future work should be grounded in what the state can realistically influence, what data are available, and where the Center can add value.

Members also discussed the importance of maintaining public trust in the work. One member asked how to communicate that affordability relief may not be immediate while still showing Minnesotans that the task force and Center are working toward concrete progress, and another member encouraged future meetings to leave room for emerging issues, including innovation and artificial intelligence.

Consumer Advocate Feedback

MDH staff summarized feedback from a May 20 community conversation with consumer advocates. Participants generally agreed that the HCAATF's priority topics match concerns they see in their own work, including provider prices and price growth, market consolidation, pharmacy benefit managers, private equity ownership, and health insurance affordability. Advocates also emphasized that these issues are connected and should not be addressed in isolation.

Consumer advocates also raised broader concerns about growing corporate control of health care, interest in stronger oversight of health care markets and prices, and questions about what data are available to understand consolidation and investor ownership in Minnesota. Task force members noted the importance of continuing to engage providers, employers, consumers, and other stakeholders as the Center moves from setting priorities into more detailed work.

Health Care Affordability Goals

Members discussed whether and how Minnesota should develop shared goals for making health care more affordable. Alex explained that this work would not replace the priority topic areas but could give the Center an organizing framework for future work. Examples included goals for total health care spending growth and ways to measure whether household health care costs are affordable compared with income or basic living expenses.

Several members supported the idea of affordability goals because they could help legislators, state leaders, consumers, employers, and advocates understand whether Minnesota is making progress. Members said goals could support transparency, public reporting, analysis, oversight, policy planning, and broader accountability, while some cautioned that the goals should not be treated as a strict spending cap or enforcement tool.

Members raised several questions for further study, including how to define cost, price, spending, and affordability; whether the word sustainable is appropriate; how to consider quality and health outcomes alongside spending growth; and how to balance statewide health care spending goals with household affordability. Members also noted that a household affordability measure may need to distinguish between regular costs, such as premiums and cost sharing, and high-cost health events, such as a cancer diagnosis or another major course of treatment.

Recap and Reactions: Survey Summary and Provider and Payer Advisory Task Force Meeting

Julie Sonier of Mathematica reviewed results from the May post-meeting survey. 12 of 15 HCAATF members responded, and market consolidation and commercial prices and price growth were the most selected priority topics. Members also suggested broadening the ownership topic beyond non-clinician ownership, adding anti-competitive conduct to the consolidation discussion, considering how employers that pay health care claims directly could be included or encouraged to participate in affordability strategies, and potentially combining insurance benefit design and value-based payment into a broader topic focused on encouraging high-value care.

Julie also summarized feedback from the June 11 PPATF meeting. Members of that task force generally agreed that the priority areas are connected and should be considered against the Center's two north stars: slower

health care spending growth and fewer Minnesotans delaying or skipping care because of cost. They encouraged the HCAATF to look at the main reasons health care costs are rising, including the mix of patients covered by different types of insurance, staffing and technology costs, state and federal rules, administrative work, and financial pressure on providers. They also said future analysis should look at differences across regions, types of services, parts of the market, ownership models, and insurance coverage patterns, instead of assuming one statewide approach will work for every community.

Priority Topic Discussion

Priority Topic #1 High Prices and Price Growth

The first priority topic focused on high prices and price growth, especially in the commercial market, which includes private insurance coverage that many people receive through employers. Julie summarized feedback from the PPATF, whose members discussed whether the commercial market is the right starting point given the state's limited authority over self-insured employer plans, where employers pay health care claims directly. They noted that commercial prices are a major affordability concern for many Minnesotans, but that Medicaid, Medicare, Medicare Advantage, and uninsured care also affect provider finances and commercial prices through financial pressures across insurance programs. They cautioned that commercial price policies need careful analysis to avoid unintended effects on provider financial stability, essential services, provider networks, and rural access.

HCAATF members discussed complex administrative rules and paperwork, as well as profit-driven intermediaries, meaning companies that earn money by managing parts of the health care system. Examples included vendors that help providers or payers navigate billing, contracting, claims, and payment rules. One member noted that future research should make clear any assumptions about whether savings in the commercial market could be redirected toward higher-value care, and members also emphasized that rural communities should be represented in policy discussions and asked what policy options could support local ownership and keep health care dollars in Minnesota communities.

Priority Topic #2 Consolidated Health Care Markets

The second priority topic focused on consolidated health care markets, which can occur when fewer organizations own, control, or have major influence over care delivery in a community or region. Julie shared PPATF feedback that consolidation can increase market power and prices, but may also preserve access, support technology investments, or keep services available in smaller communities. PPATF members said future work should examine why consolidation happens, including staffing costs, technology needs, complex administrative work, the mix of patients covered by different types of insurance, revenue pressure, and access to money for investment. They also identified monitoring consolidation transactions, such as mergers or acquisitions, after they occur as a possible research focus, including whether prices rise, or worsens, quality changes, and promised community benefits or service commitments are maintained.

HCAATF members discussed whether the topic should distinguish between nonprofit and for-profit entities. The discussion generally framed consolidation as an issue about how the health care market is structured and controlled, and noted that it can involve nonprofit systems, for-profit entities, affiliations, partnerships, and

other arrangements. Members also said the topic should include vertical integration, meaning situations where organizations in different parts of health care, such as insurers, pharmacies, pharmacy benefit managers, and provider groups, become linked through ownership or control.

Priority Topic #3 Private Equity Ownership of Health Care Entities

The third priority topic focused on private equity ownership of health care entities and other investor-owned or profit-driven intermediaries. Julie summarized PPATF feedback that Minnesota needs a clearer understanding of these ownership structures before identifying specific policy responses. PPATF members emphasized that the issue should be defined by its effect on value, affordability, access, quality, staffing, and patient experience rather than by ownership label alone, and they also noted that some investment may support technology, preserve services, or provide money for needed improvements.

HCAATF members raised concerns that profit-seeking models can redirect health care dollars away from care delivery. One member asked that long-term care be included in this work because private equity and investor ownership may be especially relevant in settings where public dollars, including Medicaid and Medicare, pay for much of the care. Members also linked this topic to complex administrative rules and paperwork, noting that a complex health care system creates opportunities for intermediaries to generate revenue by helping organizations manage billing, contracts, payment disputes, and payment rules.

Priority Topic #4 Health Insurance Affordability

The fourth priority topic focused on health insurance affordability and Minnesota's process for overseeing insurance. Julie shared PPATF feedback that health insurance affordability should include premiums, deductibles, copays, facility fees, and other out-of-pocket costs, not only the premium level reviewed when rates are set. PPATF members also discussed how difficult it can be for consumers to understand provider charges, prices agreed to by insurers and providers, insurer payments, and the patient's share of the bill.

HCAATF members discussed the relationship between MDH and the Minnesota Department of Commerce. The Department of Commerce has direct responsibility for insurance regulation, with a focus on making sure insurance companies can pay claims and protecting consumers. Members noted that the Center can help inform broader policy discussions about how health insurance costs affect access, health outcomes, and the financial burden on Minnesota residents.

Members also discussed provider administrative costs tied to patient billing. Joel Beiswenger, co-chair of the PPATF, noted that patients often have more than one financial relationship in the health care system. They may pay premiums through an employer or insurer and also owe out-of-pocket costs to providers. Providers then need systems for billing, payment collection, counseling, and follow-up, which adds cost and complexity.

Priority Topic #5 Pharmacy Benefit Managers (PBMs)

The fifth priority topic initially focused on pharmacy benefit managers, or PBMs, which are companies that manage prescription drug benefits for health plans and employers. Julie summarized PPATF feedback that PBMs are important to health care costs, but that the discussion should include the full prescription drug supply chain, meaning the path from drug makers to wholesalers, pharmacies, health plans, employers, and patients. A

narrow focus on PBMs could miss the roles of drug makers, pharmacies, wholesalers, benefit design, pharmacy access, specialty drugs, the federal 340B drug discount program, and market concentration. PPATF members also said the topic is complex and will likely require outside expertise.

HCAATF members agreed that future work should first clarify what is known, what is not known, and what data are needed to understand how money moves across the prescription drug supply chain. Members generally agreed to broaden the topic from PBMs alone to the pharmacy supply chain or prescription drug costs more broadly, while avoiding confusion between the pharmacy supply chain and chain pharmacies. Members also noted that local and independent pharmacies appear to face different pressures than pharmacies that benefit from vertical integration or market concentration.

Insurance Benefit Design and Value-Based Payment

The task force briefly returned to insurance benefit design and value-based payment, which were discussed in earlier meetings. Insurance benefit design refers to how health plans structure covered services, deductibles, copays, and provider networks; value-based payment refers to payment approaches that aim to reward quality, health outcomes, or cost control rather than only the number of services delivered. These topics were not included as separate priority areas in the draft letter because the group has not yet defined the scope of future work as clearly, but members stressed that these topics should not be lost.

One member noted that benefit design and value-based payment may help support high-value care and reduce low-value care, meaning care that may not improve health enough to justify its cost or risk. MDH noted that the Health Economics Program's required report on low-value care may create a future opportunity to return to these topics and connect them to the task force's broader work on health care costs.

Closing and Next Steps

The meeting closed with a discussion of where the task force should focus in the coming months. MDH described the option of forming two working groups with members from both task forces, however, details about size, membership, time commitment, and structure are still being developed and are expected to be discussed further at the July 28 joint task force meeting.

Members generally supported using the current task force membership and choosing early work that can show progress, build the Center's credibility, and produce useful analysis. Several members suggested that affordability goals, commercial prices and price growth, and consolidated markets may be strong starting points because they connect directly to the task force's north stars and appear to have member interest and available research. Members also noted the need to define the Center's north stars carefully, including whether Minnesota should develop a public dashboard or spending benchmark that accounts for spending, affordability, health outcomes, and value.

MDH and the HCAATF co-chairs will revise the draft statement of affordability priorities based on the June 24 discussion. The revised statement will be shared with HCAATF members for review and then shared with PPATF members before being sent to the Commissioner in July. The next meeting is the joint task force meeting on July 28, 2026, from 9:00 am to 1:00 pm at the Wilder Foundation.

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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