

# Protecting Rural Beneficiaries with a Medicare Prescription Drug Benefit



NATIONAL RURAL HEALTH ASSOCIATION



# The Whole Package: Protecting Rural Beneficiaries with a Medicare Prescription Drug Benefit

Few would argue against providing Medicare beneficiaries with a prescription drug benefit. It is, quite simply, something they deserve. Indeed, given the increasing cost of prescription drugs, the increasing numbers of elderly, and the increasing role of pharmaceutical care in maintaining health, a prescription drug benefit is an absolute necessity. It is, however, not enough.

Critical as a drug benefit is, it is only part of the package. *Insuring* drugs without also *ensuring* accessible, high-quality, and affordable pharmaceutical care (the whole package) will not protect the health and well-being of our citizens. In fact, it could harm them. Therefore, any Medicare prescription drug benefit should include provisions that protect the access of all beneficiaries — rural and urban — to local pharmaceutical care.

In keeping with its mission to improve the health of rural Americans through appropriate and equitable health care services, the National Rural Health Association convened a meeting of experts in rural pharmacy in January 2003 to discuss the rural implications of a Medicare prescription drug benefit and offer suggestions on how best to design a benefit so as to protect rural beneficiaries — to ensure that they not just get the pharmaceuticals, but that they have local access to pharmaceutical care. This report synthesizes the findings and recommendations of those experts. Their consensus: Unless a benefit is designed with rural beneficiaries in mind, great damage could be done — damage that would be irreversible.

*Failure to consider the unique features of the rural health care system in the design of a drug benefit could wreak havoc on rural pharmacies and the communities they serve. Any Medicare prescription drug benefit should include provisions that protect rural beneficiaries' access to local pharmaceutical care.*

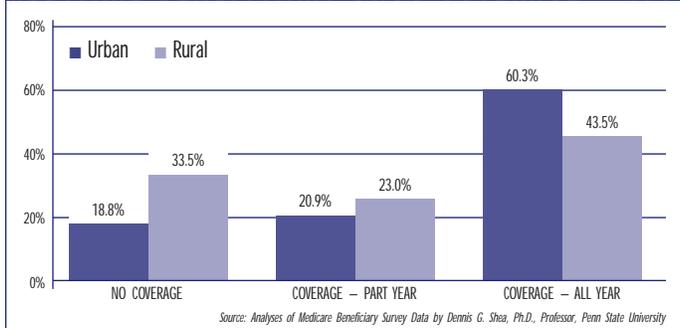
Indeed, such damage has happened in the past. In 1983, Medicare moved to an inpatient prospective payment system. By 1991, 193 rural hospitals had closed their doors, unable to survive under a pricing system based largely on an urban environment.<sup>1</sup> By 1998, 438 rural hospitals had closed, despite years of adjusting the payment formulas to “mitigate” the damage.<sup>2</sup>

Creation of a prescription drug benefit that fails to consider the unique features of the rural health care system could well wreak similar havoc on rural pharmacies and the communities they serve, ultimately harming the very people a drug benefit is meant to help.

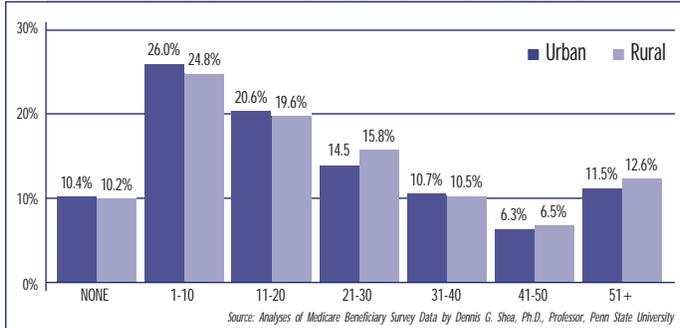
## Pharmaceutical Care: The Whole Package

The importance of prescription drugs to health care cannot be overstated. And their importance is only increasing. In 1950, 367 million outpatient prescriptions were written nationwide. Today, the number is close to three billion. Measured in number of prescriptions per person per year, Americans' usage went from 2.4 to 11. The elderly — who comprise the vast majority of Medicare beneficiaries — average 25-30 prescriptions per person per year.

MEDICARE BENEFICIARY DRUG COVERAGE - 1999



PRESCRIPTION DRUG REFILLS BY RESIDENCE - 1999



With that phenomenal increase in pharmaceutical usage comes a rise in the need for pharmaceutical care. To illustrate that point, consider that studies show when a person is on nine or more prescription drugs, the likelihood of an adverse drug reaction is 100 percent. Just as the importance of prescription drugs to health care cannot be overstated, the importance of pharmaceutical care cannot be overstated.

<sup>1</sup>Trends in Rural Hospital Closure: 1988-1991. Office of the Inspector General, U.S. Department of Health and Human Services, July, 1993.

<sup>2</sup>Rural Health in the United States, Thomas C. Ricketts, III (ed.). New York, Oxford Press, 1999.

## ***So, what exactly is pharmaceutical care?***

Contrary to popular opinion, pharmaceutical care is far more than the filling and dispensing of prescriptions. Rather, it is a critical component of the overall health care system, as important to patient health as any other component. Pharmaceutical care encompasses

- **Patient advice.** Pharmacists advise patients in any number of ways: how to take a prescription medication, whether the medication will affect or be affected by other medications, what over-the-counter treatments to take for various conditions, and in some cases, when to seek additional medical care.
- **Clinical service.** Depending on the setting, pharmacists provide patients with any number of clinical services, ranging from diagnostic testing to treatment.
- **Case management.** In order to protect patients' health and see to it that they get the best treatment, pharmacists regularly consult with physicians about patients' pharmaceutical needs — alerting physicians about potential drug interactions, offering suggestions for alternative treatments, and clarifying prescription orders.
- **Benefits management.** In the same vein, pharmacists also consult with insurance companies on behalf of patients — seeking coverage for a particular drug and correcting wrongly rejected claims.

Although they are often forgotten or taken for granted, pharmacists are a critical part of any health care system. Without them, the system will falter and ultimately fail, endangering patient health and well-being.

## **Rural Beneficiaries: Underinsured, Underserved**

The percentages of rural Americans who are older and sicker are greater than those of urban Americans. Average wages in rural America are lower. Lack of health insurance is, depending on the measure, also a relatively greater problem in rural America. A greater proportion of rural Americans also lack access to adequate health care. The story is much the same with respect to Medicare beneficiaries and prescription drugs.

Medicare beneficiaries who live in our nation's rural areas enjoy prescription drug coverage at a far lower rate than do beneficiaries who live in urban areas. Depending on the measure, the gap between rural and urban beneficiaries with coverage was, in 1999, anywhere from seven percentage points to 17 percentage points.

That fact notwithstanding, data on prescription drug refills by residence show that rural beneficiaries age 51 and older obtain more refills than their urban counterparts. As

a result of all these factors, 14 percent of rural beneficiaries in 1999 spent more than 10 percent of their income out of pocket on prescription drugs. Only eight percent of urban beneficiaries did so.

## **Rural Pharmacies: Critical Care, Critical Condition**

While pharmacists and the care they provide are a critical component in any health care system, in some rural places underserved by doctors, clinics, and hospitals, they are the entire system. Indeed, studies have found that pharmacists are more widely distributed across rural areas than primary care doctors — often thought to be the mainstay of rural health care. Yet, according to a 1996 study by the American Pharmaceutical Association, 25 percent of the nation's population lives in rural America but only 12 percent of its pharmacists practice there. This, of course, comes on top of shortages of other health care providers and facilities in rural America — further weakening the health care system serving a quarter of our nation's citizens.

Reasons for the dramatic rural shortage include the obstacles to setting up shop in areas that can be remote, isolated, and contain higher percentages of low-income clientele. On top of that are the rising workload that pharmacists shoulder and the relative lack of help in rural areas.

According to the National Association of Chain Drug Stores, pharmacists in retail pharmacies alone filled three billion prescriptions last year — up 50 percent from 1990. The association's data also show that four out of five patients who visit a doctor leave with a prescription.

On the surface, such numbers would seem only to benefit pharmacists. In fact, the rise in prescriptions is a mixed blessing. A study of rural pharmacies in Minnesota, North Dakota, and South Dakota found that more than half of the pharmacists surveyed had difficulty obtaining relief coverage for vacations and time off. Indeed, some rural pharmacists report working 12 or more hours a day (20 percent of it on the phone dealing with third-party payer issues). Obviously, the chance for error increases under such conditions.

Precarious as the state of rural pharmacy is, the situation is getting worse. Pharmacies, particularly small, independent pharmacies — 70 percent of which are located in communities of 50,000 or less — face a long list of pressures:

- **Price takers.** Rural pharmacies are essentially price takers. Pharmacist after pharmacist reports being unable to negotiate prices with pharmaceutical suppliers. Rather, they are typically presented with a contract and pricing scheme and given a few days to take it or leave it. Not surprisingly, such arrangements favor the suppli-

ers and not the pharmacists. As evidence, consider that the average pharmacy makes only a one to two percent profit margin.

- **Small margins/low volumes.** The relatively small sales of a rural pharmacy mean that “making up on volume” for the small profit margin is all but impossible. Indeed, research shows that just to be viable, a pharmacy needs to serve a population of 4,500 people. In many areas, maintaining volume, let alone increasing it, is difficult enough.
- **Mail order.** Mail-order (including Internet) pharmaceutical sales are making the challenge of maintaining volume even harder. According to the Institute for Local Self Reliance, sales at mail-order pharmacies grew 24 percent in 2000 and accounted for some 15 percent of all prescription spending. Because mail-order suppliers deal in vast quantities, they can negotiate lower wholesale prices. And because they maintain no brick and mortar outlets, their overhead is much lower than retail pharmacists. As a result, mail-order suppliers can sell drugs at lower prices. On top of that, some third-party payers steer — some would say coerce — customers into using mail-order rather than local pharmacies. In some instances, pharmacy benefit managers even own the mail-order suppliers they steer customers to — a clear conflict of interest.
- **Age.** The majority of pharmacists in rural areas are approaching retirement age. The decline of pharmacy graduates coupled with the other obstacles to rural pharmacy mean that many will not be replaced.
- **Medicaid.** Some states are seeking to curtail their Medicaid expenditures by reducing even further the low profit margins pharmacies currently make. This is particularly hard on rural pharmacies since they have a higher percentage of Medicaid business than do urban areas (save for some inner city areas).

As a result of these and other pressures, 13 percent of independent pharmacies operated at a loss in 2001; 28 percent earned zero to only two percent profit. Together, these 41 percent of independent pharmacies are vulnerable and in danger of failing. Yet, despite it all, the rural pharmacies still above water continue to provide affordable, accessible, high-quality care. “Rural” does not mean “second-rate.” We should never let it become so.

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## Losing Health Care and More

If rural pharmacies fail, they will leave a void in their communities’ health care systems, economies, and civic capacities — a void that once created, will not easily be filled.

With or without a local pharmacy, most people will be able to get the drugs they need via mailorder. What they cannot get from the postman, however, is pharmaceutical care — the whole package. The postman will not be able to advise them, consult with their doctors, and represent their interests to benefits managers. And in rural America, driving to another pharmacy still in business to get that care might mean driving 30, 50, or even 100 miles.

In addition to losing health care, communities will lose local businesses that create, on average, 1.2 to 1.6 jobs for every job at the pharmacy and generate 1.2 to 1.6 dollars for every dollar of salary paid at the pharmacy. Finally, they will lose the civic capacity that a highly educated medical professional concerned with the wellbeing of his or her community adds to that community. In small rural towns and cities such losses can be devastating.

## Ensuring Pharmaceutical Care in a Medicare Drug Benefit Plan

Medicare, because of its sheer size, can either ensure the future of pharmaceutical care as it insures prescription drugs, or it can make it virtually impossible for rural pharmacies to survive. It is, as one pharmacist put it, the light at the end of the tunnel. Whether that light represents hope or a speeding locomotive depends upon the design of the Medicare prescription drug benefit.

What will it take to ensure that a Medicare prescription drug benefit is not a speeding locomotive resulting in catastrophic losses to beneficiaries and their communities? What will it take to see to it that the benefit provides not just the drug, but also the whole package of pharmaceutical care?

A report by the Rural Policy Research Institute’s Rural Health Panel lays out five key elements. Each has important implications for protecting rural beneficiaries’ access to the whole package of pharmaceutical care.<sup>3</sup>

- **Equity.** The Medicare program should maintain equity vis-à-vis benefits and costs among its beneficiaries, who should neither be disadvantaged nor advantaged merely because of where they live.
- **Access.** The Medicare program should ensure that beneficiaries have reasonable access to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.

<sup>3</sup>An Assessment of Proposals for a Medicare Outpatient Prescription Drug Benefit: The Rural Perspective, Rural Policy Research Institute Rural Health Panel, January 9, 2003.

- **Costs.** The Medicare program should include mechanisms to make the costs affordable, both to beneficiaries and to the taxpayers financing the program.
- **Quality.** The Medicare program should promote the highest attainable quality of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.
- **Choices.** The Medicare program should ensure that all beneficiaries have comparable choices available to them — between both health care plans and health care providers.

As the Congress and Administration consider proposals to add a Medicare prescription drug benefit, they need to consider those five key criteria and build in protections for rural beneficiaries. Specifically, Congress and the Administration should consider the following recommendations.

- Rural areas are different than urban areas. Their unique characteristics present unique challenges in the design and delivery of any prescription drug benefit. Therefore, the plan should
  - Grant the Secretary of the U. S. Department of Health and Human Services the authority to recognize special circumstances that affect rural areas.
- Beneficiaries — rural and urban — need access to medications in emergency situations and access to the informational services provided by local pharmacists. Mail-order prescription services cannot provide either of these. Access to pharmaceutical care must be a key consideration. Therefore, a Medicare prescription drug plan should
  - Not rely solely on mail-order pharmacy services; it should also allow for walk-in services.
- The unique characteristics of rural America mean that a plan based solely on competition will not work there and will result in rural beneficiaries being underserved. Therefore, a Medicare prescription drug plan should
  - Not rely only on a private plan such as Medicare + Choice to be the sole vehicle for a prescription drug benefit. The government should also offer a base (default) plan in which it will assume an acceptable amount of risk so that the basic (default) plan of prescription drug coverage will be affordable to all Medicare beneficiaries with no other plan options.
  - Ensure that providers and deliverers of care are separate from those who enroll and educate beneficiaries. The government or a third-party contractor should provide consumers with objective information (including transparent information on pricing) about enrollment options. This is critically important in

rural areas given the limited number of options that will likely be available.

- Consider whether independent rural pharmacies or networks of independent rural pharmacies might be able to take on the role of a pharmacy benefit manager for rural communities.
- Rural beneficiaries are more likely to be served by community-based pharmacies that operate on a small volume and profit margin. Any move to cut costs by reducing the dispensing fees for rural pharmacists could be devastating to their economic viability. The potential loss of the local pharmacist would have a negative impact on quality of care for rural Medicare beneficiaries since they would not have access to medication management — a key need for a population that tends to take multiple medications and, therefore, needs to understand the impact of drug interactions. The plan should
  - Not seek to cut costs by reducing the dispensing fees for pharmacists.
  - Use consistent national pricing regardless of the geography or volume of the purchaser, and make that pricing transparent.
  - Develop ways to protect rural pharmacies that serve as a sole or critical point of contact for their community.
  - Create an administrative add-on for low-volume rural pharmacies.
  - Include “any willing provider” protection so that pharmacists in rural areas, including those serving Native American and Alaskan communities, are not bypassed by pharmacy benefit managers.
- The addition of a Medicare prescription drug benefit will dramatically change the scope of the health care delivery system across the health care system. The increase in utilization will create a greater need for pharmacist services to counsel beneficiaries and evaluate multiple drug interactions. This is particularly important in rural communities not served by a physician and where the pharmacist may be the only health care provider. Therefore, Congress and the Administration should consider a demonstration program to allow pharmacists in rural areas to expand their scope of services to recognize the new challenges of serving beneficiaries. This would require the following changes:
  - Pharmacists should be recognized as Medicare providers (with “provider status”) who serve patients’ drug-related needs as a part of the medical team in rural communities.

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- The payment system should include Certified Pharmacy Technician codes for pharmaceutical care, case management, and appropriate counseling activities.
- All participating pharmacies in a Medicare prescription drug benefit should be able to dispense 90-day supplies. That would put them on a level playing field with mail-order services.
- Any new benefit should include a provision that places high-risk and high-cost patients (of which there are many in rural areas) in pharmacy case management programs with appropriate compensation.
- As Congress and the Administration implement a new Medicare prescription drug benefit, they will need to evaluate and assess the impacts of it. Therefore, they should
  - Require pharmacy benefit managers and any contractors providing services to report utilization and cost data with sufficient geographic identifiers and demographics to evaluate rural policy and impact issues.
  - Grant the Administration the authority and funding to conduct research on the impact of the program on rural pharmacy patients.

Given the importance of pharmaceutical care to the health and well-being of Medicare beneficiaries, simply insuring prescription drugs is not enough. A Medicare

prescription drug benefit plan must also ensure that the full range of local pharmaceutical care — the whole package — is available, accessible, and affordable to all Medicare beneficiaries, both rural and urban. Anything less would do great harm to countless beneficiaries and the communities in which they live.

On January 15-16, 2003, the National Rural Health Association and the Federal Office of Rural Health Policy convened a Rural Pharmacy Issues meeting. Participants included pharmacists, researchers, and policymakers. The focus of the discussion: ensuring that a Medicare prescription drug benefit recognizes the unique situation of rural pharmaceutical care and its importance to the health and well-being of rural beneficiaries. This report is a synthesis of that discussion.

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