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Welcome to the Cancer Aware Podcast, where we'll discuss cancer prevention, treatments, the latest in research and important news around cancer, brought to you by the University of Michigan Health Rogel Cancer Center.

Nicole Fawcett:

It's estimated that one in three Americans have trouble paying their medical bills and worry about how that will affect their finances long-term. This may impact their decision about cancer treatment or screening procedures. Hello, I'm Nicole Fawcett, and today we're talking with Dr. Mark Fendrick, Professor of Internal Medicine at the University of Michigan Medical School and a Professor of Health Management and Policy in the University of Michigan School of Public Health.

His focus is on enhancing access and affordability to essential medical services with a focus on underserved populations. Dr. Fendrick directs the Value-Based Insurance Design Center at the University of Michigan, and his research focuses on how clinician payment and consumer engagement initiatives impact access to care, quality of care, and healthcare costs. Welcome, Dr. Fendrick.

Dr. Mark Fendrick:

So glad to join Cancer Aware.

Nicole Fawcett:

You've been working in this space for more than 30 years. What motivated you to study these issues?

Dr. Mark Fendrick:

Well, as a practicing clinician here at the University of Michigan for over three decades, I have to say there's never been a better time to be a clinician. Our ability to prevent disease, diagnose it early and effectively treat it, especially in the area of cancer, has been truly remarkable. However, one of the issues that confronts these discussions all the time is that most conversations around healthcare in America are not around health, but they're around how much money we're spending.

And the point of the matter is that just about everyone agrees that there's more than enough money in the US healthcare system. We just spend it on the wrong services, in the wrong people, in the wrong places at the wrong time. And while there's many movements afoot to figure out ways on how to pay my clinician colleagues and health systems like Michigan Medicine better, my work is focused on the consumer and how we might engage patients to actually make better decisions.

Unfortunately, the number one lever in how we engage patients in the US healthcare system is what I call blunt cost-sharing. More and more Americans are being asked to pay out of pocket for their services regardless of how well insured they are. And they're imparted in what I would call a blunt way in the fact that my patients are asked to pay the same out of pocket for those high value services that I beg them to do as this exact same amount as those services that they may want for which there's no evidence of benefit to them.

So as more and more people have been asked to pay more out of pocket for all services, it should come as no surprise that every year we measure how many people have difficulty paying for their healthcare services. And the fact that it's exceeded one-third of people, even those with "good" insurance has been particularly problematic.

And thus, a long time ago, my one-time Michigan colleague Michael Chernew, now at Harvard Medical School, and I set out to try to figure out better ways that we might actually have patients pay less for the things I beg them to do and potentially more for the things that they don't need.

Nicole Fawcett:

So aren't we all supposed to have some kind of health insurance of some kind and people even with good health insurance are still facing high medical bills? How does that happen and where does that come from?

Dr. Mark Fendrick:

One of the most popular statements on social media is the hashtag insured but not covered. And the fact that there's so many Americans who actually are now insured and the fact they have an insurance card and a health plan, many of them don't realize that the out-of-pocket cost burden even with good insurance is high and growing higher. When I started in this area, I used to worry about copayments, which are fixed amount for services that people have to pay to see their doctor or to fill a prescription.

But what keeps me up at night at the end of 2023 is something called deductibles. And while 50% of millennials don't know what a deductible is, all four of my kids have crashed at least one of my cars, so they certainly know what deductible is, and that's the out-of-pocket amount you have to pay before your insurance kicks in. When Dr. Chernew and I started in the early 2000s, a substantial minority of people had no deductibles, and those deductibles were really small.

And now as we come to the end of 2023, almost 90% of insured Americans have some form of deductible and they've risen to over \$10,000 for a family now, which is the average. Some people have more, some people have less. This deductible amount is very important in the fact that 40% of Americans don't have \$400 in the bank.

So Nicole, while many people celebrate January 1 with a new year and maybe a college football playoff victory for the University of Michigan this year, my patients with chronic conditions lament January 1st and their deductible starts over again and they have to pay large amounts out of pocket, sometimes dollars they don't have, for services that in many situations as the case of cancer may be life-threatening.

When I think about deductibles, I go back to the late 1990s when I told my mother that I was going to consider changing my more traditional academic route and start studying the impact of rising out-of-pocket costs. She responded to me and said, "I can't believe you had to spend a million dollars to show that if you make people pay more for something, they'll buy less of it." And like all things our mother says, my mother was right. And this kind of set off a very aggressive academic agenda done by our team and others showing that my mother was right.

And that if you make people pay more to get a cancer screen, they go less often. If you make them pay more to see their clinician, they go less often. When you make them pay more for their diagnostic tests and treatments, they buy them and use them less often. And while I completely support the use of high cost sharing for services people don't need, my patient should not have to have a bake sale to afford her cancer therapy that was designed to treat her tumor.

It should come as no surprise to you, but maybe surprise to our listeners, healthcare and medical bills is the number one cause of personal debt. It is the number one cause of online fundraising campaigns and the number one cause of personal bankruptcy in the United States.

So while we worry about the clinical implications of what we do as healthcare providers, we have to pay much more attention to the financial impact of what we're doing in the fact that while some of these

interventions we do may change lives, the financial implications may be very negative and lead to significant consequences that many of us in clinical medicine don't consider when we see a typical patient.

Nicole Fawcett:

So this feels like basic supply and demand, things cost more, people don't want to buy it. How did we get here?

Dr. Mark Fendrick:

As I said earlier, I wish more people spent more time talking about the amazing progress that we've made in the prevention, diagnosis, and treatment of cancer, and also the breakthrough research that goes on in places like the Rogel Cancer Center. But what it ultimately comes down to is these kitchen table issues of how much money I have and what I should spend them on.

And for the people who actually dig deep in their pockets and pay their out-of-pocket costs for the things we want them to do, the research is very strong that sometimes they have to not pay their rent or eat less healthy food or buy less gas to get to and from their jobs.

So there needs to be some type of breakthrough not only in terms of what we can do clinically, but also how we could deliver healthcare in an expeditious way so that our patients don't have this fear of creating some type of financial situation that may be worse off than the clinical issue that we're actually taking care of.

Nicole Fawcett:

So this is directly impacting patient care and the care that patients are getting and the outcomes of their cancer diagnosis.

Dr. Mark Fendrick:

Yeah, for sure. I mean, you don't have to look far or ask any of our colleagues at the Rogel Cancer Center to ask them the last time one of their patients told them that they were having trouble keep up with their financial aspects of their care. Cancer care is so problematic from a clinical, spiritual, and emotional standpoint. The last thing we want to do is add an element of added stress, which is rising in a way more so than these other aspects of care.

People when they get diagnosed with cancer will often think immediately of how they are going to afford it. It is our hope and basically the driving force of the Value-Based Insurance Design agenda to hopefully reduce, if not eliminate some of these cost concerns that patients face, particularly when they have an opportunity to take advantage of a potentially life-altering or lifesaving intervention.

Nicole Fawcett:

Is this a problem across the board or are there certain groups or demographics that are more particularly affected?

Dr. Mark Fendrick:

You can imagine what my mother said when I told her I had to spend another half million dollars to show that high levels of cost-sharing, that's the term for the amount patients have to pay for the care they need, was more negatively impactful on low-income individuals, underserved communities and

communities of color like Black and brown individuals, as well as those with multiple chronic conditions or a severe condition like cancer.

So as we turn more and more to reducing socioeconomic disparities in healthcare and bringing real attention to the issue of enhancing equity in healthcare, it should come as no surprise that blunt instruments in terms of cost-sharing and high value services are actually worsening disparities, and any attempts to mitigate those cost related issues would be equity enhancing.

Nicole Fawcett:

So is this where your Value-Based Insurance Design Center comes in? What are some of the solutions or issues that you're looking at to solve this?

Dr. Mark Fendrick:

As an academic, I'll tell you that it's much easier to study a problem in a system, whether it be healthcare, transportation, or education, than it is to actually fix it. And it was quite straightforward for Dr. Chernew and I to show, in fact, my mother was right and published many papers to show that blunt cost-sharing instruments were actually not leading to the clinical outcomes, as well as the equity situation that we were hoping to achieve.

So at the turn of the 21st century when sitting at Kang's Korean Restaurant on South University, I was complaining to Mike about a "well-insured" patient whose mother and sister had colon cancer for which his colon cancer screening was not covered. And it was in over a series of discussions that Mike and I came up with the idea that maybe consumer cost-sharing should not be low for the cheap stuff and high for the expensive stuff.

But what might be viewed intuitive and certainly not revolutionary, but how about setting cost-sharing low for the good stuff and make people pay more for the things that won't help them? This idea eventually became a term called Value-Based Insurance Design, which in its most simple way is it sets consumer cost-sharing low or no on the services that I like to say I beg my patients to do and have it be high and have deductibles play a role in those services that may be less established by the evidence.

Nicole Fawcett:

Can you give me some examples of what are those good services versus ones that you think should be priced higher?

Dr. Mark Fendrick:

Sure. Again, we try to keep cost out of this. There are things that have been listed on quality metrics for years and years and years. So in the cancer realm, it should come as those particular cancer screenings that have been recommended for decades, screening for breast cancer, cervical cancer, colorectal cancer, and lung cancer, for example.

And then there are those treatments say for Hodgkin's disease and other certain cancers that have been established in guidelines for so many years, as well as some of these new breakthrough drugs that are based on genomics and CAR T, where if the evidence is strong and a patient and their clinician agrees that this is the best path for the patient, my ultimate goal, Nicole, is it should be easy, not hard for both the clinician to deliver that service and the patient to receive it.

Now, you have many other experts in the Michigan Medicine System that will talk about the travails that clinicians face to allow them to practice the care they want to do, but our focus, of course, is trying to make it easy for the patient, removing things like prior authorizations requirements to go far away, and

most importantly, out-of-pocket costs for the services for which myself as a clinician I'm benchmarked on.

So these quality metrics have been well-established and that's where we started our implementation of Value-Based Insurance Design. For many of your listeners, they've certainly not heard of Value-Based Insurance Design before, but maybe they're now thinking there are some clinical services that under my insurance plan that I pay little or nothing out-of-pocket compared to other services.

And our probably most important accomplishment in the Value-Based Insurance Design or VBID space is we were involved in the drafting of something called the preventive services provision of the Affordable Care Act. So these are 80 services that any American with any type of insurance, except for rare exceptions, are able to get with any out-of-pocket costs.

In the cancer realm, that is the first screening test for breast, cervical, colorectal, or lung cancer, because they have received an A or B rating from a federal organization called the United States Preventive Services Task Force. When people asked me coming out of the pandemic what I do, because as you know, I'm not a typical clinician, I only see patients a day a week and I don't do basic or translational research, I would say to them, as I would ask you, "What did you pay for your COVID shot?"

And when people reply, "I paid nothing for my COVID shot," I say, "That's what I do." And it was the work that we helped contribute on the federal level that allowed the government to make a decision to require that the government pay full price for all COVID tests, vaccines and treatments in the early phases, which is the ultimate implementation of Value-Based Insurance Design, but when it comes for screening for high cholesterol, hepatitis C, depression and anxiety, the four cancers I mentioned, mental health issues.

Because experts have determined that the clinical benefits of these services are so important under the preventive services provision, it requires health plans to cover them. Now, this is only in the area of preventive care. Other examples that your listeners might've heard of that have key VBID implications is the \$35 a month insulin copay cap. That is an idea that the Value-Based Insurance Design Center worked on from its inception.

Now, Medicare beneficiaries don't pay anything out-of-pocket for their vaccines. That was an issue that the VBID Center worked with many, many others for quite some time, and now that is a law of the land. And maybe the most important thing is we're just under 13 months away that in January 1, 2025, Medicare beneficiaries will have a \$2,000 a year out-of-pocket cap for their drugs.

Meaning that for these patients, many of them with cancer diagnosis who worried about paying for their drugs for so many situations, will start 13 months from now knowing that the most they will have to pay the entire year out-of-pocket for their drugs will be \$2,000. And my colleagues at the University of Pennsylvania helped implement an additional aspect to that part of the law, which says it can be smoothed, that \$2,000, over the 12 months.

For those Americans who don't have a lot of money in the bank who get a bill for their \$2,000 cancer drug on January 1 will actually be able to pay a substantial minority of that and get their \$2,000 paid over the entire calendar year. So we are working very hard, very specific areas, some in cancer, some not, to remove these financial burdens. Because as I like to say, Americans don't care about healthcare costs, Nicole, they care about what it costs them.

So while many people in our institution and other institutions are trying to figure out how much a health plan should pay Michigan Medicine for a inpatient stay for a cancer treatment, whether patients have a baby or get bypass surgery, what I am focused on is not what the grownups in the room have to settle out the cost of those things to the people who understand, but remove the financial burden from those patients who are going to get those treatments unless they absolutely can't.

And because they do in an increasing number, we see these issues of medical debt, online fundraising campaigns, and in some very sad situations, personal bankruptcy when patients actually get the care they need but don't have the money to pay for it.

Nicole Fawcett:

It sounds like you're really making some huge progress and some of these initiatives are going to make an incredibly powerful difference for patients. I'm curious though, with the cancer screening coverage, so the initial test is covered, but what happens say I get my annual mammogram, it's free and they found something, and I need follow-up tests or follow-up care. What then?

Dr. Mark Fendrick:

So in the spirit of the law that we worked on for the ACA in 2010, many years before and in many states afterwards, the idea of cancer screening, in my opinion, was this continuum of care that you get these necessary tests until your diagnosis of cancer, unfortunately, or you don't have cancer is made. So when you look back at the implementation of the cancer screening aspects of the ACA, again, reminding you, four cancers are mandated to have the initial screening covered 100% even if you're in a high deductible health plan, that's breast, colorectal, cervical, and lung.

And it turns out that it was about 10 years ago where I was seeing patients here at Michigan Medicine where one of my residents actually told me that a patient who did not want to get screened for colorectal cancer with colonoscopy was offered a home-based test, to which he told our resident that he would be more than happy to get a home-based stool test except his neighbor did the same thing and had to spend \$2,000 out-of-pocket to get the essential necessary follow-up colonoscopy.

And although I had presumed, a bit naive, that the health plans would cover cancer screening through the entire continuum, it turns out that we immediately embarked on a very ambitious and aggressive research program that showed that the problem that our patients said in colorectal cancer screening follow-up was in fact the case in breast, cervical, and lung. That substantial numbers of patients paid non-trivial amounts out of pocket to finish the follow-up process.

And in studies led by Vanessa Dalton in our Department of Obstetrics and Gynecology and Ruth Carlos in the Department of Radiology, we showed that those amounts have actually increased over time. So here I look back and say the individuals who are the sole reason why we have the cancer screening programs, those who would benefit from early detection and treatment, are the ones who are actually paying the most out of pocket.

And that led us to embark on yet another important policy campaign with a legion of advocates and experts to basically say patients who get an abnormal initial test go into something that we call cancer screening purgatory. Independent of financial implications, being told that your pap smear was abnormal, that your screening mammogram or stool-based test for colon cancer was abnormal, or your low dose CT scan for lung cancer is abnormal for most people is not a very positive thing.

It sends you into a dark place. And the fact that there would be any barrier, physical or financial, in front of getting these patients the follow-up tests they need is basically in a word to call infuriating. So fortunately, there are several advocates thinking about this issue, and I'm very happy to report in this past year, the Biden administration put policies in place to cover without any cost-sharing follow-up colonoscopy after a positive home test for patients being screened for colorectal cancer.

This is both commercial and Medicare. So when it comes to four cancers, we get one checkbox. It turns out that we still do not have a policy in place for breast, cervical, colorectal, and lung. And it should not surprise anyone, including my mother, that the people who are most likely to either deter their follow-

up care, which is up to 40% of women with abnormal cervical screens, are people with underserved populations and low incomes. So if anything, a policy that would remedy the issues of the cancer screening purgatory would be equity enhancing.

And as we close out 2023, we're extraordinarily optimistic to think that several states will follow suit with policies like we have in place for colorectal cancer screening nationally, and that potentially the Biden administration or the next administration will put the same guidance in place to remove these barriers to these folks that will ultimately benefit from cancer screening.

Thankfully, just in the past few months, the American Cancer Society has stepped forward in a great positive way putting out a very clear statement that cancer screening is a continuum and that cost sharing for follow-up testing must be eliminated regardless of your risk. And this statement has been highly publicized.

And maybe more importantly, their first guideline since that statement was put out, the new guideline for lung cancer screening, led by Ella Kazerooni here at Michigan Medicine in the Department of Radiology, has stated very clearly that follow-up testing after the initial free low dose CT scan must be covered by public and private payers without cost-sharing.

So I'm hopeful that our Horton Hears a Who little drum coming out of Ann Arbor will actually resonate with more drummers in Washington and we'll get together in the future and find out that patients will be able to complete the cancer screening process at no cost to them, which will lead more patients coming to my fabulous colleagues at the Rogel Cancer Center to be able to get effective, less expensive, and those treatments with fewer side effects because the cancers we detect will hopefully be at earlier stages.

And we'll see improved patient outcomes, we'll have enhanced health equity, and very importantly, we'll spend our healthcare dollars the way we should, spending more on the good stuff and less on the bad stuff.

Nicole Fawcett:

It's really encouraging that you and your team are making some significant progress. It sounds like there's a lot more work to be done. In the meantime, are there any resources that you would recommend for patients and how can we also learn more about your work?

Dr. Mark Fendrick:

It's been such a pleasure to join you with Cancer Aware. I know the Rogel family well and have so many colleagues working in this space. So inspirational. I like to say my career has kind of been driven by I published and I still perished, and I thank the University of Michigan at large for allowing me to be a bit of an outlier in the academic space to be working more in the policy realm and less in the straightforward research realm.

The work that we have done since our inception in 2005 can be found all online at [www.vbidcenter.org](http://www.vbidcenter.org). VBID, of course, standing for Value-Based Insurance Design. I have benefited tremendously from colleagues across this campus in many disciplines, and we're very fortunate to have colleagues at other institutions who understand the importance of removal of financial barriers to high value care to make this happen, but understanding that that's not only the answer.

Just by making things free does not guarantee that everyone will do the things we need to do, which is why I'm so thankful for my colleagues who work in communication and patient literacy, issues of transportation and housing and all these other aspects that tie into what we hope will be a more

patient-centered, equitable delivery system, particularly in the area of clinical oncology prevention and treatment.

Nicole Fawcett:

Dr. Fendrick, thank you for the work you're doing in this space to make care more affordable, and thank you for your time today. It was really great talking with you.

Dr. Mark Fendrick:

Same for you. Go Blue!

Voiceover:

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