

Presentation – Health Care Affordability in Minnesota: Trends and Challenges and Health Care Mergers

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Minnesota Senate Health and Human Services

Date: Thursday, October 1, 2026

Time: 8:30 AM

Chair: Senator Melissa H. Wiklund

Location: Room 1100, Minnesota Senate Building

Agenda: Health Care System Mergers

What this briefing covers

1

Affordability is a national household problem — Including Minnesota and Health Care is Major Source

Households across the U.S. are struggling with affordability, and health care is a major source of growing financial pressure — including in Minnesota, as the data show.

2

Background and lessons from California

How multi-hospital systems grew in California, including Sutter Health — now in a proposed transaction with Allina Health in Minnesota — and policy options to address affordability.

3

Consolidation drove higher commercial hospital prices

California commercial hospital prices accelerated as more hospitals joined systems, reducing competition. Sutter's prices were similar to other hospitals until it formed a system and negotiated "all-or-nothing" contracts covering all its hospitals. Many other California systems have adopted this model, enabling higher prices.

4

Policy options for Minnesota

Consider policies to limit this model, such as restricting systemwide contracting — plus greater reporting and transparency on organizational links within systems and on commercial prices, to allow monitoring and regulation if needed.

Affordability is a national household problem — Including Minnesota

Health Care is Major Source

Basic household costs rose sharply in 2025, with *health care the single largest driver of the increase*.

6.1%

Rise in basic Minnesota household costs in 2025 — 2.5× the 10-year average; \$1,410 less purchasing power

25.7%

Growth in Minnesota health care spending — the fastest-rising item in the basic cost-of-living basket

64%

U.S. adults at least somewhat worried about affording health care

36%

U.S. adults skipped or postponed needed care because of cost

Minnesota: coverage and access are slipping

- Uninsured rate rose from 3.8% (2023) to 5.8% (2025) — about 116,000 more uninsured residents.
- More than 13% of lower-income Minnesotans (<200% FPL) and more than 20% of Hispanic Minnesotans were uninsured in 2025.
- 76% of adults are concerned about affording some aspect of health care; 45% struggled to get care because of cost.
- Minnesota households spend more on health care than on rent and utilities combined.

Sources: KFF Health Tracking Poll (Apr. 2026); MDH/SHADAC Minnesota Health Access Survey; Minnesota DEED cost-of-living analysis by North Star Policy Institute; Minnesota Center for Health Care Affordability.

Health insurance costs are projected to rise sharply in 2027

Minnesota insurer filings include double-digit increases in several markets; national employer costs are also projected to accelerate.

Minnesota: proposed average rate changes for 2027

10.0–13.0%

Individual market
(weighted average
+11.9%)

10.0–21.4%

Small-group market
(proposed average
increases)

21.4%

Highest small-group
proposal
(UnitedHealthcare)

National employer outlook

8.2%

Projected 2027 health-benefit cost
increase per employee

11%

if employers made no cost-reduction
changes

59%

of employers plan benefit changes in
2027

Largest proposed Minnesota increases

UnitedHealthcare (small group)	21.4%
Medica (small group)	18.9%
Sanford (small group)	14.5%
Medica (individual)	13.0%
HealthPartners (individual)	12.4%

What's driving the increases

- Hospital labor & inflation
- Specialty pharmacy growth
- Provider consolidation, provider systems, market leverage

Health insurance costs are projected to rise sharply in 2027 in Minnesota

	2026 estimated	2027 projected	Increase
Total family premium	~\$29,630	~\$34,105	\$4,475
Employer share (~73%)	~\$21,630	~\$24,900	\$3,270
Employee share (~27%)	~\$8,000	~\$9,205	\$1,205

Illustrative estimates. 2026 applies Minnesota's 14.22% final average small-group rate increase to the most recent KFF Minnesota average employer-sponsored family premium.

2027 applies the simple average (15%.) of currently proposed Minnesota small-group carrier rate increases. Employer/employee shares assume the most recent

Minnesota statewide family-coverage split of approximately 73%/27%. These are estimates, not official statewide average small-group family premiums.

Sources: Minnesota Department of Commerce; KFF State Health Facts/AHRQ MEPS-IC.

Minnesota Example – Median Annual Wage = \$60,000 (2025) Estimated Annual Net Take-Home Pay (Married with 2 Kids) –

Paycheck Component	2026	2027	Difference
Gross Annual Salary	\$60,000.00	\$60,000.00	\$0.00
Total Deductions & Taxes	(\$12,206.80)	(\$13,314.32)	(\$1,107.52)
Health Insurance Deduction/Employee Share	(\$8,000.00)	(\$9,205.00)	(\$1,205.00)
Estimated Net Take-Home Pay	\$47,793.20	\$46,685.68	(\$1,107.52)
Federal/State Taxable Gross Inco	\$52,000.00	\$50,795.00	(\$1,205.00)
% Total Deductions - Health Insu	66%	69%	
Federal Income Tax (MFJ + 2 Kids	\$0.00	\$0.00	\$0.00
Minnesota State Income Tax (MFJ	\$0.00	\$0.00	\$0.00
Minnesota Paid Family & Medica	(\$228.80)	(\$223.50)	\$5.30
Medicare Tax	(\$754.00)	(\$736.53)	\$17.47
Social Security Tax	(\$3,224.00)	(\$3,149.29)	\$74.71

Rising health care costs – A “Quadruple Whammy”

Higher employer premium contribution

1. Less compensation available for wage growth
2. Reduced job growth

and

Higher worker premium contribution + Higher Worker Out of Pocket Spending When Using Services

3. Deductions from pay for increased premium contribution
4. Increased health care spending = Less money from HH budget available for other family expenses

Minnesota employers facing rising health costs must make tradeoffs as health insurance premiums increase

Minnesota Department of Health, Center for Health Care Affordability, 2026 Legislative Report – Summary.

California Experience

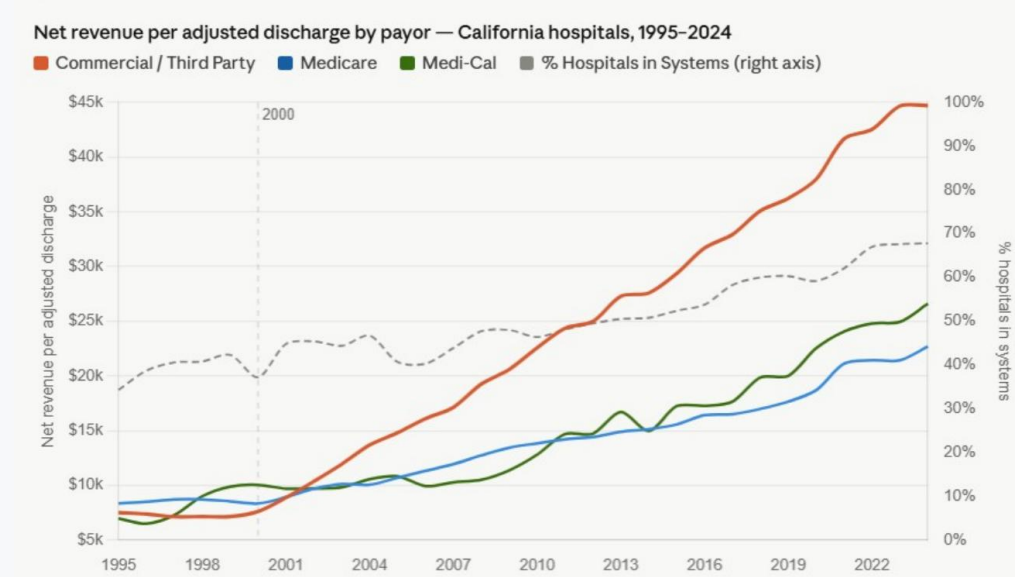
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- California Experience

Why hospital prices matter for household affordability

Hospital payments are a large component of commercial health spending, so provider prices matter for premiums and household budgets.

Net revenue per adjusted discharge by payer type and hospital system affiliation, California hospitals, 1995–2024



40%

of California commercial insurer claims spending was hospital payments in 2022–2023

California experience

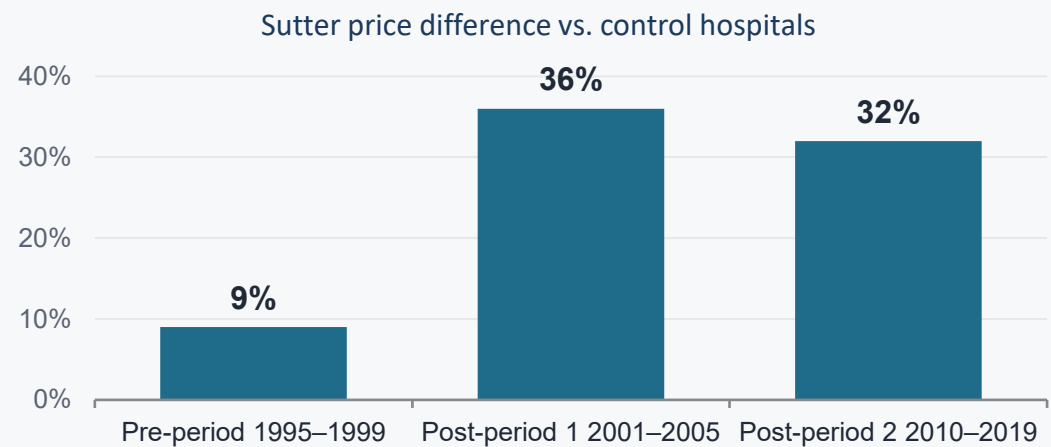
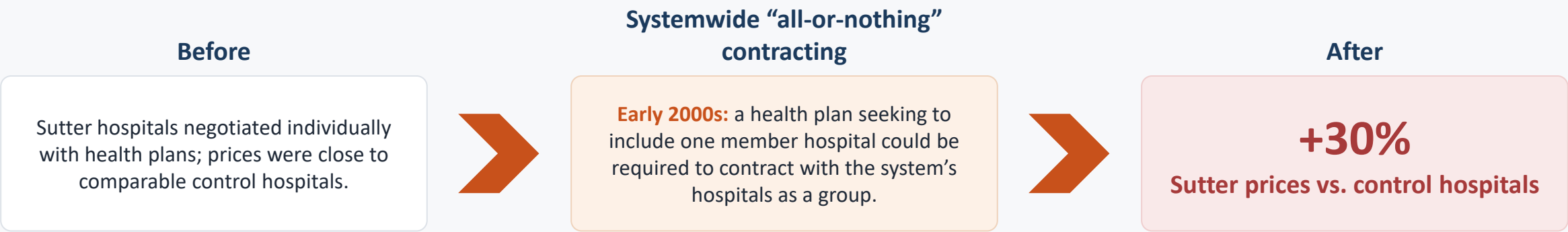
- Commercial hospital payment measures diverged sharply from Medicare and Medi-Cal after about 2000.
- California hospital system affiliation expanded at the same time; the revised California analysis finds 68% of hospitals in multi-hospital systems by 2024.
- Prior causal studies of mergers and cross-market acquisitions find higher commercial prices without commensurate quality improvements.

The policy issue is market structure, not only individual prices. When hospitals are organized and negotiate with health plans as a group, the bargaining unit can become the entire system rather than the individual hospital. This can change the consequences of network exclusion and reduce an insurer's ability to steer volume toward lower-price hospitals. California provides descriptive statewide evidence plus specific causal case studies.

Sources: HCAI/CHCF California affordability reporting; Cooper et al., QJE 2019; Dafny, Ho & Lee, RAND J Econ 2019; Arnold et al., Health Serv Res 2025.

California case study: Sutter Health and systemwide “all-or-nothing” contracting

A specific contracting change illustrates how system organization can alter bargaining leverage.



What the study shows

- Melnick & Fonkych (2024) found Sutter prices were similar to controls before the contracting change and about 30% higher afterward.
- This is a specific California case study—not evidence that every systemwide contract raises prices by the same amount.

Minnesota relevance: Sutter and Allina Health signed a definitive agreement; closing is expected by end-2026, pending regulatory review.

Sources: Melnick G, Fonkych K. J Hosp Manag Health Policy 2024;8:21 (doi: 10.21037/jhmhp-24-59); Allina Health/Sutter Health definitive agreement, May 21, 2026.

California case study: Sutter Health and systemwide “all-or-nothing” contracting

In 2021, California Attorney General reached a \$575 million settlement with Sutter to settle allegations that its anticompetitive practices led to higher healthcare costs.

Settlement Terms:

- 1 Prohibitions on anticompetitive activities**
Sutter cannot engage in “all-or-nothing” contracting, anti-tiering/steering practices, and must cease bundling services
- 2 Increased transparency**
By banning gag clauses or price secrecy terms, Sutter must allow health plans and employers to provide members pricing, quality, and cost information
- 3 Limitations on out-of-network bills**
Ensures patients visiting and out-of-network hospital do not face large surprise bills
- 4 Court-appointed monitor for 10 years**
A court-appointed monitor will monitor and investigate Sutter’s compliance, including conducting interviews and surveying insurers

Minnesota relevance: Sutter is prohibited from engaging in anticompetitive practices in California which allegedly drove up costs, but may not be in Minnesota.

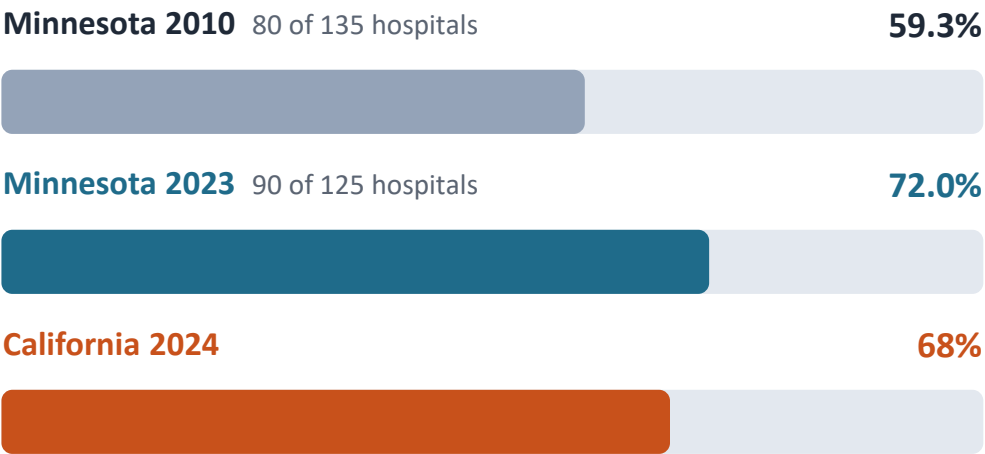
Post-settlement: Sutter remains a high-cost system, charging 368% of Medicare for inpatient and outpatient services as of 2022 (Allina Health: 252% of Medicare)

Sources: Whaley, Christopher M., Rose Kerber, Daniel Wang, Aaron Kofner, and Brian Briscoe. *Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative*. 2024. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html; State of California Department of Justice - Office of the Attorney General. “Attorney General Bonta Announces Final Approval of \$575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices.” Press Release. State of California Department of Justice - Office of the Attorney General, August 27, 2021. <https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-final-approval-575-million-settlement-sutter>; Waters, Rob. *California’s Sutter Health Settlement*. Milbank Memorial Fund, 2020. https://www.milbank.org/wp-content/uploads/2020/09/Sutter-History-Report_v3.pdf.

Minnesota already has California-level hospital system consolidation

The market structure that preceded California’s commercial price growth is already in place in Minnesota.

Share of hospitals in multi-hospital systems



What followed in California

- 1 Systems became the bargaining unit**
Systemwide “all-or-nothing” contracts required health plans to take all of a system’s hospitals or none.
- 2 Commercial prices diverged**
Commercial revenue per adjusted discharge rose far faster than Medicare and Medi-Cal after 2000 — roughly double Medicare’s by 2024.
- 3 Sutter’s prices rose relative to peers**
Gap vs. control hospitals: 9% before (1995–99), 36% after (2001–05), and 32% (2010–19).
- 4 The model spread**
Many other California systems adopted systemwide contracting, enabling higher prices.

Implication for Minnesota: Systems - Minnesota’s share of hospitals in systems (72%) now exceeds California’s (68%).
Vertical Physician Integration - 6% of primary care doctors now employed directly by health systems in Minnesota.
The conditions for systemwide contracting leverage are already present — and the proposed Sutter–Allina transaction could add the potential for California’s all-or-nothing case to Minnesota.

Sources: Minnesota hospital system affiliation, 2010–2023; California — HCAI hospital financial data (Exhibit 2), revised California analysis (2024); Melnick & Fonkych, J Hosp Manag Health Policy 2024.

Policy options Minnesota could consider as hospital systems grow

The California experience points to several options for legislative or regulatory consideration; each has potential benefits and tradeoffs.

01

Regulate Systemwide contracting

Consider rules for contracts that condition inclusion of one hospital on inclusion of all system hospitals. Potential objective: preserve insurer ability to steer patients and maintain lower-price alternatives.

Key design questions: scope, exemptions, access, and treatment of clinically integrated systems.

02

Mandate Standardized Reporting - Organizational transparency

Require clearer reporting of ownership, affiliation, acquisitions, management relationships, and system membership so regulators can see how bargaining units change over time.

Key design question: what minimum information is needed for effective monitoring?

03

Mandate Standardized Reporting - Commercial price transparency

Link system affiliation to available negotiated-price data and standardized measures so consumers, employers, and policymakers can compare payment differences across systems and track changes over time.

Key design question: how should existing hospital and insurer data be organized at the system level?

04

Set a statewide spending growth target

Use California's OHCA model as an example: a statewide target for per-capita health spending growth. Targets were 3.5% for 2025–2026 and 3.2% for 2027, with a phased approach to tighter growth.

Key design questions: target versus enforceable cap, measurement, accountability, and treatment of unavoidable cost shocks.

California is a case study, not a one-size-fits-all prescription. The relevant Minnesota questions are how system organization affects bargaining, what information regulators need, and how to balance affordability, access, and potential integration efficiencies.

Sources: Melnick & Fonkych (2024); Health Affairs research on cross-market systems; Minnesota health care affordability materials; California HCAI/OHCA, Statewide Health Care Spending Growth Target (SB 184).

STRATEGIC SUMMARY



Market Power Shift

72% system ownership shifts leverage in commercial negotiations, driving up benchmark prices.



Double-Digit Rate Hikes

Payer rate filings for 2027 = +11.9% individual, +21.4% small group.



Consumer Rationing

Over half of Minnesotans ration care or skip treatments as out-of-pocket costs outpace wage growth.

4

Quadruple Whammy

Employer costs can pressure hiring and wage growth; higher worker premiums reduce take-home pay; higher cost sharing leaves less disposable income.