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A Costly Colonoscopy Leads to a Delay in Diagnosis

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The Case

A 50-year-old man presented to a primary care clinic to establish care, as he had recently switched health insurance. As part of age-appropriate cancer screening, the primary care provider ordered a fecal immunochemical test (FIT) to screen for colon cancer. When FIT returned positive, the physician called the patient to inform him of the results and explained that a colonoscopy was the appropriate next step in the diagnostic process. The medical assistant contacted the patient with instructions for scheduling the colonoscopy.

Two months later, the clinic's nurse called the patient to see if he had obtained the colonoscopy. The patient reported that he was unable to schedule the colonoscopy due to cost. His health insurance required a 30% copayment for the test, which amounted to $2000 out-of-pocket. The clinic instructed the patient to contact his insurance company again. The clinic nurse followed up with the patient a few months later. Although the patient had contacted the insurance company multiple times, he was repeatedly informed that he would be responsible for 30% of the cost. The primary care provider spoke with the clinic's social worker who assessed options for financial assistance but could not find any for which the patient was eligible.

Ultimately, the primary care provider called the insurance company directly and was informed that if the indication for the colonoscopy was changed from *diagnostic* to *preventive* (for screening purposes), the test would be 100% covered (the full cost of preventive colonoscopies is covered under the Affordable Care Act). Because the colonoscopy represented the second step in the colon cancer screening process after a positive FIT, the primary care provider changed the indication for the test and the patient was eventually able to obtain the colonoscopy without any out-of-pocket cost. Because the initial communication about the out-of-pocket cost was between the patient and insurance company, the patient did not know to inform the insurance company that the colonoscopy was for screening purposes (rather than diagnostic purposes, as initially coded by the primary care physician) and that the copayment should have been waived. The colonoscopy demonstrated colon cancer; the diagnosis was made more than 6 months after the positive FIT. Luckily, the delay had no impact on his clinical outcome.

The Commentary

by Christopher Moriates, MD

In 2016, 63 million adults aged 19 to 64 (34%) reported having a cost-related problem accessing medical care in the past year.(1) These problems include having a medical issue but not visiting a doctor or clinic; not filling a prescription; or skipping a recommended test, treatment, or follow-up due to cost concerns. Although patients who lack insurance are at highest risk for these types of issues, merely having insurance coverage does not fully protect patients from cost-related access problems, as seen in this case. In fact, roughly 1 in 5 patients with health insurance report problems paying medical bills.(2)

Financial barriers represent a significant patient safety issue. As this case vividly illustrates, financial barriers to care have many downstream consequences including delayed or missed diagnoses, suboptimal disease management, and avoidable complications and hospitalizations. In a study of patients who had a recent acute myocardial infarction, those who self-reported financial barriers to health care services or medications had worse outcomes, including lower quality of life scores and more rehospitalizations.(3) In addition, cost-related medication nonadherence is a common problem that leads to more frequent emergency department visits, psychiatric admissions, nursing home placements, as well as decreased overall health status.(4-6) Moreover, when patients do seek necessary care and incur large health care bills, they directly face financial harm that can further erode personal health, if they forgo future medical, dental, or psychiatric care, or if they reduce spending on food, clothing, and other basic necessities.(2,7-9)

To help ensure that cost is not a barrier to receiving preventive care, the Affordable Care Act mandated that certain screening tests be fully covered. However, this protection can break down. For instance, rather absurdly, if an abnormality (such as a polyp or growth) is found during a colonoscopy, some insurance companies will deem the colonoscopy a diagnostic test (rather than a screening test), which means that patients may be responsible for paying their entire deductible or copay.(10) For patients on a high-deductible health plan, this change in test classification could make them responsible for the entire cost of the procedure, which may be thousands of dollars out-of-pocket. That sort of expense can prove prohibitive, as it was for the patient in this case.

This policy has led the American Cancer Society to make the following recommendation: "Before you get a screening colonoscopy, ask your insurance company how much (if anything) you should expect to pay for it. Find out if this amount could change based on what's found during the test. This can help you avoid surprise costs."(10) But doing so is not easy. Even for a well-supported preventive test performed on an elective basis, "ascertaining costs and benefits of colonoscopy [can be] more difficult than the procedure itself," as one health policy expert stated.(11) Although it is outside the scope of this commentary, it's important to keep in mind that prices for medical care in the United States are considerably higher than in other countries.(12) The colonoscopy in this case cost more than $6000, resulting in a 30% copay of $2000, whereas in other developed countries, a basic colonoscopy costs just a few hundred dollars total.(13)

Physicians have traditionally not been taught to address costs with patients.(14) As a result, physicians routinely miss opportunities to address financial barriers to care or to help patients reduce their out-of-

pocket spending.(15) This gap leaves patients on their own to navigate the complexities of their insurance coverage and the incomprehensible bills that arrive after tests or procedures. However, as this case highlights, even motivated and engaged patients may not be able to effectively advocate for themselves as they too may lack knowledge that would allow them to handle issues that arise, such as asking an insurer whether changing the "indication" for a procedure might impact the out-of-pocket cost. Physicians may (quite reasonably) argue that they do not have the time or expertise to help patients navigate the health care system in this way. In this case, when the primary care provider finally called the insurance company, he was able to quickly resolve a problem that had been ongoing for months, perhaps quite literally saving this man's life. Speaking to the company was the intervention that seemed to have the biggest impact on this patient's care. If physicians are not going to step in, then who will?

It does not always have to be the physician who directly handles insurance or cost-related issues for patients; it can be a surrogate, such as a well-informed staff member or nurse. Some clinics and many hospital systems now have financial navigators who can help patients with the type of situation outlined in this case. In a world in which financial harm represents a serious patient safety issue, physicians can no longer choose to ignore the problem and must take a proactive approach. Ultimately, we need to better understand why our health care system has evolved to be so complex that physicians, nurses, or financial navigators are often required to address the types of challenges described in this case.(8,9)

The solution will not be to pass more blame or responsibility to individual clinicians. Improving the system requires educating patients and clinicians to identify cost-related medical issues and determine how best to address them. Patient costs need to be easily accessible to physicians at the time tests are ordered, and a number of currently available tools make this possible. A nonprofit organization I work with, Costs of Care (www.costsofcare.org), has advocated for the implementation of mechanisms that make financial risks at the point-of-care more transparent and facilitate alerting physicians to potential cost barriers patients may face.(9) Costs of Care is currently working with stakeholders across the US to develop "cost conversation guides" that will identify the processes, tools, and pathways required to create a system that effectively helps patients navigate cost-related medical problems.

Health care costs are a major concern for patients in the US. They frequently contribute to serious patient harms in the form of delayed or missed diagnoses, or undertreatment through medication nonadherence. Clinicians and health care systems should address this problem systematically, just as they do with other patient safety issues of this magnitude.

Take-Home Points

- Financial barriers to care are common, even among Americans with insurance seeking preventive care. Cost-related medical access problems include having a medical issue but not visiting a doctor or clinic, not filling a prescription, or skipping a recommended test, treatment, or follow-up due to concerns related to cost.
- Financial barriers represent a patient safety issue that can lead to many downstream consequences including worse outcomes, lower quality of life scores, delayed or missed diagnoses, suboptimal disease management, and avoidable complications and hospitalizations.

- Physicians and other health care professionals can help patients navigate the health care system and overcome financial barriers to necessary care.
- Appropriately addressing financial barriers will require the efforts of individual clinicians as well as health care system leaders and policymakers. Like other patient safety issues, clinicians and health care systems should address this problem systematically.

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