TECHNICAL BRIEF

AB 1906

Cervical Cancer Screening

CHBRP

About the Technical Brief

This document provides details on the analytical foundation for CHBRP's analysis of AB 1906. While the main report synthesizes key findings for immediate policy consideration, this document is designed to support a deeper understanding of the background of the topic of the legislation and CHBRP's methodology and research in conducting its analysis. It contains the data sources, methods, assumptions, and other bill-specific considerations necessary for legislative staff, fiscal analysts, and other stakeholders to fully understand the scope and impact of the proposed measure.

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Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

CA – California

CalPERS – California Public Employees' Retirement System

CDC – Centers for Disease Control and Prevention

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHBs – essential health benefits

FDA – U.S. Food and Drug Administration

HPV – human papillomavirus

hrHPV – high-risk human papillomavirus

HRSA – Health Resources and Services Administration

SB – Senate Bill

SDOH – social drivers of health

USPSTF – United States Preventive Services Task Force

WPSI – Women's Preventive Services Initiative

YPLL – years of potential life lost

Terminology

CHBRP uses the following terminology for this analysis:

- **Cervical cytology (also known as a Pap test)**: a type of screening test that checks cervical cells for abnormalities caused by HPV that may progress to cervical cancer, such as precancerous cells and cancer cells. A Pap test may also find other noncancerous conditions, such as infection or inflammation.
- **Cost sharing:** Payment for use of covered health insurance benefits is shared between the payer (e.g., health plan/insurer or employer) and the enrollee. Common cost-sharing mechanisms include copayments, coinsurance, and/or deductibles (but do not include premium expenses[1]).
- **Dysplasia:** A change that causes abnormal cells called precancers to appear in the cervical tissue. These abnormal cells can become cancerous if they are not destroyed or removed. Although some HPV infections can resolve on their own, persistent infection with hrHPV can cause cells of the cervix to go through dysplasia.
- **Home test kit**: a type of self-collection screening test that can be used in the home or other private space.
- **HPV/Pap co-test**: a screening test that combines the HPV tests and the Pap test to detect high-risk HPV infection as well as cellular abnormalities.
- **HPV testing**: a type of screening test that checks cells for infection with high-risk HPV (hrHPV) types associated with cervical cancer.
- **Self-collected (or patient-collected) HPV test**: Self-collected HPV tests, also commonly referred to as patient-collected HPV tests, allow a patient to swab their own vagina in a private setting to screen for hrHPV. Some of the existing tests using this technology must be used in a clinical setting, while others can be used at home. Tests that are U.S. Food and Drug Administration (FDA)-approved for patient collection only in a health care facility under the supervision of a health care provider are not in scope for AB 1906. CHBRP uses patient-collected and self-collected terminology interchangeably throughout this analysis to align with terminology used by sources.

[1] Premiums are paid by most enrollees, regardless of their use of any tests, treatments, or services. Some enrollees may not pay premiums for different reasons. For example, their employers cover the full premium, or they receive benefits through Medi-Cal.

Legislative Text Analyzed

CHBRP analyzed AB 1906 Cervical Cancer Screening as introduced/amended on February 12, 2026 per the request of the California Assembly Committee on Health. The text analyzed is copied below.

SECTION 1. Section 1367.66 of the Health and Safety Code is amended to read:

1367.66. (a) ~~Every~~ *(1) A* individual or group health care service plan contract, except for a specialized health care service plan, issued, amended, or renewed on or after January 1, 2002, shall provide coverage for an annual cervical cancer screening test upon the referral of the patient's physician and surgeon, a nurse practitioner, or a certified nurse-midwife, providing care to the patient and operating within the scope of practice otherwise permitted for the licensee.

(2) A health care service plan contract, except for a specialized health care service plan, issued, amended, or renewed on or after January 1, 2027, shall provide coverage for an annual cervical cancer screening home test kit upon the referral of the patient's health care provider. A health care service plan contract shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this paragraph.

~~(1)~~

(3) The coverage for an annual cervical cancer screening test provided pursuant to this ~~section~~ *subdivision* shall include the conventional Pap test, a human papillomavirus screening test that is approved by the United States Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA, upon the referral of the patient's health care provider.

~~(2)~~

(4) This subdivision does not establish a new mandated benefit or prevent application of deductible or copayment provisions in an existing plan contract. The Legislature intends in this section to provide that cervical cancer screening services are deemed to be covered if the plan contract includes coverage for cervical cancer treatment or surgery.

(b) A health care service plan contract, except for a specialized health care service plan, issued, amended, or renewed on or after January 1, 2024, shall provide coverage for the human papillomavirus vaccine for enrollees for whom the vaccine is approved by the FDA. A health care service plan contract shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

SEC. 2. Section 10123.18 of the Insurance Code is amended to read:

10123.18. (a) *(1)* A disability insurance policy issued, amended, or renewed on or after January 1, 2024, and that provides coverage for hospital, medical, or surgical benefits shall provide coverage, upon the referral of a patient's physician and surgeon, a nurse practitioner, or a certified nurse-midwife, providing care to the patient and operating within the scope of practice otherwise permitted for the licensee, for an annual cervical cancer screening test.

(2) A disability insurance policy issued, amended, or renewed on or after January 1, 2027, shall provide coverage for an annual cervical cancer screening home test kit upon the referral of a patient's health care provider. A health insurance policy shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this paragraph.

~~(1)~~

(3) The coverage for an annual cervical cancer screening test provided pursuant to this ~~section~~ *subdivision* shall include the conventional Pap test, a human papillomavirus screening test that is approved by the United States Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the FDA, upon the referral of the patient's health care provider.

~~(2)~~

(4) This subdivision does not require an individual or group policy to cover treatment or surgery for cervical cancer or to prevent application of deductible or copayment provisions contained in the policy or certificate, and does not require that coverage under an individual or group policy be extended to any other procedures.

(b) A disability insurance policy issued, amended, or renewed on or after January 1, 2024, that provides coverage for hospital, medical, or surgical benefits shall provide coverage for the human papillomavirus vaccine for insureds for whom the vaccine is approved by the FDA. The policy shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

(c) This section shall not apply to vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, or disability income insurance. For accident-only, hospital indemnity, or specified disease insurance, coverage for benefits under this section shall apply only to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or certificate. This section does not impose a new benefit mandate on accident-only, hospital indemnity, or specified disease insurance.

SEC. 3. Section 14132.17 of the Welfare and Institutions Code is amended to read:

14132.17. *(a)* Annual cervical cancer tests for screening or diagnostic purposes, upon the referral of a patient's physician, is a covered benefit under this chapter, on or after January 1, 1991, to the extent required or permitted by federal law.

(b) (1) Annual cervical cancer home test kits for screening or diagnostic purposes, upon the referral of a patient's health care provider, is a covered benefit under this chapter, on or after January 1, 2027, to the extent required or permitted by federal law.

(2) A Medi-Cal beneficiary is not subject to any cost sharing, including, but not limited to, a share of cost or spend down of excess income as described in Section 14054 for the benefit described in this subdivision.

(3) This subdivision applies to both the fee-for-service delivery system and the managed care delivery system under the Medi-Cal program.

SEC. 4.

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Policy Framework

This brief provides additional material to support the findings and recommendations presented in CHBRP's Analysis of Assembly Bill 1906 Cervical Cancer Screening.[2] The following sections contain details on the California and federal landscape. Although this information is essential to the completeness of the analysis, it has been placed in this separate brief to maintain the flow of the main report. Readers are encouraged to consult this material for deeper insights into existing laws and technical details that informed the analysis and conclusions of the main report.

California and Federal Policy Landscape

Preventive Services

Both the California Preventive Services Mandate and the Federal Preventive Services Mandate require coverage of certain preventive services without cost sharing for enrollees in nongrandfathered plans and policies following four sets of Federal recommendations. Three of those sets of recommendations include services relevant to cervical cancer screening and prevention, including:[3,4]

- The United States Preventive Services Task Force (USPSTF) A and B recommendations;
- The Health Resources and Services Administration (HRSA)-supported health plan coverage guidelines for women's preventive services;
- The Advisory Committee on Immunization Practices (ACIP) recommendations that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

Additionally, in September 2025, Governor Newsom signed Assembly Bill 144, which requires nongrandfathered state-regulated health plans in California to cover preventive care services recommended by the federal government as of January 1, 2025, or recommended by the California Department of Public Health (CDPH), without cost sharing.[5]

On January 5, 2026, the HRSA-supported health plan coverage guidelines for women's preventive services[6] updated its recommendation for cervical cancer screening to include that patient-collected hrHPV testing[7] is an appropriate method and should be offered as an option for cervical cancer screening in women aged 30 to 65 years at average risk (HRSA, 2025). HRSA also recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, cervical cancer screening using cervical cytology (Pap test) every 3 years is recommended. Co-testing with cytology and human papillomavirus (hrHPV) testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with primary hrHPV testing every 5 years (preferred) or cytology and hrHPV testing (co-testing) every 5 years. If hrHPV testing is not available, continue screening with cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years. Patient-collected hrHPV testing is an appropriate method and should be offered as an option for cervical cancer screening in women aged 30 to 65 years at average risk. Additional testing may be required to complete the screening process and follow-up findings on the initial screening. If additional testing (e.g., cytology, biopsy, colposcopy, extended genotyping, dual stain) and pathologic evaluation are indicated, these services also are recommended to complete the screening process for malignancies.

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[2] California Health Benefits Review Program (CHBRP). (2026). *Analysis of California Assembly Bill 1906 Cervical Cancer Screening.* Berkeley, CA.
[3] HSC 1367.002; INS 10112.2.
[4] 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*.
[5] HSC Section 120164.
[6] The HRSA-supported health plan coverage guidelines for women's preventive services adopt certain recommendations from the Women's Preventive Services Initiative (WPSI). WPSI provides additional implementation considerations that are separate from clinical recommendations and not part of the guidelines as accepted by the Administrator.
[7] Home test kits for cervical cancer screening are a form of patient-collected testing, but not the only form. CHBRP assumes that this HRSA recommendation is inclusive of hone test kits. For additional information, see the *Policy Context* in the bill analysis report for AB 1906 Cervical Cancer Screening.

The USPSTF assigns a grade A recommendation for screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing).

As of April 2026, the first dose of the HPV vaccine is recommended in the child immunization schedule at age 11 to 12 years (CDC, 2026). The HPV vaccination is recommended in the adult immunization schedule for either the two- or three-dose course for adults 19 to 26 years, depending on age at initial vaccination or condition. The HPV vaccine is recommended for adults 27 through 45 years based on shared clinical decision-making (CDC, 2025b).

As of April 2026, CDPH recommends initiation of the HPV vaccine between 9 and 12 years, at an age the pediatric health care professional deems optimal for acceptance and completion of the vaccination series. Catch-up vaccination is recommended for all persons through age 18 years if not adequately vaccinated. Whether a patient receives the two- or three-dose course depends on age at initiation (AAP, 2026; CDPH, 2026). As of April 2026, CDPH recommendations for HPV vaccination in adults align with current CDC recommendations (see above) (CDPH, 2026).

Other Relevant California Programs

Every Woman Counts (EWC) is a state program that provides free breast and cervical cancer screening and diagnostic services to California's underserved populations. The mission of EWC is to mitigate the medical, emotional and financial effects of breast and cervical cancer and eliminate health disparities for medically underserved, low-income people. Eligibility rules for cervical cancer prevention services require that participants: be 21 years or older; meet income criteria; have no or limited insurance; be unable to receive services through Medi-Cal or a government-sponsored program; and live in California (DHCS, 2026). As of June 2025, EWC covers self-collection HPV testing for cervical cancer screening using current CPT codes for HPV testing (DHCS, 2025).

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how AB 1906 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[8,9]

Essential health benefits

In California, nongrandfathered[10] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[11] In 2027, approximately 11.5% of all Californians will be enrolled in a plan or policy that must cover EHBs.[12] AB 1906 does not exceed EHBs.

[8] The ACA requires nongrandfathered small-group and individual market health insurance – including but not limited to qualified health plans sold in Covered California – to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[9] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[10] A grandfathered health plan is "a group health plan that was created — or an individual health insurance policy 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."
[11] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[12] See CHBRP's resource, *Sources of Health Insurance in California*.

Background on Cervical Cancer

Cervical Cancer

Cervical cancer is a type of cancer that develops in the cells of the cervix, the lower, narrow end of the uterus. The primary cause of cancer of the cervix is infection with high-risk types of human papillomavirus (hrHPV). HPV is a group of more than 200 viruses, at least 13 of which are classified as hrHPV (NCI, 2025a). Although some HPV infections can resolve on their own, persistent infection with hrHPV can cause cells of the cervix to go through dysplasia, a change that causes abnormal cells called precancers to appear in the cervical tissue. These abnormal cells can become cancerous if they are not destroyed or removed (CDC, 2024; NCI, 2023).

Two main types of cervical cancers are:

- **Squamous cell carcinoma**: This is the most common type of cervical cancer, accounting for up to 90% of cervical cancers (NCI, 2023). These cancers develop from cells in the ectocervix.
- **Adenocarcinoma**: This type of cervical cancer develops from glandular cells located in the inner cervical canal (endocervix).

In some cases, cervical tumors contain features of both squamous cell carcinoma and adenocarcinoma, which are referred to as mixed carcinoma or adenosquamous carcinoma. Very rarely, cervical cancer can develop from other types of cervical cells (NCI, 2023).

Cervical cancer remains the most common HPV-related cancer. Approximately 99.7% of cervical cancer cases are associated with persistent infection with high-risk HPV types (Okunade, 2020). Additionally, the American Cancer Society (ACS) estimates that approximately 1,490 new cervical cancer cases will be diagnosed in California, with 400 related deaths will occur in 2026 (ACS, 2026).

As shown in Table 1, cervical cancer incidence rates in California between 2018 and 2022 were highest among women aged 40 to 44 years across all racial and ethnic groups. Hispanic women aged 40 to 44 years experienced the highest incidence rate at 18.4 cases per 100,000, followed by non-Hispanic Black, non-Hispanic White, and Asian/Pacific Islander women. In contrast, cervical cancer incidence rates were lowest among women aged 25 to 29 years, with Asian/Pacific Islander women in this age group having the lowest rate at 1.6 cases per 100,000 (CCR, 2026).

Table 1. Cervical Cancer Incidence Rates per 100,000 in California by Age and R/E, 2018 – 2022

Age, Years	Asian/Pacific Islander	Non-Hispanic Black	Hispanic	Non-Hispanic White
25-29	1.6	3.3	2.8	3.0
30-34	6.9	6.9	11.7	9.8
35-39	9.3	9.1	16.9	12.0
40-44	10.3	12.8	18.4	12.7
45-49	13.5	11.0	17.3	12.1
50-54	12.4	11.5	14.2	10.0
55-59	10.9	12.4	14.4	9.5

Age, Years	Asian/Pacific Islander	Non-Hispanic Black	Hispanic	Non-Hispanic White
60-64	11.9	10.9	13.7	9.1
65-69	12.0	11.8	14.1	6.4
70-74	10.2	9.5	15.8	8.4
75+	10.7	13.4	15.5	8.0

Source: California Cancer Registry, 2026 (CCR, 2026).
Notes: Age-adjusted rates are not shown if based on fewer than 15 cases.
Key: R/E = race/ethnicity.

Cervical Cancer Screening

HPV and Screening

HPV infection is most easily spread between sexual partners and is transmitted primarily through intimate skin-to-skin contact. Transmission commonly occurs during vaginal–penile, penile–anal, penile–oral, and vaginal–oral sexual activity (NCI, 2025c). HPV is the most common sexually transmitted infection in the United States, with an estimated 13 million new cases each year, and will infect approximately 85% of the population at some point in their lifetime (CDC, 2021b; 2021c).

Sexually transmitted HPVs are primarily categorized as low-risk "non-oncogenic" or high-risk "oncogenic." Low risk "non-oncogenic" types rarely cause cancer but can lead to warts on or around the genitals, anus, mouth, or throat. In some cases, they can also cause respiratory papillomatosis, a condition characterized by the development of warts in the larynx or respiratory tract, which can lead to breathing problems (NCI, 2025c). High-risk "oncogenic" HPV, on the other hand, is responsible for nearly all cervical cancers, as well as most anal, vaginal, penile, vulvar, and oropharyngeal cancers. Persistent infection with high-risk HPV (hrHPV) is the main cause of cancer, with up to 90% of cervical cancer being attributable to any HPV infection. High-risk types include HPV 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68. Among these, HPV 16 and HPV 18 are responsible for most HPV-related cancers (NCI, 2025c).

Although HPV vaccination is anticipated to lead to a 90% reduction in cervical cancer among those vaccinated during adolescence, studies have shown that the full benefits of vaccination do not occur until the vaccinated population reaches mid- to late life (Lei et al., 2020; Mix et al., 2021). As a result, cervical cancer screening remains an important preventative measure against cervical cancer (Perkins et al., 2023). Inadequate screening has been revealed as a major contributor to cervical cancer burden, with studies suggesting that approximately 25% of women in the United States are under-screened, and an additional 20% of the population requires more frequent screening due to abnormal results or immunosuppression (Benard et al., 2021; Kirschner et al., 2011; Lee et al., 2022). Conversely, studies have also reported a risk of overscreening among average-risk women. A 2022 U.S. study found that among women who qualified for routine cervical screening, 41% of women screened with Pap tests alone, 51% with co-testing, and 9% with HPV testing alone were over-screened. Age appears to be a factor in overscreening, as younger women were more likely to be over-screened compared to older women (Lee et al., 2022). The same study reported that overscreening is likely driven by both patient and provider factors. Provider-driven factors include not being updated with the most recent guidelines, concerns about missed follow-ups, and habitual screening practices. Patient-driven factors include preference for more frequent testing and uncertainty about when they were last screened (Lee et al., 2022).

Cervical cancer screening detects precancerous changes in cervical cells so that treatment can prevent the development of invasive cancer. In some cases, cancer may be found during screening. Early detection of cervical cancer can make it easier to treat (NCI, 2025a). There are three primary methods for screening for cervical cancer:

- **HPV testing:** which checks cells for infection with high-risk HPV types that have been associated with cervical cancer.
- **Cytology or Pap testing:** where cervical cells are checked for abnormalities caused by HPV that may indicate precancerous or cancerous cells on the cervix. A Pap test may also find other noncancerous conditions, such as infection or inflammation. However, Pap testing does not detect hrHPV itself, only cellular abnormalities as a result of the infection.
- **The HPV/Pap co-test:** combines both methods to detect high-risk HPV infection as well as cellular abnormalities (ACS, 2025a).

As currently available home test kits are designed to detect HPV rather than cervical cancer cells, CHBRP's analysis of AB 1906 primarily focuses on hrHPV testing. Historically, samples for both the HPV test and Pap test have been collected from the cervix during a pelvic exam in a clinical setting. More recently, technology has developed to allow for HPV testing to be performed using self-collected samples, where a speculum or pelvic exam is not required. There are two ways in which self-collection can happen:

- **Self-collection in a health clinic or office:** Tests that are approved by the FDA to self-collect specimens in a health care facility under the supervision of a health care provider (ACS, 2025b). In May 2024, two tests using self-collection of vaginal samples for HPV testing were granted FDA approval for such use (NCI, 2024). A third in-clinic self-collection test received FDA approval in September 2025 (Abbott, 2025).
- **Self-collection at home:** Tests that are approved, authorized, or cleared by the FDA to self-collect specimens in the home or a similarly private setting. Home test kits are provided by a health care provider and mailed back by the user to a lab for processing (ACS, 2025b). In May 2025, the FDA authorized the first device for self-collection of cervical specimens in the home. This test – the Teal Wand – is the only one of its kind with FDA authorization on the market as of April 2026. On April 8, 2026, the FDA cleared the Becton, Dickinson (BD) Onclarity HPV Assay for at-home use (Reuters, 2026).[13] As of the time this report was published, the BD Onclarity HPV Assay was not available for use.

The USPSTF recommends that women aged 21 to 29 years screen for cervical cancer every 3 years with cervical cytology alone. For women aged 30 to 65 years, USPSTF recommends screening every 3 years with cytology alone, high-risk HPV testing alone every 5 years, or co-testing every 5 years (USPSTF, 2018). Additionally, in early 2026, HRSA approved updated guidelines as per WPSI recommendations. For average-risk women age 21 to 29 years, HRSA recommends cervical cancer screening with cytology every 3 years. For women age 30 to 65 years, the preferred method of screening is HPV testing every 5 years. However, co-testing every 5 years or cytology alone every 3 years may be used. HRSA guidelines also state that patient-collected hrHPV testing is an appropriate option and should be offered to average-risk women in this age group (HRSA, 2025). Average risk is defined as those without a previous diagnosis of cervical cancer or high-grade precancer, have no recent abnormal results, are not immunocompromised, and have no exposure to diethylstilbestrol[14] in utero (CDC, 2021a).

As shown below in Table 2, there are currently five FDA-approved or FDA-authorized HPV self-collection devices. Three are approved for self-collection in a health care setting under provider supervision, and two are approved (authorized or cleared) for at-home self-collection. The only FDA-authorized home test kit for cervical cancer screening currently on the market (and thus the only one currently subject to AB 1906) is the Teal Wand HPV self-collection device. The Teal Wand can be requested online through the Teal Health website; ordering the kit requires attending a virtual visit with a Teal provider to review the patient's screening history and discuss the at-home screening steps. Currently, only a Teal provider can prescribe this device, and patients must access the home test kit through the Teal website. Because this step must currently be completed through Teal Health, at present there is no established mechanism for non-Teal providers to prescribe this device. As such, access relies primarily on patient self-referral; non-Teal providers may recommend their

[13] The BD Onclarity HPV Assay received FDA clearance for at-home use on April 8, 2026. As of publication date, it is not currently available for patient use. Given this timing, it was not incorporated into CHBRP's analysis of AB 1906.
[14] Diethylstilbestrol (DES) is a synthetic estrogen (female hormone) that was used to prevent miscarriage, premature labor, and related complications of pregnancy between 1940 and 1971. Research has linked exposure to DES in utero (to babies during pregnancy) to elevated risk of clear cell adenocarcinoma of the cervix and other cancers. Therefore, persons exposed to DES in utero are considered high risk for cervical cancers (NCI, 2025b).

patients order the Teal Wand through Teal Health. Following the Teal provider consultation, a self-collection home test kit is mailed to the patient, who can collect the sample at home or any private space and return it to a Teal laboratory for testing. Virtual consultation to discuss follow-up care is available through Teal Health.

Table 2. Self-Collection HPV Test Kits Approved by the FDA as of April 2026

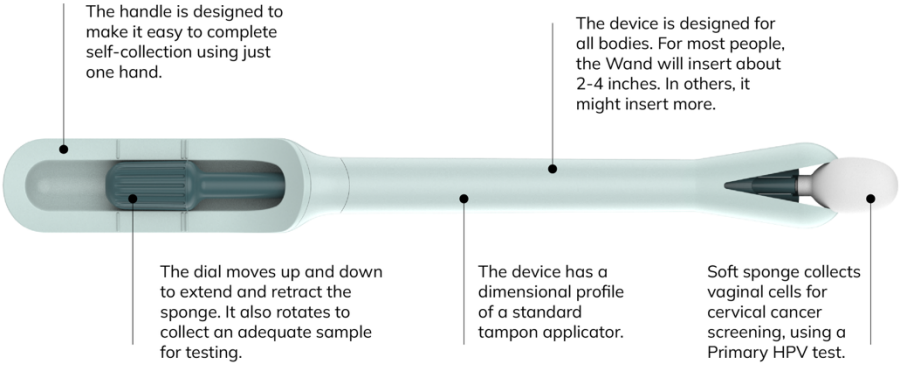
HPV Detection Test	Compatible Collection Devices*	Detection	FDA-Approval Date
Self-collection in health care setting			
Roche COBAS HPV test	Evalyn Brush	Detection of 14 hrHPV types: specifically identifies HPV 16 and HPV 18	May 14, 2024
Becton, Dickinson (BD) Onclarity HPV Assay	FLOQSwabs	Detection of 14 hrHPV types: specifically identifies HPV types 16, 18, 31, 45, 51, and 52	May 14, 2024
Alinity m HR HPV	Simpli-COLLECT, Evalyn Brush, FLOQSwabs	Detection of hrHPV types 16, 18, and 45	September 10, 2025
Self-collection at home			
Roche COBAS HPV test	Teal Wand	Detection of hrHPV types	May 9, 2025
BD Onclarity HPV Assay[15]	FLOQSwabs	Detection of 14 hrHPV types: specifically identifies HPV types 16, 18, 31, 45, 51, and 52	April 8, 2026

Source: Food and Drug Administration, 2025; Reuters, 2026.
Note: * Collection devices have only been validated for use with the specific testing platforms as listed.
Key: HPV = human papilloma virus; hrHPV = high-risk types of human papilloma virus.

As shown in Figure 1, the Teal Wand is a single-use device designed for patients to self-collect vaginal specimens for hrHPV testing. During use, the patient inserts the device into the vaginal canal and rotates a dial on the handle, which deploys petal-like components that function as a mini-speculum, to expose the sponge and gently collect cells (FDA, 2025).

[15] The BD Onclarity HPV Assay received FDA clearance for at-home use on April 8, 2026. As of publication date, it is not currently available for patient use. Given this timing, it was not incorporated into CHBRP's analysis of AB 1906.

Figure 1. Teal Wand



Source: Teal Health, 2026b.

While AB 1906 applies to Medi-Cal managed care plans, Teal Health currently cannot service Medi-Cal beneficiaries, even as self-pay patients (Teal Health, 2026a).

Barriers to Accessing Cervical Cancer Screening

Barriers to cervical cancer screening are multifaceted and often interconnected. A systematic review identified several key barriers that limit access to cervical cancer screening, including structural, socioeconomic, cultural and social, language, and individual-level barriers (Farajimakin, 2024).

- **Structural Barriers:** Limited access to health care facilities, shortages of trained health care personnel, insufficient resources, and long wait times for appointments were frequently mentioned as structural barriers to accessing screening services (Guillaume et al., 2020; Spencer et al., 2024). Additionally, a lack of provider recommendation to screen was also associated with lower screening rates (Roman et al., 2014).
- **Socioeconomic Barriers:** The cost of screening and lack of insurance coverage were consistently identified as significant barriers to screening uptake (Nilima et al., 2022; Srinath et al., 2023). Studies have shown that insured women were more likely to be updated on Pap test compared to uninsured women (Bonafede et al., 2019; Hall et al., 2018; Silvera et al., 2020).
- **Cultural barriers:** Stigma surrounding implications of receiving HPV test or cervical cancer, religious beliefs, and lack of spousal or family support are major factors influencing screening behavior, especially among immigrants and ethnic minority women (Afsah and Kaneko, 2023; Kandasamy et al., 2022). Cultural barriers may also intersect with socioeconomic challenges within these populations.
- **Individual barriers:** Lack of knowledge about cervical cancer screening (Akinlotan et al., 2017), language barriers, low health literacy (Heberer et al., 2016; Roman et al., 2014), low perceived risk, and fear of the screening process have been reported across studies (Emerson et al., 2024; Srinath et al., 2023). These individual-level barriers can also interact with broader structural and cultural barriers.

Disparities[16] in Cervical Cancer Screening

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates

[16] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

and social determinants or systemic factors exist, CHBRP describes relevant literature. CHBRP found literature identifying disparities by age, race/ethnicity, income, education, health care insurance, and access to a health care provider.

Table 3 demonstrates reported adherence to cervical cancer screening among women in California according to the USPSTF guidelines. As shown in the table, overall 83.9% of women aged 21 to 65 years reported screening for cervical cancer in accordance with the USPSTF guidelines. Disparities in screening rates were reported by age, health insurance coverage, income, education, and having a routine healthcare provider.

Age

Among women within the recommended age range for cervical cancer screening, adherence to cervical cancer screening is significantly lower among women aged 21 to 29 years (68.2%) compared to women aged 30 to 65 years (88.2%).

Race or Ethnicity

Across racial and ethnic groups, there are no significant differences in cervical cancer screening rates. While Asian/Pacific Islander women reported the lowest adherence to cervical cancer screening guidelines (76.4%) compared to American Indian/other (81.0%), Black (85.3%), Hispanic (85.4%), and White (86.4%) women, due to the small sample sizes, the differences were not statistically significant.

Insurance Status

Uninsured women reported significantly lower rates of being up to date with screening (73.9%) than those with public, private, or other types of insurance (84.9%).

Income

Women with an annual household income lower than $75,000 reported significantly lower screening adherence (80.7%) compared to those with an annual income of $75,000 or higher (90.0%).

Education

Those with less than a college education reported lower adherence to cervical cancer screening (82.2%) compared to women a college or postgraduate degree (87.1%).

Access to Provider

Women who have one or more regular health care providers had significantly higher rates of adherence to cervical cancer screening (87.6%) compared to women who do not have regular providers (71.8%).

Table 3. Adherence to Cervical Cancer Screening Among Californian Women Ages 21–65 Years, by Key Demographic Characteristics, 2016–2020

Demographic Characteristics	Adherence to USPSTF Cervical Cancer Screening, %
Total	83.9
Age*	
21 – 29 years*	68.2
30 – 65 years	88.2

Demographic Characteristics	Adherence to USPSTF Cervical Cancer Screening, %
Race/ethnicity	
American Indian/other	81.0
Asian/ Pacific Islander	76.4
Black, non-Hispanic	85.3
Hispanic	85.4
White, non-Hispanic	86.4
Insurance*	
None	73.9
Private/public/other	84.9
Annual household income*	
<$75,000	80.7
$75,000+	90.0
Educational attainment*	
Less than college	82.2
College or postgraduate	87.1
Health care provider*	
No regular provider	71.8
Regular provider	87.6
Disability status	
Have a disability	82.1
Do not have a disability	84.3

Source: CDPH, 2023.
* Indicates there is a statistically significant difference.
Key: GED = General Educational Development; HPV = human papilloma virus.

Societal Impact of Cervical Cancer in the United States

The presence of Cervical Cancer in the United States has direct and indirect economic and societal costs. Please note that the societal impact discussed here is relevant to a broader population than AB 1906 impacts, which would affect the health insurance of a subset of Californians (see the *Policy Context* section). See the *Benefit Coverage, Utilization, and Cost Impacts* section for estimates of direct cost impacts for the specific population targeted by AB 1906.

Studies have shown that cervical cancer and premalignant lesions associated with HPV infection impose a significant economic burden on the health system and patients. CDC reported that in 2020, the total cost of cervical cancer was 2.3 billion dollars, and it accounts for 1% of all cancer treatment costs (CDC, 2025a). Another study reported that the mean cost of premalignant lesions associated with HPV infection was USD 2,853 per patient, of which 68.57% was direct medical costs. Additionally, the mean cost of cervical cancer was reported to be USD 39,327 per patient, with 57.9% of the cost being indirect costs associated with it (Lotfi et al., 2023).

In addition to significant economic burdens, cervical cancer has also been associated with a significant burden on quality of life (QOL) and overall well-being. Studies have found that women with cervical cancer report poorer physical and mental health compared with individuals without cancer (Eberth et al., 2013; Shah et al., 2020). Prior research on patient quality of life also reported that cervical cancer patients have significantly lower QOL outcomes compared to those without cervical cancer (Pfaendler et al., 2015; Shah et al., 2020).

Medical Effectiveness Review

As discussed in the *Overview* section, AB 1906 would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to provide coverage without cost sharing for an annual cervical cancer screening home test kit upon the referral of the patient's health care provider. This analysis defines "home test kit" as a product approved by the federal Food and Drug Administration for the purposes of individuals collecting specimens outside of a clinical setting and ordered directly by a clinician or furnished by a standing order based on clinical criteria.

Research Approach and Methods

When relevant, CHBRP analyses focus on guidance or guidelines provided by authoritative governmental organizations. This specific analysis will discuss the conclusions and recommendations of the Screening for Cervical Cancer USPSTF Recommendation Statement. This analysis will also describe and analyze other recent studies relevant to the topical area.

It should be noted that the most recent USPSTF cervical cancer update is still an update in progress. The current recommendation is the 2018 statement (Curry et al., 2018), whereas the December 2024 draft recommendation is the first USPSTF statement to explicitly include patient-collected HPV screening and is therefore the most relevant USPSTF starting point for this analysis (USPSTF, 2024). In the USPSTF 2024 update to the existing 2018 cervical cancer screening recommendations, the USPSTF concluded that cervical cancer screening in women ages 21 to 65 years has a substantial net benefit and recommends cytology every 3 years for ages 21 to 29 years, followed by primary high-risk HPV screening every 5 years for ages 30 to 65 years using either clinician-collected or patient-collected samples. The USPSTF also states that there is adequate evidence that self-collected HPV screening has equivalent accuracy to clinician-collected HPV screening. Additionally, the Women's Preventive Services Initiative (WPSI) cervical cancer screening recommendations policy explicitly cites the USPSTF cervical cancer statement as its primary evidence base and reference for age ranges and screening intervals. Finally, under the Affordable Care Act (Women's Preventive Services Initiative, 2026), HRSA cites WPSI's women's preventive services recommendations to define what services must be covered without cost sharing (Federal Register, 2026; HRSA, 2025).

Studies of home test kits and the effectiveness of self-collected specimens for cervical cancer screening were identified through searches of PubMed and Cochrane Library. The search was limited to abstracts of studies published in English and included studies published from 2023 to present. Studies published prior to 2023 were identified through the draft report of the Screening for Cervical Cancer USPSTF Guidelines.

The medical effectiveness literature review returned abstracts for 195 articles that were reviewed for inclusion in this report. This report relied heavily on studies reviewed as a part of the guidance development process for the USPSTF recommendations described above. These studies were not reviewed individually except where noted. Five articles not directly associated with the USPSTF recommendation development were also reviewed. The other articles were eliminated because they did not focus on self-collection of specimens for HPV, were of poor quality,[17] or did not report findings from clinical research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach document.

[17] For a detailed explanation of how CHBRP defines high-quality research, see the "Selecting Studies for Inclusion in the Literature Review" section of CHBRP's Medical Effectiveness Analysis and Research Approach document.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[18] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Question

Are currently FDA-approved home test kits, and others designed to utilize self-collect samples collected via dry swab, effective for cervical cancer screening through the detection of HPV?

As mentioned, AB 1906 would require health care providers to provide coverage for an annual cervical cancer screening home test kit. As with similar kits for other conditions, the kit will require FDA approval. Therefore, the key question that will be addressed by this analysis concerns the effectiveness of any currently FDA approved kits. As these kits will, by definition, involve self-collection of specimens, a secondary question involves the effectiveness of such methods compared to clinician-collected specimens.

Methodological Considerations

As detailed in the *Background* and *Public Health* sections of this report, the main difference between home-to-lab test kits and similar processes where the specimen (self-collected or otherwise) is collected in a clinical environment is location of the self-collection of the specimen. When the specimen is self-collected outside of the clinical environment, the consumer depends upon written or other forms of instructions, and collection apparatus with have varying degree of user-friendliness. Therefore, users do not generally have immediate and clear instructions or access to experts for questions on process and safety as they would when self-collecting in a clinical environment. It is worth noting that a referral is required for the only FDA-authorized home test kit for cervical cancer screening in the United States, and this referral requires a telehealth appointment. The telehealth visit is a forum for questions and instructions, and could help ensure safe and proper usage.

Additionally, when self-collected in a clinical environment, it is generally assumed that specimens will be properly stored and transported in order to maintain maximum viability when they are processed by a laboratory (if not processed immediately on the premises). Many home-to-lab test kits have worked to address these issues by designing easy-to-use collection apparatus, providing clear instructions, and having help available in the event a consumer is encountering difficulties with the process. They also endeavor to design the return process to ensure the sample arrives at a lab as quickly as possible without being subject to undue environmental and other stresses (e.g., heat, cold, undue time lag). Once at the lab, with some exceptions, specimens self-collected at home are processed in the same way as those obtained through self- or clinician-collection. Therefore, the main factor of interest for this analysis of medical effectiveness is the equivalency of the specimens self-collected (at home or in clinic) versus clinician-collected with regard to diagnostic testing.

Outcomes Assessed

The primary outcome assessed through this analysis is equivalency or non-inferiority of self-collected specimen samples collected outside of the clinical environment versus clinician-collected specimen samples for the purposes of screening and testing for cervical cancer via the detection of HPV. Most studies reviewed present their findings as a relative comparison of the effectiveness of the two specimen collection methods.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of home test kits for the detection of cervical cancer. Each section is accompanied by a corresponding figure. The title of the figure

[18] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.

indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

Very strong evidence (formerly called *clear and convincing evidence*) indicates that there are multiple studies of a treatment and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

Strong evidence (formerly called *preponderance of evidence*) indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

Some evidence (formerly called *limited evidence*) indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

Conflicting evidence (formerly called *inconclusive evidence*) indicates that of the studies of equal quality, the number suggesting the treatment is effective is similar to the number of those suggesting the treatment is not effective.

Not enough research (formerly called *insufficient evidence*) indicates that (1) there are no studies of the treatment **or** (2) the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. *Not enough research* does not indicate that a treatment is not effective.

Are currently FDA-approved home test kits, and others that use similar technology, for cervical cancer screening through the detection of HPV effective?

Currently approved devices

The Teal Wand is currently the only FDA-authorized at-home cervical cancer screening collection device in the United States. On May 9, 2025, the FDA granted De Novo authorization and classified it as a Class II device for home collection and transport of vaginal specimens by lay users for use in an approved HPV molecular assay. In the pivotal SELF-Collection for CERVical Cancer Screening (SELF-SERV) trial (Fitzpatrick et al., 2025), 609 participants ages 25 to 65 years were enrolled, and 582 paired self- and clinician-collected samples were included in their analysis. Compared with clinician-collected cervical samples, self-collected samples collected with the Teal Wand device showed 95.2% positive percent agreement for high-risk HPV detection, 90.0% negative percent agreement, and 95.8% absolute sensitivity for high-grade dysplasia (46 of 48 cases), with relative sensitivity of 1.00 versus clinician collection. FDA reviewers also reviewed and approved the shipping-stability, 1-year device stability, and home-use/usability testing. One caveat to this pivotal study is that it was conducted in a simulated home-use environment rather than actual in-home collection. However, the overall weight of evidence was sufficient for FDA authorization and supports Teal as clinically comparable to clinician-collected HPV screening when used exactly as validated. It should also be noted that the FDA decision summary states that performance for this test kit has been validated only with the cobas HPV assay (cobas 5800/6800/8800 systems). Although the cobas systems are widely used, this may limit the adoption of this home test kit for some health providers.

In the United States, the main ongoing research effort aimed at generating FDA-grade evidence for additional at-home cervical cancer screening (HPV) self-collection kits is the National Cancer Institute's Cervical Cancer "Last Mile" Initiative and its multi-center SHIP Trial (Self-collection for HPV) (NCI, 2026). SHIP started research activities in early 2024 and tests whether vaginal samples collected by patients under simulated/unsupervised home-use conditions perform as well

as clinician-collected cervical samples, while also evaluating usability, acceptability, and effectiveness across multiple device–assay combinations. The National Cancer Institute is including SHIP as part of a staged regulatory pathway that will generate additional U.S.-based evidence needed to support expansion to collection outside health care settings, including at-home use. As such, they are independently evaluating manufacturers of other at-home self-collection kits, with evidence to be submitted to the FDA for future at-home indication decisions. In parallel, some manufacturers are pursuing their own FDA pathways. Although the Teal Wand was the first FDA-authorized home test kit for cervical cancer screening, other devices are now entering the market. As of April 2026, the BD Onclarity HPV Assay has also received FDA clearance for at-home use, though it is not yet available for patient use (Reuters, 2026).

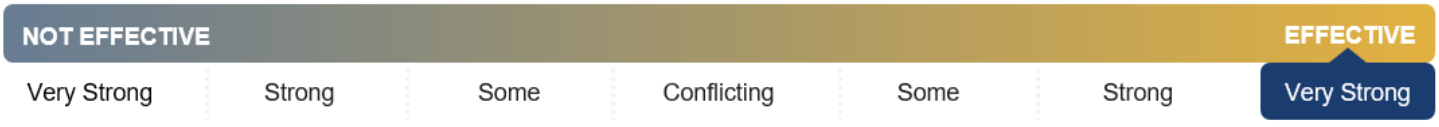
Effectiveness of self-collected samples in the clinical or home setting by means of dry swab for the detection of HPV

Across comparative literature, self-collected vaginal HPV samples perform very similarly to clinician-collected cervical HPV samples when PCR-based assays (polymerase chain reaction) are used. In the USPSTF draft evidence review (USPSTF, 2024), 14 studies of agreement and 6 studies of accuracy showed high agreement between self- and clinician-collected samples. Across these studies, pooled absolute sensitivity of self-collected samples was 0.86 and specificity was 0.81, whereas relative sensitivity versus clinician-collected samples ranged from 0.94 to 0.99 and relative specificity from 0.98 to 1.02. Another authoritative source of guidelines come from the National Cancer Institute. Their 2025 Enduring Consensus Guidelines (Wentzensen et al., 2025) summarized 56 paired clinical accuracy studies, and reported pooled relative sensitivity of 0.99 and relative specificity of 0.98 for PCR-based HPV assays, and noted that both self-collected and clinician-collected HPV testing were substantially more sensitive than cytology alone.

The narrower question of home collection versus in-clinic self-collection is more nuanced, because most accuracy studies involve self-collection performed in a clinic rather than at home. The USPSTF evidence review explicitly notes that the majority of self-collection studies were clinic-based. Even so, the available evidence suggests that the main challenge for home testing is not biological validity of the sample but factors such as device usability, dry storage, shipping time, and temperature exposure. Howard et al. (2006) report that dry self-samples appear stable for at least 30 days in mail-like conditions, and found no loss of HPV detection after up to 41 days of dry storage or after exposure to summer and winter temperature extremes (Howard et al., 2026). An earlier U.S. randomized trial found that a mailed swab-based home sample was noninferior to clinician-collected sampling for HPV detection, whereas a tampon-based home method had an unacceptably high rate of insufficient specimens (McLarty et al., 2019).

CHBRP found ***very strong*** evidence that currently FDA-approved home test kits, and others that use similar processes and technology, are effective for cervical cancer screening through the detection of HPV.

Figure 2. Effectiveness of Currently FDA-Approved Cervical Cancer Home Test Kits and Those That Utilize Similar Processes for the Detection of HPV



Cost Impact Analysis: Data Sources, Caveats, and Assumptions

Analytical Assumptions

- CHBRP assumes the unit cost of the home test kit for cervical cancer screening is $249 per kit, based on the manufacturer's listed price (Teal Health, 2026a). This includes the self-collection device and associated telehealth consultation. CHBRP applies a standard commercial-to-Medicaid cost ratio to estimate a Medi-Cal unit cost of $77.19. Modeling is sensitive to this price assumption, and the results will be different if plans negotiate a different price than $249 with Teal Health.
    - Per the Teal Health website, the Teal Wand list price to consumers without insurance is $249, reduced from $499 (Teal Health, 2026a). It is CHBRP's understanding that the rate of $249 reflects anticipated negotiated pricing.
    - For enrollees with in-network insurance, the out-of-pocket cost of the Teal Wand is adjudicated through health plan benefits at a negotiated rate of $99 (Teal Health, 2026a). Health plans and policies that are fully compliant with AB 1906 at baseline provide coverage of the Teal Wand without cost sharing, meaning the consumer retail price is not a factor in CHBRP's cost analysis for enrollees with baseline coverage without cost sharing.
    - The average unit cost of the Teal Wand is projected to increase from $87.69 at baseline to $223.71 postmandate. This shift is not due to a change in the per-kit price, but rather reflects a change in the composition of enrollees using the benefit: at baseline, most utilization is among Medi-Cal enrollees (unit cost of $77.19), whereas postmandate, a larger share of commercial enrollees (unit cost of $249) would gain coverage and begin using home test kits, thus weighting the average towards the commercial unit cost.
- The average cost of CPT 87624 for California commercial plans in the 2024 Consolidated Health Cost Guidelines Sources Database trended to 2027 using the Milliman Health Cost Guidelines™ is $62. This includes all claims that fall under the 87624 CPT code, including – but not limited to – self-collected tests.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

State Health Care Spending Target

In 2024, in an effort to slow health care spending growth and improve health care affordability for California families, California's Office of Health Care Affordability (OHCA) under the Department of Health Care Access and Information approved a statewide target for maximum annual growth in health care spending for certain health care entities. The

targets apply to per capita spending to specific entities, including health plans and insurers, provider organizations with at least 25 physicians, and hospitals (HCAI, 2022). The state is implementing this target with a phased-in approach, with a spending target of 3.5% for 2026, lowered to 3.2% in 2027 and 2028, and will be at 3% for 2029 and beyond (HCAI, 2025). Since health insurance benefit mandates may increase health care spending, such as increases to insurance premiums, administrative costs, and out-of-pocket costs, OHCA spending targets may be relevant considerations in benefit mandate policy decisions.

Potential Cost of Exceeding Essential Health Benefits

Cervical cancer screening is considered a preventive service and falls within the existing essential health benefits (EHB) category. Based on carrier survey responses and the HRSA/WPSI guideline classification of patient-collected cervical cancer screening as a covered preventive service, CHBRP does not anticipate that AB 1906 would exceed the state's definition of EHBs. Therefore, CHBRP does not project that the state would be required to defray costs related to AB 1906. For more information on EHBs, see the *Policy Context* section.

Postmandate Changes in the Number of Uninsured Persons

CHBRP assumes that if premiums increase by more than 1.7% in the small- or large-group market segments or 0.6% in the individual market, some enrollees will lapse their coverage. Because the change in average premiums do not exceed either of these thresholds (see Table 3, Table 5, and Table 6 in CHBRP's Analysis of California Assembly Bill 1906), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 1906.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of AB 1906.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

CHBRP assumes that enrollees who do not have benefit coverage without cost sharing for home test kits for cervical cancer screening would either forgo screening or seek in-clinic screening, which is separately covered. People without in-network insurance may purchase home test kits directly at retail price ($249), representing an out-of-pocket expense. Given the Teal Wand's recent market entry and limited market penetration as well as the volume of baseline coverage without cost sharing (40% of state-regulated enrollees), CHBRP projects that cost shifts to other payers would be minimal as a result of AB 1906.

Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[19] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[20]

This section describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Coverage and cost sharing for at home cervical cancer screening kits for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represented

[19] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[20] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

75% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS and Medi-Cal were queried regarding related benefit coverage.

For this analysis, CHBRP relied on Current Procedural Terminology (CPT) codes to identify services related to AB 1906. CPT is copyright 2026 American Medical Association (AMA). All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

Health Cost Guidelines

The Milliman Health Cost Guidelines™ (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing essential health benefits (EHBs) and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.
- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

Consolidated Health Cost Guidelines Sources Database (CHSD)

Milliman maintains benchmarking and analytic database that includes health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable.

Methodology and assumptions for baseline benefit coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act. It also includes individuals enrolled in Medi-Cal plans.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage and cost sharing for at home cervical cancer screening kits. On January 5, 2026, the Health Resources and Service Administration (HRSA) updated cervical cancer screening guidelines and included self-collection for cervical cancer screening as a preventive service which would not be subject to cost sharing and requires plans to comply with these guidelines as of January 1, 2027. CHBRP assumed that California plans could determine whether or not the HRSA guidelines apply to at home cervical cancer screening kits.

Methodology and assumptions for baseline utilization

- Enrollees currently using cervical cancer screening were identified in Milliman's proprietary 2024 CHSD. This database captures services that are filed for reimbursement by insurance only and may not fully capture conditions related to non-covered benefits. CHBRP identified enrollees using cervical cancer screening by CPT[21] code 87624.
- CHBRP assumed 13% of women enrolled in state-regulated commercial plans and 8% of women enrolled in state-regulated Medi-Cal plans ages 30 to 65 use cervical cancer screening a year and 1% of those would use cervical cancer screening at home kits.

Methodology and assumptions for baseline cost

- CHBRP calculated the average cost for a cervical cancer screening home kit of $249 for commercial plans and CalPERS based on cost of the Teal Wand (https://www.getteal.com/teal-wand). The Teal Wand is currently the primary home HPV test kit on the U.S. market. However, this reflects current market conditions, and costs could differ materially if more competitors enter the market or if plans negotiate different rates.
- CHBRP assumed the average cost for a cervical cancer screening home kit for Medi-Cal plans would be 31% of the commercial cost. This ratio is based on Milliman's standard commercial-to-Medicaid unit cost conversion methodology.

Methodology and assumptions for baseline cost sharing

- CHBRP assumed the cost sharing for cervical cancer screening home kits for enrollees with coverage is $0 based on carrier surveys. CHBRP also assumed that no enrollees without coverage at baseline are purchasing these kits on their own.

Methodology and assumptions for postmandate utilization

- For enrollees with coverage of cervical cancer screening home kits at baseline, CHBRP assumed the utilization of these kits would increase 2% postmandate due to the increased awareness of this benefit due to AB 1906.

[21] CPT copyright 2026 American Medical Association. All rights reserved.

- For enrollees without coverage of cervical cancer screening home kits at baseline, CHBRP assumed the utilization of these kits would increase 10% postmandate. The removal of cost sharing is estimated to increase utilization 8% based on the Milliman HCGs in addition to a 2% increase in utilization due to the increased convenience these kits provide to arrive at the assumption of a 10% utilization increase from baseline.

Methodology and assumptions for postmandate cost

- CHBRP assumed the cost for a cervical cancer screening home kit would not change as a result of AB 1906.

Methodology and assumptions for postmandate cost sharing

- CHBRP assumed the cost sharing for cervical cancer screening home kits would be $0 for all enrollees as a result of AB 1906.

Other methodology and assumptions

- CHBRP did not assume any impact due to the Rural Health Transformation initiatives for this analysis since the Rural Health Transformation initiatives are still in the early stages in California and cannot be quantified at this time.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that self-insured plans administered by responding carriers did not report substantive differences in coverage for home test kits for cervical cancer screening compared to fully insured products.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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Acknowledgments

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. An independent actuarial firm helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

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This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

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Suggested Citation

California Health Benefits Review Program (CHBRP). (2026). *Analysis of California Assembly Bill 1906 Cervical Cancer Screening.* Berkeley, CA.