The Rural Beneficiary Need for a Medicare Drug Benefit
Delivered Through the Rural Delivery System

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The Pressing Need in Rural America

- The percent of all elderly who live below 200 percent of the federal poverty level: rural: 52.3%, urban: 41.2% (AHRQ 2000; AHRQ 1998)

- The percent of seniors without prescription drug coverage, 1995 (Poisal et al. 1999): rural: 46.1%, urban: 30.1%, a 50% *difference*

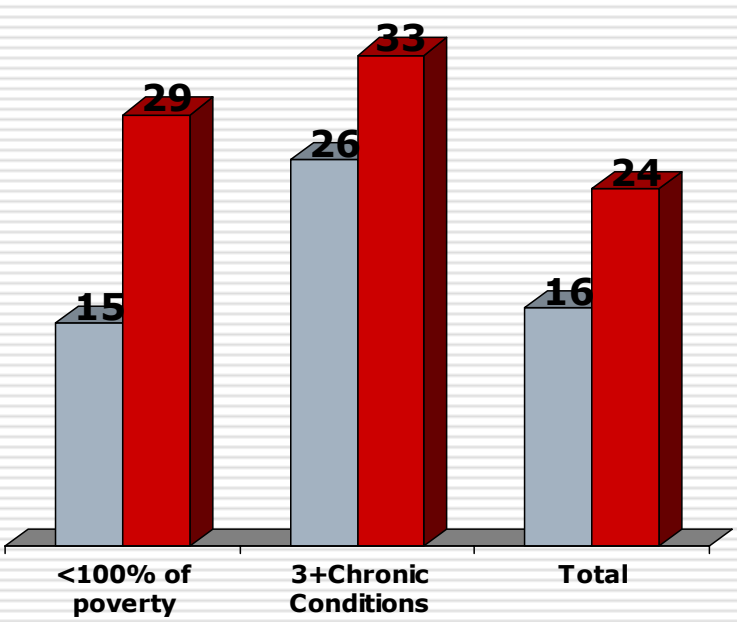
- The percent of seniors with private Medicare supplemental insurance covered by a group plan (AHRQ 2000; AHRQ 1998): rural: 65%, urban: 75.2%

The Pressing Need in Rural America (con't)

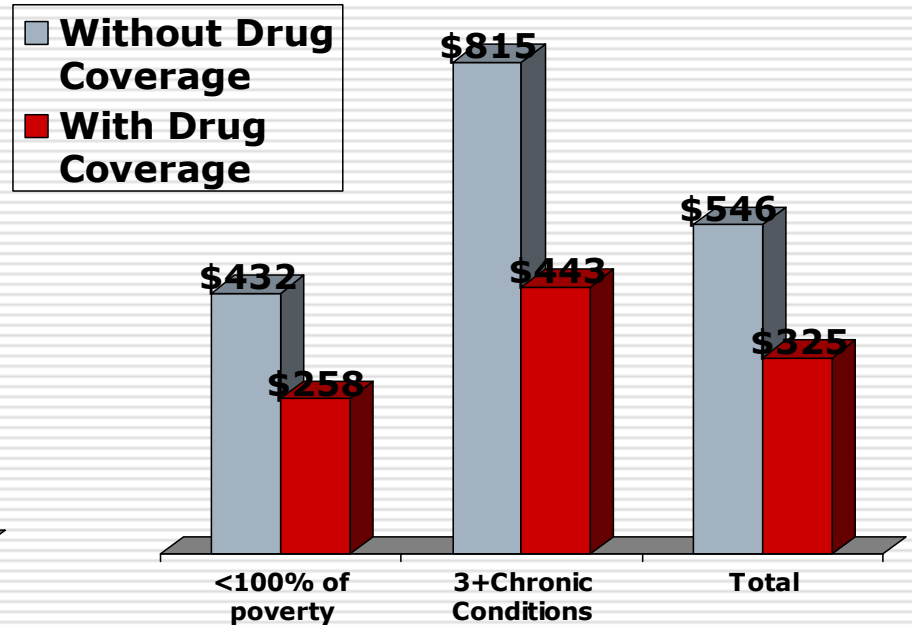
- The percent of plans covering prescription drugs (Poisal et al. 1999): individually purchased: 35.9%, group plans: 86.3%
- The percent of seniors with access to Medicare+Choice plan with drug coverage (MedPAC 2000): rural: 16.0%, urban: 79.0%
- The percent of seniors with prescription drug purchase in 1996 spending more than $500 out of pocket (AHRQ 2000; AHRQ 1998): rural: 32.0%, urban: 24.0%

Overall Data Confirm Rural Disparity

Average number of prescriptions filled per year



Average out-of-pocket drug spending per year



Source: Poisal, J.A., and L. Murray, *Health Affairs*, March/April 2001.

Modality of Drug Distribution in Rural America

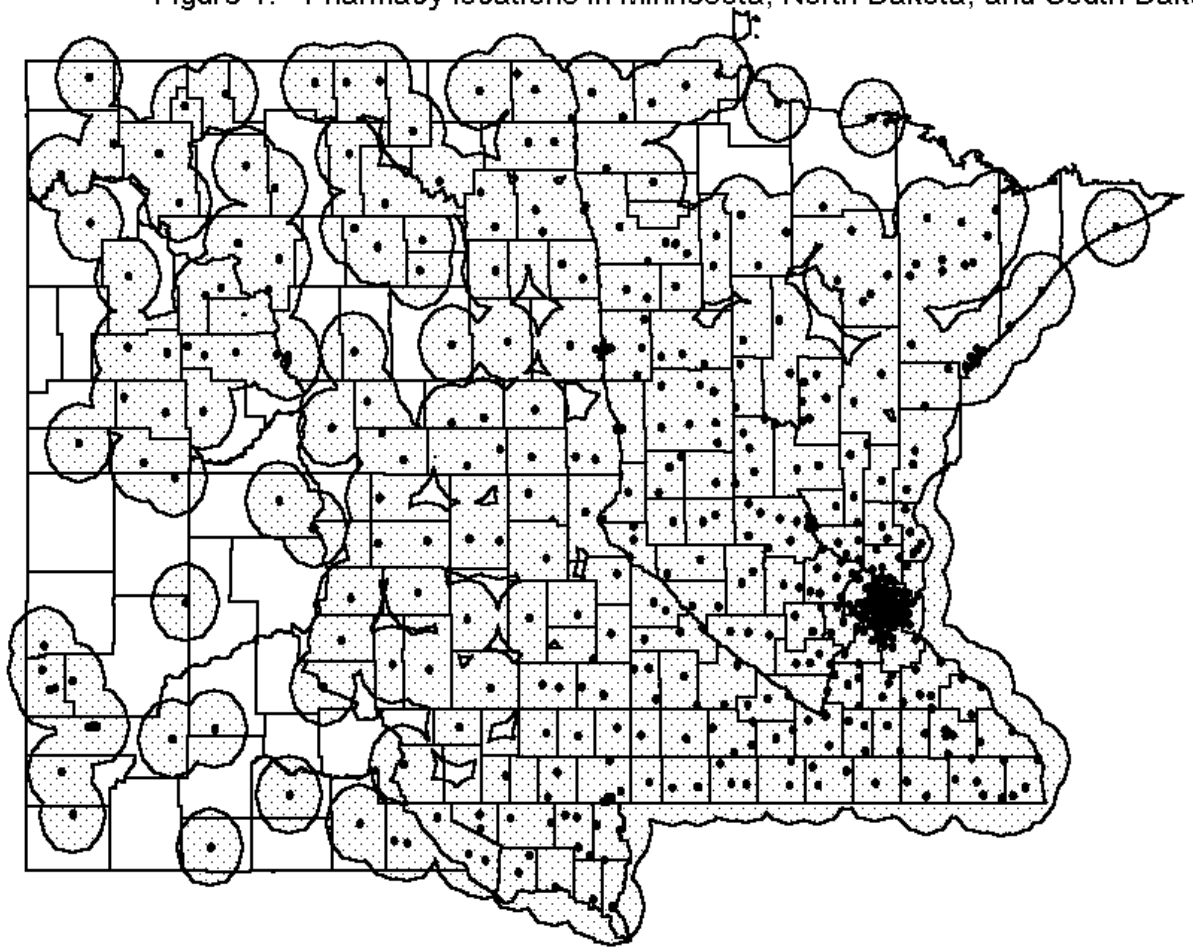
- Adequate Now, But
- A System at Risk

From a Three State Study

- North Dakota
- South Dakota
- Minnesota

- 537 Pharmacists surveyed
- Interviews in 53 communities

Figure 1. Pharmacy locations in Minnesota, North Dakota, and South Dakota



Hatched areas represent circles with a 20 mile radius around each pharmacy.
The unhatched areas do not have a retail pharmacy within 20 miles.
Data Source: 1999 state licensure data

Pharmacy Organizational Characteristics

- 68% independently owned
  - 92% ND, 74% SD, 56% MN
- 29% national or regional chains

- 1/3 in operation for > 50 years
- 45% for 10-49 years

Pharmacy Staffing

- 30% staffed by 1 pharmacist
- 47% staffed by 2 pharmacists
- 24% staffed by 3 or more pharmacists

- First/only pharmacists work 44.7 hours; second 29.5 hours; third 25.6 hours

- 83% have at least one pharmacy tech
- Most common is 2-3 techs (58%)

Prescription Delivery and Provision of Pharmacy Services in Health Care Facilities

Percent of Pharmacies that Deliver to:	
Private homes	85%
Nursing homes	79%
Clinics	40%
Other health care settings	22%

Percent of Lead Pharmacists that serve:	
Nursing homes	63%
Hospitals	19%

Rural Pharmacists' Assessments of Access to Pharmacy Services

- 70% agree/strongly agree that financial concerns make it difficult for many elderly and uninsured to access pharmacy services
- 75% disagree/strongly disagree that geographic barriers make it difficult for residents to access pharmacy services
- 77% disagree/strongly disagree that it is difficult to access pharmacy services when pharmacy is closed

Rural Areas More than 20 Miles from a Pharmacy

- 47 counties with 25% or more of land area (6 MN, 20 ND, 21 SD)
- Areas sparsely populated, underserved by primary medical care and other health care providers
- About 98,000 people
  - 7.3% of SD population
  - 4.3% of ND population
  - 0.4% of MN population

From a Study in Iowa of Prescription Claims Data

- Post 1994 data incorporating 16 communities where pharmacies closed

- Patients in communities where pharmacies closed had fewer prescriptions filled

Policy Implications: Recommendations from the 3 State Study

- Target initiatives to pharmacies critical to access
- Evaluate capacity to produce adequate supply of rural pharmacists in future
- Explore additional options for affordable relief coverage
- Consider potential impact of Medicare prescription benefit on rural beneficiaries and rural pharmacies

Designing Legislation: Suggestions from the RUPRI Panel

- Document available from 2000
- Since then Panel thinking has evolved to create criteria for assessing any redesign of Medicare
- From our work in progress examining prescription drug legislation in 2002…

Principle

Equity

- The Medicare program should maintain ***equity*** vis á vis benefits and costs among its beneficiaries, who should be neither disadvantaged nor advantaged merely because of where they live.

Provisions *Consistent* with the Principle

- The same basic prescription drug benefit will be available to all beneficiaries. Such a provision would be an improvement from the present situation in which some rural beneficiaries have no access to an outpatient prescription benefit, but urban beneficiaries do (including Medicare+Choice plans with low monthly premiums).

Provisions *Consistent* with the Principle (con't)

- A basic benefits plan must be guaranteed in all locations. Such a provision would address the situation where legislation allows multiple plans to be offered but some of those plans are not offered in rural areas because of market considerations.
- Plans shall provide beneficiaries with access to negotiated prices, regardless of whether they are covered with respect to those drugs

Principle

Access

- The Medicare program should ensure that beneficiaries have reasonable geographic and financial access to all essential medical services.

Provisions *Consistent* with the Principle

- The Secretary must develop procedures to provide coverage for beneficiaries that reside in areas not covered by any contracts.
- Pharmacy contractors must secure enough pharmacy participation to assure reasonable access, meeting reasonable distance standards

Provisions *Consistent* with the Principle (con't)

- Contractors must take into account pharmacies' resources and time used in implementing the program when establishing pharmacy dispensing fees.
- Incentives to pharmacists shall be used to create access in rural and hard to serve areas.

Principle

Costs

- The Medicare program should include mechanisms to make the ***costs*** affordable, both to beneficiaries and to the taxpayers financing the program.

Provisions *Consistent* with the Principle

- Out-of-pocket costs for most Medicare beneficiaries will be lower relative to the status quo for the many beneficiaries who currently have either no prescription drug coverage, or limited coverage.
- Appropriate low-income subsidies are included in most proposals.

Principle

Quality

- The Medicare program should promote the highest attainable ***quality*** of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.

Provisions *Consistent* with the Principle

- Specific funding is provided for information systems and infrastructure development to support quality improvement provisions.
- Rural representatives are required on committees that advise quality improvement strategies.

Principle

Choices

- The Medicare program should ensure that all beneficiaries have comparable ***choices*** available to them – among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred) and among health care providers.

Provisions *Consistent* with the Principle

- Beneficiaries will have time to make an enrollment decision that is at least equivalent to the current Part B time line. Such a provision gives rural beneficiaries the opportunity to consider fully new alternatives available to them.
- Plans are required to contract with any provider willing to meet their conditions and must allow beneficiaries to obtain prescription drugs from any provider, sometimes paying extra for that choice (point-of-service). Such a provision assures rural beneficiaries the choice of their local pharmacist.

Provisions *Consistent* with the Principle (con't)

- Plans must provide beneficiaries with benefit information that the Medicare administrator specifies and that includes consumer satisfaction surveys.
- Plans must meet minimum solvency standards. Such a provision helps to assure that plans remain in service areas, which helps to assure that rural beneficiaries will have a choice among plans.

Comments from the Field Enrich Our Understanding

- From Rural Health News. Fall, 2002

Comments from the Field Enrich Our Understanding (con't)

- "Our concern is who is going to give them the drugs. There won't be anyone to tell them how to take it. There won't be any pharmaceutical management. Too many of my guys tell me that folks bring in bottles and ask 'what is this?' We want people to get their drugs, but if they don't take them the correct way, it could be very harmful to them."

Comments from the Field Enrich Our Understanding (con't)

- And because some PBMs receive so-called rebates from some drug manufacturers, other complaints have been raised that PBMs are steering customers to certain drugs over other ones, even over drugs that were prescribed by a doctor.

"As a pharmacist," said Hoey, "I would argue that this is not in the best interest of the patient. The insurance company is getting in the middle of medical care. To me, that's a problem."

References

- M.M Casey, J. Klingner, and I. Moscovice. Pharmacy Services in Rural Areas: Is the Problem Geographic Access or Financial Access? (2002). *The Journal of Rural Health, 18(3), 467-77.*
- H. Xiao, B. Sorofman, and H.R. Manasse, Jr. The Association Between Pharmacy Closures and Prescription Drug Use: A Retrospective Analysis of Medicaid Prescription Claims in Iowa (2000). *The American Journal of Managed Care*, 6(3), 366-72.
- T.D. Rowley. Future Uncertain for Rural Pharmacies (2002). *Rural Health News*, 9(2), 1-7.
- Improving Prescription Drug Coverage for Rural Medicare Beneficiaries: Key Rural Considerations and Objectives For Legislative Proposals (2000). P2000-8. Columbia, MO: Rural Policy Research Institute. A Joint Policy Paper of the Maine Rural Health Research Center and the RUPRI Rural Health Panel. http://www.rupri.org