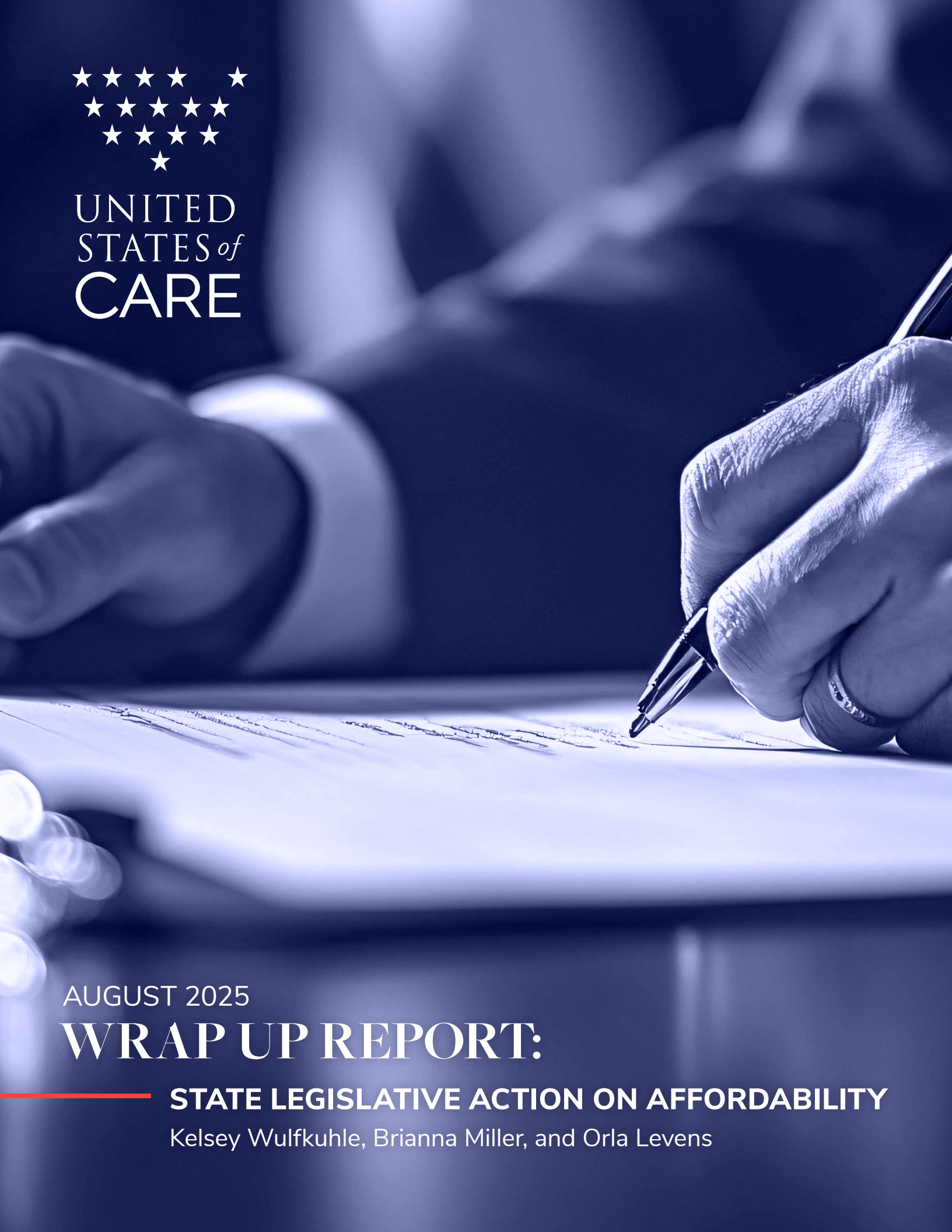


UNITED STATES of CARE

AUGUST 2025

WRAP UP REPORT:

STATE LEGISLATIVE ACTION ON AFFORDABILITY

Kelsey Wulfkuhle, Brianna Miller, and Orla Levens

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

In 2025, the high cost of care remains the biggest heath care issue for people across demographic backgrounds. Health care spending continues to climb, putting increased pressure on family budgets as people face soaring out-of-pocket costs and rising premiums. The burden of rising costs is also applying pressure on employers and squeezing state budgets. More than four in five businesses agree that current employer costs for health benefits are excessive and 87% believe that the cost of providing health benefits will become unsustainable in the future. This affordability crisis was a driving factor in state health policy during 2025 legislative sessions, as states tried to balance budget shortfalls within a tenuous health care landscape.

As legislative sessions draw to a close in many states, one thing is clear: state leaders are stepping up to strengthen health care protections where federal policies may fall short, are nebulous, or are under attack. Our analysis of the 2025 legislative session reveals three state policy trends to address the health care affordability crisis:

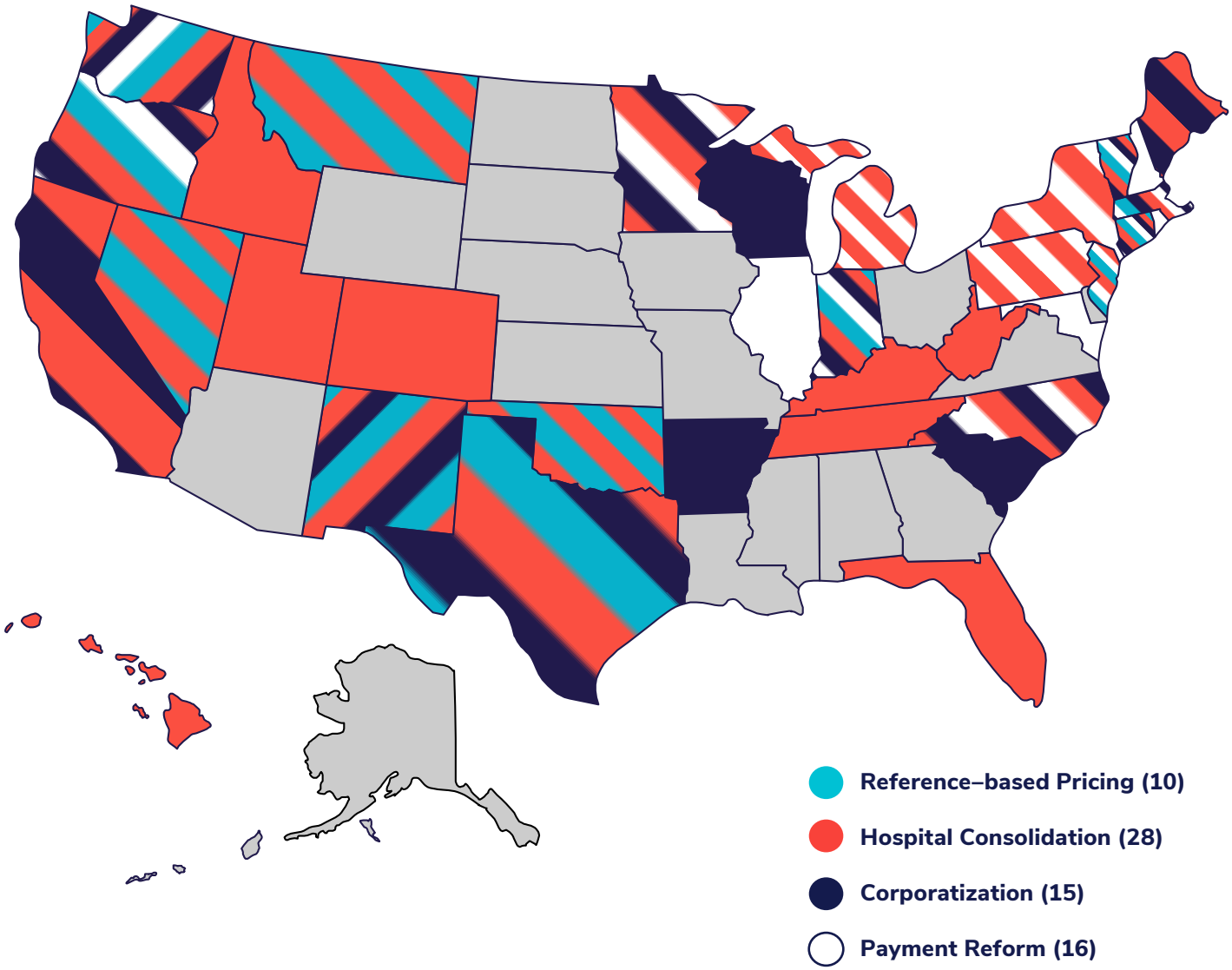
1. **States Took Action to Lower Hospital Prices and Address Hospital Consolidation**
2. **States Advanced Health Care Consumer Protections**
3. **States Preserved Access to Health Care Coverage**

In the face of federal changes, these trends reflect the transformative powers that state policy solutions can offer to address what people want and need from the health care system: accessible, affordable, and dependable coverage and care. During increasingly tumultuous times with tight budgets, these trends also prove it is possible to reduce high health care spending, improve health outcomes, and protect state budgets without cutting access to coverage. Despite this, major uncertainties for states are on the horizon due to federal activity. Informed by this insight, we provide a glimpse into how the rapidly shifting health care landscape may impact state legislatures in 2026.

State Trend #1: States Took Action to Lower Hospital Prices and Address Hospital Consolidation

In 2025, states across the country continued to advance policies to lower the cost of health care for people by working to cap hospital prices, address health system and hospital consolidation, and protect consumers against corporate control of health care that puts profit over patient care. States also looked to lower prices and improve the quality of care for patients by pursuing policies to move away from fee-for-service payment models, emphasizing quality over quantity, and putting patients first. Collectively, these efforts already improved access to care and lowered costs for consumers in many states.

I. 2025 State Action to Promote Lower Hospital Prices and Address Consolidation



Implementing Reference-Based Pricing

> *By implementing [reference based pricing via SB5083], Washington lawmakers are delivering lower premiums and out-of-pocket costs to public employees and teachers covered by the state employee health plan, and saving taxpayers almost $400 million on health care expenses.*
>
> -USofCare

See full statement here.

Rising health care costs limit people's health care choices and put a strain on family and government budgets. A main driver of those rising costs is the prices charged by hospitals, which only continue to increase as a consequence of consolidation. In the 2025 legislative session, as of publication, 10 states considered legislation to enact reference-based pricing, a policy that directly targets what hospitals can charge by benchmarking prices to a "reference price," most often a percent of Medicare reimbursement rates. This approach aims to lower the cost of health care for consumers by directly limiting what hospitals can charge, saving states money and allowing those savings to be reinvested into coverage and affordability protections for people.

Learn more about the impact of state solutions, like reference-based pricing, to lower health care prices for people, hospitals, and state budgets in USofCare's recent report.

Legislation passed in 3 states: Indiana, Washington, and Vermont. USofCare worked on Indiana's HB1004, which requires the state to study commercial hospital prices in Indiana and set average price benchmarks for nonprofit hospitals as a percentage of Medicare. USofCare also worked on Washington's SB 5083, which establishes reference-based pricing to lower health care costs and premiums for people who receive health insurance through the State Employee Benefits Board and Public Employee Benefits Board. Vermont's S126, the most comprehensive of the three, establishes a statewide move toward reference-based pricing by requiring the Green Mountain Care Board to set global hospital budgets that cap what hospitals can charge, using Medicare rates as a benchmark, while requiring the Board to monitor whether reduced hospital prices lead to lower insurance premiums. It also allows the state to extend reference-based pricing to non-hospital services like primary care and includes oversight and transparency measures to protect access to care.

Addressing Hospital Consolidation

Hospital consolidation is a known driver of high hospital and health care costs, leaving private practices, rural clinics, and community hospitals at risk of acquisition by larger, profit-driven hospital systems or entities. Hospital consolidation has significantly grown in recent years, with provider markets becoming increasingly consolidated leading to higher health care prices, impacting people through higher insurance premiums and soaring out-of-pocket costs, like copays or deductibles.

As of publication, 28 states considered legislation to **increase government oversight** of proposed health care mergers and acquisitions to protect consumers from financial decisions that would negatively impact affordability, access, and quality of patient care. Legislation passed in New Mexico strengthens review of hospital and healthcare provider mergers through New Mexico's health care authority, expanding the types of transactions subject to review, ensuring transparency through public reporting and comment periods, and prioritizing impacts on

United States of Care released results from a survey of more than 500 registered voters in Maine. 95% believe it's important for the state government to review health care mergers and acquisitions in order to ensure that changes in ownership do not reduce access and quality of care.

access, affordability, and competition. It also protects whistleblowers and imposes penalties for noncompliance, giving the state stronger tools to safeguard patients and communities. Colorado and Washington passed bills requiring companies involved in mergers to also submit their federal pre-merger notification (Hart-Scott Rodino form) to the Attorney General giving the state more oversight into health care market transactions. Many of these states also considered legislation to **prevent anticompetitive contracting**, removing contractual barriers targeting medical professionals' ability to earn a livelihood after leaving an employer. These policies aim to promote competition, expand patient access to care, and allow health care providers more freedom to practice where they choose.

Protecting People from Increased Corporatization of Health Care

Recognizing the need to protect people against the increasing corporatization of health care, 15 states also considered legislation to increase transparency into health care organization ownership, regulate real estate investment trusts and private equity ownership of health care facilities, or strengthen the corporate practice of medicine. Corporate health care ownership is increasingly being tied to negative impacts on patient safety, quality, access to care, along with increased costs for people. Oregon passed SB 951, which will limit the ways in which physician practices contract with managed service organizations (MSOs) to ensure providers stay in control of medical practices and allow the state's mergers and acquisition review board to intervene if physician practices lose control. Indiana passed HB 1666, which requires the state to annually collect and publish information about the ownership of health care entities in the state.

United States of Care recently released a memo highlighting the lessons learned from supporting Rhode Island stakeholders with implementation of the AHEAD Model. This release included a communications toolkit, which can inform stakeholder messaging and communications efforts on payment reforms such as hospital global budgets.

Advancing Health Care Payment Reform

In an effort to address soaring health care spending, at least 16 states advanced policy solutions which further health care payment reform. Solutions that promote multi-payer alignment, hospital global budgets, and prospective payments for primary care shift providers from fee-for-service models towards payments rooted in providing patient-first care. Vermont passed S.126 which mandates the implementation of hospital global budgets for all Vermont hospitals by fiscal year 2030. Legislators in Massachusetts continue to consider a bill which would establish a primary care expenditure target and direct the state's primary care board to recommend to the legislature an optional primary care prospective payment model.

Notably, the states participating in the Centers for Medicare & Medicaid Services (CMS) upcoming States Achieving Health Care Efficiency Through Accountable Design (AHEAD) Model also advanced payment reform efforts to support Model implementation. This total cost of care (TCOC) Model is designed to lower costs and improve health outcomes over a 10-year period by implementing state-led cost growth and spending targets, hospital global budgets, and increased primary care payments.

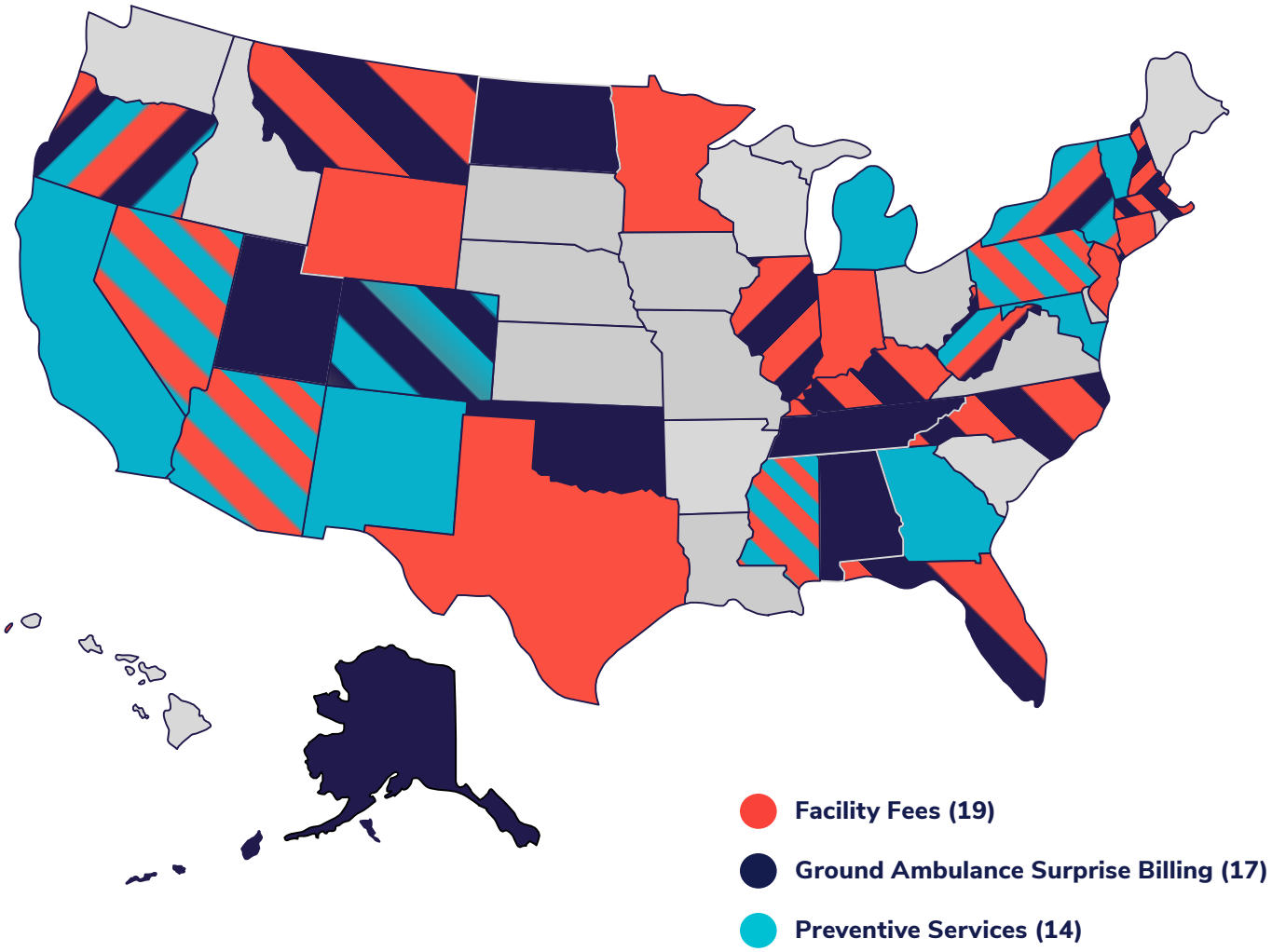
Key Insights

Momentum is growing for bold solutions to protect consumers and state budgets as states navigate a rapidly changing healthcare landscape and increasing threats to coverage. Limiting prices charged by hospitals and health systems through solutions such as reference-based pricing allows states to rein in excessive costs, establish more predictable pricing schemes, prevent surprise billing, and promote accountability. Notably, these hospital price increases are due, in large part, to a decades-long industry movement toward consolidation. Thus, legislation that increases oversight of healthcare market transactions and limits anticompetitive contracting plays a critical role in this effort. By ensuring transparency in mergers and business deals, and preventing dominant systems from using their outsized market power to block competition, these policies help maintain patient access, control costs, and preserve provider choice. Together, these strategies empower states to better manage healthcare spending while shifting the system toward more affordable, patient-centered care.

State Trend #2: States Advanced Health Care Consumer Protections

When health insurance fails to cover the things people need it to cover to stay healthy and protect people from surprises when they do have to pay out-of-pocket, people are not able to confidently make health care decisions for themselves or their families, and are often forced to live with the burden of medical debt. To protect consumers from surprise bills, hidden fees, and to address the growing medical debt crisis, states continued advancing policies to protect consumers by moving policies aimed at preventing surprise ground ambulance billing, limiting hospitals' ability to charge facility fees, and advancing protections against medical debt State advocates also worked hard to ensure patients receive the no-cost preventive care mandated by the ACA.

II. 2025 State Action to Advance Consumer Protections



Protecting People from Hospital Facility Fees

As hospitals acquire more independent physician offices, loopholes in billing practices allow hospitals to tack on fees once reserved for on-campus hospital care, known as facility fees, in more and more settings, making the same service cost two to three times more compared to an independent provider's office. 19 states considered legislation to limit or ban the use of facility fees at different sites, like outpatient clinics in Minnesota, or for various services, like evaluation and management services, telehealth, or for preventive care, such as in Oregon. Arizona introduced legislation to require outpatient treatment centers to be licensed if they charge facility fees. Many states also considered legislation to improve transparency around hospital billing practices and mandate patient notification where a facility fee is charged.

Learn about how limiting hospital facility fees, along with other policies aimed at protecting consumers from unfair and unexpected costs, translates to real savings for people through reduced out-of-pocket costs and premium reductions in this USofCare report.

USofCare polling conducted earlier this year showed **72%** of North Carolinians are **worried about being charged a facility fee.** USofCare provided support to advocates working on banning facility fees in specific locations and for certain services in North Carolina in H343.

Preventing Ground Ambulance Surprise Billing

When experiencing an emergency that requires immediate medical attention, people don't have the option or time to make sure the responding ambulance is in-network. For many, this means using an ambulance that is out-of-network, often without even knowing, resulting in a surprise bill. To address this growing and unregulated problem, 17 states introduced legislation to protect consumers from surprise bills stemming from ground ambulance services. Arkansas and Oklahoma passed bills that set a minimum reimbursement rate for ground ambulance services when no other rate is established. In such cases, insurers must pay the lesser of either 325% of the Medicare Ambulance Fee Schedule or the provider's billed charges. Finally, Utah's HB301 sets standardized reimbursement rates and billing practices for ground ambulance services by requiring insurers to pay set base rates for different levels of transport, prohibiting balance billing, and capping mileage and medication charges while requiring a state audit of ambulance billing and reimbursement practices.

Addressing Medical Debt

Rising health care costs are leaving over 100 million people in the U.S. living with medical debt, impacting communities facing the highest barriers to care. Medical debt represents the largest type of debt in collections and has devastating impacts on people's ability to access needed health care services or afford basic necessities like groceries, utilities, or housing costs. States continue to respond to the medical debt crisis with legislation aimed at reducing or eliminating medical debt for low-income individuals, improving hospital charity programs, and protecting patients from credit reporting and wage garnishment resulting from unpaid medical bills.

In 2025, 33 states considered legislation to protect consumers from medical debt, with many states pursuing options to forgive debt altogether. Florida, Maryland, Oregon, Vermont, and Virginia passed bills prohibiting or limiting extraordinary collections actions (i.e. lawsuits, wage garnishment, liens), restricting the reporting of medical debt to credit bureaus, requiring waiting periods and patient notification before pursuing collections, and mandating criteria for the sale or forgiveness of medical debt, prioritizing forgiveness and strengthening programs for financial hardship. Vermont's S27, for example, allows tax-exempt organizations to access credit reports without consumer consent for the purpose of abolishing debt and prohibits large facilities from selling debt except for that purpose.

Ensuring Access to Preventive Services

The Affordable Care Act's preventive services mandate requires most private health plans to provide people with access to preventive services, including cancer screenings, immunizations, contraception, and behavioral health assessments, at no cost. Kennedy v. Braidwood (the case formerly known as Braidwood v. Becerra), a lawsuit recently decided by the Supreme Court, sought to challenge the mandate by threatening to eliminate free access to critical preventive care services for more than 150 million people, including approximately 37 million children. In light of these threats, states took measures by enacting legislation to protect preventive services ahead of the Supreme Court decision. While the Court's recent ruling keeps the no-cost preventive services mandate in place and protects access to these critical services, we expect to see states continue to codify preventive services protections for their residents should additional threats emerge.

In 2025, 14 states introduced legislation protecting no-cost access to preventive services, with legislation passing in 3 states. Colorado's SB196, codified existing preventive care services and created a state-level advisory process to review and update services that must be covered at no cost. Maryland and Vermont passed bills to safeguard access to preventive services like key screenings, immunizations, and other evidence-based care without cost sharing–even for those enrolled in high deductible health plans.

On June 27, 2025, the Supreme Court upheld the ACA's preventive services mandate in its decision in Kennedy v. Braidwood, which protects more than 150 million people's free access to critical preventive care services, such as cancer screenings, PrEP medication for HIV prevention, and certain diabetes screenings.

> *As we move beyond this years-long court battle to protect access to no-cost preventive care, we remain concerned about potential threats to independent expert panels that advise the Department of Health and Human Services.*
>
> **– Natalie Davis,**
> CEO & Co-Founder, United States of Care

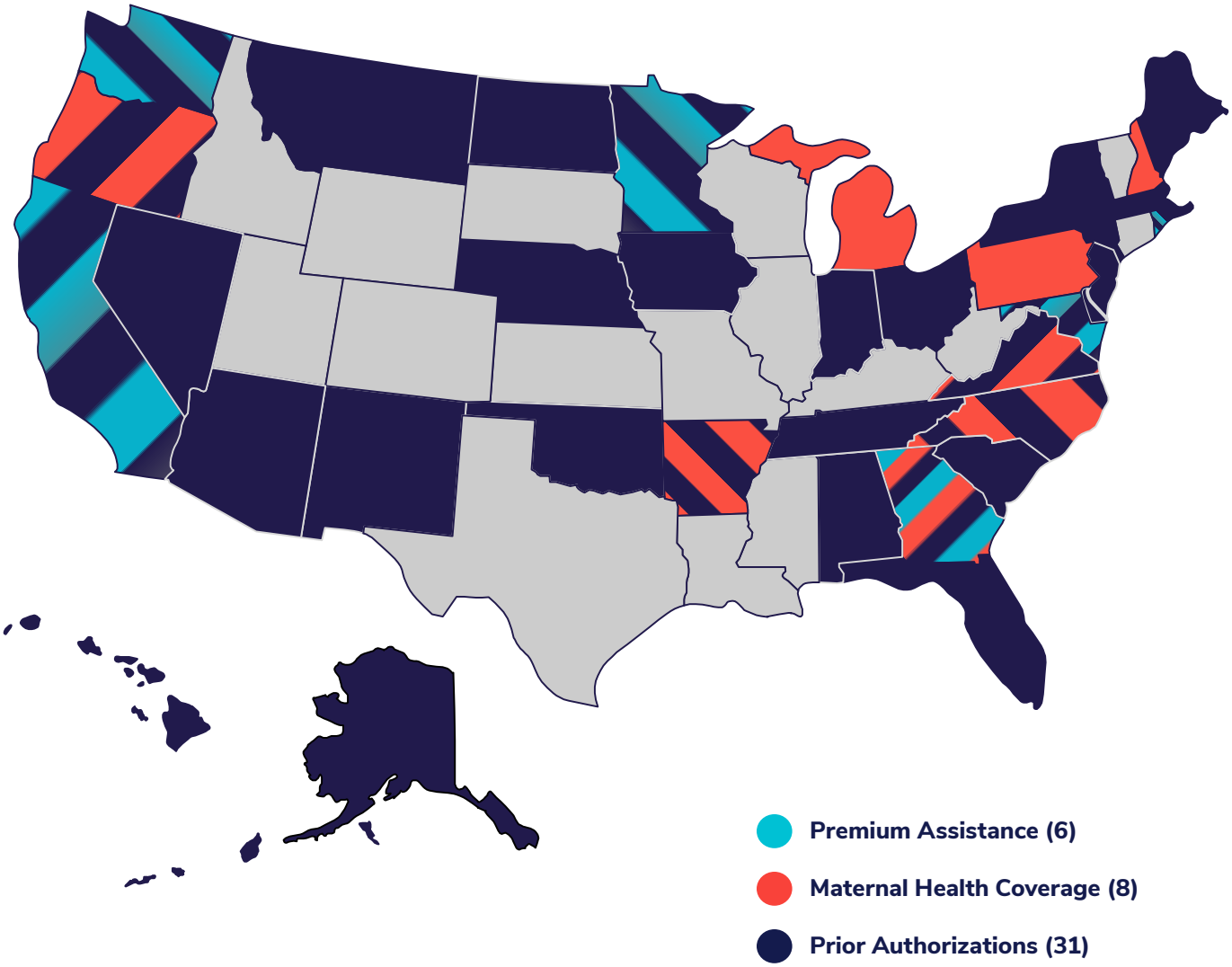
Key Insights

The year 2025 saw states across the country make meaningful progress in advancing consumer protections aimed at making health care more affordable and predictable while reducing the burden of medical debt. State efforts to protect preventive services are responding to challenges at the federal level by empowering state regulators to maintain or expand coverage based on established clinical guidelines reflecting a broader state-led movement to safeguard public health and promote early, equitable access to care regardless of federal policy shifts. Collectively, these reforms continue to shine a light on a broader national trend: **state leaders are stepping up to strengthen health care protections where federal policies may fall short, are nebulous, or are under attack.** These protections represent forward momentum in the effort to build a more transparent, affordable, and accessible health care system – a lifeline in a health care landscape pushed to the brink.

State Trend #3: States Preserved Access to Health Care Coverage

The recently passed budget reconciliation bill enacted sweeping cuts to Medicaid and Marketplace support, including a $1.1 trillion reduction in federal Medicaid spending between 2025-2034. These cuts are expected to create significant financial and coverage challenges in states, many of which already faced tough budget decisions during the 2025 legislative session. This will force states across the country to make hard choices about whether to reduce coverage, cut spending in other areas of the budget, or raise revenue, if allowed. These budget challenges will also come with significant coverage losses – approximately 11.8 million people will become uninsured as an impact of these Medicaid cuts and Marketplace coverage changes. In light of this federal uncertainty, many states took action during the 2025 to protect access to health coverage for their residents.

III. 2025 State Action to Protect Access to Health Coverage



Providing Premium Relief for People

Since 2021, most people accessing health insurance through the Marketplace have been receiving extra financial help through enhanced premium tax credits (ePTCs). This financial support is set to sunset at the end of 2025 if Congress does not extend it, increasing average annual premium payments for Marketplace enrollees by 93% in 2026. The expiration of ePTCs, coupled with new proposed federal Marketplace rules, are estimated to leave 5.1 million people uninsured. Fueled by this deadline, many states sought to mitigate the impact of ePTC expiration by advancing their own premium assistance programs.

States including Georgia, Maryland, and Rhode Island all considered legislation which would establish a state-based premium assistance program to mitigate the impact of the EPTCs' expiration and help their state residents afford health insurance. States such as Washington and California advanced budget proposals to increase state funding for their premium subsidy programs in an attempt to backfill expiring federal premium assistance. Notably, no state so far has managed to protect their residents from the impacts of expiration of these credits.

Advancing Maternal Health Coverage

In recent years, state legislatures continue looking for ways to tackle the maternal mortality crisis, often introducing bipartisan, comprehensive "Momnibus" packages filled with a range of solutions to improve maternal health. These bills introduced during the 2025 legislative session often sought to expand access to care provided by doulas and midwives, address maternal mental health challenges, and increase access to pregnancy and postpartum care. Virginia's Momnibus package included the creation of a special enrollment period which allows qualified pregnant people the ability to enroll in health coverage through the state-based marketplace. North Carolina's MOMnibus 3.0 Act would, amongst other solutions, establish a statewide funding initiative targeted at expanding access to maternal and infant health care programs in geographic areas of the state where there is limited access to maternal health care services.

Reforming Health Insurance Prior Authorization

States are increasingly looking at what people's health insurance covers, most recently scrutinizing rising insurance coverage denials. Health policy experts have increasingly pointed to prior authorizations (PAs) as a large contributor to rising denials, which often impede access to care due to slow processes and complex requirements. In 2025, 31 state legislatures pursued bipartisan reforms to PA processes. States considered legislation to simplify and streamline PA for state-regulated insurance plans – California advanced AB 539 which extends the validity of an approved PA request to one year, while North Dakota passed SB 2280, which set guidelines for PA requests that include deadlines for insurer response and requirements that denials are reviewed by medical professionals. Additionally, many states also advanced bills to limit the use of artificial intelligence (AI) in PA processes. Arizona passed HB 2175, which requires a physician to review any PA request before being formally denied, effectively prohibiting the sole use of AI in reviewing requests.

Key Insights

Through our listening and research work, we know that people want the certainty that they can afford their health care and the security and freedom that dependable health care coverage provides as life changes. These state legislative efforts provide a snapshot of state responses to ensure their residents can maintain access to their health coverage and care in an evolving health care landscape, and we expect more states to continue exploring similar policies. Moreover, these efforts prove it is possible to reduce high health care spending, improve health outcomes, and protect state budgets without cutting access to coverage. We urge policymakers to use these bills to inform future reforms that will lower health care costs for everyday people while promoting access to the coverage necessary for reaching optimal health.

States Face Major Uncertainties Due to Federal Activity

While states spent the first half of 2025 navigating legislative sessions, the Republican-led federal government has been moving full steam ahead to advance its ambitious "Make America Healthy Again" (MAHA) agenda through controversial political appointments and major policy changes that will leave states with the fallout. The shift in the majority party in the Senate and the retirements of key Republican members in the House prompted leadership shake-ups to Congressional committees, including those with jurisdiction over health care issues. While these changes bolster Republican leadership over health issues in the legislative branch, the second Trump Administration introduced high-profile entrants to lead the Department of Health and Human Services (HHS), including the appointment and confirmations of Robert F. Kennedy, Jr. as Secretary and Dr. Mehmet Oz as Administrator to the Centers for Medicare & Medicaid Services (CMS).

HHS has undergone significant organizational restructuring since January, as long-standing programs and departments were scaled back dramatically or even eliminated altogether. HHS is also closing 6 of its 10 regional offices, which serve 27 states and five territories. At the center of the HHS restructuring is the newly-created Administration for Healthy America, tasked with promoting the MAHA agenda. MAHA emphasizes the prevention of chronic disease through healthy food and lifestyle interventions, but promotes anti-vaccine sentiment and misses opportunities to prioritize increasing access to care and coverage. Further, the Administration's public rejection of Diversity, Equity, and Inclusion (DEI) has not only impacted programs like CMS's Office of Minority Health, but also has disrupted the flow of federal funding for critical programs run by states – including some alternative payment models run by the CMS Innovation Center– and even led to states being locked out of their Medicaid portals following a funding freeze.

States will also be left to deal with the fallout of the recently-enacted H.R. 1 (also known as the "One Big Beautiful Bill Act"), the Congressional budget reconciliation bill that was signed into law earlier this summer. H.R. 1 contains over $1 trillion in cuts to health care programs, including the Medicaid program and the ACA Marketplace, leading to an estimated 11.8 million people losing their coverage. State budgets will be directly impacted as a result, with many states lacking the funds needed to make up the shortfall or to implement costly work reporting requirements. In addition to the cuts to ACA Marketplaces included within H.R. 1, regulatory action, like CMS's Marketplace Integrity Rule, and the expiration of ePTCs will lead to more people losing coverage and premiums increasing.

State legislatures will have to absorb the programmatic shock from recent and upcoming federal activity related to health policy and programs. Although states face considerable uncertainty moving forward, they will continue to lead in finding innovative solutions to meet their populations' health care needs.

Looking Ahead to 2026

As advocates and legislators look towards 2026, even in the face of federal uncertainty, targeted action to lower the burden of health care costs on people (and the system) will remain important. We expect state and federal policymakers and advocates to continue pushing reforms that lower out-of-pocket costs, focus investments in primary health care, and ensure people can access the care they need while they juggle the fallout of Federal policy changes.

Responding to Federal Uncertainty

The rippling effects of looming federal funding cuts on the health care landscape more broadly underlying state efforts to advance meaningful solutions. In order to address the funding gap left by these cuts, states will have to make tough choices about whether to reduce coverage, raise revenue, or cut spending in other areas of the budget, if allowed. As federal proposals move forward, we expect many of the 42 state legislatures whose regular sessions have concluded to convene special sessions later this year to focus on tackling these budget issues. Moreover, as state legislators move into 2026 and beyond, states will also be burdened with repairing the damage of these federal cuts on health care coverage, affordability of care, and the stability of the health care system overall, outside of their budget processes. States will need to leverage a wide range of policy solutions, many covered in this report, to meet these challenges.

Learn more about the impact of state solutions, like site neutrality, to lower health care prices on people, hospitals, and state budgets in USofCare's new report "Reining in Hospital Prices: Modeling Reforms in Indiana, Massachusetts, and North Carolina."

Advancing State-Level Site Neutrality Efforts

With robust state action to address hospital facility fees and consolidation in 2025, we expect this interest to only grow. An emerging opportunity for states to move these efforts forward is through implementation of state-level site neutrality requirements. This would require providers to charge the same price for the same services regardless of setting, helping to eliminate incentives for hospitals to buy up outpatient provider offices. While efforts to move forward site neutrality have largely occurred at the federal level thus far, New York is providing a model for state-level efforts through the Fair Pricing Act. This bill aims to cap prices for certain outpatient hospital services at 150% of what Medicare pays for those same services which is estimated to save New Yorkers $1.14 billion.

Supporting Patient-First Care ("Value-Based Care") through Primary Care Investment

Through our listening work, USofCare knows that people want more time with their doctors, better communication between their providers, more personalized and customized care, and the ability to be treated as a whole person rather than a series of symptoms; collectively, a system grounded in patient-first care. Primary care is an essential component of Patient-first care approaches, with the goal of achieving better health outcomes and reducing health

disparities while lowering health care costs, acting as a first line of defense through prevention, screening, management of chronic conditions, and overall wellness. At the same time, many states are facing primary care crises, as chronic underinvestment and workforce challenges leave many state primary care systems unable to meet the needs of their state residents. In response, we expect states to more intently focus on solutions to address primary care challenges from a patient-first lens in 2026. Advancing primary care financing and payment reforms, such as setting primary care spending targets, increasing minimum reimbursements for primary care and behavioral health providers, and shifting to patient-first care models, are likely a top priority. At the same time, states should also consider opportunities to build up the primary care workforce through investments in the training of new primary care providers and retention of existing practices.

Renewed national focus on chronic disease management and preventive care as part of the MAHA agenda may offer more opportunities for investment in primary care into 2026, though structural overhauls, threats to independent expert panels, budget cuts impacting insurance coverage, along with vaccine policy instability, remain credible threats to primary care into the future.

USofCare conducted a national survey and focus groups to better understand people's current perceptions, priorities, and challenges with primary care. People want affordable, accessible, and convenient primary care, and our research demonstrates that our health care system is not realizing that vision.

Conclusion

This year's state legislative sessions made clear that people want to know that they can afford their care and coverage, 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, while at the same time addressing the damaging impacts of federal funding cuts. Despite sweeping federal spending cuts, there are plenty of opportunities for bipartisan collaboration and momentum on the critical policy reforms led by states to build a better health care system. As these reforms take shape, USofCare will continue to have a focus on the health care solutions states take as their role in maintaining access to quality, affordable health care grows.