

Where the cost actually lands

HS spending shows up somewhere whether or not it is approved upstream. The question is which line it lands on.



■ GUIDELINE TEXT ■ CLINICIAN SERIES ■ FROM THE HS FOUNDATION

THE DELAY, AND WHAT IT PRODUCES

TIME TO DIAGNOSIS
Seven to ten years
The window from a patient's first presentation to a confirmed diagnosis.

FIRST CONTACT
More than 80% not dermatology
Patients first present to primary care, OB/GYN, urgent care or the emergency department.

WHAT LATE DIAGNOSIS COSTS
More disease, fewer options
Patients diagnosed late present with more severe disease, more comorbidities, and a narrower set of treatment options than patients identified early.

These effects compound existing barriers to HS care, including diagnostic delay averaging 7 to 10 years and limited access to specialty dermatology.

JOINT AAD AND HSF GUIDELINES, DISCUSSION

The delay figure is the guideline's own. The first-contact and late-diagnosis figures are from Steven Daveluy, MD and Brent Hazelett, HS Foundation, writing on HowToTreatHS.com.

WHAT THE GUIDELINES SAY ABOUT WEIGHING COST

Effective treatments may reduce long-term economic burdens for payers and the healthcare system, and direct costs of HS therapies should be weighed against indirect costs of uncontrolled disease, including wound care, lost productivity, and disability assistance.

JOINT AAD AND HSF GUIDELINES, COST

THREE ARGUMENTS FROM HS FOUNDATION LEADERSHIP

Without a clinical anchor, coverage decisions for HS therapies have been made against an evidence base that has shifted considerably in a short period. The downstream costs of delayed and inconsistent treatment, including hospitalizations, surgical interventions, and lost productivity, are absorbed across the system, often by the same payers whose upstream coverage decisions shaped the trajectory of care.

HAZELETT, CHIEF EXECUTIVE OFFICER

Conditions like obesity, metabolic disease, diabetes, and cardiovascular disease are not academic categories. When they go unrecognized and unmitigated, they lead to serious chronic health problems, disability, higher utilization of care, and in some cases increased mortality. Managing HS well is upstream of a set of conditions that carry significant systemic cost. Payers looking at the direct cost of HS therapies in isolation are looking at only part of the ledger.

GARG, SECRETARY

ONE CASE WHERE THE MATH IS ON THE RECORD

There are therapies with strong evidence in HS that are not adequately covered because they read to a payer as cosmetic. Laser hair removal is the clearest example. A course of laser hair removal for an HS patient costs roughly \$4,800. A year of biologic therapy costs approximately \$40,000. If the laser treatment prevents the need for a biologic, the savings compound over the life of the patient.

DAVELUY, BOARD, HS FOUNDATION

FROM THE HS FOUNDATION

Laser hair removal carries a conditional recommendation in favor in the guidelines, supported by a randomized controlled trial. The Foundation's position is that a cosmetic exclusion applied to a guideline-recommended HS therapy is a classification problem rather than an evidence problem, and that it is one of the clearer places where a policy change would reduce spending rather than add to it.

COSTS THE GUIDELINES ATTACH TO UNCONTROLLED DISEASE

WHERE IT SHOWS UP	WHAT THE GUIDELINES REPORT
Pain	Undertreated pain results in preventable patient suffering, emergency department visits, unsafe self-care practices, and disengagement from treatment. 61% of patients report moderate to severe pain.
Comorbidity	Interdisciplinary management should screen for and address the medical and psychiatric comorbidities that contribute to HS burden, and treatment selection should consider them.
Surgery	Recurrence after incision and drainage is higher than after excision or deroofting, and the procedure failed to improve HS in 66% of cases in the reported evidence.

FROM THE HS FOUNDATION

Each of these is a utilization line. The guidelines do not present them as cost arguments, and they read as one when the question is where HS spending goes.

WHAT THIS ADDS UP TO

FROM THE HS FOUNDATION

HS is progressive. The spending attached to it does not disappear when a therapy is denied; it moves to emergency visits, surgical interventions, hospitalizations, wound care and disability, and to the comorbid conditions that go unaddressed while the disease advances. The Foundation's argument is not that cost should be ignored. It is that the direct cost of a therapy is one line in a ledger that a coverage decision writes the rest of.

About this piece. Prepared by the Hidradenitis Suppurativa Foundation for health plan and coverage audiences. Passages marked as guideline text are reproduced from the joint American Academy of Dermatology and Hidradenitis Suppurativa Foundation clinical guidelines for the management of hidradenitis suppurativa, with AAD copyright acknowledgment. Passages marked as clinician series are drawn from articles published on HowToTreatHS.com and attributed to their authors. Passages marked From the HS Foundation are the Foundation's own analysis and advocacy position, not guideline text. The guidelines state that they should not be interpreted as setting a standard of care, and nothing here is a coverage determination or a substitute for clinical judgment. Observations are drawn from Brent Hazelett, "HS Care Has Outgrown Its Standards," Steven Daveluy, MD, "The First Doctor an HS Patient Sees Is Usually Not a Dermatologist," and Amit Garg, MD, "HS is a Systemic Disease," all published on HowToTreatHS.com. Draft built on a pre-publication manuscript. Not for distribution until the guidelines publish. October 2026.