



UNITED  
STATES *of*  
CARE

JUNE 2026

# LEGISLATIVE WRAP UP REPORT

STATE TRENDS IN AFFORDABILITY AND ACCESS

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# *About United States of Care*

United States of Care (USofCare) is a listening-first, nonpartisan health care advocacy organization that brings people's experiences to the policy decisions that shape our health care system to ensure that everyone has access to quality, affordable health care, regardless of who they are, where they live, or how much money they make. Too often, decisions about our health care system are shaped by industry stakeholders and partisan priorities rather than the experiences of the people who rely on it every day. USofCare was founded to fix that – and to enact durable, people-centered policy solutions at the state and federal levels. We're putting people — not partisan politics or special interests — at the center of health policy.

We've done this by listening to more than 30,000 people across all 50 states. Through in-depth interviews and community conversations with individuals and small groups, focus groups and listening sessions, and national public opinion polling, we learn about how people think about health care and where they see the greatest challenges. We pay close attention to how people talk about their experiences, and use language that resonates with them.

Using this listening work, USofCare advocates for policy reforms at the state and federal levels. Translating insights from our listening work 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

Affordability emerged as the central policy priority across states in 2026 as legislators considered ways to lower the cost of living in areas ranging from housing to childcare to food security. Nowhere was this focus on affordability – or unaffordability – felt more acutely over the past few months, however, than in health care. The high cost of health care once again topped the list of people's financial concerns as health care spending continued to increase, placing pressure on employers, state budgets, and families trying to balance budgets and make ends meet.

In the absence of major action at the federal level to lower the cost of care – in fact, changes stemming from last year's HR1 (also known as the “One Big Beautiful Bill Act”) threaten to restrict access to affordable care further – the 46 state legislatures<sup>1</sup> that convened in 2026 have stepped up to introduce legislation to address people's affordability concerns and the underlying drivers of high health care costs.

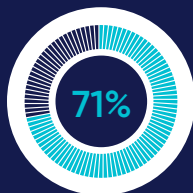
Despite shorter sessions this year and fewer bills introduced in many states ahead of the upcoming midterm elections, states continue to focus on finding commonsense, bipartisan solutions to address people's everyday health care concerns. Looking back on 2026 state legislative sessions across the country, and recognizing that a handful of legislatures are still in session, we've identified four health care policy trends that have driven the conversation in 2026 thus far and provide a window into potential state priorities for next year:

- 1 **States Took Action to Lower High Prices Charged by Hospitals**
- 2 **States Supported Policies to Limit Harmful Health Care Consolidation and Corporatization of Health Care**
- 3 **States Pursued Legislation to Improve People's Access to Care**
- 4 **States Responded to Federal Policy Changes by Preserving and Expanding People's Coverage Options**

Taken together, these areas of focus have or will lead to significant cost savings for people as legislatures continue to navigate an increasingly volatile political environment, federal uncertainty, and budget shortfalls. This report shines a light on these trends and showcases how they promote greater access to affordable, dependable, and sustainable care even during times of significant change for states. Looking ahead, state legislatures nationwide are well-positioned to build upon this year's achievements to pursue even more ambitious solutions to lower the cost of care for people in 2027 and beyond.

<sup>1</sup> State legislatures in Montana, Nevada, North Dakota, and Texas meet in regular session only every other year.

An April 2026 USofCare poll found that **71% of respondents believe that health care costs are unaffordable** for people and families.



## United States of Care's 2026 state policy priorities

provide a **policy road map** for states looking to make health care more affordable, dependable, and sustainable. Throughout this report, we use the icons below to highlight **where our priorities intersect with state actions** taken in 2026 and how states can build upon these policies for 2027 and beyond.



# STATES TOOK ACTION TO LOWER HIGH PRICES CHARGED BY HOSPITALS

State Trend #1

Far too often, rising health care costs have forced people to choose between medical care and other necessities like food and childcare – and have even led some people to skip care entirely. The top driver of these increased health care costs continues to be high prices charged by hospitals, which grew at a faster rate in 2024 than any year since 2007. These high prices are the result of a system that incentivizes consolidation, allowing these large systems to take advantage of their increased market power and demand higher and higher prices.

As a result, **hospitals charge private plans** an average of over **2.5 times** what they charge **Medicare** and these high prices are passed along to people in the form of higher premiums and out-of-pocket costs.

Given these high, and largely unchecked prices, it's understandable that hospital spending accounts for approximately 40% of every premium dollar, far outstripping spending in other spending categories like physician services or prescription drugs. These high prices contribute to higher forms of cost-sharing that adversely affects everyone with insurance, whether they need care in the hospital or not.

To make people's health care more affordable, states across the country have introduced and passed policies to rein in price growth, improve transparency, and lower costs for people across care settings. Taken together, solutions like reference-based pricing, limits on facility fees, and site neutrality signal a growing appetite by policymakers to directly address hospital pricing practices to improve affordability for consumers, employers and employees, and state budgets alike.

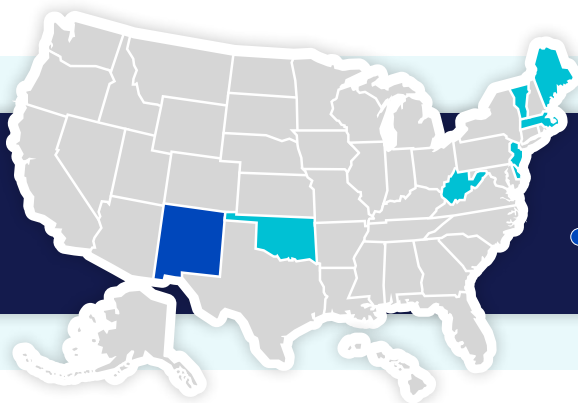
United States of Care, in partnership with the Brown University Center for Advancing Health Policy through Research (CAHPR), modeled the impact of three hospital pricing policies – facility fee bans, site neutrality, and hospital payment caps (or reference-based pricing) – in three states. The report found that **these policies could save people billions of dollars in out-of-pocket costs** in those three states alone with minimal impact on hospital operating margins.



Following her appointment to Oregon's Committee on Health Care Affordability, USofCare Senior State Advocacy Manager Kelsey Wulfkuhle has worked with other committee members to propose policies, such as hospital reference-based pricing, that address the primary drivers of health care costs.



**Kelsey Wulfkuhle**  
Senior State Advocacy Manager



## Advancing Reference-Based Pricing

- States that passed legislation in 2026
- States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY

As high prices charged by hospitals continue to increase, one strategy states are pursuing to address high hospital costs is through reference-based pricing, which establishes a “reference price” – often tied to a percentage of Medicare rates – to limit, or cap, what hospitals can charge for certain services. Doing so “right-sizes” the cost of these services and brings them more in line with the actual cost to provide them, which can lead to significantly lower health care costs for state governments and people alike while still ensuring hospitals’ financial stability. States have the flexibility to design these policies to fit their individual needs by identifying which markets or programs – such as the state employee health plan

or entire commercial market – are included and which health care services should be subject to the cap. In addition, states can also structure their reference-based pricing program to improve access to high-quality services, such as primary care or behavioral health, by creating payment floors for specific services or types of providers. Altogether, any savings derived from this policy could be reinvested into affordability or coverage programs that further benefit people or alleviate budget shortfalls.

In addition to the 13 states that already have some form of this policy, eight states introduced legislation in 2026 to establish or expand reference-based pricing within their state employee health plan (SEHP), commercial market, or other segment of their insurance market. **New Mexico's** law expands the state's successful reference-based pricing policy beyond the state's SEHP to public school employee plans and is expected to lead to approximately \$16 million in savings in FY2027 alone. Legislators in **Maine** also introduced a reference-based pricing bill that – although later amended – would've capped payments for inpatient and outpatient services at 200% of the Medicare rate.



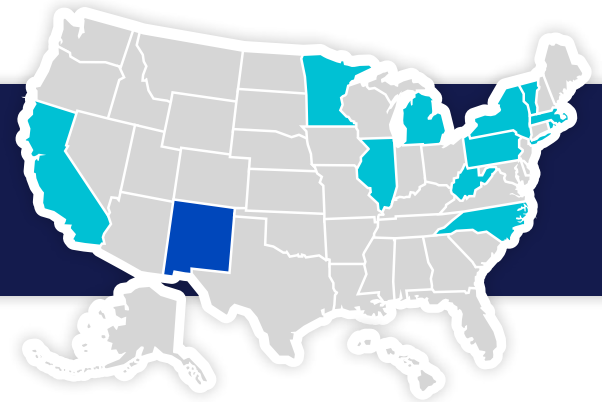
USofCare's testimony in support of Maine legislation to cap some hospital prices identified how the bill would deliver **“immediate and long-term premium and out-of-pocket savings to people and employers.”**

## Establishing Limits on Facility Fees

○ States that passed legislation in 2026    ● States that considered legislation in 2026



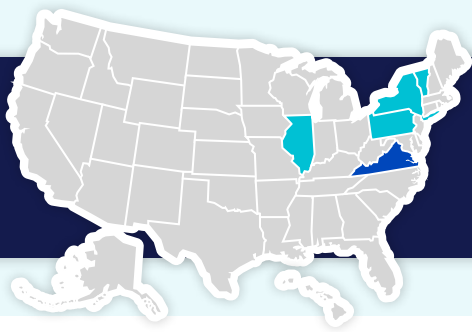
USofCARE STATE POLICY PRIORITY →



Loopholes in billing practices allow hospitals to charge more for services delivered in certain hospital-based settings, such as hospital outpatient departments (HOPDs), compared to the same services delivered at an independent physician's office, despite no change in care delivery. This leads to further consolidation as hospitals continue to purchase independent clinics and convert them into HOPDs. In addition to allowing hospitals to charge higher baseline prices for services delivered in these facilities, hospitals are also able to charge patients so-called **“facility fees”** in outpatient or telehealth settings.

These fees, which are usually reserved for care delivered in hospital settings, may **double** or **triple** the price of care.

Twelve states introduced legislation to address facility fees in 2026, building upon existing momentum in states across the country that have already taken action to protect people from facility fees. **New Mexico** once again led the way in passing legislation that would prohibit hospitals from charging facility fees for outpatient care, including preventive care and telehealth services. **Michigan, North Carolina, and West Virginia** also introduced bills that would prohibit facility fees for outpatient care. Several of these states, including **North Carolina** and **West Virginia**, also chose to include other consumer protections in their legislation, including provisions to increase facility fee transparency, promote billing reforms, or establish facility fee reporting and data collection.



## Advancing Site-Neutral Payment Policy

● States that passed legislation in 2026 ● States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY →

State policymakers looking at a more comprehensive approach are increasingly looking to state-level site-neutral policy as a way to secure significant savings for the health care system, employers, and people. Building off of similar reforms first established under Medicare, state-level site neutrality typically applies to a state's commercial market and requires these insurers to pay the same price for the same service regardless of where care is delivered for certain routine, low-complexity services. Ensuring "same service, same price" regardless of care setting would remove some of the financial incentives that drive hospitals toward further consolidation and lower costs for people broadly.

**USofCare's memo** in support of New York's Fair Pricing Act (S705/A2140) **highlighted real-world examples of how certain routine, low-complexity services cost significantly more in hospital outpatient settings compared to a doctor's office.**



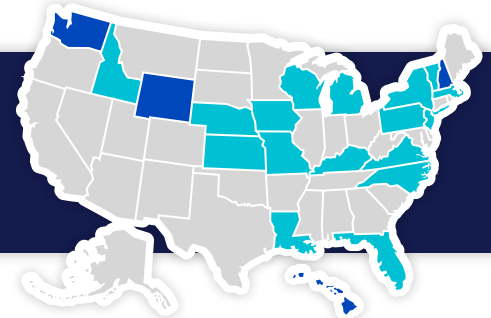
States have shown increased interest in expanding site-neutral policy beyond Medicare over the past year. **New York's** Fair Pricing Act would cap prices in the commercial market for a list of common outpatient procedures at 150% of what Medicare pays and save people more than \$213 million in out-of-pocket costs. Site-neutral legislation was also introduced in **Illinois** for both the commercial market and State Employee Health Plan and in the commercial market in **Pennsylvania** in 2026; if passed and implemented, both proposals would also result in significant consumer savings. **Virginia's** law, while narrow in scope, calls on using data from the state's all-payer claims database to analyze potential cost containment measures, including site-neutral payment policy.

## Expanding Hospital Price Transparency Requirements

● States that passed legislation in 2026 ● States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY →

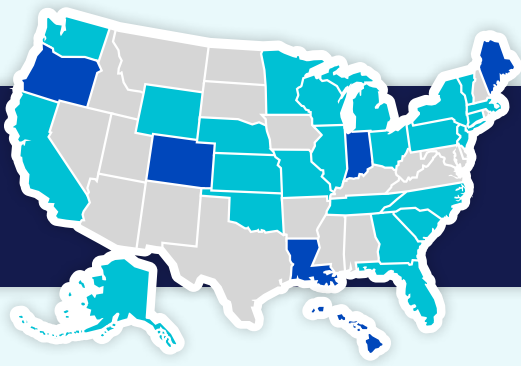


As health care costs continue to rise, people and policymakers often struggle to understand what hospitals charge for the care they provide. Greater hospital price transparency can give people, employers, and policymakers a better understanding of these prices and can be used as a tool to improve affordability, accountability, and competition across the health care system.

Despite federal requirements that went into effect in 2021, **only one-in-five hospitals are compliant** with these price transparency rules.

These rules require hospitals to disclose the prices of all services – including negotiated rates – and post a separate, consumer-friendly list of prices for 300 "shoppable" services on their websites. To supplement federal regulations, state policymakers are increasingly focused on transparency efforts that hold hospitals accountable, strengthen enforcement mechanisms, make pricing information more accessible and usable for people, and give employers and policymakers better insight into health care spending trends.

During the 2026 legislative session, 21 states, including **North Carolina** and **Pennsylvania**, introduced legislation to build upon the federal rules to strengthen enforcement of transparency requirements, expand these protections to additional provider types, and protect against any rollbacks on the federal level. Legislation signed into law in **Wyoming** codifies the federal transparency requirements and establishes state-level enforcement and penalties for hospital noncompliance, including sanctions on hospitals' state licenses. **Hawaii's** new law prohibits hospitals from engaging in debt collection practices if they are noncompliant with federal price transparency rules.



## Expanding Consumer Medical Debt Protections

● States that passed legislation in 2026    ● States that considered legislation in 2026

Rising health care costs thanks to high prices charged by hospitals have caused nearly **four-in-ten** Americans to take on **some form of medical debt**.



Medical debt disproportionally affects communities of color and those without insurance. This debt can often exceed **\$2,000**, damaging credit scores, limiting people’s ability to secure housing or loans, and discouraging people from seeking needed care. State efforts to reduce the financial burden of medical debt include restricting the reporting of medical debt to credit agencies, strengthening hospital financial assistance policies, and improving reporting transparency. Taken together, these policies can help protect people from aggressive debt collection practices and provide them with options when faced with medical debt.

Thirty states introduced legislation in 2026 to protect people from medical debt. State approaches varied, but many, including **Louisiana**, considered bills to place limits on certain extraordinary collections practices, such as wage garnishment or excessive interest rates. Other States, including **Alaska** and **Michigan**, introduced legislation restricting medical debt from appearing on people’s credit reports. **Indiana** also passed legislation requiring hospitals to notify people of any potential financial assistance they may be eligible for before initiating any collections proceedings.

### Key Takeaways

- **Hospitals are a driver of rising health care costs.** While still recognizing the critical role hospitals play in their communities, people increasingly identify high prices charged by hospitals as a barrier to affordability. They believe hospitals charge too much for health care and support government action to lower health care costs by regulating health care entities, including hospitals, directly.
- **Increased interest in policies that target hospital pricing.** Responding to changes in public opinion, policymakers have become increasingly willing to push for limits on hospitals’ pricing authority through policies like reference-based pricing, site-neutral policy, and limits on facility fees. While these policies may vary in scope, they all involve price caps or limitations imposed by policymakers to secure cost savings.
- **Significant cost savings potential with minimal impact to hospitals’ bottom line.** Meaningful savings can be achieved for people, employers, and state budgets through cost-saving policies without destabilizing hospital finances. Oregon’s reference-based pricing program within the state employee health plan led to more than **\$100 million in savings** without adversely affecting hospital finances. Even low payment rates under a state-level site-neutral policy would result in only fairly minimal impacts on hospitals’ operating margins.
- **Building upon the success of existing policies.** States are taking the lead in identifying targeted policies with a track record of saving people money – e.g. limits on facility fees and state employee health plan reference-based pricing – and scaling them more broadly to achieve maximum savings for people, employers, and state budgets.

# STATES SUPPORTED POLICIES TO LIMIT HARMFUL HEALTH CARE CONSOLIDATION AND THE CORPORATIZATION OF HEALTH CARE

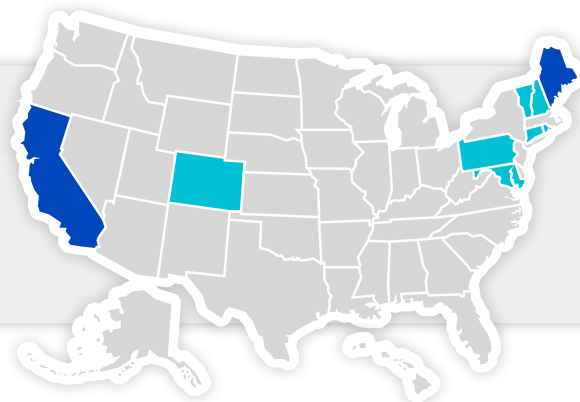
In addition to policies that directly address high prices charged by hospitals, states have also made progress in pursuing legislative solutions that address rampant consolidation that has been shown to increase health care costs, limit choice, and restrict access to needed services. Today, more than 90 percent of metro areas are considered “highly concentrated,” with nearly half of all metro areas dominated by one or two health systems. As large hospitals, health systems, and, increasingly, private equity and other corporate actors acquire independent doctors’ offices and other facilities, states recognize the need for additional oversight and review of these transactions to ensure people have access to affordable care regardless of who delivers it.

## *Increasing Oversight and Review of Health Care Transactions*

- States that passed legislation in 2026
- States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY

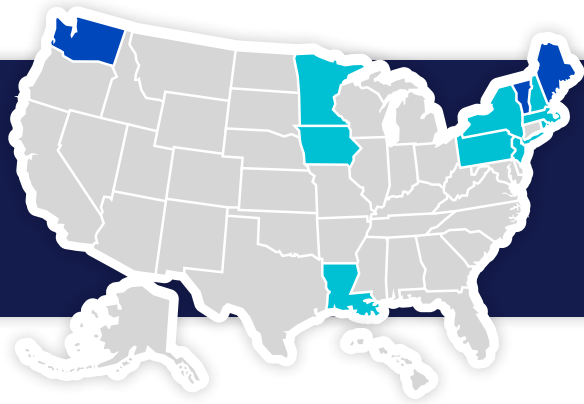


Despite the documented downsides of health care consolidation, relatively few states have policies in place to limit or review health care transactions or prohibit further consolidation, even when such transactions are likely to reduce access or increase costs for people. While the Federal Trade Commission and the Department of Justice have challenged relatively few health care transactions on the federal level, there has been increasing focus in recent years on scrutinizing pending mergers and acquisitions. Similarly, state policymakers championed greater oversight by expanding state notification and review of pending health care transactions. Some states have increased authority to block a transaction from moving forward if it doesn’t meet certain requirements. Others have the authority to approve a transaction with conditions, such as preserving access to essential care services or establishing price caps to ensure people have continued access to affordable, comprehensive care.

In 2026, nine states introduced legislation to expand state authority to review, approve, and/or deny certain health care transactions. **California** passed legislation to become the third state (joining **Washington** and **Colorado**) to require merging entities to submit a copy of their federal pre-merger notification filing (the Hart-Scott-Rodino (HSR) form) to the Attorney General to allow for additional state review and oversight into pending transactions. Other states, including **Colorado** and **New Hampshire**, introduced legislation that would also grant state Attorneys General – or in the case of **Hawaii**, the legislature – the authority to modify or outright block transactions that negatively impact the “public interest,” such as limiting people’s access to care or increasing costs.

USofCare’s testimony in support of legislation to expand oversight and regulation of health care transactions in Colorado and Washington **highlighted how certain transactions “threaten robust access to the affordable health care services people need”** in making the case for greater attorney general involvement.





## Pushing Back Against the Corporatization of Health Care

● States that passed legislation in 2026

● States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY



**Nearly a quarter** of all for-profit hospitals are now **owned by private equity**, and private equity acquisitions of physician practices have **increased by 645 percent** between 2012 and 2021.



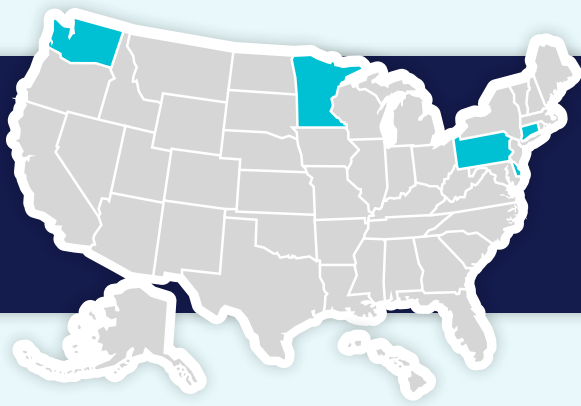
Corporate influence in health care has continued to expand in recent years, driven by increasing consolidation and investment by private equity firms and other corporate actors across care settings. As corporate actors increasingly play a role in care delivery, critical stakeholders have voiced growing concerns about its negative impacts on patient safety, care quality, and affordability. Providers have also expressed concerns about loss of health care decisionmaking and corporate entities' focus on profits over people.

This growing corporatization of health care has driven state efforts to rein in corporate influence. States have eliminated exemptions and loopholes present in state corporate practice of medicine (CPOM) doctrines in order to preserve independent clinical decisionmaking and prohibit corporations and other non-physician entities from owning medical practices. States have also expanded their oversight of corporate-backed health care transactions and ownership changes and have introduced targeted prohibitions that restrict private equity ownership in certain settings or by certain actors, such as Real Estate Investment Trusts (REITs). Taken together, these solutions allow physicians to prioritize patient safety, remain in charge of their practices, and push back against broader health care consolidation while keeping costs in check for people.



USofCare's [testimony](#) in support of Vermont legislation to regulate corporate practice of medicine and provide greater transparency into corporate health care ownership discussed how the bill's guardrails can **"ensure meaningful protections for Vermonters from the negative impacts of corporate pressure."**

As part of this response, [14 states](#) have considered legislation to limit or push back against the increasing corporatization of health care. Several states, including [Washington](#) and [Vermont](#), introduced legislation closing loopholes within their existing CPOM doctrines, while [Connecticut's](#) legislation would prohibit REITs from controlling health care entities or allowing hospitals to enter into "sale-leaseback transactions" with REITs or others to skirt exemptions. Legislation passed in both [Maine](#) and [Washington](#) to expand each state's transaction notice and review requirements to include those involving private equity firms and other corporate actors. Maine's law allows the state to block transactions that may increase costs or further impede access to care.



## Expanding Health Care Ownership Transparency Requirements

● States that passed legislation in 2026

● States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY →

Unlike federal regulations that require hospitals to disclose pricing data, hospitals and other providers are often not required to disclose detailed ownership information. More often than not, this leaves people and policymakers in the dark about who operates or controls certain entities in a time when they're growing ever more complex and interconnected. This lack of transparency is especially concerning as corporate actors rapidly expand their presence within health care and rampant consolidation further blurs the lines between provider and insurer. Without clear ownership or financial information, it's difficult for states to track these consolidation trends or identify how corporate decisionmaking affects the affordability and accessibility of people's health care. Requiring hospitals, health systems, private equity, and related corporate entities to disclose detailed information about ownership, governance, and financial and operational control can help policymakers monitor consolidation, identify opportunities for future regulation, and provide people with better insight into decisions that affect their care and costs.

Five states introduced legislation in 2026 to improve transparency around health care ownership and corporate influence. Legislation introduced in **Washington** would create a health care entity registry to capture this information and share it in a publicly accessible online tool. Other states, including **Minnesota**, that have considered legislation that requires regular or semi-regular reporting of facility ownership have included this in legislation to expand state review of pending mergers and acquisitions more broadly ([see above](#)).

### Key Takeaways

- **State action continues to be important.** In the absence of coordinated, comprehensive action by the federal government to limit harmful consolidation and better regulate health care entities in highly concentrated markets, state policymakers have taken a larger role in implementing solutions to push back against health care consolidation.
- **There is increased corporatization of health care.** Private equity and other corporate actors have been increasing their ownership share of facilities. States need to update statutes and remove loopholes accordingly to push back against this growing corporatization of health care.
- **States are prioritizing consumer protections.** State policymakers have paired efforts to limit consolidation broadly with more targeted policies to benefit consumers, such as medical debt protections and a "public interest" standard to allow state agencies the authority to block health care transactions that may negatively impact consumer affordability.

# STATES PURSUED LEGISLATION TO IMPROVE PEOPLE'S ACCESS TO CARE

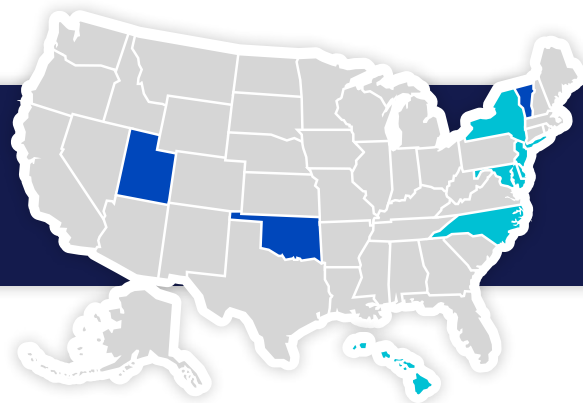
While affordability challenges continue to dominate people's health care concerns, it's important that people's health insurance covers services they say they need and want without unnecessary access burdens. States have protected people's access to needed services and treatments by placing limits on prior authorization, preserving access to primary care, and ensuring continued access to no-cost preventive care. Taken together, these policy solutions move the health care system closer toward a patient-first care model that incentivizes and promotes high-quality, low-cost care to benefit both people and the system broadly.

## *Increasing Investment in Primary Care*

- States that passed legislation in 2026
- States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY →

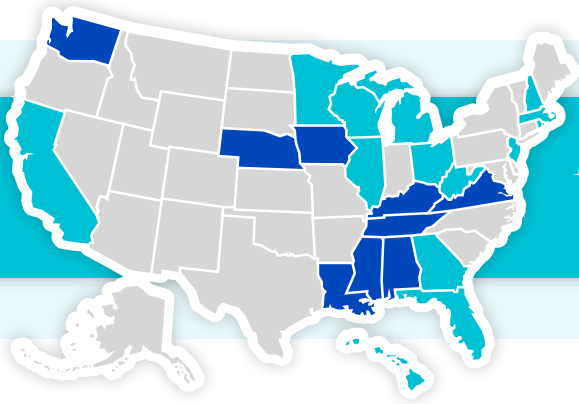


A health care system grounded in primary care allows for the personalized, patient-focused relationships that people want with their providers. Investing in these relationships increases access to needed preventive care and is associated with improved health outcomes, including improved life expectancy and fewer hospitalizations, while also lowering costs. Unfortunately, historic underinvestment in primary care and undervaluation of these services more broadly compared to more lucrative specialty care have further restricted people's access to needed primary care. This has threatened the financial viability of many primary care practices, including independent clinics, contributing to practice closures, corporate acquisitions, and further consolidation across the health care system. As more primary care practices are absorbed by larger health systems and corporate entities, people face higher costs and fewer care options. Solutions to expand primary care access, such as primary care investment targets or primary care provider payment floors, can help counter decades of primary care underinvestment and support a more sustainable primary care system.

Building on previous efforts in more than 20 states to address primary care spending, nine states considered legislation in 2026 to bolster primary care investment and access. **Delaware** and **New York** introduced legislation to require health insurers to spend at least 11.5% and 12.5% of their total medical costs on primary care, respectively. **Oklahoma's** more targeted law requires managed care companies participating in the state's Medicaid program to spend at least 11% of their total medical costs on primary care. Most notably, **Vermont's** comprehensive primary care law lays the groundwork for system transformation by creating primary care spending targets, changing how primary care providers are paid, and investing in primary care workforce development as the bill has been signed into law.

A **May 2026 report** released from USofCare and the National Partnership for Women & Families drew on previous USofCare research that found that **people want affordable, accessible, and convenient primary care**. Unfortunately, chronic underinvestment in primary care threatens people's access and leads to increased costs.





## Restricting the Use of Harmful Prior Authorization

● States that passed legislation in 2026    ○ States that considered legislation in 2026

Prior authorization often delays people’s timely access to needed care by requiring providers to obtain insurer approval before covering certain medications, procedures, or services in order to control health care costs. Despite recent steps by insurers to limit its use for certain services given widespread coverage denials, prior authorization remains ubiquitous and has resulted in significant harm and widespread administrative burden for both people and providers. In response, states have increasingly pursued legislative solutions to limit the type of services subject to prior authorization, lengthen prior authorization approvals, or ease prior authorization requirements for certain types of providers that meet certain criteria. For example, several states have implemented “gold card” legislation that allows certain providers with high prior authorization approval rates to bypass these processes. .

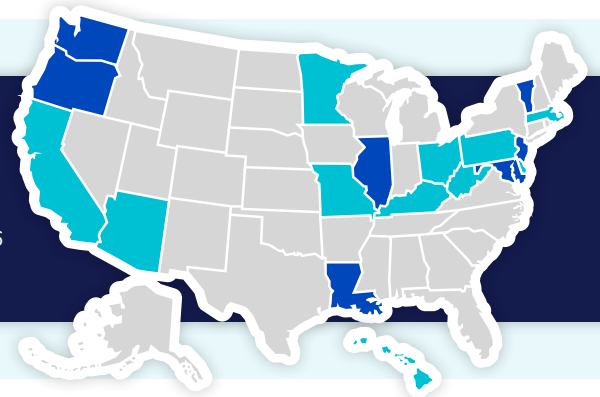
Beyond prior authorization laws already in effect, 23 states introduced legislation to further reform this process in 2026. **Virginia’s** law extends the length of an initial prior authorization to six months and at least a year for continuing approvals. **Kentucky** passed “gold card” legislation while also establishing additional reporting and transparency requirements. **Iowa’s** new law bans insurers from requiring prior authorization for certain cancer screenings and emergency care, easing the burden on people in need of more urgent care. **Alabama** and **Washington** both passed legislation that requires insurers to have a licensed physician or other qualified clinician – and not AI – sign off on any prior authorization that would deny, delay, or modify people’s access to services.

## Protecting People’s Access to No-Cost Preventive Care

● States that passed legislation in 2026    ● States that considered legislation in 2026



USofCARE STATE POLICY PRIORITY ➔



The Affordable Care Act’s preventive services mandate requires most private health insurance plans to cover dozens of preventive care services at no cost. While the mandate has been effective in expanding access to needed preventive care, lowering people’s out-of-pocket spending, and improving health outcomes, gaps in implementation remain. Last year’s Supreme Court decision in Kennedy v. Braidwood introduced significant uncertainty about the authority of federal bodies that determine no cost-sharing coverage rules. Recent actions taken by the Department of Health & Human Services, especially with regard to vaccines, have cast further doubt on whether states can rely on federal recommendations to ensure continued no-cost access to these services. Furthermore, people continue to be incorrectly billed for preventive care that should be covered for free, often due to coding errors or confusion about coverage requirements.

In response to this federal uncertainty, 18 states introduced legislation this year to protect people’s access to no-cost preventive care. Many of these bills, including legislation passed in **Maryland** and **Vermont**, established new state bodies or empowered existing state agencies to recommend preventive services to be covered with no-cost, instead of relying on federal recommendations. States have also begun to band together to issue joint preventive services recommendations to fill the gap left by the federal government, including those made by the Northeast Public Health Collaborative and West Coast Health Alliance.

## Key Takeaways

- **Momentum is building for *patient-first care reforms*.** Despite significant lobbying and dollars spent by hospitals and insurers, states continue to enact consumer-friendly policies that benefit people and families, such as reforms to the prior authorization process and increased attention to expanding access to primary and preventive care.
- **States recognize the important role primary and preventive care play in improving care and lowering costs for people.** Reversing a decades-long focus on specialty care, states are increasingly focusing their attention and budgets on expanding access to preventive, primary, and other forms of care that not only improve outcomes but lower health spending more broadly.
- **Limits to state policies exist and sometimes cannot replace comprehensive federal protections.** The scope and breadth of certain policies are limited to state-regulated plans, including plans sold on the individual and small group markets. Because the federal government regulates Medicare and self-funded plans, which collectively cover more than 140 million people, state policy solutions are not always a complete substitute for federal action; however, they can provide a helpful starting place for states looking to push for policy solutions.

In addition to pursuing their own priorities during the 2026 legislative session, states also had to contend with and respond to federal policies that impacted states' health care systems. Many of the changes stemmed from the Republican-led Congress's passage of last year's [H.R. 1](#) (also known as the "One Big Beautiful Bill Act"), the budget reconciliation bill that included more than \$1 trillion in health care cuts to Medicaid and the Affordable Care Act (ACA) Marketplaces through new work requirements and other eligibility restrictions. Taken together, these cuts are projected to cause [10 million people](#) to lose coverage over ten years and [contribute significantly](#) to existing budget shortfalls in many states. [Additional changes](#) finalized by the Centers for Medicare & Medicaid Services (CMS) will [further limit](#) people's access to care.

Notably, Congress also failed to extend the Inflation Reduction Act's enhanced premium tax credits (ePTCs) to offset the cost of Marketplace coverage ahead of their expiration on December 31, 2025. As a result, monthly premiums, already too expensive for too many families, have [skyrocketed](#), causing many people to shift to a less generous plan or lose coverage entirely. Already, enrollment in Marketplace coverage [has decreased](#) compared to last year, with [more than 20%](#) of 2025 Marketplace enrollees dropping coverage in 2026 and an estimated [four million people](#) at risk of losing coverage.

Given these and other challenges, state policymakers have taken action to minimize harms from these changes by introducing legislation to protect people's coverage options. States have also continued to explore partnership opportunities with the federal government to address shared priorities like rural health care and patient-first care.

States facing difficult decisions to balance state budgets should consider a [range of policy options](#) to secure state savings or increase revenue [before cutting access to needed health care services](#). "ensure meaningful protections for Vermonters from the negative impacts of corporate pressure."



## Expanding and Protecting Health Care Coverage Expansions

USofCare's [testimony](#) in support of Connecticut's Basic Health Plan and public option legislation highlighted the bill's potential to provide "both immediate relief and long-term solutions to ensure people in Connecticut have access to dependable, affordable, and equitable coverage and care."



Federal cuts to health care funding have forced states to consider how to preserve or expand coverage gains made over the past decade. Given significant budget shortfalls in most states driven in part by federal funding changes, legislators have had to make tough decisions about whether to continue programs that cover certain populations, such as immigrant families. Some states have had to cap enrollment, curtail benefits, or end programs entirely. At the same time, other states have looked for ways to fill gaps left by the federal government through additional coverage options and targeted subsidies to offset increased costs, especially following the lapse of ePTCs.

States have considered establishing new coverage programs or expanding existing efforts to ensure people continue to have affordable health care options, regardless of what happens on the federal level. [Colorado](#) voted to keep the state's [Cover All Coloradans](#) coverage program for immigrant children and pregnant women ineligible for Medicaid, but placed limits on enrollment and capped or curtailed certain benefits, such as dental coverage and long-term care, respectively. Legislators in [Connecticut](#) introduced legislation that would move the state towards a public option, similar to programs in [Colorado](#), [Nevada](#), and [Washington](#). The bill would also establish a [Basic Health Program](#) (BHP) to provide coverage for people with incomes between 133 and 200 percent of the federal poverty level (FPL). Other states have moved to establish or expand existing [marketplace subsidy programs](#), including [New Mexico](#), which invested \$17.3 million in its Health Care Affordability Fund to fully offset increased premium costs. [Maryland](#) and [California](#) implemented similar policies to lower premium costs for populations under a certain income threshold.



## Supporting Rural Health Care through the Rural Health Transformation Program

As part of H.R. 1, Congress created the Rural Health Transformation Program (RHTP), which provides states with \$50 billion to support rural health care over the next five years. All states applied for and received funding through the RHTP, which averaged \$200 million per state for the program’s first year. While this funding will not offset expected cuts to Medicaid and providers broadly found in H.R. 1, it provides states with an opportunity to improve health care access and outcomes in rural communities.

Many states plan to employ innovative solutions to support rural health care delivery and consumers through a variety of ways. **Alaska**, **North Carolina**, and **Indiana** plan to invest in rural training pipelines, residency expansions, and financial incentives to recruit and retrain providers in underserved areas. Other states are using RHTP funds to promote payment reform, as is the case in **Rhode Island** and **Georgia**, in implementing and applying for the AHEAD Model, respectively. **North Carolina** and **South Dakota** plan to use their RHTP dollars to advance and promote alternative payment model (APM) uptake, such as primary care capitation payments to rural providers to improve rural health care delivery. States are in the process of distributing funds to support these and other rural transformation initiatives, while at the same time looking ahead to secure funding from CMS for next year based on states’ progress toward meeting the goals outlined in their original applications.

USofCare submitted comments in support of and developed resources to assist with states’ RHTP applications last year. Once CMS announced each state’s funding amount, **USofCare highlighted how states are using this funding to support rural health**, including ways to advance patient-first care payment reforms like hospital global budgets.

## Promoting Patient-First Care

States have continued to engage with and adopt APMs developed by the CMS Innovation Center (CMMI) as part of a shift away from traditional fee-for-service payment. Most notably, six states – **Connecticut**, **Hawaii**, **Maryland**, **New York**, **Rhode Island**, and **Vermont** – continue to move ahead with implementation of CMMI’s Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, a total cost of care model that is expected to lower costs and improve health outcomes for people through state-led cost growth and primary care spending targets and hospital global budgets. In addition to the original AHEAD cohort, CMMI plans to select two more states to join AHEAD, with the goal to begin participation in 2028 or 2029.

USofCare continues to respond to states’ needs during AHEAD implementation and submit comments to support this process. USofCare Director of Federal Policy Alyssa Penna serves as a consumer representative on Maryland’s AHEAD Advisory Committee to inform the creation and development of the state’s total cost of care cost growth target.



**Alyssa Penna**  
Director of Federal Policy

While most states are still in the pre-implementation stage, **Maryland** has already entered its first performance year of the Model, which builds off of the success of the state’s previous Total Cost of Care Model. The state is working to establish its total cost of care growth and primary care investment targets for the 2027 performance year. Other states are in the earlier planning stages, working to establish the data infrastructure, stakeholder engagement, and frameworks necessary to meet the Model’s requirements.

Beyond AHEAD, states are pursuing a range of other APM strategies to move away from volume-based fee-for-service payment toward more quality care focused on payment tied to patient outcomes. **California** continues to implement statewide APM adoption targets to increase the share of payments made through value-based arrangements, while **New Jersey** has considered legislation to expand primary care APMs, such as patient-centered medical homes, within the state’s Medicaid program.

## Key Takeaways

- **Federal cuts to Medicaid and other health programs have forced states to address budget shortfalls.** By shifting Medicaid and other costs onto states, the federal government has worsened state finances and pushed states to make difficult decisions as they seek to balance budgets. Looking ahead, states should consider a range of policy options to save money or increase revenue to fill any deficits before cutting access to needed health care services that people depend on.
- **States are considering creative ways to maintain people's coverage.** States are responding to federal health care cuts, including the expiration of ePTCs, with proposals for new and improved programs, like state public options or Basic Health Plans, to avoid any disruption in care and keep people covered.
- **Federal partnerships exist for states.** Despite federal cuts, states have opportunities to draw down federal dollars and technical assistance to promote system transformation and benefit people through initiatives like the Rural Health Transformation Program and current and future CMMI payment models, such as the AHEAD Model.


# LOOKING AHEAD TO 2027

With the looming 2026 elections and fallout from H.R. 1 causing uncertainty ahead of next year's legislative sessions, health care affordability concerns will likely drive many voters' decisionmaking. Similar to 2026, many states will be working to increase revenue or cut spending to fill deep budget shortfalls, including legislatures in Montana, Nevada, North Dakota, and Texas, which will convene in 2027 after meeting only every other year. Many hope to avoid deep cuts to services that people rely on.

While the results of elections to select state governors, legislators, and other key policymakers will influence policy agendas in 2027, we expect many lawmakers to continue to work together to champion solutions to lower the cost of care broadly, with a continued focus on hospitals as key drivers of these cost increases. In doing so, these legislators will likely be influenced by some of the following dynamics:

## *Continuing Federal Uncertainty*

Despite progress in the states to address the high cost of care, Congress has failed to pass notable legislation to address these costs. One of the only major health care bills passed last year – H.R. 1 – will continue to have an outsized impact on state budgets and state Medicaid programs as states scramble to contain the fallout and monitor the impacts on state budgets and people's access to care. In addition to the law's Medicaid cuts, questions remain about the federal government's ability to get RHTP dollars out the door in time for states and subgrantees to use them. Significant uncertainty also exists surrounding H.R. 1's Medicaid work requirements, given the short, six-month implementation timeline and an overly restrictive exemptions policy that will only lead to more coverage losses for people.



USofCare's innovative **Red State Cohort** is designed to respond to the **unique challenges and opportunities present in conservative-leaning states**. USofCare is partnering with advocacy organizations in six states to facilitate cross-state collaboration, provide technical assistance, and lend policy and communications support to help these states push policies to lower the cost of care.

## *Growing Support for Action to Lower Prices on Both Sides of the Aisle*

There is growing bipartisan interest in health care affordability concerns as policies to lower the cost of care are championed by conservative and progressive lawmakers alike. Conservative lawmakers, for example, have framed reference-based pricing reforms as market-oriented solutions that allow for more competition in an increasingly consolidated health care market. Progressive lawmakers are comfortable talking about how the same policy prioritizes consumer protections and makes health care more affordable for all. Together, legislators on both sides of the aisle are increasingly teaming up to promote cost containment and transparency solutions to improve care affordability for people and their families.



## *Increasing Presence of Artificial Intelligence in Health Care*

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States will have to confront the challenges and opportunities presented by artificial intelligence (AI) in health care. While AI remains a promising tool to alleviate administrative burden, reduce provider burnout, and improve affordability, sufficient guardrails are needed to ensure AI technology – such as utilization management algorithms, provider reimbursement methodologies, and patient-facing tools – doesn't create new barriers to care or engage in discriminatory behavior. States policymakers and advocates will also likely increasingly utilize AI to inform decision- and policymaking and how they design, regulate, and enforce new policies. As a result, states will need to invest in transparent standards and oversight to ensure AI across systems is safe, equitable, and accountable.

## *Growing Public Support for Greater Government Involvement in Health Care*

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While government has largely taken a hands-off approach when it comes to health care pricing and regulation historically, people are increasingly open and supportive of policymakers playing a larger role in making health care more affordable. More than half of all people don't trust health care companies to regulate these costs on their own, and huge majorities of people support policymakers pursuing policies like greater price transparency, prohibiting facility fees in certain settings, and setting limits on hospital prices to lower costs. This support exists regardless of party affiliation and could be used as an effective counterpunch to hospital and other industry stakeholder opposition to these policies.

# Conclusion

People's concerns about affordability have only grown over the past year. Unfortunately, increased health care costs remain a significant and increasing concern for people as they're forced to consider the tradeoffs between essentials like housing, food, and childcare and needed medical care for themselves and their families. Responding to these growing challenges, states used the 2026 state legislative session to build on previous years' efforts to pass legislation to address the high cost of care and set the stage for further progress in 2027. Bipartisan coalitions of lawmakers have recognized the need for bold action to combat high prices charged by hospitals and push back against rampant health care consolidation to protect people's access to care. Over the next year, USofCare will continue to partner with likeminded consumer advocates and legislators of both parties to advance policies to make sure that everyone, no matter who they are, where they live, or how much money they make, has access to quality, affordable health care.

