Presentation on Why the Advice to "Read Your Policy" Is Not Effective

Amy Bach (UP), Brenda J. Cude (University of Georgia) , Erica Eversman (AEPI), Brent Walker (CAIF), Richard M. Weber (LILAC)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Don’t Tell Me to Read My Policy!

- NAIC Consumer Representatives
- August 2025 Consumer Liaison Committee

Why "Read Your Policy" May Fall on Deaf Ears

Where is my policy?

What am I looking for in my policy?

Policies aren't written for consumers to read.

In research to be published next year, Cude and co-authors found:

Even when asked to read policy language, consumers often misjudged the coverage

Some who saw policy language were even more likely to misjudge coverage than those who didn't

See handout

Coverage Information re Disaster Preparedness

- **Dwelling coverage per square foot** of living space
  - Adequate to replace *my* home in *this* region, given local construction costs?
- **Extended Replacement Cost**
- **Code upgrade coverage**
- **Temporary rent** coverage and for how long
- **Deductibles**
  - When and how will they apply?

Can I buy or afford more?

Coverage Information re Everyday Events/Partial Losses

- Limits or exclusions for water damage/losses, mold, smoke
- Coverage to match undamaged siding/roof tiles to restore a uniform and consistent appearance
- Length of temporary rent (ALE) coverage and amount per month
- Any losses to be paid on an RCV (Replacement Cost) or ACV (Actual Cash Value) basis
- Requirement to use vendors the insurer selects

Solutions

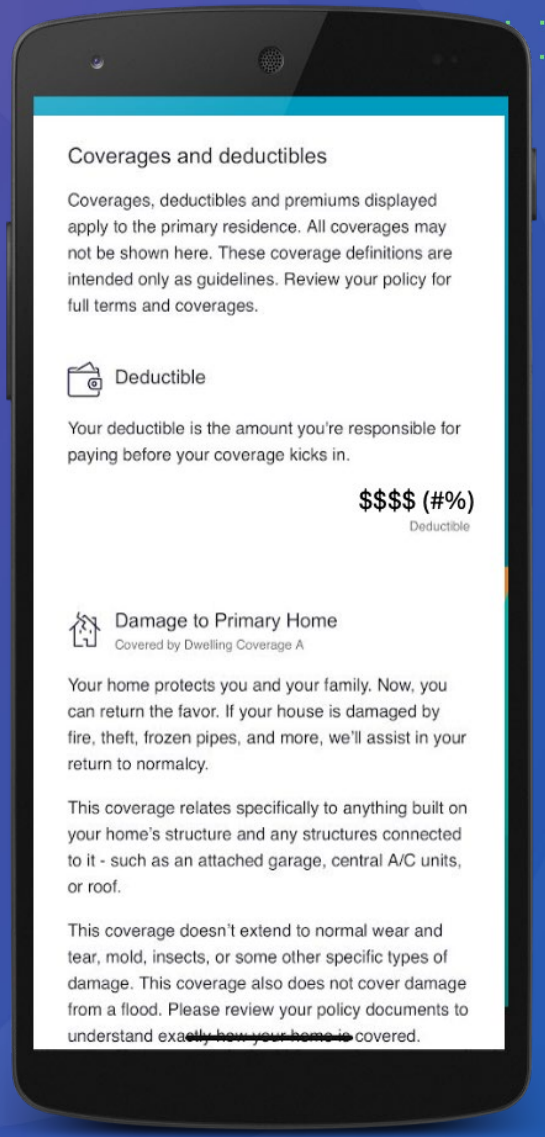
- Establish core baseline coverage standards for homeowners insurance
  - Reduce confusion across policies and improve consumer understanding
  - Easier to enforce unfair claims settlement laws
- Learn more at Property & Casualty (C) Committee meeting Wednesday at 1:45 pm

Solutions

- Strengthen state laws and regulations to require more readable policies
  - See Cude, B. J. (2024, March). *Readability standards in state insurance laws.* Presentation to NAIC's Market Conduct and Consumer Affairs Committee.

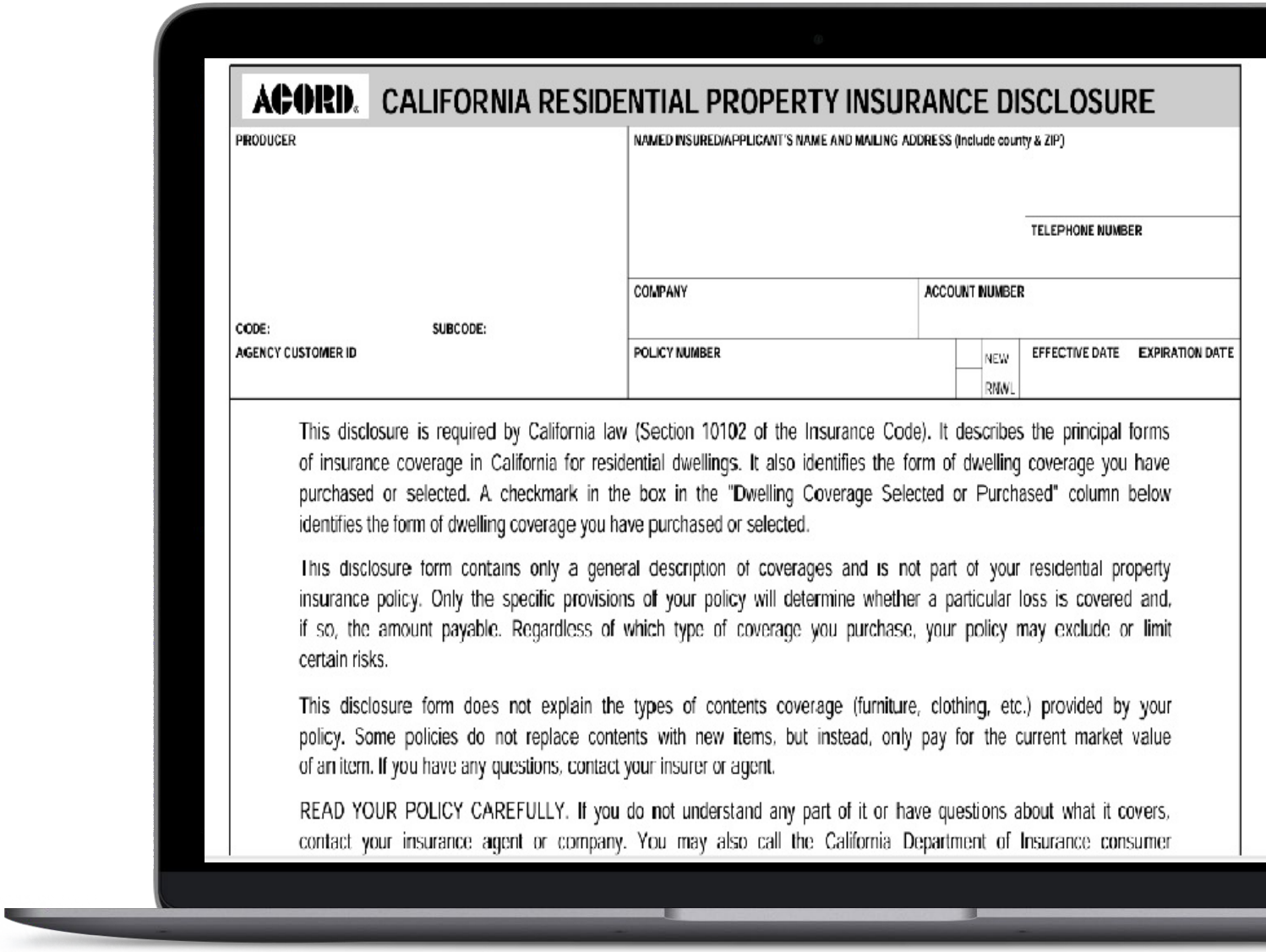
Solutions

Easy to Access/Easy to Read Information from Insurers



Solutions

Required Plain Language Disclosures



ACORD CALIFORNIA RESIDENTIAL PROPERTY INSURANCE DISCLOSURE

PRODUCER

NAMED INSURED/APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP)

TELEPHONE NUMBER

COMPANY

ACCOUNT NUMBER

CODE: SUBCODE:

AGENCY CUSTOMER ID

POLICY NUMBER

NEW RNWL

EFFECTIVE DATE EXPIRATION DATE

This disclosure is required by California law (Section 10102 of the Insurance Code). It describes the principal forms of insurance coverage in California for residential dwellings. It also identifies the form of dwelling coverage you have purchased or selected. A checkmark in the box in the "Dwelling Coverage Selected or Purchased" column below identifies the form of dwelling coverage you have purchased or selected.

This disclosure form contains only a general description of coverages and is not part of your residential property insurance policy. Only the specific provisions of your policy will determine whether a particular loss is covered and, if so, the amount payable. Regardless of which type of coverage you purchase, your policy may exclude or limit certain risks.

This disclosure form does not explain the types of contents coverage (furniture, clothing, etc.) provided by your policy. Some policies do not replace contents with new items, but instead, only pay for the current market value of an item. If you have any questions, contact your insurer or agent.

READ YOUR POLICY CAREFULLY. If you do not understand any part of it or have questions about what it covers, contact your insurance agent or company. You may also call the California Department of Insurance consumer

Solutions

A Disclosure Modeled after the Health Insurance Summary of Benefits and Coverage

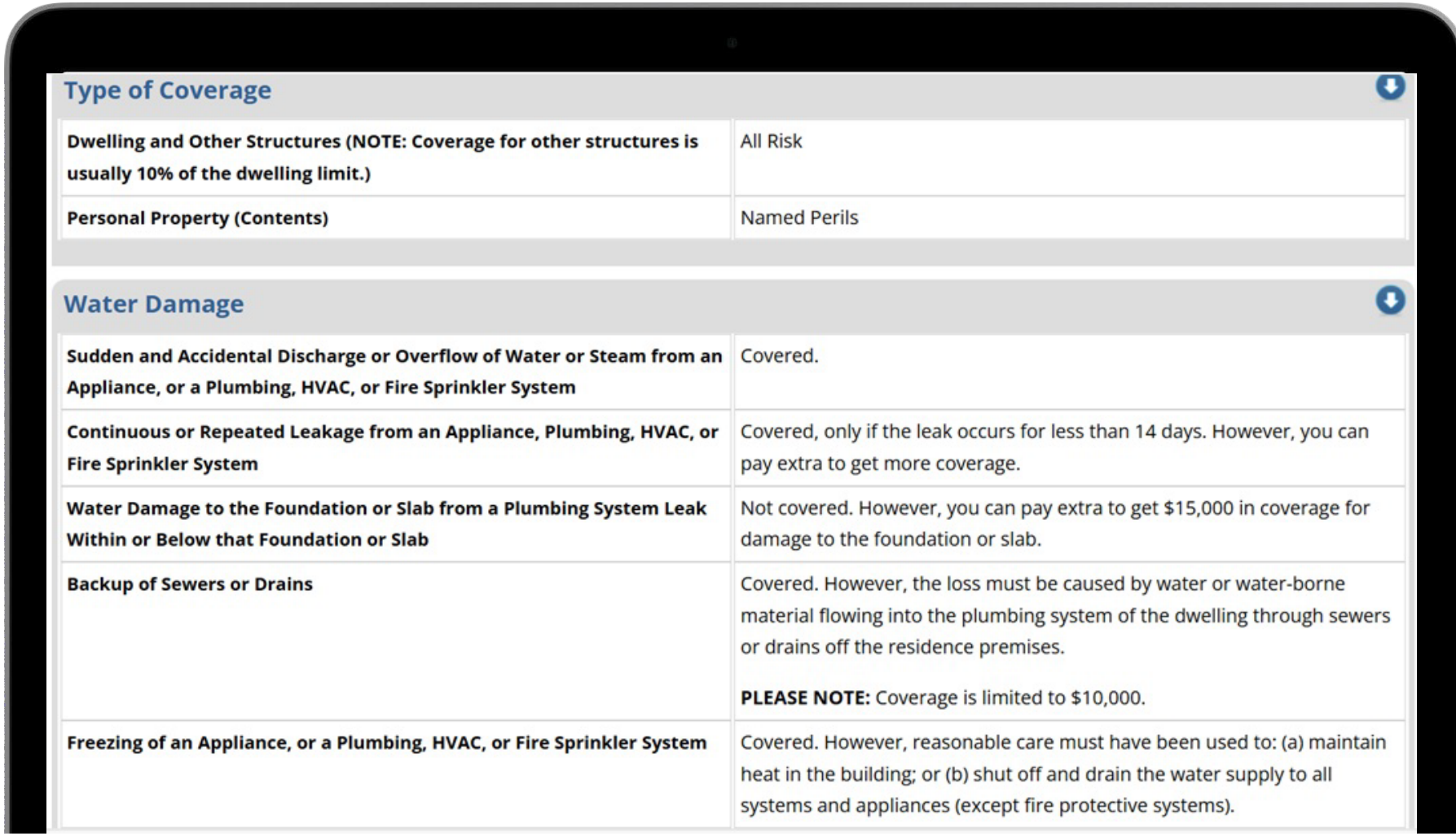
Important Questions

- What are the deductibles?
- Is there a limit on what the insurer pays?
- What property losses does this policy cover?
- Are there property losses this policy doesn’t cover?

Solutions

Online Coverage Comparison Tools

Texas Office of Public Insurance Counsel Homeowners Insurance Comparison Tool



Type of Coverage

Dwelling and Other Structures (NOTE: Coverage for other structures is usually 10% of the dwelling limit.)	All Risk
Personal Property (Contents)	Named Perils

Water Damage

Sudden and Accidental Discharge or Overflow of Water or Steam from an Appliance, or a Plumbing, HVAC, or Fire Sprinkler System	Covered.
Continuous or Repeated Leakage from an Appliance, Plumbing, HVAC, or Fire Sprinkler System	Covered, only if the leak occurs for less than 14 days. However, you can pay extra to get more coverage.
Water Damage to the Foundation or Slab from a Plumbing System Leak Within or Below that Foundation or Slab	Not covered. However, you can pay extra to get $15,000 in coverage for damage to the foundation or slab.
Backup of Sewers or Drains	Covered. However, the loss must be caused by water or water-borne material flowing into the plumbing system of the dwelling through sewers or drains off the residence premises. **PLEASE NOTE:** Coverage is limited to $10,000.
Freezing of an Appliance, or a Plumbing, HVAC, or Fire Sprinkler System	Covered. However, reasonable care must have been used to: (a) maintain heat in the building; or (b) shut off and drain the water supply to all systems and appliances (except fire protective systems).

Solutions

- Facilitate the creation of AI-enabled smart readers to help consumers understand policy coverage and exclusions
- In the meantime, should homeowners use AI tools to learn more about their coverage?

What NAIC Could Do

- Create resources for state regulators to use at NAIC and at home to improve readability requirements

- Issue a data call to companies writing homeowners insurance to learn when and how they make the *complete* policy available to consumers

Improve Consumer Communications

Tell consumers:

- How to find their policy
- That there may be endorsements that changed the policy
- Which words or sections to look for
- If the information is on the dec page or in the policy

Presentation Focused on Coverage But There's So Much More

- Information about the appeals process
- Importance of having legal property owner correctly identified on policy
- Correct and current contact information
- Rights to view policy documents in accessible format
- Requiring unique identifiers on insurance policies
  - See Eversman & Ellsworth, Fall 2022 Consumer Liaison presentation – *I bought auto insurance, but have no idea what it means or what is actually covered*

Issues Beyond Homeowners -- Auto Insurance

Policy default = Imitation parts

- Definition leaves much to interpretation
- Missed opportunity to add OEM Endorsement?

Appraisal clause

- Opportunity to challenge insurer valuation

Structure undefined

- Timing
- Who may serve as expert/umpire
- Unenforceability if consumer wins

Questions?

Presenters

Amy Bach, United Policyholders
Brenda Cude, Professor Emerita, University of Georgia
Erica Eversman, Automotive Education and Policy Institute
Brent Walker, Coalition Against Insurance Fraud
Richard Weber, Life Insurance Consumer Advocacy Center

Also contributing to the presentation:

Brendan Bridgeland, Center for Insurance Research

Presentation on Federal Updates and Remaining State Regulatory Tools to Improve Health Equity

Erin Miller (Community Catalyst), Jalisa Clark (Georgetown University), Milo Vieland (Legal Council for Health Justice)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Heavily Impacted Populations

- Immigrants
- Rural Communities
- Individuals with Limited English Proficiency
- Low-income individuals & families
- Communities of color
- LGBTQIA populations
- People with disabilities

Impact of Federal Policy Changes on Heavily Impacted Populations

Barriers to Marketplace enrollment

- Pre-enrollment eligibility verification for PTC/CSR
- End of eligibility for 5-year gap population/lawfully present immigrants under the 100%FPL; termination of DACA eligibility
- Eliminates 150% FPL SEP, income-based SEPs
- Additional Documentation for SEPs, OE coverage
- Shortens Open Enrollment Period
- Shortens time to handle data-matching issues
- 2028 OEP, **automatic re-enrollment will end altogether**

Impact of Federal Policy Changes on Heavily Impacted Populations

Rise in cost of health care coverage

- Exclusion for federal subsidies - **narrow definition of "eligible aliens"**
- Expand AV de minis range & change Premium Adjustment Percentage methodology will impact out-of-pocket costs
- $5 monthly fee for low-income enrollees that automatically renewed -
- Eliminates APTC repayment cap for lower income consumers' who mis-estimate income.
- Shortens time for filing/reconciling APTCs
- Past-due Premiums

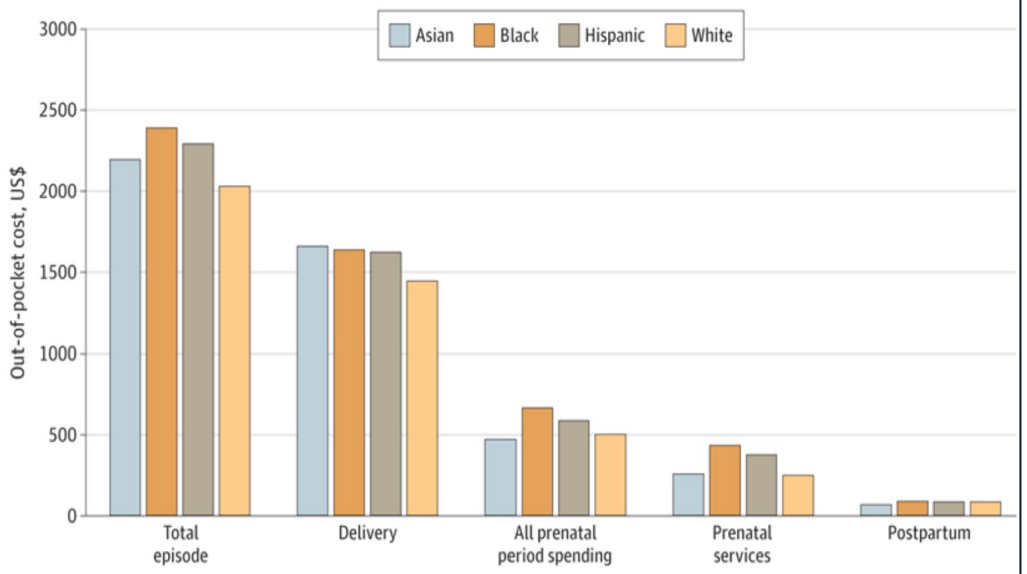
Estimated Marketplace Impacts

- CBO estimated that the change in lawfully present definition for PTC eligibility would increase the number of people without insurance by 1.0 million* in 2034. (House bill estimate)
- States are estimating significant enrollment losses – 10% , 17%, 50% – in health care programs.
- 2025 - enrollees with income under 150% FPL were largest share of marketplace enrollees (47%)
- If enhanced PTCs expire - 75% average premium increase and 90% increase for rural areas

“We all do better when we all do better.”

~Minnesota Senator Paul Wellstone

Figure 1. Mean Out-of-Pocket Spending During a Maternity Episode by Race and Ethnicity



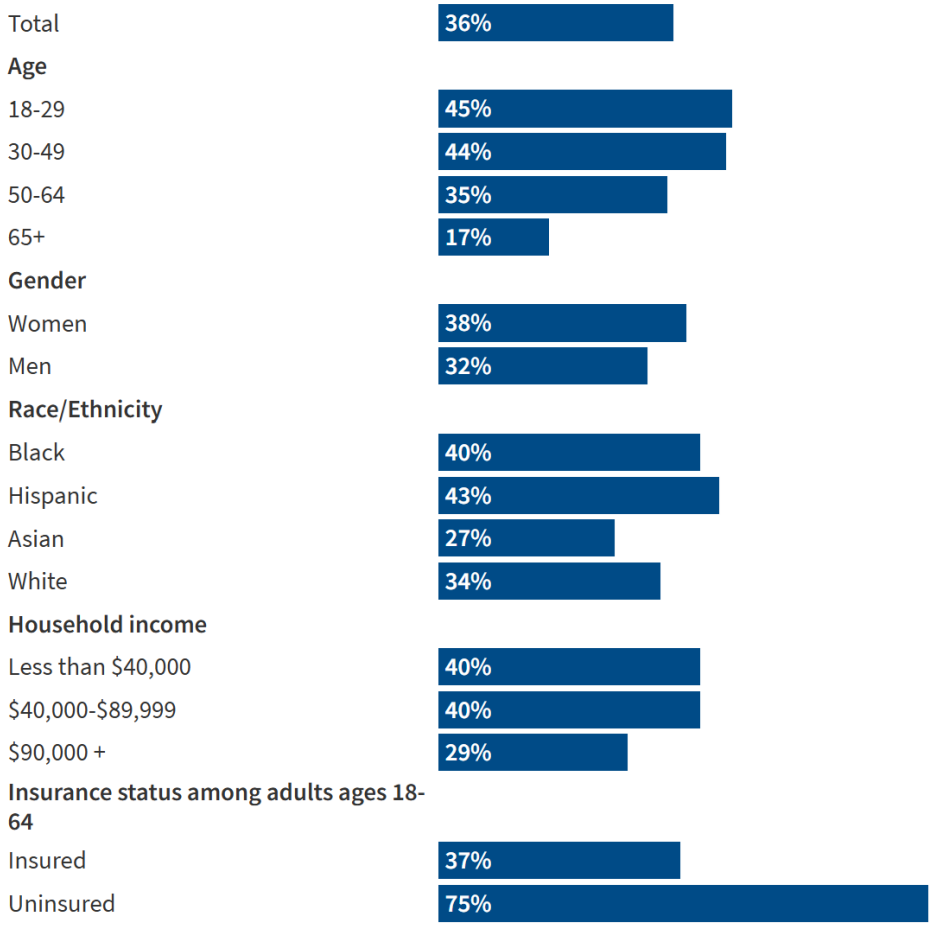
The total maternity episode includes the prenatal period, delivery, and 42 days post partum (and therefore the delivery and prenatal amounts do not sum to the total). Spending was inflated to 2022 US dollars using the Medical Consumer Price Index. All differences across race and ethnicity groups within spending categories were statistically significant ($P < .001$). See eTable 3 in Supplement 1 for the list of services classified as prenatal services.

Source: Racial and Ethnic Differences in Out-of-Pocket Spending for Maternity Care | Health Policy | JAMA Health Forum | JAMA Network

Figure 3

Three-Quarters of Uninsured Adults Say They Have Skipped or Postponed Getting Health Care They Needed in the Past 12 Months Due to Cost

Percent who say, in the past 12 months, they have skipped or postponed getting health care they needed because of the cost:



Note: See topline for full question wording.
Source: KFF Health Tracking Poll (May 5-26, 2025) • Download PNG

KFF

Parents with children under 18 (65%), especially Latino/a parents (71%) and Black parents (62%) are most likely to report medical debt.

Outreach and Education

- Agents/Brokers
  - Programs to promote producer outreach in underserved communities
- Media Marketing
  - Considering age, location, language needs, health literacy
- Navigators/Assisters
  - Increased funding to replace gaps in federal support
  - Strategic community partnerships for a wide range of outreach
- Language Access
  - Multilingual language services
  - Written translations
  - Preferred spoken and written language
  - Disability services

Examples of Navigator Target Populations

- Navigators provide enrollment services to individuals with cognitive, hearing, speech and/or vision impairments.
- Navigators provide enrollment services to pregnant women, new mothers, and women with children.
- Navigators provide enrollment services to farmers, farm workers, and rural residents.
- Bilingual Navigators provide enrollment services to Asian Pacific Americans and refugees.

Source: Rachel Swindle, Jalisa Clark, and Justin Giovannelli, “New Administration Plans to Reinstate Cuts to Funding for ACA Outreach and Enrollment Assistance,” To the Point (blog), Commonwealth Fund, Mar. 27, 2025. https://doi.org/10.26099/nwz4-2g21

First Year Open Enrollment Findings: Health Insurance Coverage for Asian Americans and the Role of Navigators

Edwin Chandrasekar [1,✉], Karen E Kim [2], Sharon Song [1], Ranjana Paintal [1], Michael T Quinn [2], Helen Vallina [2]

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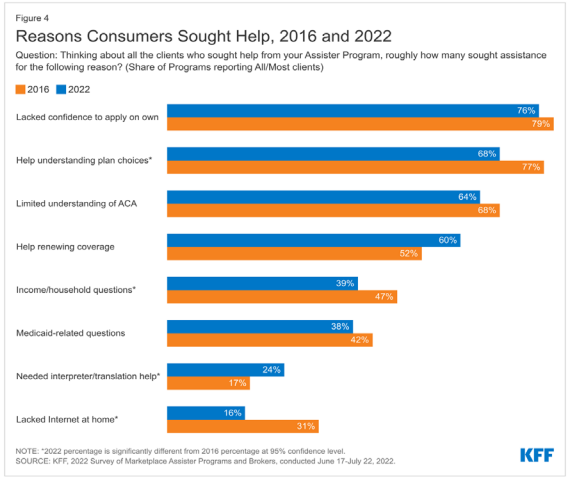

Determine Special Enrollment Periods

HR1 restricts income-based special-enrollment periods (SEPs), but allows State-Based Marketplaces to continue other SEPs.

SEPs for states to consider:

- Leaving military service
- Change in disability status
- Natural disasters
- Customers enrollment issue was not resolved before the end of OE
- Pregnancy – reduces uninsurance during a critical period and provides access to important prenatal care
- Tax-time

Management of Non-ACA plans

- Model 171
  - Empower states to protect consumers by informing them of the limitations of non-ACA products and setting minimum standard benefits for short-term and supplemental health plans.
- Adopt more protective rules
  - Limit the maximum contract term
  - Prohibit plans from retroactively canceling coverage
  - Prohibit or limit preexisting condition exclusions

Comparing Comprehensive Individual Market Coverage and Short-Term Products: What Federal Consumer Protections Apply?

Consumer protection	Description	Applies to comprehensive coverage?	Applies to short-term products?
Guaranteed availability	Must accept every individual who applies for coverage	✔	X
Ban on preexisting condition exclusions	Cannot exclude coverage of a benefit or service based on an enrollee's preexisting condition	✔	X
Ban on rescissions	Cannot retroactively cancel coverage (except for fraud or intentional misrepresentation of material fact)	✔	X
Premium rating rules	Cannot charge a higher premium based on health status or gender	✔	X
Essential health benefits (EHBs)	Must cover 10 specified categories of benefits	✔	X
Actuarial value	Must meet minimum value standards based on how much of an enrollee's medical costs are covered	✔	X
Ban on dollar limits	Cannot impose annual or lifetime dollar caps on benefits	✔	X
Annual cost-sharing limit	Enrollee's annual out-of-pocket spending on EHBs cannot exceed a federally specified cap	✔	X
Medical loss ratio	Must spend 80% of revenue on medical care and quality improvement or issue rebate to enrollees	✔	X

Download data

Data: Authors' analysis.

Source: Justin Giovannelli, Kevin Lucia, and Christina L. Goe, "Biden Administration Restricts Use of Short-Term Health Insurance Plans, But States Can Do More to Protect Consumers," *To the Point* (blog), Commonwealth Fund, Aug. 2, 2023. https://doi.org/10.26099/1w40-vv53

Benefit Design Policy Tools

- Standardized Plans
  - Simplify the shopping process
  - Tailor cost-sharing to address population needs
- Preventive Services
  - State laws to enshrine the ACA's preventive services protections
- Essential Health Benefits/State-mandated Benefits
  - Respond to consumer health care needs

Health Targets:

Diabetes

Mental Health/SUD

Specialty prescription drugs

Pediatric benefits

Cardiovascular disease

Maternal health

Provide state-funded premium or cost-sharing assistance

Potential funding sources:

- Health insurer fees
- Premium taxes
- Individual mandate revenue
- Reinsurance and other waiver passthrough
- Hospital assessments
- Taxes on nicotine, alcohol, etc.
- Additional state revenue options

Rating tools

- **Premium Alignment:** Increase alignment between premiums and underlying generosity of coverage
  - Assumes individuals are acting in their best interest and aligns induced demand and utilization with the generosity of coverage
  - → Effect is moving enrollees into higher quality plans with lower out-of-pocket costs

- **Eliminating Tobacco Rating:**
  - The tobacco industry targets low-income communities with marketing and advertising.
  - Allowing tobacco surcharges reduces insurance enrollment among tobacco users, who might be especially well-served by coverage including access to tobacco cessation benefits may be unable to afford it.
- **Narrower De Minimus AV Ranges**

Strengthen prior authorization and denial oversight

Stateline

HEALTH CARE DEMOCRACY EDUCATION ENVIRONMENT SOCIETY CRIMINAL JUSTICE

HEALTH HEALTH CARE

States try to rein in health insurers' claim denials, with mixed results

As more patients and doctors voice their frustrations, states are responding.

BY: SHALINA CHATLANI - MARCH 25, 2025 5:00 AM

- Delays and denials are among the most common reasons for complaints according to NAIC data.
- Denied claims can lead to substantial medical debt.
- State regulatory options:
  - Give insurance commissioners more authority to directly access to denied claims.
  - Set deadlines for prior authorization processes.
  - Increase regulation of AI in insurance processes – especially denials
    - Transparency and accountability
    - Ensure a human with proper clinical knowledge is in the loop

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Presentation "Threats to Mental Health and Substance Use Disorder Care: Implications of the Parity Lawsuit"

Deborah Steinberg (LAC), Lauren Finke (The Kennedy Forum)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Threats to Mental Health and Substance Use Disorder Care: **Implications of the Parity Lawsuit and Next Steps for Regulators**

Deb Steinberg, Legal Action Center
Lauren Finke, The Kennedy Forum

Updated Parity Regulations and Lawsuit

- 2020: Passage of the Consolidated Appropriations Act of 2021, amending MHPAEA
  - Requires plans to perform and document annual, comprehensive parity compliance analyses.
  - State regulators have the authority to request these comparative analyses
  - Authorized reports to Congress
- September 2024: Updated MHPAEA regulations
  - See reference notes for details
- January 2025:
  - DOL/HHS/Treasury 2024 Report to Congress
  - ERIC files lawsuit
- May 2025:
  - Trump Admin issues non-enforcement policy and agrees to "revisit" regulations
  - Court grants the motion to hold the case in abeyance - updates are due every 90 days

Retaining the Strongest Anti-Discrimination Protections in Your State

The federal MHPAEA law and regulations are the floor, not the ceiling. State regulators can consider:

- **Parity Compliance Analyses**
  - Federal law requires carriers to perform and document comparative analyses
  - State regulators have the authority to request these documents
  - Even without changing your state law or regulations, state regulators can leverage the 2024 regulations to have a standardized way of assessing comparative analyses
    - See, e.g. Virginia 2025 self-compliance tools: https://www.scc.virginia.gov/regulated-industries/companies/life-health-companies/benefits-parity/
- **Incorporate the 2024 regulations** by reference (in statute, or regulations if possible)
- **Model statutes and regulations** with additional recommendations for further strengthening (see following slides)

Instituting Transparent Generally Accepted Standards of Care

- States can require detailed crosswalks for each level of MH/SUD care that demonstrate full alignment with generally accepted standards of care that are approved by nonprofit clinical specialty associations.
- States have authority, but are not required under federal parity, to require exclusive use of nonprofit clinical specialty association criteria.
- States can also move to ensure provider documentation requirements from health plans conducting UR are no more intensive than what is required to determine whether the patient meets the criteria under the generally accepted standards of care.
- States can specify gap-filling utilization review criteria when nonprofit clinical specialty association criteria is not available and state that it must be based on generally accepted standards of care.

Completing Annual Data Collection Efforts

- Regular data collection is necessary for assessing parity compliance *in operation*
- State regulators can require health plans to annually report the following:
  - Parity comparative analyses and parity information that they would need to report to federal agencies;
  - Claims, appeals, denials overturns, and other utilization management data;
  - Network composition metrics, including in-network and out-of-network utilization rates, time and distance data, data on providers accepting new patients, data on administrative burden and time for providers to join networks, and data related to provider claims submissions and reimbursement rates.
  - State regulators should consider publicly reporting results of these findings through annual public reports and consumer-facing dashboards.

Recommended Actions to Protect Consumers Accessing MHSUD Care

- Requiring plans to provide parity compliance analyses and analyses of relevant data to assess the impact of NQTLs on access to MH/SUD benefits
- Requiring MHSUD-specific data collection and evaluating the relevant federally-recommended data related to network composition and other meaningful metrics
- Instituting transparent generally accepted standards of care to ensure that patients are receiving medically necessary MH/SUD treatment that aligns with clinical practices

For toolkits on all of these items, see State Parity Gold Standards: https://www.thekennedyforum.org/focus-areas/coverage-parity/state-gold-standards

Resources:
State Parity Gold Standards

- Available:
  - State Codification of Federal Rules
  - Generally Accepted Standards of Care
- Forthcoming:
  - Data Collection, Evaluation, and Reporting Requirements
  - Corrective Enforcement Actions

…and more!

For questions, contact us:
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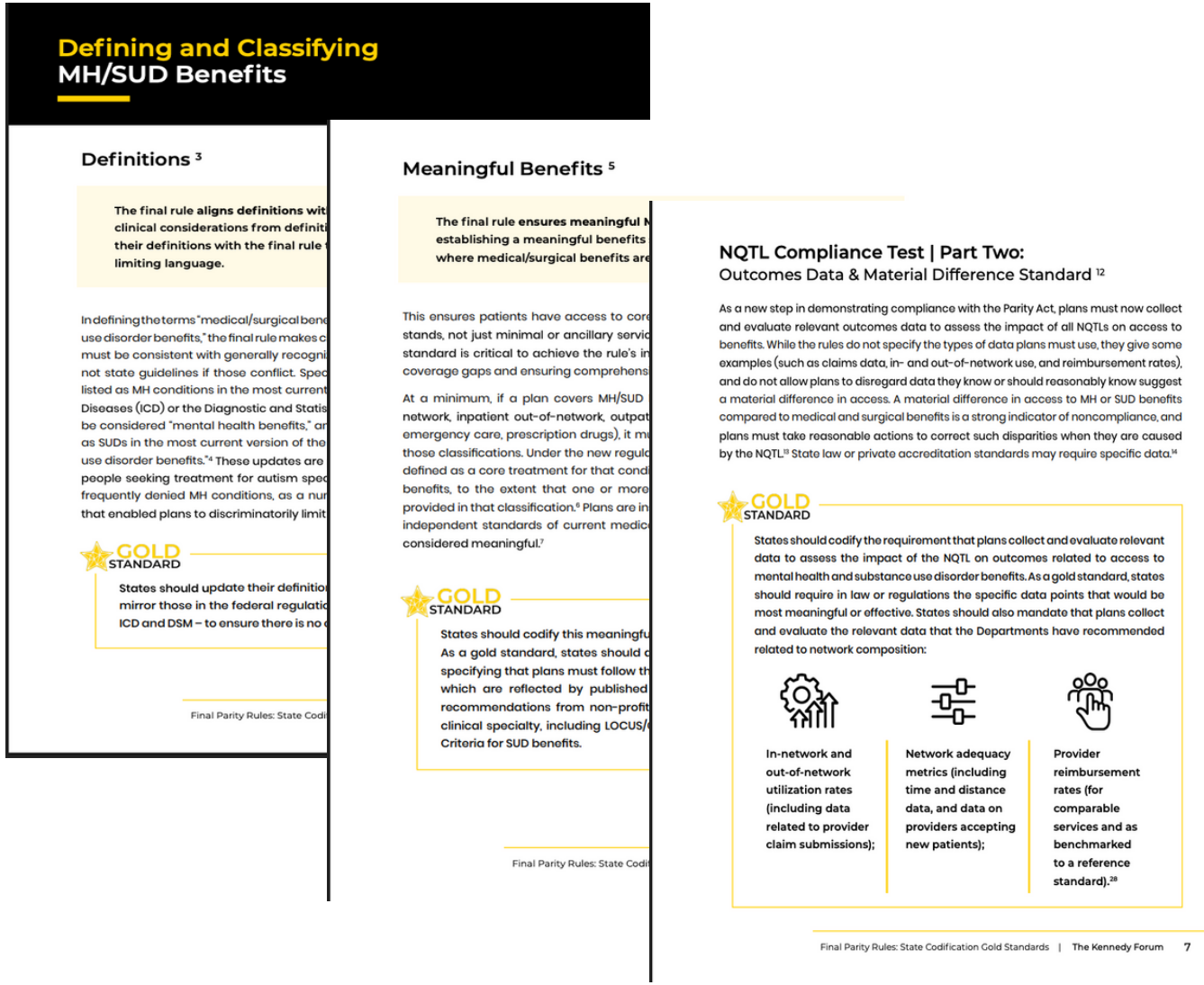
Resources: State Parity Gold Standards

Take a peek inside!



Codifying the Federal Parity Rule into State Law: Key Components

Definition of Mental Health Benefits
Meaningful Benefits
Exhaustive List of NQTLs
Prohibition on Discriminatory Factors and Evidentiary Standards
Outcomes Data
Comparative Analyses
Enforcement
Transparency

Definition of Mental Health Benefits

States should update their definitions of these terms in law or regulations to mirror those in the federal regulations – specifically, the alignment with the ICD and DSM – to ensure there is no confusion or misclassification of benefits.

Meaningful Benefits

As a gold standard, states should add a definition of “meaningful benefits” specifying that plans must follow the generally accepted standards of care developed by the non-profit professional societies for the relevant clinical specialty, including LOCUS/CALOCUS for mental health benefits and The ASAM Criteria for substance use disorder benefits.

Exhaustive List of NQTLs

If states have a list of NQTLs in law or regulations, this list should be updated to mirror those in the federal regulations. State agencies should collaborate with consumers and providers to identify any other NQTLs that should be added to this list that pose barriers to accessing mental health and substance use disorder benefits.

Prohibition on Discriminatory Factors and Evidentiary Standards

States should codify the prohibition on discriminatory factors and evidentiary standards in the design of NQTLs in law or regulations.

Outcomes Data

States should codify the requirement that plans collect and evaluate relevant data to assess outcomes related to access to MHSUD benefits. States should require in law or regulations specific data points that would be most meaningful or effective. States should also mandate that plans collect and evaluate the relevant data that the Departments have recommended related to network composition:

- in-network and out-of-network utilization rates (including data related to provider claim submissions)
- network adequacy metrics (including time and distance data, and data on providers accepting new patients)
- provider reimbursement rates (for comparable services and as benchmarked to a reference standard)

Comparative Analyses

States should codify this full comparative analysis process and content requirements. The Consolidated Appropriations Act of 2021 requires plans to perform and document an analysis showing that they are designing and applying NQTLs in a comparable way. The updated regulations go into far greater detail about this six-step process and the contents for the comparative analysis.

Enforcement

States should require plans to submit comparative analyses annually, or at a minimum specify how many comparative analyses they will review each year.
States should codify the timeframes in which plans must respond to requests and notify plan participants upon a final determination of noncompliance.
States should further provide that a final determination of noncompliance, including when an analysis was incomplete or insufficient, will result in the plan being required to cease using that NQTL. States should also identify and include in law or regulations sufficient penalties to impose on plans for such noncompliance, which can be tied to other legal provisions such as failure to comply with form filings or acts of discrimination and unfair trade practices. States may also wish to consider additional provisions to ensure plans are held accountable for actions or omissions of third - party administrators.

Transparency

States should authorize plan participants or their authorized representatives to be able to request the NQTL comparative analysis at any time, not just when they receive an adverse benefit determination. States should also explicitly codify the requirement that plans may not withhold any information from consumers in these analysis.

Presentation on Vaccines and Preventive Services Coverage

Anna Schwamlein Howard (ACS CAN), Amy Killelea (Consumer Advocate)

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Following the Science: Preserving Vaccine and Preventive Services Access Amid Federal Policy Changes

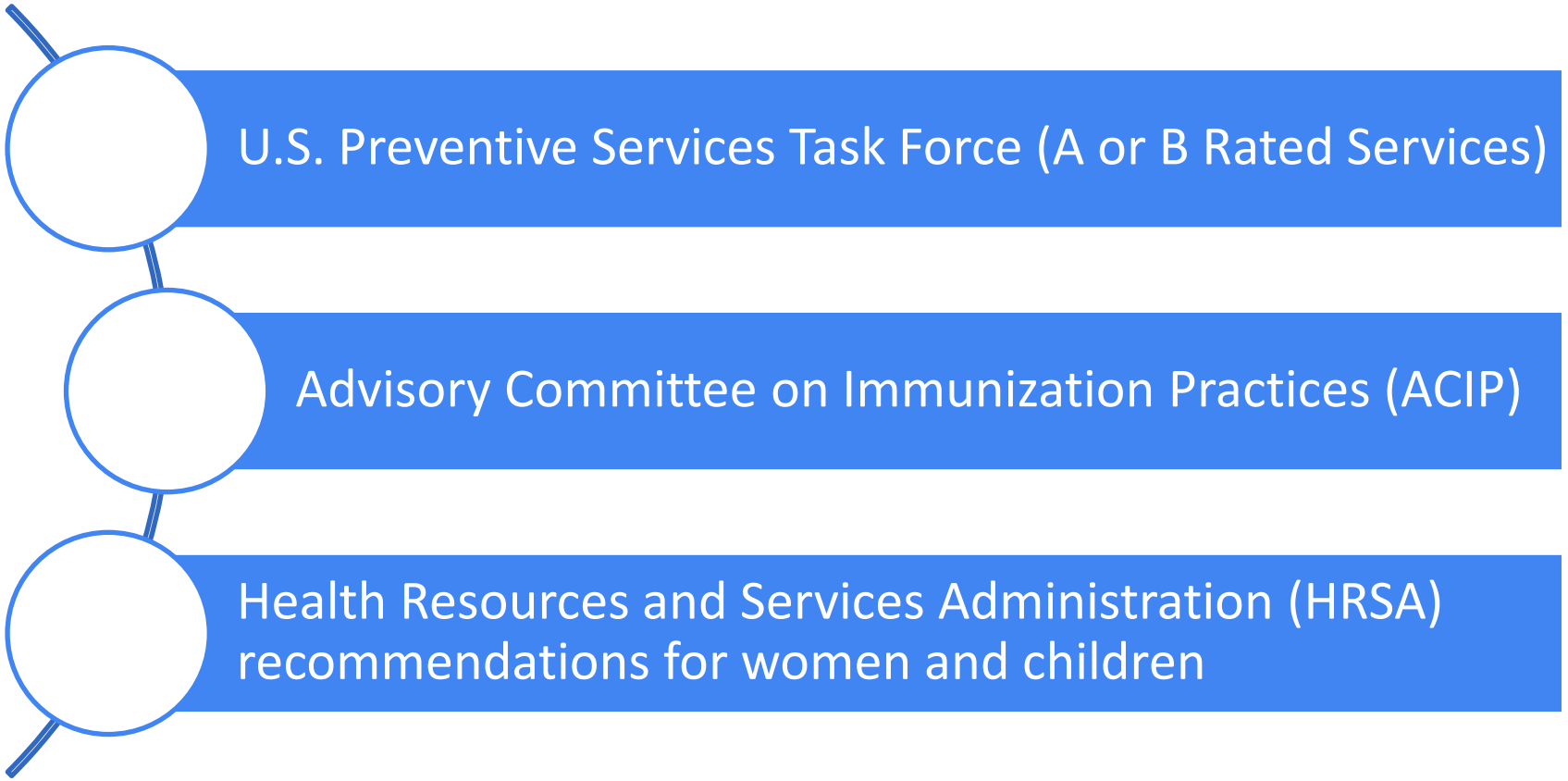
NAIC Summer Meeting 2025
Consumer Liaison

Presented by:

- Anna Schwamlein Howard, ACS CAN
- Amy Killelea

Preventive Services Coverage Requirements Tied to Clinical Standards

Section 2713 of the Affordable Care Act (ACA) ties coverage and cost sharing protections to recommendations by expert bodies

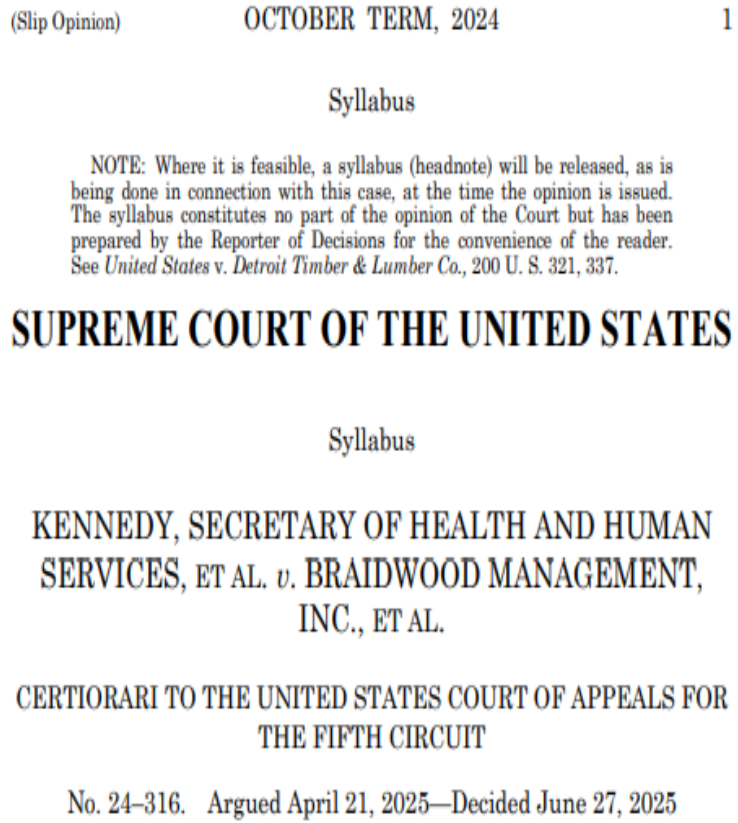


Many state laws also codify reference to these bodies for state coverage requirements!

Preventive Services Post *Braidwood*

Kennedy v. Braidwood Management

- 6-3 decision SCOTUS upholds constitutionality o ACA requirement that USPSTF-recommended services covered without cost sharing
- According to KFF, about 100 million people receive preventive services each year



(Slip Opinion) OCTOBER TERM, 2024 1

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

KENNEDY, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL. *v.* BRAIDWOOD MANAGEMENT, INC., ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 24–316. Argued April 21, 2025—Decided June 27, 2025

HRSA Recommendations for Women

HRSA Breast Cancer Screening Guidelines

- Effective for plan years beginning in 2026
- Applies to women of average risk of developing breast cancer
- Recommends coverage of follow up imaging to complete the screening process
- **Role for States:** issue bulletins clarifying coverage of follow up imaging is offered without cost sharing

The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years. Screening mammography should occur at least biennially and as frequently as annually. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (e.g., magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening.

HRSA Patient Navigation Services for Breast and Cervical Cancer Screening

- NEW recommendation: Patient navigation services for breast and cervical cancer screening and follow-up
- Effective for plan years beginning in 2026
- **Role for States:** issue bulletins clarifying coverage without cost sharing

New Guideline Beginning with Plan Years Starting in 2026

The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education.

ACIP and the Future of Vaccine Access

ACIP Shake Up: Timeline of ACIP's Undoing

- On May 27, Secretary Kennedy announced that HHS was unilaterally changing ACIP's COVID-19 recommendations
- On May 30, the CDC updated the ACIP COVID-19 recommendations to remove the recommendations for pregnant women and change the recommendation for children and adults without underlying conditions to "shared decision making"
- On June 9, Secretary Kennedy fired all 17 members of ACIP and replaced them two days later with eight new appointees, some without vaccine experience or with ties to anti-vaccine groups
- On June 25, during the first meeting of the newly constituted ACIP, the group announced it would review all existing ACIP recommendations
- At least one prominent medical society – the American Academy of Pediatrics – has pulled out of ACIP meetings and declared the group "illegitimate"

What Happens Now?

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With federal support uncertain, states and nonprofits scramble to safeguard access to vaccines

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Special project

Vaccine Integrity Project

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CIDRAP's Vaccine Integrity Project is an initiative dedicated to safeguarding vaccine use in the U.S. so that it remains grounded in the best available science, free from external influence, and focused on optimizing protection of individuals, families, and communities against vaccine-preventable diseases. Over the coming months, facilitated sessions will be held to gather critical feedback to understand what may be needed to ensure the integrity of the U.S. vaccine system, including vaccine evaluations and clinical guidelines based on rigorous and timely reviews. The Vaccine Integrity Project is supported by an unrestricted gift from Alumbra, a foundation established by philanthropist Christy Walton.

CIDRAP will provide continual updates on the initiative's progress.

States Were Prepared for Fall of ACA Preventive Services Provision, But not for Fall of ACIP or USPSTF

- Many of the state laws in place codifying ACA protections count on the continued credibility of clinical standard bodies like ACIP and USPSTF
  - Many of these laws peg their references to ACIP and USPSTF guidelines to a certain date, which preserves requirements amid federal changes, but does not have a mechanism to allow for updates
  - Several states authorize the insurance commissioner to develop a process to identify new recommendations moving forward, but these processes are vague and sometimes at odds with processes state public health departments use to guide their immunization programs

Regulator Considerations

What State Regulators Can Do

- Review state laws to understand references to ACIP or USPSTF
- Convene stakeholders, Medicaid agencies, public health agencies, consumer groups, insurers, and clinicians to ensure public trust and buy-in
- Work across states to ensure that clinical standard references for preventive services and vaccines are consistent across states
- Issue bulletins clarifying that insurers should treat “shared decision making” recommendations the same way as full recommendations for the purposes of coverage and cost sharing requirements

Questions?

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