UNITED STATES of CARE

JULY 1, 2024

WRAP UP REPORT:

2024 STATE LEGISLATIVE SESSION

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TABLE OF CONTENTS

About United States of Care

United States of Care (USofCare) is a non-partisan non-profit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people.

In 2022, USofCare released a roadmap of 12 policy solutions that reflect what people want out of the health care system. These 12 solutions, titled the "United Solutions for Care", comprise common sense policy reforms that garner broad public support across demographic, geographic, and partisan domains.

USofCare, grounded in our listening work and the United Solutions for Care, advocates for policy reforms at the state and federal levels. Translating these policy solutions into meaningful reforms for legislative and regulatory uptake is central to our advocacy efforts. As such, our experience and success advancing these policy solutions in states can influence the kinds of reforms that Congress and the administration may ultimately take up legislatively and regulatorily.

Introduction

Inflation and the affordability of health care are the top issues for the 2024 presidential candidates to address, with people seeking action from their elected leaders to lower out-of-pocket health care costs. This comes as no surprise, as the United States spends considerably more on health care than peer nations, yet health care outcomes stagnate or lag in comparison. As health care spending continues to outpace inflation, largely driven by high hospital prices, people and families are increasingly saddled with high health care costs. In fact, more than half of people report having skipped or delayed accessing the care they needed because they were unable to pay for it. Three-in-four voters across party lines rate the cost of health care in the United States as "only fair" or "poor." This affordability crisis largely drove the health care policy landscape at the state legislative level.

As legislative sessions draw to a close in many states one thing is clear – health care is on the agenda in states across the political spectrum, as legislators respond to the pressures that their constituents are feeling. Our analysis of the 2024 legislative session reveals **three state policy trends** to address the health care affordability crisis:

1. **States Advanced Policies that Promote Hospital Accountability**
2. **States Prioritized Protecting and Expanding Access to Health Coverage**
3. **States Sought Out Opportunities to Innovate and Improve Health Care Affordability for People**

These trends reflect the transformative state policy solutions that deliver on what people want and need from the health care system: accessible, affordable, and equitable coverage and care. Notably, within each of these trends is a recognition that health inequities persist nationwide, and individual states are making progress to eliminate systemic barriers to care and disparities for at-risk and traditionally underserved constituencies with targeted reforms and actions. Due to the growing need for meaningful solutions for health care affordability, this report seeks to dial in specifically on health care policy solutions which improve access to affordable health coverage.

This report details progress made in 2024 state legislative sessions to increase hospital accountability, protect people's access to needed care, and to advance innovative forms of affordable coverage. Informed by those insights, we provide a glimpse into how these reforms will impact state legislatures in 2025, as well as how they translate into federal policy.

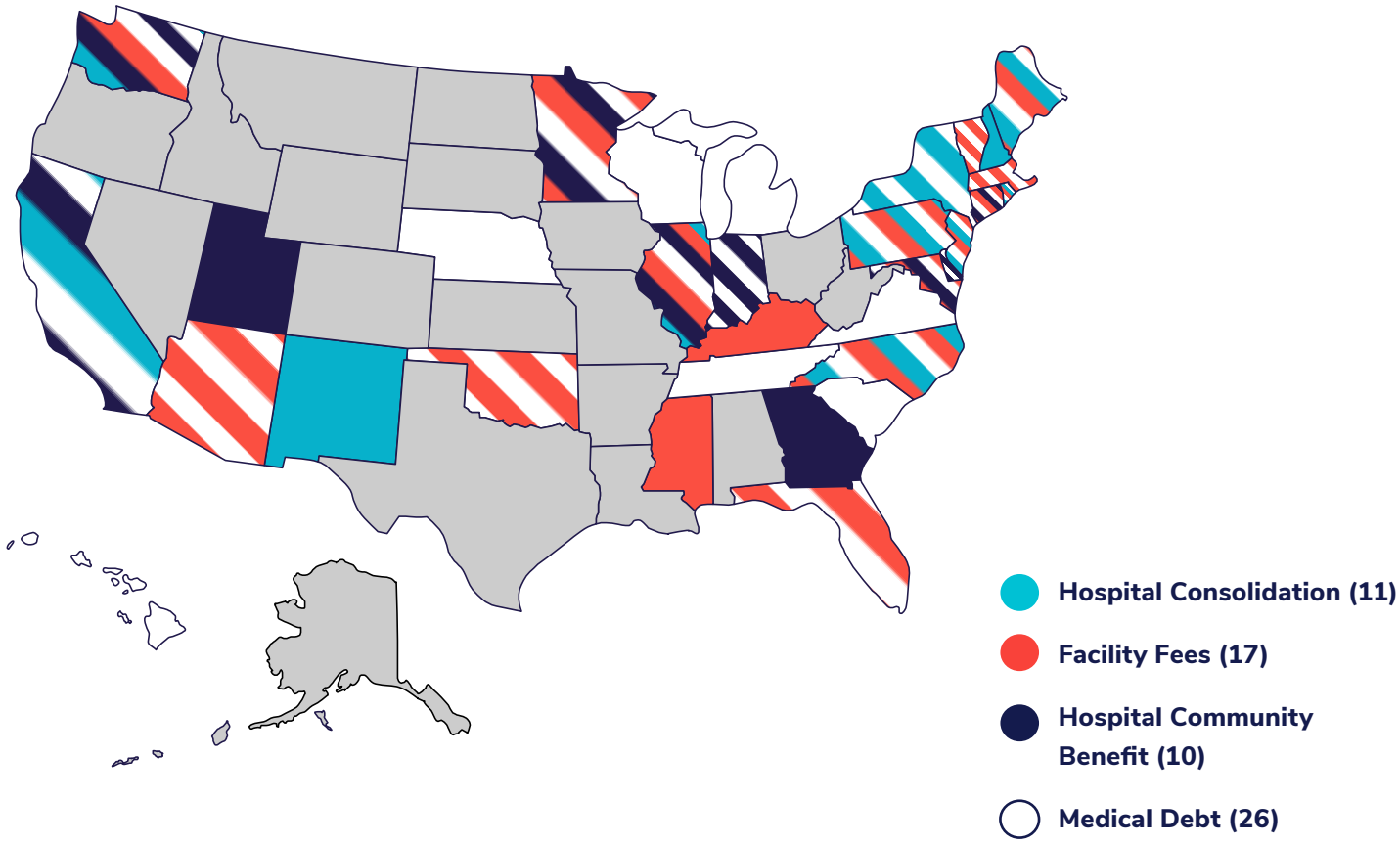
[1] As of July 1, 2024, 7 state legislatures (CA, MA, MI, NJ, NC, OH and PA) are still in regular session.

State Trend #1: States Advanced Policies that Promote Hospital Accountability

State policymakers are continuing to scrutinize hospitals and other health care providers, looking to protect people's pocketbooks and ensure that providers are accountable to the needs of the communities they serve. With hospitals driving a significant portion of the nation's health care spending, it's clear why legislators view rapidly growing hospital prices as the main driver of the affordability crisis. The rise in prices is due, in large part, to a decades-long industry movement toward consolidation, which often leads to increases in health care prices with no demonstrated improvement in quality of care.

This creates a larger-than-ever financial burden for consumers, employers, and state budgets, forcing many families to choose between paying for health care or other basic needs in order to make ends meet. This session, state legislatures pursued bipartisan solutions to increase hospital accountability by limiting the ability of health systems and hospitals to consolidate, protecting people from the negative impacts of already consolidated systems, and enforcing requirements that certain hospitals give back to the communities they serve. Notably, as highlighted below, strong proposals to reign in hospital prices saw success in many red and purple state legislatures which historically have shied away from enacting bold health care reforms.

Map of 2024 State Action to Promote Hospital Accountability



How States Are Addressing Hospital Consolidation

State solutions to address hospital consolidation include:

- ❑ Review of health care transactions and their effect on people.
- ❑ Authority to approve transactions, with or without imposing conditions.
- ❑ Continued oversight of health care transactions.
- ❑ Prohibition of anticompetitive terms in hospital contracts.

In 2024, several state legislatures advanced policies representing a wide range of approaches to address health system and hospital consolidation. Some states strengthened their abilities to review and conduct oversight of health care industry transactions as a means to protect people from the negative impacts of consolidation, either through the creation of new programs under existing state agencies or through leveraging their Offices of Attorney Generals. Oregon's Health Care Market Oversight program and the Massachusetts Health Policy Commission's transaction review initiative served as models for other states to follow.

> *United States of Care supported legislation in both New Mexico and Washington seeking to increase oversight of health entity transactions during 2024 legislative sessions.*

In New Mexico, the legislature passed SB 15, creating a process for the New Mexico Office of the Superintendent of Insurance to review and approve transactions involving a New Mexico hospital. An important aspect of health care transaction oversight is the development of review criteria and approval conditions which look at the impact of a transaction on consumers. New Mexico's bill, upon introduction, directed the state to review the transaction's impact on access to culturally responsive care, affordability, and quality of communities impacted by the merger. Unfortunately, this provision was struck out of the final version.

Washington's legislature considered SB 5241, which would establish oversight and approval of health care entity material change transactions, specifically taking into account the impact of the transaction on the affordability, availability, and access to services for all community members, with a focus on Washingtonians who are low-income, disabled, LGBTQ+, terminally ill, racial or ethnic minorities, and women. When coupled with a robust stakeholder engagement process, these requirements help to hold health systems accountable to serve the needs of their community and provide state regulators with the necessary information to protect people from corporate actors.

In addition to efforts to limit further consolidation, states including New York and Tennessee focused on solutions to protect people from already consolidated health systems through the prohibition of anti-competitive terms in contracts between hospitals, health systems, and insurance companies. These contract clauses – including most-favored-nation provisions, anti-tiering or anti-steering provisions, gag clauses, and non-compete clauses – are often leveraged by health systems to obtain reimbursement rates from payers above competitive levels.

State Progress to Regulate or Prohibit Facility Fees

Facility fees are expenses charged by hospitals and health systems in addition to the cost of treatment and the professional fees paid to providers. These unfairly billed fees result in the same service costing a higher amount, simply because it was provided in a hospital-owned outpatient facility or clinic rather than an independent physician's clinic.

In the 2024 legislative session, 16 states considered legislation to regulate the facility fees charged by health systems for services to protect people from unnecessary facility fees, recognizing the growing demand from their constituents to regulate this practice. **Recent polling shows that 74% of voters support limiting or restricting facility fees, while 81% of voters support requiring that facility fees be disclosed to patients upfront before they are seen.** Read more about United States of Care's polling showing strong support for lowering health care costs, limiting facility fees, and requiring transparency in hospital billing here.

> *"I don't think that you should be having facility fees at all, but if you are going to, you should at least tell them and then based on the urgency, you could say, yes, I will pay that, or I'm going to look somewhere else."*
>
> - FOCUS GROUP PARTICIPANT

The Maine legislature addressed facility fees through the passage of LD 2271, which implemented several recommendations of the Task Force to Evaluate the Impact of Facility Fees on Patients, which was created during the 2023 session. The bill enacts requirements for hospitals to notify patients about potential facility fees upfront. In Arizona, lawmakers considered a full prohibition on charging facility fees on services provided in hospital-owned outpatient facilities, similar to bills introduced in Massachusetts and North Carolina. These bills are the latest examples of state-level momentum to protect people from unnecessary facility fees, signaling a growing effort by legislatures to rein in this harmful practice in sessions to come.

USofCare partnered with Consumers for Affordable Health Care in Maine to survey Mainers perceptions on medical debt and facility fees, to support the passage of LD 2271. In Washington, USofCare worked with state partners to submit testimony supporting legislation to protect people from facility fees and increase transparency around billing of these unfair fees.

State solutions to protect people from facility fees include:

- ❑ Prohibit billing of facility fees through implementing site, service, or billing-based restrictions.
- ❑ Promote patient notification and transparency of facility fee billing.
- ❑ Ensuring hospital accountability through state agency enforcement mechanisms and corrective action processes for patients.
- ❑ Collect data to guide future action through requiring public data collection or study bills.

Recent Focus from States on Nonprofit Hospital Community Benefits

In addition to solutions to reign in hospital prices, many state legislatures turned their attention to how hospital financial practices impact the communities in which they serve. More than half of acute-care hospitals in the U.S. are nonprofit hospitals receiving tax exemptions in exchange for providing charity care and other benefits to local communities. While the Internal Revenue Service (IRS) has general guidelines for hospitals providing these benefits, there are no specific quantitative requirements for the amount of community benefits these hospitals must provide to maintain their nonprofit tax status, leading to large variation in community benefit spending.

A recent KFF report found that the total estimated value of tax exemption for nonprofit hospitals nationwide (about $28 billion) far exceeded their total estimated charity care costs ($16 billion), a trend that several state legislatures have taken notice of. In response, 10 states considered legislation to address hospital community benefit spending, with solutions ranging from requiring hospitals to provide financial assistance to specific patient populations (such as SNAP recipients), regulating the types of activities hospitals can count towards their community benefit activities, and/or mandate that hospitals make patients aware of their financial assistance programs.

2024 saw a growing list of cities and counties looking to protect people from medical debt, with the City of New Orleans and New York City both establishing medical debt forgiveness programs for city residents. While evidence of the benefits of medical debt relief programs on people's health and financial status is unclear, we expect to see more municipalities pursuing similar programs.

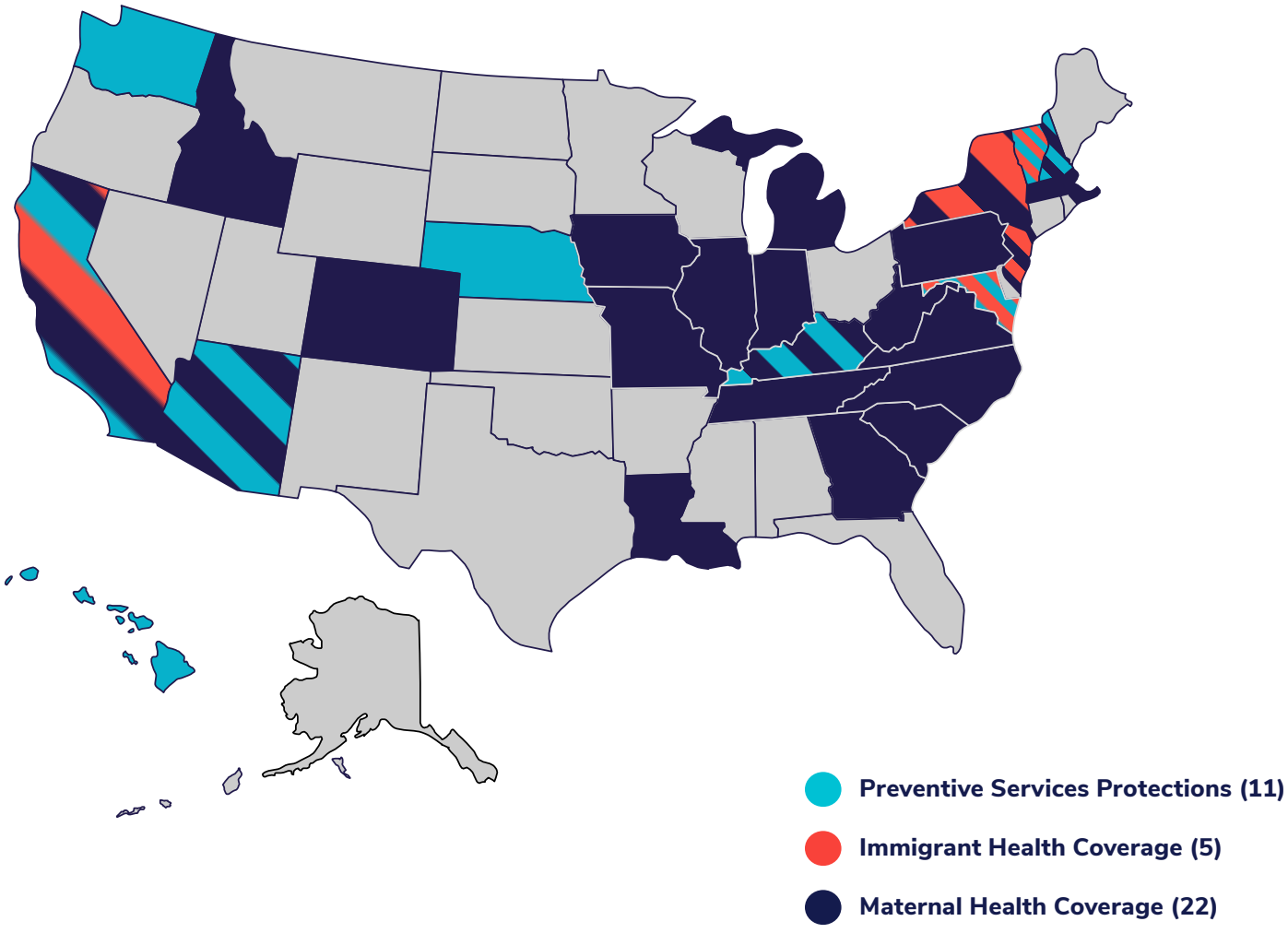
States Moving to Address Medical Debt

About four in ten adults report having debt due to medical or dental bills, with disproportionate shares of Black and Hispanic adults, women, parents, those with low incomes, and uninsured adults experiencing health care debt. Medical debt does not just impact uninsured people, as high out-of-pocket costs and complicated insurance billing practices often push even those with health insurance into thousands of dollars in debt. Given the limited federal regulation of this issue, states are stepping in to protect individuals and their families from predatory medical debt collection practices. 26 states considered legislation relating to medical debt during the 2024 session, including proposals to restrict wage garnishment for medical debts, cap medical debt payment plans, and ban medical debt from being included in credit reports.

State Trend #2: States Prioritized Protecting and Expanding Access to Health Coverage

As Affordable Care Act (ACA) plan enrollment came to a close in early 2024, many states posted record sign ups for Marketplace plans. In fact, plan selections were more than 30% higher in 2024 than they were in 2023, with some states even increasing enrollment by 60 to 80%. The wave of Marketplace enrollment coincides with the halfway point of state Medicaid redetermination processes, which has resulted in the disenrollment of more than 16.2 million people thus far. In response to concerns that the final number of people losing Medicaid coverage will likely exceed original projections, many state legislatures, in red and blue states alike, expanded eligibility for current programs to reduce coverage gaps and protected coverage for critical health services.

Map of 2024 State Action to Protect and Expand Health Care Coverage



States Prioritizing Preventive Services Protections

The Braidwood Management v. Becerra case challenged the ACA's requirement for most private insurance plans to cover recommended evidence-based preventive care services recommended by the U.S. Preventive Services Task Force (USPSTF) with no out-of-pocket costs for people. The case is currently before the Fifth Circuit Court of Appeals, which issued a pause (known as a stay) of the lower court's ruling that deemed a portion of the ACA's preventive services mandate unconstitutional.

More than 150 million people – including approximately 37 million children – with private insurance benefit from access to free preventive services.

No-cost preventive services are one of the most popular aspects of health care coverage and are scientifically proven to improve health outcomes and lower costs. Potential changes to out-of-pocket costs for these services will likely have a disproportionate impact on communities of color, low-income people, and the LGBTQ+ community, further limiting these populations' access to essential preventive services and reversing the existing progress made towards reducing health disparities. Prior to the 2024 legislative session, 17 states passed legislation to protect no-cost access to preventive services.

In anticipation and response to this decision, 8 states considered legislation in 2024 to codify no-cost coverage of all or some USPSTF-recommended "A" and "B" rated services into state law. Washington and Arizona's bills went a step further, requiring health insurers to not only cover USPSTF services at no-cost, but also the preventive services recommended for women and children by the Health Resources and Services Administration (HRSA), and vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). This comprehensive approach ensures that all preventive services are protected at no cost to consumers, even if future court decisions result in weakening the remaining protections for preventive services recommended by ACIP and HRSA. While these protections would apply to the individual and small group market as well as state employee benefit plans, state legislatures do not have jurisdiction over fully insured and self-insured plans, which are federally regulated, leaving millions of residents unprotected.

States should consider the following to ensure cost-free access to preventive care:

- ❑ Codify protections for all preventive services recommended by USPSTF, ACIP, and HRSA into state law.
- ❑ States should codify existing Essential Health Benefits requirements, which includes preventive services, and amend the state benchmark plan to include services recommended by USPSTF, ACIP, and HRSA.
- ❑ Develop tools to identify and take action against non-compliant actors.
- ❑ Ensure patients are held harmless and establish resolution processes.

In addition to supporting the development and passage of related legislation in several states, USofCare led an amicus brief submitted to the U.S. Court of Appeals for the Fifth Circuit highlighting the importance of no-cost preventive services for people. Read more about the Braidwood Management v. Becerra case on USofCare's Preventive Services Resources Hub, which also contains talking points and other resources helpful for advocating for no-cost preventive services protections.

States Expanding Health Coverage for Immigrants

In 2024, as states sought to lower their uninsured rates, legislators turned their attention to expanding health coverage to immigrant communities. Non-U.S. citizens, particularly undocumented immigrants, are significantly more likely to be uninsured than U.S. citizens. While undocumented immigrants are able to receive emergency care and limited coverage for pregnancy, they are generally not eligible to access more expansive health coverage through public health insurance programs like Medicaid and Medicare, or purchase coverage on the federal Marketplace, due to federal law. Due to a recent federal rule, Delayed Action for Childhood Arrivals (DACA) recipients are now able to purchase coverage on the Marketplace and gain access to certain federally-funded affordability programs. Further, many undocumented immigrants cannot obtain employer-sponsored coverage, since a significant portion work in low-wage jobs and in industries that are less likely to offer such benefits.

To address the challenges that undocumented immigrants face, several states considered state-funded public insurance, such as Medicaid or Basic Health Plan "look-alike" programs to offer comprehensive coverage to low-income undocumented immigrants. S 2237 in New York builds upon the state's recently approved 1332 waiver amendment to raise the income limit of their Basic Health Program (known as the Essential Plan) to offer coverage to undocumented New York residents. The California legislature is considering AB 4, which allows undocumented people in the state to purchase a state-run health plan on their exchange, as well as create a framework to provide state-based premium assistance for this population in future years. Similarly, in Maryland, legislators approved HB 728, which authorizes the state to apply for a 1332 waiver to create a state-run health exchange for undocumented immigrants. If signed by the Governor, the bill would open up coverage for more than 275,000 Maryland residents.

> ***Read USofCare's explainer of New York's recently approved Section 1332 waiver here.***

States Advancing Postpartum Maternal Health Care

The U.S. continues to have the highest maternal mortality rate of any developed nation, with a majority of pregnancy-related deaths being considered preventable. Many states' maternal mortality rates are double that of the average U.S. rate, pushing state policymakers to prioritize solutions to improve maternal health outcomes, with a specific focus on addressing the disparities that result in worse outcomes for Black women and pregnant people in recent years. Through approaches such as state maternal mortality review committees, implementing quality improvement initiatives, and ensuring greater access to maternal health care services during and after pregnancy, states are leading the development of policies to address maternal morbidity and mortality.

Many state legislatures sought to improve maternal health, reduce racial disparities that disproportionately harm Black women and pregnant people, and improve coverage stability for pregnant people through Medicaid postpartum coverage extension. Notably, at the close of the 2024 legislative session, Arkansas is the only state that has not authorized this extension. Meanwhile, Idaho and Iowa both passed legislation directing their respective state agencies to begin the application process for federal approval of a 12 month extension. Additionally, to further address racial disparities, states such as North Carolina and Virginia, now require providers to undergo training to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care.

States also established new committees to study and assess maternal health outcomes and/or strengthen existing review panels. Idaho, the only state without a maternal mortality review committee, passed legislation to reestablish a committee by July 1, 2024. Legislators in Tennessee approved a bill to establish the Maternal Health Equity Advisory Committee, which will analyze maternal health data in the state and make recommendations for action to help address the State's increasing maternal mortality rate. These bills provide a snapshot of the growing trend of state legislatures exploring innovative ways to address the maternal mortality crisis.

States Regulating the Use of Artificial Intelligence in Health Care Decision-Making

The proliferation of artificial intelligence (AI) across other industries has turned the spotlight on the implications for the use of AI in health care. While state lawmakers are still learning about the implications of AI in health care, 2024 legislative sessions marked the beginning of many important discussions around data privacy, transparency, and health equity. Policymakers sought to address concerns from both advocates and industry around the risks of using AI, especially around racial bias in AI, which can result in inappropriate and ineffective care. Approximately 12 states saw legislation specific to the use of AI in health care introduced during the 2024 session. A handful of more states examined general AI legislation that is inclusive of, but not necessarily restricted to, the health care sector. Thus far, state policy solutions to regulate AI have been largely bipartisan.

State legislators considered many bills that addressed the general regulation of AI and automated decision-making (ADM) across all lines of business, which has implications for how health systems and carriers use AI. Health-specific bills largely address three main regulatory concerns – patient notification, data privacy, and the use of AI in utilization management or clinical diagnosis decisions – though policymakers face many unanswered questions around what states' roles are in governing the design, development, and use of AI in health care and beyond. Several states – such as New York, Oklahoma, and Pennsylvania – considered bills regulating the use of AI-based algorithms in health insurance utilization review processes, ensuring that these coverage determination processes maintain human oversight.

> ***Read USofCare's research on people's opinions on the role, implications and sentiments of AI in health care here.***

State Activity on Abortion and Reproductive Health Care

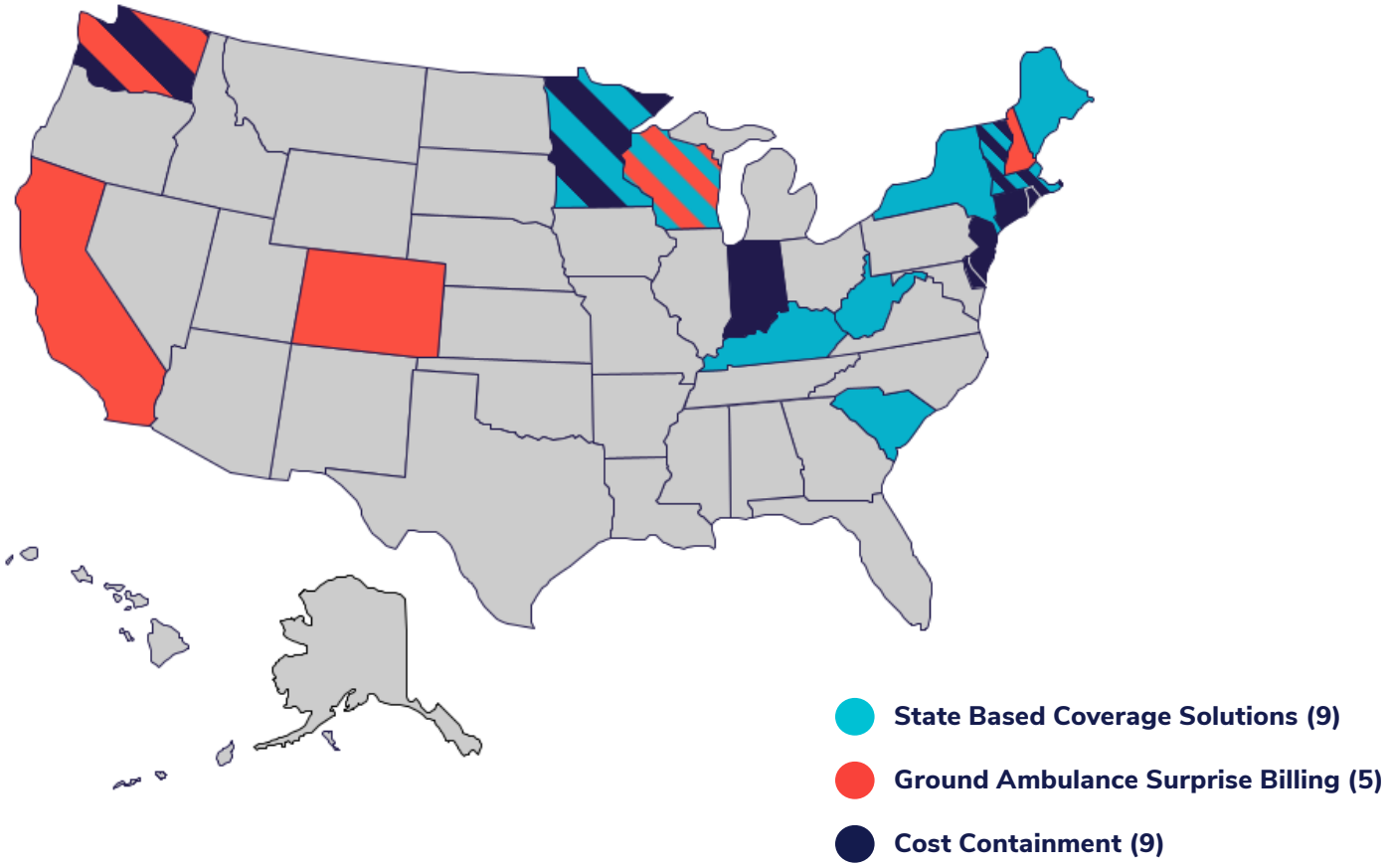
In 2024, many states continued to consider policies to enshrine or expand access to abortion, while others opted to restrict or ban access to these services. While more than 783 state bills addressing abortion services were introduced in legislatures during 2024 sessions, a majority of these bills saw no legislative action taken on them. Instead, these pieces of legislation often served as a vessel for broader values debates in both red and blue states alike. We expect state legislators to continue grappling with debates around access to reproductive health care and abortion services through 2024 and into 2025, heavily influencing state and federal election conversations in November.

State Trend #3: States Sought Opportunities to Innovate and Improve Health Care Affordability for People

Health spending in the United States is projected to reach $4.9 trillion by 2024, a 5% between from 2023. Despite paying some of the highest health care prices in the world, health outcomes in the United States lag behind those of our peer nations, with many people delaying needed care or skipping it entirely due to cost. This reality is only more pronounced for lower-income populations, which disproportionately include communities of color.

A number of state legislatures pursued policies to develop new low-cost health insurance coverage options to provide individuals and their families with dependable coverage. Additionally, state policymakers have explored reforms to make health care more affordable for their residents through solutions that protect people from surprise medical bills and medical debt, set cost growth targets, and increase prescription drug affordability.

Map of 2024 State Action to Improve Health Care Affordability



States Pursue Innovative State Based Coverage Solutions

States that have created their own affordable coverage options serve as shining examples of the success of state-based coverage solutions. In Colorado, a record 80,655 people enrolled in the Colorado Public Health Insurance Option during 2024 open enrollment, representing an increase of 188% over the 2023 enrollment period, offering Coloradans access to high quality plans they may have otherwise not been able to afford. Similarly, in plan year 2024, Washington's Cascade Select public option plan premium increases were nearly 50% lower than non-public option plans available, making public option silver plan premiums the lowest coverage option for Washingtonians in nearly 80% of counties in the state.

USofCare's 1332 Waiver Comparison Chart details state public options developed so far, while our 1331 Waiver Comparison Chart highlights the similarities and differences between state's Basic Health Plans.

In light of these successes, several states pursued flexible policies like public options and Medicaid buy-ins to meet the coverage needs of their residents. These policies draw on the strength of a state's purchasing power to bring more dependable coverage to people by negotiating fair payment rates from insurance companies or providers, establishing better provider networks, addressing health equity, and/or using existing state infrastructure. Early results of Medicaid redetermination processes have sparked legislators' interest in finding effective approaches to preserve health care access for the millions of individuals losing their Medicaid coverage while also addressing the needs of the remaining underinsured and uninsured populations.

> *USofCare continues to support state policymakers in designing and implementing state-based coverage solutions that meet the needs of their residents. States interested in developing a public option can reference USofCare's memo for important considerations. For policymakers interested in learning more about the 1332 waiver approval process, see USofCare's 1332 Waiver Process Guide.*

In Vermont, legislators considered H 721 to develop a proposal for a public option for small businesses in the state. Small businesses are the least likely to offer insurance coverage to their employees, most often citing cost as a barrier. A state-supported public option for small business could help reduce gaps in coverage for employees while offering small businesses the ability to expand their benefits package and boost employee recruitment and retention.

Proposals to create Basic Health Plans were considered in Kentucky and Wisconsin, offering sustainable and affordable coverage for individuals between 138% and 200% of the federal poverty level, many of whom regularly "churn" between Medicaid and private insurance due to income fluctuations. Wisconsin's bill also sought to address the unaffordability of health insurance coverage for small businesses, requiring the agency to develop an option for small businesses to buy into the program created. Finally, in South Carolina and West Virginia, legislators considered with Medicaid buy-in proposals, offering their residents the opportunity to purchase health coverage that mimics Medicaid at a price that is affordable for them. We expect many of these proposals to be reintroduced next year, as states capitalize on growing momentum to provide affordable coverage solutions designed with their unique needs in mind.

States Advance Ground Ambulance Surprise Billing Protections

One of the primary drivers of high out-of-pocket health care costs for people are surprise medical bills, also known as balance bills. These unexpected bills are charged for care received from an out-of-network provider in an in-network facility. Despite the passage of the federal No Surprises Act (NSA) and some states passing laws to protect consumers from surprise bills, many gaps remain. One major area of health care with few surprise billing protections are ground ambulance services, leaving many people on the hook for high balance bills not covered by their insurance.

In response, 5 states considered legislation to regulate ground ambulance billing, joining the 13 states that have already enacted protections. Washington, informed by the recommendations of the Washington Ground Ambulance Advisory Group, passed SB 5986, which bans balance billing for covered emergency and non-emergency ground

ambulance transportation. Washington, like many other states, faced the challenge of creating a reimbursement mechanism for public and private ground ambulance out-of-network services.

States have taken many different approaches to establishing rates for out-of-network ground ambulances. In Washington, legislators chose to defer out-of-network rates to those set by a local jurisdiction, or in the absence of a local rate, 325% of Medicare. While in line with several other states that have passed ground ambulance billing protections for people, policymakers looking to pursue similar policies should ensure that their legislation includes language to defer to whichever reimbursement rate is lower between a fixed percentage of Medicare and local rates.

> ***USofCare's ground ambulance surprise billing resource walks through the impact of surprise ground ambulance bills on people and offers insight into state policy solutions to help inform policymakers, advocates, and other stakeholders looking to protect people from these bills. We look forward to continued engagement with our state partners to support passage of legislation in 2025 and beyond.***

States Advance Cost Containment Solutions

In an effort to address soaring health care spending, states advanced policy solutions to contain health care costs, including implementing reference-based pricing for certain providers and setting or reviewing cost growth targets. Legislators in Delaware approved HB 350, which creates a state hospital cost review board that will be responsible for reviewing and approving annual hospital budgets starting in 2026. Until then, the bill would require hospitals to charge any payer no more than 250% of Medicare for any service offered in 2025 and 2026. Using reference-based pricing offers payers the ability to more accurately reflect the actual cost of providing services in their reimbursement rates to hospitals and other health care providers, rather than negotiating from uneven grounds due to a provider's high market share or other anticompetitive factors. Many states also considered bills to amend their state cost growth benchmark programs, a growing strategy for states to contain costs and make health care more affordable for their residents, through solutions such as including hospitals in current cost growth targets, or strengthening enforcement mechanisms for exceeding the target.

States Continue to Focus on Prescription Drug Pricing

With 1 in 3 adults reporting they are unable to afford taking their medication as prescribed, rising prescription drug prices continue to threaten family budgets and health outcomes. Given the many actors in the prescription drug space, it can be challenging for policymakers to address the root causes of this issue. Many state legislators have implemented strategies to lower costs for their residents, such as creating prescription drug affordability boards, reforming pharmacy benefit manager (PBM) practices, and setting price caps for specific prescription drugs.

In recent years, states have turned their attention to the actions of PBMs, entities that serve as the middleman between health insurance companies and drug manufacturers. The fees and incentives charged by PBMs often contribute to the high cost of prescription drugs for people, spurring 41 states to introduce legislation seeking to regulate PBMs. Legislative solutions vary from state to state, with states considering bills to increase PBM transparency through licensure and reporting requirements, setting pharmacy network and access requirements, and/or regulating drug pricing and pharmacy reimbursement practices.

Cost-sharing for prescription drugs is also growing, as health insurance companies increasingly shift soaring drug prices to people through rising premiums, copays, and deductibles. In response, many states – including Connecticut, Kentucky, and Michigan – considered legislation to create a prescription drug affordability board (PDAB). A PDAB empowers states to evaluate the affordability of prescription drugs and lower the financial burden of these medications for their residents. Going a step further, 24 states saw bills to set out-of-pocket price caps for prescription drugs introduced during the 2024 session. While all of these bills set price caps on specific drugs, like insulin or epi-pens, we expect state legislators to turn their attention to other drug types in future sessions in response to growing demands from their constituents.

Federal Policymakers Building On State Policy Successes

As lawmakers and advocates continue to set their sights on major bipartisan policy reforms, upcoming Congressional and presidential elections in November present new opportunities and challenges for building on reforms into 2025. With red and blue states continuing to advance solutions that deliver on people's health needs, now is the moment for lawmakers in the Senate and the House to capture this progress and deliver meaningful reforms to increase health care affordability and access for people. Several areas of Congressional bipartisan collaboration in 2024 followed state successes around hospital accountability, health care affordability, and coverage access reforms.

Hospital consolidation and price transparency continue to be high priority issues for both chambers of Congress. Voters across party lines and demographics overwhelmingly support policies to curb high hospital prices and implement transparency in health care billing. Building on the success of states, members of Congress supported targeted actions to lower health care costs by enacting site-neutral payment reforms and establishing new hospital transparency and accountability measures. This culminated in the passage of H.R. 5378 – also known as the Lower Costs, More Transparency Act – in the House of Representatives by a significant margin (320-71). In addition, the Centers for Medicare & Medicaid Services (CMS) continues to explore reforms that will make hospital price transparency data more accurate, and readable for patients to be able to understand the true cost of services. In 2025, we can expect that states will continue to implement reforms that drive tougher hospital accountability measures and reform dishonest hospital billing practices, while Congress will leverage opportunities it sees for bipartisan success that capitalizes on state momentum.

As primary care workforce shortages continue to be a persistent problem across states, federal regulators are looking to innovative care models to increase investment in primary care while lowering health care costs for the system at large. Existing health system payment and delivery reform efforts in states like Maryland, Pennsylvania, and Vermont are informing the implementation of CMS models focused on payment and delivery system reforms through a multi-payer approach – aligning Medicaid, Medicare and commercial payers. As CMS continues to pilot new equity-focused and patient-first centered models, states will be responsible for enacting these reforms and ensuring people benefit from lower health care costs and more comprehensive care.

> ***Through a multi-part initiative to listen to people's needs and desires for the health care system, USofCare learned how to best talk about value-based care with people, in order to emphasize how shifting to this new approach aligns with the ways people want to receive high-quality, affordable health care. Read our recommendations on communicating about Patient-First Care in a way that resonates with people here.***

Examples of state innovation and policy reforms are valuable considerations for federal regulators as they capitalize on gains states are making across affordability, access, and health equity. We will continue to monitor how key federal lawmakers and regulators signal an appetite to move legislation before the end of 2024 that echoes successes taking place in states.

Looking Ahead to 2025

As advocates and legislators look towards 2025, it is clear that people want lawmakers to pass targeted reforms to lower the cost of health care. We expect state and federal policymakers and advocates to continue pushing reforms that lower costs, improve affordability, increase transparency in hospital billing, and focus investments in primary and rural health care. As health systems look to lower health care costs and improve efficiency, we know that reforms around health care affordability and rapidly developing artificial intelligence technology will be an emerging frontier for state and federal policymakers.

State sessions in 2024 highlighted the need for policymakers to take action to ensure access to health care for rural communities. State-level conversations around ways to improve insurance coverage and choice for rural consumers, address provider shortages, and limit facility closures will likely continue as the federal government puts increased emphasis on addressing the unique challenges that rural communities face. Additionally, Congress is currently considering legislation such as H.R. 1692, the Health Care Affordability Act, which would make permanent the advanced premium tax credits for Marketplace plans set to expire in December 2025. Should Congress fail to extend the policy, we expect many states to leverage strategies to offset the impact of the program's expiration through the creation of state subsidy programs and continued funding of state reinsurance programs.

Moreover, we expect state and federal elected officials to continue to escalate attention on hospitals and providers to take meaningful action on reforms that lower health care prices for all, a solution supported by voters, payers, and members of Congress. Recently, policymakers have also taken notice of the rising trend of private equity ownership of health care facilities due to the growing number of high-profile examples of the negative impact that these corporate owners have on people's access to affordable, high-quality care. In response, we expect increased oversight by state policymakers into private equity ownership through more scrutiny of health care transactions involving private equity actors, requiring additional financial data reporting by these firms and heightened monitoring to safeguard the financial solvency of facilities purchased by private equity after a transaction occurs.

One additional high-priority issue for federal and state lawmakers in 2025 is the spotlight on the implications for use of artificial intelligence (AI) in health care. As it stands now, states are moving faster than Congress to enact legislation regulating the use of AI in health care. Approximately a dozen states saw health care-specific AI legislation introduced during the 2024 session, a trend which we expect to only grow in 2025. Federal activity on AI in health care has examined guardrails and principles as instructed by a White House Executive Order and related agency work. The proliferation of AI across other industries has meant that thus far, state and federal policy solutions to explore the regulation of AI have largely been bipartisan. Similarly to conversations in states, federal policymakers are expected to explore the impact of racial bias and discrimination in AI tool development and deployment.

If you are interested in learning more about AI-specific terms, see our glossary here, or dive more deeply into the conversation on AI in health care with our issue brief summarizing action on AI this far.

Conclusion

This year's state legislative sessions made clear that people want to know that they can afford their care and that they won't have to choose between their health and potential bankruptcy. We expect that states will continue to lead the way in advancing policies that promote hospital accountability, expand access to health coverage and pursue innovations to improve health care affordability for people. With the start of a new Congress in 2025, there are plenty of opportunities for bipartisan collaboration and momentum on the critical reforms led by states to build a better health care system. We expect federal policymakers and advocates to build upon robust state reforms and continue pushing for equity-centered policy that puts people's health care needs first.

APPENDIX A

Summary of State Action Maps

Summary of 2024 state action maps included in the report. An "X" denotes state action or progress made on the issue in 2024.

STATE	HOSPITAL CONSOL.	FACILITY FEES	COMM. BENEFIT	MEDICAL DEBT	PREVENTIVE SERVICES	IMMIGRANT COVERAGE	MATERNAL HEALTH	STATE COVERAGE SOLUTION	AMBULANCE BILLING	COST CONTAINMENT
AK										
AL										
AR										
AZ		X		X	X		X			
CA	X		X	X	X	X	X		X	
CO							X		X	
CT		X	X	X						X
DC										
DE			X	X						X
FL		X		X						
GA			X				X			
HI				X	X					
IA							X			
ID							X			
IL	X	X	X	X			X			
IN			X	X			X			X
KS										
KY		X			X		X	X		
LA							X			

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MA		X		X			X	X		X
MD		X	X	X		X				
ME	X	X		X				X		
MI				X			X			
MN		X	X	X				X		X
MO							X			
MS		X							X	
MT										
NC	X	X		X			X			
ND										
NE				X	X					
NH					X		X		X	
NJ	X	X		X		X	X			X
NM	X									
NV										
NY	X			X		X	X	X		
OH										
OK		X		X						
OR										

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STATE	HOSPITAL CONSOL.	FACILITY FEES	COMM. BENEFIT	MEDICAL DEBT	PREVENTIVE SERVICES	IMMIGRANT COVERAGE	MATERNAL HEALTH	STATE COVERAGE SOLUTION	AMBULANCE BILLING	COST CONTAINMENT
PA	X	X		X			X			
RI	X	X		X						X
SC				X			X	X		
SD										
TN				X			X			
TX										
UT			X							
VA				X			X			
VT	X	X		X	X	X		X		X
WA	X	X	X	X	X				X	X
WI				X				X	X	
WV							X	X		
WY										