NHCOA
NATIONAL HISPANIC COUNCIL ON AGING

Status of Hispanic Older Adults Annual Report: **Insights from the Field – Shining a Light on Inequities**

September 26, 2023

2023

Health Inequities /helTH in'ekwədēs/

Health inequities are differences in health status or the distribution of health resources between different population groups arising from the social conditions in which people are born, grow, live, work, and age. The two main clusters of root causes of health inequities are 1) the intrapersonal, interpersonal, institutional, and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, immigration status, gender expression, etc., and 2) the unequal allocation of power and resources—including goods, services, and societal attention—which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health.

https://www.ncbi.nlm.nih.gov/books/NBK425845/

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Note: Throughout this report, we use the terms Hispanic and Latino interchangeably.

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ACKNOWLEDGMENTS

The National Hispanic Council on Aging (NHCOA) is grateful to those who have contributed to the Status of Hispanic Older Adults: Insights from the Field: Shining a Light on Inequities. This report was produced with the support of several organizations and individuals committed to the well-being of Hispanic older adults, their families, and caregivers. Their assistance was invaluable.

A special thanks is extended to those who participated in our surveys and webinars. These participants included older adults, caregivers, and service providers who gave their time, shared their personal stories and perceptions, and provided recommendations.

We recognize the NHCOA staff members who contributed their time and effort to develop this report. Christine Perez, Pedro Lima, Fatima Velez, Margarita Navas, Marcela Cabrera, Ricardo Posada, Ana Guzman, and Christina Pacheco played significant roles in developing, organizing, and analyzing the data.

Christine Perez and Christina M. Pacheco drafted the report, and Fatima Velez designed it. Marcela Cabrera translated it into Spanish, while the entire NHCOA team participated in editing the report. President and CEO, Dr. Yanira Cruz directed the implementation of the study and production of the report.

Finally, we would like to express our deepest gratitude to our sponsors, who, with their generous contributions, allowed us to gather the data to support the creation of this report. Through the support of our funders, we had the opportunity to learn from Hispanic older adults, their families, and caregivers and engage them in discussions that contributed significantly to the recommendations included in the report.

These sponsors are Lilly, PhRMA, Pfizer, Better Medicare Alliance, Novo Nordisk, EISAI, Verizon, and Elevance Health.

POLICY RECOMMENDATIONS

Building on the findings presented in this report, NHCOA has developed several recommendations for local, state, and national leaders. We also advance specific recommendations from Hispanic community members, community-based organizations, and grassroots leaders. NHCOA forwards the following recommendations to help address health inequities faced by many Latino Americans:

1. Congress must agree on a budget deal and avoid a federal government shutdown.
A government shutdown could directly impact millions of federal workers facing delayed paychecks, including many of the roughly 2 million military personnel and more than 2 million civilian workers nationwide. Beyond federal workers, a shutdown could have far-reaching effects on government services, many of which are relied on by older adults, their families, and caregivers. It has been warned that a shutdown could rattle financial markets. Additionally, a disruption in government services could shake the public's confidence in the government to fulfill its essential duties.

2. Direct funds using a broad interpretation of "health" that includes social determinants of health and considers health equity. Legislators must consider the definition of "health" to include all aspects of the social determinants of health (conditions where people live, learn, work, and play that affect a wide range of health risks and outcomes) and allocate those funds accordingly. Additionally, health equity should be a primary consideration in the distribution of funds.

3. NHCOA applauds the bipartisan passage of the Modernizing and Ensuring PBM Accountability (MEPA) Act by the U.S. Senate Finance Committee. We encourage Congress to continue working across the aisle to reduce the cost of prescription drugs for those who need them.
Pharmacy benefit managers (BMs) are the critical link between companies that manufacture prescription drugs, health insurers that cover them, pharmacies that sell them, and patients who rely on them. PBMs determine which drugs health plans will cover and play an essential role in setting the prices patients see at the pharmacy counter. Elected officials are responsible for working together to reduce the skyrocketing cost of prescriptions that patients rely on.

POLICY RECOMMENDATIONS

4. Address the prohibition of coverage for anti-obesity medications under Medicare Part D, instituted by the Medicare Modernization Act in 2003.

Obesity affects 42% of adults in the U.S. The Centers for Disease Control and Prevention (CDC) found that non-Hispanic Black adults had the highest age-adjusted prevalence of obesity at 49.6%, followed by Hispanic adults at 44.8%. People who are obese are at higher risk for heart disease, stroke, and type 2 diabetes. Obesity is linked with added costs; one study found that the total obesity-related government expenditures, including Medicaid and Medicare spending and federal outlays, were estimated to be $91.6 billion annually. This accounts for approximately 30% of Medicare spending. 1 Obesity is a serious issue in older adults, and while Medicare covers some obesity treatments, such as Intensive Behavioral Therapy and bariatric surgery, it does not cover anti-obesity medications. Coverage also depends on the kind of Medicare plan a person has. Including FDA-approved drugs and other anti-obesity treatments in Medicare coverage would help more older adults actively manage their weight and reduce their health risks. Providing access to diverse therapy options is essential to equitable, person-centered care delivery.

5. Continue to fund and prioritize Alzheimer's and dementia research and treatment.

Congress must renew its commitment to ensure that funding continues to be invested in
Alzheimer's and dementia research to provide progress in this realm. With robust and steady
investment, scientists can advance basic disease knowledge faster, explore ways to reduce risk,
uncover new biomarkers for early diagnosis and drug targeting, and develop potential
treatments. Bipartisan legislation currently under consideration that focuses on Alzheimer's and
dementia include:

a. Alzheimer's Accountability and Investment Act (S. 134 / H.R. 620), and
b. NAPA Reauthorization Act (S. 133 / H.R. 619)

POLICY RECOMMENDATIONS

6. Prioritize and improve osteoporosis education, screening, fracture prevention, and treatment to address the inequities that exist with this disease. Partnering with community-based organizations that reach priority populations can ensure culturally responsive education and patient empowerment to raise this issue in clinics.
Despite a landmark report by the Surgeon General in 2004 and the specific recommendations from key national and scientific societies intended to prioritize and improve osteoporosis and fracture prevention, implementation has lagged. Many patients do not receive the necessary information about prevention and are not getting to test to diagnose osteoporosis or establish their risk for osteoporosis. Most importantly, most patients with osteoporosis-related fractures are not being diagnosed with osteoporosis and are not receiving any of the Food and Drug Administration (FDA)-approved effective therapies.

7. Encourage government policies and enact legislation that requires bias and equity analysis of policy decisions and legislation at all levels. Like informing policymakers about the financial impact of proposed legislation or requesting economic impact statements on relevant bills, the legislature should adopt a procedure for developing and considering equity analysis and the effects of any policy change.

8. NIH and other federal agencies must design and make available funding opportunities to increase Community-based Participatory Research that require a significant proportion of the funds to be given to community partners. The National Institutes of Health and other federal granting agencies should strongly encourage partnerships with community-based organizations to implement and disseminate grants. It is also essential to have more funding opportunities from federal agencies for minoritized investigators in science, medicine, and public health focusing on older adult populations. Additionally, federal funding opportunities should be designed to address the science of health disparities.

COVID-19 SPECIFIC RECOMMENDATIONS

9. Work with states and national leaders to identify strategies to engage Hispanic communities most impacted by COVID-19 in vaccinations, boosters, as well as treatment.

Partner with states and national leaders, such as NHCOA, to develop innovative strategies to engage Latino communities in COVID-19 vaccination and boosters. Historically resilient communities were disproportionately impacted by the pandemic. The government should prioritize reaching marginalized communities by utilizing local clinics, mobile clinics, and culturally competent providers, like community health workers.

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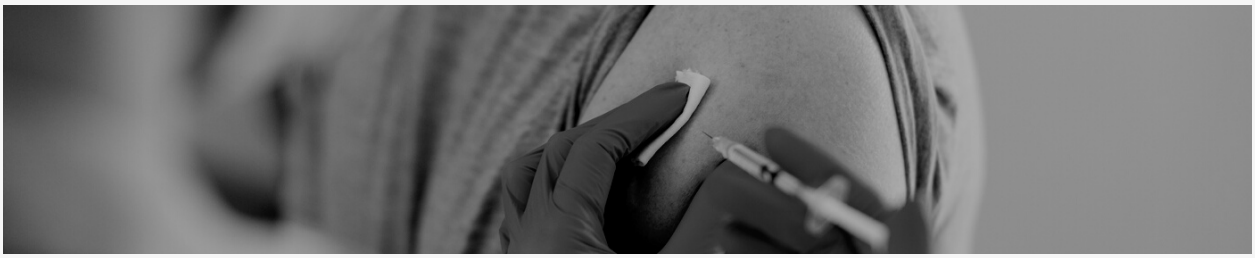
HEALTH INEQUITIES AMONG LATINO AMERICANS

The Latino population is the largest racial and ethnic minority group in the U.S. With approximately 60.6 million people, it comprises more than 18% of the U.S. population, a percentage expected to increase to more than 26% by 2050. However, Latino Americans face several challenges when it comes to health. The social determinants of health, which include access to healthcare, affordable housing, education employment, and income, affect a person's ability to have good health outcomes. Latino individuals have the lowest rate of health insurance coverage among racial and ethnic groups and often lack a primary care clinician. Compared with non-Hispanic whites, Latinos have lower median household incomes and higher housing cost burdens, longer work commutes, less access to safe green spaces for physical activity, more significant mental health stresses, and more discrimination at many levels. This yields a wide variety of chronic disease inequities for Latinos. Compared with whites, Latinos are more likely to have obesity, diabetes, liver disease, and poorly controlled high blood pressure; have higher risks of stomach, cervical, and liver cancers; and are more likely to be diagnosed at later disease stages due to being left out of screening programs, clinical trials, and preventive care.

As the US Latino population increases, it is essential to improve their overall health.



COVID-19 AND LATINO AMERICANS

The COVID-19 pandemic highlighted many inequities for Latinos and other population groups. Latinos, highly represented in frontline jobs in hospital, transportation, hospitality, and agricultural industries, experienced greater percentages of COVID-19 cases per capita in many states. Latino people also died from COVID-19 at more than two times the rate of whites during the pandemic. One of the reasons for such a high mortality rate in the Latino community was the lack of clear information about COVID-19 and misinformation shared via social media. While disparities in the uptake of at least one COVID-19 vaccination dose have narrowed and reversed for Latinos who received at least one dose (67%), fewer people have received the updated bivalent booster vaccine dose, and Latinos are about half as likely as whites to have received this booster.

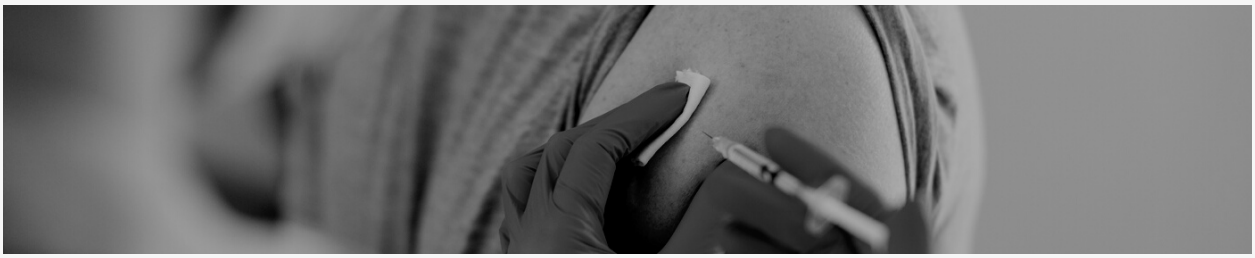
*US Department of Health and Human Services, Office of Minority Health. Cancer and Hispanic Americans. Accessed June 30, 2021. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=6*1

2023-2023 updated COVID-19 booster for 2023–2024

As of September 12, 2023, the 2023–2024 updated Pfizer-BioNTech and Moderna COVID-19 vaccines were recommended by the CDC for use in the United States. The 2023–2024 updated COVID-19 vaccines more closely target the XBB lineage of the Omicron variant and could restore protection against severe COVID-19 that may have decreased over time.

Keep yourself, your family, and your community safe; make an appointment to get vaccinated today!

Centers for Disease and Prevention. Stay Up to Date with COVID-19 Vaccines. September 15, 2023. National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases. Atlanta, GA. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#:~:text=Everyone%20aged%205%20years%20and,of%20updated%20COVID%2D19%20vaccine.



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OSTEOPOROSIS AND LATINO AMERICANS

INTRODUCTION

Osteoporosis is a major cause of disability in older adults, and it can take a severe toll on quality of life. While more than 50 million people in the United States have osteoporosis, many still do not know much about it, and myths persist. Osteoporosis is a condition in which the bones become less dense and more likely to fracture. If not prevented or left untreated, bone loss can progress painlessly until a bone breaks, typically in the hip, spine, or wrist. A hip fracture can limit mobility and lead to a loss of independence, and vertebral fractures can result in a loss of height, stooped posture, and chronic pain. It is a common misconception that osteoporosis only affects white women. However, a recently published article in Morbidity and Mortality Weekly Report showed that the percentage of Hispanic adults with osteoporosis (14.7%) was higher compared to non-Hispanic white adults (12.9%) and non- Hispanic Black adults (6.8%). The age-adjusted prevalence of osteoporosis for Puerto Rican men was 8.6%, compared with 2.3% for non-Hispanic whites and 3.9% for Mexican-American men.

In partnership with Elevance Health, the National Hispanic Council on Aging (NHCOA) conducted a national survey to understand better Latinos' knowledge, attitudes, and beliefs about osteoporosis. We surveyed 530 Latinos, and 19.4% reported being told by a doctor that they have osteoporosis.

METHODS

In 2023, NHCOA, through a cadre of promatores de salud, collected surveys from 530 Latino Americans in New Mexico, Texas, Florida, and California. Surveys were collected via pen and paper and entered intoan electronic survey form. Surveys were conducted in English and Spanish. Analysis was performed with
SPSS.

4 QuickStats: Percentage of Adults Aged ≥50 Years with Osteoporosis, by Race and Hispanic Origin — United States, 2017–2018. MMWR Morb Mortal Wkly Rep 2021;70:731. DOI: http://dx.doi.org/10.15585/mmwr.mm7019a5external icon.

RESULTS

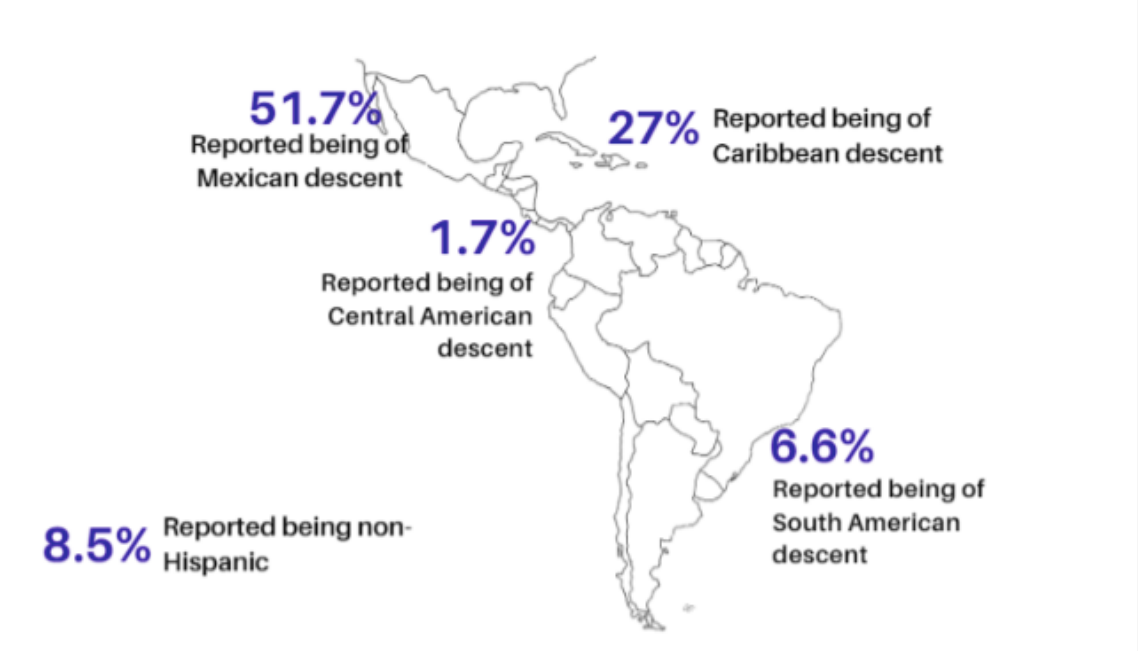
Participant Demographics (N=519)*

The total N here is dictated by the number of survey takers who answered the age question.

	Ages 18-60 N=258 n (%)	Ages 61+ N=261 n (%)
Gender: Female	181 (70.2%)	193 (73.9%)
Marital Status: Single, Divorced, Widowed	90 (34.9%)	161 (61.7%)
Education Level		
≤ Highschool	190 (74.2%)	205 (80.7%)
Some College	23 (9.0%)	19 (7.5%)
≥ College Graduate	43 (16.8%)	30 (11.8%)
Household		
Lives Alone	39 (15.5%)	80 (34.0%)
Children (under the age of 18) in the in the home	171 (70.1%)	51 (22.0%)
Relies on a caregiver	21 (8.1%)	97 (37.2%)

We had a relatively even age distribution between those aged 18-60 and those 60 and up. Regardless of age, the vast majority of all survey takers were women. More survey respondents in the age category 61+ were single, divorced, or widowed (61% vs. 34.9%). When we examine education, we see differences. Still, overarchingly, most respondents across both age groups had a high school education or less (74.2% for respondents 18-60 years old and 80.7% for respondents 61+ years old). Regarding household composition, older adults were more likely to live alone (34.0% vs. 15.5%), and adults aged 18-60 were more likely to have children under 18 in the home (70.1% vs. 22.0%). Older adults were also more likely to rely on a caregiver to assist them with their daily tasks (37.2% vs. 8.1%).

Ethnicity by Latin American Region

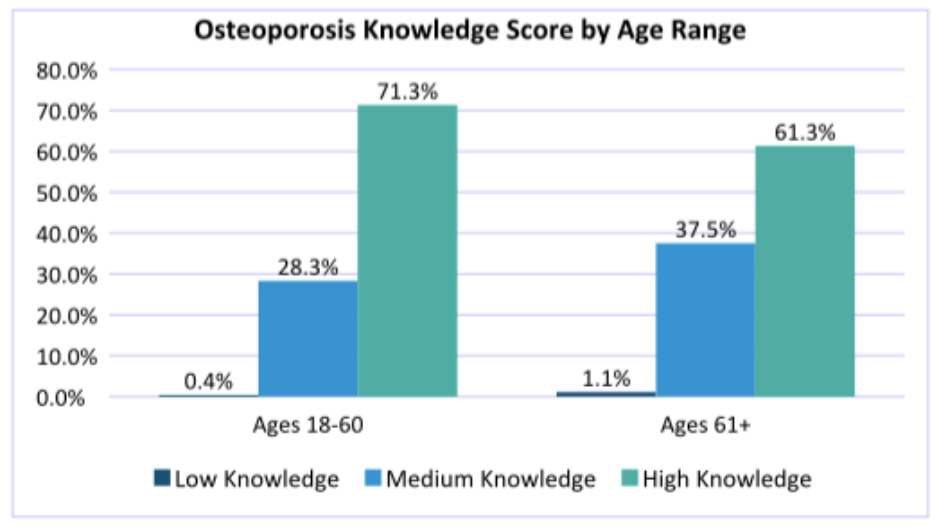


Knowledge

NHCOA asked a series of 19 true or false knowledge questions about osteoporosis. From those questions, we developed the following knowledge scores:

- **Low knowledge** is represented by 1 to 7 correct answers.
- **Medium knowledge** is represented by 8 to 13 correct answers.
- **High knowledge** is represented by 14 to 19 correct answers.

Most survey respondents (66.3%) had a "High Knowledge." We did see a statistically significant difference by age between low/medium vs. high knowledge (p=.016).



Overall, 89.1% of all survey respondents have heard of osteoporosis. The survey elucidated some significant opportunities for education among all respondents:

- Only 33.6% of respondents were able to correctly identify that a person with osteoporosis will likely not have symptoms such as pain before fracturing.
- Less than half (42.8%) correctly identified that white women with osteoporosis have the highest risk.
- Roughly 20% could not identify that sardines and broccoli are good sources of calcium for people who cannot eat/drink dairy products.
- 62.8% falsely believed that calcium supplements alone could prevent bone loss.
- Only 10.2% of respondents believed Vitamin D supplements are unsuitable for maintaining bone health.
- 18.3% did not identify high salt intake as a risk factor for osteoporosis.
- 26.6% of respondents did not know there are multiple screening tests used to diagnose osteoporosis.
- Some respondents did not make a connection between osteoporosis and body weight (16.4%), smoking and heavy drinking (21.7%), and physical activity (17%).

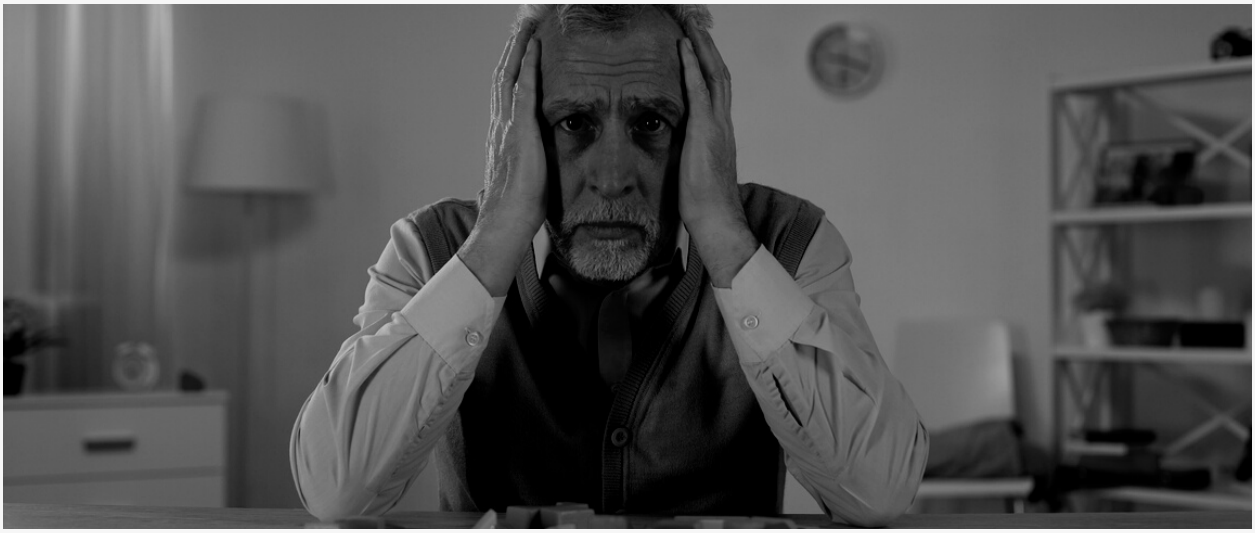
Beliefs:

- 35.5% of all respondents felt they had weak bones.
- 39.1% thought they had a high chance of developing osteoporosis.
- 42.5% felt their family history put them at higher risk for osteoporosis.

Behaviors:

- While 72.6% of all respondents reported having access to a place for exercise, only 45.5% reported exercising regularly.
- 80.6% of all respondents reported eating calcium-rich foods.
- Only 41.1% reported eating a balanced diet.
- 33.8% shared that they had a significant fracture/broken bone.
- 31.3% have a current or history of smoking.
- 20% consume eight or more alcoholic drinks per week on average.
- 46.4% take calcium supplements; 52.5% take Vitamin D supplements.
- 33.4% have had a doctor-recommended screening for osteoporosis; 34.9 have had a DEXA scan.

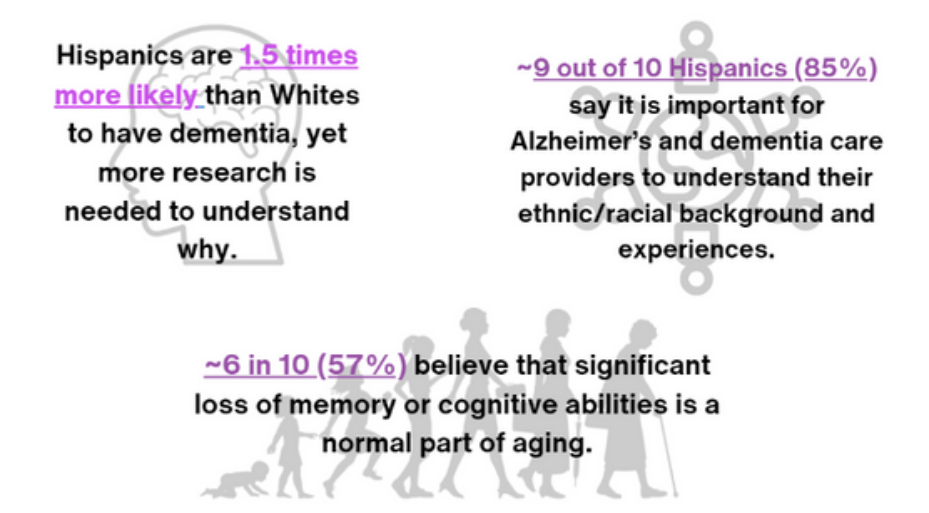
As our populations age, the weight of the inequities in osteoporosis will increase dramatically. NHCOA calls on the government to take decisive action in response to osteoporosis, which impacts individuals, families, and communities.



ALZHEIMER'S DISEASE

Introduction

Alzheimer's disease rates are projected to triple by 2060, according to the latest data from the CDC. But while everyone is at risk of developing this devastating condition as they age, Hispanics and Latinos – defined as people of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin – are predicted to have the most significant increase. By 2060, it's estimated that 3.2 million Hispanics and Latinos will live with Alzheimer's disease and related dementias. According to the Alzheimer's Association, 5 approximately 13% of Hispanics who are 65 or older have Alzheimer's or another form of dementia, yet more research is needed to understand these disparities truly.



We do know that Hispanics and Latinos are more likely to have risk factors for Alzheimer's, such as

- Low socioeconomic status
- Cardiovascular disease
- High blood pressure
- Obesity
- Depression
- Diabetes

Latinos also tend to develop symptoms seven years earlier than whites. Roughly 33% of Hispanics shared that they've faced discrimination regarding health care. Bias and discrimination can result in a reluctance to seek medical assistance if signs and symptoms of Alzheimer's or other medical conditions arise. The study by the Alzheimer's Association noted that only 44% of Latinos who noticed signs of cognitive decline talked to their doctor about their symptoms. Many Latinos believe memory loss or reduced cognitive abilities are inevitable in aging, highlighting the critical need for additional education.

To address these stark inequities, we need to engage, recruit, and retain Hispanic/Latino Americans and other diverse populations in Alzheimer's research and clinical trials, and we need the government to continue prioritizing this disease. Some recent and pending legislation on Alzheimer's and other dementias include:

NAPA Reauthorization Act (S. 133 / H.R. 619)

This bipartisan legislation would build on the progress made in the fight against Alzheimer's and other dementia over the last decade by reauthorizing the National Alzheimer's Project Act (NAPA) (P.L. 111-375), signed into law in 2011. The NAPA Reauthorization Act emphasizes the importance of healthy aging and risk reduction for Alzheimer's disease. The legislation would underscore and address health inequities for marginalized communities.

Alzheimer's Accountability and Investment Act (S. 134 / H.R. 620)

The original law, the Alzheimer's Accountability Act, was enacted in 2014, yet it will expire in 2025. Congress can renew its commitment to Alzheimer's and dementia research through the bipartisan Alzheimer's Accountability and Investment Act (S. 134 / H.R. 620). This legislation would require the National Institutes of Health (NIH) to continue to submit an annual Professional Judgment Budget to Congress to ensure Alzheimer's and dementia research receives funding at the levels needed to achieve the goals in the National Plan to Address Alzheimer's Disease.

The BOLD Infrastructure for Alzheimer's Act

In December 2018, Congress overwhelmingly passed the BOLD Infrastructure or Alzheimer's Act. The law directs the Centers for Disease Control and Prevention (CDC) to strengthen the public health infrastructure across the country by implementing effective Alzheimer's interventions focused on 17 public health issues, such as increasing early detection and diagnosis, reducing risk, and preventing avoidable hospitalizations. It will establish the Alzheimer's and Related Dementias Public Health Centers of Excellence, provide funding to state, local, and tribal public health departments, and increase data analysis and timely reporting.

Prescription Drugs to Treat Obesity

For Latino communities, the obesity epidemic has reached a crisis, with many states and communities reporting Latino obesity at overwhelming proportions. In 2013, the American Medical Association (AMA) officially recognized obesity as a disease. According to the Office of Minority Health, almost 80% of Latino American women are classified as overweight or obese, compared to 64% of non-Hispanic white women. In 2018, Latino Americans were 1.2 times more likely to be obese than non-Hispanic whites. We see similar trends among youth, with Latino American youth roughly 1.8 times more likely to be obese when compared to non-Hispanic white youth. The CDC also reported Latinos as the population group with the second-highest obesity prevalence in adults, with a staggering rate of 47.8 percent, second to Blacks/African Americans. In comparing overweight rates, which include obesity rates, Latinos surpassed the general population by ten percentage points. People who are overweight and obese are more likely to suffer from high blood pressure, high levels of blood fats, diabetes, and LDL cholesterol – risk factors for heart disease and stroke.

New opportunities for obesity treatment

A relatively new group of medications used for weight loss has emerged, providing new opportunities for obesity treatment. Initially approved to treat type 2 diabetes, GLP-1 (glucagon-like peptide-1) agonists, such as Novo Nordisk's Ozempic, Rybelsus, and Wegovy (semaglutide) and Eli Lilly's Mounjaro (tirzepatide), are highly effective weight-loss agents. However, these drugs are expensive when purchased out of pocket. Medical weight management remains one of the options for the treatment of excess weight, and recent advances have revolutionized how we treat obesity.

Questions related to access and affordability remain

Medicaid

When used for weight loss, Medicaid coverage of these drugs is currently limited, with some states taking steps to expand coverage. 7 States can decide whether to cover weight-loss drugs under Medicaid, leading to varying coverage policies across states. Under the Medicaid Drug Rebate Program, Medicaid programs must cover nearly all of a participating manufacturer's Food and Drug Administration (FDA)- approved drugs for medically accepted indications. However, weight-loss drugs are included in a small group of medications that can be excluded from coverage, and thus, some states do not cover weight-loss drugs in Medicaid, and others only cover the drugs for severe obesity with comorbidities or other restrictions.

Medicare

Medicare provides coverage for select obesity treatments, such as behavioral therapy. However, Medicare does not cover many weight loss treatments, including anti-obesity medications. This failure to provide coverage for these treatments creates gaps in the continuum of care for older adults with obesity. It limits treatment choices for beneficiaries, which can pose challenges for low-income patients.

Williams E, Burns A, Rudowitz R. Medicaid utilization and spending on new drugs used for weight loss. KFF. September 8, 2023. https://www.kff.org/policy-watch/medicaid-coverage-of-and-spending-on-new-drugs-used-for-weight-loss/

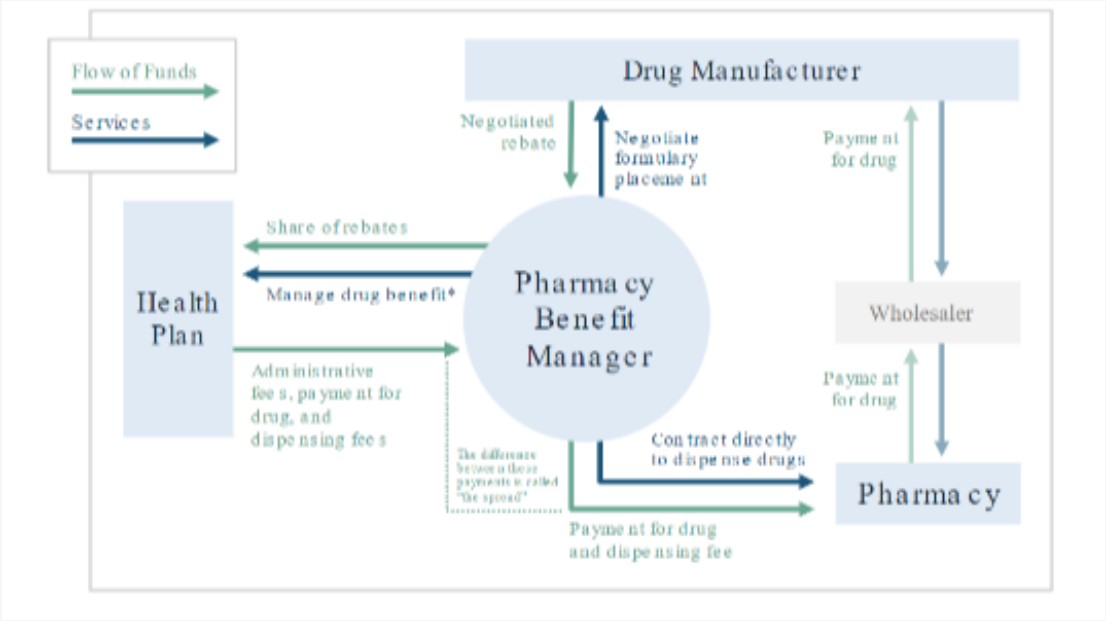
Expanding Medicare Coverage for Adults With Obesity

Including FDA-approved medications and other anti-obesity treatments in Medicare coverage would help more older adults actively manage their weight and reduce their health risks. Providing access to diverse therapy options is essential to equitable, person-centered care delivery. The Treat and Reduce Obesity Act (TROA) is a bipartisan bill designed to enable CMS to clarify that FDA-approved anti-obesity medications may be covered under Part D.

Pharmacy Benefit Managers (PBMs)

Introduction

"Pharmacy benefit managers, or PBMs, manage prescription drug benefits on behalf of health insurers, Medicare Part D drug plans, large employers, and other payers. By negotiating with drug manufacturers and pharmacies to control drug spending, PBMs have a significant behind-the-scenes impact in determining total drug costs for insurers, shaping patients' access to medications, and determining how much pharmacies are paid." PBMs have long evaded adequate scrutiny for their role in inflating the cost of prescription drugs for patients. Initially created as intermediaries to negotiate prices between health plans and insurers to confirm a patient's eligibility and administer plan benefits, now, PBMs operate virtually unchecked and game the system for their economic benefit. Though most are unaware they exist, PBMs significantly contribute to high drug costs and reduced treatment access.



Pharmacy Benefit Managers and Their Role in Drug Spending, Commonwealth Fund, April 2019. https://doi.org/10.26099/njmh-en20

Concerns Regarding PBMs and Hispanic Older Adults

- PBMs lack transparency in their negotiating process. Operating with a veil of ambiguity, PBMs are rarely pressed on the rationale behind their listed drug prices.
- PBM business models contain misaligned incentives that drive up prices. One such instance is that PBM income is derived from the price of a drug rather than the cost of services PBMs provide. This can lead to PBMs keeping drug prices high for their benefit and, in turn, harming patients. This particularly impacts Hispanic communities, already encountering other barriers to care and high costs.
- Three PBMs control nearly 80% of the prescription drug market, enabling PBMs to force pharmacies into signing contracts where drugs are sold to them at higher prices. This, unfortunately, raises costs for patients at the counter.
- Pharmacies unable to meet PBM demands cannot acquire or sell the drug, meaning that patients at certain locations, including Hispanic older adults, may be unable to access the treatments they need from the pharmacies of their choice. Driving patients away from pharmacies has resulted in the disappearance of community pharmacies disproportionately located in marginalized neighborhoods.
- The Modernizing and Ensuring PBM Accountability (MEPA) Act, passed in the Senate Finance Committee, would address PBM concerns regarding transparency, de-linking PBM income from drug prices, and contract fairness. This bill will likely be voted upon by the Senate this fall.

Rebate Reform Would Save Patients Money

- PBM rebate reform is another issue deserving attention not included in the MEPA Act.
- Many Hispanic older adults struggle to afford the treatments they need, all the while Medicare Part D PBMs receive rebates and discounts.
- Drugmakers give PBMs billions of dollars in rebates to pass them to patients at the pharmacy counter. These rebates are meant for patients who rarely see the light of day and are pocketed by PBMs for profit. This is inherently unjust and exacerbates the prescription drug affordability issue experienced by older Hispanic adults.
- The Pharmacy Benefit Manager Reform Act would require PBMs to pass on 100% of rebates, fees, and all other alternative discounts to patients at the pharmacy. This bill passed the Senate HELP Committee this summer and was sent to the Majority Leader to schedule a vote.

PBMs Ought to Share the Savings

- Another issue to mention is the failure of PBMs to share the savings they receive with the patients they purportedly serve.
- Older Hispanic patients do not always benefit from PBM-negotiated prices. Instead, the "benefit" is only financially helping the PBMs that negotiate the price from manufacturers.
- One key example is insulin, which two years ago was found to have decreased in net price by 53% and touted as proof of PBMs' added value for patients. However, the list price rose by 141%, which is the price set by PBMs and sold to pharmacies. This certainly does not benefit Hispanic older adults, who may even see the costs rise.
- Our country should require PBMs to apply the savings they receive to the list prices they sell the drugs at so that the cost of medicine becomes more affordable for older Hispanic patients.

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THANK YOU