Insurance Barriers Contribute to Health Disparities Among Commercially Insured Americans

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Appropriate use of prescription medicines improves health outcomes and quality of life for patients. By helping to protect patients from out-of-pocket costs that hinder their ability to access and adhere to important treatments, **adequate insurance coverage** for prescription drugs plays a crucial role in patients' ability to take their medicines as prescribed.

Because more than two-thirds of Americans are covered by private insurance,[1] health plans are critical to promoting **equitable access** to medications. However, extensive research demonstrates that historically underserved populations have lower utilization of and adherence to prescribed medicines for many health conditions, even if they have insurance.[2, 3] One reason that private insurance does not consistently facilitate access to medications is that **socioeconomically disadvantaged patients** often cannot afford the out-of-pocket costs or overcome other barriers imposed by their health plans.

The impact of insurance design on underserved populations is considerable. Nearly one-quarter of families with private insurance live in poverty.[1] Because income inequality is closely linked with race in the United States, the impact of **unfavorable commercial insurance** benefit design disproportionately impacts people of color. For example, Black households are twice as likely to hold medical debt as white households – a disparity that is not fully explained by whether they have health insurance.[4] Additionally, among patients with commercial insurance, Asian, Hispanic, and Black Americans are approximately 20% to 50% more likely than white Americans to be non-adherent with their blood pressure medications, and 35% to 60% more likely to be non-adherent with their cholesterol medications.[5]

While a number of important social determinants of health contribute to inequities, one primary explanation for persistent disparities in medication access is health insurance benefit designs that **increasingly shift prescription drug costs to patients.** Increased application of deductibles and coinsurance to prescription drug coverage, along with other unfavorable features of many commercial health plans, create significant challenges with affordability of many medicines and the ability to fill and be adherent to prescribed treatments. Due to systemic racism, the **racial wealth gap** persists in the United States; therefore, Black and Brown families are less likely to have available resources to pay for out-of-pocket medication-related expenses.[6] Thus, medication affordability challenges hit hardest on **lower-income communities** who are disproportionately non-white.[7,8]

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Many common insurance design features leave patients unable to afford their medicines and disproportionally hinder access for disadvantaged communities.

High-deductible health plans (HDHPs) can disproportionately harm economically vulnerable patients by exposing them to high out-of-pocket costs that hinder access and adherence to treatment. Enrollment in HDHPs is associated with lower levels of medication adherence for common chronic conditions.[9] For example, cancer survivors of all racial/ethnic groups enrolled in HDHPs are more likely to skip doses of their medications, delay filling prescriptions and be unable to afford specialist care as compared to patients not enrolled in a HDHP.[10] Furthermore, these effects are magnified among Black patients relative to white patients. Similarly, switching from traditional plans to HDHPs is associated with poorer adherence to cardiovascular medications across all racial/ethnic groups.[11] Health savings accounts (HSAs) paired with HDHPs can help to defray out-of-pocket costs for medicines; however, Black, Hispanic, and lower-income individuals are less likely to have or be able to contribute to HSAs, which may be attributed to structural causes, such as inequities in income, opportunities, and discrimination in the labor market.[12]

Coinsurance, as opposed to co-payments where a patient's obligation is a fixed-dollar amount, can pose a particularly challenging barrier to access for low-income workers, and people of color are disproportionately represented among low-wage earners. The share of health plans that use coinsurance for prescription medications has increased over time and is especially common for HDHPs,[13] further compounding the affordability issues associated with these types of plans. In many cases, there are no caps on out-of-pocket drug costs per fill in plans that use coinsurance, leading to large and unpredictable costs at the pharmacy counter.[14] Further, coinsurance is often calculated as a percentage of a medication's list price and may not reflect savings negotiated by the health plan.

Formulary exclusions can have an unequal impact on patients who cannot afford to pay the full list price of medications not covered on their health plan's formulary or to navigate the complex and time-consuming exceptions process, which can require a high degree of health literacy. Although more than 30% of adults across lower- to higher-income cohorts say their insurance plan won't cover a drug that was prescribed by their doctor, the impact of these restrictions is greater among economically disadvantaged communities. More than half of low-income patients do not fill prescriptions for medicines that are not covered by their plans.[15]

Utilization management and adverse tiering can have a significant impact on people who take medicines commonly placed on high formulary tiers or subject to prior authorization or step therapy requirements. For example, Black Americans are disproportionately impacted by sickle cell disease, but access to the newest treatments for this condition is often subject to extensive utilization management and adverse tiering.[16] Thirty-eight percent of patients who were prescribed a new sickle cell treatment cited denial of prior authorization as the reason they failed to initiate treatment, and 70% of those who didn't start treatment cited some aspect of their insurance coverage as the reason.[17]

Narrow or limited provider networks can make it hard for patients to access timely screenings and diagnoses, and they impose high out-of-pocket costs when enrollees use out-of-network providers. Forty percent of people who use out-of-network physicians do so involuntarily: 68% of these inpatient encounters are for emergency medical care, and half of patients with involuntary encounters faced unexpected costs for their care.[18] Even among patients who use a provider directory to identify in-network mental health providers, 53% encountered inaccuracies, and these patients were twice as likely to be treated by an out-of-network provider and four times more likely to receive a surprise out-of-network bill.[19] People with low incomes and those in poor health have an increased likelihood of experiencing hidden and unexpected out-of-network costs that have an outsized effect on their budget.[20,21] Limited access to providers can prevent or delay diagnosis and screenings, which are critical steps for accessing medicines and other treatments.

Pharmacy availability, location and network membership disproportionately impact people in rural and urban areas and those who do not have the means to travel long distances to access their medicines and/or achieve lower cost sharing by using an in-network pharmacy. "Pharmacy deserts" are concentrated in Black and Hispanic neighborhoods, resulting in limited pharmacy options among these communities.[22] As a result, patients in pharmacy deserts must either pay the higher costs associated with out-of-network pharmacies and/or travel farther to access the medicines they need.[23, 24, 25] Between 2003 and 2018, more than 1,000 pharmacies in rural settings closed, leaving 630 communities with no independent or chain retail drugstore.[26] Additionally, from 2009 to 2015, urban pharmacies serving disproportionally publicly insured and uninsured patients were two times as likely to close as pharmacies in other communities.[27]

More equitable coverage and better access to medicines for commercially insured patients could be achieved by adopting practices and policies that:

Address health literacy challenges by ensuring materials to aid patient decision-making related to insurance design adopt language that can be easily understood by individuals with varying education levels, literacy, and professional backgrounds.

Share the savings by allowing patients to benefit directly from the savings and discounts manufacturers provide to health insurers and pharmacy benefit managers in the form of lower cost sharing on medicines. If health plans and middlemen don't pay the full price for medicines, patients shouldn't either. This solution may have a greater positive benefit for lower income patients, who may also face trouble paying for other essential needs.

Cover more medicines from day one by requiring that some medicines, such as those used to treat certain chronic conditions, be covered by all insurance plans from day one – without being subject to a deductible.

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Make cost sharing more predictable by encouraging the use of fixed-dollar copays instead of coinsurance for medicines. Placing a limit on the maximum amount a patient will be asked to pay for medicines per prescription or per month and/or annually would also help all patients predict their out-of-pocket expenses for medicines. And, for patients with Medicare Part D, establishing an annual limit on the amount of out-of-pocket spending in one year would help ensure that seniors and individuals with disabilities aren't overburdened with high costs.

Make coupons count. Due to the high cost sharing obligations some patients with commercial insurance face, patients are increasingly turning to manufacturer cost-sharing assistance to help them access their medicines. In some cases, commercial insurers do not allow manufacturer-provided assistance to patients to count toward a patient's deductibles or annual out-of-pocket limit, meaning patients could be paying thousands more at the pharmacy than they should be. We need to end this practice so that disadvantaged patients with commercial insurance get the full benefit of the programs meant to help them access their medicines.

While there is no one-size-fits all solution to improving health equity in access to medicines, reducing insurance and patient cost barriers for medicines is a clear solution that can have wide reaching impacts on health equity.

Require standardized plans to aid consumer choice by allowing for apples-to-apples comparisons across health plans. On the Exchanges, standardized plans often have lower and more predictable cost sharing for critical items and services than non-standardized plans and can make health care more accessible and affordable.

Promote equal access to providers recognizing that groups experiencing inequity need meaningful access to care in settings they trust. Insurance plans should ensure that covered facilities, pharmacies and providers are available in rural, low-income and other underserved communities.

Prioritize adherence and disease management by encouraging programs, such as those offered by pharmacists and other medication management interventions, to be made accessible to and meaningful for all populations, especially those disproportionately impacted by chronic diseases.

There are a number of deeply rooted challenges in the U.S. that lead to disparities in access to prescription medicines and other health care services. For communities of color, evidence has shown that access is affected by **systemic racism** in the health care system (e.g., prescriber biases in receiving timely medical diagnoses) and **social determinants of health** (e.g., transportation, rurality, economic deprivation, language barriers).[28,29,30] While there is no one-size-fits all solution to improving health equity in access to medicines, reducing insurance and patient cost barriers for medicines is a clear solution that can have wide reaching impacts on health equity.

Endnotes

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