SOCIETY OF BEHAVIORAL MEDICINE

POSITION STATEMENT:

Society of Behavioral Medicine Supports Increased Knowledge about and Efforts to Address the Financial Burden Associated with Cancer Treatment

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RECOMMENDATIONS

- Create a Medicare cap for cancer treatment costs irrespective of treatment setting.
- Transition to clinical pathway payment programs.
- Limit non-ACA compliant short-term health plans.
- Expand employer support of cancer treatment.

THE COST OF CANCER CARE

Millions of individuals and their families are struggling with both the treatment related and out of pocket economic repercussions of cancer, an effect increasingly referred to as "financial toxicity."

In 2014, the Agency for Healthcare Research and Quality (AHRQ) estimated the total U.S. expenditures for cancer at $87.8 billion dollars with patient out-of-pocket (OOP) costs accounting for $3.9 billion dollars. [1] (°HRQ, 2014). These figures do not take into account indirect costs such as from lost earnings. As a result, financial toxicity can extend well beyond the active treatment phase. Among 9.5 million U.S. adults ages 50 years and older diagnosed with cancer (2000-2012), 42.2% had depleted their assets at 2 years and 38.2% were financially insolvent at four years. [2] Bankruptcy rates are 2.65 times higher in cancer survivors than matched controls.[3] A full 70 percent of Americans want to have conversations about the costs of care with their health care providers, but only 28 percent report doing so. Delaying or deferring these conversations can have major consequences for patients. According to polling conducted for the Robert Wood Johnson Foundation (RWJF) by Avalere Health, almost 20 percent of patients report forgoing care when they have questions about costs".[4] A critical element to achieve this is to have accurate cost information, including insurance coverage policies. Specifically, while patients and their families look to their physicians to help them better understand the cost implication of their treatment choices, physicians who are willing to undertake this challenging task need to have accessible and comprehensible cost information to facilitate the discussion.[5]

THE IMPACT OF FINANCIAL TOXICITY

Financial toxicity can have direct impacts on clinical outcomes and patient experiences. For example, cancer survivors who had filed for bankruptcy had a higher risk for mortality than those who had not.[6] Families often make substantial financial and other behavioral adjustments to economize following a cancer diagnosis, which can have a negative impact on the patient and other family members. These behaviors often include: (1) non-adherence to medications; (2) opting out of more beneficial therapies due to cost considerations; (3) cutting back on necessities; (4) depletion of retirement savings; and (5) the accumulation of credit card debt. Cancer survivors who experience higher financial toxicity also report greater levels of pain, have higher rates of depression, report greater levels of anxiety, and poorer overall quality of life.[7,8] These survivors also report higher symptom burden and are more likely to reduce their level of employment or stop working altogether.[9]

RECOMMENDATIONS FOR POLICY MAKERS

Prioritize cancer financial toxicity at the state and national Level. Create a financial toxicity in cancer task force or work through the Senate Cancer Coalition charged to (1)

investigate how a cancer diagnosis impacts individual and community financial health based on key demographic differences (including age, insurance status, employment status, socioeconomic status, minority status, and health care setting); (2) apply these findings toward meaningful local, state and national reform policies. Specific areas for task force investigation and possible recommendations include:

1. **Create a Medicare cap for cancer treatment costs irrespective of treatment setting.** Medicare currently has no out-of-pocket maximum for cancer treatment. Annual out-of-pocket (OOP) expenditures for a new cancer diagnoses can range from $2,116 to $8,115 (1).10 These costs are highest for those without supplemental insurance, consuming 25-63% of annual income. Further, 12-46% of OOP spending is linked to inpatient hospitalizations. Recommendations to reduce cost burden:
   i. Following actuarial analysis, Medicare should implement a catastrophic coverage threshold for all Medicare beneficiaries, setting a cap on annual OOP expenses. Such a threshold currently exists in Medicare Part D plans; we recommend extending this concept across all Medicare parts. While this shifts costs to Medicare, self-financing and budget-neutral options have been proposed to sustain this change (2). Apart from Medicare, younger adults may also be at greater risk for financial toxicity than those over 65 due to factors such as the protective effects of Medicare and other factors such as having greater wealth accumulation.
   ii. Analyze differences in inpatient and outpatient reimbursement for cancer treatment and associated out-of-pocket costs. Re-align reimbursement rates to promote outpatient care, as medically appropriate, to reduce both cost to individuals and payers. A reduction of inpatient hospitalizations is merited but one has to be sensitive to determining what actually represents avoidable hospitalizations among cancer patients. Research is merited if there is no data available.
2. **Transition to clinical pathway payment programs.** Use evidence from the ESRD Prospective Payment System to model how payments for drugs, laboratory services and support services can be bundled and applied to other high-cost heterogeneous disease processes. Consideration should also be made to pre-existing conditions protection that might get repealed as patients may have to switch insurance plans as they change employment and the pre-existing protection could be crucial.
3. **Limit non-ACA compliant short-term health plans.** A recent proposed legislative rule extends and increases access to short-term health plans from three to twelve months. These plans are not required to meet all ACA requirements, including the essential health benefits. This rule has the potential to discriminate against cancer patients. Their structure requires higher cost-sharing and lower coverage, not suitable for this population. If these plans expand in the market and healthy-individuals shift to their pools, a health insurance death spiral will be created for sicker individuals who cannot leave their plans and are faced with even higher premiums.
4. **Expand employer support of cancer treatment.** Endorse paid leave through FMLA. Use state-level experience and analysis from CA, NY, RI, and NJ to expand current legislation to require partial to full payment under the Family and Medical Leave Act (FMLA). While national discourse and growing support around this issue focuses on parental leave, cancer patients would benefit significantly from this twelve weeks of financial support, providing both short- and potentially long-term protection from some aspects of financial toxicity. Support for rehabilitation or other programs to allow the patients to return to work also merits consideration.

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ENDORSEMENTS