

**JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY**

Bill No: H1161

Title: AN ACT REGARDING CERVICAL CANCER AND WOMEN'S PREVENTATIVE HEALTH

Sponsor: Rep. William C. Galvin (*Canton*)

Hearing Date: April 29, 2025

Reporting Deadline: June 28, 2025

Prior History:

2023-24 (H1013): Reported favorably; Referred to Health Care Financing; Reported favorably; Referred to HWM

2021-22 (H1087): Reported favorably; Referred to Health Care Financing; Ordered to a House Study

2019-20 (H979): Reported favorably; Referred to Health Care Financing; No further action taken

2017-18 (H525): Ordered to a House Study

2015-16 (H852): Ordered to a House Study

CURRENT LAW:

M.G.L. c. 175 Insurance

M.G.L. c. 176A Non-Profit Hospital Service Corporations (Blue Cross of Massachusetts)

M.G.L. c. 176B Medical Service Corporations (Blue Shield of Massachusetts)

M.G.L. c. 176G Health Maintenance Organizations (HMOs)

Chapter 28 of the Acts of 2023, An Act making appropriations for the fiscal year 2024 for the maintenance of the departments, boards, commissions, institutions, and certain activities of the commonwealth, for interest, sinking fund, and serial bond requirements, and for certain permanent improvements §§ 23, 56, 58, 59, 60

The Group Insurance Commission and commercial health insurers will provide coverage for federally defined preventive services without patient cost sharing.

Federally defined preventive services means: (i) evidence-based items or services that currently have a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF); (ii) immunizations with routine use in children, adolescents and adults that currently have a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved; (iii) with respect to infants, children

and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration; and (iv) with respect to women, such additional preventive care and screenings not described in clause (i) as provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration; provided, that federally-defined preventive services also includes all other preventive services not subject to cost-sharing, as required by established federal regulatory and sub-regulatory guidance issued on or before July 1, 2023.

If a federally defined preventive services recommendation is changed during a plan year, a health insurance carrier is not required to make changes to the health plan during that plan year.

The division of insurance (DOI) will issue implementation and enforcement guidance consistent with federal requirements and will issue any necessary guidance to update the scope of preventive services.

The USPSTF recommends 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 (cotesting). Cervical cancer screening has an A Rating. All women aged 21 to 65 years are at risk for cervical cancer because of potential exposure to high-risk HPV types (hrHPV) through sexual intercourse and should be screened. Certain risk factors further increase risk for cervical cancer, including HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer. Women with these risk factors should receive individualized follow-up.

SUMMARY:

This bill would mandate that commercial health insurers provide coverage for the cost of annual cytological screenings (pap smear) and Human Papillomavirus (HPV) screenings without patient cost sharing. The bill seeks to address instances where a patient has a history of abnormal pap smears or has tested positive for HPV. In such cases, providers may code the tests as diagnostic instead of preventative, in which case patient cost sharing applies. Those who do test positive are typically screened annually in response to their increased medical risk.