The Impact of Recent Medicare and Medicaid Cuts on Patients’ Access to Independent Community Pharmacies

- **Independent Pharmacies are Important Primary Care Providers in Rural Communities:** For Medicare and Medicaid patients especially in rural areas, independent community pharmacies are a critical source of prescription medications and expert counseling on their proper use. Pharmacies are committed to serving our patients. However, pharmacies are very concerned about having to sustain additional cuts in Medicare or Medicaid reimbursement. About half of all independent pharmacies operate in communities of 50,000 or fewer people.

- **Independent Pharmacies Disproportionately Serve Seniors and Low Income Patients:** Independent community pharmacies derive 92% of their total revenues from prescriptions and on average about 50% percent of all prescriptions are Medicare Part D and Medicaid. Just minor changes in reimbursement in either program could affect whether a small independent pharmacy can remain open to serve patients. The number of independent pharmacies declined over the last year from 23,117 to 23,064.

- **Independent Pharmacies Lost $15 Billion in Revenues Over Last 5 Years:** States’ significant cuts to Medicaid pharmacy reimbursement combined with the loss of revenues resulting from the implementation of Medicare Part D have cost independent community pharmacies an estimated $15 billion in lost revenues, or 17% of their gross margin, since 2006.

- **Independent Pharmacies Have Borne Billions in Medicaid Pharmacy Cuts:** Independent community pharmacies have sustained billions in state-initiated Medicaid reimbursement cuts over the last 5 years. These cuts have also generated billions in savings for the Federal government in reduced matching payments. Additional DRA AMP-related Medicaid cuts for generic drugs will also be implemented soon that will also hit community pharmacies very hard.

- **Pharmacy Margins Less on Medicare and Medicaid Prescriptions Than Private Plans:** Some have the misconception that pharmacies make better margins on Medicare Part D and Medicaid prescriptions. The fact is, pharmacy margins on Medicare Part D and Medicaid prescriptions are less than margins on private commercial prescriptions, which are already low and declining rapidly. In Medicaid, there is a significant percentage of uncollectable copays, for which pharmacies cannot be reimbursed. The average independent pharmacy pretax net profit margin is just 3%. Between 2005 and 2010, the number of independent community pharmacies operating at a loss increased from 14% to 23%.

- **Medicare Part D Helped Seniors, Hurt Some Independent Pharmacies:** About 22% of independent pharmacies report that their financial position is declining or unstable because of Medicare Part D, which represents about a third of their business. Part D plans are significantly squeezing pharmacy reimbursement, and aggressively pushing Medicare patients to mail order.
The National Community Pharmacists Association (NCPA®) represents the interests of America's community pharmacists, including the owners of more than 23,000 independent community pharmacies, pharmacy franchises, and chains. Together they represent a $93 billion health-care marketplace, have more than 315,000 employees including 62,400 pharmacists, and dispense over 41% of all retail prescriptions.

America’s community pharmacists stand ready to assist Federal and state policymakers in better managing both overall health care and prescription drug costs. We recognize that government-funded health care programs are under tremendous pressure to better manage costs as well as deliver high quality health care. Prescription drugs are the most cost effective medical interventions that can be used, and when taken appropriately, can keep patients healthy and out of the hospitals and emergency rooms. Pharmacists play a critical role in assuring access to medications as well as counseling patients on their proper use. Through their cost-effective services, pharmacists can help reduce the estimated $290 billion that the health care system spends annually on treating the consequences of lack of medication adherence by patients.

However, as outlined below, the prospect of mounting additional Medicare and Medicaid reimbursement cuts on independent community pharmacists will only serve to hinder their ability to patients and provide health care access to their patients. Even worse, further burdens placed upon the thin thread of revenues upon which community pharmacists rely may put many of these crucial health care providers out of Medicare or Medicaid, or out of business altogether across the rural heartland and urban neighborhoods of America.

**Evolving High Costs and Low Reimbursements for Community Pharmacy**

Across all payers, independent community pharmacy reimbursements are down. As illustrated below, between 2005 and 2010, the number of independent community pharmacies operating at a loss increased from 13.9% to 23%, and in 2010 over 50% of independent community pharmacies operated at a revenues margin of 2% or less.¹

Examples of the tough economic times facing independent community pharmacy include CBO estimates that Medicare Part D generic drug reimbursement to pharmacies has fallen by an average of 2.4% between 2006 and 2010. For the Medicare Part D program, CBO offers the following estimates for yearly decreases in generic reimbursement to pharmacies²:

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### Table 1: Yearly Percent Decrease in Medicare Part D Generic Reimbursement To Pharmacies.

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Decrease:</td>
<td>-6.9</td>
<td>-0.1</td>
<td>-1.7</td>
<td>-1.5</td>
<td>-2.6</td>
</tr>
</tbody>
</table>

Moreover, according to the 2010-2011 Prescription Drug Benefit Cost and Plan Design Report, both pharmacy reimbursement and dispensing fees have trended downward since 2000 for brand-name drugs.³

### Table 2: Trends in Retail Brand Reimbursement

<table>
<thead>
<tr>
<th>Year</th>
<th>Average Percentage Discount Off AWP</th>
<th>Dispensing Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>17.50%</td>
<td>$1.62</td>
</tr>
<tr>
<td>2009</td>
<td>16.40%</td>
<td>$1.57</td>
</tr>
<tr>
<td>2008</td>
<td>16.10%</td>
<td>$1.73</td>
</tr>
<tr>
<td>2007</td>
<td>16.10%</td>
<td>$1.88</td>
</tr>
<tr>
<td>2005-06</td>
<td>15.30%</td>
<td>$1.88</td>
</tr>
<tr>
<td>2004</td>
<td>14.80%</td>
<td>$1.95</td>
</tr>
<tr>
<td>2003</td>
<td>14.50%</td>
<td>$2.05</td>
</tr>
<tr>
<td>2002</td>
<td>14.10%</td>
<td>$2.13</td>
</tr>
<tr>
<td>2001</td>
<td>13.90%</td>
<td>$2.21</td>
</tr>
<tr>
<td>2000</td>
<td>13.50%</td>
<td>$2.31</td>
</tr>
</tbody>
</table>


Persistent and sustained cuts to drug reimbursements within the Medicare Part D program and Medicaid programs have caused significant economic harm to independent community pharmacy. Further reimbursement cuts to these programs will only make matters worse, thereby putting many independent community pharmacies out of business and restricting patient access to much needed prescription medications and pharmaceutical services.

What have all these cuts to independent community pharmacies meant in terms of access to pharmacy services? Fueled by declining reimbursement rates and rising business costs, the number of total independent community pharmacies decreased slightly last year from 23,117 to 23,064. Moreover, the total number of independent pharmacies that were the only pharmacy in a rural community declined from 2,060 in March 2003 to 1,759 in December 2010.⁴

### Impact of Medicare Part D Implementation on Community Pharmacy

Medicare Part D has provided an important source of prescription coverage for millions of previously uninsured and underinsured seniors. Evidence suggests that seniors overwhelmingly prefer to obtain their medications from community pharmacies rather than mail order outlets. Independent community pharmacies offer personalized counseling and medication delivery for millions of seniors each day.

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⁴ Independently owned Pharmacy Closures in Rural America, 2003-2010, Rural Policy Research Institute, June 2011
We are an important part of the pharmacy networks of almost all Part D plans. At the beginning of the program in 2006, there were significant initial implementation problems. Medicare beneficiaries relied on their community pharmacy to help them navigate through the initial problems and help them obtain their necessary medications. Yet, the implementation of Medicare Part D permanently changed the economics of independent community pharmacy:

**Slower Medicare Part D Reimbursement:** The creation and implementation of the Medicare Part D program over the last several years has helped senior citizens, but it has also resulted in a significant loss of revenues to community pharmacy. First, Medicare Part D reimbursement lags behind cash-based reimbursement in terms of how quickly pharmacies are paid. Community pharmacy appreciates that Congress enacted Medicare Part D prompt pay legislation in 2009. Unjustified delays by PBMs in reimbursement to pharmacies allowed Medicare Part D plans to make millions of dollars off of the “float” or the time delay between when the Medicare Part D plan received reimbursement and when the plan reimbursed the pharmacy. However, even with prompt pay legislation, some state Medicaid programs used to pay pharmacies quicker than the current 14-day turn around. Moreover, some plans are finding ways to get around this legislation, like charging transfer fees to send pharmacies their money within this 14-day timeframe. These pharmacies are forced to borrow more from their lines of credit, thereby eroding their revenue margins through increased interest payments.5

**Lower Medicare Part D Reimbursements for Dual Eligibles:** Second, with the advent of Medicare Part D, elderly and low-income dual eligible seniors were moved from the Medicaid enrollment rolls to the Medicare Part D enrollment rolls. Of the seniors added to the Medicare Part D rolls, prior to Medicare Part D 35% of them were covered by Medicaid.6 For 2008, there were 9.2 million dual eligibles.7 This dual eligible transition was not a transition without costs. Negotiated Medicaid reimbursement rates, which previously applied to these dual eligibles, were replaced by Medicare Part D plan, PBM-dictated reimbursements, which were much lower.

**Lower Pharmacy Margins Under Medicare Part D Versus Other Payment Systems** Another perspective with which to examine community pharmacy revenues within the context of Medicare Part D is to compare Medicare Part D revenues with that for community pharmacies under other payment systems. As illustrated below, for 2010, the percent average gross margin for independent community pharmacies under the Part D program is lower than either the average gross margin for Medicaid or other third-party payment systems.8 Yet, Medicare Part D accounts for almost one-third of the prescription volume for an average community pharmacy.9 The data below demonstrates that the Part D program is the lowest-margin prescription drug program for community pharmacy. One researcher estimated that Medicare Part D reduced the revenues of independent community pharmacies by 22% and that the decrease in revenues was primarily driven by lower reimbursement rates under Medicare Part D.10

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7 Data based on Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office of Research, Development and Information, July 2010.
8 2010 NCPA Digest.
9 Id.
Pharmacy Closures Under Medicare Part D: Finally, and more generally, there is a correlation between independent community pharmacy closures and the Part D program. Leading up to the implementation of Part D, the number of independent community pharmacies was stable. However, the number of independent community pharmacies fell by 5% during 2006, the start of the implementation of Part D. Moreover, 22% of independent community pharmacies reported their pharmacy’s financial position as declining, poor or unstable after Part D was implemented.11

The Impact of Medicaid Cuts on Community Pharmacy Revenues

Independent community pharmacies are an important part of the health care provider network used by Medicaid patients. That is because independent pharmacies are found disproportionately in urban and rural areas where many Medicaid patients live. That is why community pharmacies simply cannot sustain any additional Medicaid reimbursement cuts. Reduced access to pharmacy services would mean that many Medicaid patients would not get their medications and would likely have to use more expensive forms of care, such as hospital emergency rooms.

In addition to lost revenues from Medicare Part D, community pharmacies have also faced significant lost Medicaid revenues over the last several years. Globally, almost every state is facing a budget deficit right now and most states respond to budget deficits by cutting Medicaid provider payments. In 2009, at least 17 states proposed cuts to Medicaid reimbursement.12 As illustrated in the chart above, Medicaid payments represent about 13% of the average independent community pharmacy’s business. Therefore, state Medicaid reimbursement cuts have a significant negative impact on pharmacy revenues.

Lower Generic Reimbursement from Stagnant Maximum Allowable Cost (MAC) Levels: Focusing on generic drugs within Medicaid, state reimbursements are, for the most part, based on state-based maximum allowable costs (MACs), which are usually lower than Federal Upper Limits (FULs). FULs are set by the Centers for Medicare and Medicaid Services (CMS). Considering that FULs have not increased in the last three years, this means that MACs are extremely low.

Moreover, state Medicaid payors that utilize MACs for reimbursement use aggressive practices to cut back on generic reimbursement to community pharmacy. Some Medicaid programs fail to adjust MAC levels, or fail to do so in a timely manner, as generic manufacturers drop out of the market and prices for remaining manufacturers’ generic drugs rise 200% to 300% or more. As a result, pharmacies are dispensing an increasing number of Medicaid generic prescriptions at a loss.

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11 Spooner, supra note 4.
12 Bell DL II. Pharmacy reimbursement: AWP, Medicaid and AMP. Presented at: NACDS Pharmacy and Technology Conference; August 9, 2009; Boston, MA.
New Average Manufacturer Prices (AMPs) will Decrease Pharmacy Reimbursement: Turning to FULs, the Deficit Reduction Act (DRA) of 2005 required that FULs be calculated using the Average Manufacturer Price (AMP). Under the DRA, reimbursement for a particular multiple-source drug, as reflected by the FULs, was to be changed from 150% of the lowest published price (WAC or AWP) to 250% of the lowest AMP. This change was expected to reduce pharmacy reimbursement by billions of dollars.

Two Government Accountability Office (GAO) studies found that use of 250% of the lowest published AMP to set FULs would have underpaid pharmacies by 36%. The AMP-based reimbursements could have averaged about 78% below what pharmacies were getting paid. An economic analysis of this Medicaid FUL reimbursement policy found that 11,000 pharmacies would have closed had the policy been implemented. That means about 20% of all pharmacies could have closed.

The DRA-based AMP change has yet to occur because of a court injunction, which has since been lifted. The new law directs CMS to set Medicaid FULs for reimbursement of generics at a rate of “no less than 175 percent of the utilization-weighted average of the most recently reported monthly AMPs for pharmacologically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis.”

The use of the weighted-average AMP instead of the lowest AMP as the basis for setting FULs may increase reimbursement to pharmacies over the reimbursement specified in the DRA. However, pharmacies may still not earn much in dollar revenue on Medicaid generic prescriptions under AMP-based reimbursement. Generics have a lower dollar cost basis, so even if the FULs under the revised AMP definition are on aggregate somewhat higher than pharmacy acquisition costs, it does not mean that pharmacies are being paid at a level that reflects their costs or will allow them to stay in business. It could mean pennies in terms of the actual difference between acquisition costs and the FUL.

In fact, the CBO still scored the ACA amended AMP provision as a budget cost saver, indicating that Medicaid payors, under the new AMPs, will still save billions of dollars in lower reimbursements to community pharmacy for Medicaid generic drugs.

Reduced AWPs Decrease Pharmacy Reimbursement for Medicaid Brand-Name Drugs: Medicaid reimbursement for brand-name drugs is usually based on AWP. In fact, 48 states use AWP for Medicaid brand-name drug reimbursement. States have been drastically reducing the percentage off AWP that they reimburse pharmacies for Medicaid brand-name drugs due to budget shortfalls.

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14 Id.
16 Id.
17 GAO Studies, supra note 16.
19 Bell, supra note 15.
In addition, in September, 2009, the database company used by most Medicaid agencies for their AWP values changed how they calculated AWP, which resulted in a huge windfall to states in reduced payment on brand name drugs. The Federal government shared in these billions of dollars in savings. The average saving per brand name prescription was about $5. Few if any states adjusted their reimbursement to compensate pharmacies for this change in AWP to make it budget neutral. Moreover, CMS did not require states to submit SPAs, even though this represented a significant reduction in pharmacy reimbursement.

**Increased Reliance on Medicaid Co-Pays Decreases Pharmacy Reimbursement:** More broadly, in recent years, state Medicaid agencies have relied upon Medicaid beneficiaries to increasingly pay co-pays as a form of Medicaid savings. The more the individual beneficiary is responsible for the cost of a given medication, the less the state Medicaid payor has to pay for the prescription. Unfortunately, many Medicaid beneficiaries are so impoverished that they cannot even afford to pay a co-pay. When this occurs, which it often does, community pharmacies usually dispense the medication anyway and absorb the lost co-pay. Accordingly, the increased reliance on Medicaid co-pays results in decreased reimbursement to community pharmacies as those pharmacies are often unable to collect those Medicaid beneficiary co-pays.

**Decreasing Medicaid Dispensing Fees Reduces Community Pharmacy Reimbursement:** For both brand-name and generic drugs, independent community pharmacies have faced cuts in Medicaid dispensing fees. Presently, states’ Medicaid dispensing fees are usually lower than pharmacies’ actual cost of dispensing, which is about $11 per prescription.\(^{20}\) The combination of inadequate and decreasing Medicaid ingredient reimbursement combined with inadequate and decreasing dispensing fees creates a perfect storm of potential financial disaster for independent community pharmacies. If independent community pharmacies face further Medicaid cuts, it is hard to see how they would be able to stay in business, or at a minimum, continue to serve Medicaid patients.

**Conclusion**

Litigation, market changes, and legislative reforms to Medicare and Medicaid prescription drug programs over the past 15 years have combined to pummel independent community pharmacy Medicare and Medicaid reimbursement. As a result, today, most independent community pharmacies operate on razor thin revenue margins. Independent community pharmacies cannot continue to survive and endure yet additional government mandated reimbursement cuts. While independent community pharmacy stands willing to assist the government in generating Medicare and Medicaid savings, and have outlined proposals to do so, we believe that further cuts to pharmacy reimbursements will only harm patient access to the drugs that they need.