The fundamental purpose of health insurance is to reduce risk against potential financial losses incurred owing to health care use. It is well established that consumers use more of both high and low value medical services when their insurance plans allow them to pay less out of pocket. This tendency means that overly generous health insurance will lead some patients to consume unnecessary care—the so-called moral hazard of health insurance coverage.1 The primary aim of cost sharing in the form of deductibles, co-insurance, and copayments is to reduce this moral hazard by shifting more of the point-of-care costs of health care use to patients.

However, there are significant unintended consequences of using moral hazard as a justification for "blunt" cost-sharing strategies, such as deductibles that necessitate high out-of-pocket costs for both nonessential and essential clinical services. In the case of emergency surgical disease or acute traumatic injuries, individuals would not be driven to overconsume surgery if their out-of-pocket expenses were eliminated. As a result, consumer cost sharing likely has minimal effect on reducing the moral hazard of unnecessary health care use for common and costly conditions, such as acute appendicitis or acute diverticulitis. Instead, the potential hazards associated with increased cost sharing for emergency surgical conditions are more complex clinical presentation and worse financial strain for patients.

The finding by Loehrer and colleagues2 of a significant association between cost sharing and patient presentation for emergency surgical conditions suggests that cost sharing is not only hazardous to patients' clinical health but also to their financial well-being. Specifically, their findings show that individuals with higher cost sharing were more likely to present with more complex acute surgical disease than those with lower cost sharing. The higher out-of-pocket spending among these patients presenting with more complex disease highlights the double burden of cost sharing for access-sensitive conditions. This double jeopardy functions to considerably reduce overall quality of life because worse disease may lead to longer recovery, a slower return to work, a higher risk of lost income, and a higher risk of unaffordable medical debt. This is an all-too-common outcome in the United States, where significant out-of-pocket spending for medical care may be catastrophic for millions of individuals. A recent analysis of the Medical Expenditures Panel Survey showed that the Affordable Care Act resulted in 2 million fewer individuals experiencing catastrophic health care spending.3 However, these gains were due to a decrease in the number of uninsured individuals and to the majority of the nearly 12 million individuals who continue to experience catastrophic health care expenditures each year having private health insurance.3

The findings by Loehrer and colleagues2 also add important nuance to our understanding of the association between insurance coverage and clinical disease complexity at presentation. Analyses of the Affordable Care Act's expansion of Medicaid eligibility have repeatedly shown that decreases in the uninsured rate were associated with more timely presentation across a variety of diseases ranging from earlier stage of cancer presentation to less complex presentation for emergency surgical and acute vascular conditions.4 In previous studies, however, it is difficult to determine whether earlier presentation is due to gains in access to ambulatory care or due to a reduction in patients' delaying care owing to an inability to pay. The finding by Loehrer and colleagues that patients with higher cost sharing are more likely to present with more complex disease suggests that affordability concerns are likely a key factor associated with more complex disease at presentation.
among individuals with inadequate financial risk protection. Historically, patients with high-deductible health plans have had fewer comorbidities, higher income, higher educational attainment, and better overall health compared with insured patients not in high-deductible plans. And yet, in the study by Loehrer and colleagues, it is precisely the patients with higher cost sharing who present to the hospital with higher rates of abscess, perforation, and shock. These findings provide supporting evidence for the concern that patients’ fear of not being able to afford care may result in delayed presentation among insured patients—even when it puts them at higher risk for worse health outcomes. This scenario is an avoidable burden.

The substantial clinical and financial hazards of high levels of consumer cost sharing for emergency surgical conditions highlight the need to incorporate a more clinically driven benefit design, specifically making the provision that services that are not subject to overuse (eg, an emergency appendectomy) are not subject to the plan deductible. Federal policy changes have recently provided health plans greater flexibility to provide predeductible coverage. A 2019 notice from the Internal Revenue Service allows high-deductible health plans to cover certain services used to manage chronic diseases—such as heart disease, asthma and diabetes—before patients meet their deductible. A growing literature supports the potential benefit of such policies. A 2020 study found that health plans that incorporated predeductible coverage of high-value cardiovascular services mitigated cost-related adverse patient outcomes. In addition, reducing the barrier to timely use of high-value services can even lead to better clinical outcomes in a cost-neutral way. Compared with longer and more costly hospital stays for more complex presentations, earlier and less complex acute illness could be treated at a lower cost to payers. The cost of predeductible coverage is actually quite low. A recent actuarial analysis estimated that providing predeductible coverage for nearly 60 common drug classes would require an increase in premium of less than 2%. A similar policy for emergency surgical care would cost substantially less.

Instead of creating financial barriers that potentially result in delayed presentation for acute illness, cost sharing could be used to deter the use of low-value services that do not benefit patients. A novel benefit design template using value-based insurance design (V-BID) principles, referred to as V-BID X, targets low-value care and increases access to high-value services without increasing premiums or deductibles. Instead of using blunt cost-sharing strategies, V-BID X plans offer a more clinically nuanced approach that incentivizes patients to use more of the health care services that improve their health and less of the services that do not. The potential value of such a design continues to gain notice as the 2021 Notice of Benefit and Payment Parameters final rule strongly recommended that federally qualified health plans incorporate V-BID X.

Unexpected surgical emergencies place a considerable clinical, emotional, and financial toll on patients and their families. Unintended consequences of cost sharing are associated with excess clinical and financial burdens that could be avoided with more nuanced benefit design. Replacing blunt cost-sharing strategies with clinically driven alternatives for common and costly acute conditions has the potential to improve clinical outcomes, reduce costs to payers, and mitigate the significant financial stress faced by millions of patients each year.
Conflict of Interest Disclosures: Dr Fendrick reported being a consultant for AbbVie, Amgen, Bayer, Centivo, Community Oncology Association, Covered California, Eli Lilly and Company, EmblemHealth, Exact Sciences, Friedman Health, GRAIL, Harvard University, Health and Wellness Innovations, Health at Scale Technologies, HealthCorum, Hygieia, Mallinckrodt, MedZed, Merck & Co, Mercer, Montana Health Cooperative, Pair Team, Penguin Pay, Phathom Pharmaceuticals, Risalto, Risk International, Sempre Health, the State of Minnesota, US Department of Defense, Virginia Center for Health Innovation, Welfth, Wildflower Health, Yale New Haven Health System, and Zansors; receiving research support from the Agency for Healthcare Research and Quality, Arnold Ventures, Boehringer Ingelheim, the Gary and Mary West Health Policy Center, the Laura and John Arnold Foundation, the National Pharmaceutical Council, Patient-Centered Outcomes Research Institute, PhRMA, Robert Wood Johnson Foundation, and the Michigan Department of Health and Human Services; and being coeditor of the American Journal of Managed Care, a member of the Medicare Evidence Development and Coverage Advisory Committee, and a partner in V-BID Health LLC. No other disclosures were reported.

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