Wisconsin Cancer Collaborative

REDUCING THE BURDEN TOGETHER

The Financial Toxicity of Cancer: Causes, Effects, and Potential Solutions

Who We Are

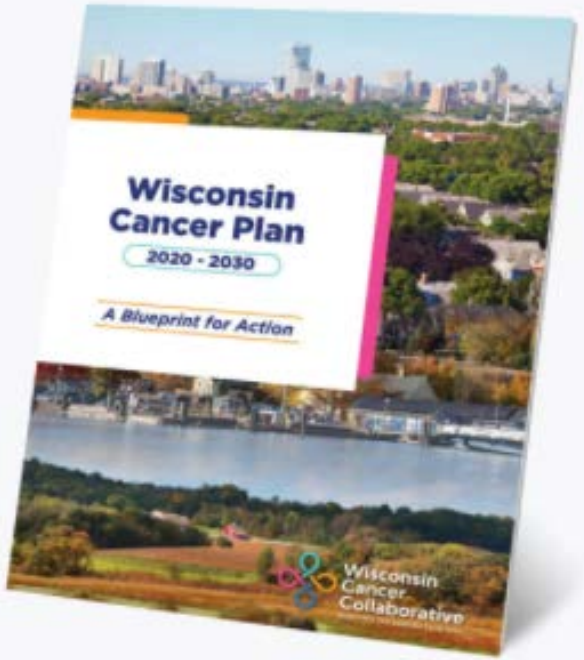
The **Wisconsin Cancer Collaborative** is a statewide coalition of **140 organizations** working together to reduce the burden of cancer **for everyone** in Wisconsin.

Join Us!

www.wicancer.org/join/

Wisconsin Cancer Collaborative

Wisconsin Cancer Plan 2020-2030



www.wicancer.org

It's time to renew your membership with the Wisconsin Cancer Collaborative!

Every two years, we ask our members to renew their membership with the Wisconsin Cancer Collaborative, by reviewing and updating their Member Profile. This keeps your membership active, helps us improve our outreach and evaluation efforts, and helps our members network and connect with partners.

This year, we are asking ALL members -- regardless of when you joined -- to review your Member Profile and **add three new items**:

- Your Wisconsin Cancer Plan priorities
- The counties you serve
- The populations you serve

Wisconsin Cancer Collaborative

View detailed instructions here: www.wicancer.org/2021renewal/

Agenda

- Welcome
- Intro to Financial Toxicity by Alexandria Cull Weatherer, MPH & Amy Johnson, JD
- Presentation by Dr. Chino
- Questions

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www.wicancer.org

Issue Brief:
The Financial Toxicity of Cancer

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Issue Brief

Wisconsin Cancer Collaborative
REDUCING THE BURDEN TOGETHER

VOLUME 16, NUMBER 2 APRIL 2021

The Financial Toxicity of Cancer

Alexandria Cull Weatherer, MPH, and Amy Johnson, JD, Wisconsin Cancer Collaborative

Introduction

More than 294,300 people in Wisconsin are currently living with a cancer diagnosis.[1] Cancer is a challenging and complex disease, and it is one of the most expensive medical conditions a person can experience.[2]

In 2020, cancer care cost the United States an estimated 173 billion dollars.[3] The average cost of treating the most common cancers is on the rise, largely because of expensive advances in technology and treatments such as targeted therapies.[3] Currently, the average patient cost of initial cancer treatment can range from $5,047 for melanoma to $108,168 for brain cancer.[4] Patients incur additional and often increasing costs throughout their lifetime and at the end of life, regardless of cancer type.[4]

There is a growing recognition that the high costs of cancer care can create severe financial distress for patients and their loved ones.[2] This financial distress can negatively affect the physical, psychological, and behavioral well-being of patients, survivors, and families, and in some cases can lead to refusal of care or non-adherence to recommended treatments.[2]

This phenomenon is known as financial toxicity.

KEY POINTS

- Cancer is one of the **most expensive** illnesses a person can have.
- Cancer can cause **severe financial distress** for patients, survivors, caregivers, and families.
- Financial difficulties **can last for many years** after diagnosis.
- Increasing access to **high-quality and affordable health insurance** is an important way to reduce cancer's financial burden.

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What is Financial Toxicity? ? What Does it Mean?

Alexandria Cull Weatherer, MPH
Outreach Specialist, Wisconsin Cancer Collaborative

Financial Toxicity

"A term used to describe problems a patient has related to the cost of medical care. Not having health insurance or having a lot of costs for medical care not covered by health insurance can cause financial problems and may lead to debt and bankruptcy. Financial toxicity can also affect a patient's quality of life and access to medical care."

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Cancer is one of the most expensive illnesses a person can have.

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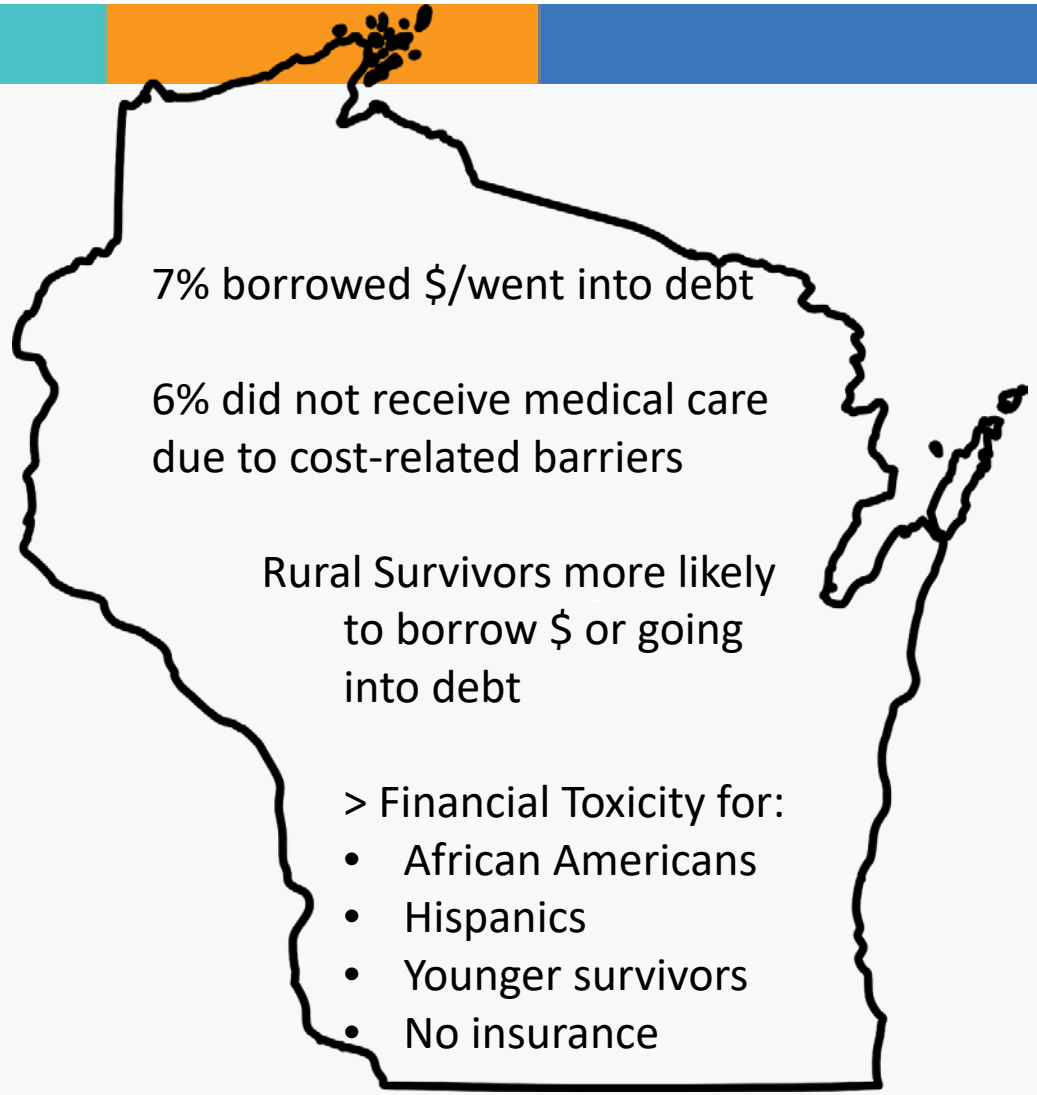
Mariotto AB et al. 2011

Financial Toxicity in Wisconsin – SHOW Survey



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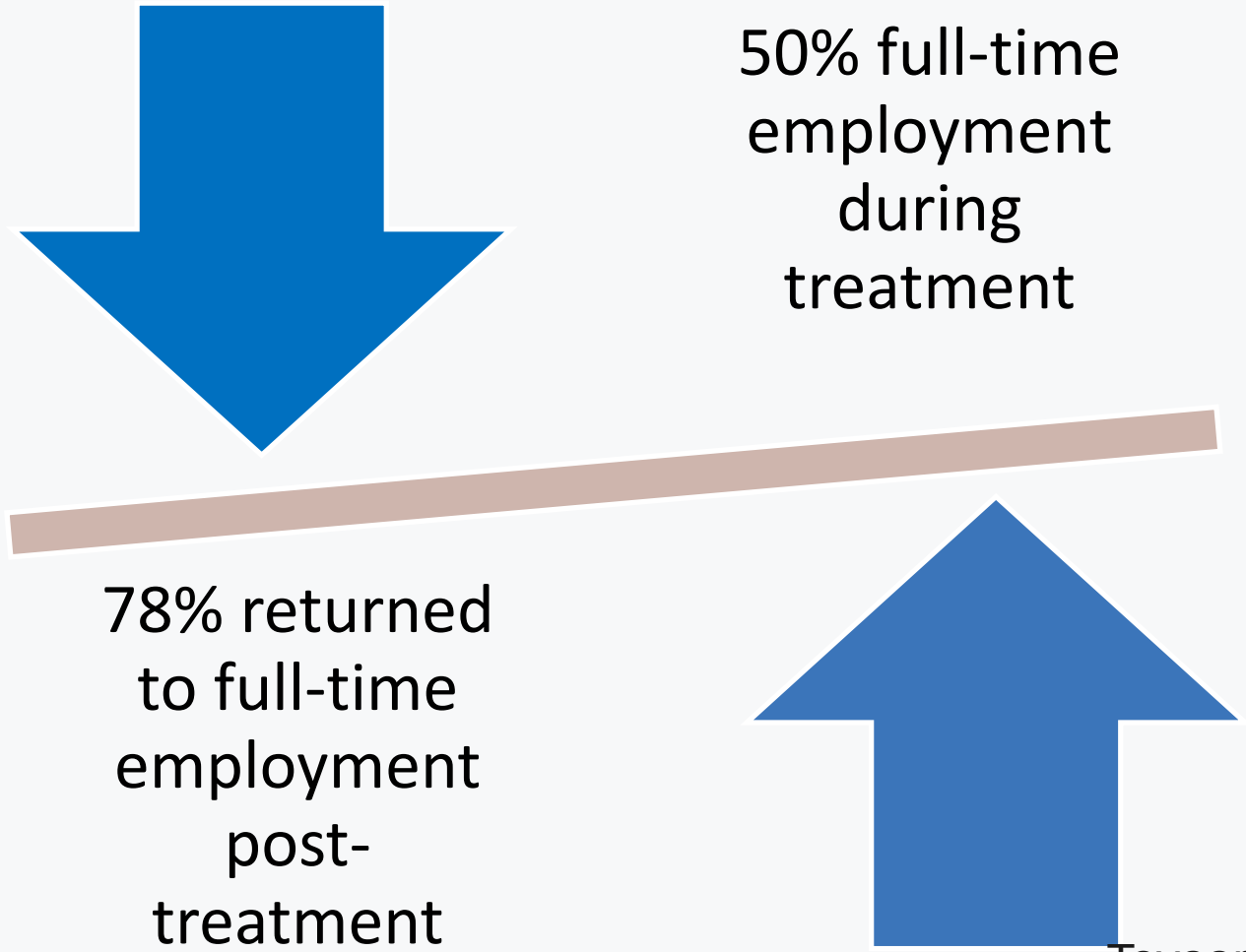
Fredrick CM et al. 2020

Financial Toxicity in Wisconsin- WON study

88% full-time employment pre-diagnosis

50% full-time employment during treatment

78% returned to full-time employment post-treatment



Tevaarwerk AJ et al. 2021

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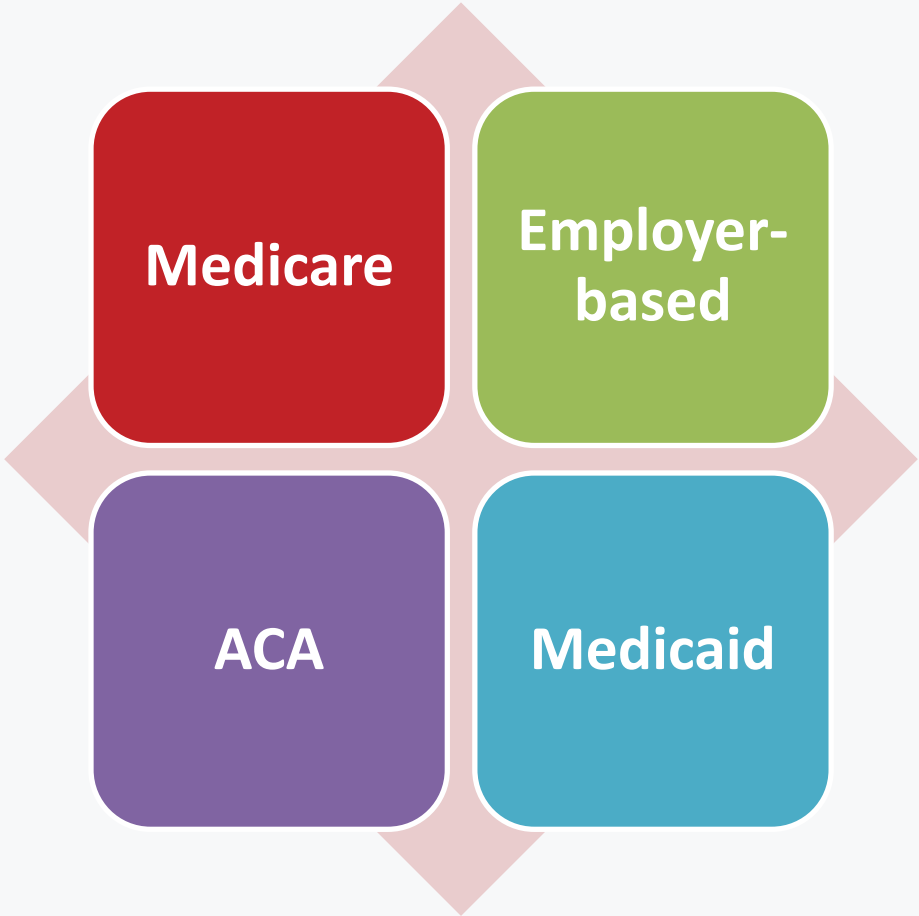
Policy Considerations

Amy Johnson, JD

Policy Coordinator, Wisconsin Caner Collaborative

Financial Toxicity Insurance Landscape



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Challenges in the Workplace

Family Medical Leave Act (FMLA)

Americans with Disabilities Act (ADA)

Social Security (SSDI & SSI)

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Dr. Chino, MD

Radiation Oncologist, Memorial Sloan Kettering Cancer Center

Wisconsin Cancer Collaborative

The Financial Toxicity of Cancer: Causes, Effects, and Potential Solutions

Memorial Sloan Kettering Cancer Center

Fumiko Chino, MD

August 12, 2021

No disclosures.

Financial Toxicity

"A new name for a growing problem"

ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

NATIONAL CANCER OPINION SURVEY
2018 KEY FINDINGS

Cancer's Financial and Access Challenges

Just as many Americans are worried about **cancer's financial impact as about dying of cancer**

61% of **caregivers** say they or a loved one have taken at least one onerous step to **pay for cancer care** including:

- 35% dipped into **savings account**
- 23% worked **extra hours**
- 14% postponed **retirement**
- 13% took on an **additional job**

43% of **cancer patients** experienced barriers to accessing the best possible care due to **health insurance coverage**

n=4,016

ASCO 2018 National Cancer Opinion Survey

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Full Disclosure — Out-of-Pocket Costs as Side Effects

Peter A. Ubel, M.D., Amy P. Abernethy, M.D., Ph.D., and S. Yousuf Zafar, M.D., M.H.S.

5 References 80 Citing Articles

October 17, 2013
N Engl J Med 2013; 369:1484-1486
DOI: 10.1056/NEJMp1306826

Audio Interview

Interview with Dr. Peter Ubel on a new focus on informing patients about the likely out-of-pocket costs of care. (7:30)

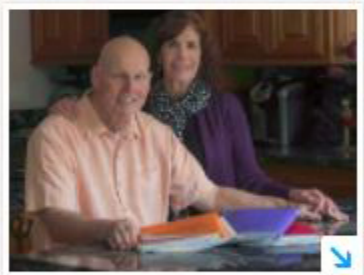
Download

FEW PHYSICIANS WOULD prescribe treatments to their patients without first discussing important side effects. When a chemotherapy regimen prolongs survival, for example, but also causes serious side effects such as immunosuppression or hair loss, physicians are typically thorough about informing patients about those effects, allowing them to decide whether the benefits outweigh the risks. Nevertheless, many patients in the United States experience substantial harm from medical interventions whose risks have not been fully discussed. The undisclosed toxicity? High cost, which can cause considerable financial strain.

USA TODAY TMI

Soaring costs force cancer patients to skip drugs, treatment

Liz Szabo, Kaiser Health News Published 2:51 p.m. ET March 15, 2017



(Photo: Robert Durell for Kaiser Health News)

John Krahne received alarming news from his doctor last December. His brain tumors were stable, but his lung tumors had grown noticeably larger.

The doctor recommended a drug called Alecensa, which sells for more than $159,000 a year. Medicare would charge Krahne a $3,200 co-pay in December, then another $3,200 in January, as a new year of coverage kicked in.

For the first time since being diagnosed 10 years ago, Krahne, now 65, decided to delay filling his prescription, hoping that his cancer wouldn't take advantage of the lapse and wreak further havoc on his body.

DISCLOSURES:
Well…

Widowed Early, A Cancer Doctor Writes About The Harm Of Medical Debt

August 10, 2017 · 11:45 AM ET
Heard on All Things Considered

ALISON KODJAK

Andrew Ladd and Fumiko Chino at their wedding in 2006, after his cancer diagnosis. Ladd died the following year, leaving behind hundreds of thousands of dollars in medical debt.

Courtesy of Dr. Fumiko Chino

Ten years ago, Fumiko Chino was the art director at a television production company in Houston, engaged to be married to a young Ph.D. candidate.

What is Financial Toxicity?

Financial Toxicity:

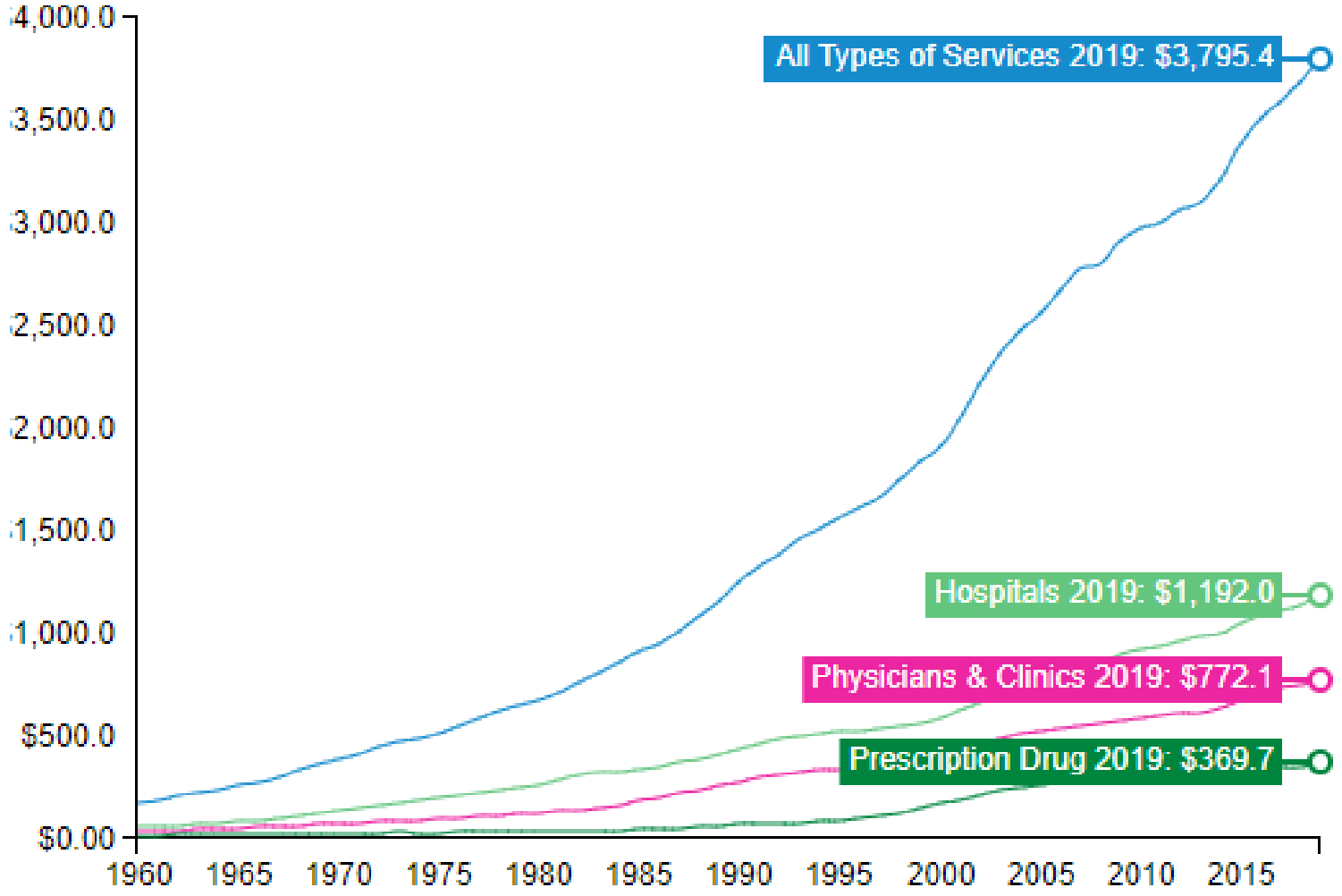
Problems a patient has related to the cost of medical care. Cancer patients are more likely to have financial toxicity than people without cancer.

-National Cancer Institute

"Even with health insurance, the high costs of cancer care are leaving some vulnerable American families adrift in debt. […] Out-of-pocket costs can have real effects on quality of life and quality of care."

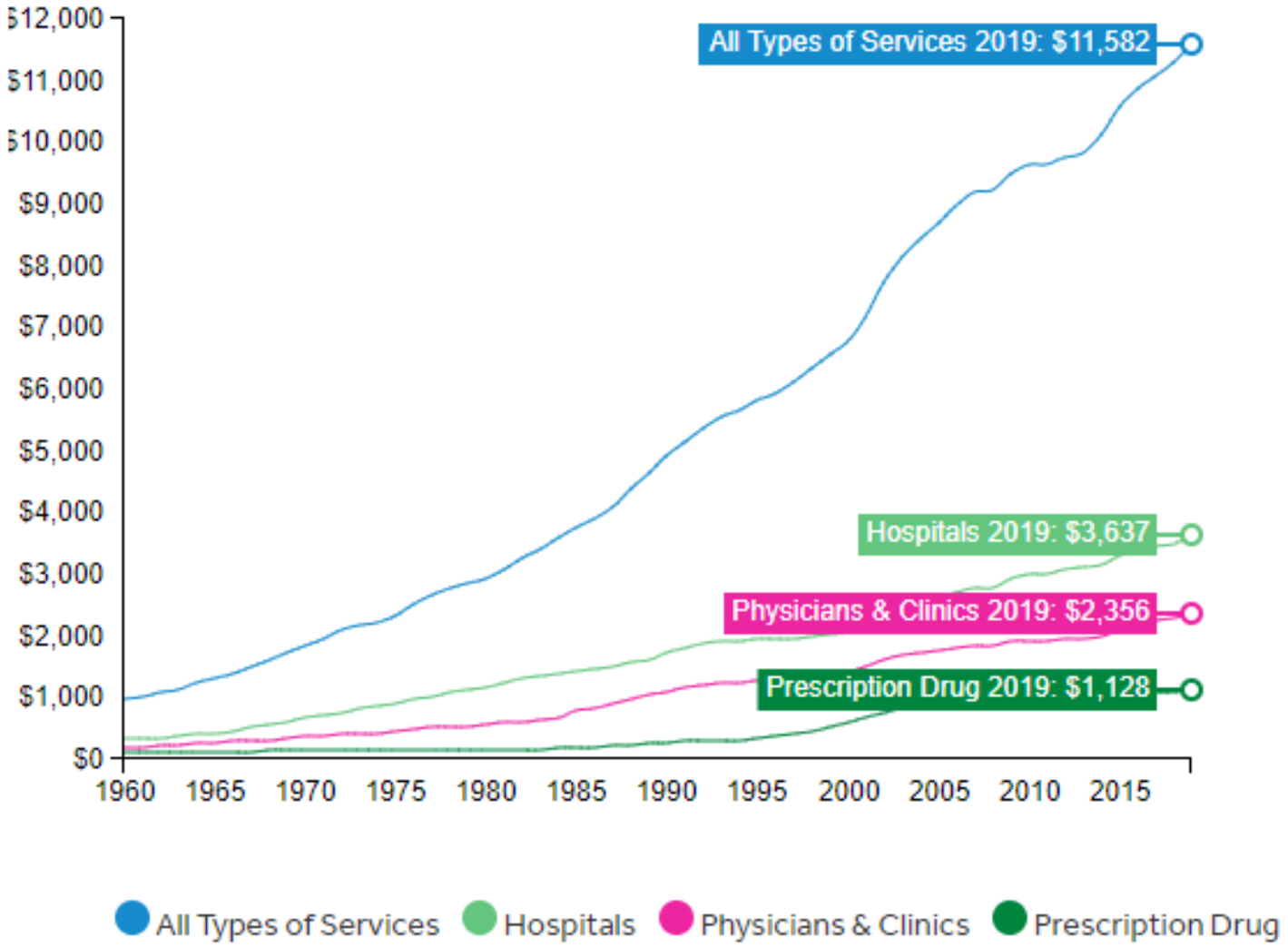
-Chino, *JAMA Oncology*, 2018

Rising Health Care Costs (Billions)



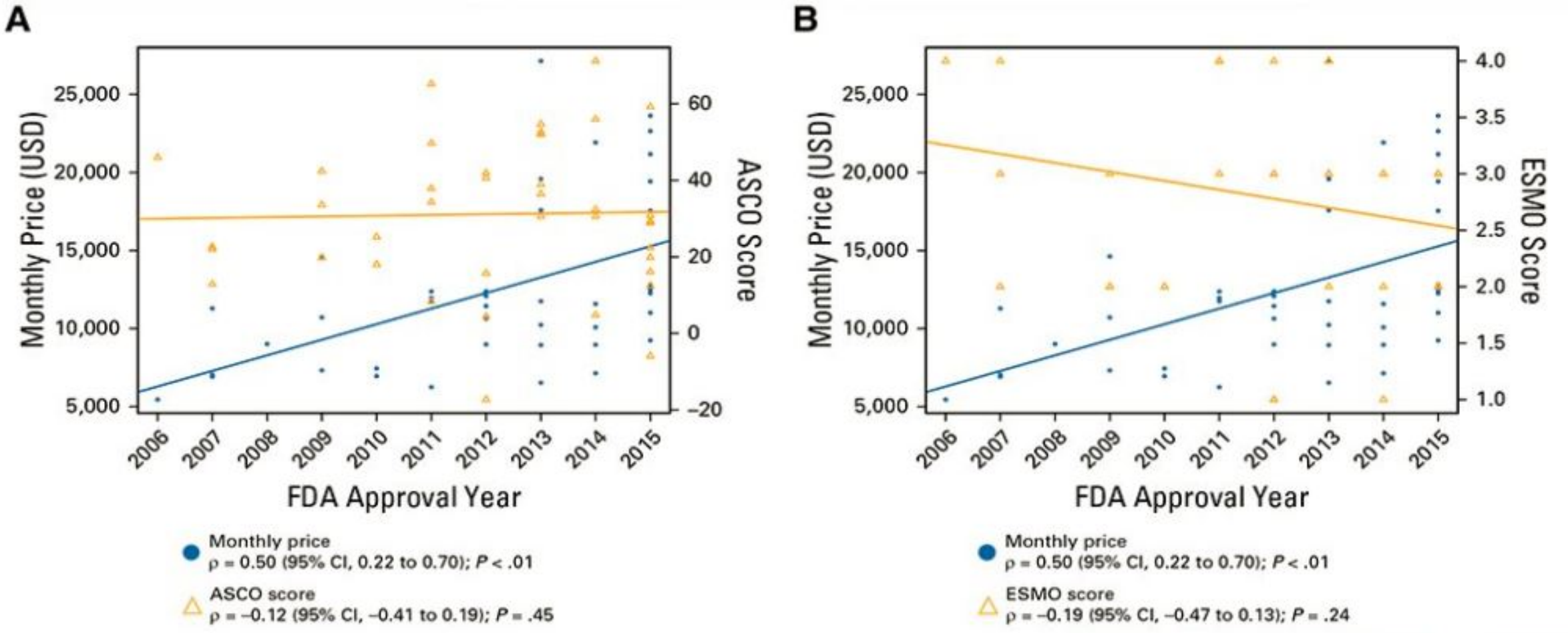
Kaiser
U.S. HEALTH EXPENDITURES
1960 - 2019

Rising Health Care Costs: per capita (inflation adjusted)



Kaiser
U.S. HEALTH
EXPENDITURES
1960 - 2019

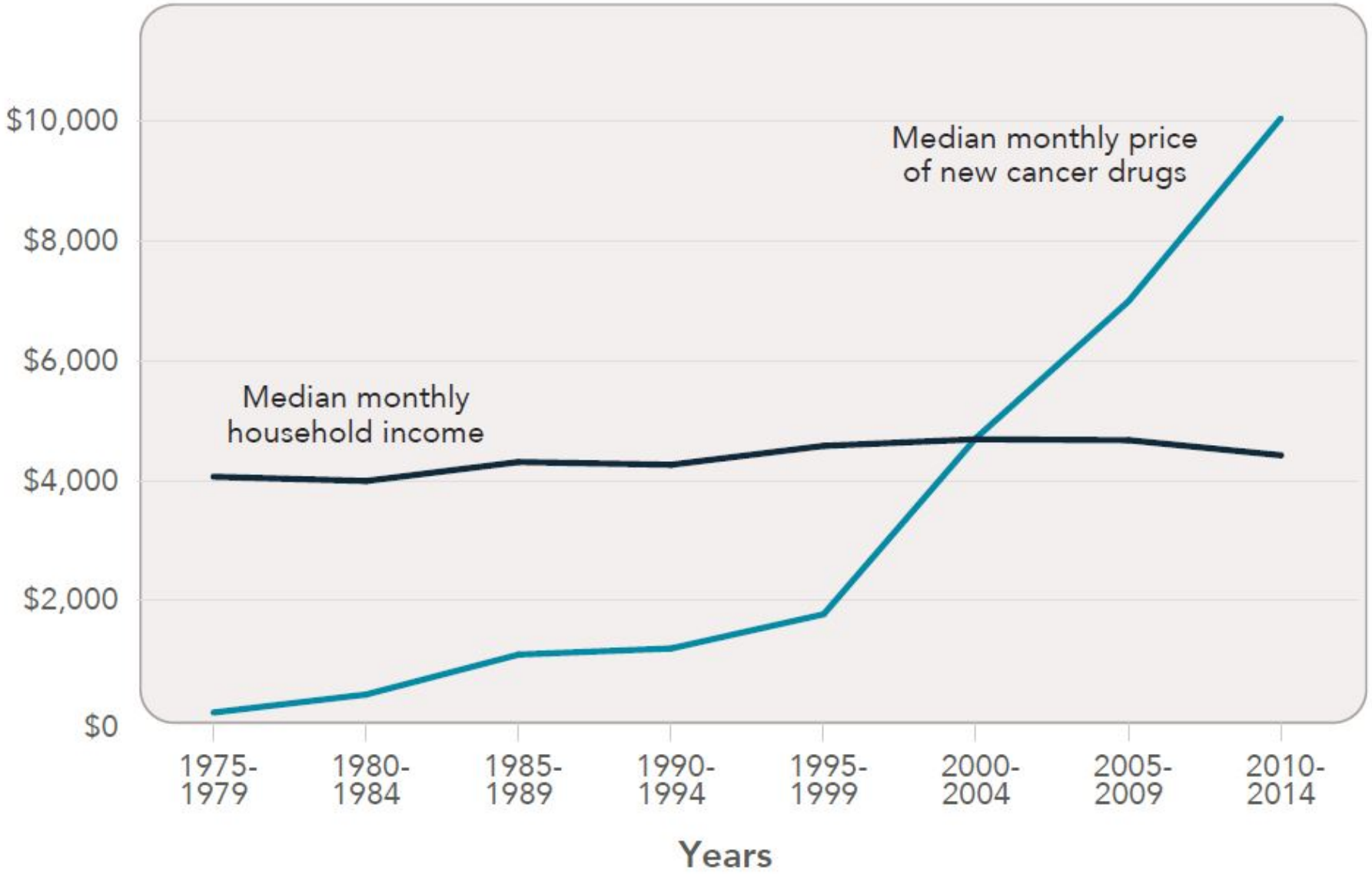
Anticancer drug costs are rising



but **clinical benefit is stagnant** (or decreasing)

Saluja, *JOP*, 2018

Increased Cost Sharing: costs vs income



Prasad, *Nat Rev Clin Oncol*, 2017

Increased Cost Sharing: underinsurance

16% of patients reported high or overwhleming financial distress

Realtive cost of care with high distress was 31% vs 10% for those with no, low or average financial distress

Patients are paying almost 1/3 of their income in healthcare related costs

More than 1/3 of insured cancer patients faced out-of-pocket costs greater than expected

Unexpected treatments costs lowers willingness to pay for care

Chino, *JAMA Oncology*, 2017

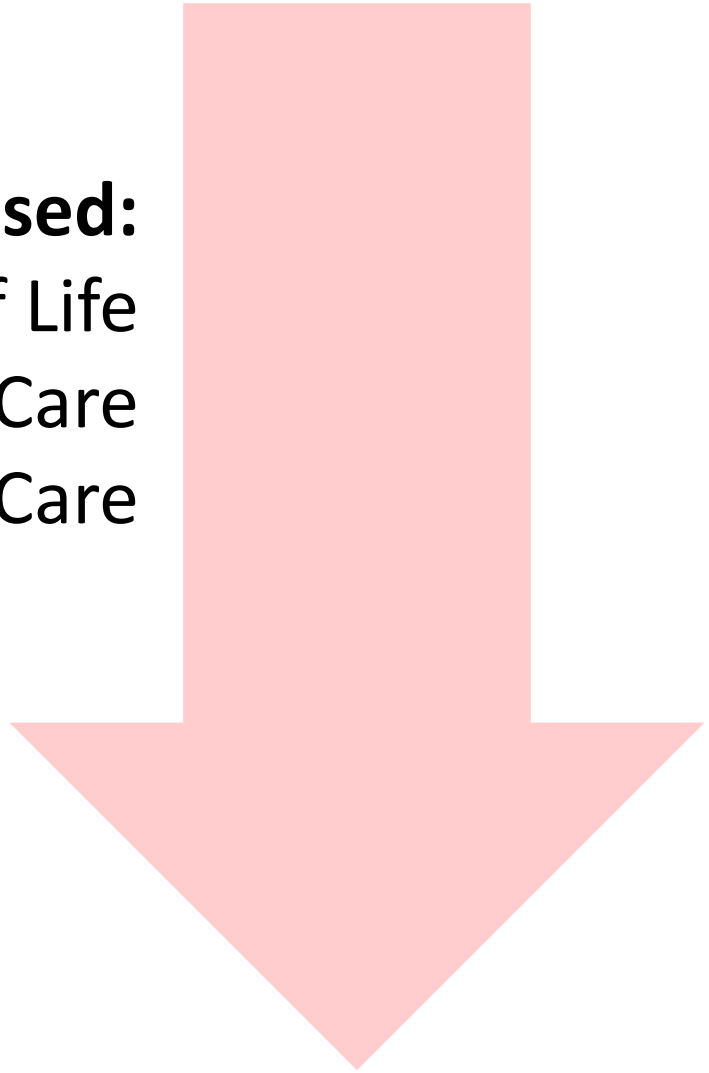
Why does Financial Toxicity Matter?

Decreased:

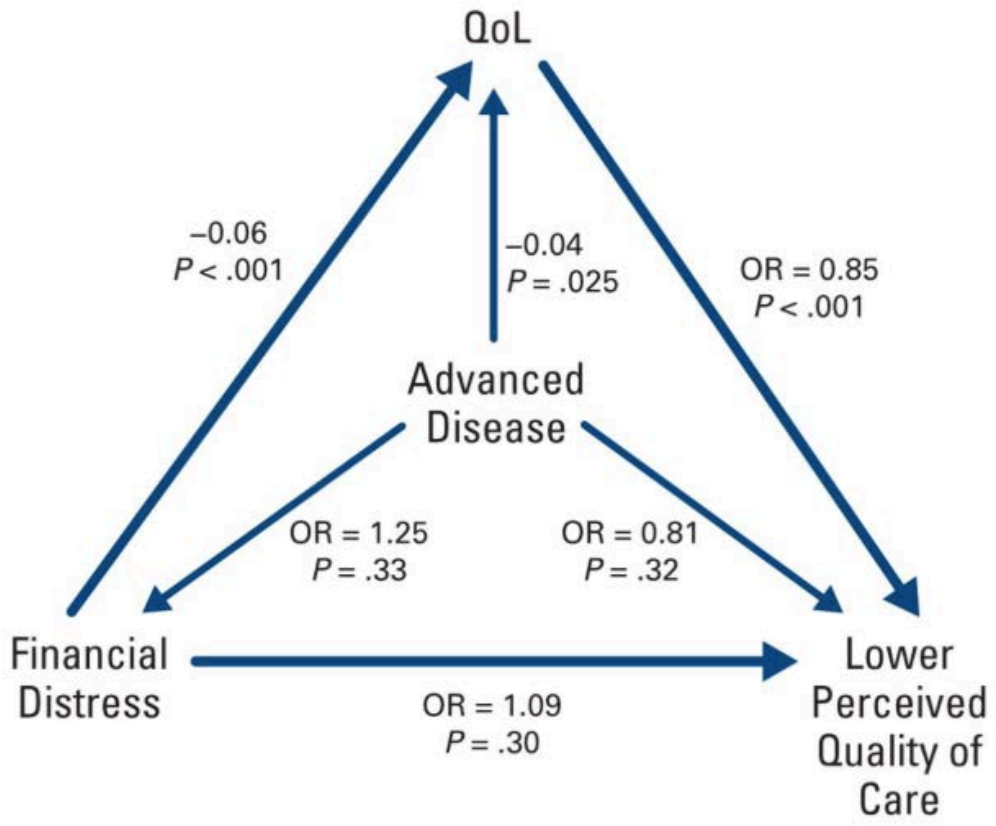
Quality of Life

Satisfaction with Care

Quality of Care



Decreased Quality of Life

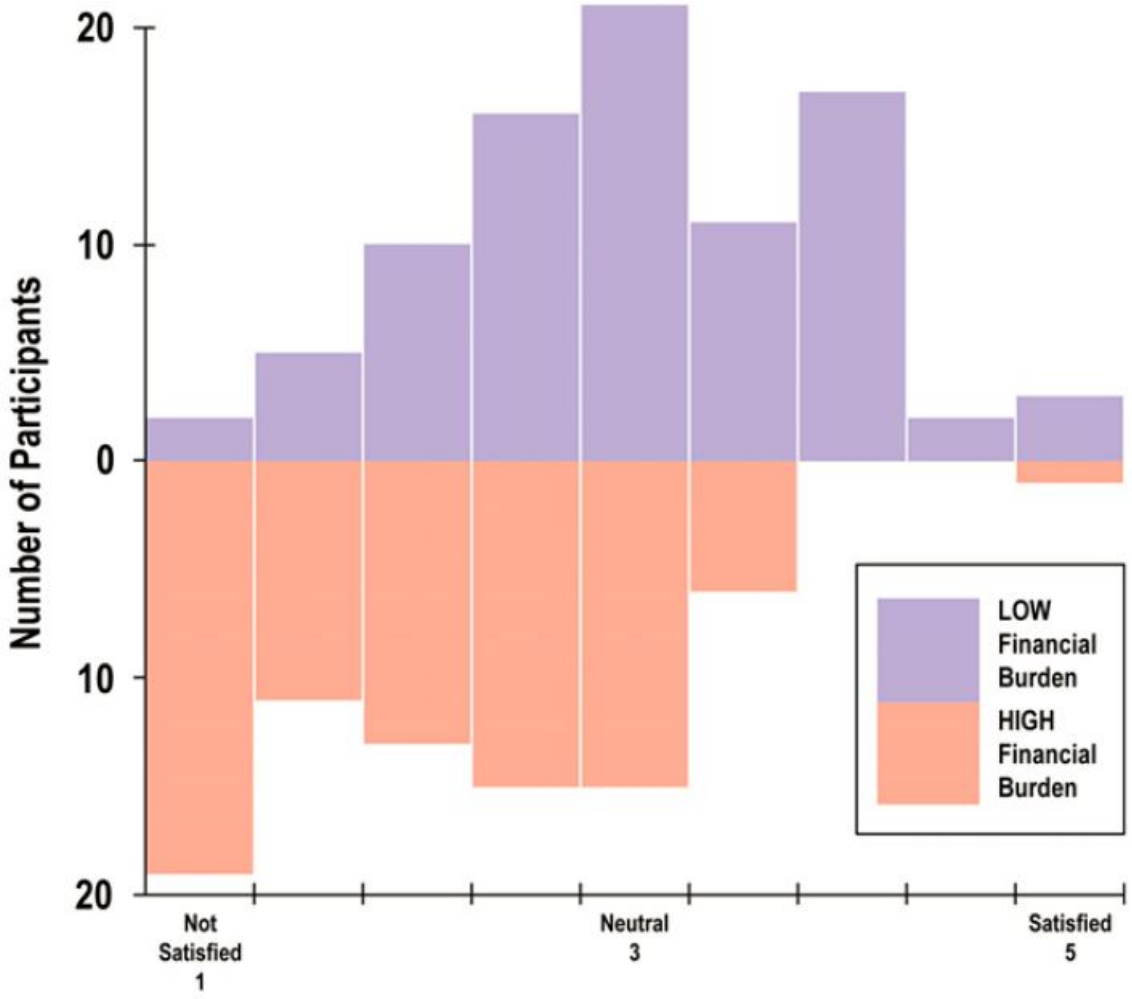


Patients with “a lot” of financial problems were much less likely to rate their QOL as good (OR 0.24)

Greater financial toxicity was associated with higher patient-reported anxiety, fatigue, and social functioning and lower patient-reported physical functioning

Zafar, *JOP* 2015
Fenn, *JOP* 2014
Ver Hoeve, *Supportive Care in Cancer*, 2021

Decreased Satisfaction with Care



High financial burden decreases:

- General satisfaction with health care
  (coefficient: -0.29; lower to upper bound: -0.57 to -0.01; p=0.04)
- Satisfaction with technical quality of care
  (coefficient: -0.26; lower to upper bound: -0.48 to -0.03; p=0.03)
- Satisfaction with financial aspects of care
  (coefficient: −0.62; lower to upper bound: −.94 to −.31; p < .01)

Chino, *Oncologist* 2014

Decreased Quality of Care

Medication nonadherence = 27%

This included:

- 22% who didn't fill Rx due to cost
- 14% who skipped doses to make meds last longer
- 5% who skipped, took less, or didn't fill their chemotherapy prescriptions

Bestiva…Chino, et al *JOP* 2013

Why does Financial Toxicity Matter?

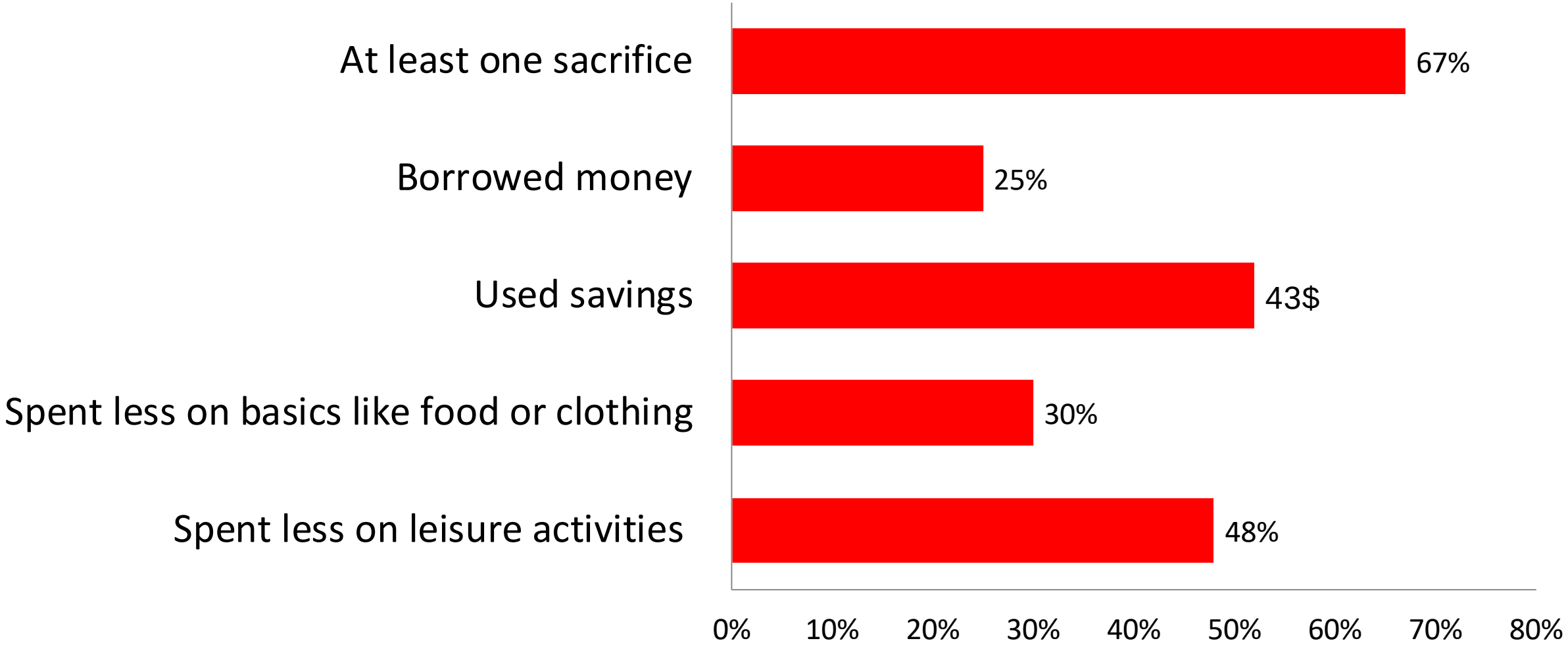
Increased:

Personal/Family Burden

Risk of Bankruptcy

Risk of Mortality

Increased Personal/Family Burden



Chino, *JOP*, 2018

Risk of Homelessness

1 in 20* Black or Latina women with early stage breast cancer **lost their home** due to the financial impact of their cancer treatment

*4.7% of black, 6.0% of Latinas

Jagsi, *Cancer,* 2018

Increased Risk of Bankruptcy

In a study of 197,840 citizens,
4,408 had declared bankruptcy

2.65x

Risk of bankruptcy with Cancer Diagnosis

Ramsey, *Health Affairs* 2013

Increased Risk of Death

In a study of 7,570 matched patients, bankruptcy after a cancer diagnosis was associated with

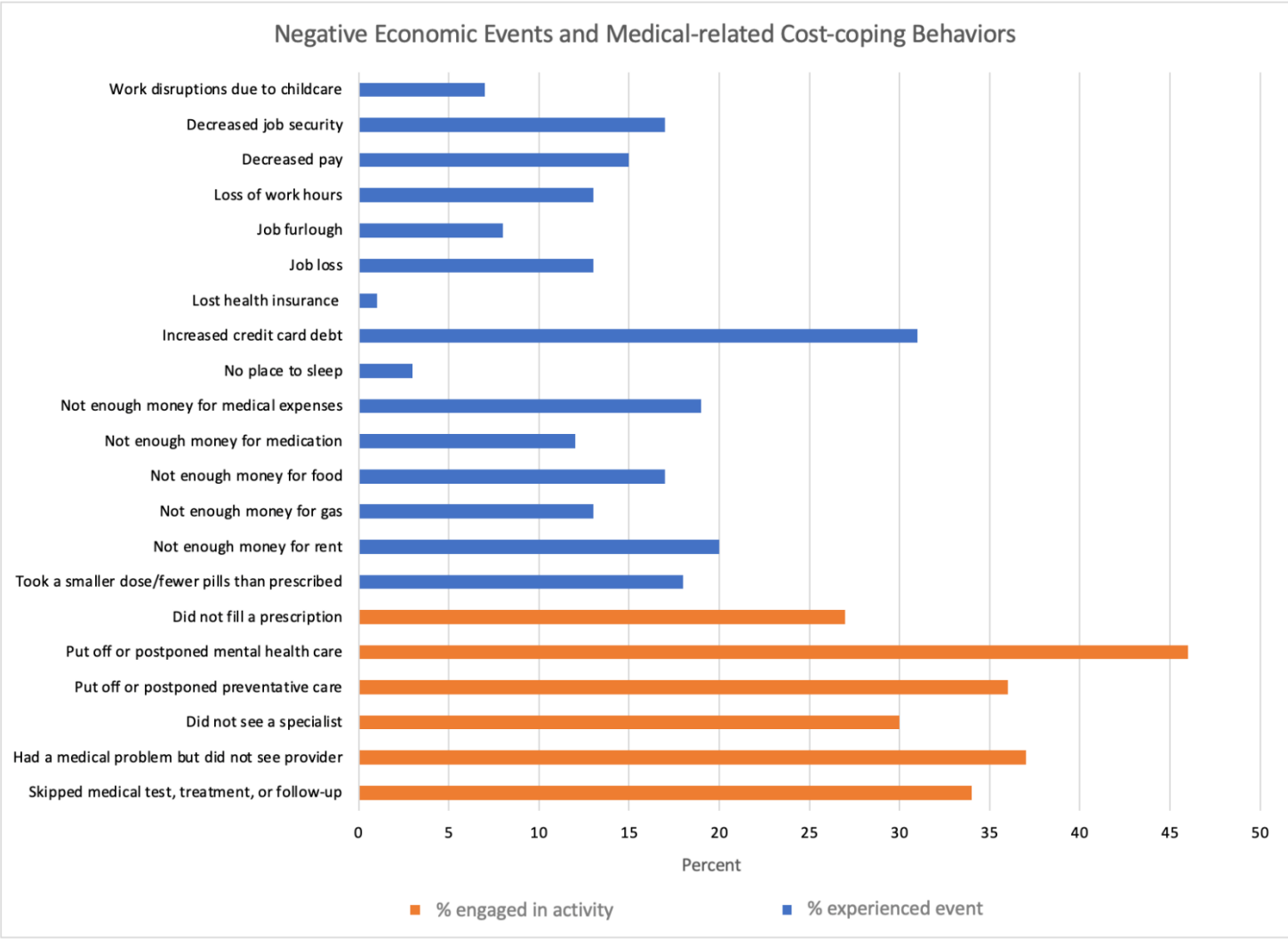
79%

increased mortality risk

HR 1.79 (1.64-1.96)

Ramsey, *JCO*, 2016

Increased Burden due to COVID-19



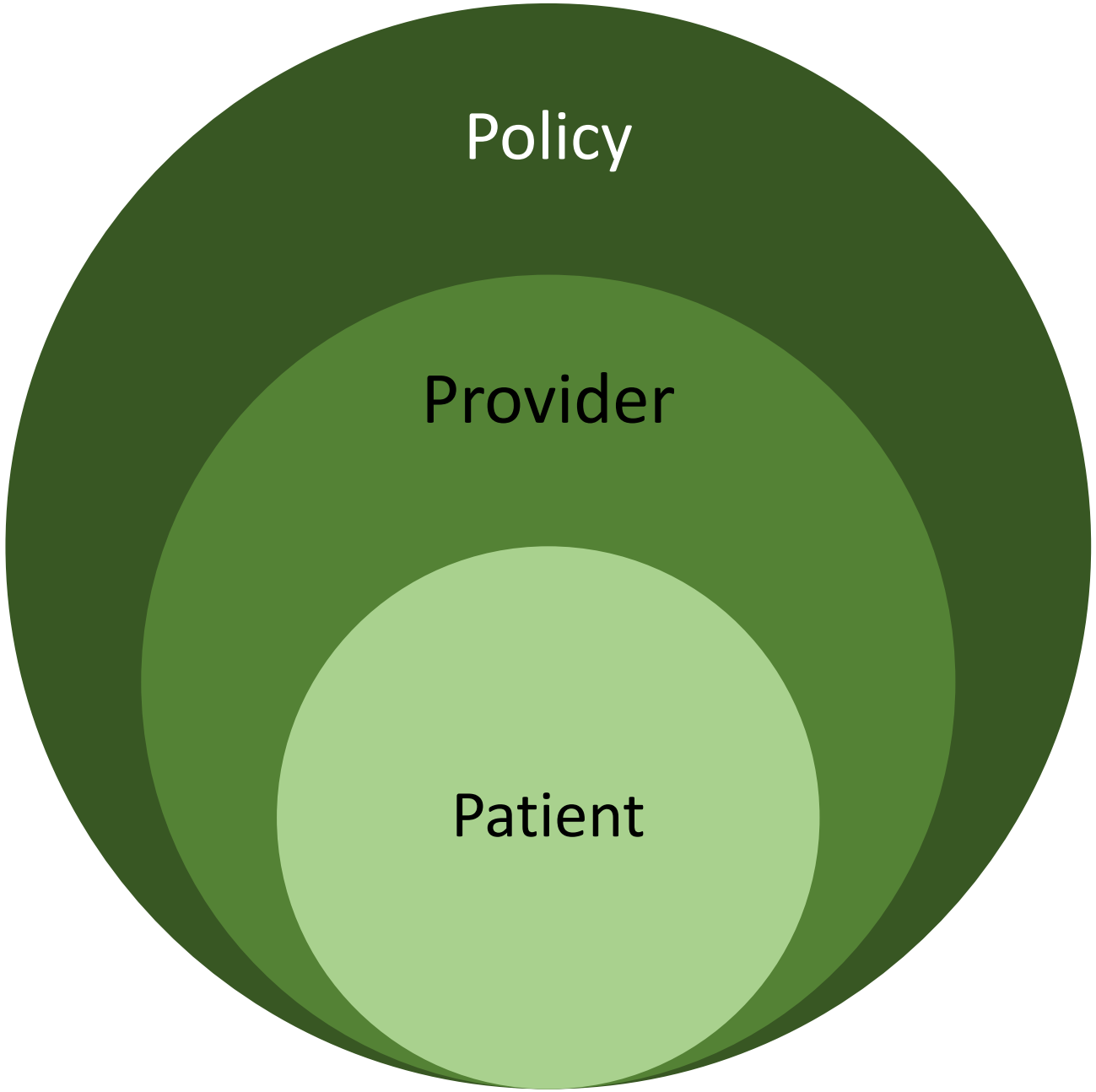
2/3 AYA survivors experienced a negative economic event **as a result of the COVID-19 pandemic:**

- 19% lost their job or were furloughed
- 17% experienced decreased job security
- 21% did not have enough money to pay rent/mortgage

- *37% had a medical problem but couldn't afford to see a doctor*

Thom… Chino, *Cancer*, 2021
n=212

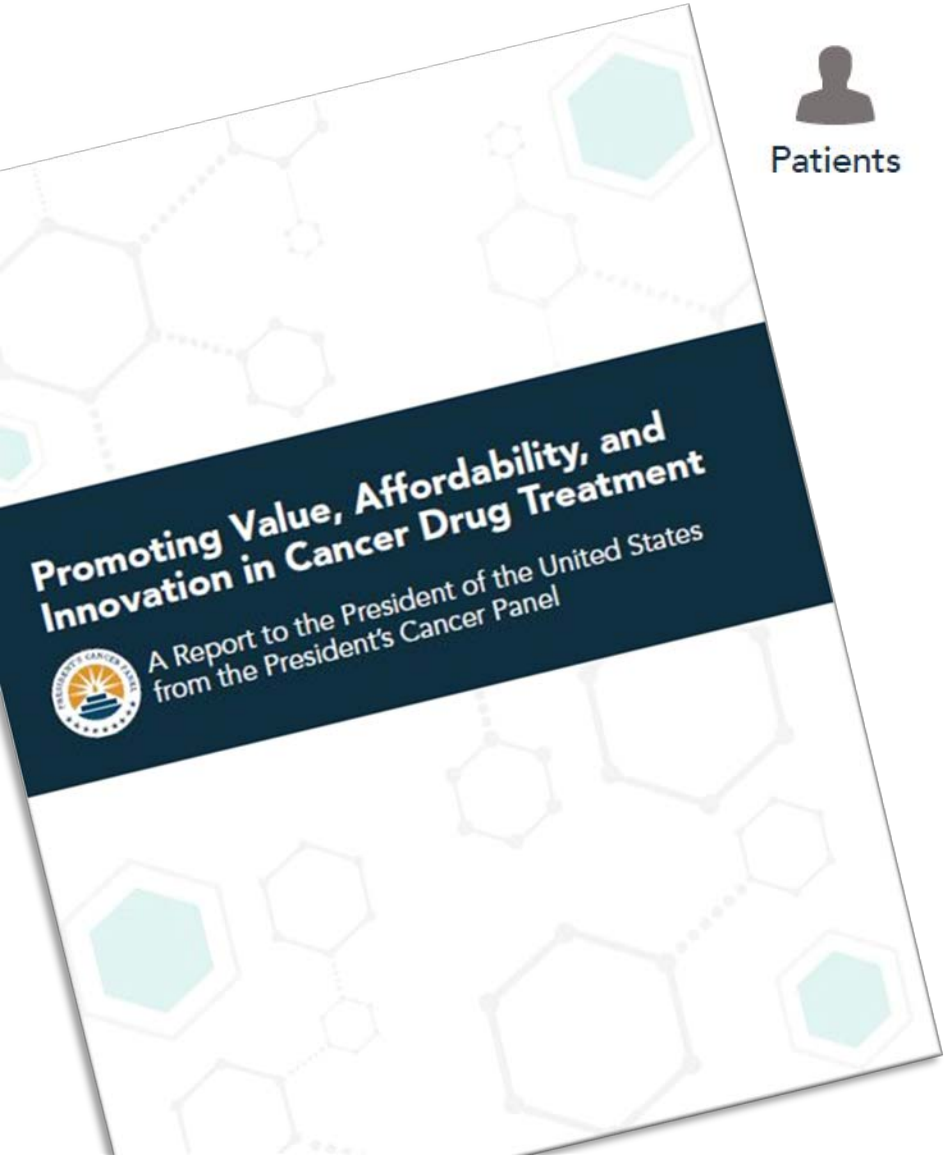
Where do we go from here?



Solutions exist within systemic, interpersonal, and individual frameworks

Zafar, *JNCI* 2015

Policy Guidelines

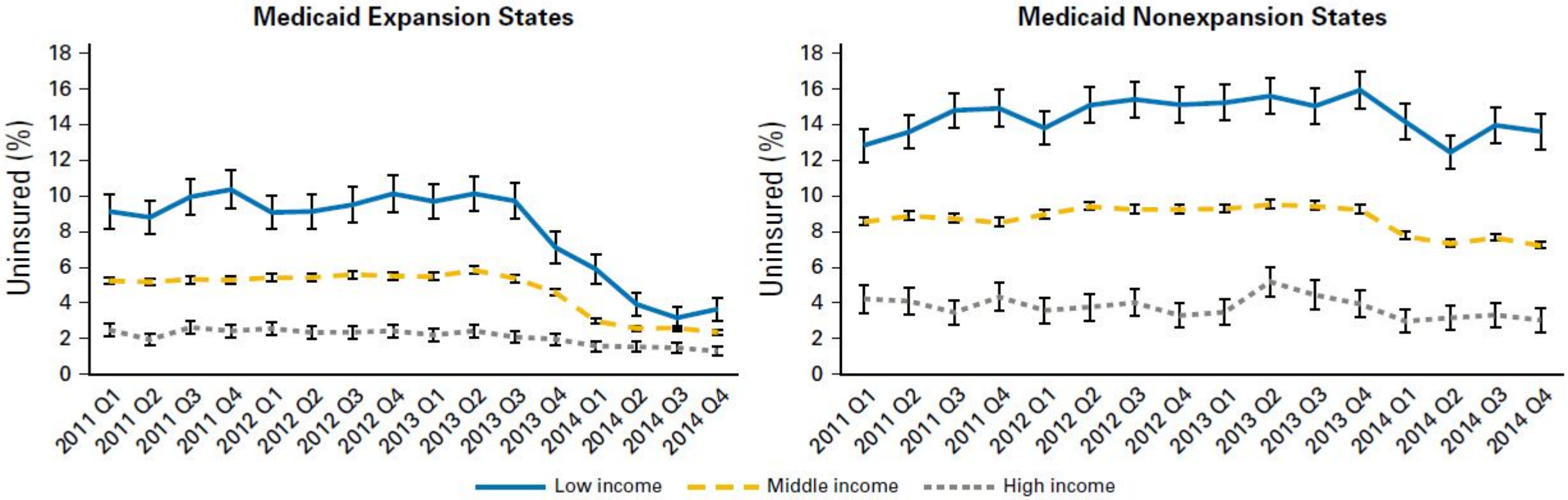


Patients | Providers | Healthcare Systems | Payers | Biopharmaceutical Companies | Researchers | Society

"A broad set of stakeholders must contribute to efforts to align cancer drug prices with their value, ensure affordable access to cancer drugs for all patients, and promote future innovation in cancer drug development."

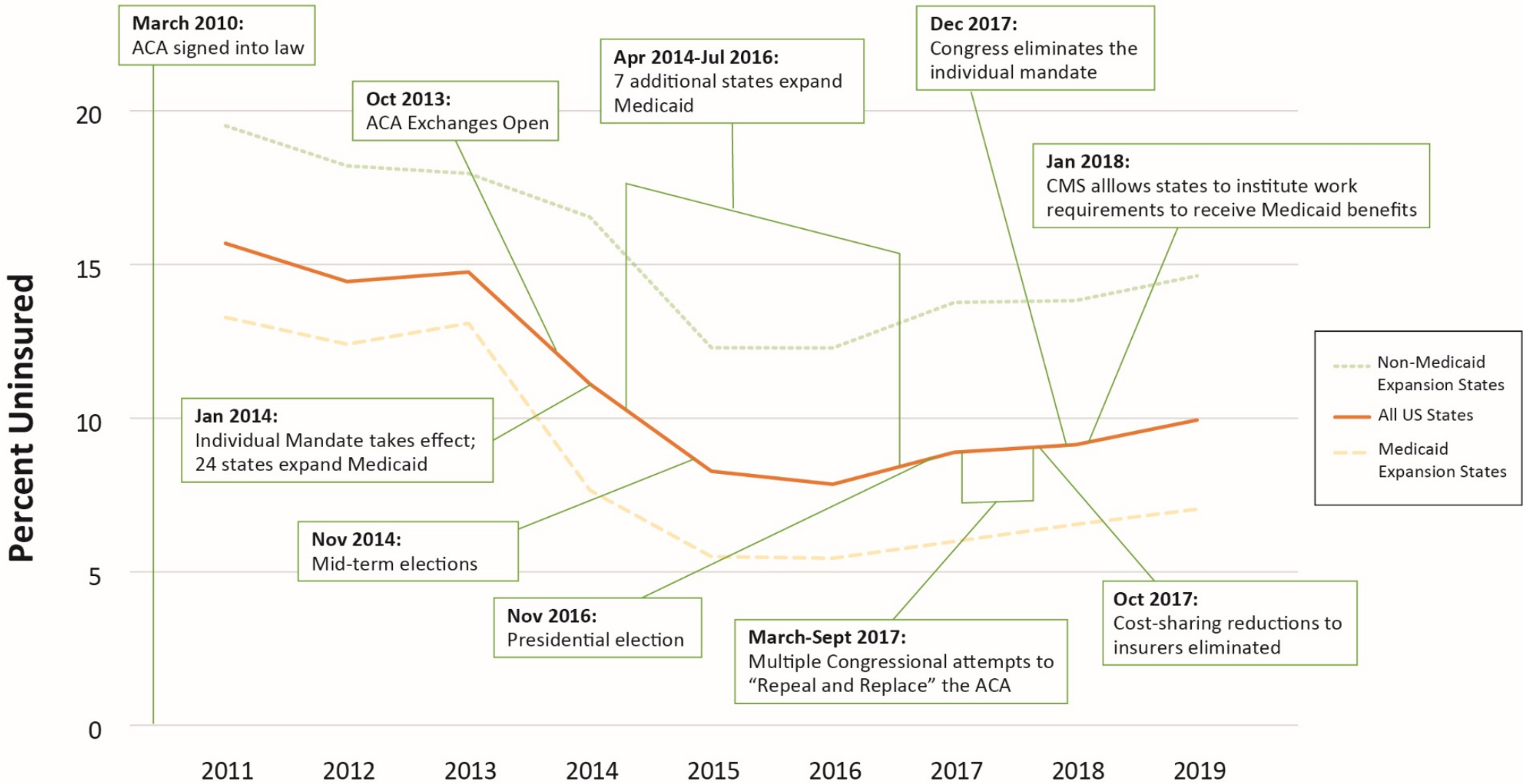
President's Cancer Panel, 2018

National Health Care Initiatives: Affordable Care Act

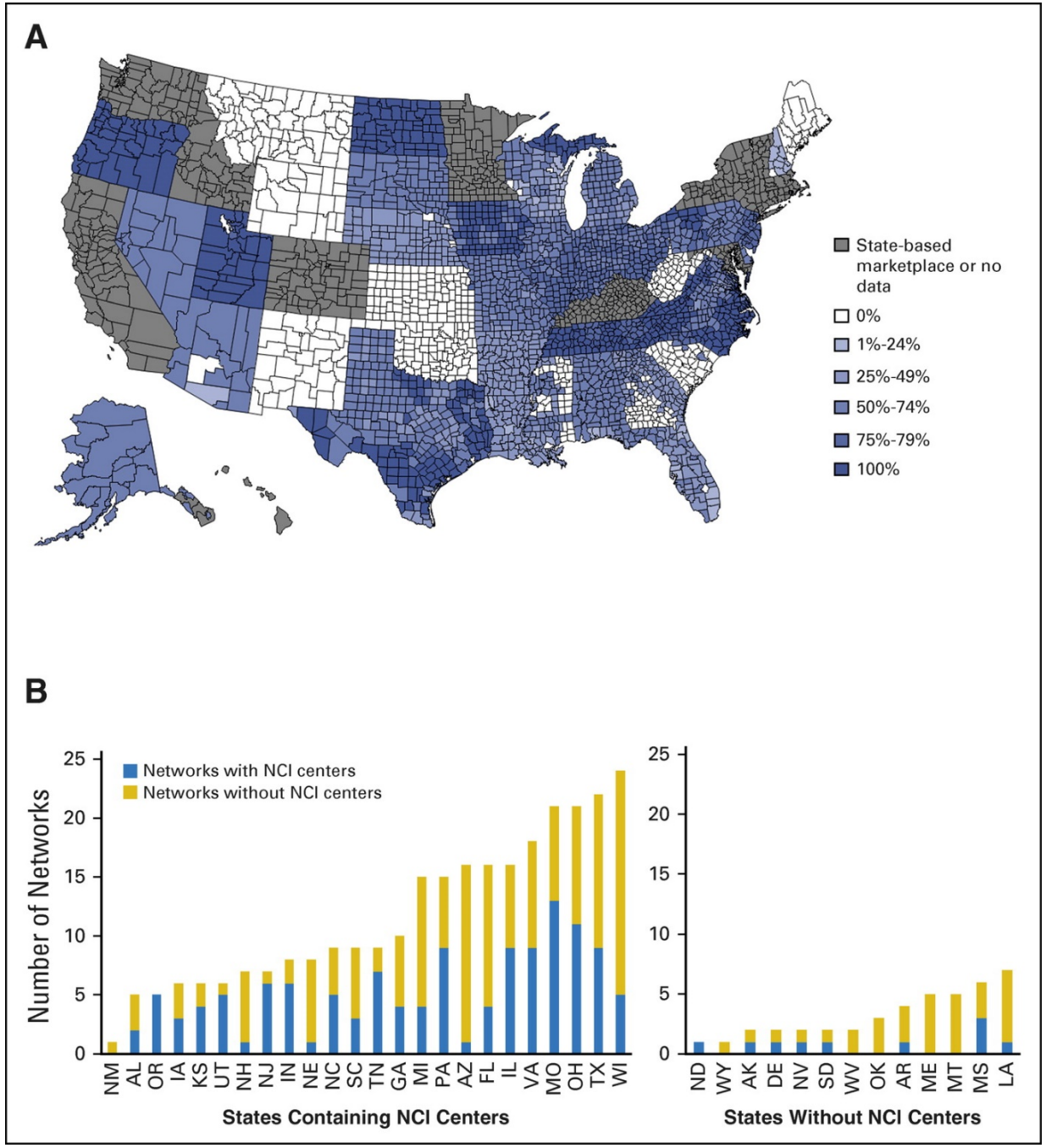


Jemal, *JCO*, 2017

Uninsurance in Adult Cancer Patients and Survivors (Age 18-64)



Moss….Chino, *Lancet Oncology*, 2020



VOLUME 35 · NUMBER 6 · FEBRUARY 20, 2017

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Check for updates

Access to Accredited Cancer Hospitals Within Federal Exchange Plans Under the Affordable Care Act

Kenneth L. Kehl, Kai-Ping Liao, Trudy M. Krause, and Sharon H. Giordano

Author affiliations and support information (if applicable) appear at the end of this article.

Published at ascopubs.org/journal/jco on January 9, 2017.

Corresponding author: Kenneth L. Kehl, MD, University of Texas MD Anderson Cancer Center, 1400 Holcombe Blvd, Unit 463, Houston, TX 77030; e-mail: klkehl@mdanderson.org.

0732-183X/17/3506w-645w/$20.00

A B S T R A C T

Purpose

The Affordable Care Act expanded access to health insurance in the United States, but concerns have arisen about access to specialized cancer care within narrow provider networks. To characterize the scope and potential impact of this problem, we assessed rates of inclusion of Commission on Cancer (CoC) –accredited hospitals and National Cancer Institute (NCI) –designated cancer centers within federal exchange networks.

Methods

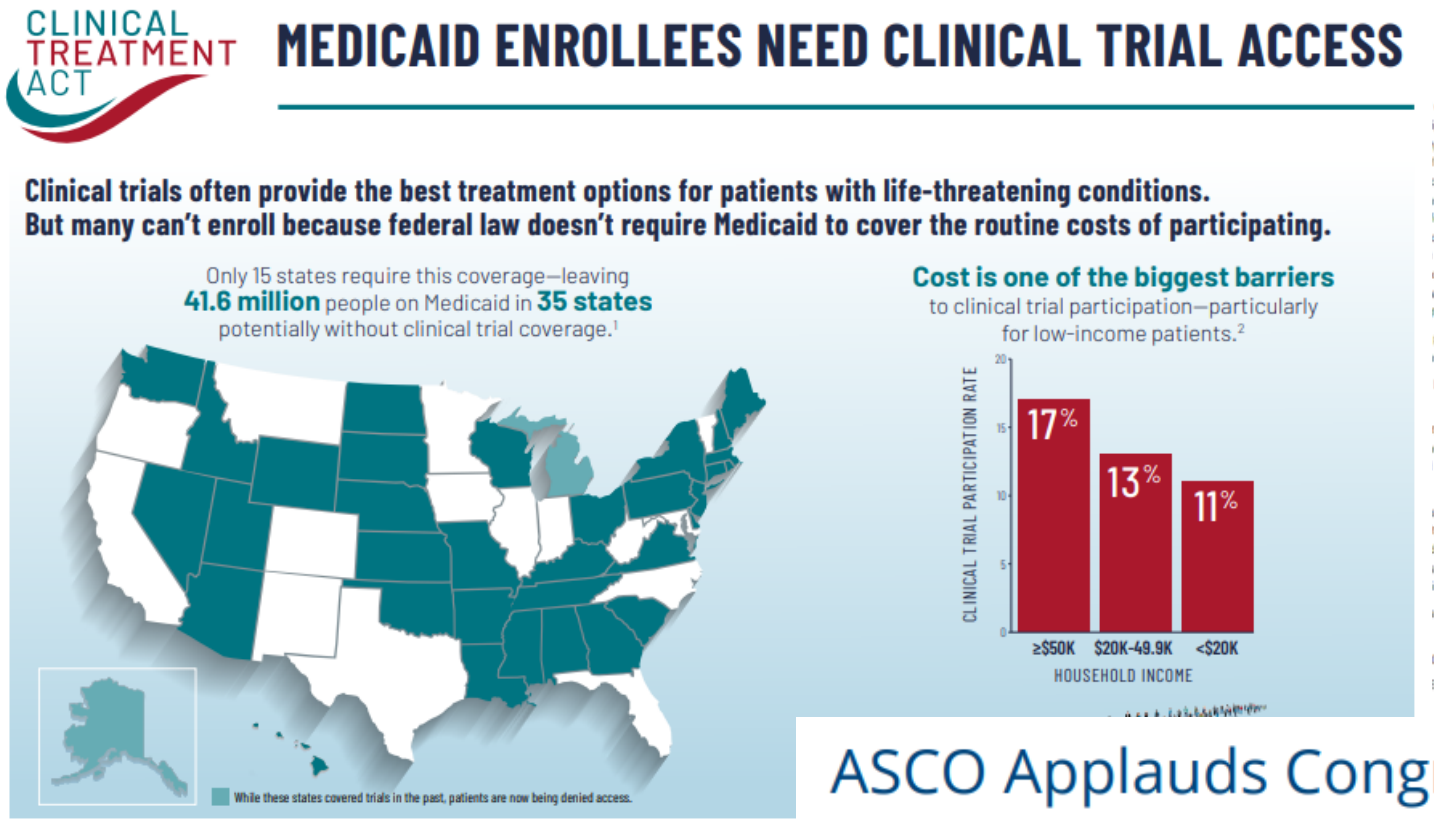
We downloaded publicly available machine-readable network data and public use files for individual federal exchange plans from the Centers for Medicare and Medicaid Services for the 2016 enrollment year. We linked this information to National Provider Identifier data, identified a set of

95% of networks included at least one CoC-accredited hospital, but just

41% of networks included NCI-designated

Kehl, *JCO*, 2017

The Role of National Advocacy



JOURNAL OF CLINICAL ONCOLOGY ASCO SPECIAL ARTICLE

American Society of Clinical Oncology Policy Statement on Medicaid Reform

Blase N. Polite, Jennifer J. Griggs, Beverly Moy, Christopher Lathan, Nefertiti C. duPont, Gina Villani, Sandra L. Wong, and Michael T. Halpern

EXECUTIVE SUMMARY

Entitlement reform is likely to dominate the discussion of the upcoming Congress, and the Medicaid provisions of the Affordable Care Act (ACA) are being implemented this year. The American Society of Clinical Oncology (ASCO) has an opportunity to help shape the debate about how cancer care will be delivered to our most vulnerable patients. As Medicaid continues to evolve in the post-ACA era, ASCO sets forth the following guiding principles with the goal of providing access to high-quality cancer care for all low-income individuals.

Principles

1. No individual diagnosed with cancer should be without health insurance that guarantees access to high-quality cancer care delivered by a cancer specialist.
2. Patients with cancer who have Medicaid should receive the same timely and high-quality cancer care as patients with private insurance.
3. Medicaid payments should be sufficient to ensure that Medicaid patients can have access to quality cancer care.

cost-sharing purposes (similar to preventative services, services provided to hospice patients, and so on).

3. Extend clinical trial protections included in the ACA to patients with Medicaid coverage, and allow patients with Medicaid coverage to cross state lines to participate in those trials.
4. Eliminate artificial barriers between current Medicaid beneficiaries and newly eligible beneficiaries, and apply ACA final-rule mandates for cancer screening and diagnostic follow-up without copay for all Medicaid beneficiaries.
5. Require coverage for genetic testing, without deductibles or copays, in any patient deemed at high risk for an inheritable cancer risk syndrome as defined by published guidelines.
6. Improve the 340B Drug Pricing Program so that it is used for its original intent: to incentivize care for the uninsured and underinsured and patients with Medicaid coverage, regardless of care setting.
7. Eliminate variation between Medicare and Medicaid physician payment rates for can-

treatment by raising Med-
Medicare rates.
ity in running Medicaid
requirement to meet pre-
uality metrics.
ractices to be designated as
nd develop expanded re-
care coordination and pa-
r oncology practices.

ROUND

part, to provide insurance
of Americans who are cur-
rently uninsured. This is primarily accomplished through Medicaid expansion for all uninsured adults with a family income below 133% of the FPL. The federal government provides 100% of the costs of expansion from 2014 to 2016. The proportion of

50 states.

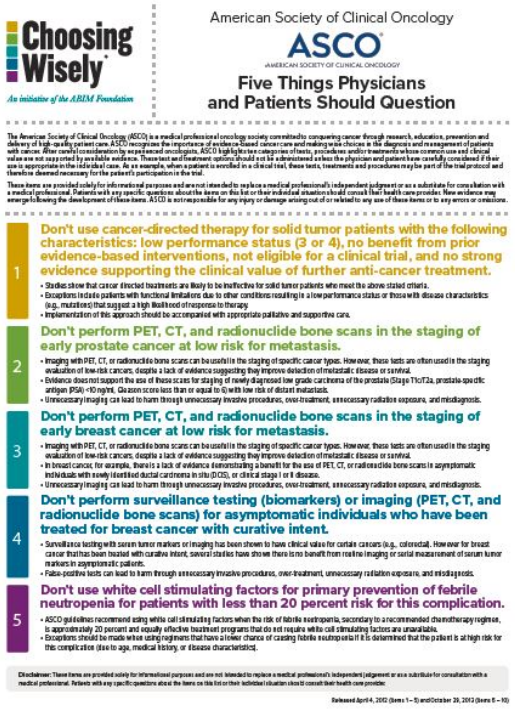
2. Ensure oral parity for patients with Medicaid coverage and include oral and intravenous cancer therapies, as well as supportive care medications, as exempt services for

ASCO Applauds Congress for Expanding Clinical Trial Access for Medicaid Beneficiaries

End-of-year legislative package includes ASCO-backed CLINICAL TREATMENT Act
For immediate release
December 22, 2020

National Health Care Initiatives: ASCO, ASTRO and SSO Choosing Wisely

10 Cancer Tests and Treatments Routinely Performed **Despite Lack of Evidence**



Choosing Wisely
An initiative of the ABIM Foundation

American Society of Clinical Oncology
ASCO
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Five Things Physicians and Patients Should Question

The American Society of Clinical Oncology (ASCO) is a medical professional oncology society committed to conquering cancer through research, education, prevention and delivery of high-quality patient care. ASCO recognizes the importance of evidence-based cancer care and making wise choices in the diagnosis and management of patients with cancer. After careful consideration by expert medical oncologists, ASCO highlights two categories of tests, procedures and/or treatments whose common use and clinical value are not supported by available evidence. These tests and treatment options should not be administered unless the physician and patient have carefully considered if their use is appropriate in the individual case. As an example, when a patient is enrolled in a clinical trial, these tests, treatments and procedures may be part of the trial protocol and therefore deemed necessary for the patient's participation in the trial.

These items are provided solely for information purposes and are not intended to replace a medical professional's independent judgment or as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their health care provider. New evidence may emerge following the development of these items. ASCO is not responsible for any injury or damage arising out of or related to any use of these items or to any errors or omissions.

1 **Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.**

- Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above stated criteria.
- Exceptions include patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.
- Implementation of this approach should be accompanied with appropriate palliative and supportive care.

2 **Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.**

- Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (Stage T1c/T2a, prostate-specific antigen (PSA) <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

3 **Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.**

- Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve detection of metastatic disease or survival.
- In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic individuals with newly identified ductal carcinoma in situ (DCIS), or clinical stage I or II disease.
- Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

4 **Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.**

- Surveillance testing with serum tumor markers or imaging has been shown to have clinical value for certain cancers (e.g., colorectal). However for breast cancer that has been treated with curative intent, several studies have shown there is no benefit from routine imaging or serial measurement of serum tumor markers in asymptomatic patients.
- False-positive tests can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

5 **Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.**

- ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to a recommended chemotherapy regimen, is approximately 20 percent and equally effective treatment programs that do not require white cell stimulating factors are unavailable.
- Exceptions should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for this complication (due to age, medical history, or disease characteristics).

Disclaimer: These items are provided solely for informational purposes and are not intended to replace a medical professional's independent judgment or as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their health care provider.

Released April 4, 2012 (Items 1 – 5) and October 29, 2013 (Items 6 – 10)

"Opportunities to improve the quality and value of cancer care"

8 **Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.**

- PET and PET-CT are used to diagnose, stage and monitor how well treatment is working. Available evidence from clinical studies suggests that using these tests to monitor for recurrence does not improve outcomes and therefore generally is not recommended for this purpose.
- False positive tests can lead to unnecessary and invasive procedures, overtreatment, unnecessary radiation exposure and incorrect diagnoses.
- Until high level evidence demonstrates that routine surveillance with PET or PET-CT scans helps prolong life or promote well-being after treatment for a specific type of cancer, this practice should not be done.

10 **Don't use a targeted therapy intended for use against a specific genetic aberration unless a patient's tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.**

- Unlike chemotherapy, targeted therapy can significantly benefit people with cancer because it can target specific gene products, i.e., proteins that cancer cells use to grow and spread, while causing little or no harm to healthy cells. Patients who are most likely to benefit from targeted therapy are those who have a specific biomarker in their tumor cells that indicates the presence or absence of a specific gene alteration that makes the tumor cells susceptible to the targeted agent.
- Compared to chemotherapy, the cost of targeted therapy is generally higher, as these treatments are newer, more expensive to produce and under patent protection. In addition, like all anti-cancer therapies, there are risks to using targeted agents when there is no evidence to support their use because of the potential for serious side effects or reduced efficacy compared with other treatment options.

De-escalation Research

VOLUME 36 · NUMBER 14 · MAY 10, 2018

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Prospective International Randomized Phase II Study of Low-Dose Abiraterone With Food Versus Standard Dose Abiraterone In Castration-Resistant Prostate Cancer

Russell Z. Szmulewitz, Cody J. Peer, Abiola Ibraheem, Elia Martinez, Mark F. Kozloff, Bradley Carthon, R. Donald Harvey, Paul Fishkin, Wei Walter M. Stadler, and M

Open access Original research

ESMO Open
Cancer Horizons

Check for updates

Low-dose nivolumab can be effective in non-small cell lung cancer: alternative option for financial toxicity

Shin Hye Yoo,[1] Bhumsuk Keam,[1,2] Miso Kim,[1] Se Hyun Kim,[3] Yu Jung Kim,[3] Tae Min Kim,[1,2] Dong-Wan Kim,[1,2] Jong Seok Lee,[3] Dae Seog Heo[1,2]

Szmulewitz, *JCO*, 2018; Yoo, ESMO Open, 2018

True Comparative Effectiveness Research

ORIGINAL ARTICLE FREE PREVIEW

Minimally Invasive versus Abdominal Radical Hysterectomy for Cervical Cancer

Pedro T. Ramirez, M.D., Michael Frumovitz, M.D., Rene Pareja, M.D., Aldo Lopez, M.D., Marcelo Vieira, M.D., Reitan Ribeiro, M.D., Alessandro Buda, M.D., Xiaojian Yan, M.D., Yao Shuzhong, M.D., Naven Chetty, M.D., David Isla, M.D., Mariano Tamura, M.D., et al.

November 15, 2018

ClinicalTrials.gov

Submit Studies ▾ Resources ▾ About Site ▾

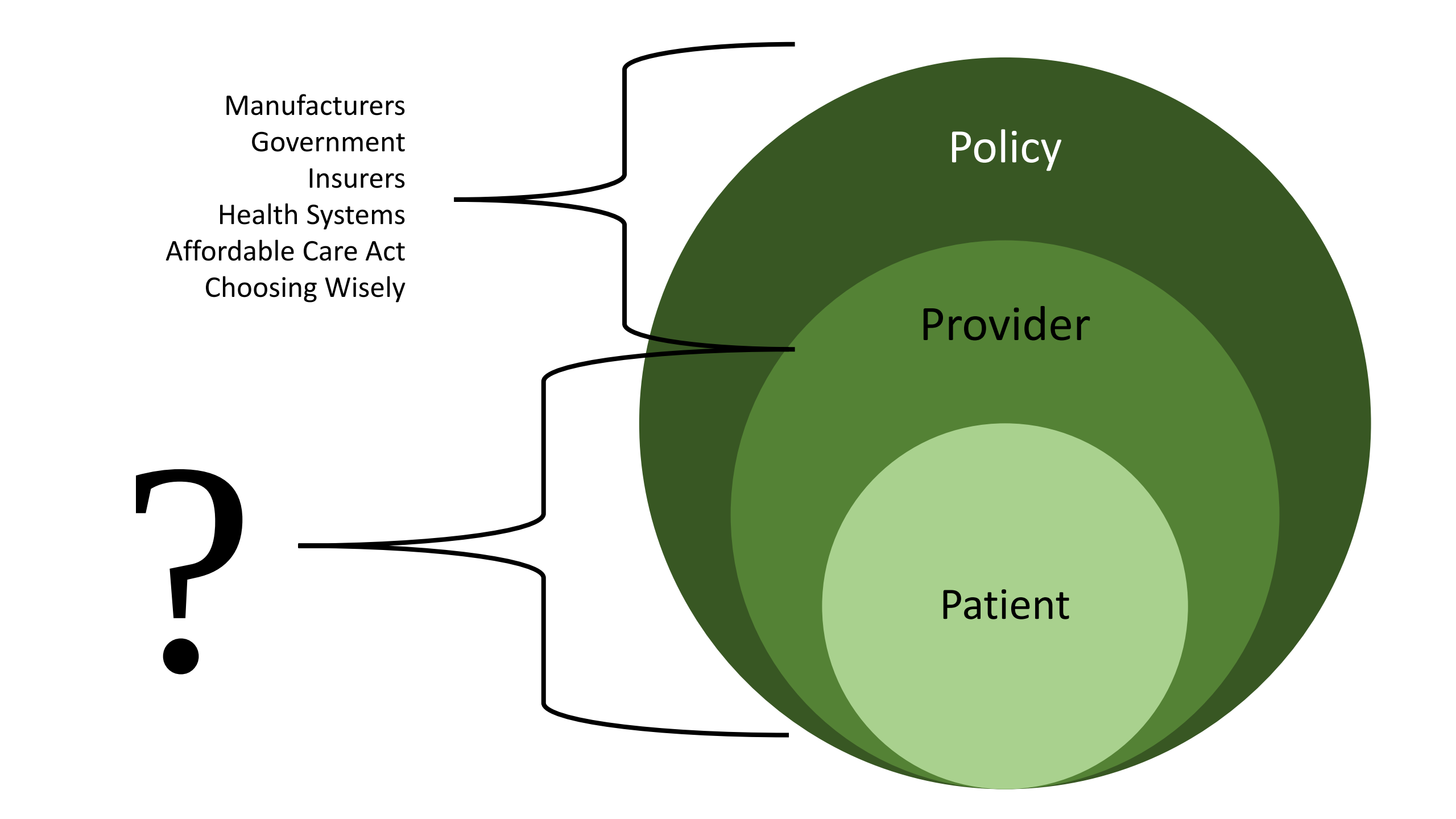
Home > Search Results > Study Record Detail

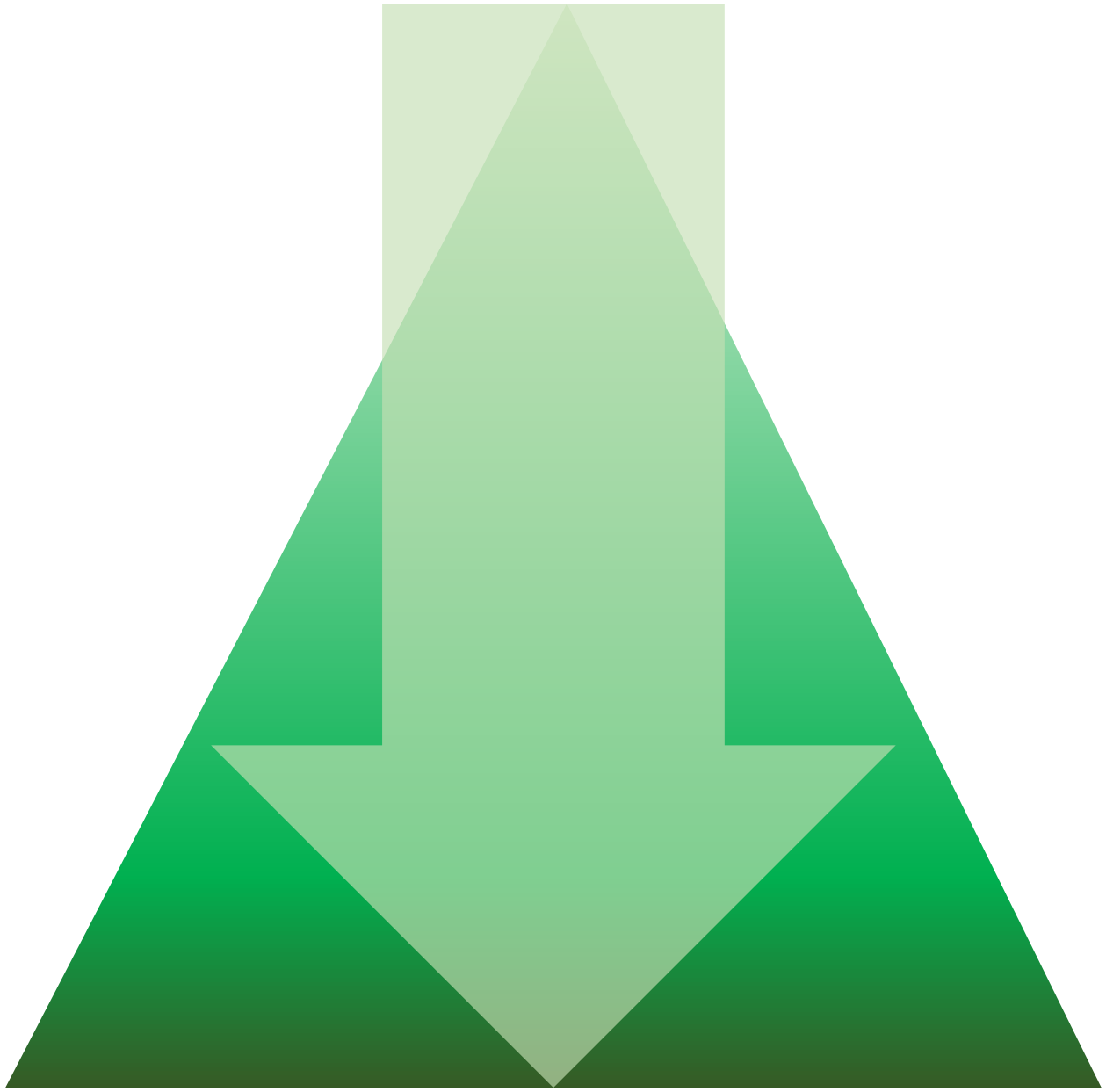
Save this study

Randomized Trial of Intensity-Modulated Proton Beam Therapy (IMPT) Versus Intensity-Modulated Photon Therapy (IMRT) for the Treatment of Oropharyngeal Cancer of the Head and Neck

ClinicalTrials.gov Identifier: NCT01893307

Ramirez, *NEJM*, 2018, https://clinicaltrials.gov/ct2/show/NCT01893307


Manufacturers
Government
Insurers
Health Systems
Affordable Care Act
Choosing Wisely
?
Policy
Provider
Patient



1° Prevention:

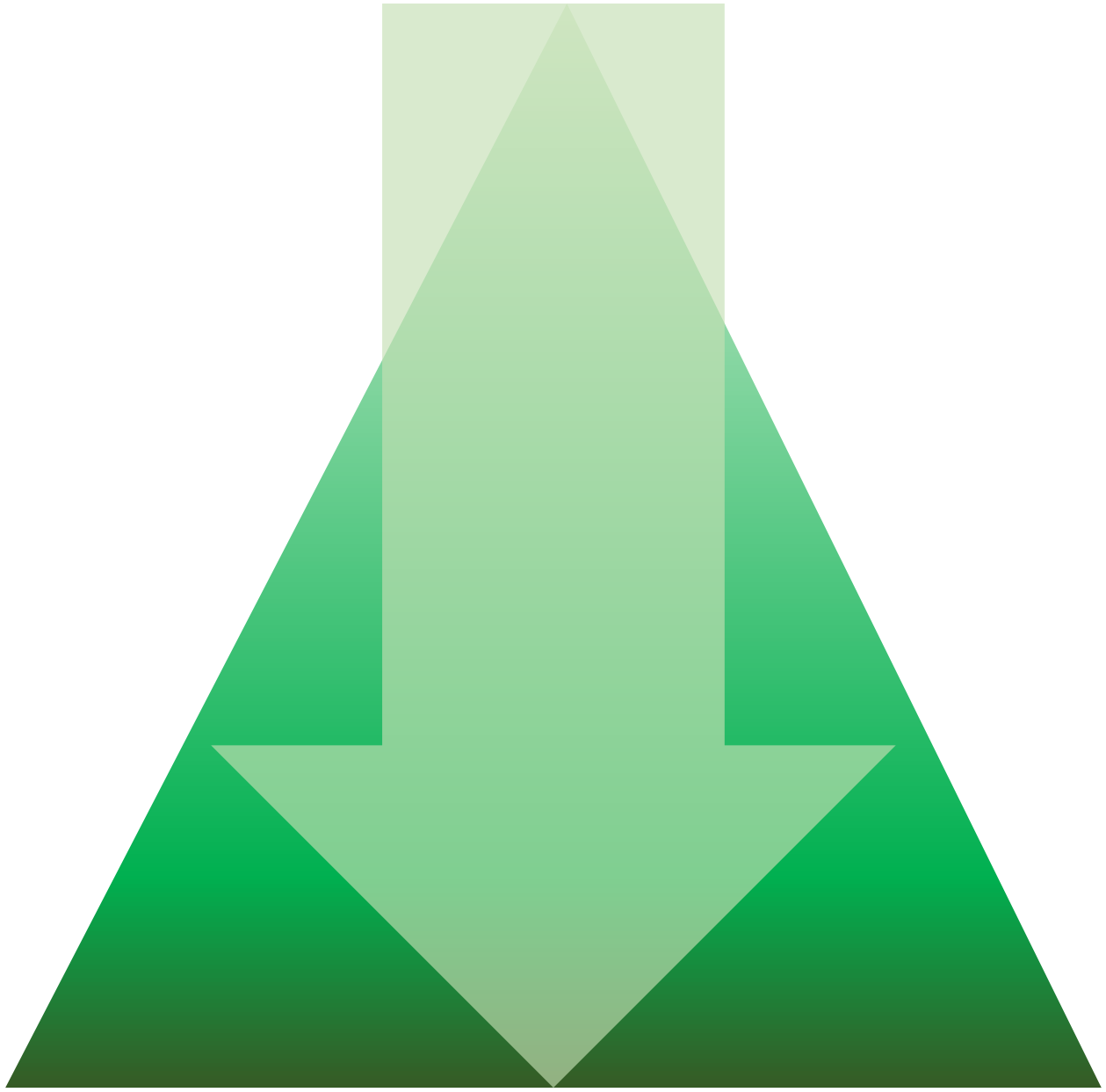
Prevent disease or injury before it ever occurs

2° Prevention:

Reduce impact by detecting and treating disease or injury as soon as possible

3° Prevention:

Soften the impact of an ongoing illness or injury that has lasting effects



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Prevent Financial Toxicity from Forming

Patient Level:

- Education
- Optimize Insurance (Financial Navigators, NaVectis, ACC “bootcamp”)
- Optimize Financial Assistance (proactive not reactive, Vivor, TailorMed)
- Improve Access (maintain work, health insurance)

Provider Level:

- Education
- Value Based Care (ASCO Value Framework)
- Encourage High Value Care and Eliminate Low Value Care (cost aware prescribing patterns, price transparency)
- Shared Decision Making (identify goals of care, true costs of treatment)

Education: Financial Counseling

Randomized up front meeting with Financial Care Counselors who provided:

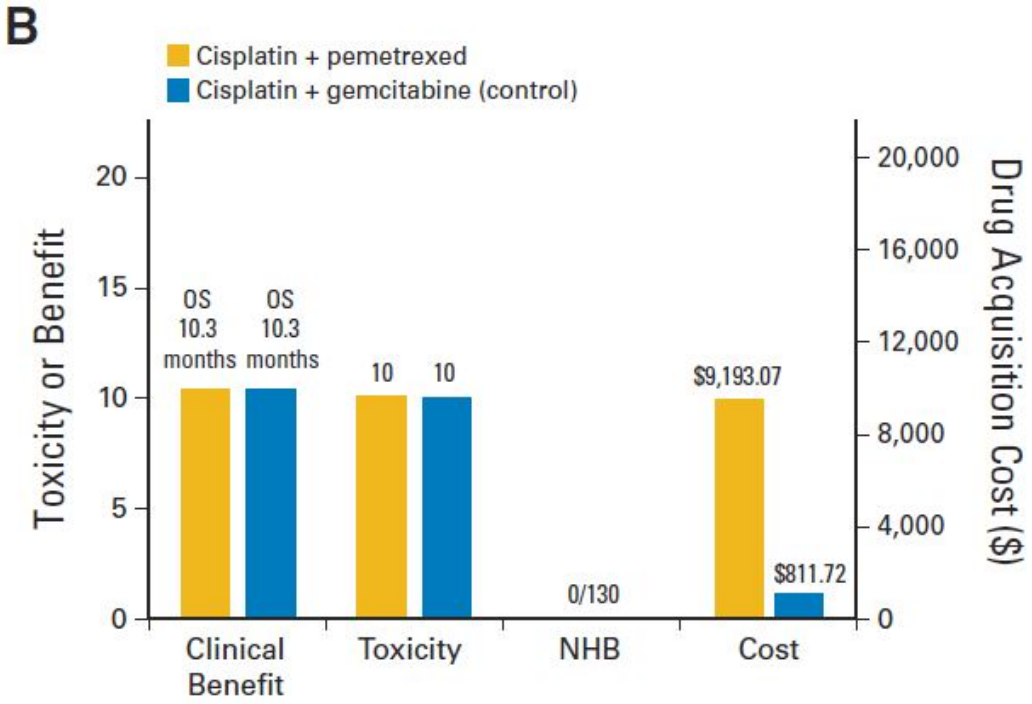
- an estimation of patient OOP
- Definitions and details of specific insurance benefits
- contact numbers for patient services and billing for future questions

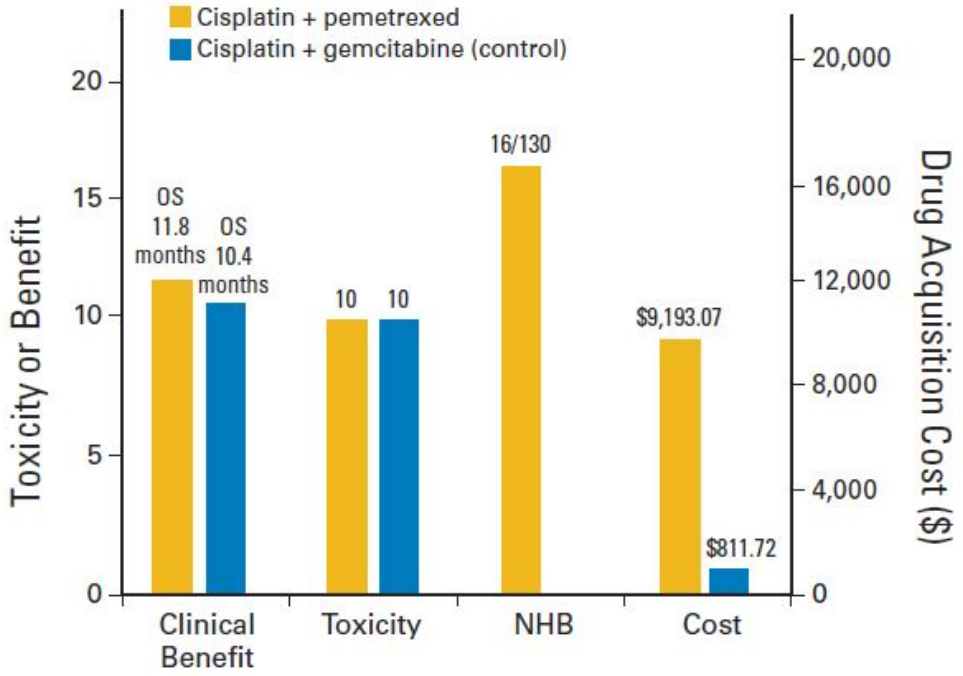
88%

said talking with a financial counselor helped them understand their out-of-pocket costs better

Kircher, *JOP,* 2018

Value Based Care: the ASCO Value Framework





Goal: to facilitate discussion between providers and patients on the value of available treatment options

Schnipper, *JCO*, 2015

Price Transparency

Of 63 evaluated NCI-Cancer Centers:

- 20.6% (n=13) had a complete machine-readable file
- 38.1% (n=24) had incomplete data/incorrect formatting
- 65.1% (n=41) had a patient-facing price transparency tool
- 69.8% (n=44) had a chargemaster list

Table: Payer-Negotiated Rate Ranges for Oncological Services*

Oncological Treatment (CPT)	Average Minimum Negotiated Rate (Range)	Average Maximum Negotiated Rate (Range)	Average Maximum Total Negotiated Rate (Range)
Colonoscopy with polyp/tumor removal (45384)	$1036.95 Medicare maximum allowable		
	$890.46 (297.00-1,545.11)	$3,371.19 (1,371.00-6,316.00)	-
Single Fraction Radiation Therapy to a Bone Metastasis (77334, 77295, 77300**, 77412, 77336)	$2,476.89 Medicare maximum allowable		
	$2,149.84 (297.00- 3,492.42)	$13,273.65 (4,304.19-33,411.34)	$16,182.48 (5,072.01-37,183.30)

Prices in US Dollars
CPT = Current Procedural Terminology Code
*Payer-Negotiated Rate: the amount a specific commercial payer or insurer contracts to pay for health care services by a provider or medical facility, these prices may vary across a payer's different plan types
Required elements for CMS transparency rules include: gross charges, discounted cash price, payer-specific negotiated charge, minimum and maximum negotiated charges; the available minimum and maximum negotiated rates are shown here
**Quantity 4 was used for 77300 given estimated use of 4 fields for radiation

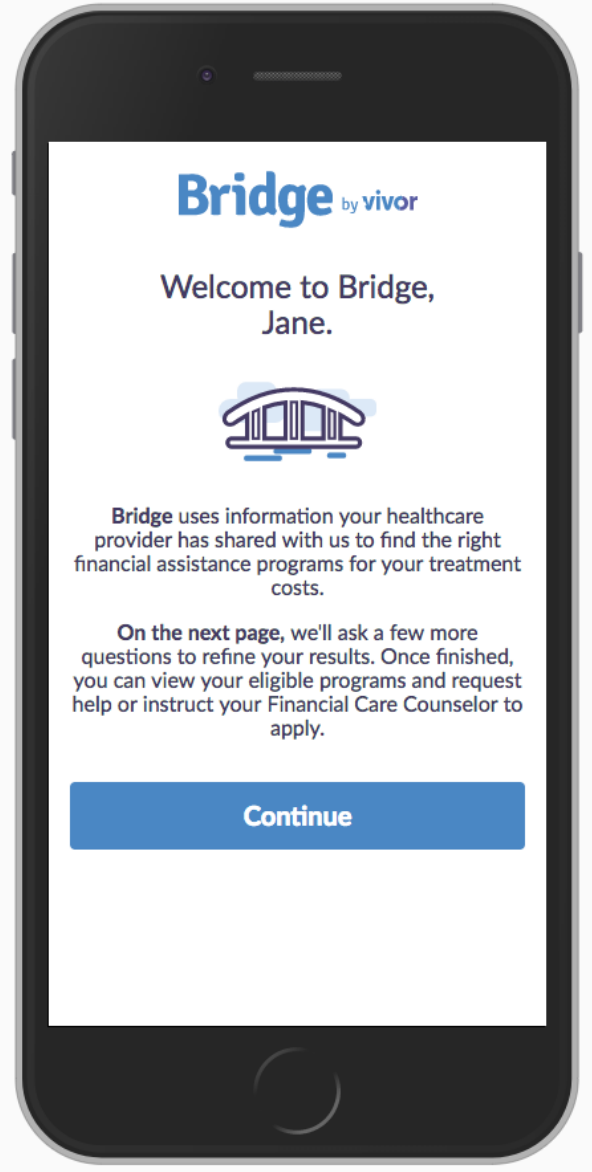
Chino, *under Review*, 2021

App Based Financial Navigation

Randomized trial of a mobile app to identify eligible financial assistance programs and initiate contact with financial counselors

- Did not meet primary or secondary outcomes (OOP costs, financial distress)

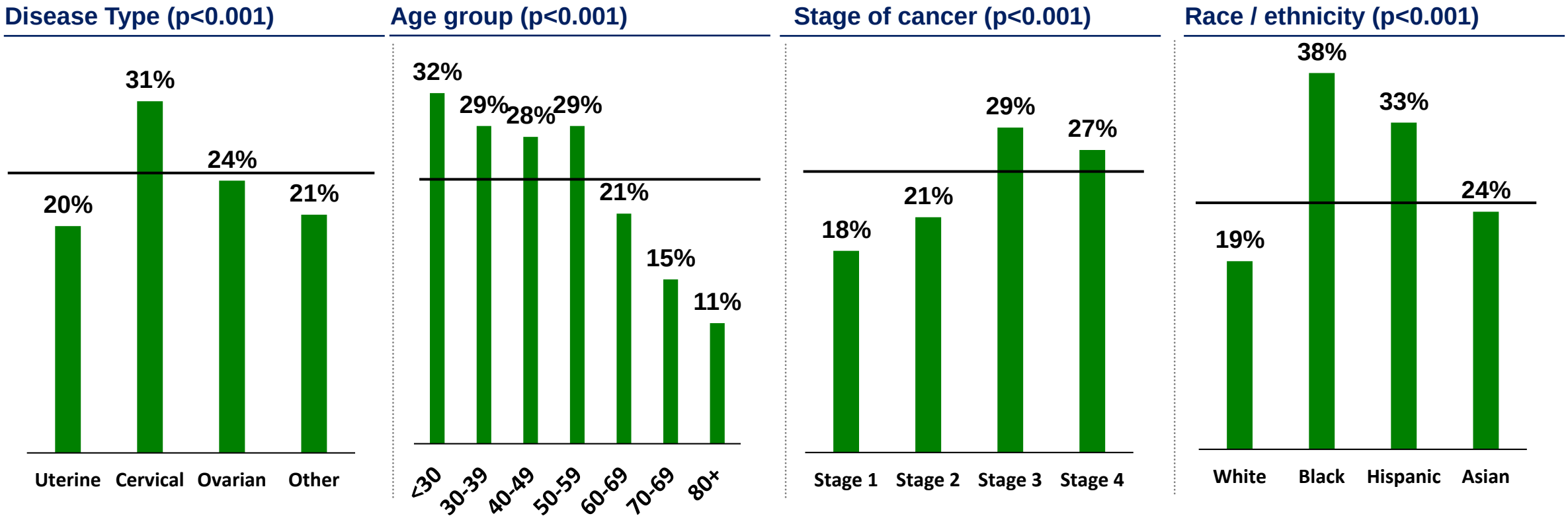
	Applied for financial assistance	Received financial assistance
Control group	10.4%	8.5%
Intervention group	35.4%	30.0%



Tamasky, *JOP,* 2021
n=200

Identify those at high risk.. before they experience financial toxicity

Risk of financial toxicity by demographic, *relative risk vs baseline*

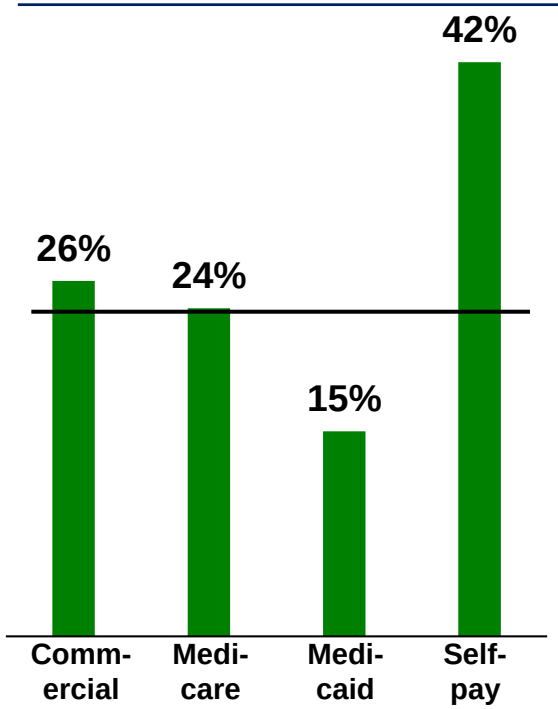


SOURCE Financial toxicity univariate analysis of active patients between Jan 2016 and Dec 2018 (n = 5,188)

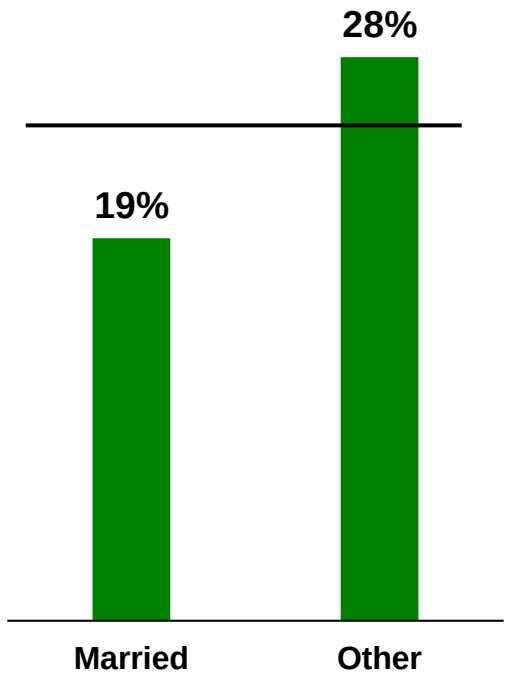
n=5,188

Aviki…Chino…Abu-Rustum, *Manuscript under review*

Insurance status (p<0.001)



Marital Status (p<0.001)

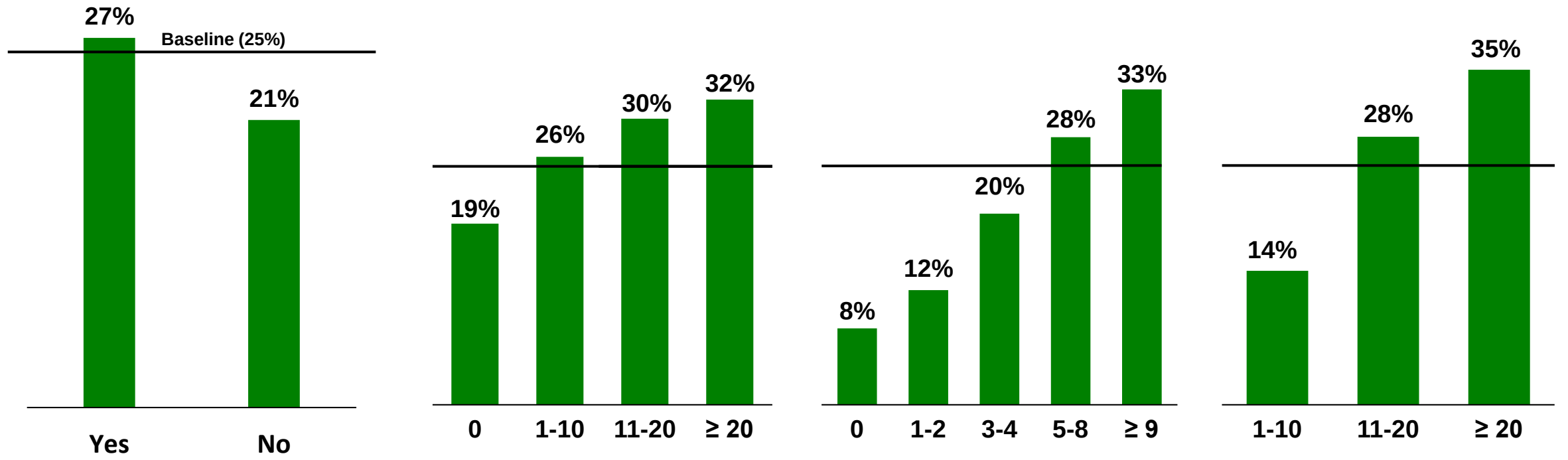


SOURCE Financial toxicity univariate analysis of active patients between Jan 2016 and Dec 2018 (n = 5,188)

n=5,188

Aviki…Chino…Abu-Rustum, *Manuscript under review*

Risk of financial toxicity by healthcare utilization metrics, *% of patients experiencing financial toxicity,* ***all p<0.001***



SOURCE Financial toxicity univariate analysis of active patients between Jan 2016 and Dec 2018 (n = 5,188)

n=5,188

Aviki…Chino…Abu-Rustum, *Manuscript under review*

Variable		Adjusted Odds Ratio	95% CI
Age			
	<30	Referent	Referent
	30-39	1.03	0.62, 1.73
	40-49	0.93	0.58, 1.53
	50-59	0.94	0.59, 1.51
	60-69	0.66	0.41, 1.06
	70-79	0.47	0.28, 0.79
	≥80	0.34	0.19, 0.62
Marital Status			
	Partnered	Referent	Referent
	Not Partnered	1.83	1.57, 2.13
Race/Ethnicity			
	White (non-Hispanic)	Referent	Referent
	Black (non-Hispanic)	2.18	1.71, 2.76
	Hispanic	1.93	1.47, 2.52

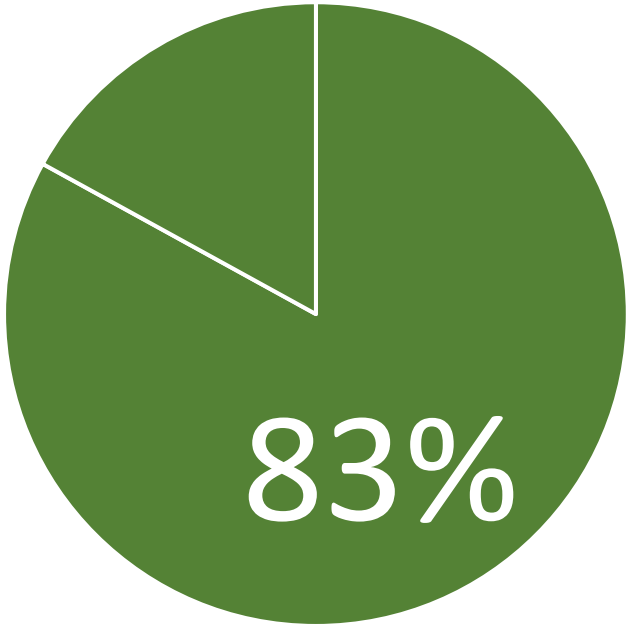
Variable		Adjusted Odds Ratio	95% CI
Insurance Type			
	Commercial	Referent	Referent
	Medicaid	0.53	0.40, 0.71
	Medicare	0.60	0.48, 0.74
	Self-pay	1.78	1.28, 2.45
Imaging Studies (MRI/PET/CT)			
	0	Referent	Referent
	1-2	1.64	1.11, 2.50
	3-4	2.59	1.72, 4.00
	5-8	3.43	2.25, 5.35
	≥9	3.46	2.21, 5.53
Outpatient Clinician Visits			
	1-10	Referent	Referent
	11-20	1.95	1.56, 2.43

Only variables that were significant in the multivariate model are listed

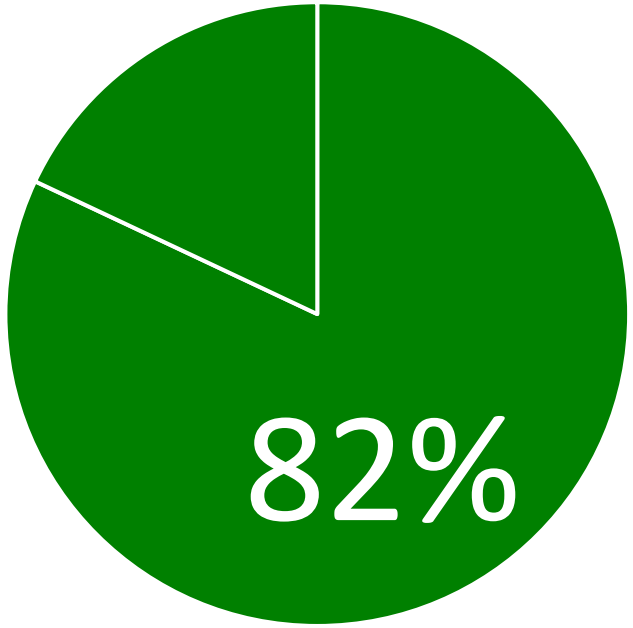
Aviki…Chino…Abu-Rustum, *Manuscript under review*

High Value Care: Can we change behavior?

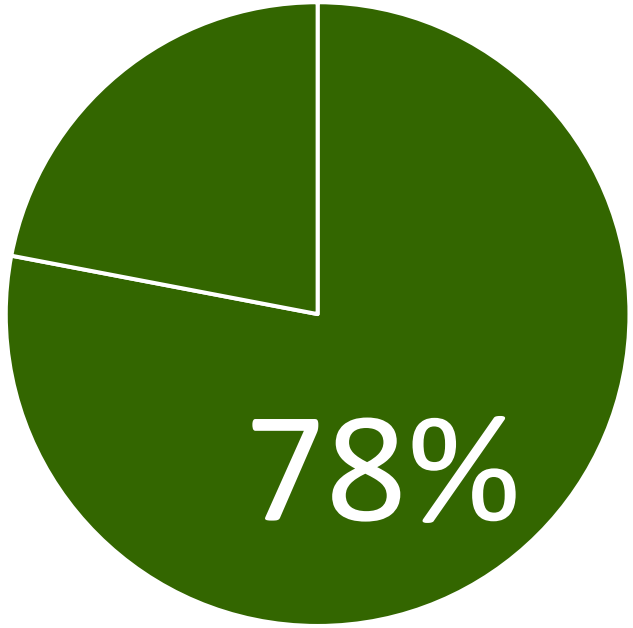
89% believe that ≥20% of patients on active treatment have significant financial issues related to paying for their cancer treatment; **16%** though that ≥60% of patients have this concern



There are ways to either *prevent or mitigate* patient financial toxicity



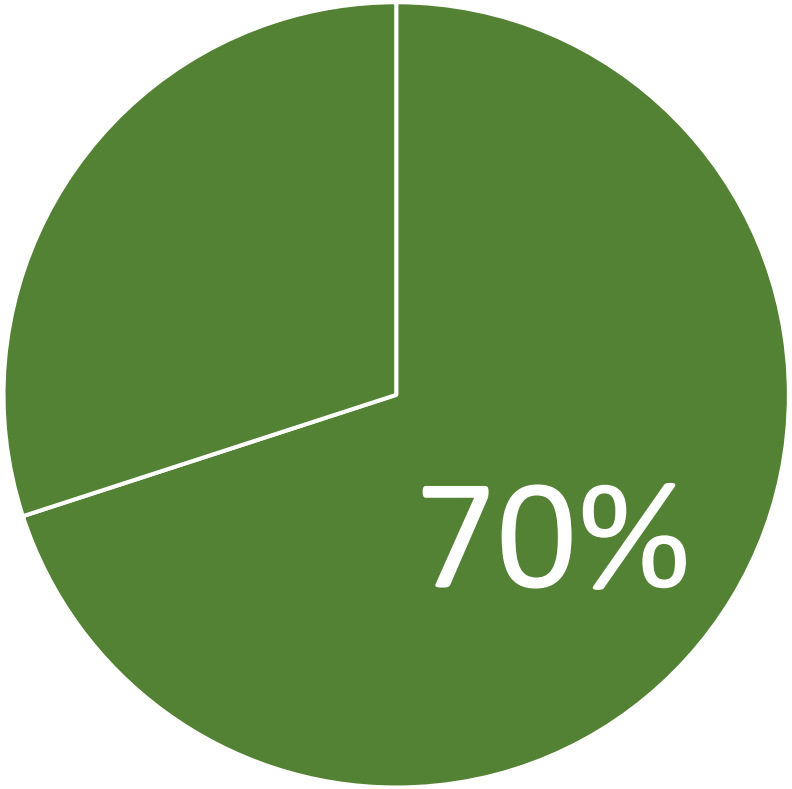
We should play an *active role* in minimizing financial toxicity



We should *be aware* of a patient's risk for financial toxicity prior to making treatment recs

n=346

Aviki and Chino, *Manuscript in progress*



Believed they could *modify test or treatment plans* to reduce costs for patients at high risk for financial burden if they knew

24%

Would modify treatment *dosing/frequency*

67%

Would change *follow up interval*

66%

Would change *testing/imaging frequency*

65%

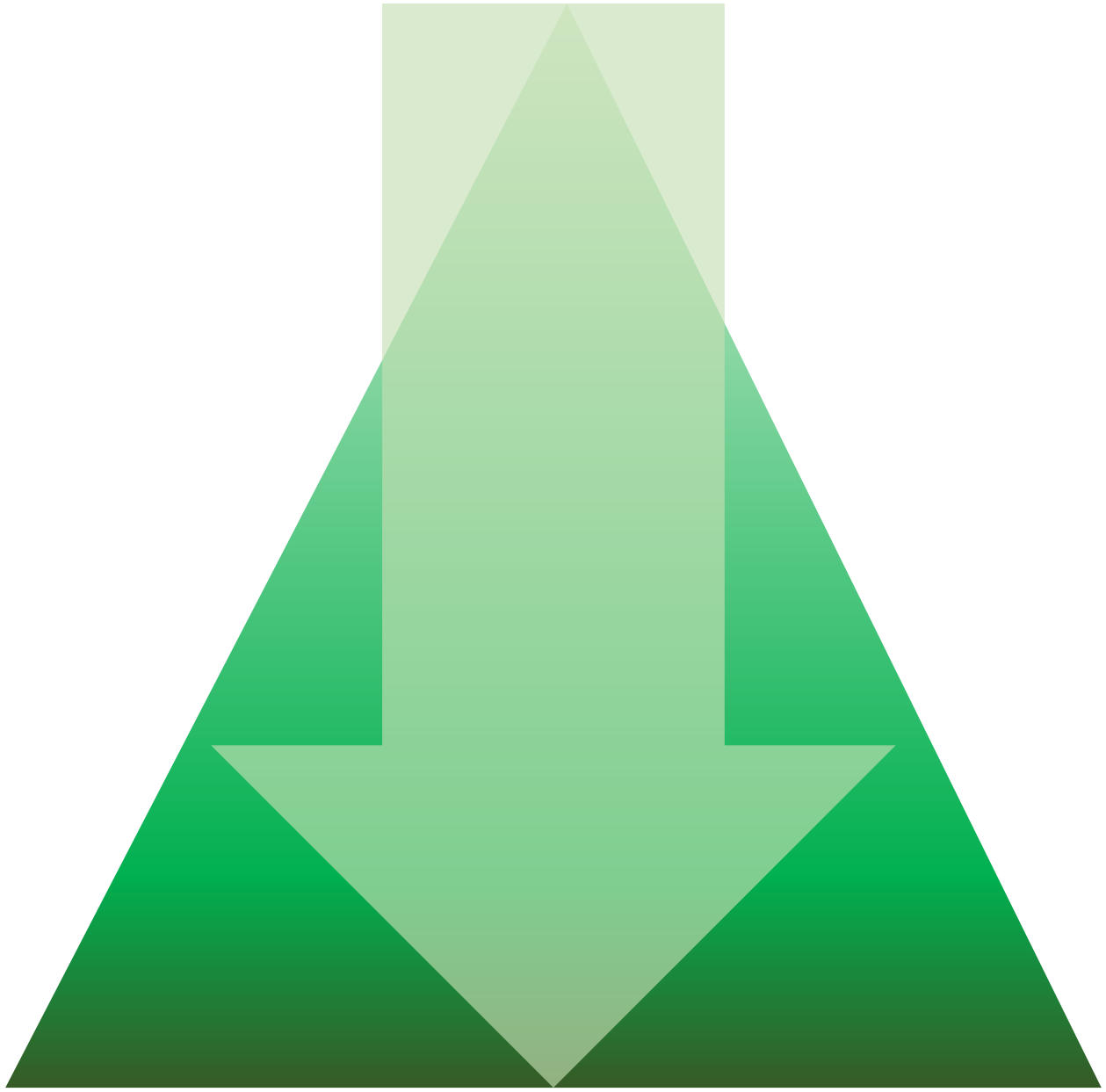
Felt *national guidelines* should incorporate patient affordability concerns

Only **22%** had received any training on costs, affordability, or value-based care

Only **5%** had received any training on cost conversations

n=346

Aviki and Chino, *Manuscript in progress*



1° Prevention:
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3° Prevention:
Soften the impact of an ongoing illness or injury that has lasting effects

Screen for Financial Toxicity Early and Often

PROBLEM LIST
Please indicate if any of the following has been a problem for you in the past week including today.
Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment dec

		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
		Breathing
		anges in urination
		ation
❑	❑	Indige
❑	❑	Memory/c
❑	❑	Mouth so
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual

National Comprehensive Cancer Network (NCCN) Problem List

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school

The COmprehensive Score for Financial Toxicity (COST)

	Not at all	A little bit	Some-what	Quite a bit	Very much
I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment	0	1	2	3	4
My out-of-pocket medical expenses are more than I thought they would be	0	1	2	3	4
I worry about the financial problems I will have in the future as a result of my illness or treatment	0	1	2	3	4
I feel I have no choice about the amount of money I spend on care	0	1	2	3	4
I am frustrated that I cannot work or contribute as much as I usually do	0	1	2	3	4
I am satisfied with my current financial situation	0	1	2	3	4
I am able to meet my monthly expenses	0	1	2	3	4
I feel financially stressed	0	1	2	3	4
I am concerned about keeping my job and income, including work at home	0	1	2	3	4
My cancer or treatment has reduced my satisfaction with my present financial situation	0	1	2	3	4
I feel in control of my financial situation	0	1	2	3	4
My illness has been a financial hardship to my family and me	0	1	2	3	4

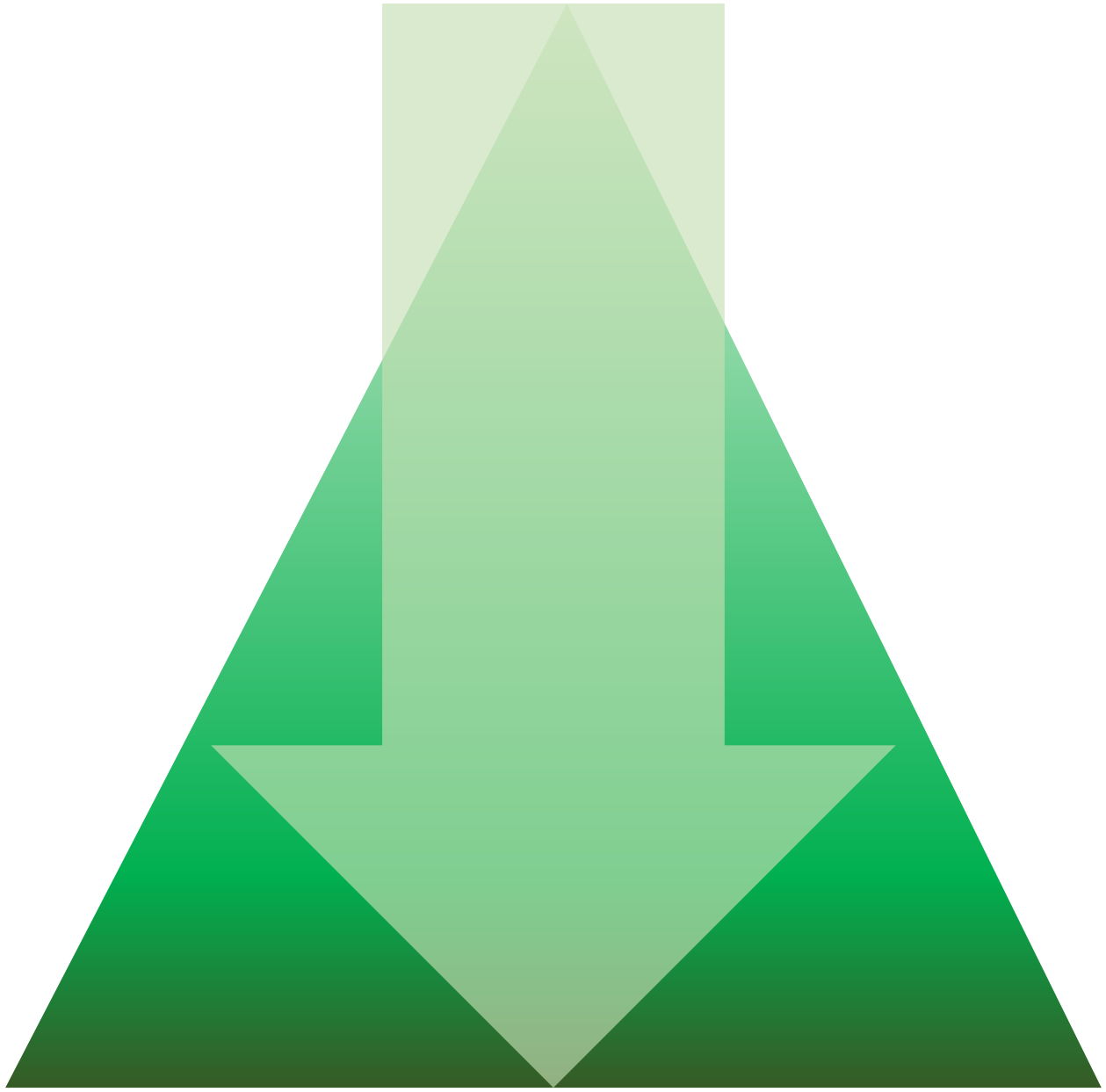
http://www.facit.org/facitorg/questionnaires

de Souza, *Cancer,* 2017

MSK Pilot: Systematically screen patients for financial burden

TQ1	**At any time in the past 3 months, have you taken less medication than was prescribed for you because of the cost?** ☐ Yes, all the time ☐ Yes, some of the time ☐ Yes, rarely ☐ No
TQ2	**Is the amount of income that you have available in a typical month <u>not enough</u> for any of the following needs?** [check all that apply] ☐ Food ☐ Housing ☐ Clothing ☐ Medicine ☐ Repairs to home ☐ Transportation
TQ4	**Have you had to use your savings in order to pay for cancer treatment?** ☐ Yes, all my savings ☐ Yes, some of my savings ☐ Yes, a little of my savings ☐ No ☐ I have no savings
TQ5	**Have you had to take on new loans or borrow money in order to pay for cancer treatment?** [check all that apply] ☐ Yes, bank loans ☐ Yes, credit card debt ☐ Yes, mortgage on home ☐ Yes, personal loans ☐ No

- COST Score (screen in at 20)
- Single Question Linear Analogue Self Assessment for QOL (0-10)



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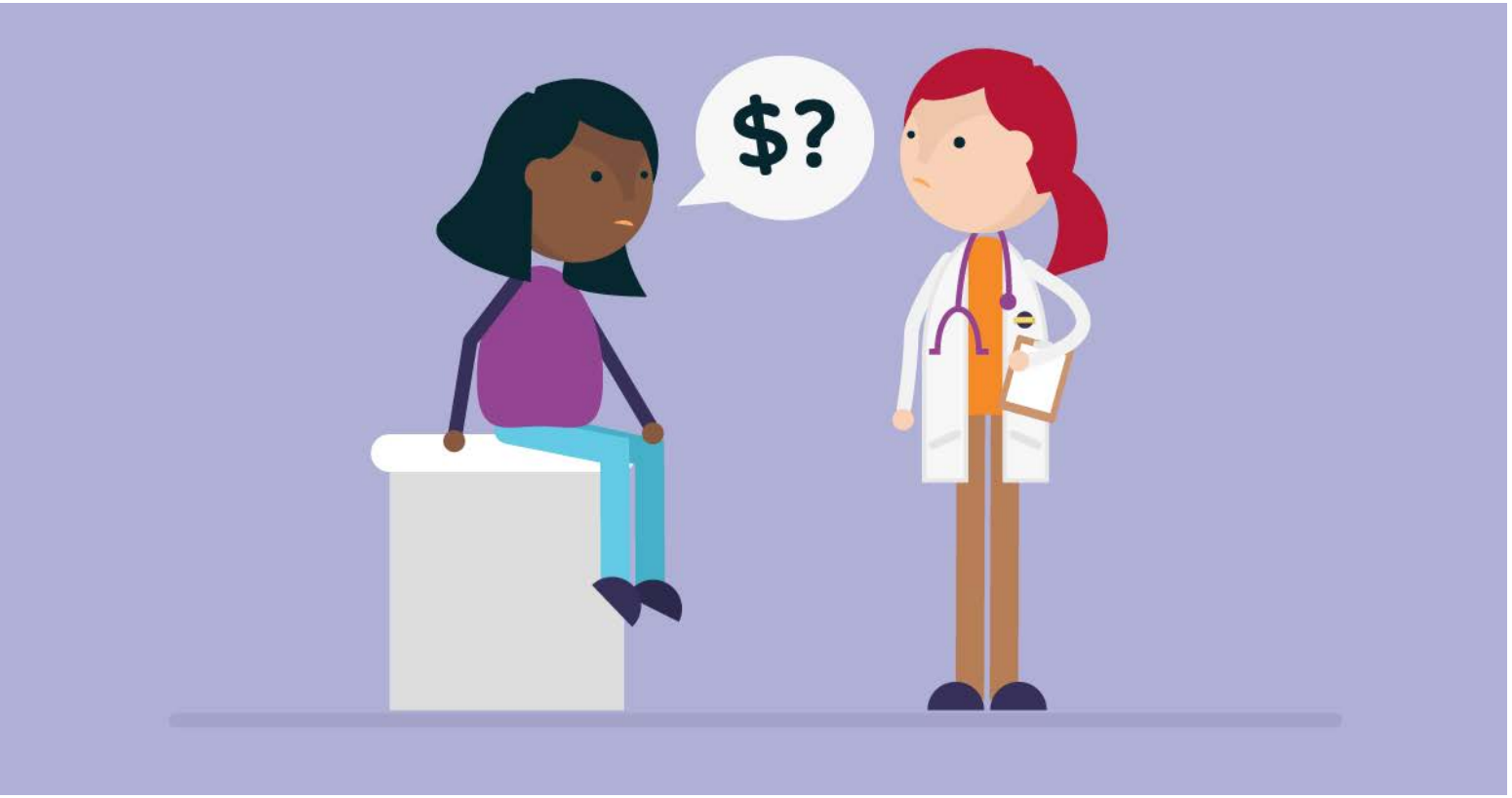
Cost Conversations

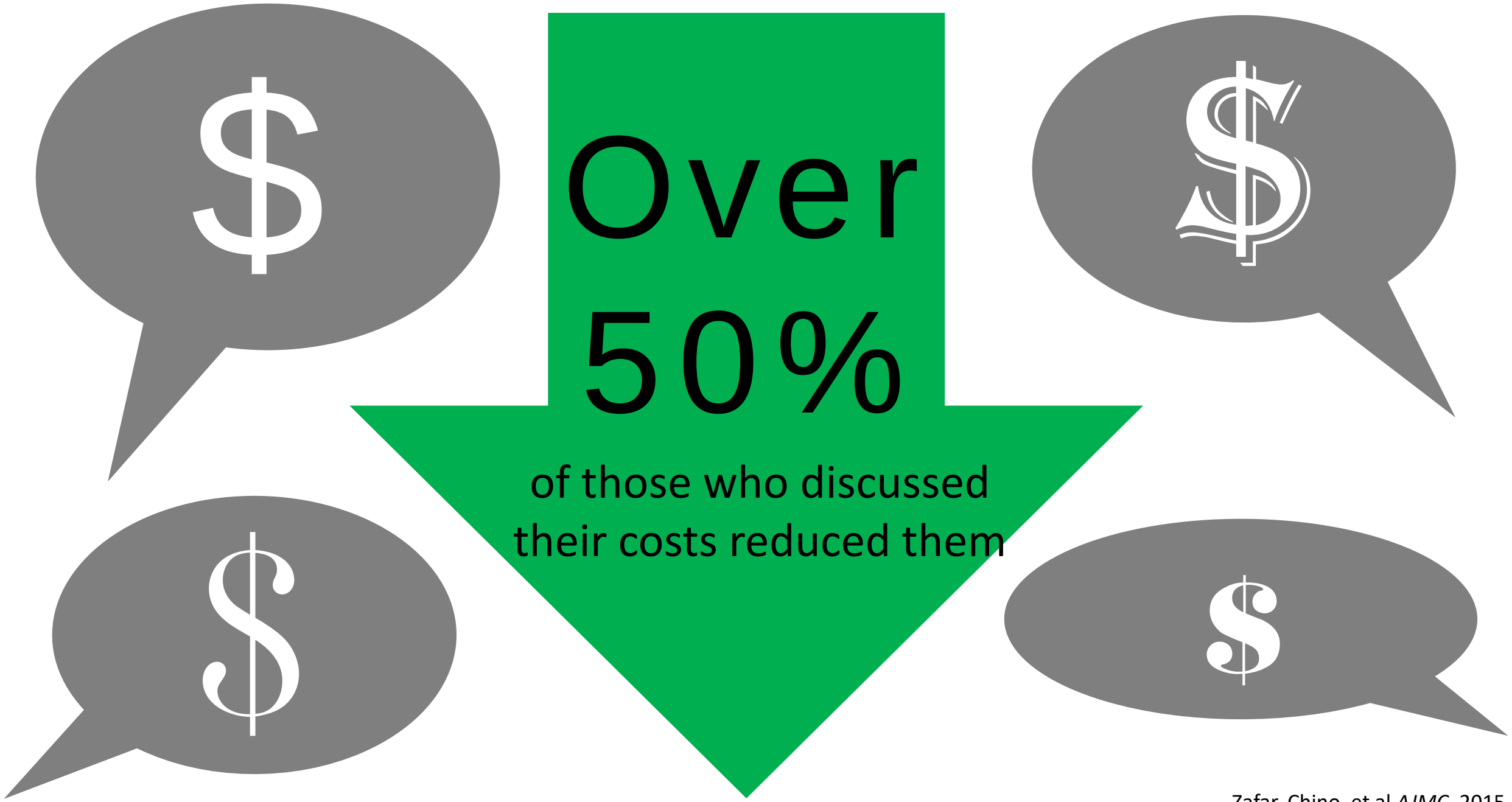


50-80% cancer patients desire a cost conversation with oncologist

But only **19%** actually talked to their doctor

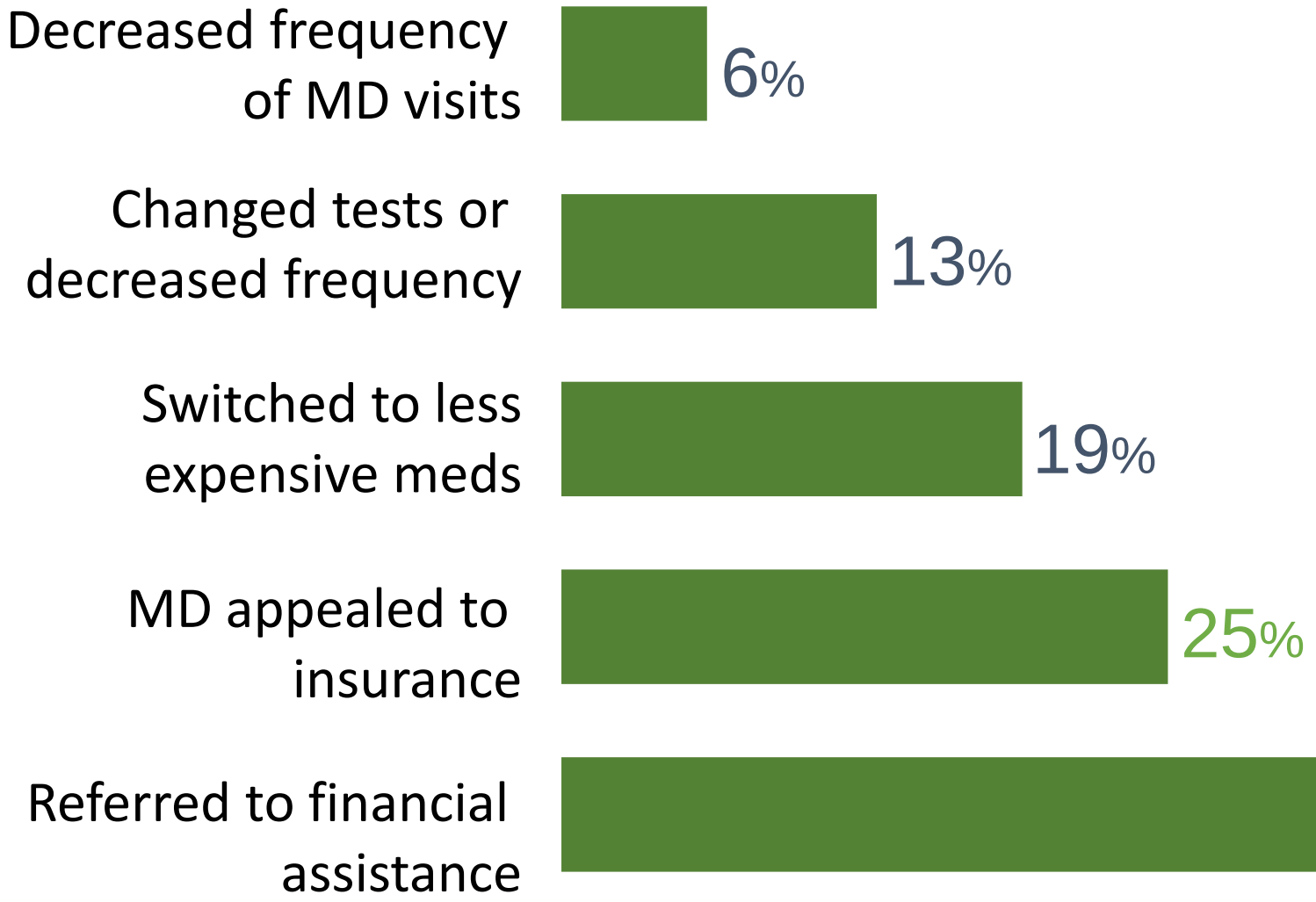
And only **28%** talked to ANY health care professional

Zafar, Chino, et al *AJMC*, 2015
Kelly, *JOP*, 2015



Zafar, Chino, et al *AJMC*, 2015

How did cost conversations help?

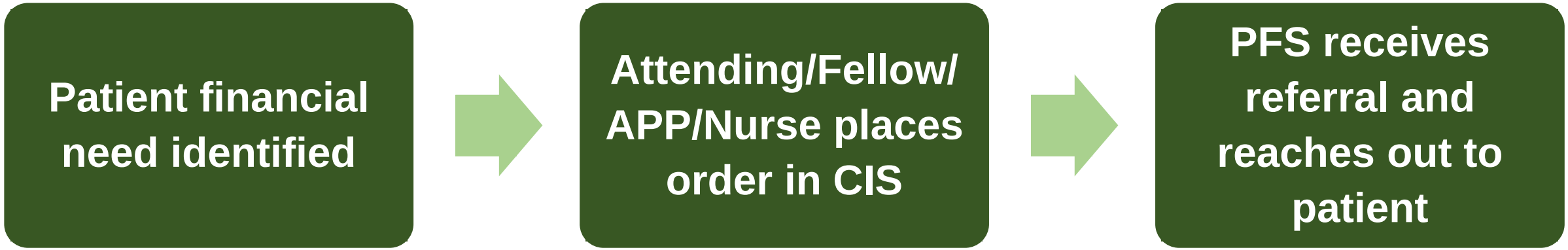


Vast majority of costs were reduced without changing cancer treatments

(not compromising care)

Zafar, Chino, et al *AJMC*, 2015

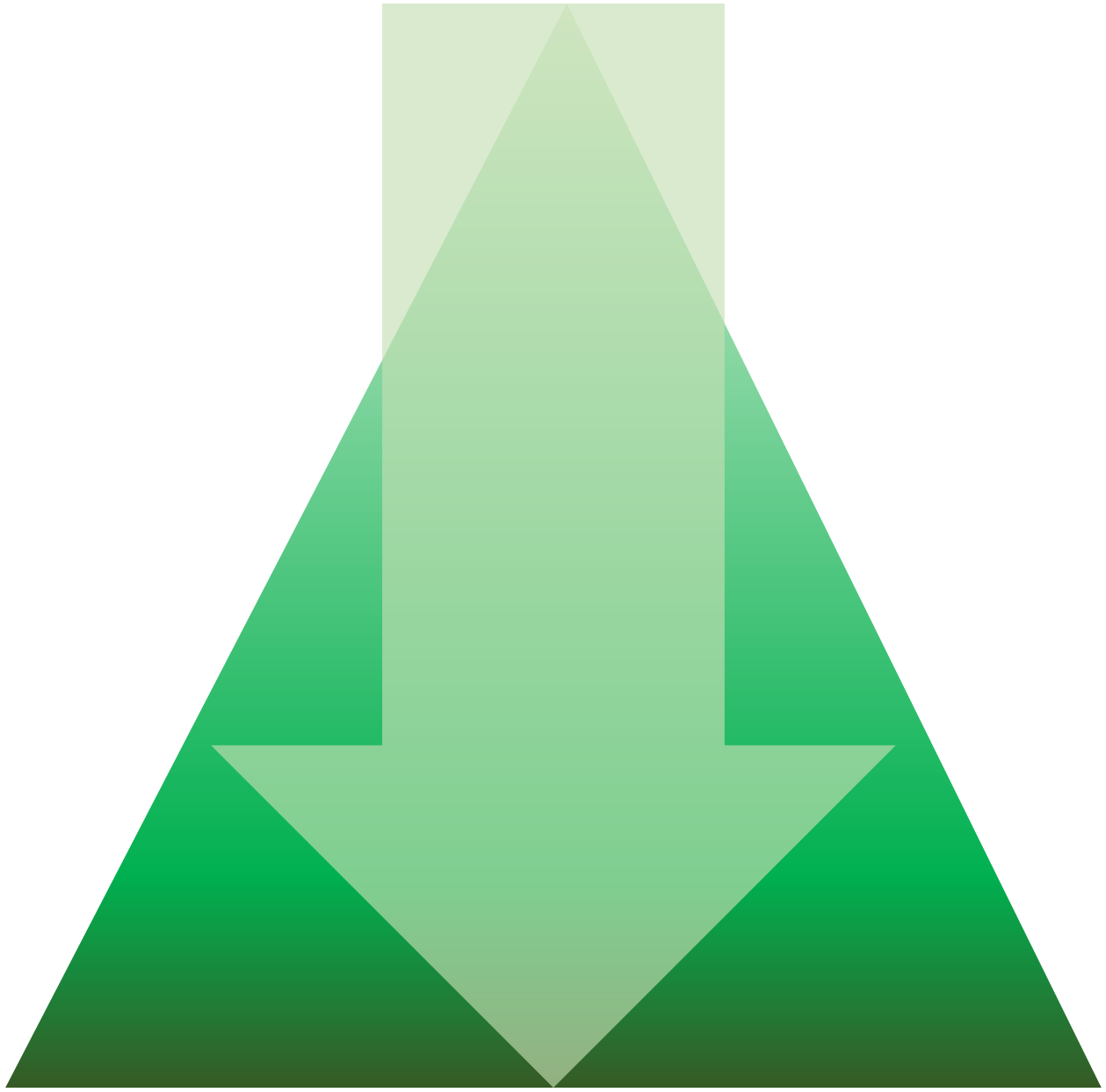
MSK Pilot: Empowering the clinical team



Reason For Consult (check box so multiple answers can be input):

Drop down list to include:

- Copay for chemotherapy treatments, oral antineoplastic medications, supportive medications
  - If known please specify medication:
- High balance/ high out of pocket costs,
- Quality of Life – Transportation, childcare, food, housing, home utilities
- Out of network insurance
- Other



1° Prevention:

Education, financial navigation, value-based care, eliminate low value care

2° Prevention:

Diagnose early by screening often

3° Prevention:

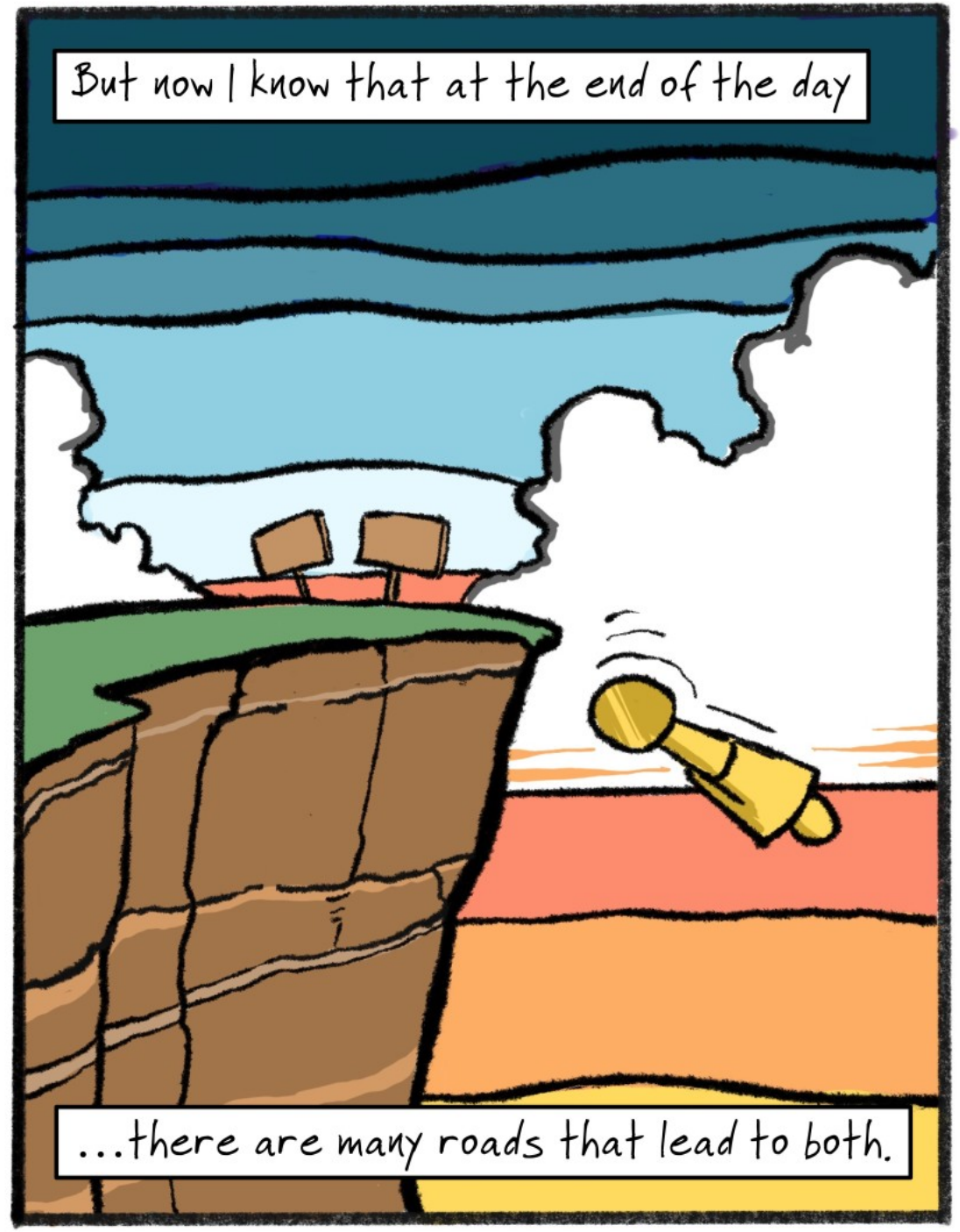
Normalize cost conversations, refer for assistance when appropriate

Mitigating Financial Toxicity *is Possible*

… but Financial Toxicity *is Growing* in the US

… and Cancer Outcomes are *at Risk*


Amid the terror of life-threatening illness, such sacrifices seem like the only viable option in a cruel game that forces you to choose between bankruptcy and death.
BANKRUPTCY
DEATH


But now I know that at the end of the day
...there are many roads that lead to both.

Thank you.

Questions? Comments?

Please take our poll! Will pop up on your screens shortly.

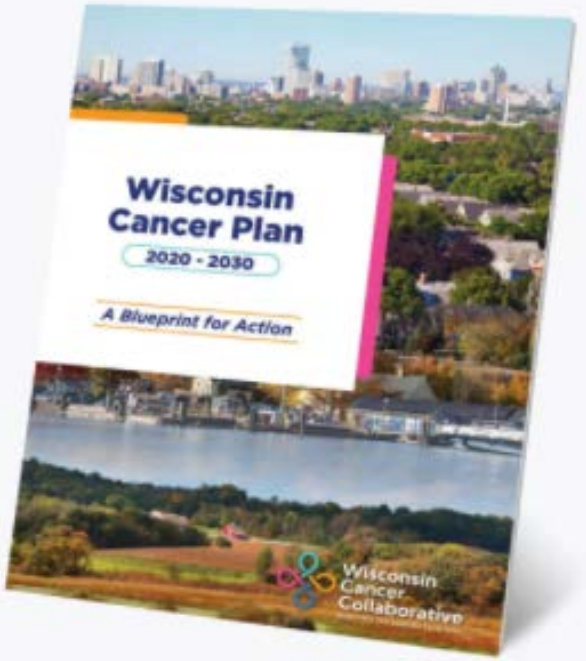
Wisconsin Cancer Collaborative

Stay tuned for resources you can use!

Wisconsin Cancer Plan & Financial Toxicity

Chapter 4: Treatment

- **Priority 1:** Increase availability and access to quality cancer care.
  - **Strategy E:** Reduce cancer care costs incurred by patients and families.
- **Priority 3**: Increase patient and caregiver access to non-clinical support services, including care coordination, patient navigation, psychosocial support, and rehabilitation services.
  - **Strategy A:** Increase insurance coverage for non-clinical support services for survivors and caregivers.



Wisconsin Cancer Collaborative

https://wicancer.org/resource/the-financial-toxicity-of-cancer-issue-brief/

Resources – Issue Brief

If you haven't yet, check out our Financial Toxicity Issue Brief

Issue Brief

Wisconsin Cancer Collaborative
REDUCING THE BURDEN TOGETHER

VOLUME 16, NUMBER 2 APRIL 2021

The Financial Toxicity of Cancer

Alexandria Cull Weatherer, MPH, and Amy Johnson, JD, Wisconsin Cancer Collaborative

Introduction

More than 294,300 people in Wisconsin are currently living with a cancer diagnosis.[1] Cancer is a challenging and complex disease, and it is one of the most expensive medical conditions a person can experience.[2]

In 2020, cancer care cost the United States an estimated 173 billion dollars.[3] The average cost of treating the most common cancers is on the rise, largely because of expensive advances in technology and treatments such as targeted therapies.[3] Currently, the average patient cost of initial cancer treatment can range from $5,047 for melanoma to $108,168 for brain cancer.[4] Patients incur additional and often increasing costs throughout their lifetime and at the end of life, regardless of cancer type.[4]

There is a growing recognition that the high costs of cancer care can create severe financial distress for patients and their loved ones.[2] This financial distress can negatively affect the physical, psychological, and behavioral well-being of patients, survivors, and families, and in some cases can lead to refusal of care or non-adherence to recommended treatments.[2]

This phenomenon is known as financial toxicity.

KEY POINTS

- Cancer is one of the **most expensive** illnesses a person can have.
- Cancer can cause **severe financial distress** for patients, survivors, caregivers, and families.
- Financial difficulties **can last for many years** after diagnosis.
- Increasing access to **high-quality and affordable health insurance** is an important way to reduce cancer's financial burden.

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https://wicancer.org/resource/the-financial-toxicity-of-cancer-issue-brief/

Save the date! – September Networking Webinar

“Share the Care: Cancer Issues in Wisconsin's Native Communities”

Join our September webinar to deepen your understanding of the cancer issues affecting Wisconsin's Native communities. Learn more about the pressing need to address cancer disparities in the American Indian community, efforts to increase cancer screening rates, and how you can get involved in Share the Care's work.

***Presented by Carol Cameron**, Program Manager, Wisconsin Inter-Tribal Pink Shawl Initiative*

10:00-11:30

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Register here: https://wicancer.org/events/webinars/

Thank You

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