FINANCIAL TOXICITY

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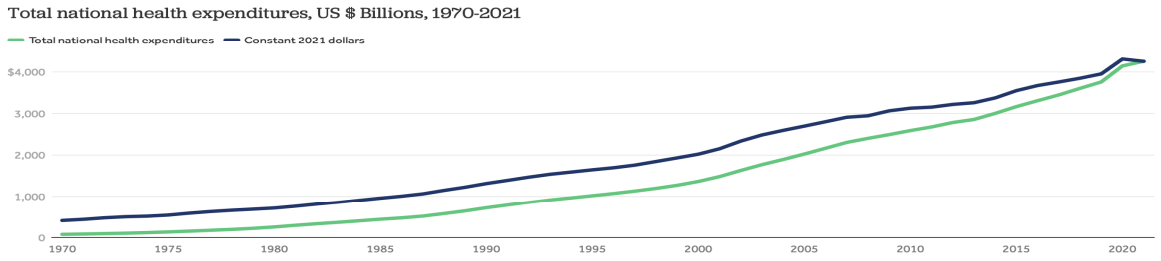
SESSION OBJECTIVES

- Classify the various costs of healthcare delivery.
- Compare and contract different healthcare reimbursement methods for patients.
- Describe the concept of financial toxicity and its application to health care.
- Create strategies to address the cost of care with patients in healthcare organizations.

2023: STATE OF HEALTH CARE
(THE COMMONWEALTH FUND, 2023)

- The US will spend a projected $4.7 trillion – or 18 percent of the nation's economy on health care.
- Per capita, the US spends about $1,300, nearly double the average of similar countries.
- Despite the high cost of care, health outcomes are generally no better than those of other countries in areas such as life expectancy, infant mortality, and diabetes.
- Total healthcare costs are anticipated to rise from $4.7 trillion in 2023 to $7.2 trillion by 2031, growing by an average of 5.5 percent per year.
- Healthcare spending is projected to grow faster than the economy, increasing from 18 percent of gross domestic product (GDP) in 2023 to 20 percent of GDP in 2026.

Total health expenditures increased moderately in 2021

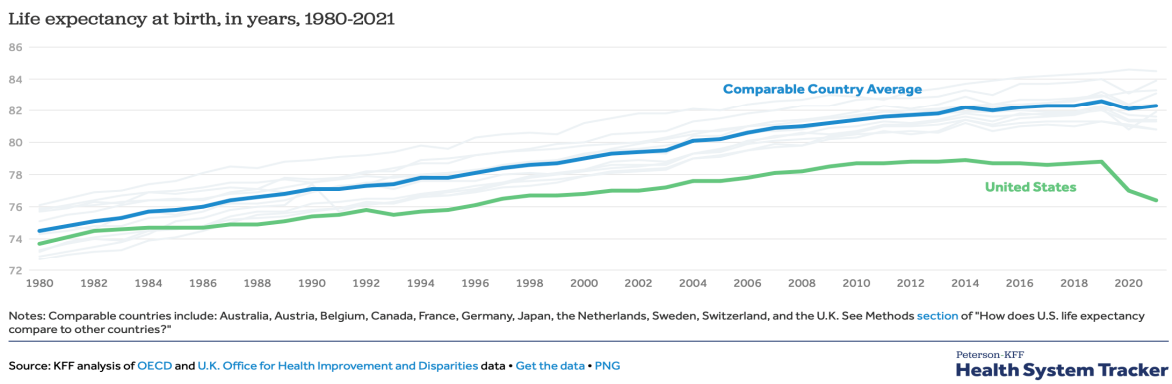


Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

Source: KFF analysis of National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF Health System Tracker

US HEALTHCARE EXPENDITURES



US LIFE EXPECTANCY

WHY IS HEALTH CARE SO EXPENSE
(KAISER FAMILY FOUNDATION, 2023)

- **Multiple Systems**
  - Complex with separate rules, funding, enrollment dates, and out-of-pockets associated with various forms of health insurance whether its employee-based, private insurance, or government-provided plan.
- **Rising Drug Costs**
  - The US healthcare system spent $603 billion on prescription drugs in 2022.
- **Higher Salaries for Medical Professionals**
  - The average annual salary for a family MD was $235,930. ED physicians command an average salary of $310,640.
- **Profit-Driven Hospitals**
- **Defensive Medical Practices**
- **Varying Health Prices**

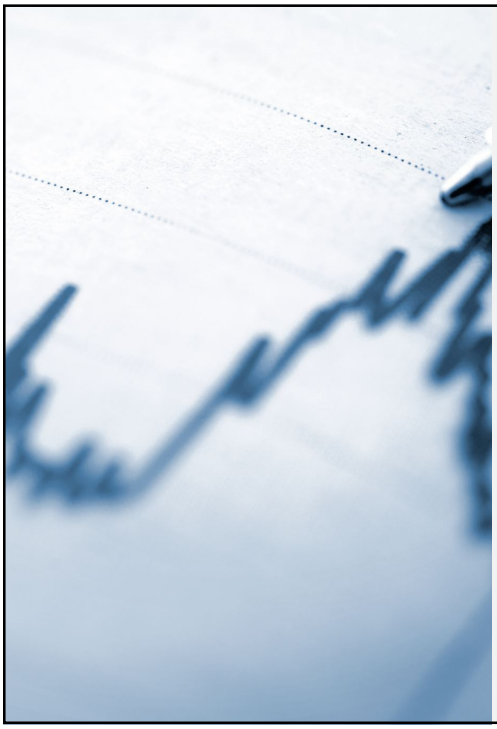
HEALTHCARE REIMBURSEMENT (INSURANCE)
(KAISER FAMILY FOUNDATION, 2023)

More people were insured in 2022 as compared to 2020.

Almost 92 percent of the US population are insured. It is estimated that 8.3 percent of the US population do not have insurance, however, at least 2% of the uninsured population are eligible for insurance.

Of those that are insured:

54% of individuals are insured through their employer (private health insurance);
8% are insured through the Healthcare Exchange;
18 percent have Medicaid;
17.5 percent have Medicare; and,
3.5 percent has TRICARE / VA / CHAMPVA coverage.



THE REAL COST OF HEALTH CARE
(KAISER FAMILY FOUNDATION, 2023)

- Even if you have health insurance:
  - The typical non-elderly family spends about $8,200 per year or 11% of their income on health care, not including employer contributions.
  - The average person earning about $50,000 per year spends about $5,250 on health care.
    - $800 in out-of-pocket costs
    - $1,400 premium contributions; and
    - $3,050 in state & federal taxes.
  - Household health spending increases significantly when health status worsens, largely due to the additional out-of-pocket costs associated with greater use of health care services.

WHAT IS THE PATIENT LEVEL IMPACT OF THE COST OF HEALTH CARE?

FINANCIAL TOXICITY

- Financial toxicity (FT) is the potential consequence of financial distress experienced by patients due to related direct and indirect out-of-pocket (OOP) treatment expenditures (Carrera, et al., 2018; Witte et al., 2019)
- FT has been associated with **negative quality of life** (Fenn et al., 2014; Kale et al., 2016; Zafar et al., 2015), **early mortality** (Ramsey et al., 2016), **non-compliance** (Knight et al., 2018), **non-adherence** (Zhao et al., 2019; Zullig et al., 2013), **and poor psychological wellbeing** (Meeker et al., 2016; Sharp et al., 2013).
- The prevalence of FT among patients is reported to be about 28–48 percent (Altice et al., 2017; Gordon et al., 2017).

DRIVERS OF FINANCIAL TOXICITY

- ***More people are being treated in the United States for disease.***
  - Often, the increased treatment is not for their benefit. There is overdiagnosis and overtreatment of diseases that might not ultimately affect a patient's mortality.

- ***Clinical and technological advances.***
  - Technology is expensive, but not always good quality or cost effective. The clinical benefit of some new medications is "stagnant or decreasing," but the costs continue to rise.
  - Increased provider costs in using technology – providers are charging for "email consultations" to answer a patient's email (Kaiser Family Foundation, 2023).

- ***More costs are pushed onto patients.***
  - While the cost of care has sharply increased since 1995, patients' income has essentially stayed flat. Further, it is posited that 43% of all patients are underinsured and the insurance they do have is not enough to pay for their treatment.

OUT-OF-POCKETS COSTS

- Out-of-pocket costs include the following:
  - ***Co-payments:*** Amount paid for each healthcare service, such as a doctor appointment or prescription.
  - ***Deductible:*** Amount paid for medical care before health insurance plan begins to pay.
  - ***Co-insurance:*** Percentage of costs paid for a service that health insurance covers after you have paid your deductible; for example, most co-insurances are 20% with health insurance paying 80%.
- Patients with cancer, cardiovascular disease, kidney disease, and diabetes are more likely to report higher out-of-pocket spending as compared to patients with other diseases (Valero-Elizondo et al, 2022).

HISTORY OF COST-SHARING
(RAND, N.D.)

- Cost-sharing refers to the patient's portion of costs for healthcare services covered by their health insurance plan.
- Cost sharing can trace its history back to the RAND Health Insurance Experiment, the largest health policy and experimental study of how cost-sharing affects people's use of health services, quality of care, and health status.
- Rand recruited 2,750 families from six sites (7,700 people) under the age of 65. Families were randomly assigned to one of five types of health insurance plans:
  - Free care from a fee-for-service group (no patient fees)
  - Three types of cost-sharing fee-for-service (25%, 50%, or 95% co-insurance);
  - Free care from HMO
- **Research question**: Does free medical care lead to better health as compared to health insurance plans that require the patient to share in the costs?

THE RESULTS
(RAND, N.D.)

- The study suggested that cost sharing can help with cutting costs and reducing waste without damaging health or quality of care for most people.
- Participants who paid for a share of their health care used fewer health services than did a comparison group given free care with no significant effect on the quality of care received by participants.
- However, the study showed that cost sharing can reduce both needed and unneeded health services in roughly equal proportions:
  - Care for hypertension, dental health, vision, and selected symptoms worsened for the sickest and poorest patients under cost sharing.
- Therefore, the study concluded that cost sharing should be minimal or nonexistent for low-income individuals, especially those with chronic disease.

JANET'S STORY

A 67-year-old, insured woman with metastatic breast cancer recently described how her life changed due to costs of cancer care.

- "We don't travel; we don't do anything now because it's a $100,000 illness. And it sucks.… What are you going to do? Caught between a rock and a hard spot."

Cancer is one of the most expensive diseases to treat, second only to heart disease (Witte et al., 2019).

- Costs associated with cancer services include transportation, parking, and co-pays.
- Compounded by reduced or loss of income.

Cancer expenses are rising due to:

- An aging population;
- More patients with access to treatment;
- Innovation; and,
- Overutilization of services.

THE EVIDENCE

Alexander et al. (2003) found:

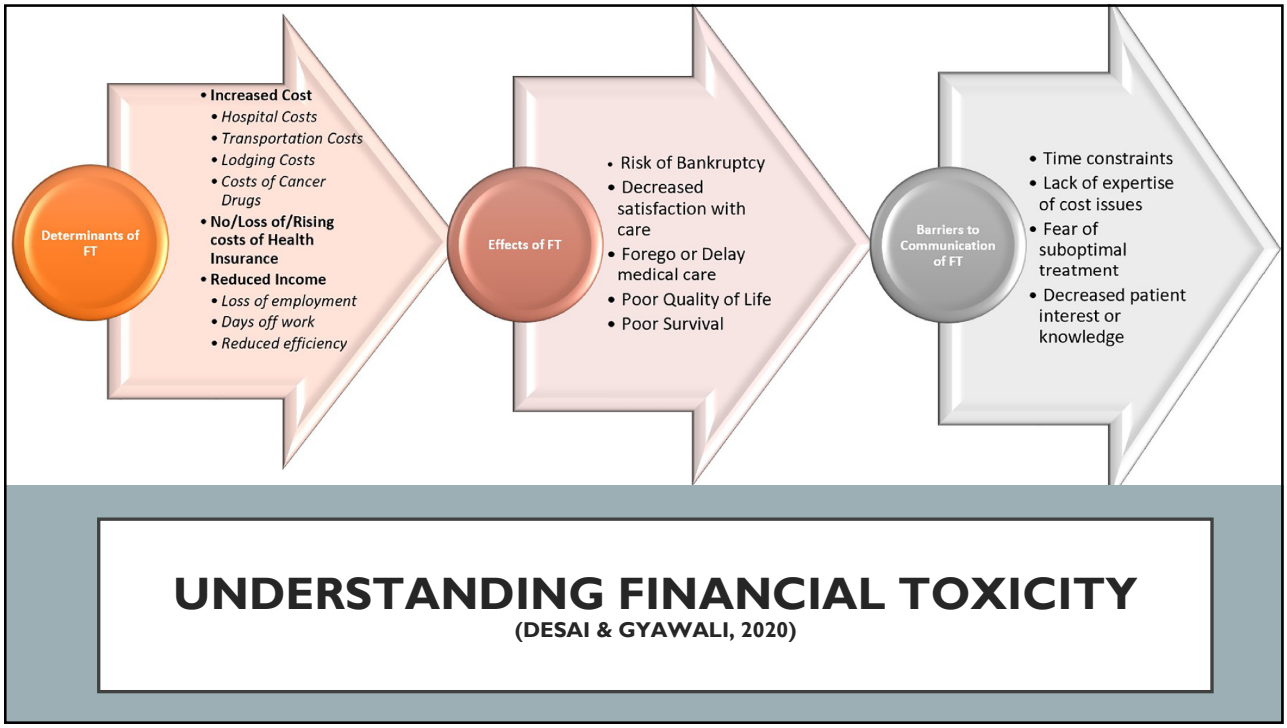
- Sixty-three percent of participants reported a preference for discussing costs with their doctors, however, 85% had never actually had the discussion.

Markman & Luce (2010) found:

- Nineteen percent (19%) believed that the cost of treating their disease caused their family a large amount of distress.
- Eleven percent (11%) considered the costs of treatment "a great deal" when choosing a treatment course.
- Nine percent (9%) decided against a treatment course because of cost.

Bullock et al. (2012) found that while most patients wanted to talk to their doctors about costs, they did not consider costs when making treatment decisions and did not want their physicians to consider costs either.

Given the challenges of financial toxicity, **Lentz et al. (2019)** posited the use of financial toxicity screening tools to evaluate patients for financial toxicity and provide assistance to patients about assistance that may be available to them.



UNDERSTANDING FINANCIAL TOXICITY

(DESAI & GYAWALI, 2020)

HEALTHY PEOPLE 2030: SDOH

- Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- SDOH can be grouped into five domains:
  - Economic Stability
  - Education Access and Quality
  - Health Care Access and Quality
  - Neighborhood and Built Environment
  - Social and Community Context

SDOH & FINANCIAL TOXICITY
VALERO-ELIZONDO ET AL. (2022)

- In a large, nationally representative study involving 15,758 patients, the researchers found:
  - All five domains were strongly and independently associated with financial toxicity.
  - Individuals in the most disadvantageous SDOH quartile had a 68% prevalence of financial toxicity.
  - SDOH components other than economic stability significantly contributes to financial toxicity.
  - Financial toxicity is a much more frequent phenomenon in non-elderly individuals.
  - High social vulnerability (resiliency of communities; the ability to survive and thrive) is strongly associated with financial toxicity.
  - Reverse causation is plausible; individuals diagnosed with a disease who experience financial toxicity may develop adverse SDOH such as high financial distress, psychological distress, or food insecurities.

STRATEGIES TO ADDRESS FINANCIAL TOXICITY

National Level:

- Policy changes that address:
  - The appropriate cost of care;
  - Value-aligned pricing strategies;
  - Align cost of drugs and treatment to the level of evidence;
  - Discouraging the approval of low-value drugs that show minimal to no clinical benefit; and,
  - Evidence-based screening tools for financial toxicity.

Hospital Level:

- Cost transparency,
- Availability of financial counselors in hospitals, and
- Elimination of low value practices.

Provider Level:

- Increased awareness of Financial toxicity;
- Decrease low value practices;
- Discussing financial toxicity with patients; and,
- Use of the financial counselors.

Patient Level:

- Patient support groups
- Use of Financial Counselors

CONCLUSIONS

Financial toxicity is a real clinical problem with adverse consequences for patients, families, providers, and organizations.

Financial toxicity has the potential to be applicable to ANY healthcare issue.

Objective measurement, recognition, and discussion of Financial Toxicity is an important step among patients and providers.

As nurse leaders, we are responsible to address this important issue of financial toxicity.

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