A Bleak Future for Independent Community Pharmacy Under Medicare Part D

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The Medicare Part D prescription drug program was implemented in 2006 to provide prescription drug coverage for elderly and disabled citizens. Recent data indicate that Part D provides prescription drug coverage for 3.4 million American seniors who did not otherwise have prescription insurance. Analyses of prescription claims data suggest that Part D has increased prescription drug utilization among Medicare recipients by 3.9% to 12.8%, and survey data have demonstrated increased prescription drug utilization among Medicare recipients who were nonadherent with their medication because of cost. Seniors are generally happy with Part D, and while there are no survey data to document the opinions of those representing pharmaceutical manufacturers and Part D prescription drug plans, it is probable that they are pleased with the current state of Part D as well. It seems that all of the parties with a direct interest in Part D are benefiting from the program—all except for one group.

A Shifting Customer Mix, Increased Administrative Burden, and Delays in Payment

The business of pharmacy has undergone significant changes following the implementation of Part D. Gross margins on prescriptions covered by Part D tend to be lower than those prescriptions covered by Medicaid, commercial health insurers, or cash customers following Part D implementation, pharmacies have faced reduced payments due to a change in their customer case-mix. While prescription volume among Medicare beneficiaries has increased under Part D, the size of the increase at some pharmacies has been less than anticipated, in part because 86% of Part D beneficiaries had prescription drug coverage in the year before enrolling in Part D through commercial insurers, Medicaid, or multiple sources. The movement of pharmacy customers into Part D programs increases the likelihood that prescriptions for maintenance medications will be handled by mail order pharmacies, reducing the increase in prescription volume at community pharmacies. Further, the enrollment of some cash customers into Part D has not only brought a reduction in payment for these previously high-margin prescriptions, but also forces pharmacies to wait for payment from the prescription drug plan (as opposed to payment at the time of purchase by a cash customer), creating or augmenting cash flow issues for pharmacies.

The implementation of Part D has been particularly tough on independent community pharmacies. The clientele of independent pharmacies is older than those who frequent other types of community pharmacies; customers of independent pharmacies are nearly twice as likely as the average pharmacy customer to be eligible for Part D. As such, the conversion rate of prescriptions to Part D payment is likely to be higher in independent pharmacies than other community pharmacies. During the open enrollment period of November and December 2006, independent pharmacies reported spending an average of 4.5 hours each day dealing with administrative issues related to Part D (such as contracting with Part D prescription drug plans and answering patient questions on Part D plan choices, formularies, and costs). While many pharmacist-owners or their paid staff performed the majority of this work themselves, it displaced their usual activities, leaving them with less time for filling prescriptions, counseling patients, bookkeeping, and managing their inventory. In many instances, independent pharmacists were required to extend their workday to complete their work. This time expenditure places independent pharmacies at a competitive disadvantage relative to chain pharmacies, where most of the administrative issues related to Part D are handled by staff at corporate headquarters, and store pharmacists can refer patients to company-developed online tools to help seniors compare prescription drug plans.

Although the number of prescriptions dispensed has increased since the implementation of Part D, gross margins are down, indicating that the average community pharmacy is doing more while making less money. Independent pharmacies do not typically generate the front store revenue necessary to offset this loss in prescription gross margins. Few independents can match the size of the chain pharmacy, where new stores average 13,000 to 14,500 square feet and allow front store sales to account for 30%-35% of revenues. This proportion stands in sharp contrast to the findings of a recent survey of rural independent pharmacies, where front store sales accounted for no more than 15% of revenues at nearly 80% of the surveyed pharmacies, and no more than 5% of revenues at an astonishing 31% of pharmacies.

Independent pharmacies have also been negatively impacted by the slow payment times from Part D prescription drug plans. In an analysis by Shepherd et al., independent pharmacies had a slower median time to payment following adjudication by Part D plans compared with chain pharmacies in 2006 (31 days vs. 29 days). Further, delays in payment have increased the cash flow issues faced by independent pharmacies, forcing them to borrow more from their lines of credit, which now average over
$70,000 per store. Interest payments on these credit lines erode the pharmacy’s operating margin, leaving less money available for paying salaries, marketing, and capital investments. While Part D creates cash flow issues for all pharmacies, chain pharmacies have access to cash on hand and a variety of financing mechanisms to help them manage their accounts receivable that most independent pharmacies do not have.

Medicaid Reimbursement and Other Business Threats

Independent pharmacies face challenges beyond Part D. The ongoing pharmacist shortage has driven up salaries, making it more expensive for independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by some discount retailers and chain pharmacies to offer cash additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists. The decision by independent pharmacy owners to employ additional pharmacists or hire relief pharmacists.

As a result of the Deficit Reduction Act of 2005, the federal upper limit on Medicaid reimbursement for prescriptions (as measured by the median value) may be substantially lower. Such, annual sales at a “truly typical” independent pharmacy increased for the typical independent pharmacy as a result of this change in implementation as initially designed, the Government Accountability Office (GAO) estimates that the Medicaid reimbursement rate for multisource generics would be an average of 36% below the acquisition cost. Lastly, under an Internal Revenue Service (IRS) rule set to take effect in 2009, pharmacies are required to have an inventory information approval system (IIAS) to process debit cards for flexible spending accounts and health reimbursement arrangements. While pharmacies that have 90% or more of their gross receipts come from items that qualify as medical expenses under IRS code are eligible for a waiver from the IIAS requirement (an estimated 78% of independent pharmacies qualify for this exemption), credit card companies have not developed a process to recognize stores that qualify for this exemption. This problem leaves many independent pharmacies with another difficult choice: purchase an IIAS-compliant point of sale system (at a cost of $8,000 to $30,000), or hope that a solution is developed to recognize pharmacies eligible for the exemption before the IRS rule goes into effect.

All of the above factors have made owning and operating independent community pharmacies very challenging. According to the National Community Pharmacists Association (NCPA), the number of independent community pharmacies in operation in the United States during 2006 fell from 24,500 to 23,348, a 5% decline. As the number of independent pharmacies had remained at a stable level in the years leading up to the implementation of Part D, observers have speculated that Medicare Part D was the factor responsible for this large decrease in the number of independent pharmacies. Further, 22% of respondents to a survey of independent pharmacies reported their pharmacy’s financial position as declining, poor, or unstable following the first year of Part D.

Evaluation of Economic Model of Medicare Part D in Independent Community Pharmacy

In the October 2008 issue of JMCP, Carroll reported the results of a financial model using data from NCPA’s survey of independent pharmacies and IMS Health national market research data in order to estimate the impact of Part D on the profitability of independent pharmacies. This model is an excellent resource for those seeking to understand the effects of Part D on community pharmacies, and its findings are likely to be of interest to health economists, policy analysts, pharmacy trade groups, and others. The author should be commended for creating such a finely crafted and worthwhile tool. The model estimated that although Part D led to a modest 0.4% increase in prescription volume for the typical independent pharmacy, the lower Part D reimbursement rate led to an absolute decline in the gross margin for all prescriptions of 0.7% and a mean decrease in net income before taxes of 22%, or $27,651. In the sensitivity analyses that accompanied his analysis, Carroll found no scenario in which the net profit increased for the typical independent pharmacy as a result of Part D.

Due to the limitations of available data (point estimates without measures of error), the model was forced to rely upon the mean values for revenues, expenses, and prescription volume obtained from a national sample of independent pharmacies. One potential limitation of mean values is that they can be skewed by outliers; for example, while the mean salary for major league baseball players in 2008 was $3.15 million, the median salary was $1 million, greater than a 3-fold difference. While Carroll’s model utilized a baseline value of $3.49 million for annual sales at the typical independent pharmacy, this mean value may have been driven up by a small group of high-performing stores; as such, annual sales at a “truly typical” independent pharmacy (as measured by the median value) may be substantially lower. If and when median data become available, it may be of interest to run the analysis again using median values for revenues, expenses, and prescription volumes, and examining the degree to which the model results change. When run with mean values, the model found that the typical independent pharmacy remained profitable following Part D implementation, even under the least favorable conditions. Substituting median values may produce some scenarios in which independent pharmacies were no longer profitable following Part D implementation, something that occurred in reality in 2006 with a net loss of 1,152 stores nationwide.

Carroll uses the results of his model and other evidence to suggest that the profitability of the physical act of dispensing prescriptions will continue to decline for community pharmacies, and that the future of community pharmacy lies less in dispensing and more in patient care services such as medication...
therapy management (MTM). While there is no question that the profitability of dispensing prescriptions has lessened significantly, it is unclear if patient care services can help improve the balance sheet of independent pharmacies. A survey of independent pharmacies offering MTM services found that only 42% of respondents thought that MTM services were profitable given the resources necessary to provide the service. Further, independent pharmacies face several obstacles in incorporating patient care services into their practice. Many independent pharmacies are staffed by a single pharmacist, who may not be able to take time away from his or her customary activities in order to devote time to patient care services. Smaller pharmacies may lack the space needed for patient care areas, while pharmacies of all sizes may have physical barriers that may impede patient care activities. Additionally, some pharmacists may feel that they do not have sufficient training or expertise in patient care activities to offer them. In a survey of independent community pharmacists, the most frequently cited reasons for not offering MTM services were time or staffing constraints, a lack of private space, the time requirements for mandatory training/certification, and beliefs that reimbursements for MTM services were too low.

**More Attention is Needed**

Despite all of the challenges facing independent community pharmacies, there have been some recent developments that might point to better days ahead. After a significant decline in 2006, the number of independent community pharmacies operating in the United States stabilized in 2007. In July 2007, Congress overrode President George W. Bush’s veto and passed the Medicare Improvements for Patients and Providers Act, which included provisions to (a) require Part D prescription drug plans to reimburse pharmacies within 14 days of claim adjudication starting January 1, 2010; and (b) delay the implementation of the AMP pricing formula for generic Medicaid prescriptions until September 2009, allowing Congress to modify the reimbursement formula in light of the recent GAO report. Congress is also considering The Community Pharmacy Fairness Act, which would create an exemption to antitrust laws allowing independent pharmacies to collectively negotiate contract terms with pharmacy benefit managers.

Aside from interest pieces in local newspapers and the lobbying efforts of NCPA, the effect of Part D on the independent community pharmacy has gone largely unnoticed. A quote from Arthur Miller’s *Death of a Salesman* seems appropriate: “I don’t say he’s a great man. Willy Loman never made a lot of money. His name was never in the paper. He’s not the finest character that ever lived. But he’s a human being, and a terrible thing is happening to him. So attention must be paid. He’s not to be allowed to fall into his grave like an old dog. Attention, attention must be finally paid to such a person.” It is time attention is given to independent pharmacy owners. They provide valued services to their clientele, and in many instances operate the only pharmacy within a community. The closure of an independent pharmacy not only affects the business owner and his or her staff, but can also mean the end of convenient access to pharmacy services for patients, including the very Medicare beneficiaries for whom Part D was created.

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**DISCLOSURES**


**REFERENCES**


