

The Effect of Medicare Part D Plan Switching and Formulary Changes on Sole Community Pharmacies and the Patients They Serve

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OVERVIEW

Sole community independent pharmacies (i.e., those located at least 10 miles from the next closest retail pharmacy) are the primary access point to pharmacy services for residents in just over one thousand small communities throughout the United States. These pharmacies are susceptible to changes in the Medicare Part D program: Six out of ten receive 90 percent or more of their store's revenue from prescription sales and on average 37 percent of these prescriptions are paid for by Medicare.¹ Under Part D, Medicare Prescription Drug Plans (PDPs) can frequently change formularies, but beneficiaries who are not dually eligible for Medicare and Medicaid can only switch PDPs once a year (beneficiaries who are dually eligible can switch plans as often as once a month). These phenomena can create administrative burdens for small pharmacies, which must find ways to accommodate their patients by assisting with prior authorization of new medications or by contracting with a new PDP. Changes in formularies and plans can also disrupt timely access to medications. This brief presents findings from a 2008 survey of 401 pharmacist-owners of sole community independent pharmacies. The findings will help policymakers better understand the extent and impact of beneficiary plan switching and changing formulary lists.

KEY FINDINGS

- A median of 12.5 percent of Medicare beneficiaries who were enrolled in a PDP in 2007 changed plans for 2008.
- Half (49 percent) of the pharmacist-owners interviewed had patients who were auto-reassigned to PDPs with which the pharmacy did not contract.
- Among Medicare beneficiaries who could not change plans midyear (not dually eligible), an average of 30.2 percent were affected by PDP plans changing formulary lists.
- Seventy-five percent of pharmacist-owners had dually eligible patients auto-reassigned to plans that did not cover at least one of their current medications.

IMPACT OF PATIENTS SWITCHING PLANS

The reported percentage of a sole community pharmacy's Medicare patients who switched PDPs between 2007 and 2008 ranged from zero to 95 percent. The median value, among the 372 responses to this question, was 12.5 percent. Our findings are consistent with CMS reports which found that 12 percent of Part D enrollees switched plans during this same time period. According to CMS, the majority (68 percent) of those who switched between 2007 and 2008 were low-income subsidy beneficiaries, a large portion of whom were dually eligible beneficiaries (eligible for both Medicare and Medicaid) and automatically reassigned by CMS to different plans in order to reduce premium costs.²

When dually eligible Part D beneficiaries are auto-reassigned to a new PDP, no consideration is given to whether their pharmacy contracts with the new plan. As a result, beneficiaries may be reassigned to a plan with which their sole community pharmacy has not contracted. Forty-nine percent (n=196) of the pharmacist-owners interviewed had patients reassigned to plans they did not have a contract with. Of these 196 respondents, 93 had 10 or more patients reassigned to such a plan. Several of the pharmacist-owners interviewed told us they resolved this issue by attempting to contract with new plans before their patients experienced any disruption in their medications. Others filled temporary prescriptions while their patients worked on switching to a plan accepted by the pharmacy.

While reassignment to a PDP that is not accepted by a beneficiary's preferred pharmacy may not be a large concern for patients with local access to multiple pharmacies, it is an issue for those living in communities with only one pharmacy. A recent study found that 73 percent of the sole community pharmacies (defined by Freeman et al. as the only retail pharmacy in the community, regardless of distance to the next nearest pharmacy) in 16 states did not participate in at least one plan available to their community.³ Beneficiaries who are reassigned to a plan that is not accepted by their sole community pharmacy may have to obtain medications through mail-order companies, travel the distance to the next nearest participating pharmacy, or if possible, switch to a PDP accepted by their local pharmacy.

IMPACT OF CHANGING FORMULARY LISTS

Currently, PDPs are allowed to change their formulary lists once a year when beneficiaries enroll, by adding or removing drugs, making lower-cost substitutions, changing the preferred status, or changing utilization requirements. In some cases formularies can be changed midyear if approved by CMS or deemed necessary by the FDA. For example, brand names can be replaced by new generics or formularies can be modified based on new information on drug safety and effectiveness. Pharmacist-owners who were interviewed reported that on average 30.2 percent of non-dually eligible patients were affected by formulary changes, with responses ranging from as few as zero percent of patients to as high as 100 percent. Non-dually eligible beneficiaries, who are unable to switch plans midyear, may be more likely to be adversely affected by changes to their PDP's formulary list, primarily because of the length of time they may be required to wait before they can switch to a plan with a formulary that covers their medication.

Dually eligible beneficiaries can also be affected by PDPs changing formulary lists, but if changes occur, they, unlike non-dually eligible patients, have the option of immediately switching to a PDP that covers their medications. More often, dually eligible beneficiaries experience changes in formulary lists due to auto-reassignment. Seventy-five percent (n=300) of pharmacist-owners interviewed had dually eligible patients auto-reassigned to plans that did not cover at least one of their current medications. Of these respondents, 187 had 10 or more patients auto-reassigned to such a plan.

IMPACT OF REASSIGNMENT ON PATIENT ACCESS TO MEDICATIONS LOCALLY

Over half of the pharmacist-owners interviewed (n=231) reported having patients who were unable to fill a prescription when they needed it because of reassignment problems. The number of patients experiencing problems ranged from one to 250, with an average of 19 patients (n=206). Although not specifically queried, some pharmacist-owners reported that they continued to fill prescriptions for these patients until the issues causing the disruption in coverage were resolved, often without receiving reimbursement for the medications that were dispensed. There were also respondents whose patients went without their medications or had to find an alternate pharmacy that was able to fill the prescription.

IMPLICATIONS

These findings confirm the importance of CMS rules requiring that beneficiaries receive information about the effect of PDP changes. When changes to a patient's PDP occur, whether due to patients actively changing their plans, through auto-reassignment to another plan, or through formulary changes, efforts must often be made by both the patient and the pharmacist to avoid a possible disruption in the patient's access to medications. Changes in Part D PDPs can also have a negative impact on sole community pharmacies through increased administrative burden and decreased revenue due to loss of patients to plans with which the pharmacies do not contract. Both of these factors ultimately affect the financial viability of sole community pharmacies, and could result in lack of consumer access due to pharmacy closure.

Current methods used to automatically reassign dually eligible patients to new Part D PDPs are in question. CMS reports no differences in health outcomes (i.e., death rates and rates of hospital/ER visits) between regular beneficiaries and reassigned beneficiaries, a finding that also holds true for vulnerable populations such as those who are disabled; those with mental health conditions, diabetes, congestive heart failure; or those of different race or ethnicity. However, the effects of auto-reassignment on residents of small communities with only one retail pharmacy have not been reported by CMS.⁴ Preliminary estimates from CMS indicated that another 1.1 million beneficiaries would be auto-reassigned in fall of 2009.⁵ To reduce disruption in services, policymakers should consider the possible impact of these practices on residents of small communities with limited availability of pharmacy services.

STUDY METHODS

A semi-structured interview protocol was used in this study. To be included in the survey, pharmacies had to be independently owned and located 10 miles or more from the next closest pharmacy. A subset of pharmacies likely to meet these study criteria were identified using data from the National Council for Prescription Drug Programs, Inc., which contains information about the 74,108 pharmacies in the United States with active provider numbers. Pharmacies with the following characteristics were identified: independently owned (including franchise licenses); operating as a community retail pharmacy; the only pharmacy within its ZIP code; and the only pharmacy within a ten-mile or more Euclidian buffer from the next closest pharmacy. Application of these criteria resulted in a final sample of 1,148 independently owned pharmacies. Eligibility to participate in this study was verified during the initial telephone contact by use of screening questions. The study goal was to complete 400 interviews. Attempts were made to contact the owners of all the pharmacies in the sample. No contact was made with 5 pharmacies (no answer or busy signal), for 151 pharmacies the pharmacist-owner was never reached in ten or more attempts, 43 stores were confirmed closed, and 68 did not meet the study criteria. Of the remaining 881 pharmacies, 401 participated, for a response rate of 46 percent.

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