URBAN INSTITUTE

Guide to Equity in Pharmacy Services

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May 2024

ABOUT THIS GUIDE

This guide equips advocates and changemakers with key information about pharmacy services, including an overview of the system's inequities, and highlights the policy and accountability levers that can **advance equity.**

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit **urbn.is/4054rNQ.**

The other topics covered include the following:

- behavioral health care system
- Children's Health Insurance Program
- health care for the uninsured
- Indian Health Service
- Marketplace insurance
- Medicaid
- Medicaid-Medicare
- Medicare
- Veterans' Affairs

OVERVIEW

The United States spends more on medical care than any other country in the world, including net spending of more than $603 billion on prescription drugs in 2022, with drug prices at least two times higher than in other high-income countries. However, prescription coverage benefits and medication access are not equally available. Black, Hispanic/Latinx, Native American and Alaska Native, and other people from racial and ethnic minority groups are at a higher risk of preventable illnesses and deaths than white people because of a lack of affordable prescription medications, including because of factors such as discrimination and bias within the health care system, affordability, and limited access to health care and pharmacy services. In 2021, Dr. Utibe Essien coined the term "pharmacoequity," defined as ensuring that all individuals, regardless of race and ethnicity or socioeconomic status, have access to the highest-quality medications required to manage their health needs. The US has yet to meet this goal.

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POPULATION

Everyone likely needs a prescription medication at some point in their lives to treat acute health problems. However, people who are older and have complex health care needs and chronic physical and behavioral health conditions, such as diabetes or depression, may need to take multiple medications daily for long periods or over their entire life. People from racial and ethnic minority groups are disproportionately affected by chronic health conditions, including

because of systemic racism, generational trauma, and barriers to accessing health care, and therefore are more likely to need prescription medications than white people.

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PROVIDERS AND SERVICE DELIVERY

There are over 88,000 pharmacies in the US, employing nearly 332,000 pharmacists. Most pharmacies are chains operated by large nationwide entities such as Walgreens, CVS Health, Rite Aid, and Walmart. Often, pharmacies are located within grocery and department stores, hospitals, and clinics. Some chain pharmacy stores are open 24 hours a day. About 20 percent of all pharmacies are independent community pharmacies, also known as "mom-and-pop" drug stores. Independent pharmacies operate on a smaller scale, allowing them to have a more personalized flow of service than chain pharmacies and form relationships with health care providers and patients. Beyond filling prescriptions and educating patients about prescription and over-the-counter medications, pharmacies often provide testing and immunization for communicable diseases such as influenza and COVID-19. Some pharmacies may offer clinic services for minor injuries and illnesses and routine check-ups.

Pharmacists are an integral part of the health care team. Pharmacists have graduate-level education and often work in collaboration with support staff who assist with administrative tasks and dispensing of medications, such as pharmacy technicians, clerks, and assistants. Some pharmacists obtain additional training to specialize in treatments such as chemotherapy or infectious diseases and often closely collaborate with health care providers in treating patients. Others may work in clinical research and drug development. While most US pharmacists are white women, the field is growing diverse, with more Black and Hispanic/Latinx women joining the profession.

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FINANCING

Public and private insurers and patients bear the cost of prescription medications. Regardless of insurance coverage, patients are responsible for some cost of their prescription medications through copays, deductibles, and other cost sharing. The out-of-pocket price a person pays for the prescription drug varies widely based on many factors, such as health insurance type and prescription drug coverage, the brand and formulation of the drug prescribed, whether

generic options are available, and any discounts that insurers and health programs may negotiate with drug manufacturers. In 2022, patients spent $82 billion in out-of-pocket costs for prescriptions.

- ***Medicare*** often covers some but not all of the cost of prescription drugs. A traditional Medicare beneficiary spends an average of $651 out-of-pocket annually on prescriptions, and one in four beneficiaries is responsible for over $1,000 in out-of-pocket expenses for drugs.
- ***Medicaid*** prescription drug coverage and cost-sharing requirements vary by state. In 2018, 36 states required copayment from beneficiaries for covered prescription drugs, usually $3 or lower. Federal law establishes out-of-pocket Medicaid prescription drug cost caps of $4 for preferred drugs and $8 for nonpreferred drugs for individuals with incomes at or below 150 percent of the federal poverty level, while enrollees with higher incomes have slightly higher caps, and children and pregnant people are exempted from cost-sharing.
- For those with ***employer-sponsored health insurance***, virtually all (98 percent) of workers had prescription drug coverage in 2022.
- Uninsured or underinsured patients often pay for their medications, which is called ***self-pay***. Self-pay patients may be exposed to the highest prices for prescription drugs, as they do not have any payer or other representative negotiating for lower prices and fees. Several companies and organizations, such as GoodRx, ScriptSave WellRx, and the American Association of Retired Persons, help patients compare prices and find discounts for prescription medications.

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BARRIERS TO PHARMACOEQUITY

High drug pricing is one of the most significant barriers to equal access to medications in the US. Other barriers relate to insurance coverage policies and practices, geographic access to pharmacies and other structural barriers, and a lack of diversity in drug development and clinical trials. These barriers can negatively affect patients' care and health outcomes and result in increased hospitalization and emergency department use, disability, and death.

Affordability barriers

US patent rules and lobbying efforts have allowed drug manufacturers to prevent the development of cheaper generic versions of many prescription medications and keep prices high, often at the expense of patients. For example, inhalers for common conditions such as asthma are very expensive. Some people who take prescription drugs ration the amount of medication they take because of the costs. Over 9 million people skipped doses, took less than prescribed, or delayed a prescription refill in 2021. Adults with disabilities and those reporting fair or poor health, people without health insurance coverage, and people from racial and ethnic minority groups were disproportionately represented among those who did not take medications as prescribed to reduce costs.

Health insurance coverage barriers

Lack of health insurance contributes to cost barriers for people living in poverty, including because some states have not expanded Medicaid or certain immigrants are not eligible for federally funded medical assistance. Even when people have insurance, pharmacy benefit designs increasingly shift the costs of expensive medications to patients, including for medications that people with chronic life-long conditions such as diabetes and HIV depend on, thus posing serious affordability concerns for those with lower incomes. Furthermore, health insurers rely on utilization management programs, such as preferred drug lists and prior approval requirements, to control costs. Similarly, insurers may create preferred pharmacy networks, limiting the number of pharmacies members can access.

Accessibility barriers

Though nine in 10 US residents live within five miles of a pharmacy, less than half live within one mile of the nearest pharmacy. This means that not owning a car and lack of public transportation can make access to pharmacies challenging for patients with limited resources. Accessibility to pharmacies is a challenge in rural areas and communities of color. Nationwide, Black and Hispanic/Latinx neighborhoods have lower access to pharmacies than white neighborhoods, including because of more frequent pharmacy closures and fewer new pharmacy openings and big chain pharmacies. Furthermore, research shows that pharmacies in low-income neighborhoods have higher drug prices than those in wealthier neighborhoods. Smaller pharmacies in underserved communities are more likely to have common medications out of stock.

Social determinants of health

Unmet social needs such as unstable housing, food insecurity, and lack of transportation have been shown to affect medication adherence, as people often prioritize meeting their basic needs for food and shelter over medical needs. Language barriers, such as limited ability to speak and understand English, can result in patients not filling their prescriptions or not taking them as prescribed.

Bias in clinical research, coverage decisions, and drug approvals

Drugs must undergo rigorous clinical trials with humans to identify potential side effects and assess treatment effectiveness. People from racial and ethnic minority groups are not sufficiently represented in the development and testing of new drugs, and therefore, we do not have good evidence on how drugs may differentially affect people who are nonwhite. When insurers make decisions about lists of covered prescription drugs based on clinical research that lacks diversity, underrepresented groups may be harmed. Moreover, some pharmaceutical companies have allegedly misused racial equity arguments to obtain approvals for unproven drugs that could, in fact, disproportionately expose people of color to unnecessary risks and side effects.

The Stress of Obtaining Vital Medications

"I was diagnosed with multiple sclerosis in 2007 and, more recently, Crohn's disease in 2019. It's extremely stressful to pay for two incredibly expensive treatments. It's hard to even look at my medical bills. It already takes so much out of me to live with the physical symptoms of MS and Crohn's, but in addition I am forced to fight with my insurance company and figure out how to pay for these drugs that I need. The stress I feel also contributes to a vicious cycle: Stress can make Crohn's disease flare up, but having MS also makes me more susceptible to anxiety and other mental health issues."

—Julie Miller, Providence, Rhode Island, excerpted from "Featured Stories" Patients for Affordable Drugs, accessed May 15, 2024, https://patientsforaffordabledrugs.org/story/julie-miller-2.

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DISPARITIES

Racial and ethnic disparities in the use of essential prescription medications have been well-documented. Examples include medications such as antidepressants, diabetes medications, and drugs for dementia and heart disease. These disparities have been associated with negative outcomes, including increased hospitalizations and decreased rates of survival. Health care practitioner bias contributes to these disparities. People from racial and ethnic minority groups are less likely than white patients to be prescribed novel treatments, higher quality medications, and commonly used generic therapies. During the pandemic, Black patients were less likely to receive available treatments for COVID-19 both in hospitals and clinics. Studies have also documented racial and ethnic disparities in the prescribing of pain medications and treatments for substance use disorder, where patients of color are less likely to be prescribed opioids to treat pain and medications to treat substance use disorders than white patients.

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OVERSIGHT AND ACCOUNTABILITY

Congress is primarily responsible for developing and enforcing federal laws and regulations about the production and distribution of medications in the US. Several federal agencies under the US Department of Health and Human Services are responsible for drug regulations at the federal level, including the following:

- **Food and Drug Administration (FDA)** is responsible for approving new prescription and over-the-counter drugs and ensuring that these drugs are safe and effective.
- **The Centers for Medicare and Medicaid Services (CMS)** is primarily responsible for administering Medicare, Medicaid, the Children's Health Insurance Program, and Marketplace programs. As part of this role, CMS makes decisions and provides guidance on Medicare-covered prescriptions and how Medicaid programs pay for drugs. Under the Inflation Reduction Act, CMS will negotiate with pharmaceutical companies over drug prices paid by Medicare.
- Watchdog entities, including **the Government Accountability Office, Office of General Inspector, and the Medicare Payment Advisory Commission,** conduct independent research and analysis and advise the federal government on issues related to federal health care programs.

At the state level, **state governments** regulate prescription drugs through legislation, and Medicaid programs set policies around administering pharmacy benefits to Medicaid beneficiaries, including provisions such as utilization management and cost-sharing requirements for prescription medications.

Consumer advocacy organizations, such as I-MAK and Patients for Affordable Drugs, are advocating for laws and regulations that will make prescription medication accessible and affordable to all.

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POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

Efforts to inflate the cost of prescription drugs point to the urgent need for better regulation of the pharmaceutical industry. For example, a recently filed lawsuit alleges that the manufacturer of adalimumab (Humira)—a medication that treats autoimmune disorders—engaged in a fraudulent scheme to overcharge patients and insurance companies for the drug in violation of consumer protection laws. Another example is the limited access to preexposure prophylaxis (PrEP), which is a medicine to reduce the chance of getting HIV, because of high medication costs. Scholars have argued that PrEP affordability is an equity issue that shows the need for additional policy reforms and regulation of drug pricing to fulfill the promise of ending the AIDS epidemic, particularly in racial and ethnic minority communities. While the public largely agrees that the cost of prescription drugs is a major problem, the federal government does not regulate drug pricing. The recently passed Inflation Reduction Act of 2022 is the first major federal legislative effort to lower prescription drug costs for Medicare beneficiaries. States are increasingly considering laws to address prescription drug costs through measures such as imposing out-of-pocket caps on life-saving medications like insulin and strengthening transparency and oversight of pharmacy benefits.

Achieving pharmacoequity requires addressing structural racism and implementing policies to allow unencumbered access to evidence-based medications for all people who need them while promoting rigorous research and innovation in treatment development. Examples of policies and strategies that could reduce barriers and advance pharmacoequity in the US include the following:

Improving affordability

- Improving access to health insurance could make prescription drugs more accessible for millions of uninsured people. This could be achieved by expanding Medicaid in all states and territories, removing barriers to public insurance for lawfully residing immigrants, and expanding eligibility criteria and financial assistance for people purchasing coverage in health insurance Marketplaces.
- Requiring insurers to include free or low-copay preventative medication benefits and implement cost-sharing caps on prescription medications for chronic health conditions, cancer treatment, and rare diseases.
- Increasing access to lower-cost treatment options by promoting generic and biosimilar drugs through patent policy reforms and FDA regulations.

Addressing access barriers

- Improving availability of retail pharmacies in rural areas and Black and Hispanic/Latinx neighborhoods.
- Reducing insurance barriers to prescription medications, such as by strengthening pharmacy network adequacy requirements and guidance and oversight over the prior authorization process and other utilization management practices.
- Providing access to culturally and linguistically effective medication management services, such as having patient pharmacy navigators available at pharmacies, clinics, and other locations to assist patients in understanding dosing directions and managing multiple prescriptions.

Addressing unconscious bias in clinical research and prescribing

- Enforcing compliance with laws and regulations that mandate diverse representation in clinical trials.
- Increasing racial and ethnic diversity of pharmacists and pharmaceutical researchers, and training health care practitioners on implicit bias in prescribing and treatment protocols.
- Increasing transparency in prescribing practices through tools such as clinical dashboards and electronic health record alerts and reviews to ensure all patients, regardless of race and ethnicity, are prescribed the most appropriate and effective medication for their conditions.

Incorporating equity considerations in oversight and accountability

- Developing pharmacoequity measures to help health care programs and insurers identify and address issues that delay or prevent a patient from receiving adequate medications and therapies.
- Increasing investments in community-based pharmacotherapy research, including partnering with diverse communities to better understand factors that pose barriers and contribute to disparities in access and adherence to prescribed medications and identifying effective policy solutions and strategies to mitigate barriers and disparities.

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GLOSSARY

Accountability is an assurance that an individual or organization is evaluated on performance or behavior related to something they are responsible for.

A **copay** is a financial contribution that an insured person makes toward the cost of health care services.

Culturally and linguistically effective health care is the ability of providers and organizations to effectively deliver health care services that meet patients' social, cultural, and language needs.

A **deductible** is a specified amount of money that the insured person must pay before an insurance company will pay a claim.

A **generic drug** is a medication created to work similarly and provide the same clinical benefit as brand-name medicine.

Generational trauma refers to the passing down of traumatic experiences or stressors from one generation to another.

Employer-sponsored insurance is health insurance offered to employees and their dependents (and, in most cases, spouses) as an employment benefit.

The **federal poverty level** is a measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid and Children's Health Insurance Program coverage**.**

Health disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Measures are tools that help assess or quantify health care processes, outcomes, patient experiences, and organizational structures and/or systems associated with providing high-quality health care.

Medicaid is a federal health insurance program for people with low incomes.

Medicare is a federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Oversight is the responsibility for a job or activity and ensuring it is done correctly.

Over-the-counter medications are medicines that people can buy without a prescription.

A **prescription drug** is a pharmaceutical drug permitted to be dispensed only to patients with a prescription from a health care provider.

Prior authorization is a required approval from a health plan before a patient receives a service or fills a prescription for the service or prescription to be reimbursed.

Side effects are a drug or treatment's unintended and typically undesirable effects.

Substance use disorder is a chronic health condition that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. Symptoms can range from moderate to severe, with addiction being the most severe form.

ACKNOWLEDGMENTS

This guide was prepared for the Urban Institute’s Unequal Treatment at 20 (UT@20) initiative with generous support from the Robert Wood Johnson Foundation, the Commonwealth Fund, the Episcopal Health Foundation, the California Endowment, and the California Health Care Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

The authors gratefully acknowledge helpful comments, suggestions, and guidance from Lisa Clemans-Cope, Faith Mitchell, and UT@20 Advisory Committee member Mary Awuonda. The authors also recognize and greatly appreciate the advice and contributions of members of a RWJF-funded community advisory board focused on health equity, in particular Dung Ngo and Shereese Rhodes.

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