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Drivers of Rising Health Care Costs And their Impact on Vulnerable Populations



The Health Equity Collaborative

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Introduction

Americans are more focused than ever on the rising out-of-pocket cost of health care, both in terms of personal finances and the national economy. Hard-working Americans, especially those from vulnerable populations, have noticed that average insurance premiums, which total \$21,342 per family of four, and other expenses like out-of-network specialists and prescription drugs have reached record levels. Overall, national health care spending is close to \$4 trillion per year.

Despite pandemic hospital closures temporarily decreasing the nation's overall health expenditure in 2020, this total expenditure has shot upward at an alarming rate for decades, along with individual liability for health expenses. Meanwhile, median family income has not kept up. Thus, both insurance payments and tax burdens related to health care constitute a greater share of family expenses.

This is a serious issue for advocates focused on health equity. Families from vulnerable populations face unprecedented difficulty in meeting basic human needs, like neo-natal and pediatric care, emergency medicine, and treatments for chronic illness. The principle of racial equity precludes any notion of a two-tiered system with first and second-class citizens, but in terms of health care, that is exactly what Black and Brown Americans face. According to a Kaiser Family Foundation study released this year, the share of uninsured Americans in minority communities was as much as 14% higher than in white communities. The Affordable Care Act alleviated this inequity somewhat, but also introduced new complications that could be more difficult for disadvantaged populations to navigate.

The heightened focus on both the rising cost of health care and its impact on vulnerable populations presents equity advocates with an unprecedented opportunity to offer solutions to these problems and have them heard by leaders in government and the health care industry. However, more analysis of the problem itself—such as understanding the underlying causes and variation in types of emergent predicaments associated with the rising out-of-pocket cost of health care among vulnerable families—must be done before satisfactory solutions can be produced. This study will attempt to define the problem by identifying how health care expenses impact vulnerable populations, which health care sectors constitute the primary cost drivers, and which cost-saving strategies will best address the trends we are seeing on behalf of the populations who need it most.

About the Author



HEALTH EQUITY COLLABORATIVE

The Health Equity Collaborative (HEC) is an advocacy initiative comprised of civil rights organizations, public health non-profits, and diverse patient groups centered around supporting equity and combatting disparities experienced by marginalized communities. HEC is officially a project of MANA Action, a 501c4 not-for-profit organization allied with MANA National, a National Latina Organization that advocates for equality and empowers Latinas through leadership development.

Rising Costs of Health Care

Overview

Despite public awareness of and growing concern over rising health care costs, there is minimal public knowledge about how our health care system works, where expenditures go, and what is included in calculations of overall health care spending. For this reason, one of the primary goals of this study will be to clearly present how our health care system operates and thereby delineate which aspects of its operation are most responsible for increased expense over time. Then, solutions must pinpoint the areas where the most impactful changes can be made to affect cost savings.



The vast majority of Americans can afford health care only by participating in a commercial health insurance plan or receiving Medicare or Medicaid. While most private plans are obtained as a benefit through employment, many plans are obtained through an insurance exchange or private insurance marketplace. Health insurance coverage provides two main benefits: first, the insurance company will negotiate lower costs for checkups, procedures, and other medical expenses for providers in network on behalf of the insured. Secondly, the health insurance will cover all or part of covered expenses, depending on the type of plan and type of care.

Unfortunately, price manipulation, middlemen, and nontransparent bargaining often prevent market forces from keeping the price of care in an affordable range. And because most insured Americans focus solely on the portion of medical bills they directly owe, the true cost of health care remains a mystery and the element of consumer choice remains minimal. While manipulation of market forces and misaligned incentives cannot be blamed for all affordability challenges in the health care market, they represent a reasonable and actionable area to begin seeking reform on behalf of vulnerable populations.

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Structural Challenges

There are numerous system challenges to blame for the rising cost of health care, but it is first important to understand that health care does not operate like ordinary markets. Innumerable regulations are of course part of this reality, but there are also technological and human issues at play.

Some of the structural difficulties in restoring order and equity to the health care market are as follows:

- Much life-saving technology cannot be priced for demand, as the consumer base will never be large enough to keep prices low. Research and development for medical devices, pharmaceuticals to treat rare diseases, and new surgical techniques cost far more than an individual can afford to pay. Therefore, patients rely on insurance companies, who spread out the cost of these goods and services across the entire membership base.
- Hospitals, which account for about a third of the nation's health care costs, prioritize profitability and are biased in favor of operations and procedures that enable continued operation. There is evidence that for-profit hospitals especially mark up costs of services and drugs.
- Health care plans purchased through an employer are paid for with premiums that are largely invisible to the end-user. Therefore, unless faced with deductibles or cost-sharing that might make enrollees aware of the cost of care, enrollees may undertake checkups and procedures that have an artificially sunk cost. High prices can thus be passed on to the insurer without much pushback from the "customer" who is insured.
- Americans suffer in growing numbers from chronic illnesses and their complications, which are not effectively managed or prevented through better use of medicines and other disease management techniques—and are compounded by the effects of systemic racism.
- The proliferation of rules, regulations, and non-overlapping systems has made competition and consumer choice extremely rare. Laws governing the creation of new facilities and the production of medical supplies also stifle innovation and disruption. All of these trends serve established industry interests and raise costs.

- Administrative costs in the health care industry far exceed standard overhead costs in nearly every sector except government itself. This has much to do with the multiplication of differing standards for enrollment restrictions and deadlines, various types of employer and private insurance and managed care plans, the involvement of taxpayer-funded assistance and welfare, the admixture of co-payments, deductibles, and out-of-pocket costs, and private adjudicators and adjusters governing the varying tiers of coverage.
- Medicaid patients have limited cost sharing and premiums based on statute. These residual costs are often passed on to private insurers and out-of-pocket payments. There is no transparent process for how the revenue lost in statutory cost limits is made up by price increases elsewhere.
- Americans engage in malpractice suits and other patient litigation at above-average rates. Considering that medical error is the third leading cause of death in America and disproportionately impacts vulnerable populations, this is understandable, but it also drastically increases the liability cost for practitioners.
- The U.S. population is aging, as the fertility rate (1.7) is far below replacement and the number of Americans under the age of 18 will be lower than the number over the age of 60 by the year 2030.

It is important to remember that structural challenges such as these are hurdles to be overcome, not reasons to abandon reform efforts. We must not give up on making health care more affordable, especially in light of the impact on vulnerable populations.

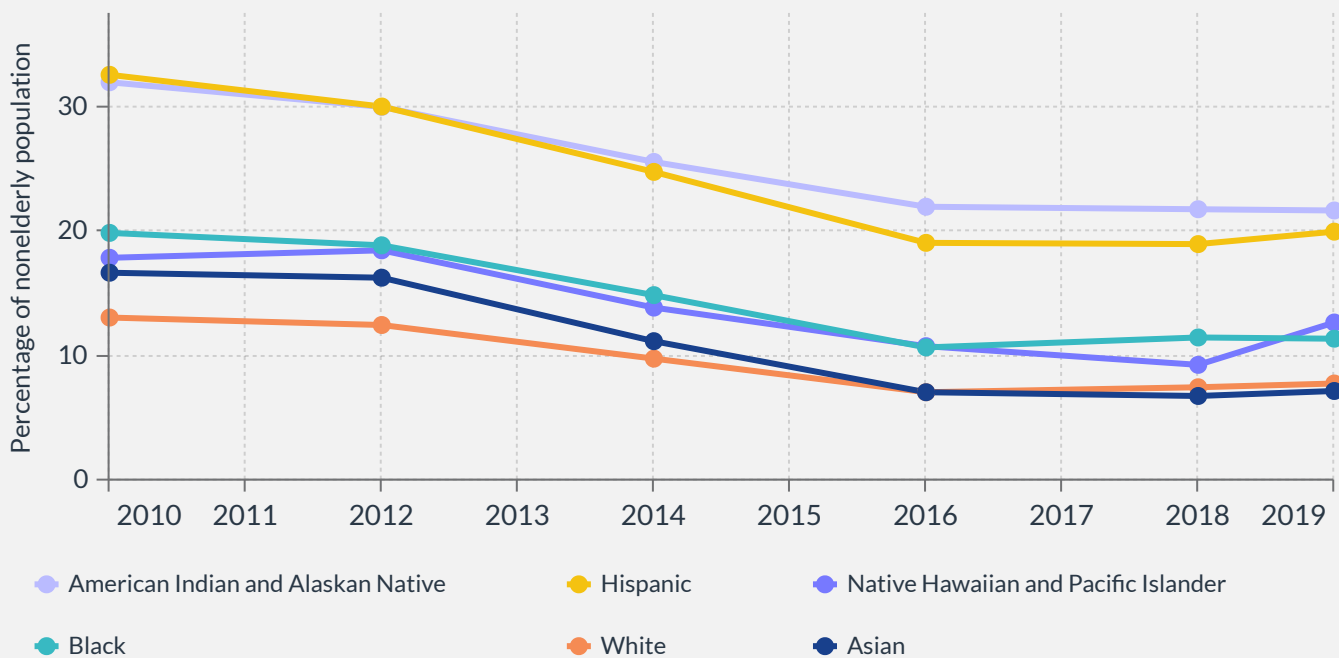
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Impact on Vulnerable Populations

The National Institutes of Health (NIH) defines “vulnerable populations” as “Americans who are racial, ethnic, sexual, or religious minorities, the elderly and disabled, the uninsured or socioeconomically disadvantaged, and those suffering from rare medical conditions.” Vulnerable populations suffer disproportionately from rising health care costs because of discrimination in the process of finding stable employment, culturally normative outreach and processes by health care suppliers, and all the unique challenges of structural racism and other forms of prejudicial discrimination, such as lack of resources often resulting from historic injustice, and unique needs that are, in the aggregate, overlooked by society.

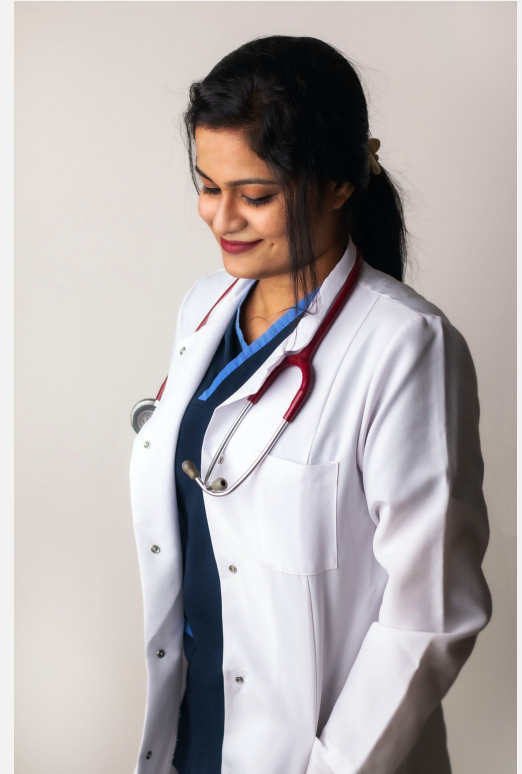
Medical injustice extends beyond the implicit racism of unequal care and into explicit racism, including overt racial and ethnic discrimination by providers, insurers, and others. Black Americans, for example, experience higher rates of morbidity and mortality because of health care professionals and provider bias resulting in a lower quality of care than white patients even when controlling for income, insurance, provider network, and lifestyle choices. Multiple studies have shown that treatment types, discharge schedules, and rigor of practice are higher for these white patients than their black counterparts. For example, black patients’ rate of amputations versus attempts to restore a limb is demonstrably lower than the same rate for white patients. Increased health care costs only exacerbate problems such as these, and to a greater extent than for white Americans.

Uninsured Rates by Race and Ethnicity, 2010 - 2019



Source: Samantha Artiga. (2021, July 16). *Health coverage by Race and ethnicity, 2010-2019*. KFF. From KFF analysis of the 2010-2019 American Community Survey.

The same trends obtain for sexual minorities as well. Lesbian, gay, bisexual, and transgender communities face multiple types of discrimination. First, the systemic bias and prejudicial discrimination described above in relation to racial and ethnic minorities, when applied to the LGBTQ+ community, in particular, can create barriers to care and complications from undertreated HIV/AIDS. Second, LGBTQ+ Americans can also face rejection and stigma from family, friends, and society at large, which compounds psychological trauma and can reduce access to medical care. Similar problems with both stigma and access may affect Americans with permanent disabilities. For all such groups who already feel the weight of increased out-of-pocket care costs, overall cost increases widen the outcomes gap between these populations and the average American.



Many initiatives to improve equity have demonstrated that addressing racial, sexual, and other disparities actually has the effect of reducing costs while improving outcomes. For example, in Texas, analysts working on behalf of the Episcopal Health Foundation calculated that racial health disparities and inequity created \$7.7 billion of additional, unplanned health care costs in a single year by increasing the rate of hospitalizations for minorities. And in Mississippi, a telehealth pilot program aimed particularly at impoverished areas saved \$339,000. Nationally, studies estimate that eliminating health disparities for vulnerable populations could save hundreds of billions, even trillions, of dollars. Thus, the answer is not to accept disparities as an unchangeable fact, nor to treat the rectification of disparities as an additional expense, but to view historic inequity as an unacceptable waste of potential and an opportunity for both positive change and cost savings.

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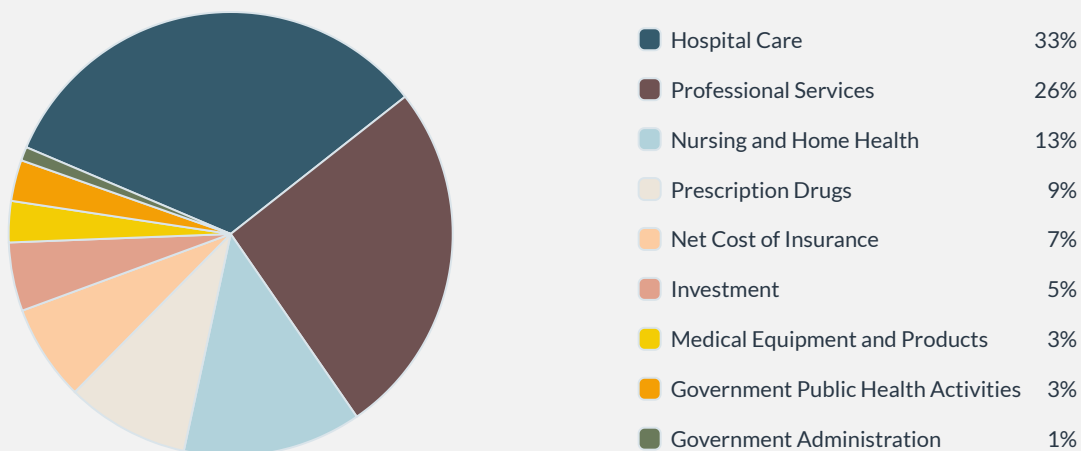
Health Care Sectors as Cost Drivers

Hospitals and other Medical Facilities

Hospitals constitute the largest health care cost driver by far. According to the Brookings Institution, 33 cents of every dollar is spent on hospital care, while expenses that receive far more attention in conversations about health care costs account for far less. Retail pharmaceuticals, for example, account for 9 cents, while medical equipment accounts for 3 cents of every health care dollar. In the years following the enactment of the Affordable Care Act, the hospital sector began reporting profit margins in excess of 8%, far higher than the overall margins of the biopharmaceutical or even insurance industries. Less than half of American hospital funding is used for staff, so despite the fact that hospitals employ some of the most diverse sectors of health care professionals, there is less labor expenditure than capital expenditure.

Capital expenditure at hospitals can include financial investment and speculation, building renovations and expansions for beautification, service enhancement, and ambulation, acquisitions and mergers with technical facilities and private practices, medical technology (hardware and software), financial and legal consulting, infrastructure (such as parking), and marketing. Only a marginal portion of this investment goes to hospitals in neighborhoods representing underserved populations, which leads to significant disparities in care and can even create health care deserts in neighborhoods that lose facilities due to a lack of capital investment. Part of this dearth of hospital resource allocation is a result of administrative bloat and market domination by profit-seeking hospitals. The upshot of these trends is that capital expenditure exacerbates the plight of vulnerable populations.

National Health Care Expenditures by Type



Source: 2018 data. Nunn, Ryan, et al. "A Dozen Facts about the Economics of the US Health-Care System." *Brookings*, Brookings Institute, 6 Apr. 2020.

Misguided Public Health Initiatives

Public health initiatives are a core component of American health care. The federal government and every state, along with many cities and municipalities, plan to spend on public health initiatives in each year's budget. But public health spending can become immense cost-savers in the long term. "An ounce of prevention is worth a pound of cure" continues to serve as the ultimate nostrum for health care costs. But budgeting for these initiatives in the short term can be very difficult given their scope, expense, and the lack of data-driven decision-making in the public health field.

The COVID-19 pandemic especially revealed the need for public health spending. Over \$93 billion of taxpayer money currently funds public health initiatives like the American Rescue Plan for research, education, outreach, recruitment of community leaders and study participants, and private health care policy standardization. However, researchers have noted that the pandemic revealed a chronic shortage of public health spending driven by skepticism and subsequent deprioritization. According to a research project funded by the Robert Wood Johnson Foundation, public health initiatives have failed in specifically demonstrating a positive cost-benefit ratio when it comes to the actual health of the public. The deficiency of results data collection and nontransparent cost-benefit analyses seem endemic to the industry, leading to public health initiatives that are controlled by political and financial interests. Public health should not become marketing for corporations or politicians; it should be focused on making measurable gains on behalf of a public whose health is at risk.

The loss of focus in public health is especially unfortunate when we consider the power of well-managed public health initiatives to help vulnerable populations. To take one example, public education about common childbirth risks among these populations, such as the CDC's Hear Her campaign to prevent maternal mortality, is specifically targeted toward English as a Second Language (ESL) audiences with the intention of rectifying historic inequities in maternal mortality among these populations. Studies show that redressing the lack of education and driving cultural change among vulnerable populations on subjects like obesity, sexually transmitted disease, and drug use could have an outsized impact on the overall health of these populations. But even the best intentions cannot prevent public health programs from being fiscally inefficient, and thus less effective at protecting and preparing their intended audience.

Managed Care and Insurance

Health plans are unlike other types of health care cost drivers in that the service they provide can be not directly related to improving the health of client members. Rather, insurance providers often operate as a middleman and health care equalizer. In theory, they enable anyone at any income level that can pay the plan's premium or is able to obtain a government-sponsored health plan like Medicaid to afford both preventative and remedial care. Plan enrollees do not incur the sometimes exorbitant prices for care because the cost is distributed among plan members. But because they solve such a complex problem—the fact that the true cost of health care is unaffordable to the vast majority of the population—they are often given a pass, even while many insurance providers exhibit a number of inequities, inefficiencies, and exploitative practices that disproportionately impact vulnerable populations.

One longstanding and highly visible example of health insurance inequality is the higher cost of care for women and transgender individuals. Although the Affordable Care Act specifically prohibits insurance companies from taking into account gender or health status when determining premiums, factors that correlate with gender are often factored into premium calculation. In addition, the very acknowledgment of gender as a binary categorization is an unnecessary aggression against transgender and non-gender-conforming individuals seeking care.



These disparities are more pronounced, but similar in nature, to racial disparities researchers have discovered in health insurance. Black and Brown Americans are far less likely to be covered by health insurance, including 30 million who are completely uninsured. While many factors contribute, this is in large part the result of states that refuse to expand Medicaid to adults with incomes below the poverty level—and 90% of those who are uninsured for this reason live in formerly slave-owning states. In this historical sense, like so many other aspects of modern life, insurance gaps bear the legacy of systemic racism.

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Therefore, reducing the cost of insurance to make it more inclusive and efficient is paramount. Some solutions, such as making insurers more involved in care coordination to control costs like facilitating sharing of health data, or promoting solutions that might lower costs like telehealth, must be considered. But the cost reduction strategy that would have the most impact on behalf of vulnerable populations is to reduce administrative costs of managed care and insurance. David M. Cutler of Harvard University estimates that for any given health expense, administrative costs factor between one third and one fourth of costs. Cutler argues that these costs derive from the lack of solid data sharing between the experts responsible for claims adjudication, prior authorization determinations, and quality measurement. In other words, the high cost of administration is an “unforced error” that can be resolved through technology, uniform rules, and enforcement of those rules on insurance providers.



Pharmaceutical Benefit Managers

Despite accounting for less than a tenth of U.S. health care costs, prescription drugs receive an outsized share of criticism for soaring prices. In a 2020 Gallup poll measuring Americans’ opinion of different industries, the pharmaceutical industry received a positive reaction from only 34% of respondents, second-worst to the federal government. This is because of the everyday interaction that millions of Americans have with prescriptions for chronic pain, emergencies, or long-term therapeutics. For vulnerable populations, these interactions are often negative. Rapid increases in pricing can destabilize fixed-income budgets, long wait times can force people to take off work, and strictly-enforced rules for prescriptions can make it hard to obtain needed medicine.

Pharmaceuticals, particularly those treating complex, rare and understudied diseases are expensive to research and produce. Breakthroughs in treating chronic and infectious disease especially take years to develop, test, and produce—especially with the heavy regulatory burden on manufacturers. Patent laws set up to protect the intellectual property of drug innovations prevent competition from generic versions of pharmaceuticals but are key to incentivizing investing in this R&D.

Even more than these industry-specific challenges, however, a significant and often unrecognized driver in the cost of drugs is a middleman known as the Pharmacy Benefit Manager (PBM). The PBM works on behalf of insurance companies, negotiating large rebates from manufacturers of 40% on average for coverage and tier placement. These rebates are not shared directly with patients, and these middlemen collect as much as half the spending on brand-name medicines. Discounts do not directly help vulnerable populations because they are not applied directly to consumer out of pocket costs.

PBMs have largely remained unregulated while prices continue to escalate. Drug rebates have skyrocketed from \$102 billion in 2014 to \$187 billion in 2020, with PBMs continuing to pocket outsized profits from these disbursements intended for patients. Despite wielding significant power to control costs, PBMs have directly benefitted from lack of oversight in the rebate market all the while maintaining a vested interest in keeping higher, not lower drug prices.

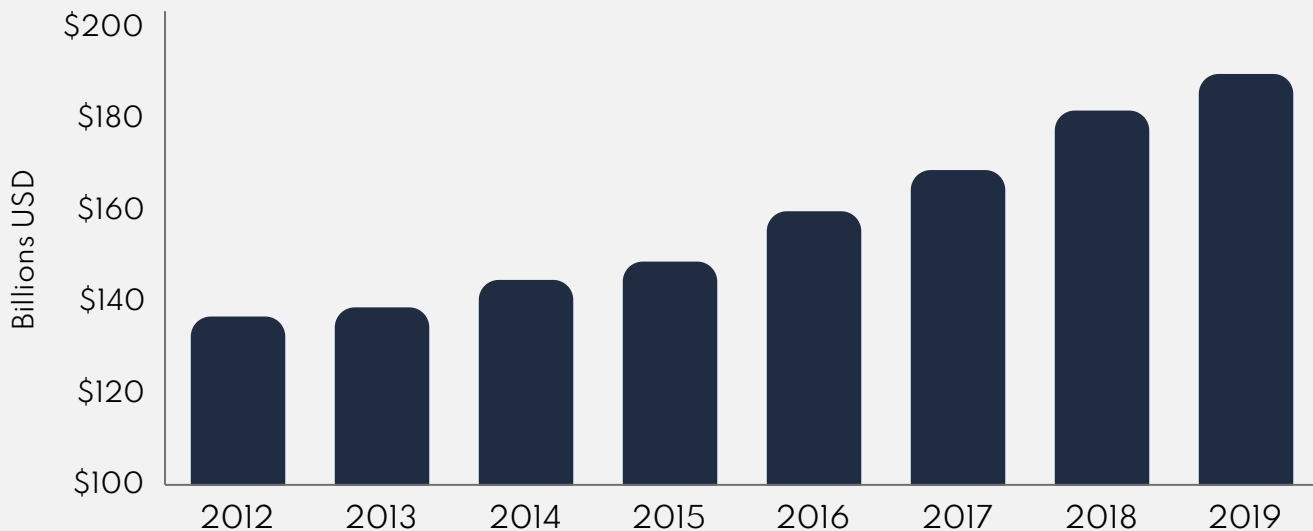
Medical Equipment

Medical equipment is a broad category that can range from a single-use plastic splint or thermometer to complex technology like a hyperbaric chamber or laser cutter. Nearly all medical equipment and devices used and distributed by medical care facilities are marked up more than comparable retail versions. Though technically possible, patients—especially those from vulnerable populations unused to negotiating—are unlikely to pick and choose which medical equipment they will authorize professionals to use. Therefore, medical equipment and device suppliers and hospitals are mostly free to set prices at the levels they want, even when they are not covered by insurance and patients must pay for them directly.

Around 6% of all health care spending goes to medical equipment. According to researchers from the London School of Economics, American spending on medical equipment is increasing twice as fast (around 5% per year) as spending on pharmaceuticals. The out of pocket costs of medical equipment often make these supplies unaffordable for patients. If left unchecked, the price of decent medical equipment could exceed the ability of all but the wealthiest care facilities to pay—leaving vulnerable populations unable to access the equipment they need to avoid a challenging or even life-threatening situation.

Medical equipment is especially necessary for vulnerable Americans who suffer from long-term disabilities or chronic illness. For those who have undergone amputations, for example, expensive and complicated equipment become a daily necessity. Even simple medical equipment can be very expensive when it is marked up several hundred percent, as is often reported. The American ideal is to never leave our fellow citizens to suffer due to insufficient resources.

Total Spending on Pharmaceutical Research and Development

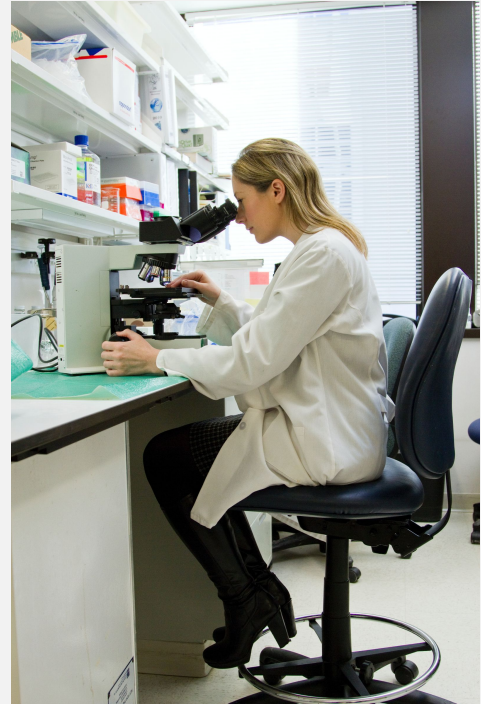


Research and Development

The American biopharmaceutical research ecosystem develops more innovative medicines than any other country in the world. In recent years, rapid advances in scientific discovery have ushered in a new area of medicine, transforming our ability to treat, and in some cases, cure some of the most challenging diseases. However, the R&D process for new drugs is lengthy and costly, with a high risk of failure. On average it takes 10 to 15 years for a medicine to make its way from the start of the R&D process to FDA approval, and only 12% of investigational medicines entering phase I are ultimately approved by the FDA. The average cost to develop a new medicine is estimated at \$2.6 billion, which includes the cost of medicines that fail, as most candidates never make it past a Phase I clinical trial. Rapid scientific and technical advances, alongside increasing regulatory burdens are only leading to a more complex clinical development process.

In 2019, the pharmaceutical industry alone spent \$83 billion on R&D, according to the Congressional Budget Office—and the industry’s massive year-over-year investment in R&D, reaching more than a trillion over the last two decades, is accompanied by a dedication to bringing new treatment options to patients. In 2021 the FDA approved 60 new drugs and biologics, with over 50% being first in class treatments. Tremendous progress has been made with new medicines today that just a few years ago may have been regarded as science fiction. Any negative impact to R&D may result in fewer new medicines for patients, including those with no existing treatment options. While a robust R&D ecosystem is supported by extensive investment, we must consider that the overall spending on prescription medicines is a small share of total health spending.

Additionally, the overall net impact of a robust R&D system that produces new medicines for patients, is positive, especially for vulnerable populations with high unmet need. R&D does contribute to rising health care costs, but the net impact of R&D on vulnerable populations is positive. With the help of insurance systems supported by both private insurance and government programs like Medicaid, today's most innovative medicines can be made widely available, even to patients in underrepresented populations. The expense of producing these technologies is often the largest portion of biopharmaceutical company spending. The pharmaceutical arm of Johnson & Johnson, for example, stated in its 2020 transparency report that they had spent more than double on R&D that year than on marketing and advertising.



America's unique innovative R&D ecosystem has made the United States a global bioscience leader and is built on policies that encourage both the public and private sectors to play complimentary roles in research and development. But these policies are not self sustaining. The United States must continue to show its dedication to leading the world in health and science.

Despite the costly and risky nature of R&D, we must continue to see it as a priority and as a long term investment in the health and wellbeing of the American people, including for the most vulnerable populations. Those who need medical innovations the most are relying on leaders in Congress and at pharmaceutical companies to continue investing in their health and care. Realizing the promise and the potential of the pipeline will require increased collaboration across a range of sectors and fields and protecting the system from anything that could impede this progress.

We must continue to see R&D as a priority and as a long term investment in the health and wellbeing of the American people, including for the most vulnerable populations.

Health Care Cost Savers

Education and Preventative Medicine

The major difference between the health and wellness of Americans today and that of decades past is that we now have unprecedented technologies and medications to cure disease, but at the same time, we suffer from unprecedented levels of chronic disease and long-term conditions.

This reversal has been caused by deterioration of air and water quality, individual lifestyle changes, and especially social determinants of health. Due to racial inequities and other social factors, vulnerable populations suffer disproportionately from ailments such as diabetes, cardiovascular disease, lung cancer, and stroke. Not having access to quality food or medical care can lead to chronic disease that is otherwise preventable through education and regular interventions like exams and checkups.

Public health initiatives that are nuanced and address the principal needs of underserved populations, especially social determinants of health, can help patients avoid unhealthy choices and become more proactive. Several studies and meta-analyses have shown that public health initiatives do make an impact in this regard. Given the massive expense of health care for chronic disease, public health initiatives have often been cost-saving—sometimes immensely, according to 2017 surveys of numerous public health programs in the U.S. and Britain. And while reducing costs, these programs also have the added benefit of asymmetrical impact on vulnerable populations, another reason they should become a priority for policymakers.

Prioritization of Vulnerable Populations

Health inequity is arguably the most important crisis in our health care system not only because it drives costs up, but also because it negates our standard of justice. Some inequity is implicit; it involves unequal distribution of power and resources based on race, gender, sexual orientation, and other categories. Other inequity is explicit; that is, it refers to the actual imbalance of money and social capital that directly creates economic and environmental conditions that socially determine health.

Vulnerable populations suffer injustice in both ways on a daily basis, and the expense of trying to extend health care to these populations without rectifying health inequity is greater than the expense of rectifying the inequity first. There is a significant return on many investments in disease and injury prevention, which disproportionately impact vulnerable populations.

For example, every dollar spent on preconception care programs for women with diabetes saves \$5.19 in avoided complications—and every dollar spent on school-based HIV/STD prevention programs saves \$2.65 in treatment costs, according to an analysis by the Association of State and Territorial Health Officials. And early interventions on behalf of sexual minorities have an outsized impact on the prevention of suicide and opioid abuse.

For this reason, health equity initiatives are a cost saver, as mentioned in Chapter 2. This may seem counter-intuitive until it is fleshed out.

When resources are prioritized for the small, wealthy segment of the population at the expense of all others, the larger underprivileged group will suffer from income loss due to deteriorating health or disability. This forces the tax base to incur a larger welfare liability and employers to lack a robust workforce. As the economy suffers, medical providers incur more expenses, and are forced to ultimately deliver lower-quality care at greater expense. This crisis can be circumvented and reversed if we strike at the root of the problem with curative policies explicitly designed to work against structural and cultural injustice on behalf of vulnerable populations.

Competition

For Americans from vulnerable populations, economic arguments about the costs of pharmaceuticals and other medical supplies do nothing to change the realities they face. Every racial, sexual, or ethnic minority who is forced to go into debt or undergo hardship just to afford a prescription refill or a CPAP machine understands that the problem is systemic. In a nation that prides itself on making quality care available to every American who needs it, more must be done to reduce the price of these purchases, many of which are everyday necessities.

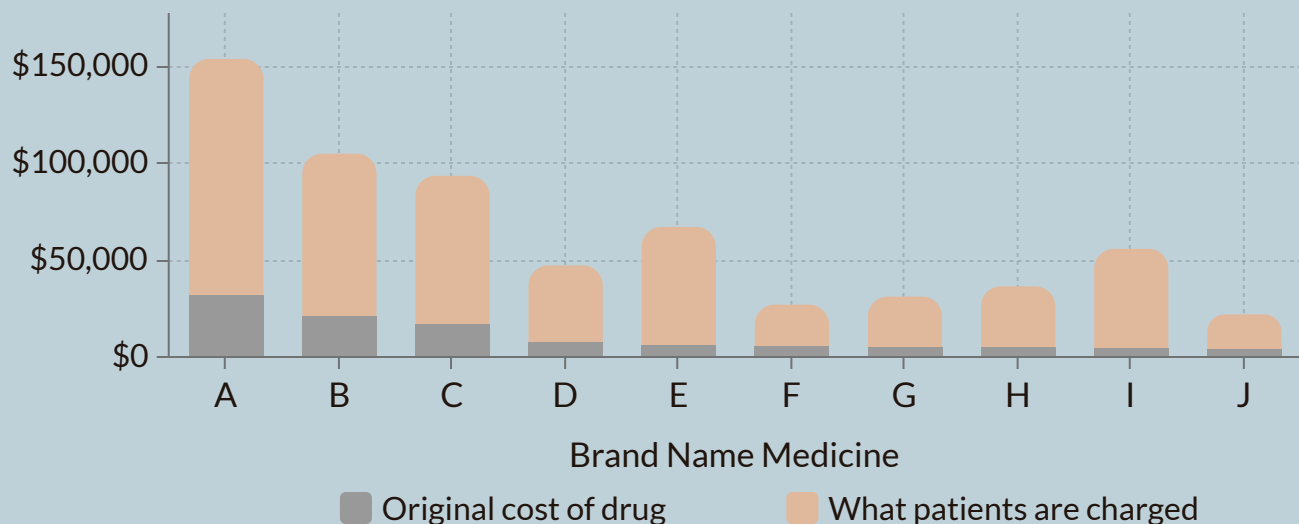
Policies that incentivize competition and reward innovation irrespective of projected product demand would achieve lower average prices and reduce the burden on low-income Americans and those who cannot access a broad selection of medications. For example, federal laws requiring price transparency at any point of sale, or enforcing uniform prices regardless of insurance, would inform the public and increase equity. Finally, finding policy solutions like additional tax incentives for R&D could soften the blow that these expenditures incur.

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Pharmaceutical Middlemen Reform

As mentioned in Chapter 3, Pharmacy Benefit Managers (PBMs) are the area of highest priority for regulatory reform in pharmaceutical pricing. PBMs, third-party middlemen who determine the prices and coverage of prescription drugs for insurance providers, use rebate schemes to raise out-of-pocket prices for consumers and turn these exorbitant costs into their own profits. In recent decades, PBM manipulation has become a shadow boom industry, with just three companies controlling 85% of the entire market.

Mark up on brand name medicines



Source: The Moran Company. *Hospital Charges and Reimbursement for Drugs: 2019 Update Analysis*. July 2019.

In January 2021, the U.S. Senate Finance Committee released an investigative report on pricing schemes focused on insulin, finding that “PBM’s formularies of covered drugs can affect patient’s out-of-pocket spending for up to 50% of their co-pay.” Increasing scrutiny and legislative regulations on PBMs would create immense cost savings. The 116th Congress’s “C-THRU Act” would enforce transparency on rebates, discounts, and other accrued payments, including their impact on Medicare Part D. This would ensure that Medicare enrollees receive a fair share of rebate savings by requiring cost-sharing for Part D enrollees to be based off the negotiated price of the drug. Another policy solution, the Drug Price Transparency Act of 2021, would limit which type of prescription drug rebates are exempt from federal anti-kickback laws. This would narrow the range of possible pricing schemes PBMs could use. Middlemen do not deserve to profit while health care costs skyrocket beyond the reach of most Americans, including those in vulnerable populations.

Conclusion

This overview of the impact that rising costs for out of pocket health care have on vulnerable populations presents policymakers with both a vivid picture of what is broken and a clear path to fixing it. As mentioned in Chapter 2, many areas of greatest expense are high-cost for structural reasons that need to be left as-is: for example, America’s ideal of maintaining a high quality of life even for those who are not wealthy or privileged is commendable, as is our reputation for innovation. But health care sectors, such as hospitals, that are primary cost drivers continue driving prices that are unreasonable and burdensome for patients, payers, and employers because of perverse incentives, lack of competition and administrative bloat.



For some populations, this is not simply an academic question about budgets or legislation; this is a crisis that directly impacts vulnerable Americans’ ability to access decent medical care. When hospitals silently undermine capital investment in low-income communities; when public health initiatives that are a lifeline for many racial minorities and other vulnerable populations grow careless about demonstrating impact; when insurance gaps leave Black and brown children and adults with no ability to pay for staggeringly expensive hospital visits or prescriptions—this amounts to a humanitarian crisis in the wealthiest country on earth. This is simply unacceptable.

To remedy these inequities, health care professionals and policymakers must identify opportunities to use interventions and education to reduce the unique health risks that vulnerable populations face—and seek more broad recognition that such public health programs are cost-effective with real, demonstrable metrics.

This is not simply an academic question about budgets or legislation; this is a crisis that directly impacts vulnerable Americans’ ability to access decent medical care.

Health care budget planners must also take into account the cost savings of preventing chronic health problems in vulnerable populations and use a similar cost-saving logic to ensure that improving these patients' health is a priority for decision-makers. Where soaring health costs are attributable to monopolistic pricing, the answer to helping the underprivileged is as simple as finding ways to introduce competition that drives prices down. And when the answer is not so simple—as, for example, in the case of unscrupulous middlemen like Pharmacy Benefit Managers—legislative reforms must restore equity by taking money out of the hands of third-party price manipulators and putting it back in the pockets of those who need it most.

Most importantly, all stakeholders in the nation's health care system must remember that keeping Americans healthy and fighting for justice on behalf of racial, sexual, religious, and ethnic minorities are not two different things, they are the same thing. There are many ways to measure health, but ensuring that no American is a second-class citizen must be an important part.

By slowing excessive cost growth that impacts patients and reforming specific types of cost drivers that make health care less affordable, we can ensure that everyone has access to quality medical facilities, feels cared for and valued by medical professionals, and is educated and informed so as to prevent health crises.

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