Medicare Part D: Good for Patients and an Opportunity for Pharmacists

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By almost any measure, the Medicare prescription drug benefit (Part D) is a resounding success. Twenty-five million Medicare beneficiaries enjoyed guaranteed access and choice of a drug benefit in 2008.¹ Based on the bids submitted by Part D plans for 2009, the Centers for Medicare and Medicaid services (CMS) estimates that the average monthly premium for standard Part D coverage will be \$28, an amount 37% lower than originally projected when the benefit was established in 2003.² More than 85% of Medicare Part D beneficiaries report being satisfied with their drug benefit.³ Finally, the program has been far less costly to taxpayers than expected—now estimated to be 38.5% (\$243.7 billion) less than the originally projected budget for the period 2004-2013.⁴

A key reason for the economic success of Part D is that it uses competition among Medicare prescription drug plans (PDPs) and pharmacies to control costs.⁴ The PDPs are free to use formularies and cost-sharing incentives (e.g., multi-tier copayment structures) to encourage use of generic medicines, preferred brands, and choice of pharmacies for long-term therapies. Plans negotiate rebates with manufacturers and reimbursement with pharmacies in order to offer competitive premiums to beneficiaries. To optimize the use of appropriate medicines, Part D also established a mechanism for enrollees with multiple chronic conditions and high drug costs (estimated to be 8%-14% of beneficiaries)⁵ to receive medication therapy management (MTM) services from health professionals, including pharmacists.

Impact of Part D on Pharmacies

The pharmacy profession plays an important role in the delivery of the Medicare drug benefit. Part D simultaneously increased overall medication use by 158 million prescriptions in 2006,⁶ increased generic drug utilization (from 60.3% in 2006 to 67.8% in the first quarter of 2008),⁷ and provided a payment mechanism for MTM services, all of which are potentially in the economic interest of pharmacies. However, the competitive model inherent in Part D also creates downward pressure on reimbursement rates for prescriptions dispensed in community pharmacies. The net economic effect of Part D on community pharmacies—and independent stores in particular—has not been empirically measured in a systematic way.

In the October 2008 issue of *JMCP*, Carroll reported the results of a financial model of the effect of Part D on the profitability of independent community pharmacies. Carroll concluded that for a “typical” pharmacy with \$3.49 million in total sales in

2005, the gross margin on prescriptions decreased from 22.7% to 22.0% under part D in 2006, and net income declined by about \$28,000 (-22%).⁸ The most influential factor was the assumed decrease in gross margin on prescription sales due to Part D reimbursement rates that would otherwise have been higher if enrollees had remained cash or Medicaid customers. In sensitivity analyses, Part D always reduced net income to the pharmacy but never created a net loss.⁸

Carroll’s analysis must be interpreted carefully due to important limitations. First, the most influential assumptions about payer mix and gross margin by payer were based on the average of 431 pharmacy owners’ self reports (it is unknown how many drew their estimates from actual financial statements). Second, the results may not apply to all pharmacies because the 22% decline in net income is predicated on the “typical” store having only 8% of total sales from nondispensing activities.⁸ In a pharmacy with a larger base of nondispensing revenue, the percentage decline in net income would be smaller. Third, the model focused exclusively on income from prescription dispensing; potential gains in revenue from medication therapy management services, vaccine administrations, and nonprescription sales were not considered. Fourth, the model compared only 2006 (the first year of Part D) with 2005. The impacts of changes that could be helpful to community pharmacies—such as expanded coverage of vaccinations, educational outreach to reduce confusion during open enrollment periods, and potentially favorable long-term effects such as increased medication adherence attributable to expanded coverage and lower out-of-pocket costs to beneficiaries — were not considered.

These limitations mean that the impact of Part D on pharmacy profits may now be less than Carroll estimated for 2006; this assessment is corroborated by recently released data from 2007 that reveal stable sales and a slightly higher gross margins compared with 2006.⁹ Still, Carroll’s main conclusion is intuitive: the competitive model for Part D probably reduces the profitability of dispensing prescriptions. As Carroll points out, the declining margin on prescription sales is a 2-decade trend driven by the conversion of cash-paid prescriptions to insurance-paid prescriptions. The future of community pharmacy lies less in dispensing and more in patient-care services such as MTM.⁸

In a commentary appearing in the November/December 2008 issue of *JMCP*, Spooner described a “bleak future for independent community pharmacy under Medicare Part D.”¹⁰ In addition to the factors modeled by Carroll, Spooner cited 2 issues with

Part D that created economic difficulties for independent community pharmacies: slow payments to pharmacies from Part D plans and administrative burden on pharmacy staff during open enrollment. Moreover, he noted that independent community pharmacies have historically operated smaller stores than chains and thus have less front-end revenue to offset lower margins on prescriptions. Spooner argues that the closing of 1,152 independent community pharmacies in 2006 was in part attributable to Part D. In fact, it is unclear how many of these pharmacies were actually closed as distinguished from being sold to other companies and thus no longer classified as “independent.” We are also aware of no systematic evidence that Part D was the direct cause of these closures. It may be more accurate to describe these issues as transitional challenges that could have been expected with the largest modification to Medicare (and to the pharmaceutical marketplace) since the program’s inception. Recent policy changes have addressed the first year transitional challenges. Confusion at open enrollment was publicly acknowledged by CMS as an issue in June 2006, and the excess burden on pharmacies was quickly reduced by an array of CMS outreach and educational efforts.¹¹ The Medicare Improvements for Patients and Providers Act of 2008 will require plans to pay pharmacies within 14 days starting January 2010.¹² This aggressive payment timeline should make the payment terms of Part D more financially attractive than those of most third-party plans. The number of pharmacies classified as independent community pharmacies was stable from 2006 to 2007 and profitability was up slightly in 2007 compared with 2006.⁹ These numbers suggest that after grappling with significant transition-year challenges in 2006, independent community pharmacies have fulfilled Carroll’s prediction that despite some shrinkage of margins, stores remain profitable even under the most conservative assumptions.

Mixed Messages

The pharmacy profession seems divided in its response to Part D. Not surprisingly, the Academy of Managed Care Pharmacy is supportive of this competitive model based on managed care principles.¹³ The American Pharmacists Association (APhA) and National Association of Chain Drug Stores (NACDS) have moved to expand and demonstrate the value of pharmacists’ therapy management services. APhA and NACDS have developed a formal service model for MTM services that includes the core elements of medication therapy review, personal medication records, a medication-related action plan, intervention and/or referral, and documentation and follow-up.¹⁴

In contrast, some independent community pharmacists believe they should be exempted from competition with chain pharmacies to maintain higher margins on prescription dispensing. The so-called “Community Pharmacy Fairness Act of 2007,” introduced in the last Congress,¹⁵ would create an exemption to antitrust laws to permit independent pharmacies to negotiate collectively with health plans and pharmacy benefit management

companies (PBMs) over payment rates and other contract terms of Medicare Part D. Proponents hope that this shelter from competition with chain pharmacies will result in the ability to bargain for greater reimbursement under Part D. The Congressional Budget Office estimated that enacting the bill would cost \$640 million over the 2008-2018 period.¹⁶ More dangerous than the cost to taxpayers, however, is the precedent. In testifying against the proposal, David Wales, Deputy Bureau of Competition Director of the Federal Trade Commission, stated: “Giving health care providers...a license to engage in price fixing and boycotts in order to extract higher payments from third-party payers would be a costly step backward, not forward, on the path to a better health care system.”¹⁷ In light of the fiscal and budgetary pressures now facing our nation and our health care system, costly protections from competition for these businesses are unlikely. More importantly, the act of seeking an antitrust exemption sends the wrong message to policymakers and the public by emphasizing pharmacy’s role in drug distribution rather than appropriate medication use.

The Opportunity for Forward-Thinking Pharmacists

We are heading to a reformed health care system that will emphasize and reward higher value and better quality in the delivery of health care. Community pharmacists could be at the forefront of this change by following 5 specific steps:

First, define and embrace a new model of pharmacist care that asserts a more active role in Medicare enrollees’ health, unequivocally and with a unified voice. Part D created an historic opportunity for pharmacists to fulfill the role of medication therapy managers and adapt their practices to patient-focused services that add value to the health care system by improving outcomes and lowering the costs of inappropriate medication use. Hepler and Strand’s 1990 call to action, “Opportunities and responsibilities in pharmaceutical care”¹⁸ was lauded by the profession¹⁹ and adopted as a mission for the future of pharmacy practice and education.^{20,21} It seems extraordinarily prescient today:

“Pharmacy has shed the apothecary role but has not yet been restored to its erst-while importance in medical care... Pharmacists and their institutions must stop looking inward and start redirecting their energies to the greater social good... Pharmacists must abandon factionalism and adopt patient-centered pharmaceutical care as their philosophy of practice. Changing the focus of practice from products and biological systems to ensuring the best drug therapy and patient safety will raise pharmacy’s level of responsibility and require philosophical, organizational, and functional changes... Pharmacy’s reprofessionalization will be completed only when all pharmacists accept their social mandate to ensure the safe and effective drug therapy of the individual patient.”¹⁸

Nearly 20 years later, these changes have begun to occur in the professional education of pharmacy students, but more outward focus in practice is needed to earn this social mandate. In

describing its own evolution, APhA connects the dots between Part D and the reprofessionalization of pharmacy: “Medication therapy management, a component of the Medicare Part D prescription drug benefit launched in 2006, provides the means for pharmacists to complete the transformation of their profession from one focused on the drug product to a clinical service focused on the patient.”²²

Second, the profession must walk the talk. In order to compete in the future, community pharmacies have to change the business model from one that has them beholden to the commodity they put in a bottle. This requires the development and demonstration of new business models focused on the value that pharmacists can create from the profession’s unique position in the health care system. Focusing on the unmet needs of patients in the community will reveal new opportunities to deliver screening services, preventive care (including immunizations), drug information and education, drug utilization reviews, and support for adherence to chronic therapies. Organizations such as Mirixa and Outcomes Pharmaceutical Health Care have developed innovative models, networks of independent and chain pharmacies, infrastructure, and payment opportunities for delivering and documenting non-dispensing services. The experience of one of these organizations is described by Barnett et al. in a coincident article in this issue of *JMCP*.²³ An important next step is to define the pharmacist’s role in the “patient-centered medical home” and other emerging models of team-based health care delivery. Some pharmacy chains have already captured a new foothold in the marketplace by answering consumer demand for more convenient access to clinicians with retail clinics. Independent community pharmacies could compete favorably by building upon and even improving this model in collaboration with local practitioners.

Third, develop credible evidence of the value of these services. In addition to the report by Barnett et al, pilot efforts published to date suggest that MTM services provided to Medicare beneficiaries may indeed improve medication use and outcomes.^{24,25} However, more robust data measuring the clinical and economic impact of MTM are needed. At a recent Medicare Payment Advisory Commission (MedPAC) meeting in November, 2008, analysts reported that information about the effectiveness of MTM programs is lacking.⁵ Evidence of these programs’ effect on medication adherence, appropriate prescribing, drug spending, and utilization of other services are of particular interest to Medicare. The evidence must be “high quality,” meaning that studies should be representative and should employ optimal experimental and quasi-experimental designs. The formation of the Pharmacy Quality Alliance (PQA) shortly after the implementation of Part D was a major laudable move by pharmacy leaders to develop performance measures against which the value of pharmacy services may be measured and new compensation models developed.²⁶ Expanding upon PQA’s starter set of medication utilization-based measures to include consensus metrics for

clinical and economic outcomes is an important next step.

Fourth, use the quantitative evidence from step 3 to develop and advocate for performance-based payment models. If the data support it, the profession could also advocate for expanded coverage of drug therapy management within the broader context of health care reform—and not only from Medicare. With Medicaid and private payers, independent community pharmacists could negotiate coverage for MTM services on the condition that data are systematically collected in the process of care, to better understand the value of the services. This approach could be thematically modeled on the Medicare coverage policy option known as “coverage with evidence development.”²⁷ As the body of performance metrics and evidence of value for MTM services grow, pharmacies may also share economic risk with payers for the return on investment in MTM services.

Finally, there are ways for independent community pharmacies to enhance their competitiveness within Part D while enhancing access to pharmacy services for seniors. Part D’s retail pharmacy access standards dictate that at the state level, each PDP must have in its network at least 1 retail pharmacy within 2 miles of 90% of beneficiaries in urban areas; within 5 miles of 90% of beneficiaries in suburban areas, and within 15 miles of 70% of beneficiaries in rural areas.²⁸ Recognizing that a high proportion of independent community pharmacies serve rural and suburban areas, if existing Part D access standards were applied differently, more rural independent pharmacies could realize much greater market power in Part D; this objective could be accomplished without sweeping legislative changes or unseemly quests for antitrust exemptions.

Reimbursement for MTM services under Medicare Part D has created an historic opportunity for the pharmacy profession to step further into the role of managing medication therapy outcomes as well as delivering medications to patients. While there is still a lot of work to do, the course has been charted and organized pharmacy is making progress in delivering and quantifying value. Over the years, many politicians and policymakers have come to recognize and respect the fiercely competitive and innovative spirit of independent community pharmacists. While Medicare Part D isn’t perfect, it has been improved since 2006 and we believe that in seeking legislative relief from competitive prescription reimbursement contracts, independent community pharmacists could be taking policymakers’ eyes off the ball—creating a distraction that will consume valuable time, energy, and political capital. Securing payment for proven quality and value delivered to patients in a competitive environment is the sustainable business model for pharmacists, just as it is for all providers in this rapidly changing health care system. Rather than a curse, Medicare Part D is the kind of opportunity that pharmacy’s leaders have sought for decades.

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DISCLOSURES

Benner reports no conflicts of interest related to the subjects discussed in this article. Kocot was Senior Advisor to the Administrator of the Centers for Medicare and Medicaid (CMS) from 2004-2007. At CMS, Kocot was a member of the agency's senior management team during the implementation of Part D; he was also a key contributor in the launch of the Pharmacy Quality Alliance (PQA). Prior to that, he was Senior Vice President and General Counsel at the National Association of Chain Drug Stores.

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