Health Care Affordability Advisory Task Force

February 25, 2026

Today's Objectives

- Review past task force discussions, progress to date, and pathway to recommendations
- Briefly recap, and create space for reactions to, the Provider and Payer Advisory Task Force meeting discussion
- Begin to dive into priority topics the task force initially identified:
  - "Non-value-added" spending
    - Administrative complexity
    - Intermediary and investor-related spending that does not improve access or quality
  - High and variable prices
    - Highlight variation by hospitals in Minnesota and across states
- Within these topic areas, brainstorm and refine ideas for future discussion

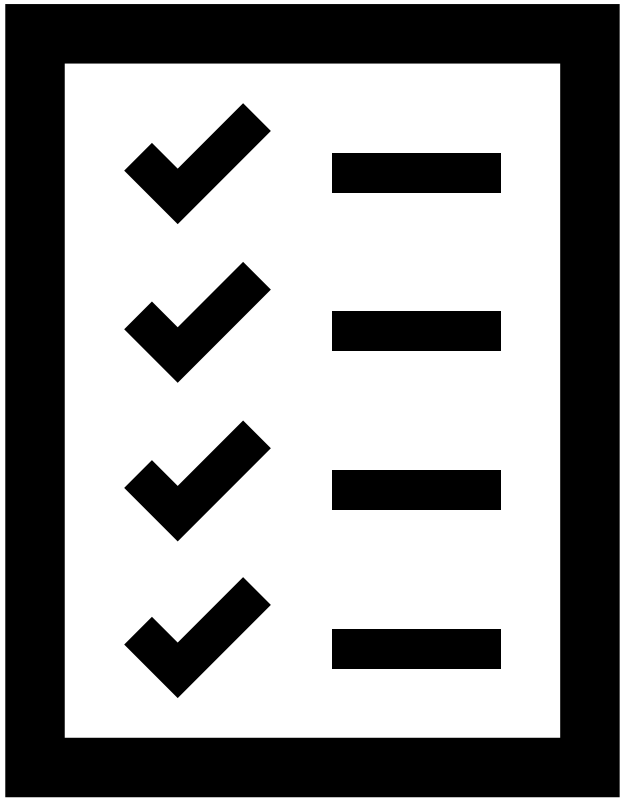
Today's Agenda

- Where we're going and how we'll get there – **CHCA**
- Recap and reactions: Provider and Payer Advisory Task Force Meeting – **CHCA, Mathematica**
- "Non-value-added" spending – **Mathematica**
- High and variable prices – **Mathematica**
- Brainstorming exercise - **Mathematica**
- *Break*
- Prioritizing ideas and the path forward– **Mathematica**
- Closing and next steps – **CHCA**

Where We're Going and How We'll Get There

Alex Caldwell | Director, Center for Health Care Affordability

Accomplishments to Date



1. Achieved alignment on a draft roadmap for developing policy recommendations
2. Drafted selection criteria and guiding principles and values
3. Selection of initial learning priorities

Roadmap to Recommendations: Round 1

1. Understand the Charge
2. Review the Landscape
3. Narrow and Prioritize
4. Develop Policy Options
5. Refine Re-commendations in June 2026

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

Next Steps: April & May Meetings

Round 1: Fall 2025 through Spring 2026

Narrow and Prioritize	Develop Policy Options	Refine Recommendations
• Identify key spending/affordability challenges where action is feasible. • Determine criteria for selecting priorities. • Milestone: select initial policy topics by early 2026.	• Refine and/or vet potential policy solutions, including inputs from technical working groups and/or guest presentations.	• Develop and refine practical, evidence-informed recommendations for the Center. • Milestone: Complete recommendations by late spring 2026.

Data, analysis and research will occur throughout (both quantitative and qualitative including other states' policies)

Round 2: Mid-2026 through Mid-2027

Narrow and Prioritize	Develop Policy Options	Refine Recommendations

Priority Area Selection Criteria

- Discussed in October:
  - Size and/or timing of potential impact on health care spending
  - Is the topic relevant across stakeholder groups, or limited to certain groups?
  - Is the topic's relevance systemwide, or limited to specific payers/services/populations?
  - Factors playing the biggest role in Minnesota health care spending growth (e.g., specific services, price vs utilization)
  - One-time vs ongoing savings
  - Is this topic something that state policymakers can influence directly?

Illustrative Examples: Potential Task Force Recommendation Types

Type	Example Recommendations
Exploratory	"The **HCAATF should further study** administrative cost savings associated with [*insert topic(s)*] and characterize each by savings potential and impact on other factors like quality"
Framework-setting	"MDH should develop a proposal for **adopting a statewide goal** to limit [*insert topic(s)*] to no more than XX% annually and assess options to enforce this target through contracting, legislation, or regulation"
Specific	"The **legislature should enact a law** requiring all commercial payors to adopt [*insert topic(s)*] practices statewide by 202X"

Questions

- What questions do you have about the timeline to developing policy recommendations, and the level of detail in those recommendations?

Framework for Identifying the Scope of the Challenge

Failure of Care Delivery

- Ineffective or harmful care
- Lack of adherence to evidence-based practices
- Poor preventive care

Failure of Care Coordination

- Disjointed care
- Inadequate communication
- Avoidable complications or hospital readmissions
- Lack of interoperability

Overtreatment or Low-Value Care

- Low-value testing, treatments, or procedures
- Prolonged duration of services

Pricing Failure

- Variability and inflation in pricing of medications and services
- Provider consolidation and market power

Fraud and Abuse

- Fraudulent billing or other improper claims
- Cost of administrative processes to catch and prevent fraud

Administrative Complexity

- Inefficient administrative processes
- Excessive overhead costs and processes

State Policy Strategies Recap 1 - 5

Strategy	Description
Strategy 1: Implement a Health Care Cost Growth Target	Establish a target for per capita health care cost growth and measure performance against that target; hold entities accountable for meeting the target
Strategy 2: Promote Adoption of Population-Based Provider Payment	Encourage or require adoption of advanced alternative payment methodologies, particularly those that move provider payment toward meaningful risk sharing
Strategy 3: Cap Provider Payment Rates or Rate Increases	Set a limit on prices paid or restrict provider increases in state-regulated markets
Strategy 4: Contain Growth in Prescription Drug Prices	Establish prescription drug affordability boards (PDABs), upper payment limits, international reference pricing, or penalties for “excessive” prices
Strategy 5: Improve Oversight of Provider Consolidation	Reinforce state’s ability to review and disapprove mergers and prohibit anticompetitive contracting terms to counter impact of health care consolidation on provider prices

Source: Hwang et al., 2022, *State strategies for slowing health care cost growth in the commercial market*

State Policy Strategies Recap 6 - 10

Strategy	Description
Strategy 6: Strengthen Health Insurance Rate Review	Use the insurance rate review process as a lever for health care cost containment
Strategy 7: Adopt Advanced Benefit Designs	Promote strategies that encourage consumers to choose lower-cost providers, such as reference-based benefit design and “smart shopper” programs
Strategy 8: Promote Use of Community Paramedicine	Enable EMS providers to provide a range of services to patients without transport to an emergency department to reduce unnecessary emergency and inpatient care
Strategy 9: Improve Behavioral Health Crisis Systems	Expand behavioral health crisis services to reduce use of more costly ED and inpatient services, and leverage multi-payer support for these programs
Strategy 10: Reduce Administrative Waste	Address product choices and administrative processes that contribute to waste by streamlining plan choices, health care utilization review, and billing functions

Source: Hwang et al., 2022, *State strategies for slowing health care cost growth in the commercial market*

Potential Priorities Identified To Date

- "Non value added" spending, including but not limited to:
  - Administrative complexity
  - Intermediary and investor-related spending that does not improve access or quality
- High and variable prices

Focus of today's discussion

- Population-based payment that enables providers to address current system failures
- Benefit design:
  - Standardize to reduce administrative complexity
  - Innovate to align consumer incentives with desired behaviors (e.g., tiered networks)

Future topics

Recap and Reactions: Provider and Payer Advisory Task Force (PPATF) Meeting

Alex Caldwell | Director, Center for Health Care Affordability

Key Takeaways from Task Force Meeting

- Members expressed appreciation for this group's work on definitions, values, and principles
- Importance of innovation to improve affordability. Examples of which included:
  - Leveraging telehealth
  - Regional coordination
  - AI and the impacts it could have on productivity in health care
- Explore ways in which we can reduce the cost of providing care to patients
- Additional key points raised by members included:
  - How does Minnesota compare to other states in terms of spending and drivers of spending growth?
  - Consideration of the work that other groups are doing such as the Prescription Drug Advisory Board (PDAB)

Key Takeaways from PPATF Survey

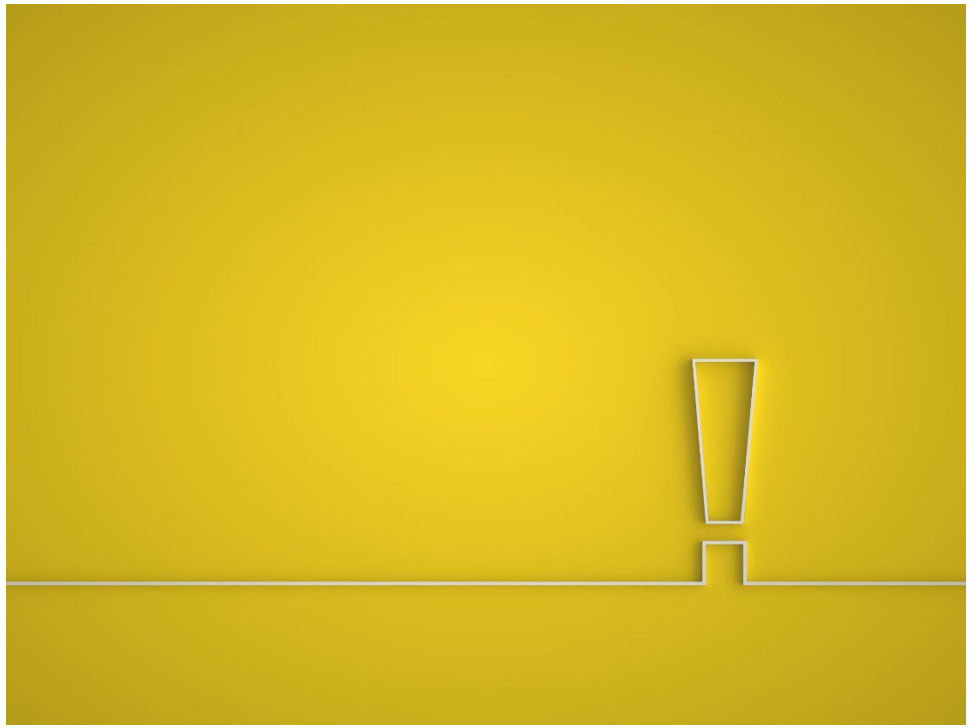
Survey Topic	Responses
Non-value-added spending examples	• Prior authorization (delays, denials, rework) • Revenue cycle complexity (billing, coding, debt collection) • Duplicative credentialing & reporting requirements

Opportunities to reduce non-value-added spending	• Prior authorization reform
	• Administrative simplification
	  • Standardize billing and reporting
	  • Align quality measures

Opportunities to reduce the underlying cost of providing health care	• Increase productivity (How do we leverage AI and telehealth?) • Address workforce shortages • Shift focus to personnel, such as primary care doctors, care coordinators, and community health workers that can help address upstream drivers of health

Key Takeaways from PPATF Survey, continued

- Key Takeaways
  - Administrative complexity consumes substantial labor and financial resources without clear patient value
  - There are clear “pain points” that are common across stakeholder groups, like prior authorization, lack of standardization, and lack of interoperability
  - Long-term affordability will also require productivity gains, workforce strategy, and better data infrastructure



Group Discussion

- What are your initial reactions to the summary of the PPATF discussion and survey?

“Non-Value-Added” Spending

Julie Sonier | Mathematica

Overview of This Section

- Administrative functions in the health care system
  - In-depth example: prior authorization
- Roles of intermediaries
  - In-depth example: pharmacy benefit managers

Administrative Functions

- **Claims processing** – the administrative function through which health care services or prescriptions are reviewed, adjudicated, and paid according to plan rules and provider contracts
- **Billing and payment** – the processes by which providers generate bills for services rendered and receive payment from insurers and patients
- **Accounting** – financial record-keeping and reconciliation activities that track revenues, expenses, and payments associated with health care delivery and coverage
- **Prior authorization** – utilization management function in which a health plan requires advance approval before agreeing to cover or pay for a specific service, medication, or procedure
- **Quality reporting** – involves the collection, submission, and analysis of data used to measure health care quality, performance, and outcomes for regulatory, accreditation, or payment purposes
- **Enrollment and eligibility** - refers to administrative processes that determine who is covered by a health plan, for what benefits, and during which time periods
- **Network participation** – the administrative and contractual processes through which health care providers and facilities agree to participate in a health plan's provider network
- **Payment rate negotiations** – the administrative and contractual processes through which health plans and providers establish the prices and reimbursement terms for covered services

Administrative Complexity Contributes to High Health Care Spending

- Spending on administrative functions in the U.S. far exceeds that in other countries
  - A KFF analysis of Organization for Economic Co-operation and Development (OECD) health statistics found that in 2021 per capita spending on administration in the U.S. totaled $925 while in comparable nations' per capita spending averaged $245
- It also makes up a sizable percentage of overall health care spending
  - In the U.S. it is estimated that 15-30% of all Health Care spending is attributable to administrative spending and at least half of that spending is reflective of excessive spending

Source: Peterson-KFF Health System Tracker, 2023; Shrank et al., 2019

Administrative Complexity

- Administrative complexity contributes to excess spending in a variety of ways. Examples include:
  - **Lack of standardization** - absence of common, uniform administrative formats, definitions, and processes across the health care system
  - **Frequency of rule changes** - how often payers update administrative requirements, coverage policies, or operational rules that providers and patients must follow
  - **Manual workarounds** - labor-intensive processes used to compensate for system fragmentation, lack of standardization, or poor interoperability

Administrative Burden

- Who is ultimately impacted by excess administrative costs and complexity and how does this contribute to non-value added spending?
  - Providers absorb staff time and infrastructure costs that take away from providing care
  - Contributes to provider burnout
  - Patients experience confusion, delays, and access barriers
  - Plans incur operational overhead that increases spending in areas unrelated to core functions
  - State agencies incur more costs for oversight and compliance

Source: Kyle and Frakt, 2021

Discussion Topic: Prior Authorization

Reason for focus on this topic:

1. Task force interest
2. Large spending category
3. Significant interest from policy makers in Minnesota and around the country

Prior Authorization: Definition and Intended Purpose

Definition:

Prior authorization is a utilization management process in which a health plan requires advance approval before it will cover or pay for a specific health care service, procedure, medication, device, or diagnostic test.

Purpose:

- Prior authorization is intended to prevent low-value or unnecessary care and steer providers towards lower-cost, equally effective options which in turn should reduce overall health care spending.
    - Despite being a useful tool for containing costs, there are rising concerns about the administrative burden it creates

Prior Authorization: Spending

- Estimated to account for $35 billion in administrative spending and the average cost is about $40 to $50 per submission for private payers and about $20 to $30 for providers
- In their 2024 prior authorization physician survey the American Medical Association found that:

Source: Sahni, et al., 2024; American Medical Association, 2024

Prior Authorization: Spending Container vs. Driver

What are our opportunities for improving the use of prior authorization?

Apply to the right services

- Data for commercial plans is limited, but in 2024 Medicare Advantage insurers approved the vast majority of PA requests (92.3%)

Ensure that benefits outweigh burden

- In surveys providers have expressed that PA contributes to significant administrative burden
- Pulls resources away from clinical care towards admin tasks

Consistent and streamlined

- PA requirements are highly variable, frequently changing, and/or poorly standardized across payers, leading to increased error rates, and delays that result in additional downstream costs

Source: Biniek et al., 2026; Cutler, 2020

Prior Authorization: Legislative Efforts

- Legislation passed in 2020 requires Minnesota health plans to post annual PA data on the company's public website allowing for more transparency related to health plan practices
- MN 2024 Budget Bill
  - Expands the list of services that may not be subject to PA
  - Requires health plans to have and maintain a system that automates the PA process through application programming interfaces (APIs)
  - Limits circumstances under which PA for treatment of chronic conditions can be required to be renewed
  - Requirement for an annual report to the Commissioner of Health on PAs

Source: CMS, 2024; Minn. Stat. § 62M.18; Minn. Stat. § 62M.07

Prior Authorization: Examples of where to go from here

Minnesota Deep Dive

- Better understand total administrative cost of PA in Minnesota (providers + payers), including:
  - Cost per PA request
  - Variation across markets (commercial, MA, Medicaid)
  - Denial and overturn rates
- Estimate impacts of new PA limits (e.g., 2024 state legislation) in terms of medical and administrative spending increases and savings

Other State Solutions

- What strategies are other states trying (e.g., “gold carding”) and what would it look like to apply those approaches in Minnesota?
- How do Minnesota’s exempted services compare to other states?
- To what extent are other states seeing PA reform translate to more affordable care?

Discussion Topic: Roles of Intermediaries

Reason for focus on this topic:

1. Task force interest
2. Focus of increased scrutiny and action at the state and Federal levels

Intermediaries

There are several different types of middlemen/intermediaries in the U.S. healthcare system. These include:

- **Third party administrators (TPAs)**: companies that administer health benefits on behalf of employers or plan sponsors, particularly for self-insured plans, without assuming insurance risk
- **Revenue cycle management (RCM) companies**: provide services to health care providers to manage the financial processes associated with patient care, from billing through payment
- **Claims denial management and repricing firms**: specialize in identifying, contesting, appealing, or reprocessing denied or underpaid claims, and in some cases recalculating payment amounts based on contract terms or benchmarks
- **Pharmacy benefit managers (PBMs)**: intermediaries that administer prescription drug benefits on behalf of health plans, employers, or public programs

Pharmacy Benefit Managers

Pharmacy benefit managers (PBMs) are intermediaries that

- **administer** prescription drug benefits
- **negotiate** prices and rebates with manufacturers
- **manage pharmacy networks** on behalf of plan sponsors

Pharmacy Benefit Manager: Concerning Practices

Purpose	Policymaker Concerns
Negotiate lower drug costs for payers and administer pharmacy benefits efficiently.	PBMs steer patients toward higher-priced drugs and extract hidden fees, sometimes increasing overall drug costs rather than lowering them.
Use rebates and negotiated discounts with manufacturers to reduce net drug costs.	PBMs may retain rebates or benefit from higher list prices, disincentivizing switching to lower-cost alternatives.
Act as intermediaries to manage complex pricing and reimbursement flows.	Industry operations are opaque, with lack of visibility into pricing decisions, rebates, fees, and markups.
Contract with pharmacies to ensure network access and payment for dispensing.	Practices like spread pricing (charging payers more than reimbursement to pharmacies) can squeeze independent pharmacies and distort payments.
Leverage scale to improve formulary management and medication access.	PBMs have consolidated significantly (the three biggest PBMs process >80 % of prescriptions), raising concerns about market power and conflicts between profit incentives and patient interests.

Source: Robbins and Abelson, 2024

Pharmacy Benefit Managers: Recent Federal Policy Actions – Commercial Market

Consolidated Appropriations Act, February 2026

- Allows for increased oversight of PBMs that provide services to employer health plans through data transparency
- Requires PBMs to pass through 100 percent of drug rebates and discounts to employer health plans under ERISA.

Department of Labor Proposed Rule, January 2026

- Requires PBMs to disclose information about direct or indirect compensation they receive to plan fiduciaries of self-insured group health plans.

Source: Freed et al., 2026

Pharmacy Benefit Managers: Minnesota Policy

Current policies in place

- PBMs are licensed annually with the Department of Commerce
- Required rebate reporting and certain transparency disclosures
- Spread pricing is prohibited in Medicaid MCO contracts
- Gag clauses are prohibited and there are established statutory safeguards governing PBM audits of pharmacies
- Beginning in 2027, Medicaid Managed Care must use a single PBM

Source: Minnesota Department of Commerce, n.d.; Minn. Stat. § 62W.07, 2025, Minn. Stat. § 256B.696, 2025, KFF, 2024

Pharmacy Benefit Managers: Examples of where to go from here

Minnesota Deep Dive

- Review publicly available PBM Transparency Reports to assess fees, drug prices, rebates received by the PBMs from drug manufacturers, and the share of rebates retained by the PBMs

Other State Solutions

- Are there policy options that other states are pursuing that Minnesota has not yet considered?
- To what extent have other state solutions resulted in measurable impact on pharmacy prices or health care spending?

Clarifying questions

- What clarifying questions do you have?

High and Variable Prices

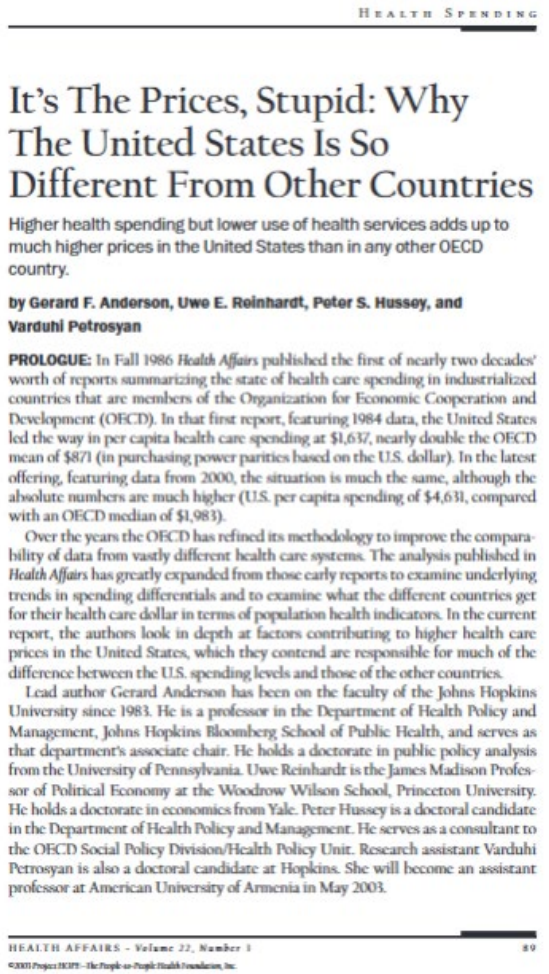
Julie Sonier | Mathematica

It’s the Prices, Stupid: Key Takeaways

The U.S. spends more on health care than other developed countries

High prices, rather than utilization, contribute to the gap between U.S. and other country’s spending

The gap between public and private payers’ prices has grown



HEALTH SPENDING

It’s The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

PROLOGUE: In Fall 1986 *Health Affairs* published the first of nearly two decades' worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and Development (OECD). In that first report, featuring 1984 data, the United States led the way in per capita health care spending at $1,637, nearly double the OECD mean of $871 (in purchasing power parities based on the U.S. dollar). In the latest offering, featuring data from 2000, the situation is much the same, although the absolute numbers are much higher (U.S. per capita spending of $4,631, compared with an OECD median of $1,983).

Over the years the OECD has refined its methodology to improve the comparability of data from vastly different health care systems. The analysis published in *Health Affairs* has greatly expanded from those early reports to examine underlying trends in spending differentials and to examine what the different countries get for their health care dollar in terms of population health indicators. In the current report, the authors look in depth at factors contributing to higher health care prices in the United States, which they contend are responsible for much of the difference between the U.S. spending levels and those of the other countries.

Lead author Gerard Anderson has been on the faculty of the Johns Hopkins University since 1983. He is a professor in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, and serves as that department's associate chair. He holds a doctorate in public policy analysis from the University of Pennsylvania. Uwe Reinhardt is the James Madison Professor of Political Economy at the Woodrow Wilson School, Princeton University. He holds a doctorate in economics from Yale. Peter Hussey is a doctoral candidate in the Department of Health Policy and Management. He serves as a consultant to the OECD Social Policy Division/Health Policy Unit. Research assistant Varduhi Petrosyan is also a doctoral candidate at Hopkins. She will become an assistant professor at American University of Armenia in May 2003.

Source: Robinson, 2003

It’s the Prices, Stupid: Key Takeaways, continued

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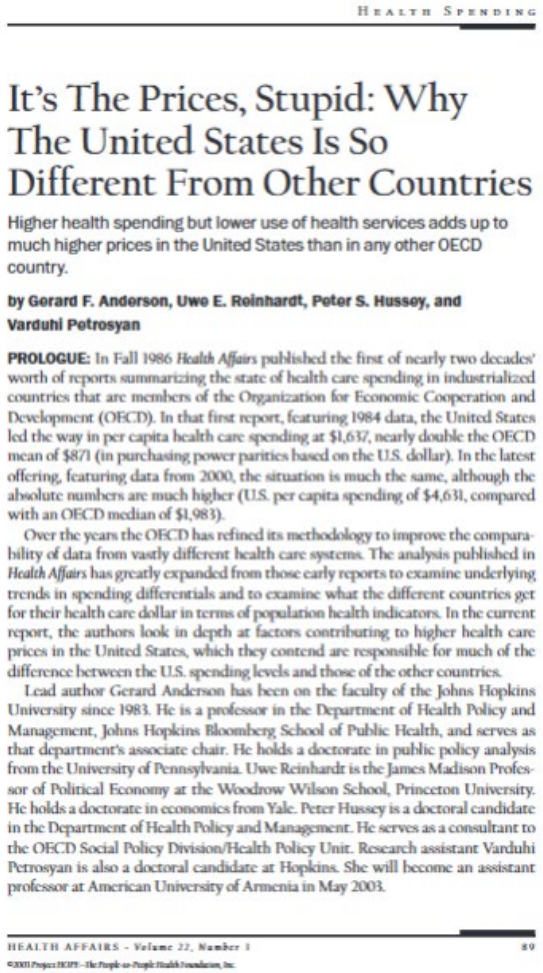

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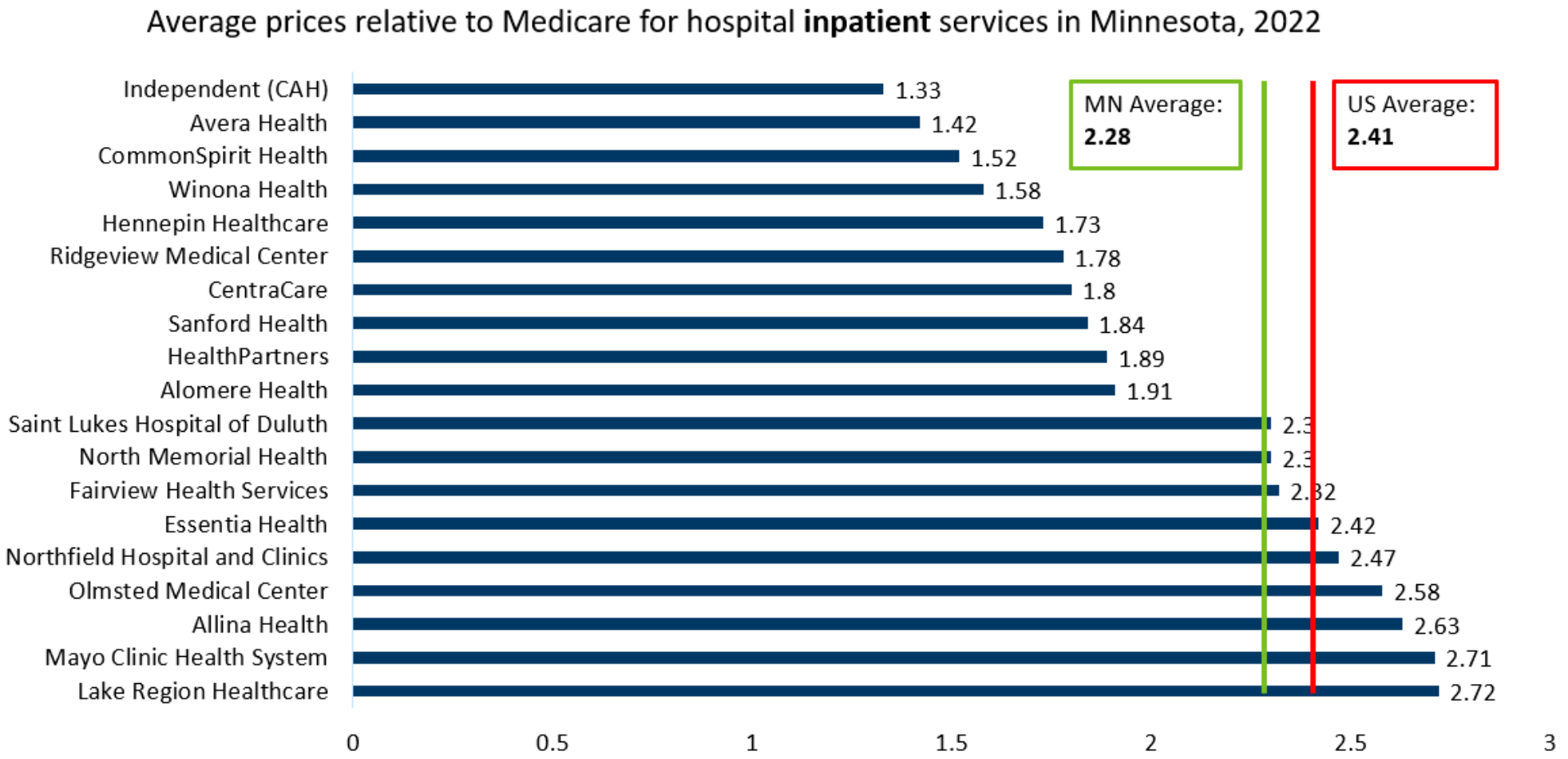
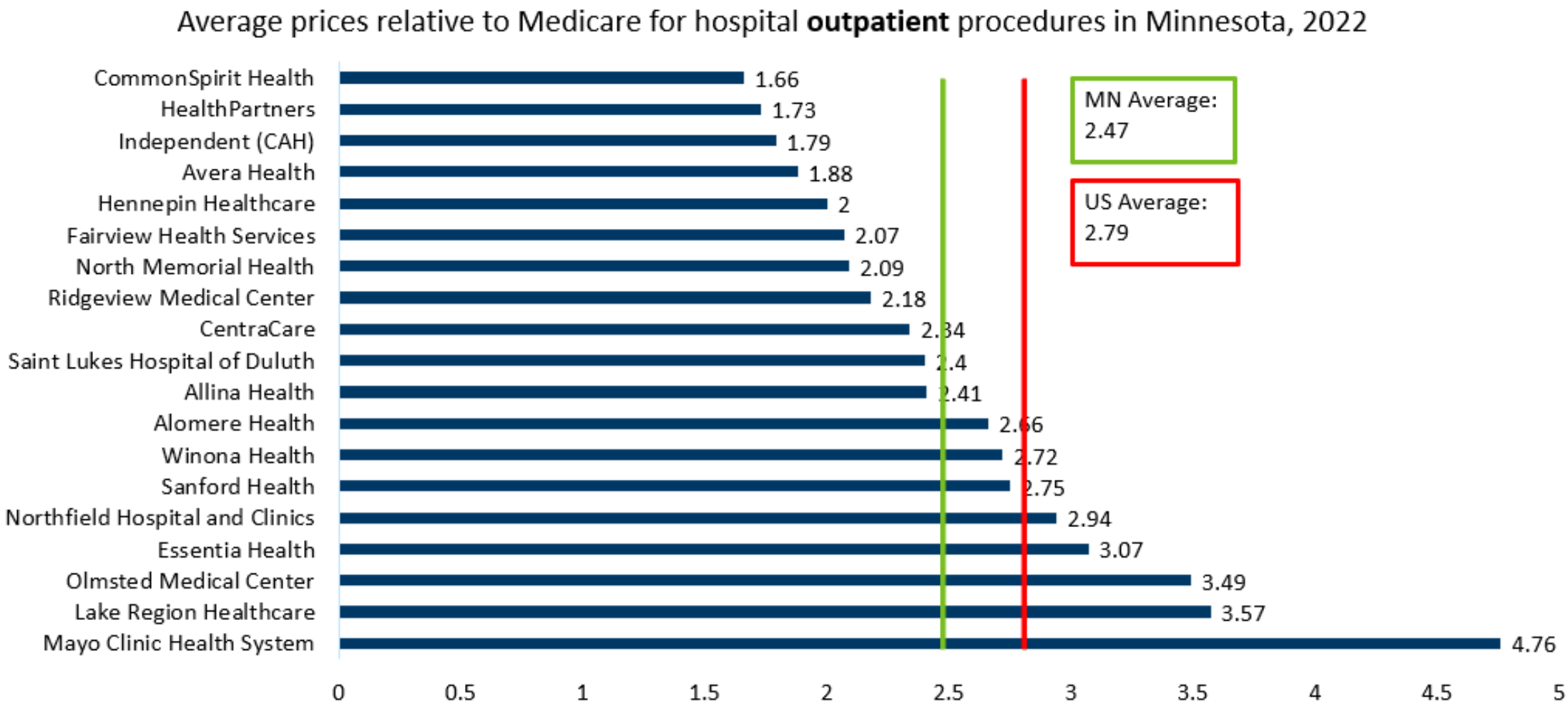
Source: Robinson, 2003

Price Variation: Hospitals (Inpatient Procedures)



Source: Whaley et al., 2022

Price Variation: Hospitals (Outpatient Procedures)



Source: Whaley et al., 2022

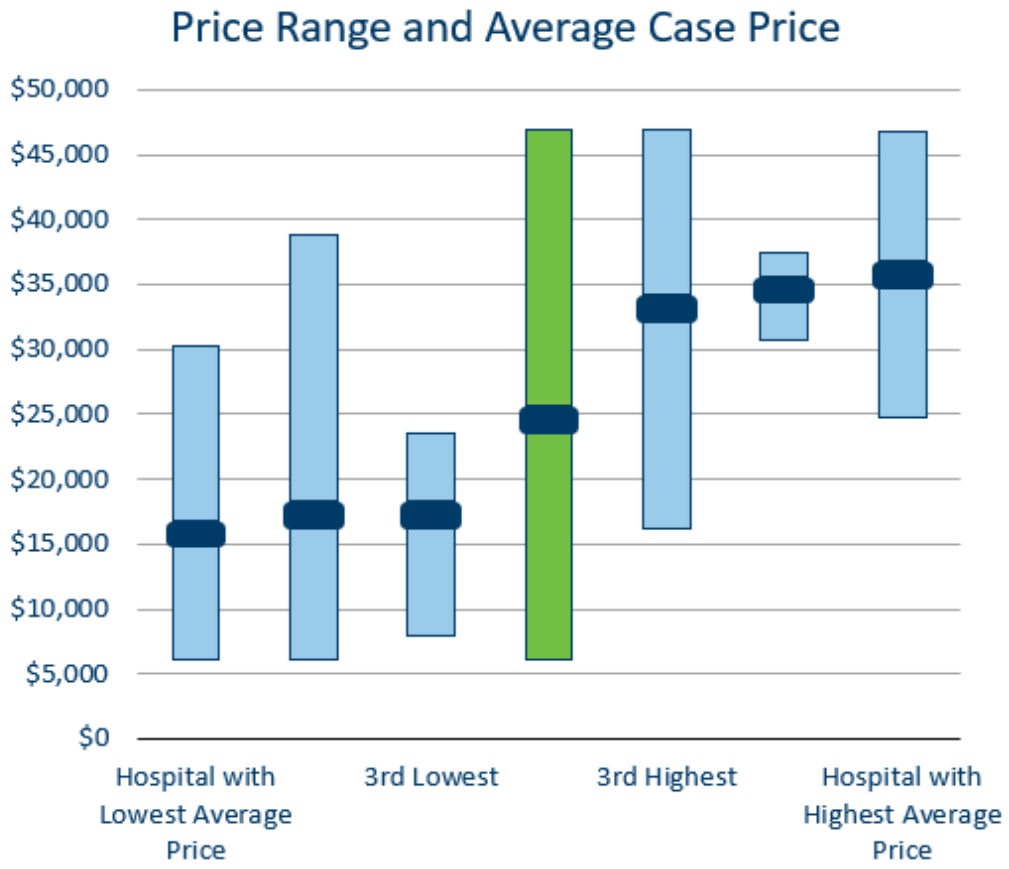
Price Variation: Commercial Case Price
Example: Total Knee Replacement (APR-DRG 302)

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

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.



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

High and Variable Prices: Examples of where to go from here

Other State Solutions

- Assess the impacts of **other state price control programs** (e.g., reference-based pricing) on health insurance premiums and system sustainability
- Examine facility fee restrictions such as those passed in Colorado
  - What would an analysis of facility fees look like in Minnesota?
- To what extent are other states seeing measurable impacts of price regulation on health care spending and affordability measures?

- **Minnesota Deep Dive**
- How much do prices vary for:
  - the **same service** (reimbursed by different payors) within a single hospital?
  - the same service and same payer, but in **different care settings**?
- How much is variation attributed to **input costs versus market power**?
- At what reimbursement rate for hospital expenses for hospital inpatient and outpatient services will hospitals "break even“?
  - NASHP Commercial Breakeven analysis

Questions

- What clarifying questions do you have?

Brainstorming Exercise

Julie Sonier | Mathematica

Exercise Instructions

In-Person

- For each of the three focus areas write at least 2-4 ideas on separate sticky notes for priority topics the task force can focus on in future meetings:
  - Administrative complexity
  - Intermediaries and investor-related spending
  - High and variable prices
- Place the sticky notes on the corresponding posters around the room
- There is also a “parking lot” for ideas that do not fall into those three focus areas, but is a priority for you

Online

- For each of the three focus areas send at least 2-4 ideas for priority topics the task force can focus on in future meetings in an email to Elle at elle.talsma@state.mn.us
- Indicate whether any of the ideas are for the “parking lot”

Affordability Advisory Task Force: Break

Thank you for joining the meeting. The Affordability Advisory Task Force is currently taking a break. The Task Force will reconvene at approximately 11:05 a.m. CDT.

Prioritizing ideas and the path forward

Julie Sonier | Mathematica

Next steps

What: Health Care Affordability Advisory Task Force Meeting

When: April 21, 1 to 4pm

Where: Wilder Foundation, Auditorium A

Stay tuned for:

Provider and Payer Advisory Task Force meeting on March 27, 9am-12pm

Thank You!

Center for Health Care Affordability

Health.Affordability@state.mn.us

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