Financial Support Models

A case for use of financial navigators in the oncology setting

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BACKGROUND: Financial toxicity causes significant psychological and practical distress for patients and can affect their ability and willingness to undertake optimal treatment. Although different models of financial support are typically available to patients undergoing cancer treatments, not all models can offer equal amounts of support and effective solutions, particularly to those patients at the highest levels of risk for this toxicity.

OBJECTIVES: This article discusses the two most prevalent models available to healthcare institutions to provide financial support (financial counseling and financial advocacy) and makes recommendations for implementation of a more comprehensive, proactive financial navigation model.

METHODS: This article reviews current and emerging financial support models.

FINDINGS: Financial toxicity is on the rise, and the financial navigation model shows promise in decreasing the number of patients experiencing financial hardship.

KEYWORDS
out-of-pocket costs; health insurance; financial toxicity; financial navigation

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NEW TREATMENT OPTIONS, SUCH AS TARGETED THERAPIES and immunotherapies, are showing great promise in extending the lives of patients with advanced-stage cancer, but these advances come with a high price tag. By 2020, healthcare costs associated with cancer will increase to a range of $173 billion to $207 billion (Tran & Zafar, 2018). These costs are increasingly being transferred to the patient through increased health insurance premiums, deductibles, coinsurance, co-pays, and out-of-pocket responsibilities (McCarthy-Alfano, Glickman, Wikelius, & Weiner, 2019). In addition, many patients with cancer also undergo multiple treatment modalities, such as surgery and radiation therapy, which increases the cost of care and often limits patients' ability to maintain their prediagnosis income level (de Boer, Taskila, Ojajärvi, van Dijk, & Verbeek, 2009; Ekwueme et al., 2014). These direct medical costs, in combination with the many indirect costs of cancer, create an environment that promotes financial toxicity as an additional patient burden. Financial toxicity is a term coined to describe the adverse effects of out-of-pocket healthcare costs on the well-being of patients with cancer (Zafar, 2015). This article provides a history of patient financial counseling and advocacy services in the healthcare setting and proposes a proactive model of financial navigation that better addresses patients' financial toxicity needs.

Current Financial Support Models

Traditional financial counseling services have been offered in the hospital setting for decades. In general, the counselor in this role assists patients to apply for Medicaid and the hospital charity program and will often assist patients to estimate the cost of proposed care and to explore payment options. They may also help patients enroll into credit programs that secure payment to the provider. In most hospital systems, the financial counselor is located in a different area in the building from the clinical oncology setting where patients receive treatment, limiting access. This can result in counselors reacting to—rather than being proactive about—patient issues, as well as a disjointed delivery of counseling services.

In contrast to the financial counseling model of service, a financial advocacy model has emerged as a response to the limitations created by the counseling model. Clinical social workers, pharmacy staff, and other advocates within the oncology service line have attempted to deal with the

massive influx of referrals of patients expressing financial distress. The advocacy model uses specific programs designed to lessen the financial burden for the patient. Programs like co-pay assistance, premium assistance, and free drug programs are the most common tools used in this approach. In addition, attention to the patient's basic needs, such as housing costs, transportation, and utility expenses, is often a central part of this advocacy role. Staff functioning in the role as a financial advocate have, for the most part, self-educated themselves in finding programs that can help lessen the financial burden and associated emotional distress (Michigan Cancer Consortium, 2018). At times, the financial advocate can be proactive, but the advocate more often remains reactive because the service is based on referrals rather than seeking out patients in advance of treatment.

> "Financial navigators should proactively intervene as early as the day of consultation and no later than at treatment initiation."

Proposed Financial Navigation Model

An alternate model to financial counseling or financial advocacy is the financial navigation model. The model has been piloted and showed promise with patients with cancer as a strategy to alleviate some of the effects of financial toxicity (Sherman, 2014; Tobias & Ring, 2014; Yezefski, Steelquist, Watabayashi, Sherman, & Shankaran, 2018). The financial navigator addresses financial toxicity by being proactive in guiding patients through the complexities of the many health insurance options available, resulting in a reduction of patient out-of-pocket responsibilities.

In addition to the problem-solving approaches discussed previously in other models, the financial navigation model proactively optimizes the patient's insurance coverage. Still keeping optimal care as the focus, financial navigation may influence the patient's treatment plan, informing the patient and providers about implications as the treatment plan develops and is implemented. These implications, based on optimizing the patient's insurance coverage, contribute to decision making and evaluation of treatments, treatment options, and treatment timing. Ultimately, the financial navigation model helps maximize the patient's healthcare coverage and minimize the patient's out-of-pocket costs.

Medicare beneficiaries, as well as Patient Protection and Affordable Care Act enrollees, may have the ability to reduce the cost-sharing burden of care by switching to other policies within those systems or using federal and state programs that help reduce cost-sharing responsibilities of the beneficiary. However, most beneficiaries of these health insurance policies are not aware of these opportunities. Types of Medicare coverage can be found in Table 1. A well-informed financial navigator can proactively assist patients by navigating these complex systems and educating the patient on coverage options that will reduce the out-of-pocket burden for the patient. When the patient's out-of-pocket costs are reduced, both patients and providers benefit because providers can then more easily submit for reimbursement for care from the coverage carrier.

As part of optimizing the patient's insurance coverage and using external assistance programs, financial navigators can determine if the patient qualifies for public assistance programs to supplement insurance coverage. These programs include the Medicare Savings Program (MSP) and Low-Income Subsidy (LIS). Patients who are enrolled in MSP or LIS do not need to wait for the national open enrollment period (October 15 through December 7) to enroll into Part C because they can enroll into Part C any time during the year. These Medicare policies typically have an out-of-pocket maximum range of $3,400–$6,700. After a

TABLE 1.
TYPES OF MEDICARE COVERAGE

MEDICARE COVERAGE	TYPE OF COVERAGE	COST SHARING
Part A	Inpatient care	$1,364 deductible
Part B	Outpatient care	Unlimited 20% coinsurance
Part C	Medicare Advantage Plan	Out-of-pocket maximum of $6,700
Part D	Prescription drug benefit	$5,100 coverage gap and unlimited 5% cost sharing during catastrophic coverage

Note. Based on information from Centers for Medicare and Medicaid Services, 2014, 2018, 2019.

patient's insurance has been optimized, enrollment into a co-pay assistance program will further reduce the cost burden. Studies have demonstrated a significant return on investment for the provider when implementing a robust financial navigation model (Tobias & Ring, 2014; Yezefski et al., 2018).

The financial navigation model is more complex than the previous two models and requires proactive engagement with the patient, a higher degree of expertise with understanding the complicated health coverage instruments, a solid understanding of the disease and treatment process, and allowance for the financial navigator to have some level of influence on the treatment plan. Not every patient with cancer will need this more advanced model, meaning that the two previous models will, at times, provide solutions that will effectively reduce financial toxicity. However, healthcare providers should recognize that, as the health insurance landscape grows continually complex and the cost of treatments continues to rise, an increasing number of patients will need expert navigation to reduce financial toxicity.

Implementing the Financial Navigation Model

Financial navigation models can be particularly effective with certain patient populations. Some of the patient populations at

FIGURE 1.
CASE STUDY ON FINANCIAL TOXICITY

John, a 68-year-old married man diagnosed with advanced-stage lung cancer, is in need of radiation therapy and immunotherapy. The expected cost of one year of treatment is about $350,000. John has coverage with Medicare parts A, B, and D, and his household monthly gross income is $1,690. He and his wife have $11,000 in their savings account. Because his medical coverage is limited to Medicare parts A and B, he will have unlimited 20% responsibility for his outpatient care. Under this current scenario, John's responsibility for care is estimated to be about $44,000 this year. From John's responses to the National Comprehensive Cancer Network Distress Thermometer and Problem List screening tool, which he completed during his initial clinic visit, his distress is rated as a 9 on a scale from 0 (no distress) to 10 (extreme distress). John noted insurance, worry, and not being sure how to pay for treatment as problems.

John's financial advice would focus on applying for Medicaid and/or the hospital charity program. Because John is eligible for Medicare, an asset qualifier would need to be in place for him to qualify for Medicaid. In most states in the United States, he would need to prove that he has less than $3,000 in assets because he is married. He would, therefore, need to reduce his $11,000 savings down to below $3,000, resulting in added harm to his sense of financial security. In addition, in most states, he would also have a "spend-down" responsibility because his monthly income is $1,690. This refers to the monthly patient financial responsibility that needs to be met before Medicaid will pay the remainder of the medical bill for that month. Medicaid issues spend-down responsibilities to individuals whose income is above the threshold to qualify for full Medicaid. This cost-sharing responsibility could easily be $500–$800 a month. Applying for the hospital charity program would also lessen the financial burden to the patient. However, most patients with cancer have many providers involved with their care, and some of them may not participate in the hospital charity program, resulting in continued high cost-sharing responsibilities for the patient. Even if the patient qualified for all of his medical bills to be forgiven by the hospital charity program, it is important to ask if that is what is in the best interest of the patient and provider. Financial toxicity is only slightly eased with this approach.

Given John's stated emotional distress, it is likely that his nurse would initiate a referral to an oncology social worker, who may be considered as a financial advocate. When attempting to solve John's problem using this approach, several solutions will most likely be offered. The patient would easily qualify for assistance from the pharmaceutical company in the manner of being offered free medication. This would reduce some of the pending financial toxicity that John would have experienced for his immunotherapy treatments, but it does not solve his 20% responsibility for his radiation treatments. Using pharmaceutical assistance programs is one way to lessen the financial burden that the patient would experience. However, most patients with cancer receive more treatment modalities than just a pharmaceutical product. Emergency department visits, biopsies, scans, radiation therapy, and hospitalizations are only a few of the items for which the patient would have cost-sharing responsibilities. A hybrid approach may be taken where no-cost medication and charity are offered to the patient, which would reduce the financial burden. Another intervention would be to enroll the patient into a co-pay assistance program, in addition to some of the solutions offered previously. However, the final outcome would leave John in continued financial distress and most likely increased charity and/or bad debt for the provider because external assistance programs only assist with a portion of his treatment needs. Financial toxicity, although reduced, will continue to affect patients like John without additional intervention.

When a financial navigator—as opposed to a financial advocate—intervenes and assists with John's financial toxicity, the focus will be on insurance optimization in combination with using external assistance programs. Because of John's income and assets status, he qualifies for several public programs that will ultimately provide opportunity for insurance optimization. John qualifies for the Medicare Savings Program (MSP), which, in this case, will pay his and his wife's Medicare Part B premium. An automatic enrollment occurs into the Low-Income Subsidy (LIS) program for Part D because of MSP approval. Because of his LIS and MSP approval, John could also enroll into a Medicare Part C policy any time during the year, and that policy will go into effect the first of the month after the month of enrollment. These Medicare policies typically have an out-of-pocket maximum range of $3,400–$6,700. As a result, John's out-of-pocket responsibility could be reduced from $44,000 to less than $6,700 and save more than $300 per month in parts B and D premiums. Co-pay assistance programs can further reduce the out-of-pocket responsibilities of this patient.

highest risk are the uninsured, underinsured, patients on high-cost oral medications, Consolidated Omnibus Budget Reconciliation Act (COBRA) recipients, Affordable Care Act enrollees, patients with Medicare A/B only, patients with advanced-stage disease, and patients who are new to Medicare. The new-to-Medicare population greatly benefits from proactive education on the Medicare system, preventing Medicare beneficiaries from enrolling into plans that have high cost-sharing responsibilities for oncology care. Providers who are treating these patient populations should strongly consider investing in their financial advocacy programs and include financial navigation as part of the treatment plan for the patient.

A comprehensive financial navigation model requires an institutional commitment to the proactive provision of services to high-risk patient groups and the implementation of a dedicated financial navigator role within the oncology service line. Financial navigators should proactively intervene as early as the day of consultation and no later than at treatment initiation. This approach does not depend on referrals, but rather is a systematic prediction of pending financial toxicity based on diagnosis, treatment options, and current coverage status. Figure 1 illustrates a case study of a patient experiencing financial toxicity.

Patients benefit when the financial navigator receives comprehensive educational preparation. This includes a deep understanding of different types of health insurance coverage, treatment path, short-/long-term effects of the disease process, and extended mentorship from others (within or outside of their institution) with experience in the role for a year or more as they become acclimated to the new job and move toward independent practice (Sherman, 2014). As the number of oncology financial navigators grows, an ongoing network to provide peer support and continuing education on new financial requirements and support options will be ideal, similar to other professional roles.

IMPLICATIONS FOR PRACTICE

- Recommend implementation of a more comprehensive and proactive financial navigation model.
- Proactively identify and support patients at the highest risk for financial toxicity rather than refer when problems become evident.
- Require ongoing education and adaptation to market changes within the health insurance coverage system for the financial navigation role.

Healthcare organizations with successful financial navigation models should have financial navigators with a singular focus to proactively support the patient; comprehensive training of financial navigators; and a system to update financial navigators about insurance coverage, regulations, and assistance programs. The ideal candidate for the financial navigator role should possess clinical, financial, and mental health acumen. Financial navigators must be prepared to have treatment-planning conversations with the ordering physician and help the healthcare team and patient understand how different coverage instruments can complement the treatment regimen. Financial navigators need to have empathy and the skills to have difficult conversations with patients, and they must exhibit utmost professionalism balanced with a clear passion for the role. As the financial navigator role evolves, studies can establish clear definitions of the role, educational preparation, and possible certification criteria and guidelines about the scope of practice associated with the role (see Figure 2).

FIGURE 2.
ROLES RELATED TO FINANCIAL SUPPORT

FINANCIAL COUNSELOR

- Assists with Medicaid enrollment and charity program applications, sets up payment plans, and provides cost estimates
- Most financial counselors have an associate degree or high school diploma

FINANCIAL ADVOCATE

- Assists with enrollment in co-pay assistance programs, patient assistance programs, and financial support programs (for daily expenses)
- Most financial advocates have a bachelor's degree.

FINANCIAL NAVIGATOR

- Provides insurance optimization in combination with external assistance programs, navigates patients through complex health insurance coverage, and is involved during treatment planning
- Most financial navigators have a bachelor's degree or higher, a background in disease process, and financial acumen.

Note. Based on information from Saulet, 2014

Conclusion

Financial navigation is a professional role that requires expert knowledge of the many health coverage instruments and the multiple external assistance programs available, in combination with understanding the disease and treatment process. Health systems should strongly consider investing in formal training for their financial navigators, and the financial advocacy industry should begin the process of establishing certification requirements for the role. Some preliminary work has been done to create financial navigation services in the oncology setting, but further expansion of the role and larger-scale implementation is needed to reduce the prevalence of financial toxicity.

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The authors take full responsibility for this content. Sherman has previously served on speakers bureaus for Genentech, consulted for Vivor, and spoken for Abbvie Pharmaceuticals. Fessele previously owned stock in Flatiron Health. The article has

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