NC Rural Health Research & Policy Analysis Center

Findings Brief, February 2009

Sole Community Pharmacies and Part D Participation: Implications for Rural Residents

Victoria Freeman, RN, DrPH, Indira Richardson, MPA, Rebecca Slifkin, PhD

BACKGROUND

The Medicare Part D Drug Plan (Part D), which was implemented on January 1, 2006, allows Medicare's 44 million elderly and disabled beneficiaries to join a private Prescription Drug Plan (PDP) or join a Medicare Advantage Plan that provides supplemental health insurance with a prescription drug benefit. Under the Part D program, beneficiaries can choose between multiple competing PDPs. This choice affects not only the insurance costs and benefits, but also the pharmacies that beneficiaries can use in order to have their prescription purchase covered by the PDP, as each pharmacy decides with which of the many available PDPs they will contract. Therefore, in small rural towns that are served by only a single retail pharmacy, beneficiary access to local pharmacy services including counseling depends on whether or not the local pharmacy contracts with the enrollee's PDP.

This brief describes the contracting patterns of sole rural community pharmacies in 16 states, to assess the extent to which each pharmacy contracts with the most commonly used PDPs available in their state. When the sole pharmacy does not contract with all major plans, road miles to the next closest retail outlet were calculated to assess the minimum distance a beneficiary who was enrolled in a plan with which their local pharmacy did not participate would have to travel in order to have a prescription paid for by their PDP.

KEY FINDINGS

- On average, rural sole community pharmacies contracted with 82.1% of the most commonly used plans in their state.
- Almost three-quarters of pharmacies did not participate in at least one plan.
- Half of the communities where the sole pharmacy did not contract with all PDPs have another pharmacy less than 10 miles away.
- For 16% of communities with a pharmacy that did not contract with all plans, the next nearest pharmacy was more than 20 miles away.

The full final report of this study is available at
http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/report/FR95.pdf

North Carolina Rural Health Research & Policy Analysis Center
Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill
E-Mail Address: NCRural@unc.edu, Phone: 919-966-5541

SOLE COMMUNITY PHARMACY CONTRACTING WITH PART D PLANS

Across the 16 states included in this study[i], 670 sole community pharmacies contracted on average with 82.1% of the most commonly used plans serving their state (Table 1). Almost three-quarters (73.1%) did not contract with all plans, although the number that contracted with less than three-quarters of the plans was relatively small (n=168, 25.1%). Contracting with PDPs by sole community pharmacies varied by state, with state-level mean participation rates ranging from a high of 90% to a low of 43%.

Table 1: Sole Community Pharmacy Participation* in Prescription Drug Plans for All Pharmacies Combined (N=670)*

Average participation for individual pharmacies		82.1%
Median participation for individual pharmacies		88.9%
Range of participation for individual pharmacies		0 – 100%
Number and % of pharmacies that participate in:		
0 plans	3 pharmacies	0.4%
1-25% of plans	16 pharmacies	2.4%
26-50% of plans	34 pharmacies	5.1%
51-75% of plans	115 pharmacies	17.2%
76-99% of plans	322 pharmacies	48.1%
All plans	180 pharmacies	26.9%

*Includes participation in plans with a combined enrollment of at least 75% of a state's Part D beneficiaries, an average of 10 plans per state.

CONSEQUENCES OF LESS THAN FULL PARTICIPATION

When sole community pharmacies participate with all PDPs, Medicare beneficiaries need only consider costs and benefits when choosing between competing plans. However, if sole community pharmacies do not contract with all plans, there are several consequences for the beneficiaries they serve. Beneficiaries who are aware that their local pharmacy does not contract with all plans may limit their choice to those plans with which their local pharmacy participates, possibly choosing a plan with less than optimal benefits. Beneficiaries who do not realize they need to consider their local pharmacy's contracting patterns may inadvertently choose a plan with which their local pharmacy does not contract, necessitating travel to another community to received covered services. Regular Medicare beneficiaries who inadvertently choose a plan with which their pharmacy does not contract must wait a full year until they are allowed to switch to another PDP.

Beneficiaries who are eligible for a low income subsidy, which includes individuals dually eligible for Medicare and Medicaid (hereafter referred to as LIS), may be auto-assigned to a plan. If their local pharmacy does not contract with this plan these beneficiaries would be forced to travel to another community for care until they were able to switch plans. In contrast to regular Medicare beneficiaries, LIS beneficiaries may change plans throughout the year but could face disruption in pharmacy services while the change of plans is being processed.

i. States selected included Alabama, Alaska, Arizona, Arkansas, Florida, Illinois, Maine, Nebraska, Nevada, North Carolina, North Dakota, Pennsylvania, Texas, Vermont, Washington, and Wyoming.

ALTERNATIVE RETAIL OUTLETS

To assess the availability of nearby pharmacies for those who choose a PDP with which their local pharmacy does not contract, the distance to the next-closest pharmacy was calculated for the 490 sole community pharmacies that did not contract with 100% of the most common PDPs in their state (Table 2).

Table 2: Distance to Closest Alternative Pharmacy for Pharmacies Not Participating in 100% of Plans*

	% (n) of Pharmacies where Closest Alternative Pharmacy is:					
	<10 miles away		10-20 miles away		>20 miles away	
Level of participation:						
0 plans	33%	(1)	33%	(1)	33%	(1)
0-25% of plans	19%	(3)	44%	(7)	38%	(6)
26-50% of plans	32%	(11)	29%	(10)	38%	(13)
51-75% of plans	49%	(56)	36%	(41)	16%	(18)
76-99% of plans	55%	(176)	33%	(107)	12%	(39)
Total	50%	(247)	34%	(166)	16%	(77)

*Includes participation in plans with a combined enrollment of at least 75% of a state's Part D beneficiaries, an average of 10 plans per state.

For half of the rural communities where the sole local pharmacy does not contract with all available PDPs, the next-closest pharmacy is less than 10 miles away. For 16% of pharmacies not contracting with all plans, the nearest alternative pharmacy is more than 20 miles away. These calculations only address the potential burden of travel for those small-town residents who may not be able to use their local pharmacy, as it is not known whether travel to the next closest pharmacy would provide access since that pharmacy also may not participate in all plans. Furthermore, it appears that in communities that are more remote (i.e. the distance to the next closest pharmacy is far), pharmacies are more restrictive about the PDPs with which they will contract, limiting beneficiary choice.

DISCUSSION

These analyses raise important considerations for rural residents selecting a Part D plan for their chronic and acute medication needs. Because participation in plans by sole community pharmacies is not universal, both regular and LIS Medicare beneficiaries are at risk for selecting or being assigned to a plan with which their local retail pharmacy does not contract. For LIS beneficiaries, this may represent a temporary disruption as they can change plans throughout the year. However, lack of access to critical medications while the change in insurance plans is being processed is a serious concern for this population. For regular Medicare beneficiaries, selection of the "wrong" plan in terms of participation of their local pharmacy has longer term consequences, as these beneficiaries must wait a year before changing to a plan accepted by their local pharmacy.

Prior to Medicare Part D, rural beneficiaries were less likely to have had insurance that covered prescription medication, and so may be unfamiliar with the factors that must be considered when choosing an insurance plan. Enrollment in Part D is not simple, as enrollees must determine the cost of plans, the coverage they provide, and the retail outlets that can be used. For beneficiaries using medications for chronic conditions,

coverage for their specific medications is also an important part of their decision. Whether or not their local pharmacy participates in a plan being considered may be the last issue beneficiaries contemplate or, in the case of persons unfamiliar with insurance restrictions, may not be considered at all. Clear instructions on Part D enrollment websites and forms that inform the enrollee of the requirement that they use only certain pharmacies are essential. Additionally, it is important that advocates who work with Medicare beneficiaries make those they counsel aware of all of the aspects of plan choice they must consider and the various access implications of those choices. Under current Part D regulations, pharmacists are precluded from recommending a specific benefit plan to their patients. This restriction removes one of the most often used sources of pharmacy information for rural residents.

There are limitations to this study. The analysis included only a portion of states and those chosen may not represent the country as a whole. Additionally, only those plans with the majority of enrollees were searched and it is possible that they have many enrollees because most pharmacies participate in the plan. If anything, this analysis overestimates the participation rates of sole community pharmacies in Part D plans.

METHODS

PDP participation rates were examined for all rural sole community pharmacies in 16 states. Pharmacy name and location was obtained from state Board of Pharmacy lists of licensed pharmacies. Rural pharmacies were defined as location in a nonmetropolitan county or in a metropolitan county with a rural urban commuting area (RUCA) code of four or higher. The sample was restricted to only retail pharmacies, including compounding pharmacies, and to those pharmacies that were the only pharmacy listed for their town name. The final pharmacy file consisted of 670 sole community pharmacies, with the number of pharmacies per state ranging from three to 120.

Enrollment information for PDPs in each study state was obtained from the Centers for Medicare and Medicaid Services website and included data as of August 2007. Only plans that were considered to be available to the general public including LIS beneficiaries were included. On average, study states had enrollees in 30 plans with the number of plans per state ranging from 18 to 49. Forty-one (41) PDPs with unique contract identification numbers were searched for the 16 states as a group.

For each sole community pharmacy, a selected group of PDPs was searched to determine if the pharmacy contracted with these plans. PDPs were selected based on the number of enrollees in the state and the availability of a pharmacy locator function at the PDP website. Using these criteria, we determined pharmacy participation in plans that had a combined enrollment of at least 75% of each state's Part D enrollees. To determine participation of individual sole community pharmacies in PDPs, the internet-based pharmacy locators available at the websites of the individual PDPs were used, mimicking the process that a potential Part D enrollee might use to determine if a pharmacy in their town participated in a PDP. Distance to the next closest pharmacy was calculated based on street address of the pharmacy when available (85%) or ZIP code or other approximation when street address was not listed, e.g., pharmacy address was a post office box.

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