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Racial Disparities in Medication Use: Imperatives for Managed Care Pharmacy

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ABSTRACT

The COVID-19 pandemic and the social unrest pervading US cities in response to the killings of George Floyd and other Black citizens at the hands of police are historically significant. These events exemplify dismaying truths about race and equality in the United States. Racial health disparities are an inexcusable lesion on the US healthcare system. Many health disparities involve medications, including antidepressants, anticoagulants, diabetes medications, drugs for dementia and statins, to name a few. Managed Care Pharmacy has a role in perpetuating racial disparities in medication use. For example, pharmacy benefit designs are increasingly shifting costs of expensive medications to patients, creating affordability crises for lower income workers, who are disproportionately persons of color. Additionally, the quest to maximize rebates serves to inflate list prices paid by the uninsured, among which Black and Hispanic people are over-represented. While medication cost is a foremost barrier for many patients, other factors also propagate racial disparities in medication use. Even when cost-sharing is minimal or zero, medication adherence rates have been documented to be lower among Blacks as compared with Whites. Deeper understandings are needed about how racial disparities in medication use are influenced by factors such as culture, provider bias, and patient trust in medical advice. Managed Care Pharmacy can address racial disparities in medication use in several ways. First, it should be acknowledged that racial disparities in medication use are pervasive and must be resolved urgently. We must not believe that entrenched health-system, societal and political structures are impermeable to change. Second, the voices of community members and their advocates must be amplified. Coverage policies, program designs, and quality initiatives should be developed in consultation with those directly impacted by racial disparities. Third, the industry should commit to dramatically reducing patient cost sharing for essential medication therapies. Federal and state efforts to limit annual out-of-pocket pharmacy spending should be supported, even though increased premiums may be an

undesirable (yet more equitable) consequence. Finally, information about race should be incorporated into all internal and external reporting and quality improvement activities.

Introduction

The COVID-19 pandemic and the social unrest pervading US cities in response to the killings of George Floyd and other persons of color exemplify dismaying truths about race and equality in the United States. Rates of SARS-CoV-2 infection and hospitalizations have been higher among Blacks than for Whites, and Blacks have been more than twice as likely to die to from COVID-19.^{1,2} These disparities mirror other health inequities among Blacks in the US, including higher rates of being uninsured,³ higher infant⁴ and maternal⁵ mortality, poorer health outcomes of chronic disease,⁶⁻⁸ and diminished life expectancy overall.⁹ These troubling realities undoubtedly add to the passion and anger expressed by the millions of protesters that took to our nation's streets. Their voices urge us all to reflect on our roles in perpetuating inequities, whether active or passive, and to commit in both spirit and action to advance change.

On June 18, 2020 the Academy of Managed Care Pharmacy issued a statement entitled *AMCP Stands Against Racial Injustice*, stating that "we felt this letter was a crucial step for AMCP to take in the fight against racism and inequality."¹⁰ In contributing this unsolicited Viewpoint article, I intend to add to AMCP's statement by providing additional context and opinion, and offering recommendations for action. I am a long-standing AMCP member and a former member of the JMCP Editorial Advisory Board (EAB). However, the views expressed in this article are my own, and were developed without any consultation from AMCP leadership or EAB members. Additionally, this article predominantly addresses disparities involving Black and Hispanic Americans, yet the issues and recommendations discussed extend to other groups who also experience disparities in medication use

In 1966, Dr. Martin Luther King Jr., in remarks associated with the Second National Convention of the Medical Committee for Human Rights, stated that “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”¹¹ In the ensuing years the US Health and Human Services (HHS) has endeavored to respond. Racial disparities were detailed in a landmark report of the Secretary's Task Force on Black and Minority Health in 1985,¹² which led to the creation of the HHS Office of Minority Health (OMH). More recently, in 2011 HHS issued an Action Plan to Reduce Racial and Ethnic Health Disparities,¹³ which included priorities, goals and strategies to address “deeply rooted disparities that have defied major efforts toward progress for years.” The US Assistant Secretary for Planning and Evaluation published a progress report on this Action Plan in November, 2015,¹⁴ which described activities by federal agencies to address barriers and promote equity in health and health care. Also in 2015, the OMH provided its biennial progress report on disparities to Congress, as required by the Affordable Care Act (ACA). The OMH under the Trump Administration has not provided these required reports for 2017 or 2019.¹⁵ Also notable is the Institute of Medicine’s 2003 report entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,¹⁶ which included specific examples of racial disparities in prescription medication use. Additionally, the US Agency for Healthcare Research issues annual reports of healthcare quality and disparities that include comparisons across racial groups.¹⁷ Despite these efforts, racial health disparities remain as an inexcusable a lesion on the US healthcare system.

Health disparities often involve medications, as prescription drug therapies are fundamental to basic health care. Managed Care Pharmacy promotes “*A structured approach to financing and delivering covered health care benefits designed to provide affordable access to improve the quality of care in a cost-effective manner.*”¹⁸ Not explicitly stated in this definition, though assumedly implied, is the aim to provide affordable access and quality for all. Is Managed Care Pharmacy living up to this ideal? Racial disparities have been documented in the utilization of essential evidence-based drug therapies, including antidepressants,¹⁹ anticoagulants,²⁰ diabetes medications,²¹ drugs for dementia,²² and statins,²³ to name a few. Racial or ethnic disparities in medication use have been associated with the failure to achieve therapeutic goals, increased

rates of hospitalization, and decreased survival.²⁴ Pharmacists have responded with initiatives to address disparities in medication use among underserved and vulnerable populations, more recently with heightened focus on the social determinants of health.²⁵ However, medication cost remains a formidable barrier to closing the disparities gap in medication use between Blacks and Whites, including both the uninsured and those having a pharmacy benefit.

Black and Hispanic people in the US earn less than Whites. According to the U.S Bureau of Labor Statistics, the median weekly full-time pay for Whites in 2018 was \$916, contrasted with \$694 for Blacks and \$680 for Hispanic workers.²⁶ Hispanic and Blacks are also more likely to be paid poverty-level wages than Whites.²⁷ Therefore, out-of-pocket prescription drug payments consume a higher percentage of the earnings of these groups, who may prioritize paying rent or obtaining food as a necessary trade-off.²⁸⁻³¹ Patient cost sharing within the modern pharmacy benefit is often quite low. The average patient out of pocket contribution for a prescription medication in 2019 was \$10.34,³² which is less than half of the average price for a prescription medication nearly 30 years ago (\$22.06 in 1990) when more than half of prescriptions were paid for using cash.³³ However, this comparison does not address prices paid by today's patients who lack health insurance, or the deviation in patient out-of-pocket spending associated with current pharmacy benefit designs.

Today's low average out-of-pocket prescription costs are driven by the increasing array of generic medications used in the management of prevalent chronic diseases. Examining patient out-of-pocket payments for brand name medications, and specialty medications in particular, reveals a different story. According to a report by the IQVIA Institute for Human Data Science on prescription drug spending and affordability, approximately 10% of brand name prescriptions in commercial and Medicare Part D plans required an out-of-pocket cost of \$50 or more in 2019.³² Moreover, the most frequent high-cost claims (> \$125) were for medications indicated for diseases that disproportionately affect Blacks, including diabetes,^{34,35} HIV,³⁶ obesity,³⁷ respiratory disease,^{38,39} and stroke.^{40,41} The Medicare Part D benefit design also exposes patients to extremely high out-of-pocket costs. Yearly patient copayments for guideline

recommended medications for cancer can exceed \$10,000 under the Medicare Part D design.⁴² In the commercial sector, for benefits sponsored by large employers, more than half of designs with a tier for specialty drugs require coinsurance.⁴³ Other trends in pharmacy benefit design include rising deductibles, and for high-deductible health plans, coinsurance within all tiers.⁴³

Pharmacy benefit designs can pour salt on the wounds of those affected by disparities, parsing patients into the haves and have nots. Concerns about the impact of increased pharmacy cost sharing on medication access are not a new phenomenon,⁴⁴⁻⁴⁶ and approximately 24% of insured low-income Americans reported skipping medications or doses due to cost in 2016.⁴⁷ This exemplifies a shortcoming of unbridled capitalism in health care.⁴⁸ While market forces can drive innovation and empower thriving systems for healthcare service delivery, perfectly competitive markets allocate goods and services according to the consumer's (patient's) willingness and ability to pay. As wealth and race are correlated,⁴⁹ pharmacy cost-sharing is therefore not only an issue of patient affordability but also a matter of racial justice.

While the average per capita out-of-pocket spending for medications is not dramatically higher in the US, other nations' systems provide more protection against the highest levels of out of pocket spending.⁴⁷ Many in the US are at the peril of financial ruin should they develop a disease that requires an expensive therapeutic. Indeed, more than half of US bankruptcies have a medical origin, and most filers had health insurance.⁵⁰ Disparities also exist in rates of accrued medical expenses, with Blacks being more than twice as likely than Whites to compile medical debt.⁵¹

Racial disparities in medication access among the uninsured

The Managed Care Pharmacy community must elevate its advocacy for the uninsured, who face substantial economic barriers in accessing medication. While racial disparities in health insurance coverage have improved since the passage of the ACA,⁵² these gains are threatened by the law's uncertain future. Among non-elderly adults, 14.4% of Blacks and 24.9% of Hispanic

people nationally lacked health insurance in 2018, compared with only 8.6% of Whites.⁵³ Uninsured individuals paid an average cash price of \$43.67 for a generic prescription, and \$105.74 for a brand name prescription in 2019.³² Prices have been driven higher by the push for steeper rebates, placing upward pressure on drug list prices to yield greater discounts.⁵⁴ Hence, rebate savings accrue to covered populations, at the expense of those lacking coverage, among which approximately half are persons of color.⁵⁵

The Managed Care Pharmacy community should consider medication access for the uninsured to be a concern within its domain. Many of the uninsured were recently insured, and may be insured again. Data from the National Health Interview Survey for 2018 reveal that among the non-elderly uninsured, 21% had recently lost or changed their job, while 13% recently lost eligibility for Medicaid.⁵⁶ More must be done to aid those who are transitioning out of having prescription drug coverage. It might prove to be cost-effective to subsidize medication costs for the temporarily uninsured, rather than to later incur claims for disease complications. We should strive to overcome the system fragmentation that disincentivizes such an approach. Aside from the business case, from an ethical perspective in my view it is shameful that we allow so many low-income Americans to be uninsured and without access to prescription drug coverage, while subsidizing prescription medication costs for all Part D beneficiaries, irrespective of their wealth. Therein lies the power of advocacy, which must now be leveraged to eliminate racial disparities in medication use among the insured and uninsured alike.

Health systems have been tasked with responding to the health-related needs of the community. Examples include Medicare's Accountable Health Communities model, and the ACA-mandated community health needs assessment reports that are required of non-profit hospitals.^{57,58} Moreover, there is a growing recognition of the critical need to more fully and effectively engage community stakeholders to improve clinical care and enhance health system designs. In their paper entitled *Transitioning from Learning Healthcare Systems to Learning Health Care Communities*, Mullins et al write: "...the greatest disparities between low and high income patients as relates to differences in the degree of engagement with the health system

and providers are seen in the USA.”⁵⁹ Accordingly, those in Managed Care Pharmacy must increasingly engage community stakeholders in efforts to devise and implement strategies that reduce racial disparities in medication use. These efforts must be deliberate, prioritized and sustained.

It’s not only about cost

While medication cost is a foremost barrier for many patients, other factors propagate racial disparities in medication use. Even when cost-sharing is minimal or zero, such as in Medicaid pharmacy programs, medication adherence rates have been documented to be lower among Blacks as compared with Whites.⁶⁰⁻⁶³ Deeper understandings are needed of how medication-related disparities are influenced by factors such as culture, provider bias, and trust in medical advice. Much can be learned by listening to members of communities affected by health disparities, as noted above. Moreover, Managed Care Pharmacy professionals must heighten collaborations with other health system professionals who serve those who are subjected to racial disparities. These workers include nurses, community health workers, clinical social workers, and community health center administrators, among others.

What about the drug manufacturers?

There is an elephant in the room yet to be addressed: medication prices. I am optimistic that Managed Care Pharmacy will have a major role in transitioning drug payment models away from volume-driven rebates towards value-based arrangements that recognize innovation and superior outcomes. Manufacturers should provide discounts or returned funds when the purported outcomes of a medication therapy are not fully realized, and these arrangements should include evaluating outcomes among racial groups. The data tracking required by value-based payment arrangements provides the impetus to more formally incorporate data on race, socioeconomic status, and social determinants of health when measuring key performance indicators. Additionally, Pharmacy and Therapeutics committees should demand that dossiers

for new drugs contain information about the impacts of a new drug on health disparities. This might include incorporating details of known health disparities for the condition of interest, and describing barriers to treatment access that may affect vulnerable groups..

There are also implications for pharmacoeconomic data. It is encouraging that cost-effectiveness analyses (CEAs) are increasingly used by Managed Care Pharmacy decision-makers in pricing negotiations.⁶⁴ Yet these economic analyses typically consider a long timeframe of therapy, and assess cost from the perspective of the health system, not the patient. While the CEAs for many specialty drugs purport cost-effectiveness according to predefined thresholds, many such medications require extremely high patient cost sharing. Cost-effectiveness is not a measure of affordability. Yet cost-effectiveness analysis should not be eschewed as irrelevant to disparities; indeed, its application can optimize spending over the long run, enabling resources to be redirected to reduce patient cost sharing.

There is also a potential role for CEAs in evaluating the trade-offs in foregoing newer higher-priced medications in favor of “tried and true” lower cost agents. Such studies would seem to be particularly salient for therapeutic areas where newer drugs are supplanting older evidence-based medications, such as in diabetes, mental health illnesses, and some types of cancer. A better understanding of these trade-offs would inform efforts to optimize program resources, while potentially substantially reducing patient out-of-pocket expenditures. This is not to suggest that some patients would be relegated to receive inferior medications. Rather, when making a difficult choice between purchasing an expensive new medication, or obtaining food or paying rent, it would be helpful for patients to know how much potential health benefit would be foregone by selecting a next-best therapy that doesn’t involve the same magnitude of financial strain.

Suggestions for action

The Managed Care Pharmacy community can help to eliminate racial disparities in medication use in several ways. First, it should be formally acknowledged that racial disparities in

medication use are pervasive and must be resolved urgently. One must not believe that entrenched health-system, societal and political structures are impermeable to change. Second, the voices of community members and their advocates must be amplified. Coverage policies, program designs, and quality initiatives should be developed in consultation with those directly impacted by racial disparities. Third, Managed Care Pharmacy should commit to dramatically reduce patient cost sharing for essential medication therapies, for both insured and uninsured populations. Federal and state efforts to limit annual out-of-pocket pharmacy spending should be supported, even though increased premiums may be an undesirable (yet more equitable) consequence. Finally, information about race should be incorporated into all internal and external reporting and quality improvement activities. As the adage goes, "If you can't measure it, you can't improve it."⁶⁵ Relatedly, managed care and pharmacy journal requirements should specify that researchers include race as a covariate whenever possible, and consider yearly issues on the topic of racial disparities in medication use, particularly of studies involving interventions.

Conclusion

Former United States Representative and civil rights leader John Lewis said that "When you see something that is not right, not just, not fair, you have a moral obligation to say something, to do something."⁶⁶ The Managed Care Pharmacy community can do its part by resolving to do more to eliminate racial disparities in medication use. Black Lives Matter.

Postscript: I hope that this essay will elicit responses from those who have been steadfastly working to address racial disparities in medication use. It is a failing of this article that I have not described the efforts of the many groups and individuals committed to this cause. We must all listen and learn from you.

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