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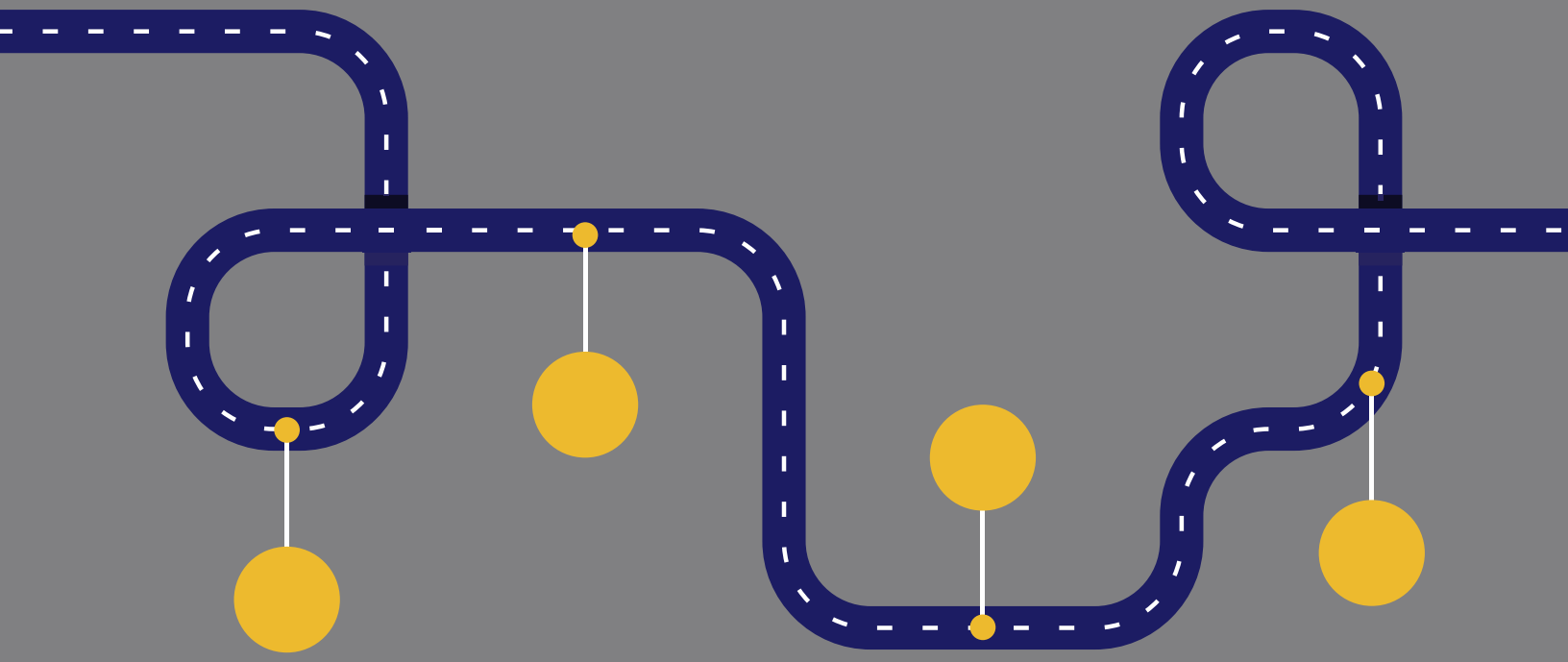
UNITED STATES of CARE

Ensuring Access to Preventive Care Under Private Insurance:

••• A Legislative Roadmap for States •••



August 2026

People across the country depend on cost-free preventive care to stay healthy, diagnose conditions early, and avoid more serious and costly health problems down the road. Although the Affordable Care Act (ACA) guarantees access to cost-free preventive care for people with private insurance, due to changes in the composition of federal expert bodies tasked with making preventive services recommendations, uncertainty exists for people, providers, insurers, and others who rely on, provide, or cover these essential services. This uncertainty, combined with inconsistent enforcement of existing requirements, threatens access to preventive care that people have come to depend on. State legislation is an important tool to reduce this uncertainty, provide stability, and preserve people's access to evidence-based preventive services without out-of-pocket costs such as copayments and deductibles, even if the federal government falls short. By strengthening state-level protections, policymakers can ensure continued preventive care access and peace of mind for people in their state.

Background

The ACA requires most commercial insurers to provide coverage without copayments, deductibles, or cost sharing for preventive care services recommended by three federal bodies, the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA).[1] More than 150 million people, including 37 million children,[2] rely on the preventive services coverage requirement to access cost-free preventive care services including cancer screenings, behavioral health screenings, immunizations, contraception, and HIV prevention medication.

Preventive Services That Must Be Covered at No Cost to Plan Members Under the ACA

United States Preventive Services Task Force (USPSTF): *Services with a grade A or B*	USPSTF is a volunteer panel of experts in disease prevention and evidence-based medicine. They review and grade preventive services including screenings, behavioral counseling, and preventive medications for all people. Their recommendations can apply to care for people of all ages.
Advisory Committee on Immunization Practices (ACIP): *Vaccines recommended by ACIP and adopted by the Centers for Disease Control & Prevention (CDC)*	ACIP is an advisory committee that makes recommendations to the CDC regarding the use of vaccines for civilians in the U.S. Recommendations must be adopted by the CDC to be incorporated under the ACA preventive care coverage requirement.
Health Resources and Services Administration (HRSA): *Women's Preventive Services Guidelines*	The Women's Preventive Services Initiative (WPSI) develops evidence-based recommendations to improve adult women's health. WPSI recommendations must be adopted by HRSA to be covered under the ACA preventive care requirement.
Health Resources and Services Administration (HRSA): *Bright Futures preventive services recommendations for infants, children, and adolescents*	The American Academy of Pediatrics develops evidence-based, age-specific preventive care guidelines. These guidelines must be adopted by HRSA in order to be covered under the ACA preventive care requirement.

In its 2025 decision in *Kennedy v. Braidwood Management, Inc.*,[3] the U.S. Supreme Court rejected a constitutional challenge to the ACA's preventive services coverage requirement that most private health plans cover no-cost preventive care recommended by the USPSTF, and upheld the requirement. The Court noted that the Secretary

of Health and Human Services (HHS) has considerable control over the USPSTF, including the power to remove USPSTF members at will (before their terms end) and to effectively block all new recommendations before they take effect.[4]

Although *Braidwood* left the ACA's preventive care requirements intact, the scientific, evidence-based authority of the above federal bodies is in jeopardy. HHS has replaced ACIP's membership, resulting in litigation and an effort to rewrite ACIP's charter to dilute its focus on vaccine science.[5] Following the dismissal of the chair and vice chair of the USPSTF, there are concerns that similar membership changes may befall USPSTF, with future appointees lacking the appropriate expertise required of USPSTF members who may not consider clinical best practices when making recommendations.[6] Certain evidence-based recommendations by the USPSTF, such as HIV pre-exposure prophylaxis (PrEP) – which has an A rating due to its efficacy at preventing HIV – may be vulnerable and subject to political, and not evidence-based, considerations.[7] Although no changes have been made yet to the USPSTF's recommendations since the *Braidwood* ruling, future threats to the credibility of the recommendations remain, causing states, plans, providers, employers, and people significant confusion over federal coverage rules. Additionally, there has been minimal enforcement at the federal level of the preventive care requirements, causing people to be unlawfully charged copayments or deductibles for services that should be free.[8]

Given the uncertainty and lack of enforcement on the federal level, states should enact or revise legislation that bolsters coverage for preventive care services and protects people's cost-free access to these services that they've come to rely on. As evidenced by states like Colorado and Washington that have already begun this work, multiple models exist to protect people's access to preventive care, and the right option(s) for a state may depend on various considerations. This resource outlines a flexible model and considerations to help guide state policymakers and advocates.

Core Principles

State laws to protect access to no-cost preventive care provide people continued access to evidence-based care that protects their health. While state efforts to achieve this goal vary, effective state laws should reflect the following principles. Additional details and considerations regarding policy options to codify these principles are provided in Sections III and IV below.

1. **Preventive services must be accessible with no out of pocket costs.** Unlike medical treatment or diagnostic services, preventive care is generally prescribed for people who are asymptomatic. Its purpose is to help people stay healthy through services such as early diagnosis (before someone becomes symptomatic) or preventive medications. However, out-of-pocket costs can be a significant deterrent to health care access, particularly for preventive care, which is primarily for people who are not sick (or do not know themselves to be sick).[9] It is therefore critical that preventive services be accessible without out-of-pocket costs such as copayments and deductibles.

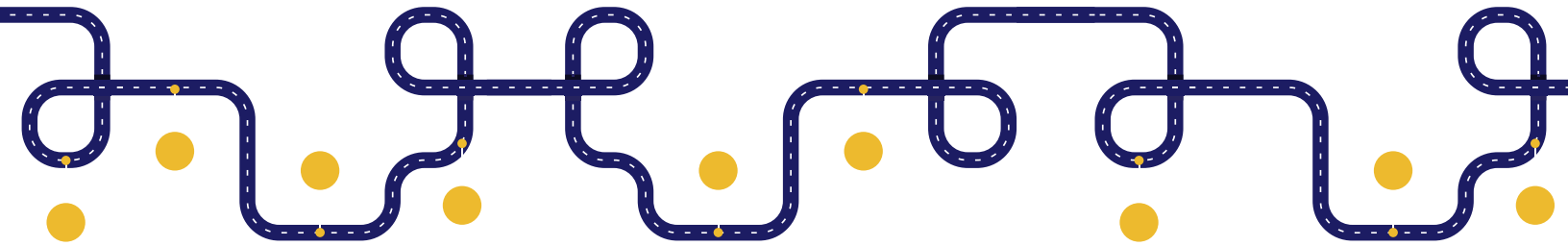
2. **Access to evidence-based preventive services must be protected.** Providers generally rely on research-backed guidelines to determine what preventive care is appropriate for which patients. When translated into coverage requirements, these guidelines also provide clear, justifiable standards for medically necessary services insurers must cover. Laws requiring no-cost access to preventive services should therefore be tied to credible, evidence-based guidelines regarding what preventive care is recommended. To do this, state laws should:
    - **Protect access to existing evidence-based services recommended by qualified experts in prevention, evidence-based medicine, and primary care.** This access must be continued until similar experts, including providers with backgrounds in internal medicine, pediatrics, family

medicine, obstetrics and gynecology, nursing, and psychology, have carefully reassessed the evidence and issued a well-reasoned conclusion that the recommendation should be updated. State laws should accomplish this by defining "preventive services" covered under state law to include a set of comprehensive, evidence-based early interventions and screenings, including immunizations, recommended by a qualified body or bodies with appropriate expertise.

- **Guarantee flexibility to reflect advances in best practices.** State legislation should include a means to ensure ongoing flexibility in the selection of covered preventive services, so as to ensure swift updates to coverage rules to reflect the current state of evidence-based medicine. Mechanisms include:
    - Identifying an entity with appropriate expertise to update the list of covered, cost-free services. While there are entities other than ACIP that publish vaccination recommendations,[10] there is currently no single, nationwide alternative source of recommendations for all USPSTF- and HRSA-recommended services, so states may consider delegating this responsibility to an existing health board or regional collaborative, creating a new regulatory entity, or adopting medical society recommendations or other private institutions' recommendations where applicable;
    - Authorizing a qualified regulatory entity to update the law in accordance with updated recommendations; and
    - Requiring insurers to adopt new coverage mandates and to inform consumers of the changes in plan documents.

- **Ensure that coverage of preventive services is comprehensive and eliminate loopholes that can lead to hidden costs for people with private insurance.** For example, state laws can:
    - Confirm that an insurer must cover a preventive care service out-of-network cost-free if a provider in-network option doesn't exist;
    - Require coverage of related services "integral-to" the delivery of preventive care (screenings, lab services, follow-up exams, facility fees, counseling, pain management, etc.); or
    - Regulate the use of utilization management techniques that create barriers to access to the services, modalities, or medication formulations most appropriate for the consumer.

3. **Promote transparency and opportunity for stakeholder engagement whenever coverage of preventive services may be changing.** For example, if a state entity is charged with updating the list of preventive services that are covered at no cost, the update process should include an opportunity for all stakeholders—including affected communities, providers, advocates, and insurers—to review and comment on the draft changes before they take effect. Regulators charged with evaluating and responding to community input should evaluate its alignment or nonalignment with scientific evidence regarding the effectiveness of preventive care.



Building a State Preventive Care Access Law: A Step by Step Approach

Additional Policy Design Considerations

ERISA and limits to state regulation: State policies to protect people's access to no-cost preventive services are limited by federal law that preempts states from regulating self-funded employer health plans. As a result, state-level preventive services protections can only apply to state-regulated plans, including fully-insured group plans, individual and small group plans, and state employee health plans. States and advocates may have opportunities, however, to influence the coverage decisions of self-funded plans through direct conversations with large employers. Self-funded plans also must follow the federal ACA preventive care requirement.

Cost defrayal: States that require coverage of preventive services in addition to recommendations made by the USPSTF, ACIP, or HRSA may need to update their Essential Health Benefits (EHB) benchmark plans. Otherwise, they might need to defray the cost of those additional required services. These considerations apply to regulation of Qualified Health Plans only.

Tax considerations for Health Savings Accounts (HSAs): HSAs offer certain tax advantages for people with High-Deductible Health Plans (HDHPs). These tax advantages require limits on pre-deductible coverage for services, with an exemption for certain preventive services. Requiring HDHPs to cover additional preventive services pre-deductible (beyond those already required to be covered under the federal ACA preventive care rule) may have tax consequences for HSAs.[14]

Nondelegation concerns: States may be legally limited in the manner and degree to which they may incorporate recommendations from non-state entities (such as federal agencies and nongovernmental groups) into state law. States that incorporate recommendations from non-state entities into state law should therefore consider empowering a state regulatory official or body to review and adopt the recommendations of the non-state entities.

Similar to the ACA at the federal level, many state laws ensure no-cost access to preventive care by requiring insurers to cover preventive services without cost-sharing. Prior to the recent changes to the make-up of USPSTF and ACIP, many states defined preventive services, at least in part, as services recommended by the USPSTF, ACIP, and HRSA.

However, some states have incorporated alternate sources of recommendations developed through rigorous, evidence-based review, such as vaccines and services for children recommended by the American Academy of Pediatricians (AAP) or the American Academy of Family Physicians (AAFP), services for women recommended by the American College of Obstetricians and Gynecologists (ACOG), or vaccines recommended by the Vaccine Integrity Project. States are increasingly looking to these bodies as alternative sources of evidence-based recommendations.

State laws also vary in other ways, such as whether they incorporate recommended preventive services as of a certain date, whether they empower a state regulatory authority to add to or change the list of recommended preventive services, and whether they require all formulations or modalities of services to be covered without utilization management.

State legislatures should consider which structure best fits the state's insurance and public health goals, regulatory landscape, policymaking infrastructure, and circumstances. Below is a rubric with considerations to support states in developing a policy that meets their needs. This rubric is not exhaustive of all policy options, nor is it legal advice. Rather, it is intended as a starting point to help guide state leaders through possible state policy solutions to protect preventive care access.

Step 1: Define Preventive Services

States must decide which set(s) of preventive services recommendations are required to be covered under the state's definition of preventive services. In choosing which sets of preventive services must be covered, policymakers should consider factors such as expertise within primary and preventive care, a body's responsiveness to or insulation from democratic processes, and any risks of perverse incentives (or simply accusations of perverse incentives).

Entity	Examples (non-exhaustive)
Core federal bodies	US Preventive Services Task Force, Advisory Committee for Immunization Practices, Health Resources and Services Administration
Additional federal bodies	CDC guidelines, Veterans Affairs/Department of Defense Clinical Practice Guidelines
Professional medical societies	American Academy of Pediatrics, American Academy of Family Physicians, American Cancer Society, American College of Obstetricians & Gynecologists, American Society of Clinical Oncology, Infectious Diseases Society of America, International Antiviral Society-USA, American Heart Association
Other nongovernmental bodies	Vaccine Integrity Project
State governmental bodies	Nurse-Physician Advisory Task Force for Colorado Healthcare

Step 2: Require Plans to Cover Preventive Services Without Cost Sharing

States should require all state-regulated insurance providers or carriers (or a subset of insurers) to cover preventive services as defined in state law without any cost-sharing, including co-payments, co-insurance, or deductibles.

Depending on how state insurance law is organized, the law may have to specify the kinds of plans subject to this requirement. In states where different statutes regulate different kinds of plans (such as large group, fully insured plans; individual or small group plans; HMOs; government employee or student plans; or other plan types) the same statutory language may need to be adopted into different statutes in order to apply the preventive care coverage rules consistently to all state-regulated plans.

Step 3: Determine How Updated Recommendations Will Be Incorporated

To ensure that state preventive care laws reflect updates to preventive care best practices based on new evidence or newly available services or modalities, the laws must have a method for incorporating updates to preventive care recommendations. At the federal level, the ACA preventive care rule does this by incorporating the recommendations of USPSTF, ACIP, and HRSA—generally speaking, when expert organizations revise these recommendations based on new evidence, insurers must cover preventive services as described in the updated recommendations.

Some state laws mirror the ACA by defining covered preventive services as those recommended by the USPSTF, ACIP, and HRSA. This structure has the advantage that it does not require a state regulator to act in order

for new recommendations to be incorporated into state law. At the same time, this limits the state's ability to diverge from the federal lists of covered services as any changes made by the federal bodies are automatically incorporated into state law. Under this framework, states likely cannot add additional services or block the addition of services that do not reflect best practices or current evidence without enacting further legislation.

Other states define preventive services as those services that had a recommendation in effect as of a specific date, such as the date a law is enacted or some earlier date. An example of this is available here. The benefit of this approach is that it protects access that patients currently have and guards against backsliding. The state should also adopt a method for regularly incorporating updates to the recommendations that reflect advances in best practices. States may wish to choose this model to allow state regulators to decide whether and when new recommendations are incorporated into state law, independent of federal recommendations.

If the state is adopting the latter option, its policy will likely also need to consider the following:

Step 3.1: Establish a Starting Date

If preventive services are defined by the recommendations that existed as of a specific date, then the law will need to establish that date. Options include:

- **The date of enactment:** A law could incorporate all recommendations by the referenced bodies in effect the date the law is passed. However, if state policymakers want to carve out recently issued recommendations made by federal bodies or other entities that don't reflect best practices, they may want to choose a date prior to the law's passage.
- **A date pre-enactment:** A law could incorporate all recommendations in effect as of any specific past date for which there is a policy rationale. One such option would be April 16, 2025, the last ACIP meeting date before ACIP's non-partisan, expert members were collectively dismissed by the HHS Secretary.

Protecting Access to Specific Services

Certain preventive care services have been subject to political or ideological attacks, including contraceptives, PrEP, and the human papillomavirus (HPV) vaccine. While people are best served by legislation that protects access to comprehensive preventive care services–rather than piecemeal protection for individual services–certain preventive services may be associated with unique barriers to access, such as the need for related services "integral to" access. States looking to protect access in statute to specific services to be covered cost-free should be aware that statutory language cannot be subsequently changed without further action by the legislature. Protections for specific services should be written broadly enough to avoid becoming quickly outdated if best practices change or evolve.

Step 3.2: Empower a State Regulator to Incorporate Updates

If the state is adopting a model that requires affirmative action by a state regulator to incorporate updates to the recommendations, then the state should identify one or more regulatory bodies with appropriate capacity and expertise responsible for taking this action. This could be a state health, public health, or insurance official, or a state-specific advisory body, such as the Nurse-Physician Advisory Task Force for Colorado Healthcare (NPATCH). Depending on the state landscape, states may wish to establish a new, independent body to oversee the process of updating the recommendations covered under the law.

Step 3.3: Decide How the Regulator Should Incorporate Updates

The law should instruct the regulator how to incorporate

updates to preventive services recommendations. Updated recommendations can be incorporated via a one-way or two-way ratchet:

- **One-way ratchet**: A regulator could be empowered only to add, and not delete, new recommended services, even if a service has been downgraded or removed by its recommending body. This approach has the advantage of protecting services from being removed on political grounds, rather than medical best practice. However, this risks being criticized as potentially out-of-step with medical evidence, if new evidence emerges that a previously recommended service is no longer beneficial for patients.
- **Two-way ratchet**: As an alternative, a regulator could be empowered to both add or remove recommendations consistent with changes adopted by recommending bodies, avoiding both the advantages and disadvantages outlined above.

To encourage timely regulatory updates, states should consider including mandatory language requiring regulators to act within a certain time period. (For example: "[The Regulator] shall issue updates within 90 days of issuance of new recommendations.")

Finally, to promote transparency, states should consider allowing public health and medical experts, patient advocacy groups, and others to weigh in. The state could require an opportunity for notice and comment by the public, reflecting current practice by the USPSTF itself. However, a mandatory notice and comment process generally takes more time and agency resources than simply issuing guidance. The state should also consider incorporating guardrails that instruct the regulator to assess comments based on scientific evidence.

Related State Preventive Care Policy Components

In addition to the recommendations above, a state preventive care policy should also include language to protect people's access to no-cost care by maximizing the statute's reach, facilitating enforcement, and eliminating loopholes that create additional barriers to care:

- **Clarify the scope of preventive services protections.** States should require plans to cover all FDA-approved formulations, modalities, or methods of administration cost-free for recommended services, such as colon cancer screening alternatives to colonoscopy, contraception, and long-acting injectables for PrEP. Additionally, all services integral to the provision of recommended preventive services, such as polyp removal during colonoscopy or screenings required for PrEP, should also be covered without cost.[11] States should codify these provisions via regulation or statute.[12] States should also make clear that nothing in statute prohibits an insurance plan from covering preventive services in addition to those required by statute. States may also wish to include language confirming that benefits for an enrollee under this statute should be the same for the enrollee's covered spouse and dependents, or language that restricts utilization management for preventive services.[13]

- **Strengthen enforcement of coverage requirements**. State legislation should include a means of enforcing coverage requirements by authorizing the commissioner of insurance or another appropriate entity to take enforcement actions for noncompliance, such as
  - Opening an investigation;
  - Establishing insurer penalties for non-compliance, such as fines per violation or suspension of insurer license;
  - Reviewing provider billing errors and establishing penalties for upcoding; or

- Conducting market conduct exams or audits to ensure compliance.

- **Require insurers to adopt policies that reduce consumer and provider confusion and ease access to cost-free preventive care benefits.** States should require insurers to adhere to uniform billing or coding standards that indicate when preventive services should be eligible for zero out-of-pocket costs. Insurers should be required to make this information available to providers.

- **Promote awareness of no-cost coverage requirements.** Education of both people and providers related to the no-cost coverage requirement is lacking. State legislation should clarify insurer obligations to ensure providers and plan members are familiar with zero cost-sharing requirements. Insurer obligations could include, for example:
  - Requiring plan documents or notices to clearly state that preventive services are available at no cost and that plan members may appeal if they believe they have been wrongly charged co-pays for preventive services;
  - Requiring plans to provide accurate information on their website for providers regarding how preventive services should be coded to avoid improper billing; and
  - Requiring plans to reimburse providers for time spent counseling patients about recommended preventive services and cost-free coverage.

- **Collect data to promote accountability and transparency.** State legislation should include requirements for insurers to report data metrics to assess the degree to which the preventive care coverage requirements are being fully implemented. For example, states could require the reporting of the number of appeals filed alleging improper imposition of cost sharing for covered services and the outcomes of those appeals. Legislation should include authorization for state officials to enforce data sharing requirements and funding for the resources and staff time to analyze this data.

For more information regarding coverage of preventive services, visit the United States of Care Preventive Services Hub. For questions regarding this roadmap, please contact info@chlpi.org.

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Endnotes

1 42 U.S.C. § 300gg-13(a) (coverage of preventive health services by group health plans); 42 U.S.C. § 1396a(k)(1) (coverage of preventive health services by Medicaid, by reference to 42 U.S.C. § 1396u-7(b)(5) and 42 U.S.C. § 18022(b)(1)(I)).

2 Assistant Secretary for Planning and Evaluation (ASPE), Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act (January 11, 2022), https://perma.cc/V4DZ-8V8K.

3 *Kennedy v. Braidwood Management, Inc.*, 606 U.S. 748 (2025), available at: http://supremecourt.gov/opinions/24pdf/24-316_869d.pdf.

4 *Braidwood*, 606 U.S. at 762–68.

5 Helen Branswell and Anil Oza, New ACIP charter broadens criteria for members, calls for review of alternatives to vaccines, STAT (June 25, 2026), https://www.statnews.com/2026/06/25/acip-charter-responsibilities-rfk-jr/.

6 Maggie Astor, *Kennedy Fires Leaders of Key Health Task Force*, N.Y. Times (May 20, 2026), https://www.nytimes.com/2026/05/20/well/rfk-jr-firings-preventative-services-task-force.html.

7 *See, e.g.*, Joseph Addington, *Time for Kennedy to Kill the USPSTF*, The American Conservative (July 9, 2025), https://www.theamericanconservative.com/time-for-kennedy-to-kill-the-uspstf/.

8 The NAIC Consumer Representatives, *Preventive Services Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented*, Consumer Health Advocacy at the National Association of Insurance Commissioners (Aug. 13, 2023), https://consumeradvocacyforhealth.org/resource/preventive-services-coverage-and-cost-sharing-protections-are-inconsistently-and-inequitably-implemented/.

9 *See e.g.*, Lorraine T. Dean et al., *Estimating the Impact of Out-of-Pocket Cost Changes on Abandonment of HIV Pre-Exposure Prophylaxis*, 43 Health Affs. 36, 39 (2024); Quyen Ngo-Metzger et al., *Estimated Impact of US Preventive Services Task Force Recommendations on Use and Cost of Statins for Cardiovascular Disease Prevention*, 33 J. Gen. Intern. Med. 1317, 1317–18, 1321 (2018); Geetesh Solanki et al., *The Direct and Indirect Effects of Cost-Sharing on the Use of Preventive Services*, 34 Health Servs. Rsch. 1331, 1339–40, 1348 (2000).

10 *See* the Vaccine Integrity Project, https://vaxintegrity.cidrap.umn.edu/.

11 See FAQs About Affordable Care Act And Women's Health And Cancer Rights Rights Act Implementation Part 68 (Oct. 21, 2024), https://www.cms.gov/files/document/faqs-implementation-part-68.pdf.

12 See FAQs About Affordable Care Act Implementation Part 47 (July 19, 2021), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-47.pdf.

13 *See, e.g.,* 26 C.F.R. 54.9815-2713 (permitting use of "reasonable medical management techniques" only "to the extent not specified in the relevant recommendation or guideline").

14 At least one jurisdiction has carved out HSAs from PrEP-specific coverage rules to avoid this issue. *See* D.C. Code 31-1611.

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