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Addressing Financial Toxicity in Cancer Care Through Medical Financial Assistance (MFA) Policy

"Financial toxicity" describes the financial burden experienced by cancer patients and their families, impacting around half of cancer survivors. High treatment costs and associated expenses contribute to cancer being the leading cause of medical-induced bankruptcy among patients and caregivers.

Key Stakeholders

- Policymakers and planners in government and institutions
- Health systems leaders and hospital administrators
- Health economists and researchers

Key Takeaways

- Individuals with chronic conditions like cancer face severe financial strain due to treatment costs and lost income, with low-income, working-aged adults and racial and ethnic minorities at highest risk.
- Medical Financial Assistance (MFA) programs, federally mandated by some hospitals and health plans, are critical lifelines—especially adolescents and young adults—but vary widely in accessibility and generosity.
- At the health system level, financial navigation aims to improve patients' understanding of cancer treatment costs and to connect them with various options for financial assistance or lower cost medications through hospitals, foundations, pharmaceutical companies and public and private insurance.

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- Recent policies, including the Inflation Reduction Act, now allow Medicare to negotiate drug process, lowering out-of-pocket costs for cancer patients.

- Twenty states, including California, have proposed or passed legislation to standardize MFA programs (e.g., uniform eligibility rules)

Policy Options

Current state policy options aim to reform primary aspects of the MFA (e. g., eligibility rules), Community Benefit policies (e. g., spending limits, incentives) and concurrent policies (e. g., debt collection rules). This policy brief will concentrate on the implementation and impact of medical Financial Assistance (MFA) programs as a key intervention to reduce financial toxicity for patients.

Executive Summary

"Financial toxicity" refers to the financial burden and distress that can affect patients and their family members due to cancer treatment, impacting approximately half of cancer survivors. **(1)** Whether financial toxicity is primarily a consequence of the current healthcare landscape and insurance system, or an intrinsic risk of medical interventions, is subject to discussion. Nonetheless, cancer care can lead to significant financial burdens that reduce quality of life and limit access to essential treatments. These financial burdens often extend beyond immediate costs, leading to long-term economic consequences such as bankruptcy and severe financial distress. For instance, the high costs associated with cancer treatments, which start immediately and include various non-medical or indirect expenses, contribute to cancer being the leading cause of medical-induced bankruptcy among patients and their caregivers. **(2)**

According to Ramsey et al., cancer patients who file for bankruptcy have an 80% greater risk of dying than those who do not file for bankruptcy. **(3)** Recent federal policy changes aim to circumvent these rising costs. Recent federal policy changes aim to circumvent these rising costs. Under the Inflation Reduction Act, Medicare can negotiate prices for high-cost cancer therapies, beginning with ten drugs in 2026 and expanding over time, thus helping reduce out-of-pocket spending for cancer patients on Medicare. **(4)**

"Patient monetary matters in cancer treatment and care is much more than a concern for a patient's financial well-being. A wide swath of middle-and-lower income individuals lose everything they own, and all sense of personal agency."

Dr. Dale O'Brien, MD, MPH

1. https://pubmed.ncbi.nlm.nih.gov/34850932/
2. https://pubmed.ncbi.nlm.nih.gov/33544246/
3. https://pubmed.ncbi.nlm.nih.gov/26811521/
4. https://www.oncology-central.com/how-could-the-inflation-reduction-act-influence-cancer-drug-pricing/

While the high cost of cancer care—including immediate treatment expenses and the increasing prices of medications—may serve as the primary driver of financial toxicity, this burden is further exacerbated by factors such as low household income, socioeconomic status, underinsurance, chronic conditions, and varying federal and state-level policies. All lead to higher rates of financial distress and persistent inequities among different groups. Additionally, research indicates that patients from minority groups are more likely to face financial hardships due to cancer compared to white patients, highlighting the prevalent racial disparities in the US healthcare system.

How Financial Toxicity Affects Patients

Cancer patients endure severe financial strain in the year following a diagnosis, with medical care and drug costs exceeding $42,000. **(5)** Studies shows that cancer patients with higher out-of-pocket expenses are more likely to delay starting their medications or discontinue them altogether. **(6)** Approximately 85% of cancer patients leave the workforce during their initial treatment, often leading to a total loss of employment and work-related benefits. **(7)** Over 40% of patients spend their entire life savings within the first two years of treatment, and about 30% of United States (U.S.) adults with a history of cancer report experiencing difficulties paying their medical bills, having to borrow money, or filing for bankruptcy because of their cancer. **(7, 8)**

What is Medical Financial Assistance (MFA)?

Medical Financial Assistance (MFA) programs are an effective approach to mitigate financial toxicity in cancer care and are often sponsored by charitable foundations, patient advocacy organizations, and pharmaceutical companies. In general, MFA programs combine forgiveness of medical debt with lower out-of-pocket costs for future care over a defined period, supporting both insured and uninsured patients in non-profit, for-profit, and government-owned hospitals. A hospital may be legally required to have MFA policies, or it may choose to implement one voluntarily. Charitable foundations and patient advocacy organizations provide grants to help cover the cost of copayments or other expenses related to prescription medications.

Pharmaceutical companies also offer programs that grant patients access to brand-name medications at little or no cost, acting as a safety net for those with insufficient insurance coverage. Notably, the federal Anti-Kickback Statute prohibits anyone with government insurance from getting financial assistance from pharmaceutical companies.

5. https://pubmed.ncbi.nlm.nih.gov/32522832/
6. https://pubmed.ncbi.nlm.nih.gov/29261440/
7. https://pubmed.ncbi.nlm.nih.gov/29906429/
8. https://pubmed.ncbi.nlm.nih.gov/26733701/

Policy Landscape Surrounding MFA

As part of section 501(c)(3) of the Internal Revenue Code, hospitals can qualify for tax-exempt status if they provide, "to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it." **(9)** Since 2015, the Affordable Care Act (ACA) added Section 501(r) to the Internal Revenue Code, requiring non-profit hospitals to meet additional criteria, including the establishment of a formal written financial assistance policy for medically necessary and emergency care. However, hospitals are allowed to exclude certain services that they do not classify as medically necessary.

Based on 2025 Commonwealth Fund data, 21 states have taken legislative action to provide financial assistance and set certain minimum standards that exceed the federal standard. **(10)**

For example:

- Eleven states (CA, CO, IL, ME, MD, NY, NV, RI, SC, VT, WA) require MFA compliance as a condition of licensure or impose legal penalties.
- Five states (CO, IL, MD, VT, NY) prohibit discrimination against undocumented immigrants, while three states (FL, OK, SC) explicitly exclude them from MFA eligibility.
- Five states (CO, MD, NY, RI, SC) use a uniform MFA application, and 11 states (CA, CO, GA, ME, MD, NY, OR, RI, SC, VT, WA) guarantee patients the right to appeal MFA denials.
- Seven states (FL, GA, NJ, NY, NC, OH, OK) tie MFA compliance to state funding, while two (DC, DE) enforce it through certificate-of-need approval for hospital expansions.

Among the 30 states without statutory or regulatory financial assistance requirements for hospitals, strategies vary from attorney general agreements (MN) to state-funded programs (MA) or indirect incentives, but there is no mandate to provide MFA.

Impact of MFA Programs

While the policy landscape highlights how states regulate medical financial assistance, it is equally important to examine how such programs influence patient outcomes and health care utilization. In a study of Kaiser Permanente of Northern California, Adams et al. found that MFA increased the likelihood of inpatient admissions by 59%, ambulatory visits by 20%, and emergency visits by 53%, indicating that MFA substantially increases health care utilization. **(11)** Patients also filled more prescriptions (+27.5 prescription drug days supplied) and were more likely to undergo laboratory testing (+7.1 percentage points), thus leading to greater detection and improved management of chronic conditions. For example, abnormal cholesterol detection nearly doubled and prescriptions for diabetes and depression increased by approximately 26% and 33%, respectively. These findings underscore the potential of MFA programs to improve access to medical care and reduce financial barriers.

9. https://www.healthaffairs.org/content/briefs/nonprofit-hospitals-community-benefit-requirements
10. https://www.commonwealthfund.org/publications/fund-reports/2025/jul/state-protections-against-medical-debt-look-policies-across-us
11. https://pmc.ncbi.nlm.nih.gov/articles/PMC9634821/

Although empirical data sheds light on the impact of MFA programs, insights from community providers offer a complementary perspective to highlight their real-world significance. Dr. Dale O'Brien, MD, MPH, is a Clinical Associate Professor of Medicine in the Oncology Division at Stanford University and a community physician who has spent decades advocating for cancer care in underserved populations through his role as Executive Director of the Cancer Patients Alliance. He observed:

"Patient monetary matters in cancer treatment and care is much more than a concern for a patient's financial well-being. A wide swath of middle-and-lower income individuals lose everything they own, and all sense of personal agency. These stressors result in worse clinical outcomes. Thus, financial toxicity becomes existential toxicity. These issues must be addressed at the state policy level."

Dr. O'Brien's perspective highlights the urgent need for state policymakers to view medical financial assistance as an essential component of cancer care and patient well-being.

Conclusion

The landscape of financial assistance policies is critical in mitigating the financial toxicity associated with cancer treatments. Despite existing federal and state regulations aimed at providing financial relief, significant gaps and inconsistencies remain. The high costs and complex financial requirements for these treatments exacerbate the economic burden on patients, making it imperative for clinicians to be well-versed in both federal and state-specific regulations. Understanding the intricacies of the policy landscape enables clinicians to advocate for their patients effectively, bridging the gap between hospital and outpatient settings and contributing to better overall patient care and outcomes. Addressing the financial challenges directly will not only enhance patient access to cutting-edge therapies but also improve the quality of life for those battling cancer.