Addressing the Financial Burden of Cancer Treatment
From Copay to Can’t Pay

Veena Shankaran, MD, MS
Division of Public Health Sciences, Fred Hutchinson Cancer Research Center, Seattle; and University of Washington School of Medicine, Seattle.

Scott Ramsey, MD, PhD
Division of Public Health Sciences, Fred Hutchinson Cancer Research Center, Seattle; and University of Washington School of Medicine, Seattle.

Patients with cancer spend a substantial amount of money on health care services and are at higher risk for financial hardship, including personal bankruptcy, than the general population. Evidence that this so-called financial toxicity has a negative impact on clinical outcomes is emerging. High out-of-pocket spending on cancer treatment has been shown in recent studies to be associated with decreased treatment adherence and poorer quality of life. The growing intersection between the financial and clinical aspects of cancer care represents an emerging challenge to the oncology community. In this article, we present 5 strategies to address the financial burden of cancer treatment.

Restructure Cost Sharing and Insurance Design

Insurers use cost sharing as a way of increasing patients’ “skin in the game,” with the logic that patients would use health care resources more judiciously when faced with higher out-of-pocket costs. As employer-based insurance plans have seen annual increases in deductibles, copayments, and use of multitiered formularies (in which specialty cancer drugs are typically associated with the highest cost sharing), patients with cancer are paying for a greater portion of their care yet lack the opportunity (because of the necessary duration of treatment) to deescalate cancer treatment services without compromising their care. Increased cost sharing for patients with cancer may therefore have the unintended consequences of greater financial hardship, decreased treatment adherence, and possibly poorer clinical outcomes.

Many argue that addressing the high cost of cancer drugs through broad policy changes such as allowing Medicare to negotiate drug prices would decrease out-of-pocket payments and financial hardship for patients with cancer. We agree that cancer drug pricing must be addressed but also believe that implementing changes in insurance plan structure would offer a more immediate solution to the growing financial burden of cancer care. Annual out-of-pocket cost limits under the Affordable Care Act may provide some protection against unfettered spending for high-intensity care. Indeed, there are many barriers to discussing cancer treatment costs, including physicians’ lack of time or expertise and patients’ fear of receiving substandard care. This is particularly true given that patients often associate newer and more care with better care; such a perception might motivate patients to choose such tests on the basis of a physician’s willingness to prescribe them, even if these services are not covered by insurance or are associated with high copayments. It is the job of the oncology community to protect patients from unnecessary interventions and their associated out-of-pocket costs. In this context, the well-known exhortation that physicians must “do no harm” should encompass financial harm.

Create Tools to Gauge Patients’ Risk for Financial Hardship

Several studies have demonstrated that patients who are at risk for financial hardship do not routinely bring their concerns to the attention of their physicians. Indeed, there are many barriers to discussing cancer treatment costs, including physicians’ lack of time or expertise and patients’ fear of receiving substandard treatment recommendations on the basis of their perceived inability to pay. The first step in addressing these barriers is to make assessment of “financial health” a routine part of clinical assessment, a key objective of an upcoming cooperative group study (SWOG S1417). Routine financial assessments may reduce the reluctance associated with discussing personal finances, provide an opportunity to identify patients at greatest risk for financial hardship in real time, and prompt earlier use of patient assistance programs through foundations or pharmaceutical companies (which have traditionally been underused).
Improve Cost Transparency
Lack of transparency about what cancer care costs and large variation in what patients and insurers are charged for cancer care services are contributing to the increasing cost of cancer care in the United States. We argue that price transparency (and specifically transparency about potential out-of-pocket costs) at the point of care could also help decrease the financial burden for patients. Providing out-of-pocket cost information for all possible treatment options could help steer patients toward effective regimens that will cost them less. For example, a patient with colon cancer might prefer the convenience of oral capecitabine but ultimately choose the equally effective infusional fluorouracil if their out-of-pocket cost share is much lower. Upfront out-of-pocket cost information may also help patients budget other spending to accommodate cancer treatment costs. Including out-of-pocket cost information in the discussions with advanced cancer patients about third- and fourth-line treatment might also reduce requests for treatments that have low likelihood of improving survival or quality of life but high likelihood for causing financial distress for the patient and his or her surviving family members. Development of user-friendly programs or applications that can quickly generate out-of-pocket cost estimates for prescriptions, diagnostic tests, and other services could enhance patient-physician conversations about treatment alternatives, risks, benefits, and financial assistance resources.

Provide Financial Counseling as a Part of Cancer Care
Despite good intentions, oncologists may not be able to address all of their patients’ financial concerns. Patients need to understand what a cancer diagnosis and the related costs mean for their employment, income, assets, future earnings, and family’s financial security. These are complicated issues that typically fall outside the domain of the health care profession. For example, money management, budget planning, and employment benefits can be explained best by individuals in the financial sector. Developing internal capacity for financial counseling within the clinical setting or partnership with community organizations that can help improve patients’ financial literacy would fill an important gap. As an example, our group is partnering with a nonprofit community-based organization that provides free financial counseling services to individuals throughout western Washington (Consumer Education and Training Services [CENTS], http://www.centsprogram.org) to develop a financial literacy and counseling program for patients with newly diagnosed cancer. We believe that this program will help patients take a more proactive role in managing their finances during and after cancer treatment.

Conclusions
The oncology community can implement several strategies to lessen the financial distress that complicates the lives of patients with cancer and their families. High-quality, comprehensive cancer care should involve attention to the financial complications of treatment.

ARTICLE INFORMATION
Published Online: April 9, 2015.
Conflict of Interest Disclosures: None reported.
REFERENCES