Commercial Healthcare Prices Working Group

September 11, 2026

Today's Objectives

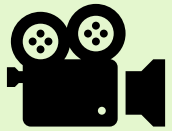
- Present the updated scope of work for the commercial healthcare prices working group
- Review available evidence on hospital price variation, levels, and growth as reflected in work by the Health Economics Program (HEP) and other publicly available sources
- Discuss the factors that drive price variation, high prices, and price growth
- Highlight state policies aimed at addressing price variation, high prices, and price growth

Today's Agenda

- Working Group Objectives and Roadmap – CHCA
- Healthcare Spending in Minnesota – MDH Health Economics Program
- Narrowing the Scope: Hospital Prices – Mathematica
- Hospital Prices – What We Already Know – Mathematica
- Break
- What Drives High and Variable Commercial Hospital Prices – Mathematica
- State Policies – Mathematica
- Closing and Next Steps – CHCA

Housekeeping

- Slides will be available on the Center's website
- Bathrooms are outside the room at the end of the hallway
- Please remain on mute when not speaking
- Tech problems? Please try logging back in, or email Health.Affordability@state.mn.us.



This meeting is being recorded.

Closed captioning is available.

What Do We Mean By “Prices”?

- Price is the amount paid to healthcare providers per unit of service
- Price is distinct from:
  - Cost (the amount of resources it takes to produce a unit of service)
  - Charges (the list prices of services)
  - Spending/expenditures (price times quantity)

Working Group Objectives

- Develop a shared understanding of significant commercial healthcare price issues related to hospital inpatient and outpatient services in Minnesota
- Identify a set of policy approaches that address high and/or variable hospital prices paid by commercial health plans
- Propose a set of policy options and a recommended policy approach to the Health Care Affordability Advisory Task Force (HCAATF)
  - Policy options could focus on price ***levels***, price ***growth,*** price ***variation***, or a combination of these issues

Working Group Roadmap

- Today:
  - Review data on healthcare spending and prices, and factors that influence prices
  - Review how other states have addressed commercial healthcare prices and what we know about impacts of these policies
  - Identify areas for deeper dive
- **Meeting #2 (October 27):** Present additional data and information on areas of focus, begin to identify potential policy approaches
- **Meeting #3 (December 2):** Evaluate policy options and recommend approaches for consideration to the Health Care Affordability Advisory Task Force (HCAATF)

Questions for Discussion

- What questions do you have about the working group objectives and roadmap?

Introductions

Alex Caldwell | Director, Center for Health Care Affordability

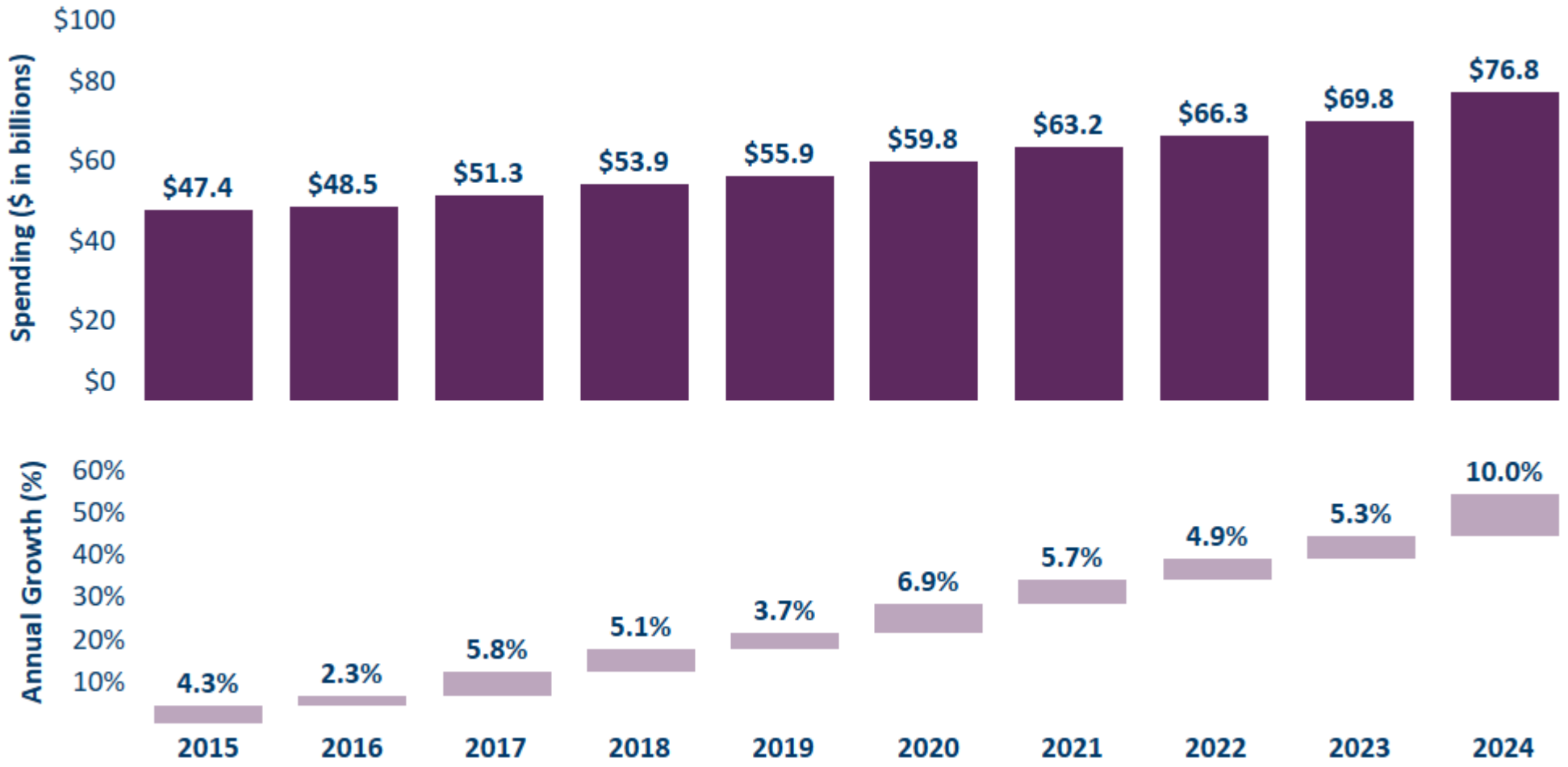
Introductions

- We will go around to each person in the room and you will have a minute to share:
  1. Your name
  2. What task force you are on

Healthcare Spending in Minnesota

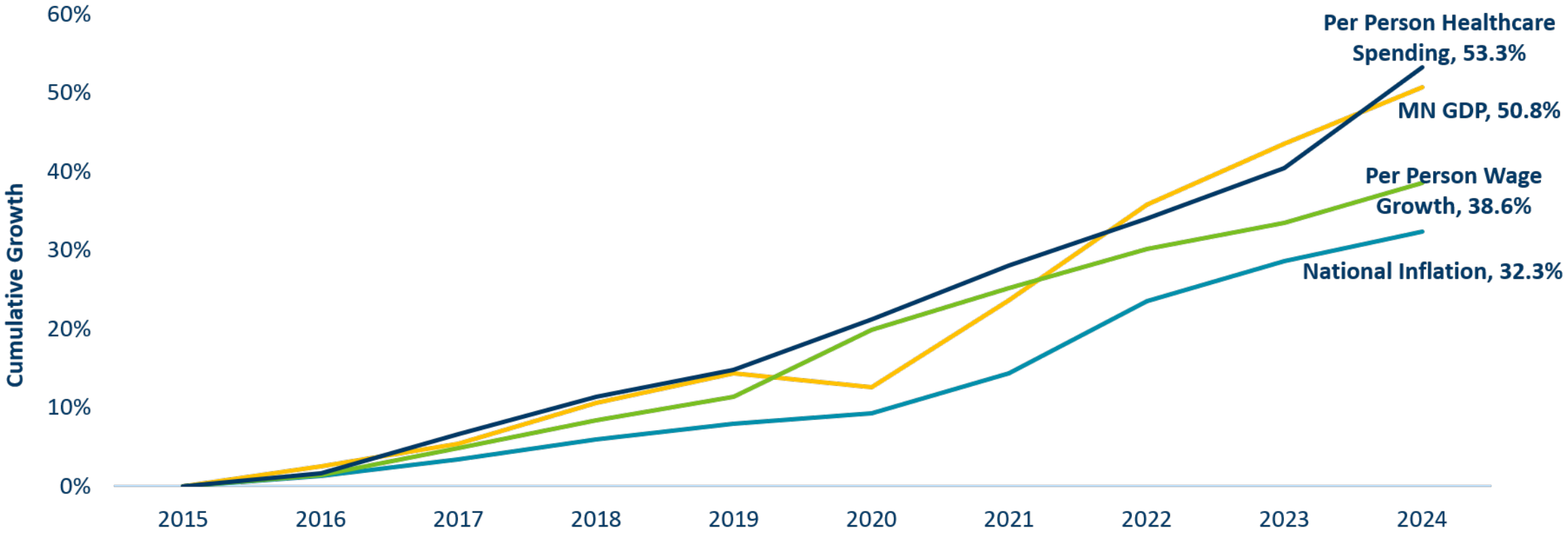
Stefan Gildemeister | Director, Health Economics Program

Estimates of MN Healthcare Spending, 2024



Source: MDH Health Economics Program, preliminary 2024 healthcare spending estimates. Healthcare spending is Minnesota spending (private and public payers); it does include enrollee out-of-pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance. Estimates include private long-term care spending. Revisions to historical time series may lead to slight variation from previously published estimates.

Cumulative Growth in Key Minnesota Healthcare Cost and Economic Indicators



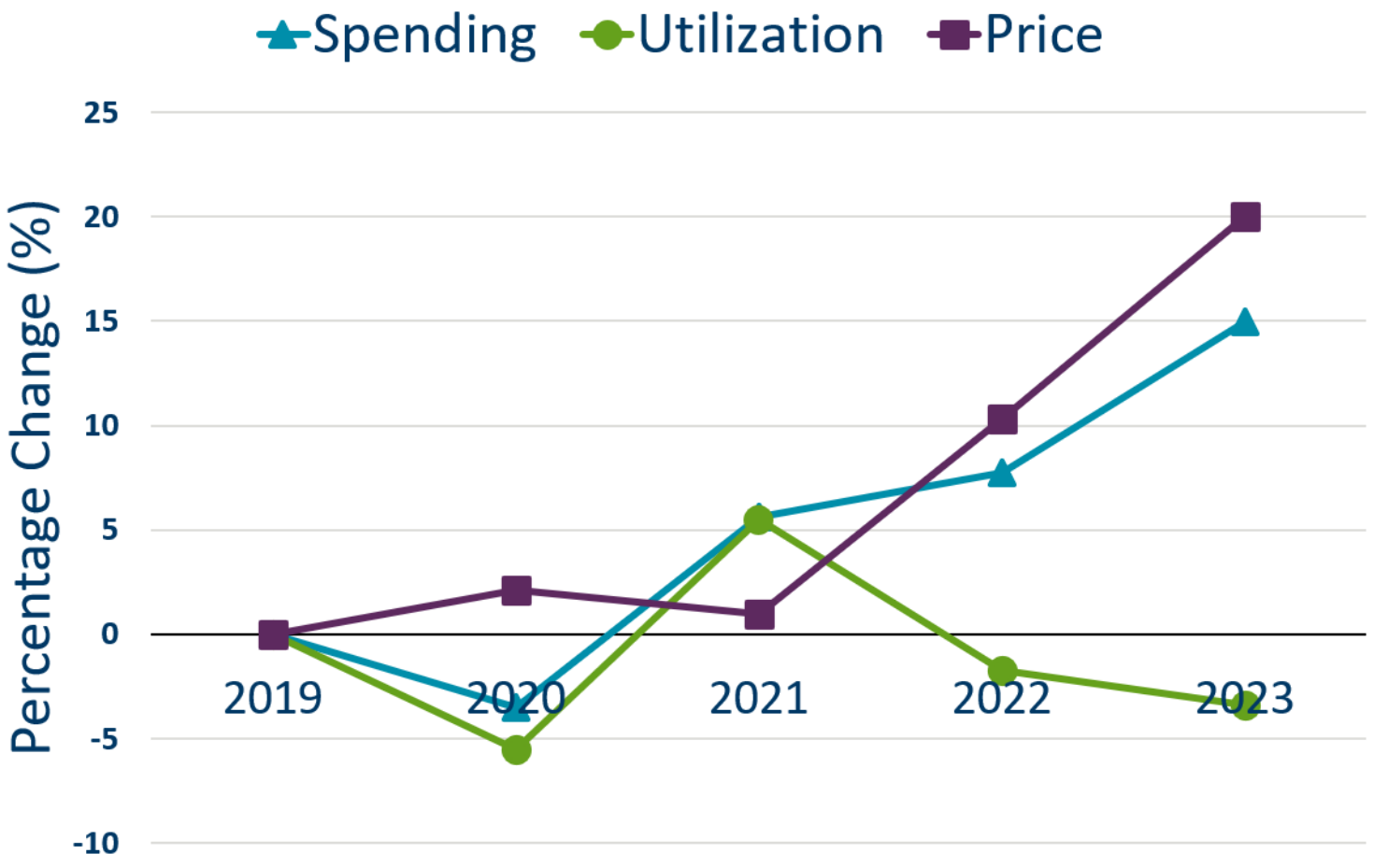
Healthcare spending is Minnesota spending per person (private and public payers); it does include enrollee out-of-pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.

Sources: MDH Health Economics Program, preliminary 2024 healthcare spending estimates; 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), accessed July 2026; per person wage growth from Minnesota Department of Employment and Economic Development as of May 2026.

Cumulative Growth in Healthcare Spending, Prices, and Utilization, 2019 to 2023 (Commercial)

Key Takeaways:

- Annual estimated per-person healthcare **spending** grew 15.0% from 2019 to 2023.
- **Prices** grew 20.0%, and **utilization** declined slightly (-3.4%)
- Despite COVID-19 disruptions, **price** growth remains biggest driver of commercial healthcare spending growth.



Source: Health Economics Program analysis of data from the Minnesota All Payer Claims Database, Extract 27.
Health Care Spending, Cost, and Use in Minnesota: 2019-2023, September 2025

Changes in Spending, Prices, and Utilization, 2019 to 2023, by Service Category (Commercial)

	2019 to 2023 Change				
	Total	Inpatient	Outpatient	Professional	Retail Rx
Spending	15.0%	2.6%	17.0%	10.5%	34.5%
Utilization	-3.4%	-16.2%	6.9%	-4.3%	-4.6%
Prices	20.0%	22.5%	9.5%	15.5%	41.0%

Source: Health Economics Program analysis of data from the Minnesota All Payer Claims Database, Extract 27.

From 2019 to 2023:

- **Inpatient (facility)** spending remained flat despite a substantial decrease in utilization, due to an increase in unit prices (*not adjusted for service mix*).
- **Outpatient (facility)** and **professional** spending and prices increased. **Outpatient** utilization increased, whereas **professional** utilization decreased slightly.
- **Retail prescription drug** spending increased considerably, driven by consistently and substantially increasing prices while utilization remained flat.

Narrowing the Scope: Hospital Prices

Julie Sonier| Mathematica

Why Are We Focusing on Hospital Prices?

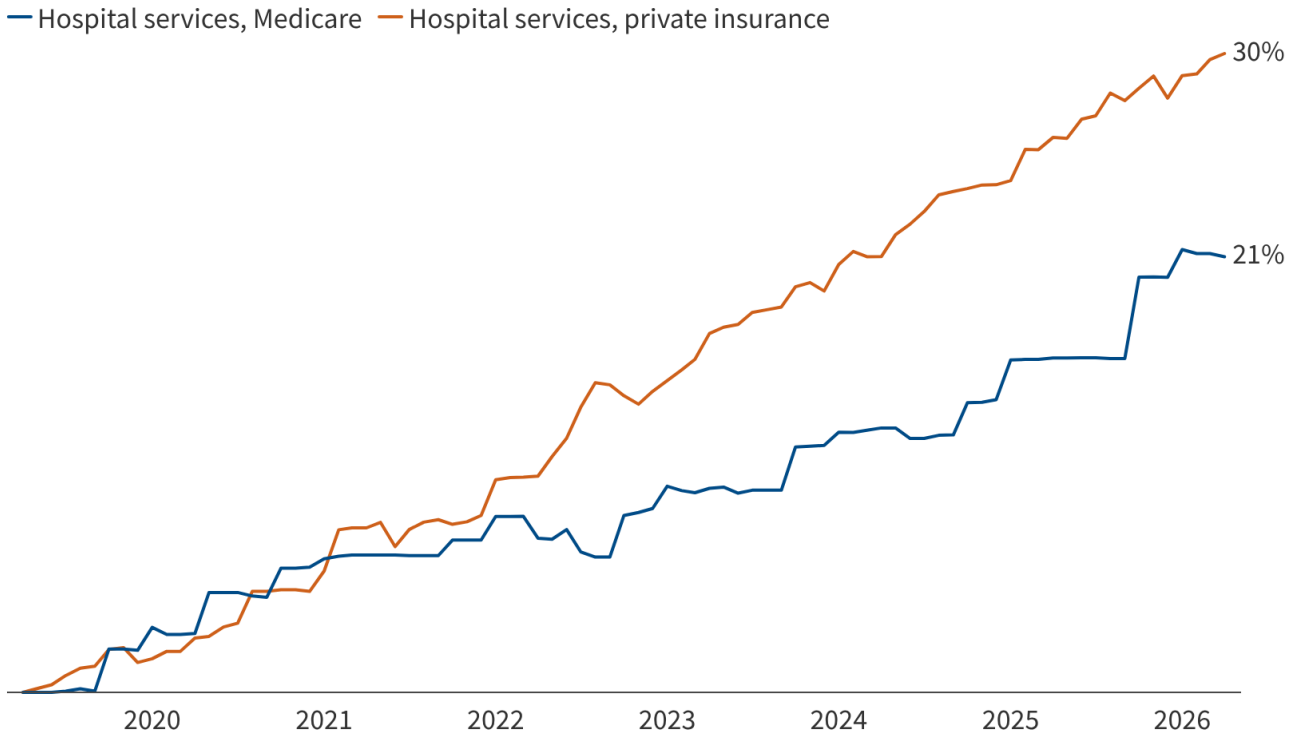
- Nationally, the gap between commercial and Medicare hospital prices is wide and that gap is growing
- Hospitals are the largest category of healthcare spending in Minnesota, so focusing here can affect overall affordability
- Among the major categories of spending, hospital prices have been growing the fastest
- Higher hospital prices are not associated with higher quality

Hospital Prices Are Rising Faster in Commercial Insurance than in Medicare

Figure 1

Hospital Prices Have Risen Much Faster for Private Insurance Than Medicare Since 2019

Hospital prices rose by 30% for private insurers versus 21% for Medicare from April 2019 to April 2026



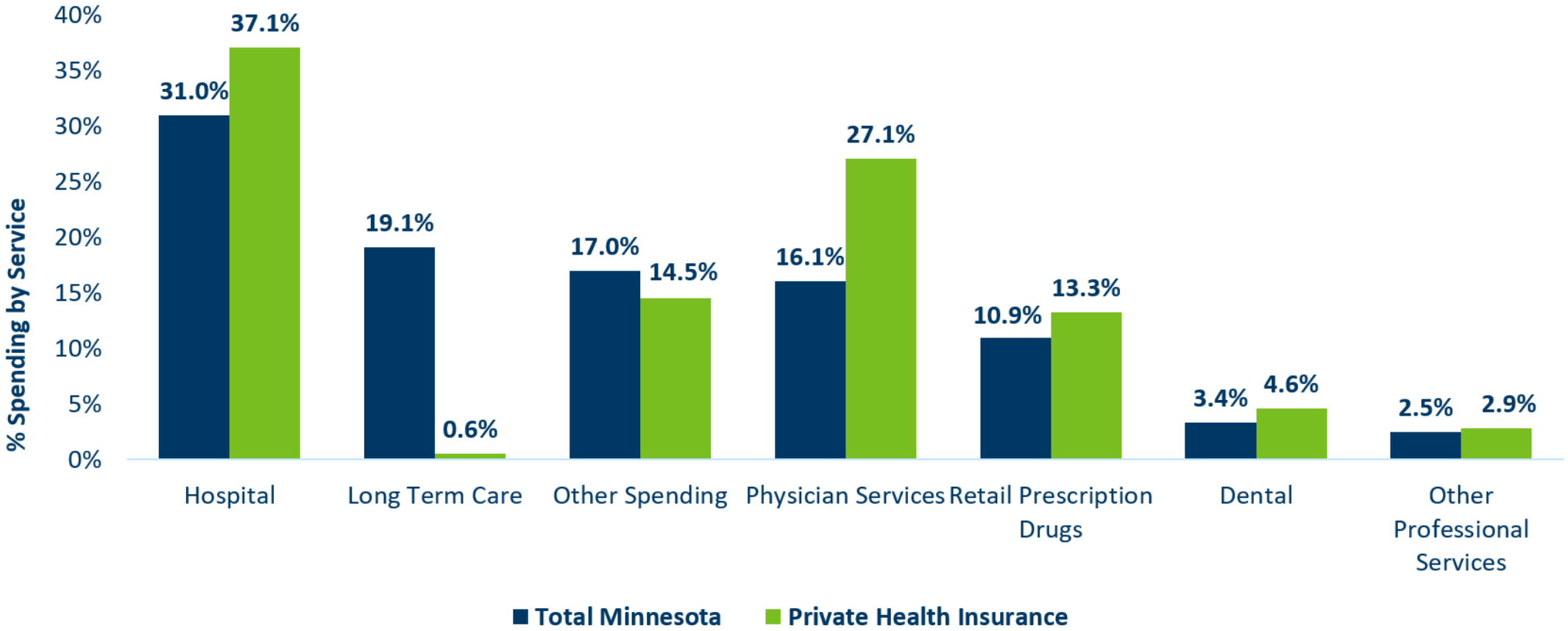
Note: Cumulative percent change in the Producer Price Index (PPI). Hospital indices are for care at general medical and surgical hospitals. Data are not seasonally adjusted. Data for January 2026 to April 2026 are preliminary and subject to revision.

Source: KFF analysis of Bureau of Labor Statistics (BLS) PPI data, 2019-2026 • Get the data

KFF

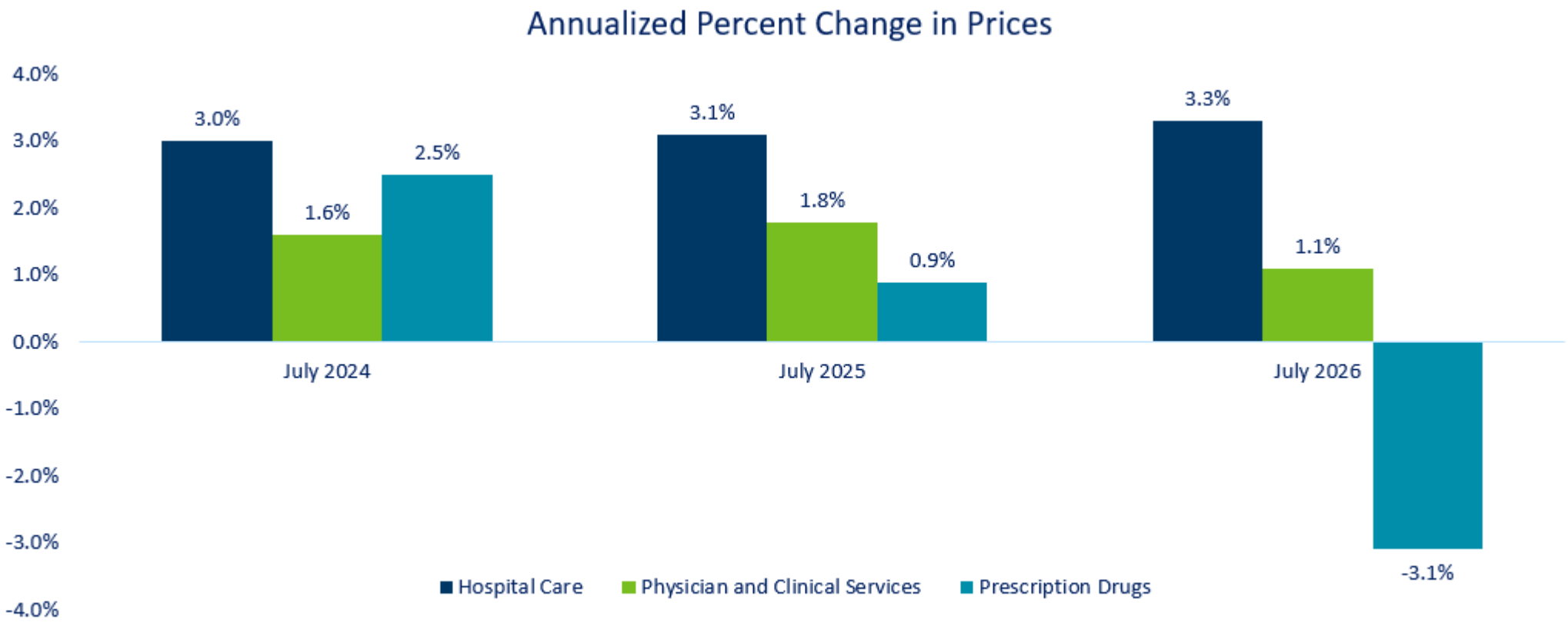
Reference: KFF

Hospital Services Are the Largest Share of Healthcare Spending in Minnesota



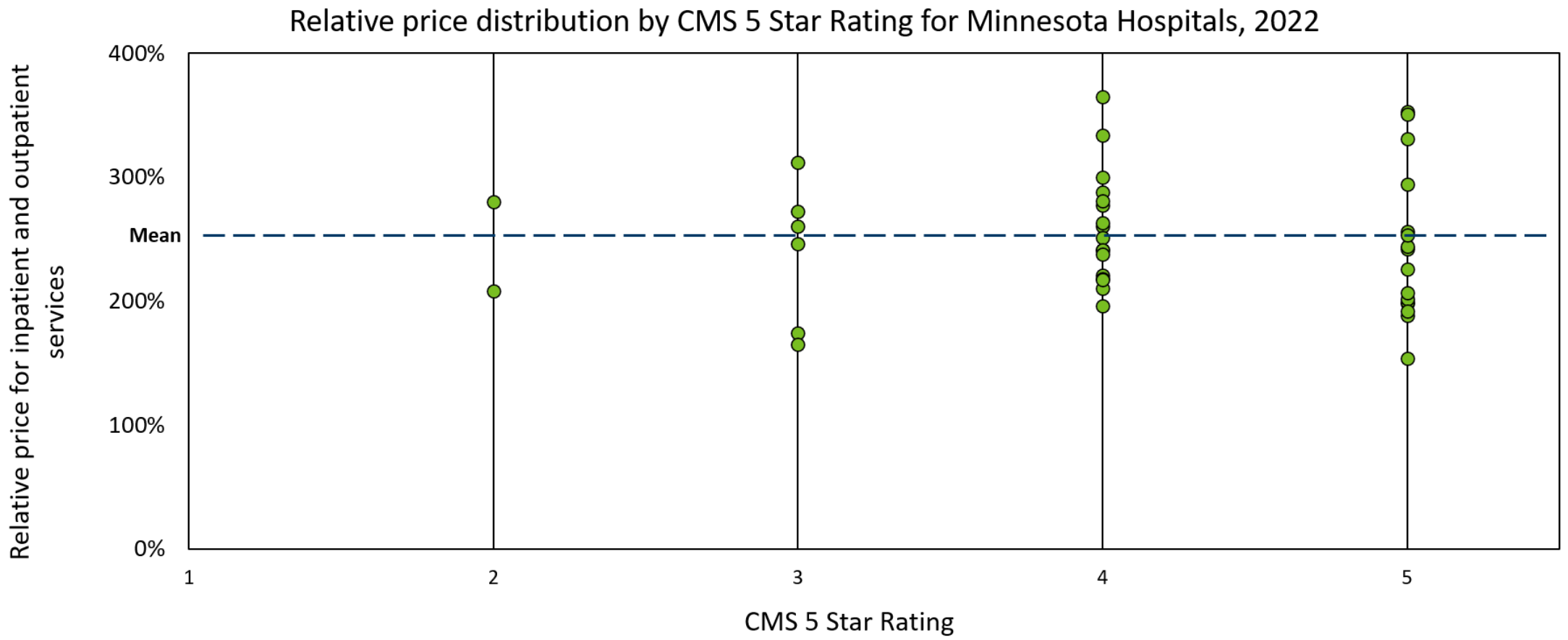
Source: MDH Health Economics Program, preliminary 2024 healthcare spending estimates. Total Minnesota healthcare spending is Minnesota spending (private and public payers); it does include enrollee out-of-pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance. Private Health Insurance is just commercial health care spending and does NOT include enrollee out-of-pocket spending for deductibles, copayments/coinsurance, and services not covered by insurance.
Long-term care includes home health care services. Other spending includes chemical dependency/mental health, durable medical, health plan administrative expenses and revenues in excess of expenses, public health spending, correctional facility health spending, Indian Health Services, not itemized spending, and uncategorized spending.
Other professional services includes services provided by health practitioners who are not physicians or dentists.
Revisions to historical time series may lead to slight variation from previously published estimates.

Hospital Prices Have Been Growing Faster Than Other Major Categories of Spending



Source: Altarum Health Sector Economic Indicators, August 2026 Price Brief. Based on data from the U.S. Bureau of Labor Statistics for the 12-month periods ending in July 2024, July 2025, and July 2026 respectively.

Minnesota Displays a Lack of Association Between Price and Quality



Source: Whaley et al., 2022

Why Are We Focusing on Hospital Prices? Other Considerations

Other considerations:

- Data availability – data on hospital prices in Minnesota are readily available and reliable
- Other states have also focused on commercial hospital prices, so we have an opportunity to review what they have done and what the impacts have been

Questions for Discussion 1

- What questions or concerns do you have about focusing the working group's discussion on hospital prices?

Hospital Prices – What We Already Know

Julie Sonier| Mathematica

RAND Hospital Transparency Study

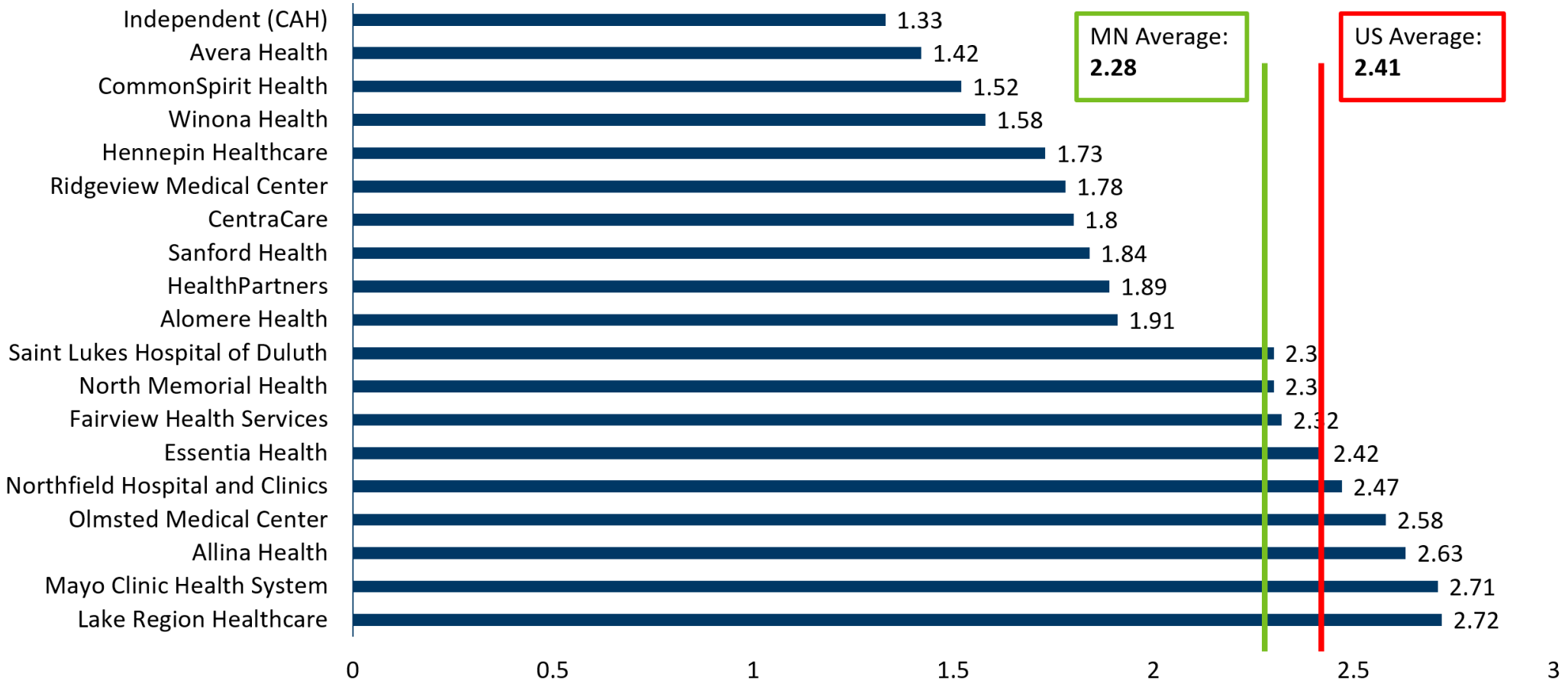
- RAND used claims data from employers and health plans to compare **commercial payments for hospital services across hospitals and markets**. The analysis provides two complementary measures:
  - **Standardized prices** show the actual average amount paid for a standardized unit of hospital care, allowing comparisons across hospitals that adjust for differences in the mix and utilization of services.
  - **Relative prices** express commercial payments as a percentage of what Medicare would have paid a specific hospital for the same services, providing a benchmark that accounts for differences in services and hospital-specific Medicare payment rates.
- **Why both matter:** Standardized prices show the **dollar variation in commercial prices across hospitals**, while relative prices show **how commercial payment levels compare with a consistent benchmark**. Together, they help distinguish where care is expensive in absolute dollars from where commercial insurers pay particularly high rates relative to Medicare.

RAND Analysis

- Inpatient facility, outpatient facility, and professional services provided as part of hospital care
- Hospital and health system comparisons
- State comparisons

Average Commercial Prices Relative to Medicare for Hospital Inpatient Services in Minnesota, 2022

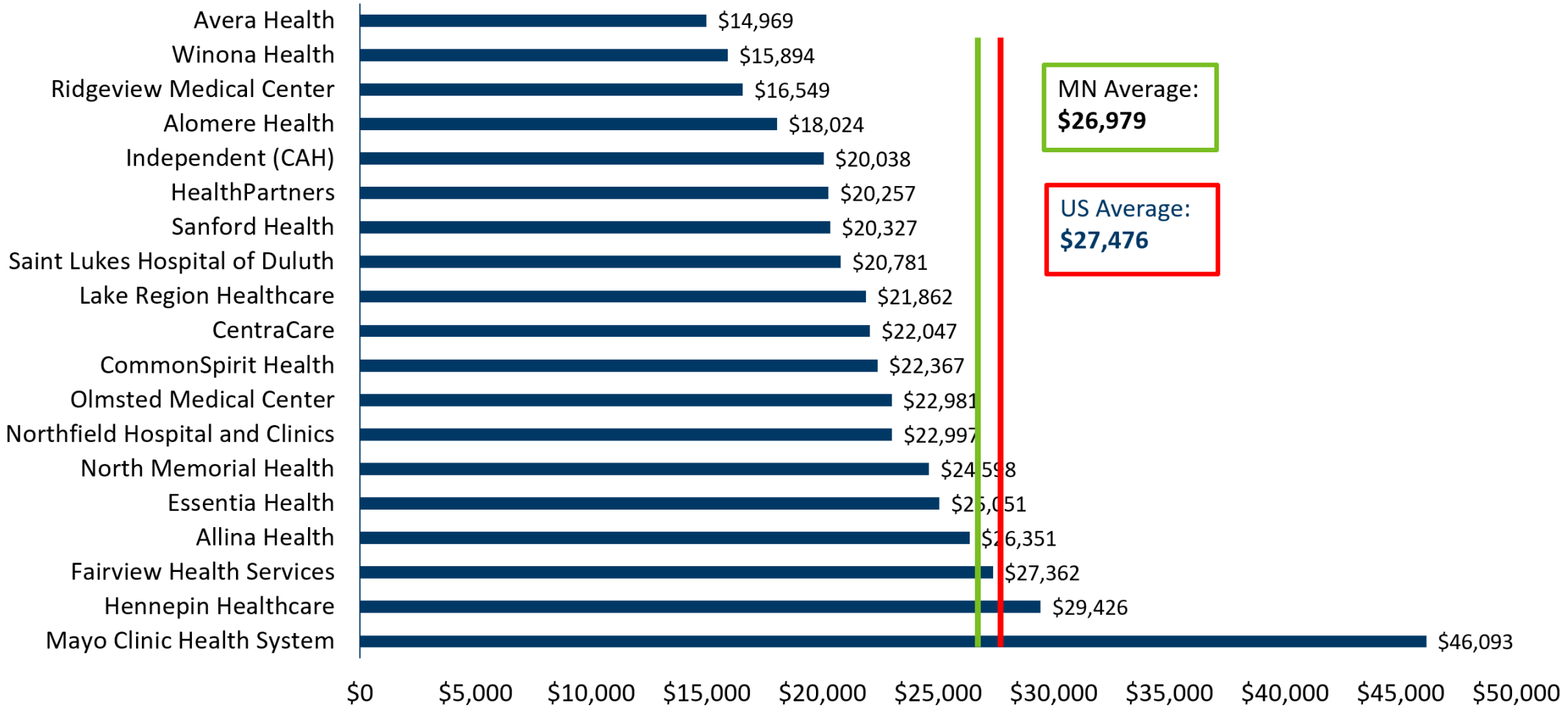
Six Minnesota health systems are paid prices that are greater than 2.41 times what Medicare pays



Source: Whaley et al., 2022

Average Commercial Standardized Prices* for Hospital Inpatient Services in Minnesota, 2022

Standardized prices for Minnesota health systems range from $15k to $46k per inpatient stay

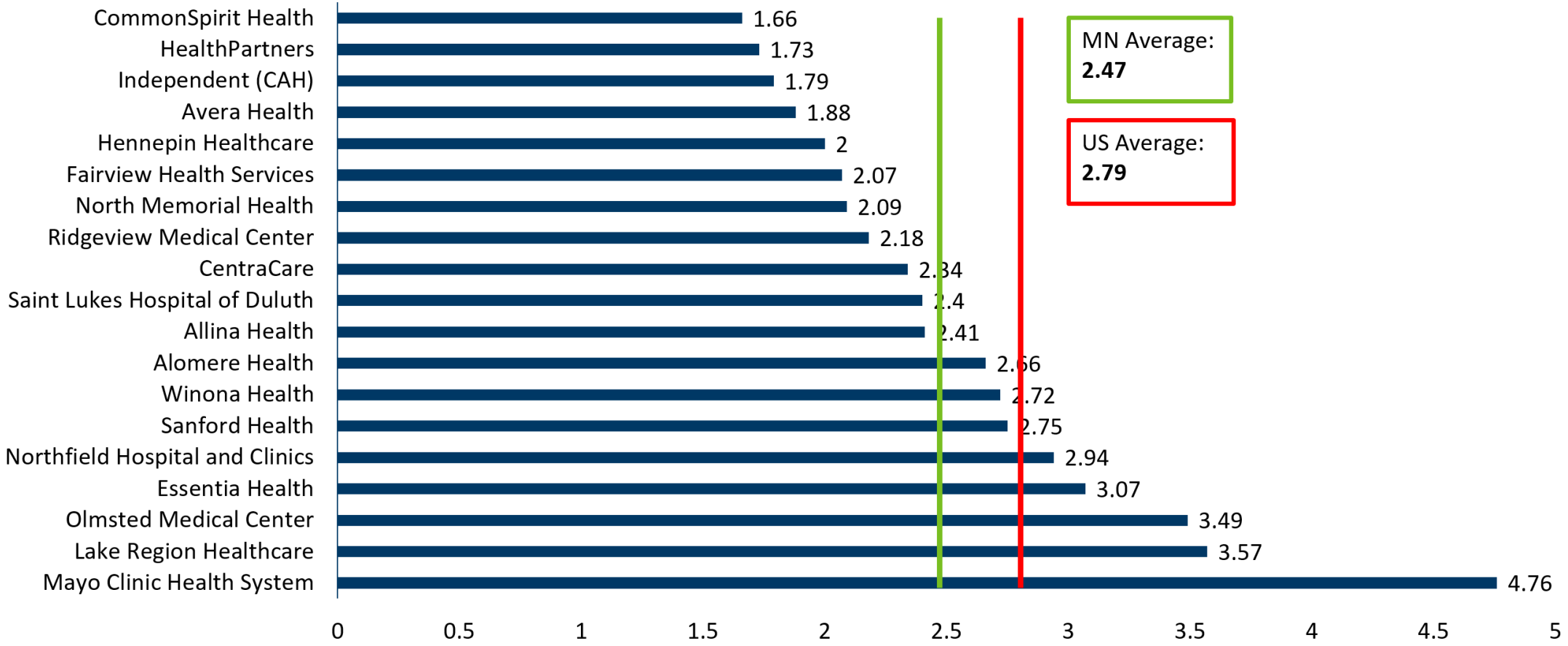


Source: Whaley et al., 2022

*standardized prices per unit of services, adjusted for case mix using Medicare relative weights

Average Commercial Prices Relative to Medicare for Hospital Outpatient Services in Minnesota, 2022

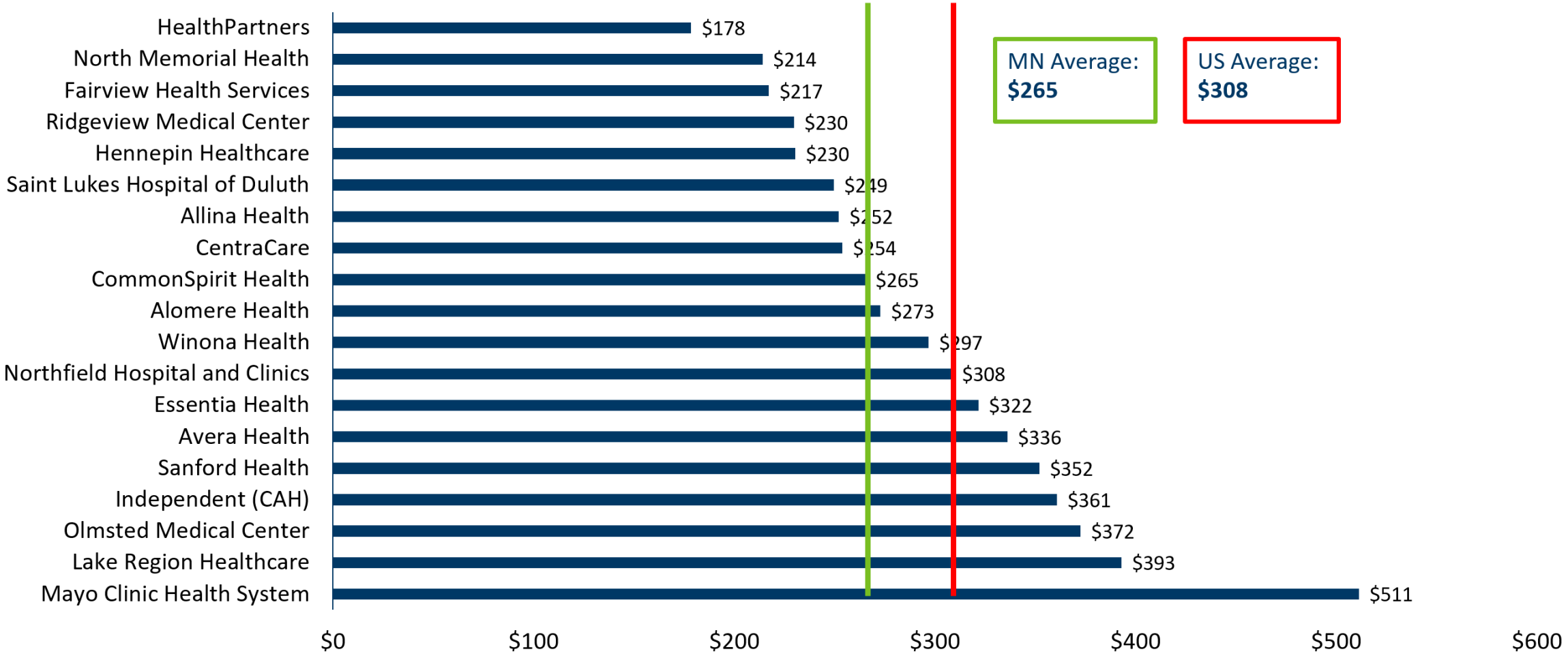
Five Minnesota health systems are paid prices that are greater than 2.79 times what Medicare pays



Source: Whaley et al., 2022

Average Commercial Standardized Prices* for Hospital Outpatient Services in Minnesota, 2022

Standardized prices for Minnesota health systems range from $178 to $511 per outpatient service

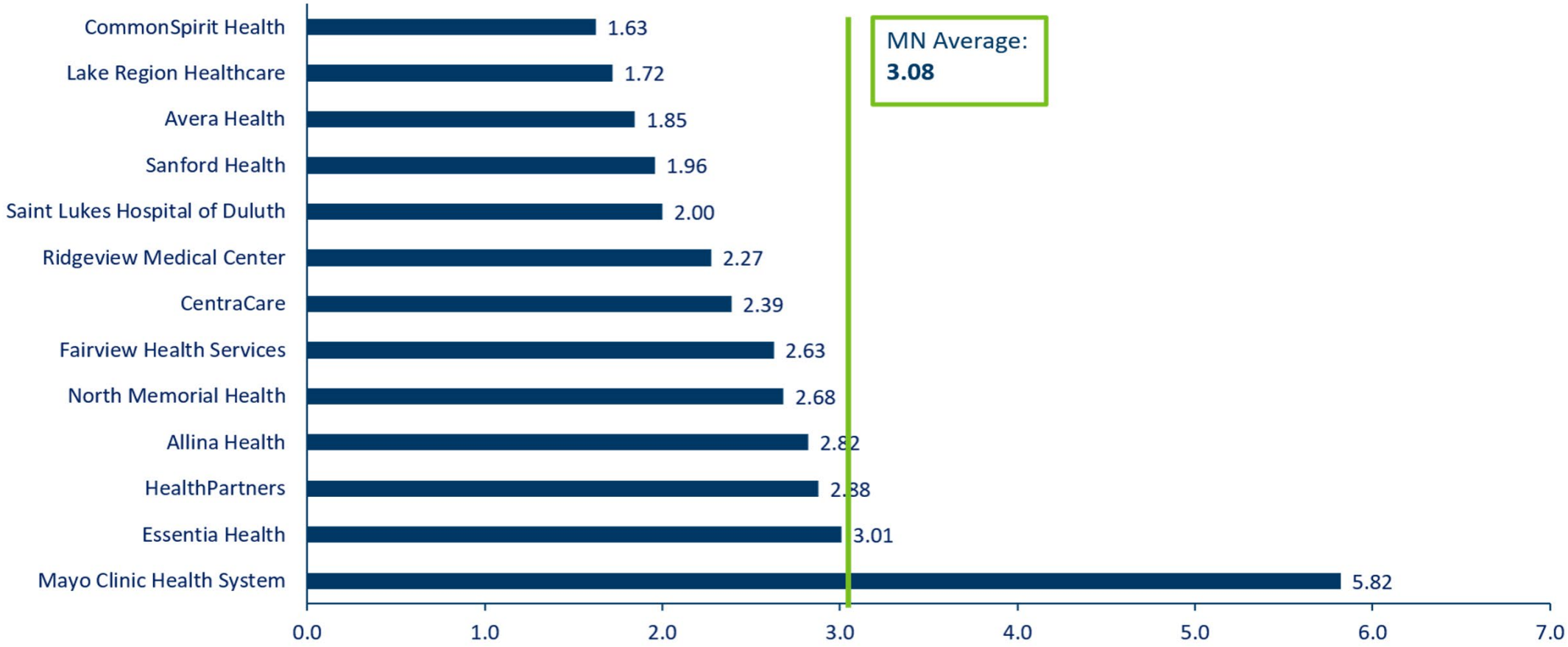


Source: Whaley et al., 2022

*standardized prices per unit of services, adjusted for case mix using Medicare relative weights

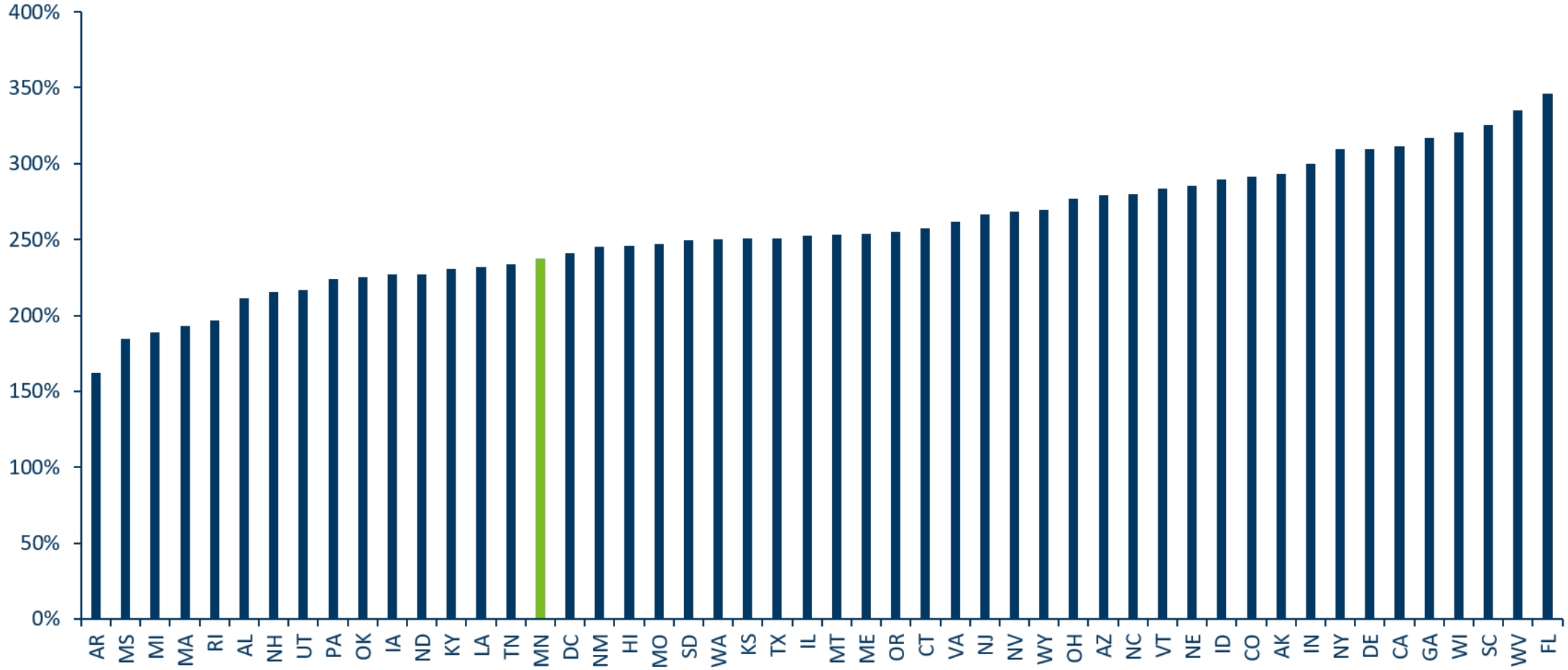
Average Commercial Prices Relative to Medicare for Hospital Professional Services in Minnesota, 2022

Minnesota health systems are paid prices that range from 1.63 to 5.82 times what Medicare pays for physician services



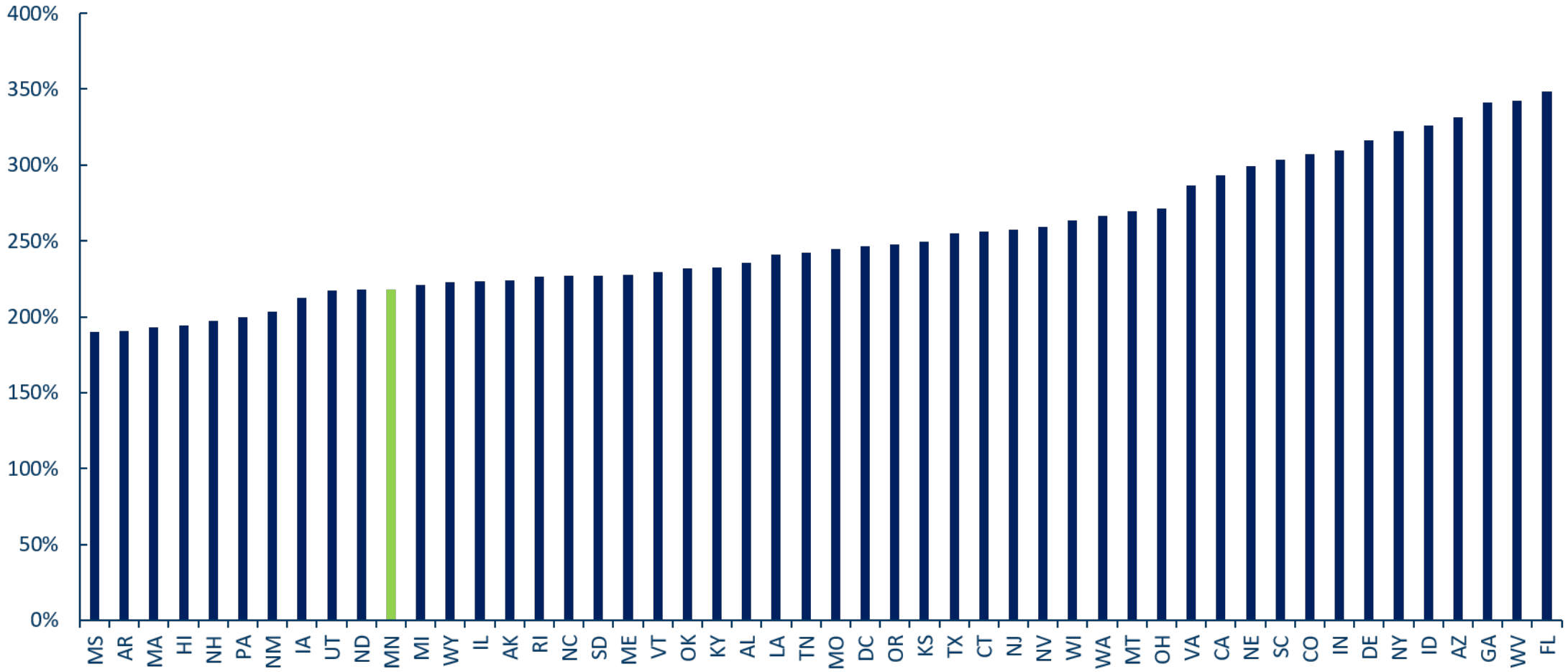
Source: Whaley et al., 2022

State Comparison: Commercial Hospital Prices Relative to Medicare, 2022



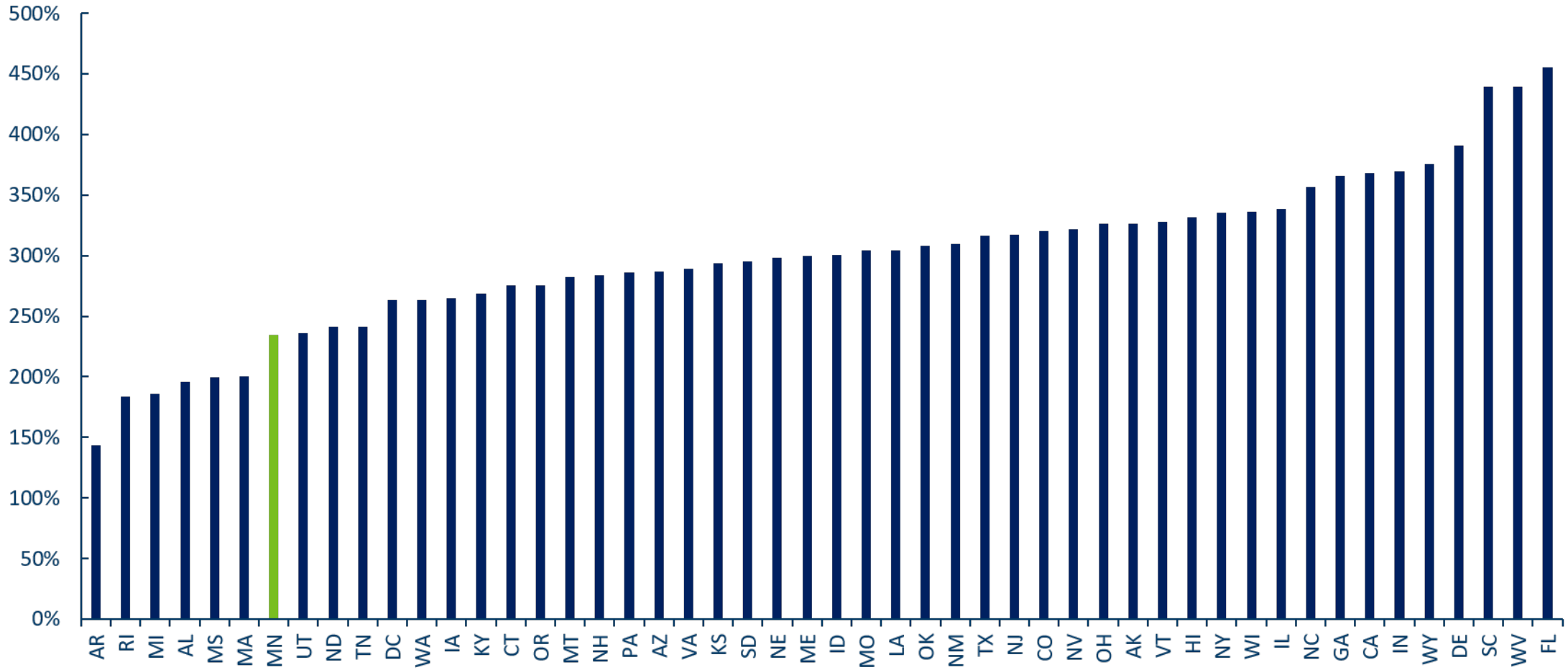
Source: Whaley et al., 2022

State comparison: Commercial Inpatient Facility Prices Relative to Medicare, 2022



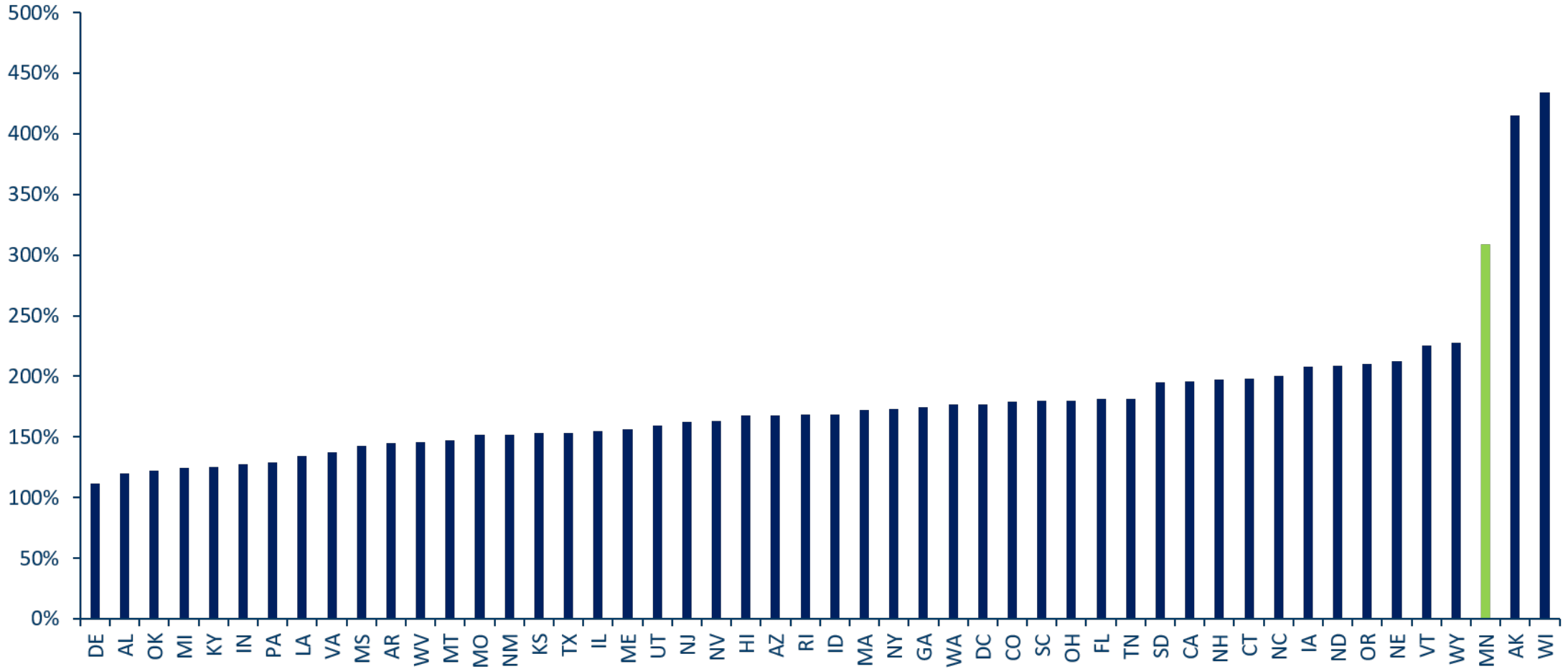
Source: Whaley et al., 2022

State Comparison: Commercial Outpatient Facility Prices Relative to Medicare, 2022



Source: Whaley et al., 2022

State Comparison: Commercial Hospital Professional Services Prices Relative to Medicare, 2022



Source: Whaley et al., 2022

Takeaways from RAND Price Study

- Within Minnesota, there is **wide variation** across health systems: the highest priced systems are two to three times more expensive than the lowest-priced systems
- Relative and standardized prices **vary widely** across state for inpatient facility, outpatient facility, and hospital professional services
- Compared to other states, Minnesota ranks 40th for inpatient facility, 44th for outpatient facility, and 3rd for hospital professional services relative prices

Price Variation: Commercial Case Price*
Example 1: Total Knee Replacement

An analysis of price variation **statewide**, **among different hospitals**, and **within the same hospital** finds the following variation for a knee replacement:

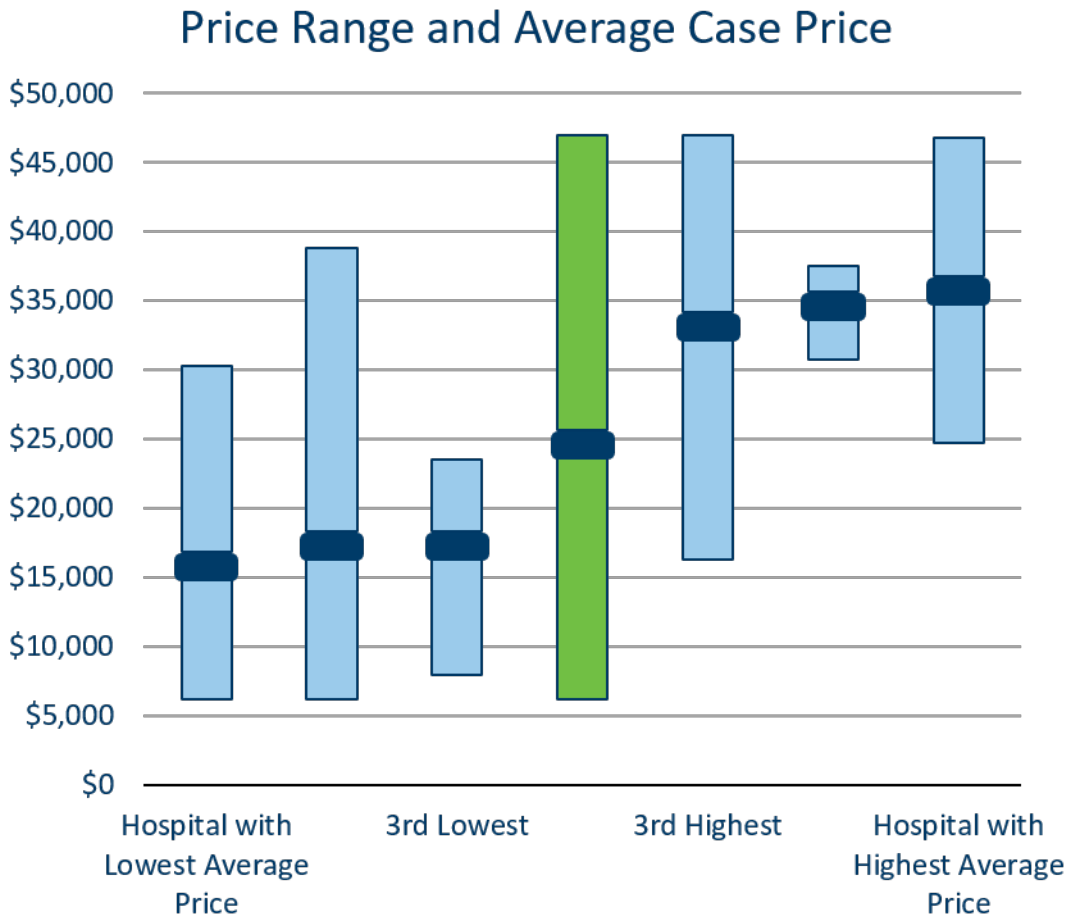
Statewide average price: $23,997

Statewide range of ≈$40,000 between highest and lowest price episodes

Considerable variation within hospitals

At most expensive hospital:

- **Hospital's average price: $35,171**
  - $19,957 (130%) higher than lowest average price hospital ($15,214).
- Price range: $24,618 to $46,732.



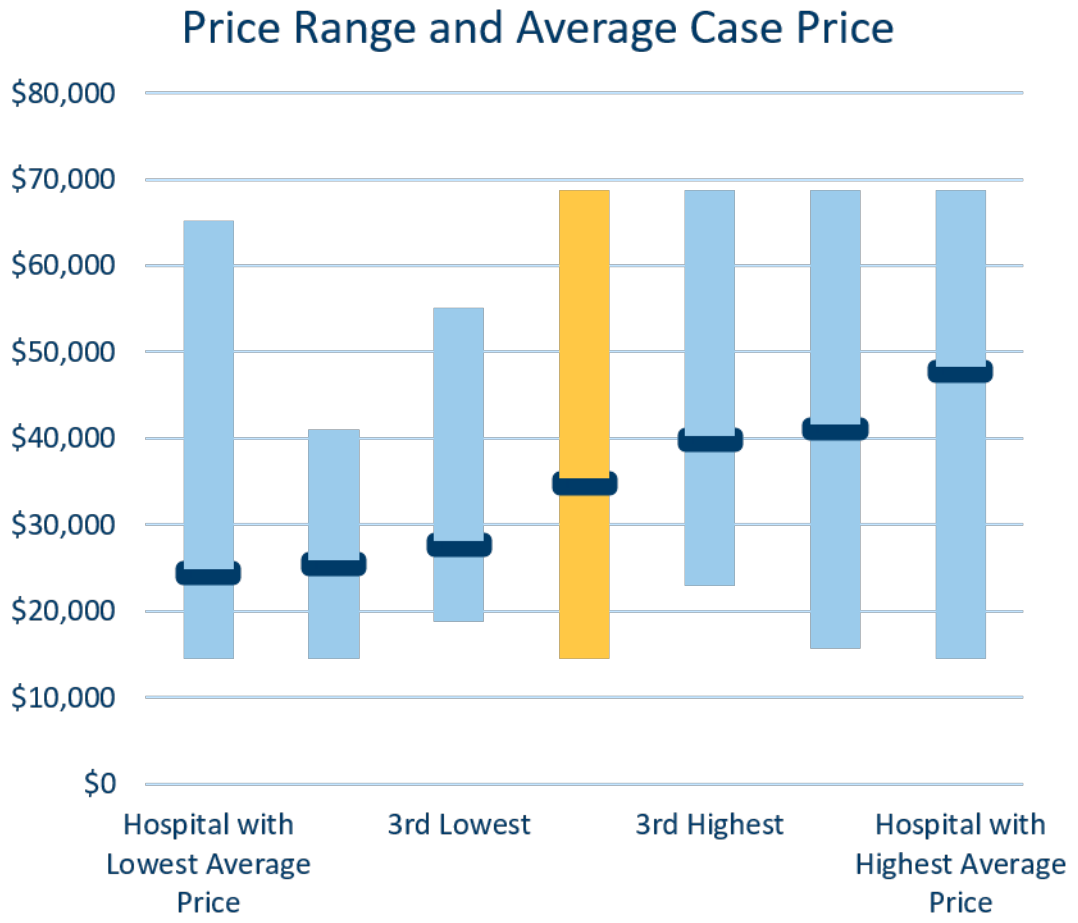
**Estimated prices include facility fees (professional fees not included).*

Source: Minnesota Health Economics Program analysis of Minnesota All Payer Claims Database. Commercial Case Price Variation Report.
Notes: Study Period: July 2014 to June 2015. Prices were estimated based on facility costs only. Restricted to minor or moderate severity (DRG SOI 1 or 2)
High or low outlier prices assigned prices at the 97.5 or 2.5 percentile, respectively. Hospitals with low case counts were excluded.

MN APCD
All Payer Claims Database

Price Variation: Commercial Case Price*
Example 2: Major Bowel Procedures

- The average case price at the most expensive hospital was $47,276
  - This is 2.0 times or $23,363 higher than the lowest average price hospital ($23,913)
  - Statewide, case prices varied by more than $54,000
  - There was considerable variation within each hospital



Estimated prices include facility **and professional fees.*

Source: Minnesota Health Economics Program analysis of Minnesota All Payer Claims Database. Commercial Case Price Report (Part 2) - June 2014-June 2015
Notes: Study Period: July 2014 to June 2015. Prices were estimated based on facility costs only. Restricted to minor or moderate severity (DRG SOI 1 or 2) High or low outlier prices assigned prices at the 97.5 or 2.5 percentile, respectively. Hospitals with low case counts were excluded.

MN APCD
All Payer Claims Database

Other Potential Data Sources for Insights on Prices

- Price transparency: federal rules require hospitals and health plans to publish data on negotiated prices
  - Hospital data: rates paid by all payers, hospital services only
  - Health plan data: rates paid by commercial payers only, all services
- In practice, both the hospital and health plan price transparency data sets are very large and difficult to use

Questions for Discussion 4

- What questions does the group have about the existing analysis of hospital prices?

Break

What Drives High and Variable Commercial Hospital Prices?

Julie Sonier| Mathematica

High Commercial Hospital Prices and Price Growth Reflect Both Rising Input Costs and Market Dynamics

- **Hospital operating costs:** Labor, supplies, technology, capital, and administrative expenses contribute to hospital costs and can create pressure for higher commercial prices
- **Provider market power:** Hospitals that are difficult for insurers to exclude from networks can negotiate higher prices and larger increases over time than hospitals with less bargaining leverage. Hospital mergers and greater market concentration can strengthen provider bargaining power and are generally associated with higher commercial prices, particularly in already concentrated markets
- **Limited constraints on negotiated prices:** Unlike Medicare rates, commercial prices are negotiated and generally lack administratively established limits on price levels or annual growth

References: CBO, 2022; Whaley et al., 2024

Large Price Differences May Reflect Market Leverage Rather Than Differences in Costs or Quality

- **Some variation reflects differences in input cost:** Labor and other operating costs, patient complexity, service mix, quality, and hospital characteristics can affect prices
- **Cost structures also vary:** Administrative spending, executive compensation, capital investments, and other expenses differ across hospitals, although higher spending does not necessarily mean higher costs are required to deliver comparable care
- **Market leverage matters:** Large commercial price differences that remain after accounting for costs and other characteristics can reflect differences in hospitals' bargaining power as opposed to an indication of the quality of care
- **Public payment gaps do not fully explain commercial prices:** Medicare and Medicaid payments may be below hospital costs in some circumstances, and limited cost shifting can occur, but evidence indicates that differences in commercial prices are driven more strongly by market structure and bargaining leverage than by public-payer exposure alone

References: CBO, 2022; Whaley et al., 2024

Questions for Discussion 2

- What questions does the group have about the reasons for high and variable commercial hospital prices?
- What context will be important to consider as we move forward?

State Policy Scan

Julie Sonier| Mathematica

State Policy Scan: Current Questions

- What problem is addressed?
  - Price levels, price growth, or price variation?
- What is the policy approach?
- What evidence do we have about the policy's impact?

Some States Are Directly Constraining High or Rapidly Growing Hospital Prices

POLICY PROBLEM: High hospital price levels and price growth

Rhode Island

Scope: State-regulated fully-insured commercial market

Approach: Uses insurance rate review to limit annual hospital price growth in state-regulated commercial plans

Impact: Evaluation found about a 9% relative reduction in commercial hospital prices; fully insured premiums also declined relative to comparison markets

Reference: Hostert and Ryan

Vermont

Scope: Fully-insured and self-insured markets

Approach: Establish maximum prices that Vermont hospitals can accept for services using reference-based pricing

Impact: Still in implementation - too early to evaluate. The reforms are intended to constrain hospital prices (and, through separate provisions on global budgets, overall hospital spending), but measurable effects on affordability, access, and hospital finances are not yet available

Facility Fee and Site-Neutral Policies Target Higher Prices Tied to Hospital Outpatient Settings

POLICY PROBLEM: Higher payments for similar outpatient services based on where care is delivered or how the site is owned

Connecticut

Scope: Hospital and health system outpatient settings

Approach: Prohibits facility fees for specified outpatient services and requires related reporting and consumer protections.

Impact: A 2025 evaluation found a 6.9% relative decline in outpatient charges as a share of total hospital charges, with no statistically significant change in overall operating margins.

Reference: Braun et al.

New York — proposed Fair Pricing Act

Scope: Specific ambulatory services across provider settings

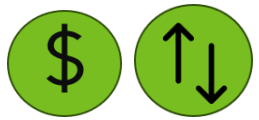
Approach: Would cap payment for specified routine ambulatory services at 150% of the Medicare non-hospital rate and prohibit a separate facility fee.

Impact: N/A – not enacted; related national commercial modeling estimates substantial savings from a 150% Medicare site-neutral benchmark.

Reference-Based Benefits and Price Transparency Target High and Variable Prices for Shoppable Services

POLICY PROBLEM: Large price differences for services that can often be compared or shifted across providers

California — CalPERS



Scope: CalPers public employee health plan

Approach: Sets a maximum amount CalPERS will pay for selected services, including joint replacement, and gives members incentives to use lower-priced facilities

Impact: Use of lower-priced facilities increased and the joint replacement program generated estimated first-year savings of about $3.1 million, due to shifts in volume to lower-priced facilities and reductions in prices at higher-price facilities

Reference: Robinson and Brown

New Hampshire

Scope: Shopping incentives apply to participating plans but price transparency is statewide

Approach: Uses its all-payer claims database to publish provider-specific prices through NH HealthCost and support consumer shopping.

Impact: Research found modest price reductions for imaging services, but use of price-shopping tools has been limited.

Reference: Brown

Site Neutral Payment: National Level

- Impact on healthcare expenditures depends on:
  - Payer (for example, Medicare, commercial payers)
  - Scope of services involved (for example, hospital outpatient services, drug administration only)
  - Pricing rules (for commercial, typically capping prices at X% of Medicare fee for service payment rates)
- CMS has taken a number of steps toward site neutral payment in recent years, mostly applying to off-campus hospital outpatient departments:
  - 2019-2020: clinic visits at outpatient hospital departments
  - 2026: drug administration services ($290 million impact)
  - Proposed for 2027: expand site-neutral approach to certain imaging services ($260 million impact)

Questions for Discussion 3

- What questions does the group have about other states' policy approaches?
- What other data or tools do you want to explore?
- What additional data or research are necessary to move forward and think about recommended policy directions?

Next Steps

What: Investor Ownership and Influence Working Group

When: September 24, 1 pm to 4 pm

Where: Wilder Foundation, Auditorium A

Stay tuned for:

- The Health Care Affordability Advisory Task Force October Meeting on October 13th from 9 am to 12 pm

Thank You!

Center for Health Care Affordability

Health.Affordability@state.mn.us

References

- Congressional Budget Office. (2022). The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services |Congressional Budget Office (https://www.cbo.gov/publication/57422)
- Whaley, C. M., Kerber, R., Wang, D., Kofner, A., & Briscombe, B. (2024) Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative | RAND (https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html)
- Hostert, N. and Ryan, M. (2025). Rhode Island's Health Care Affordability Standards: Lessons for Other States Seeking to Control Health Care Spending | Milbank Memorial Fund (https://www.milbank.org/publications/rhode-islands-health-care-affordability-standards-lessons-for-other-states-seeking-to-control-health-care-spending/)

References, continued

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- Robinson J. and Brown, T. (2013). Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery | Health Affairs (https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0188)