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EDITORIAL – COLORECTAL CANCER

I've Got Bad News and Bad News: The Cost of Colorectal Cancer Care

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Receiving a cancer diagnosis is devastating. However, once the dust settles and the focus turns to treatment, another anxiety enters the patient's mind—"How much is this going to cost, and how am I going to pay for it?" This is particularly relevant to the 61% of Americans who live paycheck to paycheck with little financial reserve.[1] Here we have the concept of financial toxicity, where out-of-pocket (OOP) costs can cause significant financial problems for patients with cancer. Financial toxicity has been linked with increased mortality in patients with cancer, likely owing to overall poorer well-being, impaired health-related quality of life, and subpar quality of care.[2] Given this, The National Cancer Institute (NCI) has identified measuring, understanding, and addressing cancer-related patient financial hardship as a top priority.[3]

In this month's *Annals of Surgical Oncology*, Paro et al. present an analysis of 5 years of IBM MarketScan data with the goal of describing OOP costs for privately insured patients undergoing resection for colorectal cancer.[4] They calculate total and OOP costs within 1 year prior to and 1 year post surgery. In 10,935 patients, they observe that privately insured patients with colorectal cancer pay a median of US $4417 in OOP costs or 4.5% of total costs. However, these OOP costs vary widely on the basis of period of care (pre-, peri-, and post-) and insurance type. For example, patients with a Consumer Directed Health Plan or High Deductible Health Plan paid as much as US $1400 and US $3242 more, respectively, than patients with a comprehensive plan, where patients paid US $2119 more than patients with a Health Maintenance Organization plan. This important study not only provides novel and discreet data on the OOP cost for patients but also sets the stage for a broader discussion on the role of the surgeon in navigating the financial toxicity of cancer care.

OOP costs are well known to pose a substantial economic burden to patients with cancer and their families. The economic burden of cancer care can be categorized in three ways: psychosocial costs, indirect costs (mostly losses in productivity), and direct costs.[5] Direct costs can be further categorized into medical and nonmedical costs paid either by third-party payers (e.g., healthcare systems or private insurers) or by patients out-of-pocket.[6] High OOP costs can lead to financial hardship, which in turn leads to a number of adverse outcomes, including increased symptoms, decreased satisfaction with care, lower quality of life, and higher mortality.[7]

To address this on the patient side, we must continue to practice the mantra that holistic cancer care is not just about the medical and surgical treatment but also the entire psychosocial well-being of the patient. Recognizing the significant and variable OOP cost for insured patients is an important piece of this picture. Traditionally, cancer survivorship plans have failed to deal with the financial impact of cancer treatment or follow-up care. Embedding financial support into cancer survivorship plans, such as financial planning, could address a highly prevalent patient need.[8]

How about on a surgeon level? Paro et al. write that "by providing estimates of excess OOP costs associated with several patient and treatment level factors, results of the current study may inform patient–provider discussions on treatment preferences." However, the complexity of healthcare plans, coupled with the lack of transparency in pricing, makes counseling patients in any meaningful way beyond the scope of most surgeon's practice. Still, we can

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and should be advocates for our patients. This can include engaging and working with cancer centers, nurse navigators, and other programs to aid in the financial burden of cancer care. The authors' position that "patients should be counselled about the options available to switch to a more favorable health insurance plan during the next available open enrollment period" is well taken and provides a concrete action point.

Getting though neoadjuvant therapy, surgery, and adjuvant therapy is an enormous burden for our patients. The fact that our current healthcare system then layers on top financial stress is a true one–two punch. The work by Paro et al. provides much needed numbers on what insured patients with colorectal cancer can expect to pay and how this varies with certain factors. It also brings up important questions about the role that we, as surgeons, play in this process. Out-of-pocket costs are unfortunately here to stay and likely will increase with time. How we can best support our patients through this financial toxicity remains a work in progress.

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