Summary: Consumer Healthcare Prices Working Group Meeting | 10/27/2026

Date: October 27, 2026

Location: Amherst H. Wilder Foundation, Auditorium A

Meeting Summary and Key Themes

Alex Caldwell, Director of the Center for Health Care Affordability, opened the second Commercial Healthcare Prices Working Group meeting. The meeting focused on how other states address commercial hospital prices and how Minnesota might design a policy to limit price growth. Working group members were asked to discuss policy choices and tradeoffs, not to select a policy or make final recommendations.

Working Group Status Update

Alex reviewed the September meeting, including the group's interest in hospital price growth, the relationship between prices and quality, and how rising costs for labor and other resources affect hospitals. She noted that a goal for acceptable hospital price growth could help the state evaluate whether a policy succeeds.

Working group members observed that the services provided by hospitals and the ways hospitals are organized continue to change. They also noted that hospitals differ in financial health, service needs, and the communities they serve. The Minnesota Hospital Association's recent report on hospital financial challenges was raised as context for the discussion.

Alex outlined the meeting agenda and discussion topics, including which hospitals, patients, and services a policy might cover, and whether requirements should vary based on hospital circumstances. The December 2 working group meeting will consider possible policy approaches and recommendations for the Health Care Affordability Advisory Task Force.

How Other States Are Addressing Hospital Price Growth

Michael Bailit of Bailit Health described several strategies that other states use or are considering to address commercial hospital prices. These include limits on hospital prices, limits on annual price increases, hospital budgets that set total payments in advance, and policies that reduce payment differences for the same services across care settings. He also discussed facility fees, price transparency, oversight of healthcare mergers, and restrictions on certain contracting practices.

Oregon limits what its state and school employee health plans pay many hospitals for inpatient and outpatient services. Some smaller and rural hospitals are excluded. An evaluation found that the policy lowered spending, although members asked how broadly it affects residents and whether similar exemptions would be appropriate in Minnesota. Other states, including Vermont and Indiana, have adopted or are developing broader price limits, with different start dates and implementation challenges.

Rhode Island limits how much commercial insurers can increase hospital payments each year. Bailit described studies that found slower growth in hospital prices and health insurance premiums compared with other states. Working group members asked whether the policy might result in higher prices for other services or patients. Bailit said available evidence does not fully answer that question. Members also discussed hospital global budgets. Experiences have differed across states, with evidence of savings in Maryland and more limited findings in other programs.

The presentation also examined site-neutral payment, which seeks to reduce price differences when the same outpatient service can be safely provided in different settings, and restrictions on hospital facility fees. Members noted that these options could help with specific costs but would need careful design. They also discussed price information, rules affecting hospital mergers, and restrictions on contracts that limit competition.

Members asked which policies are easier to implement and which could have a larger effect on spending. Bailit noted that a limit on annual price growth is generally simpler to put in place and less immediately disruptive to hospitals than a broad limit on existing prices, although savings would build more gradually.

Defining the Problem and Preventing Unintended Effects

Working group members discussed why commercial hospital prices rise. Possible reasons included higher costs for staff, supplies, and other resources, as well as hospitals' ability to negotiate higher payments when competition is limited. Some members said the group should clearly describe which problem it wants a policy to address before choosing an approach. Others cautioned against delaying action indefinitely while waiting for more detailed data.

Members also emphasized that lower hospital revenue would not automatically lead to better efficiency. Hospitals might instead reduce services that patients need, including maternity care, behavioral health services, or emergency care. The group raised concerns about the possibility of hospitals moving price increases or services to other parts of a health system that are not covered by a policy. Bailit suggested identifying these risks in advance so safeguards could be considered as part of policy design.

Policy Design Considerations For Minnesota

Which Hospitals and Patients Should Be Covered?

Julie Sonier of Mathematica led the policy design discussion. She noted that Minnesota has 127 licensed hospitals, including about 90 rural acute care hospitals and about 76 critical access hospitals. Working group members considered whether a policy should apply to all hospitals, exclude certain groups, or use different requirements for hospitals in different circumstances.

Several members favored broad coverage to help ensure that patients across the state benefit. They questioned whether excluding entire categories of hospitals, such as rural or critical access hospitals, might leave people in some communities facing higher prices. Others pointed to low patient volumes, the cost of keeping essential services available, and the needs of financially vulnerable hospitals. Members also discussed whether a price growth policy should apply to individual hospitals regardless of whether they belong to a larger health system or to entire health systems that operate multiple facilities.

The group considered which insured populations a policy should apply to. In 2023, about 3.2 million Minnesotans had private insurance, including approximately 1 million in fully insured plans and 2.2 million in employer plans that pay their own claims, known as self-insured plans. Some members preferred including as much of the private insurance market as possible to avoid unequal effects across patients and employers. Others noted that the reach of a policy depends on the legal authority used to carry it out.

Which Services Should Be Covered?

The working group discussed starting with inpatient and outpatient hospital facility payments and whether to include related services. Members considered physician services, freestanding ambulatory surgery centers, and prescription drugs given in hospitals or doctors' offices.

Some members thought similar services should face similar rules regardless of where care is provided, while others questioned whether expanding the policy beyond hospitals would make it harder to implement or move it away from the main problem. The group also discussed whether large health systems could shift prices to services left outside a hospital-only policy. Bailit noted that some state approaches use a separate price cap for drugs administered in outpatient settings.

Uniform Rules or Hospital-Specific Adjustments?

Members weighed the simplicity of one price growth limit for all covered hospitals against the need to recognize different financial and community circumstances. Some supported adjustments to protect essential services and activities, such as medical education, charity care, maternity care, and behavioral health services. Others warned that too many exceptions could weaken a policy and be difficult to administer fairly.

Members also discussed whether to pair limits on price growth with efforts to support primary care or other needed services. Several participants viewed limits on future price increases as less disruptive than immediately lowering existing prices, especially because hospitals use income from some services to help pay for others. The group did not decide how any adjustments or safeguards should work.

Closing and Next Steps

Alex thanked working group members and Michael Bailit for the discussion. CHCA will use the comments and questions raised to prepare for the December 2 meeting, which will focus on potential policy approaches and recommendations. Members were invited to share additional questions before that meeting.

The Investor Ownership and Influence Working Group is scheduled to meet on November 6, and the Health Care Affordability Advisory Task Force will meet on November 20 to hear updates from the working groups. CHCA

indicated that meeting materials, the recording, and a public meeting summary would be available on its website.

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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