EXPLAINER

Preventive Services: Federal and California Law

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California Health Benefits Review Program (CHBRP)
University of California

Preventive services include screenings, vaccinations, and counseling intended to detect or prevent disease. California legislation analyzed by the California Health Benefits Review Program (CHBRP) frequently addresses preventive services. This explainer describes what qualifies as a preventive service, federal and state laws that require health insurers to cover preventive services, and the federal recommending bodies that make evidence-based recommendations about preventive services.

Background: What are Preventive Services?

Preventive health services aim to hinder the development of illness, disease, or other health-related issues through early detection, prevention of illness, and overall health maintenance (AbdulRaheem, 2023; CMS, 2025). These services can range from health education to vaccination and screening, depending on their targeted purpose. Preventive services can be categorized into three groups:

- **Primary preventive services** aim to avert the onset of diseases or illnesses before they occur. These services promote healthy lifestyles and are generally applied at a population level, focusing on health promotion such as health education, a healthy diet, or physical activity. Primary services also involve specific health protection measures targeting diseases, such as vaccination for influenza or human papillomavirus (HPV) (AbdulRaheem, 2023).
- **Secondary preventive services** focus on detection of a disease or condition, prompting diagnosis and treatment to slow or hinder its progression within a person and, in some cases, the risk of further transmission to others. This can include screenings for blood pressure, HIV, and lung cancer (among others) (Keyes et al., 2025).
- **Tertiary preventive services** aim to manage and rehabilitate patients with existing chronic conditions to limit further complications and improve their quality of life. Some examples of these services include diabetic management, mental health support, and sexually transmitted infections (STI) counseling (Keyes et al., 2025).

Federal and State Coverage Requirements

The Patient Protection and Affordable Care Act (ACA), signed into law in March 2010, aimed to address high rates of uninsurance, excessive out-of-pocket expenses, and varied coverage limits (Tolbert et al., 2025).[1] In part, this included

[1] For more information on the Affordable Care Act, please refer to the US Department of Health and Human Services (HHS) website.

addressing coverage for preventive services. Prior to the passage of the ACA, there was no federal requirement for insurers to cover preventive services; as such, coverage of preventive services varied among health plans, meaning that some peoples' plans paid – at least partially – for preventive services on the enrollee's behalf while others did not. Many people who did have coverage were still required to pay cost sharing for the cost of a covered preventive service, typically in the form of a deducible, copayment, and/or coinsurance.

The ACA established the Federal Preventive Services Mandate, which mandates that nongrandfathered[2] group and individual market health insurance plans provide coverage of specified preventive services without cost sharing, including a deductible, copayment, or coinsurance.[3] California later codified this mandate into state law.[4]

Specified preventive services typically fall under four broad categories:

- Evidence-based screenings and counseling
- Routine immunizations
- Childhood preventive services
- Preventive services for women

Enrollees may be responsible for cost sharing for specified preventive services when delivered by an out-of-network provider. The U.S. Preventive Services Task Force (USPSTF), one of the federal recommending bodies that makes recommendations regarding preventive services, only evaluates primary and secondary preventive services, generally for people without signs or symptoms of a condition (USPSTF, 2025). Therefore, tertiary services are not typically subject to the no-cost-sharing requirement of these mandates, and plans may cover them with or without cost sharing depending on other existing laws (Forsberg, 2025). See below for more information about the USPSTF and other recommending bodies.

Both the state and federal mandates apply only when a service is delivered as preventive care. Many services can be provided as either preventive or diagnostic depending on their use case; for example, mammography, ultrasound, and MRI can be used for both screening and diagnosis. As such, the same test may have no cost sharing when performed as a screening but be subject to cost sharing when performed as a diagnostic follow-up after an abnormal result or identification of symptoms, which can be associated with delayed or skipped follow-up care (ACS CAN, 2025; Ngo et al., 2023).

Federal Recommending Bodies

Not all preventive services are subject to the above-mentioned federal and state mandates. Preventive services that are subject are issued by four sets of federal recommendations: the United States Preventive Services Task Force (USPSTF) A and B recommendations; the Advisory Committee on Immunization Practices (ACIP) recommendations as adopted by the Director of the Centers for Disease Control and Prevention (CDC); the Health Resources and Services Administration's (HRSA)-supported health plan coverage guidelines for women's preventive services; and the HRSA-supported comprehensive guidelines for infants, children, and adolescents (CDC, 2024). Plans are required to provide coverage without cost sharing for relevant services within 12 months of the recommendation's publication.

United States Preventive Services Task Force

The USPSTF is an independent, volunteer panel of experts that issues evidence-based recommendations on the provision of clinical preventive services for patients. The USPSTF assigns grades to either recommend a preventive service or indicate if evidence is uncertain. The USPSTF assigns one of five letter grades – A, B, C, D or I – to its recommendations; those with an A or B grade are subject to the Federal and California Preventive Services Mandates. A

[2] A grandfathered health insurance plan is one that was purchased on or before March 23, 2010. Plans or policies may lose their grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers. These plans may not include some rights and protections provided under the ACA.
[3] Affordable Care Act Section 1001, modifying Section 2713 of the Public Health Service Act.
[4] HSC §1367.002 and INS §10112.2.

grade A recommendation means the USPSTF recommends the service and finds high certainty that the net benefit is substantial. A grade B recommendation means the USPSTF recommends the service and finds high certainty that the net benefit is moderate, or that there is moderate certainty that the net benefit is moderate to substantial (USPSTF, 2022a). As of November 2026, the USPSTF's recommendations with A and B grades include recommendations related to:[5]

- **Cancer:** breast, cervical, colorectal, lung, and skin cancer screening
- **Chronic Conditions:** hypertension, prediabetes/Type 2 diabetes, cardiovascular disease (CVD) prevention, depression and anxiety screening, hepatitis B/C screening, obesity
- **Health Promotion:** dental caries prevention, fall prevention, tobacco use prevention/cessation, intimate partner violence screening
- **Pregnancy-Related Services:** gestational diabetes, preeclampsia prevention, Rh(D) incompatibility testing, breastfeeding support, syphilis screening
- **Sexual Health:** chlamydia/gonorrhea screening, HIV screening and PrEP, STI counseling

As stated above, the USPSTF does not evaluate tertiary preventive services. Some primary and secondary services also fall outside the mandate because they receive a C, D, or I letter grade. A "C" letter grade indicates moderate certainty that the net benefit is small and clinicians selectively offer or provide this service based on individual circumstances, professional judgement, and patient preferences (USPSTF, 2018). A "D" letter grade indicates moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits, and the USPSTF recommends against these services (USPSTF, 2018). An "I" letter grade indicates that the available evidence is too limited, weak, or inconsistent to determine whether the benefits outweigh the harms (USPSTF, 2018). For example, screening for atrial fibrillation (AF) in asymptomatic adults aged 50 and older illustrates this gap. AF is a major risk factor for stroke, and approximately 20% of patients with an AF-associated stroke are first diagnosed with AF at the time of the stroke or shortly after (USPSTF, 2022b). Anticoagulants, medications used to prevent blood clots, can reduce stroke risk in patients with clinically diagnosed AF, but no trials have examined the benefits of treating AF detected through screening, and anticoagulant therapy carries a documented risk of major bleeding (USPSTF, 2022b). Since research found that the benefits and harms could not be determined, AF screening received an "I" letter grade from the USPSTF and therefore is not required to be covered without cost sharing (Kahwati et al., 2022).

Advisory Committee on Immunization Practices

ACIP is a federal advisory committee that makes recommendations on pediatric and adult vaccines. ACIP's recommendations are considered adopted by the CDC for routine use if they are listed on the CDC immunization schedules, which are divided by age and population groups who are at-risk (CDC, 2024). Current schedules include pediatric vaccines through the age of 18, including vaccinations for diphtheria, tetanus, pertussis, measles, mumps and rubella, influenza, COVID-19, and HPV, as well as adult vaccines for people aged 19 and older, protecting against respiratory syncytial virus (RSV), shingles, mpox, influenza, and COVID-19 (CDC, 2024).

Health Resources and Services Administration

HRSA is an agency within the Department of Health and Human Services (HHS) that makes recommendations through its Bright Futures Project and the Women's Preventive Services Initiative (WPSI) (Forsberg, 2025).

Bright Futures Project is a national health promotion and prevention initiative funded by HRSA, through a cooperative agreement with the American Academy of Pediatrics (AAP), to support primary care for infants, children, and adolescents. Pediatric preventive service guidelines are developed by a panel of experts brought together by the AAP. HRSA then reviews and determines whether to adopt their guidelines (HRSA, 2024). Adopted recommendations are then published and known as the Periodicity Schedule (AAP, 2020). This is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. Some of these recommendations include physical screenings and procedures by age (e.g. height and weight measurements, vision and hearing screenings, and STI screenings for

[5] More information about the state and federal requirements to cover specified preventive services is included in CHBRP's resource, Federal Recommendations and the California and Federal Preventive Services Benefit Mandates. Table 2, pp. 4-17.

adolescents) and developmental screenings by age (e.g. behavioral/social/emotional concerns, and depression and suicide risk) (Congress.gov, 2026).

The WPSI is a collaborative program funded by HRSA and led by the American College of Obstetricians and Gynecologists (ACOG) through a cooperative agreement.[6] ACOG periodically convenes a coalition of national health professional organizations representing clinicians, patients, and academics to conduct a review of current scientific evidence and make recommendations to existing guidelines (WPSI, 2026). HRSA then determines whether to adopt WPSI's recommendations, which are finalized as the HRSA Women's Preventive Services Guidelines (HRSA, 2026). Some of the current guidelines include the full range of U.S. Food and Drug Administration (FDA)-approved contraceptives, family planning practices, and sterilization procedures which are part of contraceptive care. The full range of contraceptives currently includes those listed in the FDA's Birth Control Guide. Patient navigation services for breast and cervical cancer are also recommended, including person-centered assessment and planning, health care access and health system navigation, referral to appropriate support services, and patient education (WPSI, 2026).

California State Law

California Preventive Services Mandate

California codified the Federal Preventive Services Mandate into state law in September 2020 through the passage of Senate Bill (SB) 406, known as the California Preventive Services Mandate.[7] This bill required group and individual nongrandfathered health plans and policies to, at a minimum, provide coverage for specified preventive services without any cost-sharing requirements, indefinitely extending the specified preventive services set by the same four recommending guidelines established by the Federal Preventive Services Mandate. In September 2024, Governor Newsom signed Assembly Bill (AB) 2258, which amended SB 406 to extend the existing mandate of coverage without cost sharing to cover additional services, including home test kits for sexually transmitted diseases and specified cancer screenings.[8]

Assembly Bill 144

In September 2025, Governor Newsom signed AB 144, requiring nongrandfathered, state-regulated health plans in California to cover, without cost sharing, preventive services subject to the federal mandate as of January 1, 2025, as well as those recommended by the California Department of Public Health (CDPH).[9,10] AB 144 serves as a baseline of recommendations and authorizes CDPH to modify or supplement those baseline recommendations specified by the federal government as of January 2025 with subsequent evidence-based recommendations issued by the USPSTF, ACIP, or HRSA, as well as other medical and scientific organizations, including the AAP, ACOG, and the American Academy of Family Physicians (AAFP). The law requires CDPH to publish recommendations and updates, modifications, or supplements.[11]

Given the authority extended to CDPH via AB 144, services mandated to be covered without cost sharing in California may differ from those mandated federally in the future. For example, in January 2026, HHS announced changes to the U.S. childhood vaccine recommendation, directing the CDC to reduce routine vaccinations (CDC, 2026). CDPH did not adopt these changes, leading to a divergence between federal and state guidance.[12] In 2026, CDPH used its authority under AB 144 to add AAP's updated child and adolescent immunization schedule, ACOG's maternal immunization schedule, and HRSA's updated recommendation for cervical cancer screening (CDPH, 2026).

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[6] The Women's Preventive Services Initiative (WPSI) grant period ended on February 28, 2026. The project was supported by HRSA in HHS under grant number UHOMC29440, Bright Futures for Women's Health: Standard Practice Guidelines for Well Women Care.
[7] HSC §1367.002 and INS §10112.2.
[8] HSC §1367.002 and INS §10112.2.
[9] AB 144 also requires coverage without prior authorization for certain services specific to COVID-19 or Public Health Emergencies.
[10] HSC §120164.
[11] CDPH's recommendations can be found on their website.
[12] On March 16, 2026, a U.S. District Court judge issued a temporary legal pause on new or altered federal childhood immunization schedules.

Conclusion

Federal and California Preventive Services Mandates have expanded preventive care coverage without cost sharing since the passage of the ACA. The Federal Preventive Services Mandate was signed into law in 2010 and since then has been codified into California state law, aiming to ensure that Californians have access to preventive services as recommendations evolve over time. For more detailed information on which preventive services are currently subject to state and federal mandates, please reference CHBRP's resource *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*.

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

To read any of the 200+ bill analyses CHBRP has completed, see the Completed Analysis page on CHBRP's website. In addition to analysis of introduced legislation, CHBRP produces other publications including several annually updated resources, as well as issue briefs and explainers.

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