Impact of Federal Policy Change that Eliminated Patient Out-of-Pocket Costs for Follow-up Colonoscopy After a Positive Stool-Based Test

A Retrospective Claims Analysis of Commercially Insured Adults

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Background

- Although follow-up colonoscopy after a positive stool-based test is essential for colorectal cancer screening completion, rates are suboptimal.
- While the preventive services provision of the Affordable Care Act (ACA) eliminated patient cost sharing for initial colorectal cancer screening (including colonoscopy) for insured individuals, patients commonly incurred substantial out of pocket costs for follow-up colonoscopy.
- To reduce patient financial burden and increase follow-up colonoscopy rates, in 2023 the Centers for Medicare & Medicaid Services expanded the definition of CRC screening to include the colonoscopy following a positive stool-based test and thereby eliminated cost-sharing under the ACA.

Objectives

Was the policy implemented as intended?
1) Estimate patient out-of-pocket (OOP) costs for follow-up colonoscopy before and after the federal policy change

Did the policy achieve its intended goal?
2) Estimate rates of follow-up colonoscopy completion rate before and after the federal policy change

Methods

Data Source

Optum de-identified administrative claims of commercially insured adults linked with laboratory data

Study Population

Adults aged 45-75 years with a positive mt-sDNA or FIT test between November 2020 – October 2024

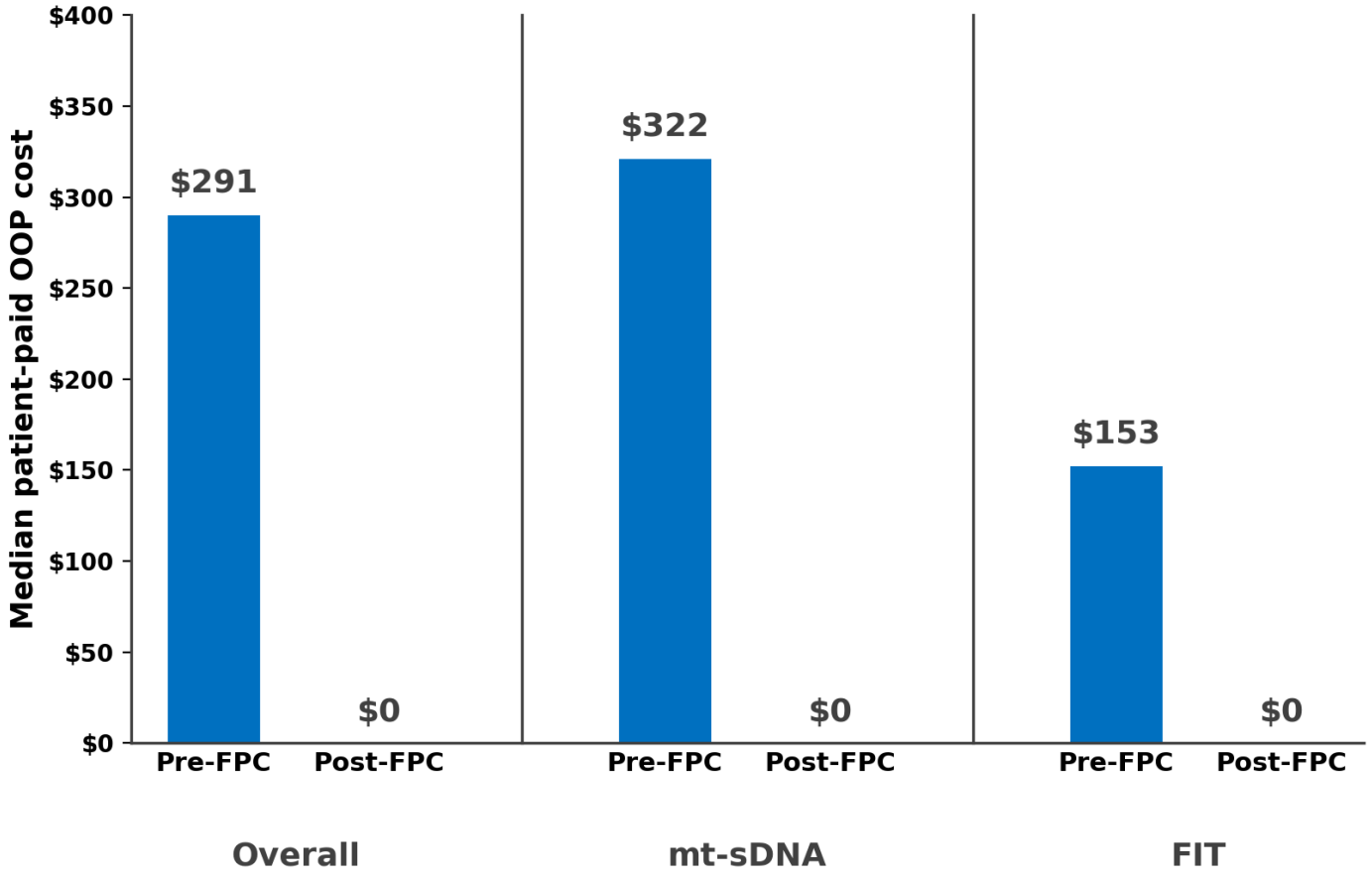
Results: Characteristics of patients with a positive stool-based test

Characteristic	Overall			mt-sDNA			FIT		
	Pre-FPC N=16,859	Post-FPC N=22,360	P-value	Pre-FPC N=13,522	Post-FPC N=22,077	P-value	Pre-FPC N=3,337	Post-FPC N=2,283	P-value
Age, years — median	58	57		58	57		58	58	
Female, n (%)	8.325 (49.4)	10,783 (48.2)	0.023	6,877 (50.9)	9,790 (48.8)	<0.001	1,448 (43.4)	993 (43.5)	0.939
Quan-Charlson comorbidity score — mean (SD)	0.41 (0.97)	0.43 (0.99)	0.211	0.38 (0.91)	0.41 (0.96)	0.007	0.53 (1.19)	0.55 (1.21)	0.552

FPC: federal policy change. Pre-FPC period: November 2020 – January 2023; Post-FPC period: February 2023 – October 2024

Results: Policy Implementation

Median patient out-of-pocket costs decreased to $0 for follow-up colonoscopy with and without polypectomy



FPC: federal policy change. Pre-FPC period: November 2020 – January 2023; Post-FPC period: February 2023 – October 2024

Percentage of patients who paid $0 after the policy change:

Overall: 36.3% → 60.3%

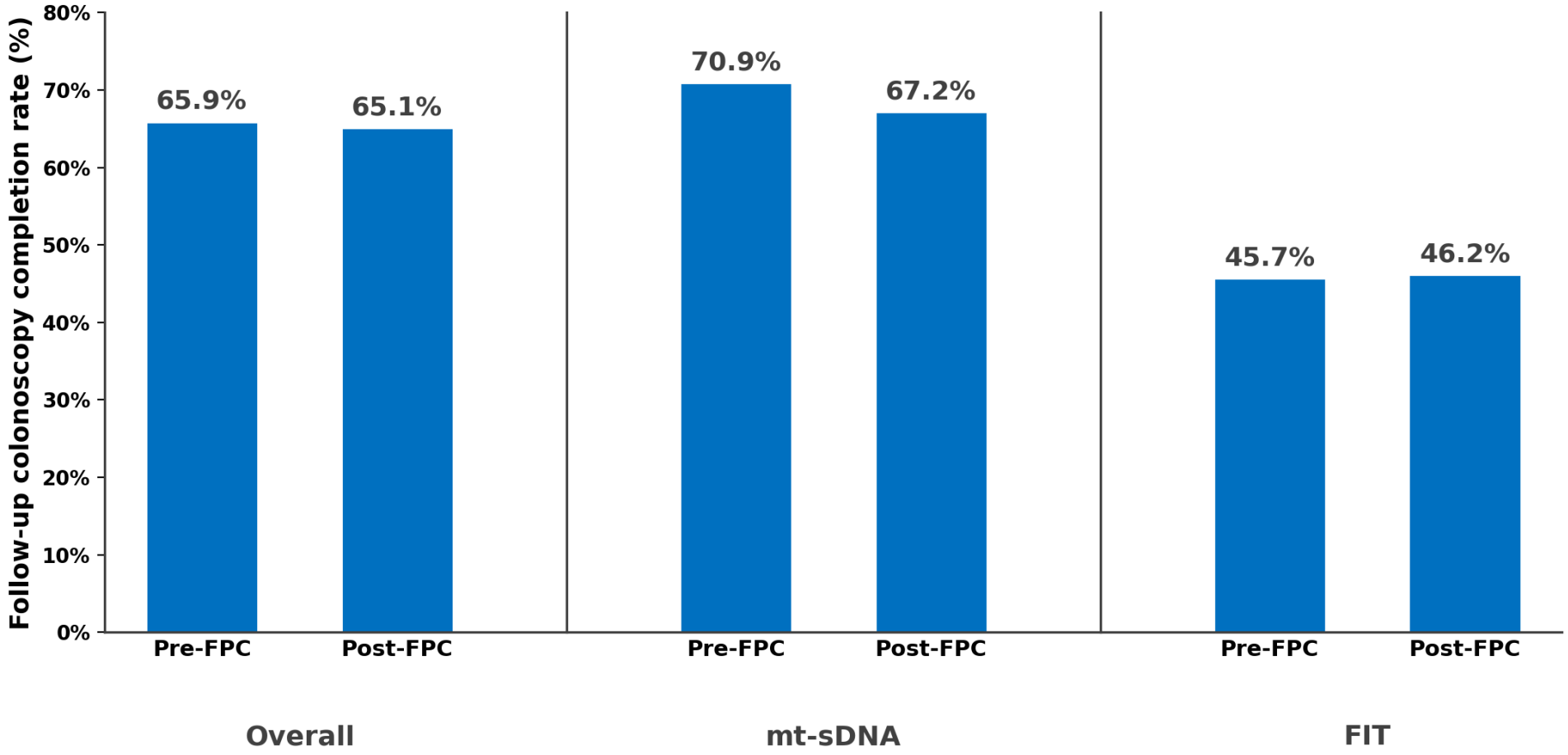
mt-sDNA: 35.9% → 60.7%

FIT: 39.4% → 55.4%

The 39.7% of patients who incurred out of pocket costs after policy implementation paid a mean of $879

Results: Policy Goal Achievement

Follow-up colonoscopy completion rate within 180 days after a positive SBT did not change following policy implementation



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Implications:

Additional barriers to follow-up colonoscopy completion persist beyond patient cost-sharing, including:

Patient Level Barriers

- Literacy
- Fear of colonoscopy
- Competing health issues
- Access to colonoscopist
- Concern about bowel prep
- Lack of transportation/chaperone

PCP Level Barriers

- Lack of communication of need for colonoscopy if stool-based test is positive
- Failure to alert patients of abnormal results
- Completion of referral for/scheduling of colonoscopy

System Level Barriers

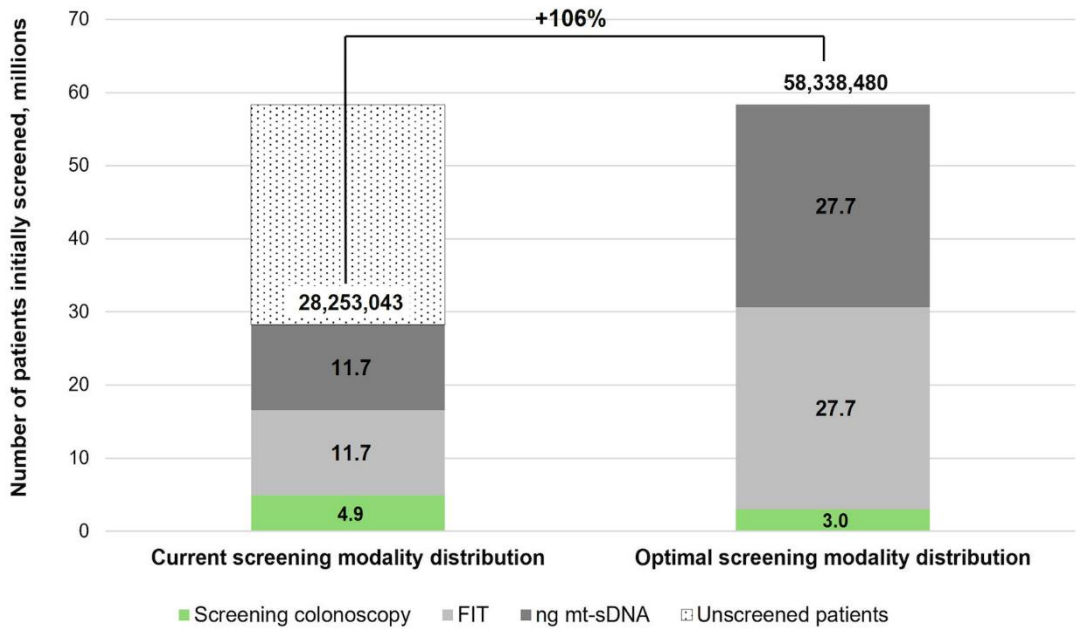
- Fragmented referral processes
- Limited colonoscopy capacity

Levin, T. R., et al. (2026). Improving follow-up of abnormal stool test results used for colorectal cancer screening. *Gastrointestinal Endoscopy*. https://doi.org/10.1016/j.gie.2026.05.028
Issaka, R. B., Bell-Brown, A., Kao, J., Snyder, C., Atkins, D. L., Chew, L. D., Weiner, B. J., Strate, L., Inadomi, J. M., & Ramsey, S. D. (2022). Barriers associated with inadequate follow-up of abnormal fecal immunochemical test results in a safety-net system: A mixed-methods analysis. *Preventive Medicine Reports, 28*, 101831. https://doi.org/10.1016/j.pmedr.2022.101831

Discussion: Optimizing Colonoscopy Capacity

Shifting initial screening to more stool-based testing will allow:

Screening of all eligible patients

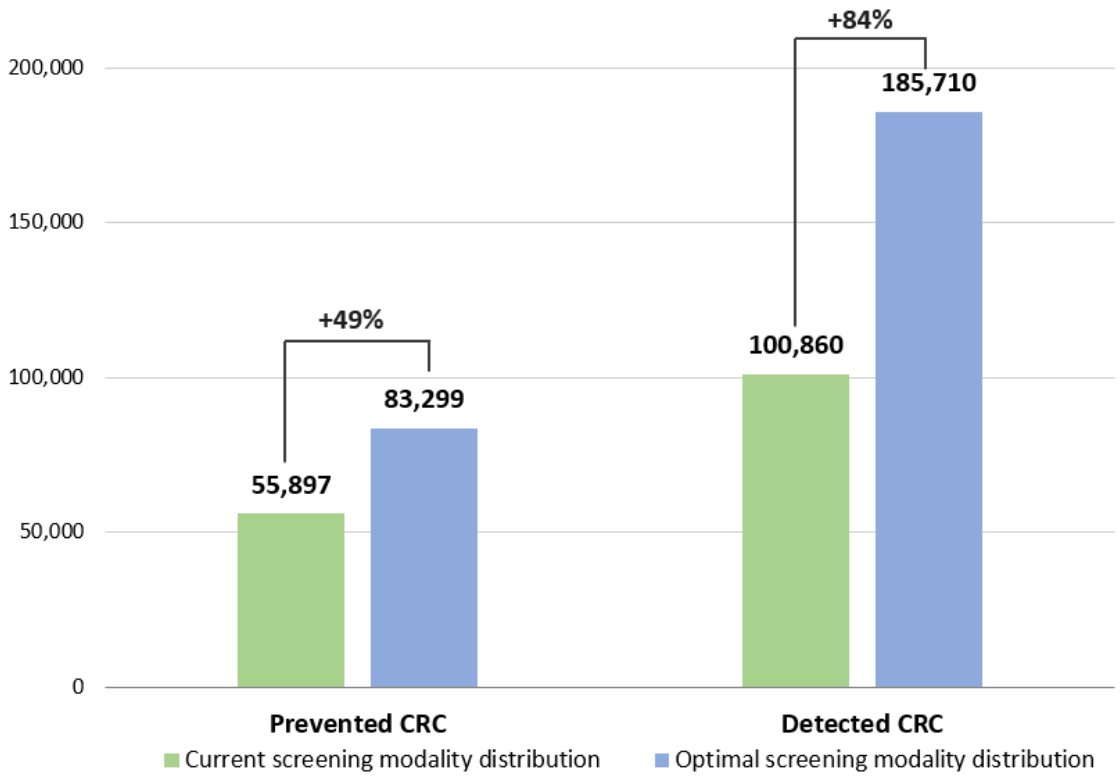


Fendrick AM, Kurlander JE, Vahdat V, Estes C, Gohil S, Limburg PJ, Lieberman DA. Optimizing Colonoscopy Capacity to Maximize Colorectal Cancer Outcomes. Gastro Hep Adv. 2026 Mar 19;5(5):100930. doi: 10.1016/j.gastha.2026.100930. PMID: 42028263; PMCID: PMC13101593.

Discussion: Optimizing Colonoscopy Capacity

Shifting initial screening to more stool-based testing:

More CRC cases prevented and detected



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Discussion: Optimizing Colonoscopy Capacity

Shifting initial screening to more stool-based testing:

Maximize colonoscopy efficiency, while maintaining full capacity



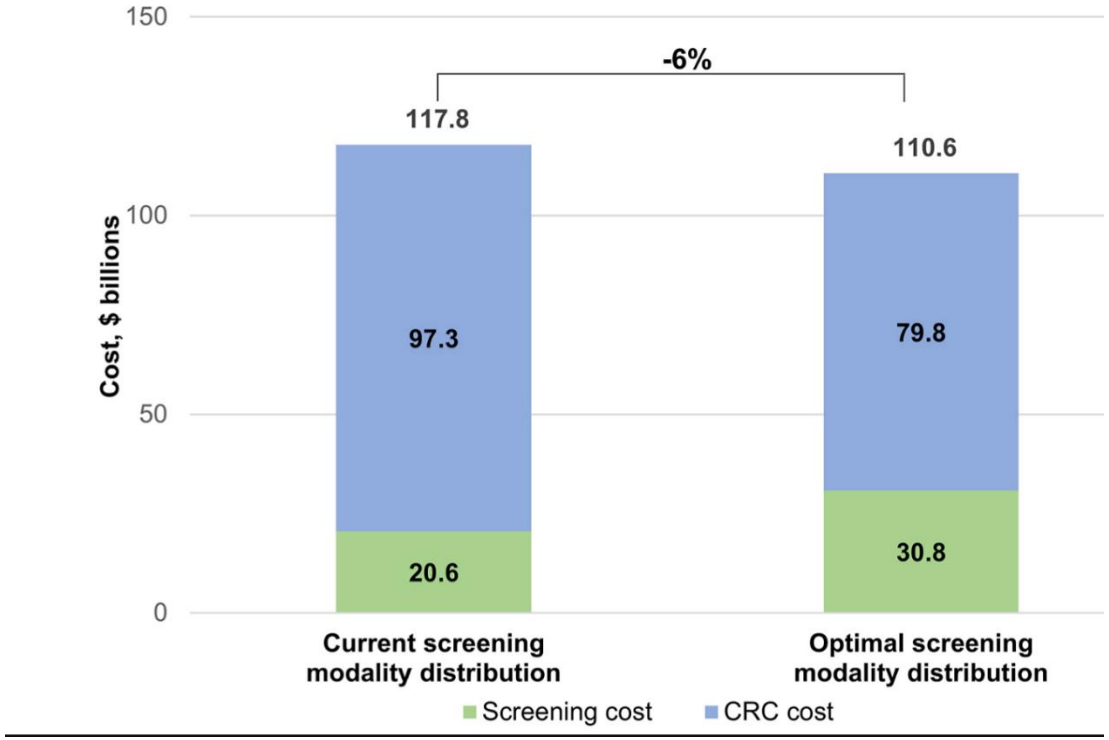
4% increase in colonoscopy revenue due to higher polypectomy rates

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Discussion: Optimizing Colonoscopy Capacity

Shifting initial screening to more stool-based testing will allow:

Lower total CRC costs, despite more spending on screening



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Conclusions

- A federal policy change that eliminated out-of-pocket costs for follow-up colonoscopy led to a prompt and substantial reduction in cost-sharing for most patients.
- Despite elimination of patient cost-sharing, follow-up colonoscopy completion rate remained unchanged – potentially due to several reasons, including limited colonoscopy capacity.
- To achieve the full clinical and economic benefits of CRC screening:
  - More stool-based CRC screening and enhanced patient navigation
  - For gastroenterologists
    - If at full capacity – prioritize follow-up colonoscopy
    - If not at full capacity – prioritize follow-up colonoscopy