

**COMMENTARY**

# Kennedy v Braidwood Ruling Affects Women and Cervical Cancer Screening

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**The Affordable Care Act (ACA) requires private insurance plans to cover preventive services, receiving a Grade A or B rating by the United States Preventive Services Task Force (USPSTF) without cost sharing. Cervical cancer prevention is one such service. Family medicine provides more than half of all the cervical cancer screenings in the US. While the ACA has led to an increase in screening, half of the people assigned female at birth who develop cervical cancer have never been screened. In addition, 20 to 40% of screening-eligible people in the US do not participate in screening. Of those who do screen, and their screen is abnormal, only 34% attend their diagnostic colposcopy examination. Colposcopy with biopsy and endocervical curettage requires consequential copay for the examination and pathology, which increases financial toxicity. Beginning in 2027, policies similar to those in place for breast and colorectal cancer screening that require insurance plans to cover the entire diagnostic workup without cost sharing under the ACA preventive services provision, will be implemented for cervical cancer screening. (J Am Board Fam Med 2025;38:1113–1116.)**

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The recent United States (US) Supreme Court (SCOTUS) *Kennedy v. Braidwood* (formerly, *Braidwood v. Becerra*) decision upheld the Affordable Care Act (ACA) requirement that insurance plans cover preventive services receiving an A or B rating by the United States Preventive Services Task Force (USPSTF) at no cost (ie, copays, coinsurance, or deductibles) to patients. Since cervical cancer screening (CCS) is among these

preventive services, the SCOTUS ruling preserving the ACA coverage mandate, coupled with Health Resources and Services Administration (HRSA's) recent recommendation that cervical cancer navigation services be included among the services to be covered without patient cost-sharing,<sup>1</sup> provide an opportunity to improve cervical cancer prevention, early detection, and treatment in the US.

No-cost initial CCS tests for insured, age-eligible Americans have been available since 2010. As of 2025, the incidence of cervical cancer among 35- to 44-year-olds in the US is 13.4/100,000.<sup>2</sup> Developed countries, similar to the US, have a lower incidence at 9.1/100,000,<sup>3</sup> significantly higher than the World Health Organization (WHO) goal of 4/100,000.<sup>4</sup>

Studies examining the impact of the ACA preventive care mandate indicate that the removal of cost-sharing led to an increase in the receipt of cervical cancer screening.<sup>5–11</sup> Despite these improvements in access, more than half of the Americans diagnosed with cervical cancer in the last decade had not been screened.<sup>12</sup> Given these daunting statistics, we must increase the uptake and expand the modalities used for cervical cancer screening to

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reduce the morbidity and mortality associated with this preventable malignancy.

### **The Need for No-Cost Sharing for Cervical Cancer Screening Is High, but Not Enough**

HPV-based screening is recommended by the draft USPSTF guidelines published in December 2024. Yet, over a quarter of the screening-eligible people in the US do not receive any CCS,<sup>13</sup> and the proportion of the population without CCS continues to rise.<sup>14</sup> Year after year, low screening rates are observed among screening-eligible insured people, at 74% for commercial HMO plans, 73% for commercial PPO plans, and 55% for Medicaid plans.<sup>15,16</sup> Again, half of those who had cervical cancer never had a screen.<sup>12</sup>

### **Cost Is One of the Many Reasons for Not Getting Screened**

Reasons for not initiating and completing cervical cancer screening via the traditional provider-collected sample using a speculum are many. Social drivers of health, education, and literacy lead the list,<sup>17</sup> and are worse for those whose first language is not English.<sup>18</sup> Access to appropriately trained clinicians is limited. More than half the counties in the US do not have a practicing gynecologist.<sup>19</sup> Family medicine provides more than half of the cervical cancer screenings.<sup>20</sup> Access is limited even in locations with trained clinicians because office hours do not align with employment rules for time off.<sup>21</sup> But, among these many reasons for not screening or following up after an abnormality, costs leading to financial toxicity are most feared.

A third of people who are not up to date with cervical cancer screening cite cost as the deterrent.<sup>6,22</sup> Cost sharing contributes to racial, ethnic, and socioeconomic inequities in cervical cancer outcomes, as evidenced by data showing that half of all cervical cancer diagnoses are made in people with no prior screening; only 44% of Black women with cervical cancer had prior screening.<sup>12</sup> Well-intentioned mass-screening events for people of color, often occurring in church basements or mobile vans, have resulted in the women being confused about the screening results and where to get follow-up care.<sup>23</sup> Basic needs, such as housing, food, security, and paying

bill, supersede the perceived need for CCS<sup>24</sup> despite the no-out-of-pocket costs mandated by the ACA.<sup>1</sup>

### **Guideline Changes in Screening Techniques and Tests Remain Covered by the ACA**

The ACA mandates no cost sharing for preventive services that meet the Grade A or B recommendation from the USPSTF. In December 2024, the USPSTF issued Grade A draft guidelines for primary HPV testing by clinician or self-sampling for cervical cancer screening.<sup>25</sup> The USPSTF recommendation of self-screening with primary HPV testing allows people who otherwise would not have permitted a clinician to screen them to do their own screening. The benefits of self-sampling screening include the continued ACA mandate of no copays for the screening. Self-sampling is estimated to increase the cervical cancer screening rate to 90% of the US eligible population,<sup>26</sup> which in turn, is estimated to bring the incidence of cervical cancer down to 4/100,000, the WHO goal.

### **Under 34% of Those with an Abnormal Screen Get a Follow-Up Colposcopy**

When people have an abnormal index cervical cancer screen, the follow-up colposcopy examination required for diagnosis often requires out-of-pocket costs that can approach \$1000.<sup>27</sup> These costs impede access and contribute to the low rates (34%) observed for colposcopic follow-up.<sup>28</sup> The many factors why an eligible individual might not undergo cervical cancer screening are magnified by the large out-of-pocket cost for the colposcopy examination.

In response, the American Cancer Society produced a position statement advocating for policies similar to the federal guidance implemented in 2023 that required Medicare and commercial insurance plans in the US to cover a follow-up colonoscopy after positive stool testing with no patient cost-sharing. Building on this, in 2025, HRSA endorsed the Women's Preventive Services initiative (WPSI) guidelines, including navigation services for breast and cervical cancer screening. Under the ACA preventive care mandate, HRSA recommended that services be covered without patient cost-sharing. A similar policy that eliminates cost-sharing for indicated follow-up diagnostic testing after an initial abnormal CCS test is warranted.

## Future Opportunity Is Now

Efforts to reduce the immense clinical and economic burden of cervical cancer must span the continuum from diagnosis through treatment. The Supreme Court's preservation of the preventive services mandate and the implementation of HRSA recommendations for CCS navigation offer a "second chance" for at least 2 key constituents. Our patients. We can offer better education to eligible individuals about no-cost screening and the importance of follow-up diagnostic testing, helping them navigate the screening continuum. Ourselves. We can offer complete screening, diagnosis, and treatment for this preventable cause of cancer-related death. It is rare to have such an opportunity to improve patient outcomes and reduce medical expenditures, creating a "win-win-win" scenario for patients, clinicians, and payers alike.

On January 5, 2026, the Women's Preventive Services Guidelines, supported by HRSA, and for purposes of the preventive services provision of the ACA, were updated to indicate that primary HPV testing is the preferred cervical cancer screen and that all women should be offered self-sampling.<sup>1</sup>

It further states that as of January 1, 2027, the follow-up studies which are required after an abnormal initial screening test (e.g. colposcopy) must be covered without cost-sharing for insured individuals for the purposes of increasing the number of individuals completing the screening process.

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