Health Care Affordability Advisory Task Force and Provider and Payer Advisory Task Force Joint Meeting

Date: July 28, 2026, 9:00 a.m. - 1:00 p.m.

Amherst H. Wilder Foundation, Auditorium A

Meeting Summary and Key Themes

Alex Caldwell, Director of the Center for Health Care Affordability, welcomed members of the Health Care Affordability Advisory Task Force (HCAATF) and the Provider and Payer Advisory Task Force (PPATF) to their first joint meeting. Members introduced themselves and shared what they hoped the Center would accomplish. Across both task forces, members emphasized the need to move from discussion toward action while protecting access, quality, fairness, and the long-term strength of rural health care.

The meeting focused on four goals: building relationships across the two task forces, placing their work within the broader state and federal policy environment, gathering feedback on the two proposed working groups, and beginning a shared discussion of the Center's longer-term vision for health care affordability.

Framing the Next Phase of Work

Julie Sonier of Mathematica reviewed the Center's two North Stars: slowing the growth of health care spending in Minnesota and reducing the number of Minnesotans who delay or skip needed care because of cost. She also reviewed the task forces' work to date and the HCAATF's five initial priorities for future policy work: high prices and price growth, consolidated health care markets, private equity ownership of healthcare entities, health insurance affordability, and prescription drug spending and transparency.

The discussion also covered major policy developments that may affect health care affordability. Federal changes under H.R. 1 are expected to increase the number of people without health insurance, uncompensated care, paperwork, and financial pressure on Minnesota providers. The Rural Health Transformation Program will support limited investments in rural technology, chronic disease care, and workforce development, but it will not replace ongoing Medicaid funding losses. Julie also noted that upcoming studies from MDH on low-value care and administrative health care spending may inform future task force work.

Members were introduced to the two proposed working group areas of interest: High and Variable Commercial Health Care Prices and Investor Ownership and Influence in Health Care. Members asked why these topics were selected when federal Medicaid changes may have more immediate effects. MDH explained that the topics could affect many Minnesotans, involve state policy tools, and provide an opportunity for the Center to play a distinct role and make progress in the near term. The Department of Human Services oversees the State's

Medicaid program and is responsible for implementing provisions required under H.R. 1. Other HCAATF priorities remain under consideration for future work.

Julie then outlined additional details related to the working group structure. The working groups will study a focused issue in greater depth, hear from experts, review policy options, and recommend an approach to the HCAATF with input from the PPATF. Participation is encouraged but not required. Each group is expected to include about 10 to 15 core members, meet in a public hybrid format, and report back to both task forces.

Following the discussion of the policy environment and overall working group structure, Task Force members participated in small group discussions focused on each of the proposed working groups. The small groups were asked to identify questions about each working group's scope and objectives, components of the draft scopes that should be added, modified, or excluded, and additional information they would like MDH to provide to the working groups to support their discussions.

Working Group 1: High and Variable Commercial Health Care Prices

The proposed working group will examine commercial prices paid by private health plans and consider policies that could address high prices, rapid price growth, or price differences that are not explained by quality or other clear factors. MDH will provide Minnesota-specific price information, comparisons with Medicare and other benchmarks, and evidence on approaches used in other states.

During the small group report-out, members said the working group should clearly define what is meant by price and decide whether to focus on price levels, price growth, price variation, or a narrower set of services. They asked that the working group also examine why prices differ, including market power, geography, care setting, ownership, billing practices, labor and supply costs, uncompensated care, and other financial pressures.

Members emphasized that any policy should be evaluated for its potential effect on total spending, access to care, provider financial stability, especially in rural and underserved communities. They requested information and evidence on the impacts of reference pricing, price-growth limits, same-service/same-price policies, and facility fee rules, including unintended effects. Members were also interested in policies and protections used in other states. Members encouraged MDH to consider patient and employer needs, coordinate with the investor ownership working group where topics overlap and involve state partners such as the Department of Commerce.

Working Group 2: Investor Ownership and Influence in Health Care

The proposed working group will examine affordability concerns related to investor ownership and influence, identify gaps in Minnesota's ability to track ownership and control, and consider policies that could prevent or address harmful market conduct and outcomes. MDH will describe relevant arrangements, their presence in Minnesota and nationally, current reporting requirements, and approaches used in other states.

During the small group report-out, members asked for a clear definition of which types of ownership, management, and contracting arrangements are in scope and what level of control or influence should receive attention. They said Minnesota needs a better picture of where these arrangements are present, which parts of the health care system are most affected, and

what information state agencies already collect. Members are particularly concerned about ownership arrangements and market conduct that results in significant resources being extracted from Minnesota's healthcare system.

Members recommended examining why clinicians and organizations seek outside investment and how these arrangements affect prices, access, quality, staffing, clinical decision-making, and patient experience over time. They asked MDH to consider both possible harms and benefits, including whether investment preserves access to services or supports innovation. Members also highlighted links to market consolidation and requested information on agency roles and other states' policies for disclosure, transaction review, ongoing monitoring, and accountability.

Initial Discussion of Health Care Affordability Standards

Alex Caldwell introduced the Center's plan to convene an Affordability Standards Technical Panel while the working groups are underway. Possible standards could include a limit on how quickly total health care spending should grow each year and a measure of affordability from a household spending perspective. The HCAATF will discuss initial ideas in October before the technical panel meets later in the fall.

Members generally supported developing affordability standards as a way to create common definitions, guide policy analysis, and help policymakers and the public judge progress. They said the standards should at least initially be used as planning and public accountability tools rather than strict regulatory limits. Members asked for examples of how other states use these standards and how the Center would apply them when reviewing policy options. Some members also suggested setting minimum investment goals for high-value services such as primary care, rather than focusing only on limits for total spending.

Members said household affordability measures should reflect differences in income and family needs. They emphasized keeping patients and consumers at the center of the work and considering access, quality, health outcomes, and value along with spending.

Closing and Next Steps

MDH will revise the working group scopes based on member feedback and survey members about their preferred group, relevant experience, interest, and availability. MDH and the task force co-chairs will use the responses to create groups with a balanced range of perspectives.

The High and Variable Commercial Health Care Prices working group is scheduled to begin on September 11, 2026. The Investor Ownership and Influence in Health Care working group is scheduled to begin on September 24, 2026. Both groups are expected to meet three times during the fall and report back to both task forces at a joint meeting in January 2027. The HCAATF will also meet in October to discuss affordability standards.

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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