

No. 24-316

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IN THE  
Supreme Court of the United States

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ROBERT F. KENNEDY, JR., SECRETARY OF HEALTH AND  
HUMAN SERVICES, ET AL.,  
*Petitioners,*

v.

BRAIDWOOD MANAGEMENT, INC., ET AL.,  
*Respondents.*

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**On a Writ of Certiorari to the  
United States Court of Appeals  
for the Fifth Circuit**

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**AMICUS BRIEF OF AMERICAN COLLEGE OF  
GASTROENTEROLOGY  
IN SUPPORT OF NEITHER PARTY**

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March 3, 2025

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## **INTEREST OF THE *AMICUS CURIAE*<sup>1</sup>**

Founded in 1932, the American College of Gastroenterology (ACG) is the country's preeminent organization of gastroenterologists. With more than 20,000 members, ACG champions the prevention, diagnosis, and treatment of digestive disorders. It does so through education, training, and research.

ACG publishes three peer reviewed scientific journals that practicing clinicians rely on: the American Journal of Gastroenterology; Clinical and Translational Gastroenterology; and ACG Case Reports Journal; as well as and Evidence-Based Gastroenterology which reviews and evaluates relevant clinical studies in other journals for the benefit ACG's membership. Together, they have more than 300,000 readers each month.

ACG offers various educational programs to its members and others. The programs include an annual scientific meeting, a post-graduate course, regional courses and weekly virtual ground rounds.

To help clinicians deliver state-of-the-art evidence-based medical care to their patients, ACG develops and publishes guidelines on important gastroenterology and hepatology topics, including, for example, colorectal cancer screening.

ACG also funds clinical research. Since establishment of the ACG Institute for Clinical Research & Education in 1994, ACG has distributed more than \$34

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<sup>1</sup> No counsel for a party authored this brief in whole or in part and no such counsel or party made a monetary contribution intended to fund the preparation or submission of the brief. No one other than the American College of Gastroenterology funded preparation of this brief.

million overall in research grants and career development awards. In 2024 alone, it disbursed more than \$2.7 million in grants to clinical researchers.

Finally, ACG engages in public advocacy, representing the interests of clinicians and patients before lawmakers and regulators. One of ACG's proudest achievements is helping to secure legislation that requires government programs and private insurers to cover the cost of colorectal cancer screening.

## **INTRODUCTION AND SUMMARY OF THE ARGUMENT**

ACG takes no position on the legal questions presented. ACG writes to alert the Court to the case's practical implications.

Preventive services and medical screening are important aspects of public health.

Some medical screening identifies early warning signs, even before a disease has developed, thereby enabling timely prophylaxis. Other screening identifies disease at an early stage, when treatment is more likely to be effective. Put simply: medical screening saves lives.

Preventive screening is more cost-effective than treating a disease, and treating a disease in its early stages is generally cheaper than treating a disease in its more advanced stages.

To secure the benefits of medical screening and other preventive care, the Patient Protection and Affordable Care Act (ACA) requires Medicare, Medicaid, and certain private insurers to cover certain preventive-care services without requiring insured individuals to pay deductibles, copayments, or other out-of-pocket expenses.

The United States Preventive Services Task Force (USPSTF) reviews the medical literature and science to help the Department of Health and Human Services (HHS) identify the preventive care services that must be covered. With a proven track record of saving lives, USPSTF has recommended—and HHS has mandated—that private insurers regulated by the ACA cover colorectal cancer screening.

Colorectal cancer screening includes colonoscopies and other, non-invasive tests that can detect warning signs before colorectal cancer develops. The data are clear: colorectal cancer screening saves lives by stopping colorectal cancer—the second most common cause of cancer mortality in the U.S.—in many cases even before it happens.

Given the unambiguous data, the USPSTF has recommended—and HHS, adopting that recommendation as its own, has required—that private insurers cover colorectal cancer screening without requiring individuals to pay out-of-pocket expenses. Because out-of-pocket expenses are one of the principal barriers stopping individuals from getting colorectal cancer screening, the ACA's elimination of such expenses materially increases the rate at which people get screened—and thus significantly enhances public health.

ACG expresses no opinion on the questions presented. It asks only that the Court be cognizant of the real-world implications of its decision, whatever that may be.

## ARGUMENT

### I. Colorectal cancer screening saves lives.

Colorectal cancer is the third most common cancer in the United States and, behind only lung cancer, the

country's second leading cause of cancer mortality.<sup>2</sup> Aasma Shaukat et al., *ACG Clinical Guidelines: Colorectal Cancer Screening 2021*, 116 *Am. J. Gastroenterology* 458, 458 (March 2021). It is estimated that this year alone more than 150,000 people will be diagnosed with, and more than 50,000 people will die of, colorectal cancer in the United States. Am. Cancer Soc'y, *Cancer Facts and Figures 2025*, at 13, available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/2025-cancer-facts-and-figures-acf.pdf>.

Overall, the incidence of colorectal cancer—*i.e.*, the number of new cases diagnosed each year—has declined in recent decades. The incidence of colorectal cancer fell gradually from 1975 to 2000 and then fell sharply from 2003 to 2012. The “steep decline is thought to be primarily driven by screening.” Rebecca L. Siegel et al., *Colorectal Cancer Incidence Patterns in the United States, 1974–2013*, 109 *J. Nat'l Cancer Inst.* 1, 1 (2017). Colorectal cancer screening reduces the incidence of such cancer by allowing “removal of precancerous polyps” from the digestive system before they become cancerous. 116 *Am. J. Gastroenterology* at 458; *accord* Douglas A. Corley et al., *Adenoma Detection Rate and Risk of Colorectal Cancer and Death*, 370 *N. Eng. J. Med.* 1298, 1299 (Apr. 3, 2014).

Colorectal cancer screening also increases the rate at which people survive colorectal cancer after it has been diagnosed. Indeed, the significant increase in the

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<sup>2</sup> The USPSTF also recommends lung-cancer screenings. USPSTF, *Lung Cancer: Screening*, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening>.

overall five-year survival rate between 1970 and now—from 50% of diagnosed cases to 65% of diagnosed cases—is attributable in no small measure to “earlier detection through screening.” Cancer Facts and Figures 2025, at 13; Am. Cancer Soc’y, Colorectal Cancer: Facts & Figures 2023–2025, at 12, available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf>; see also Alexander Kusnik et al., *Trends in Colorectal Cancer Mortality in the United States, 1999–2020*, 16 Gastroenterology Rsch. 217, 217 (Aug. 2023) (“The age-adjusted mortality rates ... for [colorectal cancer] consistently declined from 20.7 [per 100,000 individuals] in 1999 to 12.5 [per 100,000 individuals] in 2020.”). “Colonoscopy can reduce the risk of death from colorectal cancer through detection of tumors at an earlier, more treatable stage.” 370 N. Eng. J. Med. at 1299. When detected and treated early, the overall 5-year survival rate for colorectal cancer is 91%. Colorectal Facts & Figures 2023–2025, at 13–14. The later the cancer is detected, the lower the survival rate, which falls to 15% when the disease is detected at an advanced stage. *Id.*; accord Derek W. Ebner et al., *Trends in Colorectal Cancer Screening from the National Health Interview Survey: Analysis of the Impact of Different Modalities on Overall Screening Rates*, 17 Cancer Prevention Rsch. 275, 275 (June 2024).

Prompt detection of colorectal cancer through screening is particularly important to the five-year survival rate because early-stage colorectal cancer “often has no symptoms.” Am. Cancer Soc’y, Colorectal Cancer: Facts & Figures 2020–2022, at 2, available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer->

facts-and-figures/colorectal-cancer-facts-and-figures-2020-2022.pdf. Colorectal cancer screening enables the detection and treatment of “asymptomatic cancer” before it spreads throughout the body. *Colorectal Facts & Figures 2023–2025*, at 4.

Unfortunately, “[o]nly 1 in 3 cases” of colorectal cancer cases are detected before the cancer has reached an advanced stage. *Colorectal Cancer: Facts & Figures 2023–2025*, at 14.

Bad as that is, the true tragedy is that 90% of colorectal cancers are preventable with screening. Ben Boursi & Nader Arber, *Current and Future Clinical Strategies in Colon Cancer Prevention and the Emerging Role of Chemoprevention*, 13 *Current Pharm. Design* 2274, 2277 (2007). Unlike other types of cancer screening, where the goal is to detect cancer at an early stage, the goal of colorectal cancer screening is to detect and remove precancerous tissue. The great benefit of colonoscopy is that precancerous polyps can be detected and removed in one procedure. 116 *Am. J. Gastroenterology* at 461; *accord* 370 *N. Eng. J. Med.* at 1299. It is therefore unsurprising that “[l]arge, well-conducted randomized, controlled trials ... have demonstrated that” colonoscopy and other methods of colorectal cancer screening “can reduce disease incidence and disease-specific mortality.” Jennifer S. Lin et al., *Screening for Colorectal Cancer: An Evidence Update for the U.S. Preventive Services Task Force*, at 5 (May 2021), available at <https://www.ncbi.nlm.nih.gov/books/NBK570917/>.

The benefits of colorectal cancer screening are striking. After a systematic review of the epidemiological data, the USPSTF concluded that “if screening were performed from ages 45 to 75 years with one of the USPSTF recommended strategies, an estimated 286 to

337 lifeyears would be gained, an estimated 42 to 61 cases of colorectal cancer would be averted, and an estimated 24 to 28 colorectal cancer deaths would be averted, per 1000 adults screened.” USPSTF, *Screening for Colorectal Cancer: US Preventive Services Task Force Recommendation Statement*, 325 J. Am. Med. Ass’n 1965, 1972 (May 18, 2021).

The problem from a public-health perspective is that the rate of colorectal cancer “screening in the US is suboptimal.” Maira A. Castañeda-Avila et al., *Racial and Ethnic Disparities in Use of Colorectal Cancer Screening Among Adults with Chronic Medical Conditions: BRFSS 2012–2020*, 21 Preventing Chronic Disease 1, 2 (Feb. 2024). Overall, the screening rate among adults 50 to 75 years old is less than 70%. 17 Cancer Prevention Rsch. at 275–76. The Centers for Disease Control (CDC) has determined that “[i]ncreasing screening prevalence to 80% could reduce the number of people diagnosed with colorectal cancer by 22% by 2030” and “could reduce deaths from colorectal cancer by 33%” over that same period. Nat’l Ctr. for Chronic Disease Prevention & Health Promotion, *Health and Economic Benefits of Colorectal Cancer Interventions* (Oct. 16, 2024), <https://www.cdc.gov/nccd/php/priorities/colorectal-cancer.html>.

The lack of sufficient screening is particularly pronounced among certain subpopulations. The screening rate among Hispanics with limited English proficiency is especially low when “compared with all other racial and ethnic groups,” but the screening rates among Blacks, Asians, and Hispanics generally are also lower than the screening rate for Whites. 21 Preventing Chronic Disease at 4; Fang Lei & Eunice Lee, *Cancer Screening Rates Among Asian Americans: A Cross-Sec-*



*tional Secondary Data Analysis Study*, 30 *Cancer Control* 1, 6 (2023). One consequence is that “African Americans are about 20% more likely to get colorectal cancer and about 40% more likely to die from it than most other groups” because “[t]hey often experience greater obstacles” to colorectal cancer screening. Am. Cancer Soc’y, *Colorectal Cancer Rates Higher in African Americans, Rising in Younger People* (Sept. 3, 2020), <https://www.cancer.org/cancer/latest-news/colorectal-cancer-rates-higher-in-african-americans-rising-in-younger-people.html>. One estimate, cited in ACG’s clinical guidelines for colorectal cancer screening, suggests that 19% of racial disparity in colorectal cancer death rates between white and black Americans is due to lower screening rates alone. 116 *Am. J. Gastroenterology* at 465.

The importance of colorectal cancer screening is only increasing.

Historically, colorectal cancer typically emerged later in life. Screening therefore has traditionally targeted those 50 and older. Indeed, the decline in the incidence of colorectal cancer over the past two decades is in significant part attributable to “the widespread uptake of screening that began around 2000 among adults ages 50 and older.” *Cancer Facts and Figures 2025*, at 13.

Unfortunately, the incidence of colorectal cancer among younger people—who are less likely to be screened—has risen, presumably as the result of changes in diet and other environmental factors. In 1995, only 11% of colorectal cancers were in people younger than 55; by 2019, 20% of colorectal cancers were in people younger than 55. *Colorectal Cancer Facts and Figures 2023–2025*, at 1; *see also* 109 *J. Nat’l Cancer Inst.* at 1.

The upward trend is particularly alarming because younger people are not only being diagnosed with colorectal cancer at a higher rate than before but are also being diagnosed at later stages of the disease, when treatment is less effective. Reinier G. S. Meester et al., *Trends in Incidence and Stage at Diagnosis of Colorectal Cancer in Adults Aged 40 Through 49 Years, 1975–2015*, 321 *J. Am. Med. Ass’n* 1933, 1933–34 (May 21, 2019). Given this trend, it is estimated that by 2030 “early-onset colorectal cancer . . . is expected to become the leading cancer-related cause of death for people age 20 to 49.” Charles R. Rogers et al., *Early-Onset Colorectal Cancer Survival Differences and Potential Geographic Determinants Among Men and Women in Utah*, 42 *Am. Soc’y Clinical Oncology Educ. Book* 825, 825 (Apr. 2022); accord Lola Rahib et al., *Estimated Projection of US Cancer Incidence and Death to 2040*, 4 *JAMA Network Open* 1, 9 (Apr. 7, 2021). The rise in colorectal cancer among the young means that more people will die of colorectal cancer—and will do so in the prime of their lives, when they are most productive. Unless abated, the current trend will increase the number of personal tragedies and the magnitude of economic losses.

In light of this undesirable demographic development, ACG, the American Cancer Society, and USPSTF now “recomin[] screening for colorectal cancer in adults aged 45 to 49 years” to “reduce incidence of . . . and mortality from” colorectal cancer. 325 *J. Am. Med. Ass’n* at 1968; 116 *Am. J. Gastroenterology* at 460; accord *Cancer Facts and Figures 2025*, at 14.

## **II. Colorectal cancer screening is cost-effective health care.**

Colorectal cancer screening is a cost-effective way to save lives. As the CDC has observed, “[m]ore routine screening would reduce cases, deaths, and costs.” Health and Economic Benefits of Colorectal Cancer Interventions.

Colorectal cancer is expensive to treat. The National Cancer Institute, part of the National Institutes of Health, estimates that in 2020 the cost of cancer care in the United States was \$208.9 billion. Nat’l Cancer Inst., Cancer Trends Progress Report (March 2024), <https://progressreport.cancer.gov>. Treatment of colorectal cancer accounted for 11.6% of that sum or \$24.3 billion. *Ibid.*

The cost of treating colorectal cancer has “increased dramatically over the past years.” Iris Lansdorp-Vogelaar et al., *Cost-Effectiveness of Colorectal Cancer Screening—An Overview*, 24 *Best Practice & Rsch. Clinical Gastroenterology* 439, 445 (Aug. 2010). As a result, multiple studies have shown that “the cost-effectiveness of ... screening is becoming more favourable compared to no screening and that most ... screening strategies even become cost-saving, because the treatment savings from preventing” colorectal cancer “by screening outweigh the screening costs.” *Ibid.* Screening makes it substantially more likely that “colorectal cancer is diagnosed at the localized stage,” *i.e.*, before it has spread beyond the colon, which in turn means that the “expensive new therapies” used to treat late-stage colorectal cancer “are not required.” Nat’l Colorectal Cancer Roundtable, *Increasing Colorectal Cancer Screening—Saving Lives and Saving Dollars* 1, 1 (Sept. 29, 2007).

Because increased rates of colorectal cancer screening among those aged 50 to 64 “could reduce” both colorectal cancer “incidence and mortality,” the costs associated with “the additional screening ... can be largely offset by long-term Medicare treatment savings.” Simon L. Goede et al., *Cost-savings to Medicare from Pre-Medicare Colorectal Cancer Screening*, 53 *Med. Care* 630, 630 (July 2015). Consistent with these findings, researchers estimate that “[i]ncreasing screening prevalence to 70% among adults age 50 to 64 could reduce Medicare spending by \$14 billion by 2050.” Health and Economic Benefits of Colorectal Cancer Interventions; *see also* Increasing Colorectal Cancer Screening—Saving Lives and Saving Dollars at 3 (“By increasing colorectal cancer screening rates in the 50 to 64 population, we will reduce suffering, save lives, *and* reduce cancer costs to Medicare.”) (emphasis omitted).

### **III. Cost is a major barrier to colorectal cancer screening.**

Despite the clear consensus on the importance of colorectal cancer screening, only an estimated 72% of eligible adults are considered fully up-to-date on colorectal cancer screening. CDC, Use of Colorectal Cancer Screening Tests (June 12, 2024), <https://www.cdc.gov/colorectal-cancer/use-screening-tests/index.html>.

“Adults without health insurance are less likely to be screened.” Health and Economic Benefits of Colorectal Cancer Interventions. But even those with insurance can have difficulty accessing colorectal cancer screening.

Studies show that out-of-pocket expenses deter or prevent many people, particularly those of lower socioeconomic status, from getting colorectal cancer

screening. Indeed, “the financial cost of colonoscopy” has been “reported to be a major barrier to screening.” Robert S. Kerrison et al., *Patient Barriers and Facilitators of Colonoscopy Use: A Rapid Systematic Review and Thematic Synthesis of the Qualitative Literature*, 145 *Preventative Medicine* 1, 7 (2021). In one study, “a participant who really wanted a colonoscopy stated it was a choice between ‘colonoscopy and other necessities, such as food and medication.’” *Ibid.* In another, a participant reported that they had “no insurance and can’t afford the out of pocket expenses.” M. Muthukrishnan, *Patients’ Self-Reported Barriers to Colon Cancer Screening in Federally Qualified Health Center Settings*, 15 *Preventative Medicine Reports* 1, 3 (Sept. 2019). Given these economic realities, “[a]ccess” to colorectal cancer screening “can be limited, even at free clinics, when out-of-pocket costs make screening unaffordable or when health plans restrict coverage of tests.” Resa M. Jones et al., *Patient-Reported Barriers to Colorectal Cancer Screening: A Mixed-Methods Analysis*, 38 *Am. J. Preventative Medicine* 508, 511 (2010).

Because of the financial barriers to colorectal cancer screening, “[s]ignificant disparities in health equity exist among patient populations based on socioeconomic status [and] insurance coverage.” Tania Centra & Catherine Fogg, *Addressing Barriers to Colorectal Cancer Screening in a Federally Qualified Health Center*, 35 *J. Am. Ass’n of Nurse Practitioners* 415, 423 (July 2023). These disparities in access to colorectal cancer screening are lethal: “socioeconomic challenges such as lack of insurance and low-income are associated with higher ... mortality.” 15 *Preventative Medicine Reports* at 1.

**IV. Colorectal cancer screening rates would likely fall and death rates would likely rise if the decision below is affirmed.**

Recognizing the medical and economic benefits of colorectal cancer screening, Congress has repeatedly enacted legislation to increase screening rates.

Well before passing the ACA in 2010, Congress passed legislation mandating Medicare coverage for colorectal cancer screening for high-risk individuals as part of the Balanced Budget Act of 1997. 42 U.S.C. § 1395m(d)(3) (1998). Congress subsequently extended coverage to all individuals covered by Medicare as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Pub. L. 106-554, § 1(a)(6), 114 Stat. 2763 (Dec. 21, 2000); *see also* 42 U.S.C. § 1395m(d)(3).

In 2010, spurred by its understanding that expanded colorectal cancer screening is a cost-effective way to save lives and control healthcare costs and that high out-of-pocket costs are a major barrier to such screening, Congress enacted the ACA, which mandated that private insurers cover certain preventative services without “impos[ing] any cost sharing requirements.” 42 U.S.C. § 300gg-13(a). Covered services include those recommended by USPSTF (*id.* § 300gg-13(a)(1)), which has recommended “screening for colorectal cancer in adults aged 45 to 49 years” and those “aged 50 to 75 years.” USPSTF, A & B Recommendations, <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>.<sup>3</sup>

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<sup>3</sup> USPSTF has also recommended hepatitis B and hepatitis C screenings for certain adults. Both hepatitis B and hepatitis C “can lead to chronic infection causing cirrhosis, liver cancer and

Requiring private health insurers to cover the cost of colorectal cancer screening corrects a timing-based market failure. Most individuals younger than 65 are covered by private insurance, while most individuals older than 65 are covered by Medicare. This means that the cost of colorectal cancer screening in those younger than 65 is borne by private insurers, while the benefits of such screening are reaped primarily by Medicare, which generally must pay to treat colorectal cancer when it emerges in individuals older than 65. As a result, private insurers have little incentive to

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death.” HHS, Hepatitis B Basic Information (Mar. 31, 2023), <https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/hepatitis-b-basics/index.html>; HHS, Hepatitis C Basic Information (Nov. 30, 2022), <https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/hepatitis-c-basics/index.html>. Like early-stage colorectal cancer, hepatitis B is particularly dangerous” because it is a ‘silent infection,’ which means it can infect people without them knowing it.” Hepatitis B Foundation, Why Is Hepatitis B So Dangerous?, <https://www.hepb.org/what-is-hepatitis-b/faqs/why-is-hepatitis-so-dangerous/> (last updated May 9, 2022). Indeed, “[m]ost people who are infected with hepatitis B are unaware of their infection for many years and can unknowingly spread the virus to others through direct contact with their infected blood and sexually.” *Id.* Similarly, “[a]bout 40% of people with chronic hepatitis C are unaware of their infection.” Hepatitis C Basic Information. Estimates vary, but roughly 1 to 2.4 million people in the U.S. are chronically infected with hepatitis B and between 2 and 2.5 million are chronically infected with hepatitis C. Hepatitis B Basic Information; Hepatitis B Foundation, Hepatitis B Facts & Figures, <https://www.hepb.org/what-is-hepatitis-b/what-is-hepb/facts-and-figures/>; Hepatitis C Basic Information. Both hepatitis B and hepatitis C are becoming more prevalent in the U.S. HHS, Viral Hepatitis in the United States: Data and Trends, <https://www.hhs.gov/hepatitis/learn-about-viral-hepatitis/data-and-trends/index.html>. Efforts to slow the rate of increase would be hampered if USPSTF’s recommendations are no longer followed.

cover colorectal cancer screening despite its demonstrable success in lowering colorectal cancer incidence and mortality. See Uri Ladabaum et al., *Contrasting Effectiveness and Cost-Effectiveness of Colorectal Cancer Screening Under Commercial Insurance vs. Medicare*, 113 Am. J. Gastroenterology 1836, 1844 (2018).

The ACA's preventive care mandate has proven very successful. "In a large, population-based cohort study, implementation of the ACA and reduction of cost sharing [for screening] were associated with a significant decrease in [colorectal cancer] incidence and related death." Catherine Lee et al., *Impact of the Affordable Care Act on Colorectal Cancer Incidence and Mortality*, 62 Am. J. Preventative Medicine 387, 393 (2022). The reduction in colorectal cancer "incidence and mortality that were observed after implementation of the ACA are likely attributed to increased uptake of screening colonoscopies due to the removal of cost sharing for preventive services." *Id.* at 391. Research has found that "annual colonoscopy rates among men ages 66–75 increased significantly (by 4.0 percentage points) after the Affordable Care Act" eliminated cost-sharing. Mary K. Hamman & Kandice A. Kapinos, *Affordable Care Act Provision Lowered Out-Of-Pocket Cost and Increased Colonoscopy Rates Among Men in Medicare*, 34 Health Affairs 2069, 2069 (2015). It is estimated that "the elimination of cost sharing for [colorectal cancer] screening owing to the ACA was associated with a 17% drop in [colorectal cancer] incidence." 62 Am. J. Preventative Medicine at 389. In absolute numbers, it is estimated that the ACA-fueled increase in screening has prevented "approximately 65,327 of 290,346 deaths" that would otherwise have occurred. *Id.* at 391.



This Court’s decision in this case has potentially serious implications for colorectal cancer prevention. Indeed, one group of public-health scholars has argued that sustaining the decision below “could reverse the progress made in [colorectal cancer] prevention and control and will likely increase treatment costs and [colorectal cancer] deaths and widen existing health disparities.” Rosita Van Den Puttelaar et al., *Implications of the Initial Braidwood v. Becerra Ruling for Colorectal Cancer Outcomes: A Modeling Study*, J. Nat’l Cancer Inst. 1, 4 (Oct. 3, 2024).<sup>4</sup> Projecting “[a]n 8-percentage-point decline in screening participation,” which “could increase [colorectal cancer] incidence by 5.1% and [colorectal cancer] mortality by 9.1%,” researchers estimate that there will be seven additional colorectal cancer cases and four additional colorectal cancer deaths “per 100,000 individuals in 2055 compared with the current state,” if this Court affirms the decision below. *Id.* at 1, 2.

“In the long term,” according to these scholars, if the decision is affirmed, “total costs are expected to be higher than in the current scenario because of increased [colorectal cancer] incidence and delayed diag-

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<sup>4</sup> Because wealth is not evenly distributed across population groups and because poorer people are less able to afford co-pays and other out-of-pocket expenses previously associated with colorectal cancer screening, the ACA’s elimination of such expenses “may be associated with a reduction in racial disparities to preventive care resources.” 62 Am. J. Preventative Medicine at 391. Conversely, as at least some researchers have argued, the effect of affirming the decision below “would likely be greatest for individuals with limited financial resources, potentially widening existing disparities in [colorectal cancer] outcomes in the United States.” J. Nat’l Cancer Inst. at 2 (Oct. 3, 2024).

noses, both of which substantially increase corresponding treatment costs.” J. Nat’l Cancer Inst. at 2 (Oct. 3, 2024).

These consequences could reach far beyond the ACA itself. Thirty-four states have enacted law mandating coverage of colorectal cancer screening; sixteen of these states rely on USPSTF for guidance, including Texas where this case originated. *See* Cal. Ins. Code § 10123.207; Colo. Rev. Stat. § 10-16-104; Del. Code tit. 18, § 3346; Haw. Rev. Stat. § 432:1-617; Ind. Code § 27-8-14.8-3; Ky. Rev. Stat. § 304.17A-257; Neb. Rev. Stat. § 44-7,102; N.J. Stat. § 17B:27-46.1y; N.M. Stat. § 59A-22-47; Or. Rev. Stat. § 743A.124; Tex. Ins. Code § 1363.001; Va. Code § 38.2-3418.7:1; Vt. Stat. tit. 8, § 4100g; Wash. Rev. Code § 48.43.043; Wis. Stat. § 632.895.16m. At the possible cost of lives, implementation of these laws may also be thrown into question were the decision below affirmed.

These are the potential ramifications of the Court’s ruling. ACG asks that the Court bear them in mind when weighing the legal issues before it.

## CONCLUSION

The Court should appreciate the public-health implications of its decision.

Respectfully submitted,

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March 3, 2025