RUPRI Center for Rural Health Policy Analysis

Policy Brief

Policy Brief No. 2007-6 November 2007 www.unmc.edu/ruprihealth

Reliance on Independently Owned Pharmacies in Rural America

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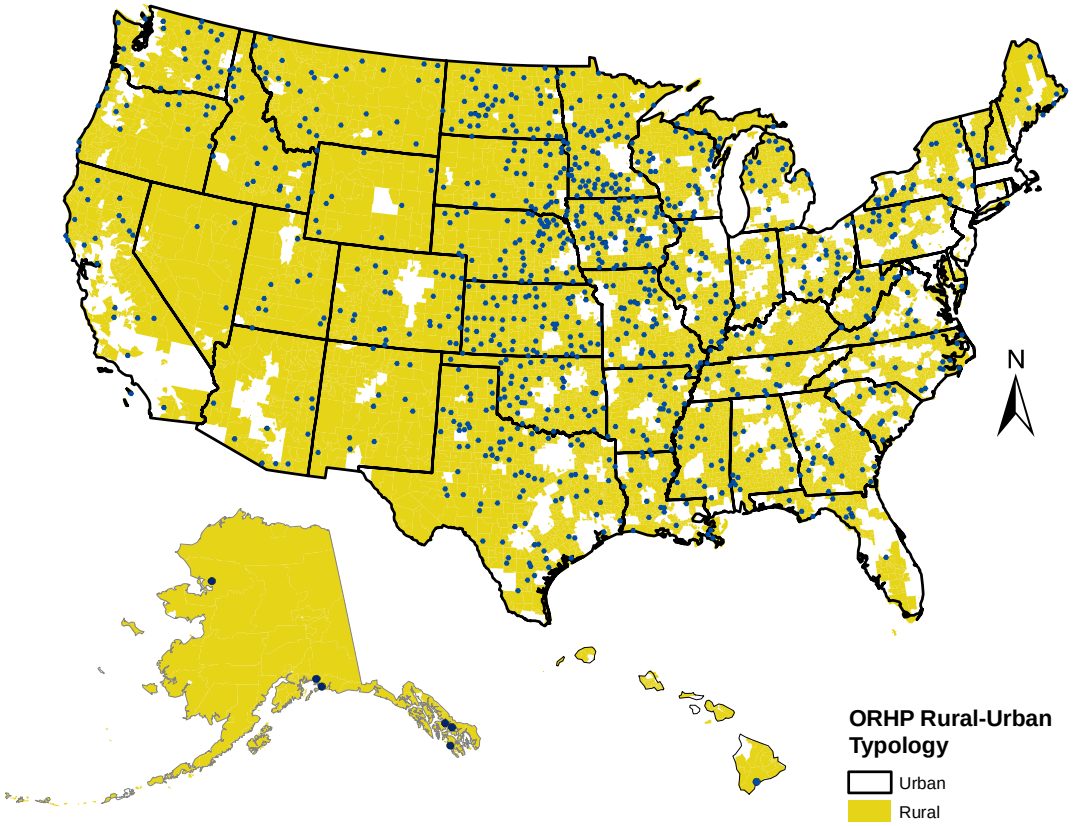
Introduction

The purpose of this policy brief is to provide researchers, policy makers, and stakeholders with the locations of independently owned pharmacies in rural America that are the sole sources of access to local pharmaceutical services. Organizations representing those pharmacies have argued that the advent of Medicare prescription drug plans threatens the financial viability of those pharmacies (Grisnik 2006). In addition, some pharmacists have expressed concerns about changes in Medicaid reimbursement for pharmaceuticals brought about by the Deficit Reduction Act (DRA) of 2005. We focus on those communities with only one pharmacy, independently owned, to lay a foundation for analyzing vulnerability of pharmacy services in rural America.

Key Findings

- There are 7,455 independently owned rural pharmacies in the United States (Table 1).
- Of those, 2,019 are the only pharmacies in their community.
- Of those, 1,044 are located at least 10 miles from the next nearest pharmacy (which by definition is in a different community) (Figure 1).

Figure 1. Communities With Only One Pharmacy, Independently Owned, 10 Miles or More From Any Other Pharmacy



Source of provider data: National Council for Prescription Drug Programs, 2007.
Source of rural designations: Office of Rural Health Policy, Health Resources and Services Administration, 2005.
Map produced by the RUPRI Center for Rural Health Policy Analysis, cartography by Nicole Vanosdel, 2007.
Note: Alaska and Hawaii not to scale.

Table 1. U.S. Rural Communities With Independent Pharmacies

	Total Rural Independent Pharmacies	Communities With Only One Pharmacy, Independently Owned	Communities With Only One Pharmacy, Independently Owned, 10 Miles From Any Other Pharmacy	2000 Population in Communities With Only One Pharmacy, Independenttly Owned, 10 Miles From Any Other Pharmacy
United States	7,455	2,019	1,044	1,667,386
Alabama	257	54	16	19,329
Alaska	32	6	6	13,807
Arizona	28	13	10	37,648
Arkansas	261	54	23	31,178
California	138	49	21	45,575
Colorado	61	34	29	57,222
Connecticut	25	9	0	0
Delaware	7	0	0	0
Florida	95	21	9	12,016
Georgia	351	60	20	28,266
Hawaii	70	7	1	1,378
Idaho	69	26	20	35,797
Illinois	244	58	28	42,936
Indiana	108	29	8	14,679
Iowa	234	94	66	104,067
Kansas	215	79	65	113,100
Kentucky	418	48	9	8,814
Louisiana	269	49	18	35,347
Maine	33	11	9	8,861
Maryland	46	17	1	2,409
Massachusetts	6	0	0	0
Michigan	255	93	27	45,240
Minnesota	181	89	67	95,568
Mississippi	319	43	20	26,853
Missouri	296	64	44	72,355
Montana	96	31	30	40,733
Nebraska	147	57	53	64,053
Nevada	15	4	3	5,340
New Hampshire	28	8	1	4,264
New Jersey	8	2	0	0
New Mexico	57	11	11	25,611
New York	157	69	23	29,903
North Carolina	353	63	15	12,862
North Dakota	87	46	46	48,831
Ohio	222	78	20	36,986
Oklahoma	281	74	43	67,170
Oregon	71	26	15	23,990
Pensylvania	247	74	18	22,196
Rhode Island	1	0	0	0
South Carolina	169	37	14	18,129
South Dakota	85	39	33	35,705
Tennessee	294	42	12	19,436
Texas	432	110	86	196,255
Utah	45	14	10	20,342
Vermont	35	12	3	3,449
Virginia	176	55	13	13,106
Washington	85	41	24	40,678
West Virginia	122	38	11	11,214
Wisconsin	180	70	34	59,823
Wyoming	44	11	9	14,865

Source: U.S. Census Bureau and National Council for Prescription Drug Programs.

Background

The early experience of rural independently owned pharmacies with Medicare Part D brought stories of extreme financial difficulties attributed to the new program. A story in October 2006 reported rural independently owned pharmacies closing in Wyoming, North Dakota, and North Carolina. That story quoted a member of the Wyoming State Board of Pharmacy saying the closures were in towns with other pharmacies but that closures in towns with only one pharmacy could be a big problem for access (Paul 2006). The financial difficulties that rural independently owned pharmacies now face may have existed before Medicare Part D due to the pricing strategies of commercial insurance, which are mimicked in the Part D program. Passing the costs of staying in business as an independently owned pharmacy in a remote location to consumers is difficult if nearly all the pharmacy's customers are enrolled in an insurance plan that limits payment (Stratton 2001). The DRA provisions also figure to have an impact on the financial viability of rural independently owned pharmacies, as states will move to setting Medicaid pharmacy reimbursement rates based on the Average Manufacturer's Price rather than the Average Wholesale Price. The DRA also made changes to the upper payment limit methodology, which is likely to have an impact on cash flow for rural independently owned pharmacies that serve a high number of Medicaid beneficiaries. Previous reports by the RUPRI and North Carolina rural health research centers have reported concerns of rural independent pharmacies located at least 10 miles from the nearest alternative (Radford et al. 2006, 2007). Given these concerns, the policy lens regarding access to pharmacy services will most likely focus on isolated rural independently owned pharmacies. Therefore, this policy brief and accompanying resources available on the RUPRI Center Web site will be valuable resources.

Methods

Data were obtained from the National Council for Prescription Drug Programs (NCPDP) that included the location of, and other information on, the more than 70,000 pharmacies in the United States. Using the categorization of pharmacies by NCPDP, we created a subset of those pharmacies meeting the following criteria (in order of use): independently owned (which included franchised pharmacies); retail; rural, using the ORHP definition of rural;[1] and only pharmacy in the community. This set of pharmacies was then geocoded using the exact address when available, and when the address was not available, geocoded to the central point in the community, the ZIP code, or the county (in that order of preference). To further subset isolated pharmacies, we used a 10-mile Euclidian (straight line, or "as the crow flies") buffer of the community. The state maps in this policy brief show all pharmacies that are the only ones in their communities, differentiating those that are isolated (Figures 2 and 3); the national map shows only those that are isolated (Figure 1) (other state maps and the national map are available at www.unmc.edu/ruprihealth).

Figure 2. Nebraska Communities With Only One Pharmacy, Independently Owned

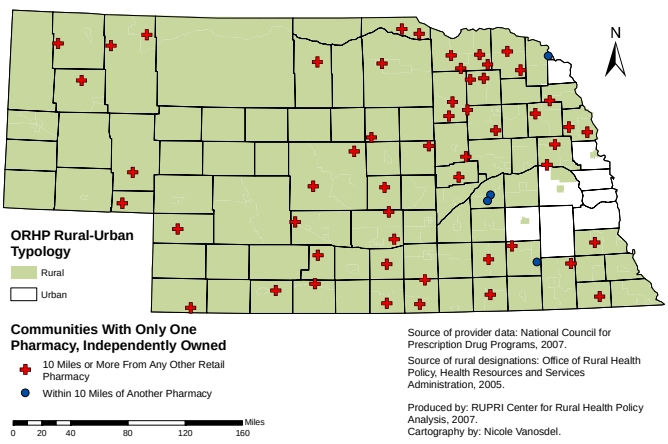
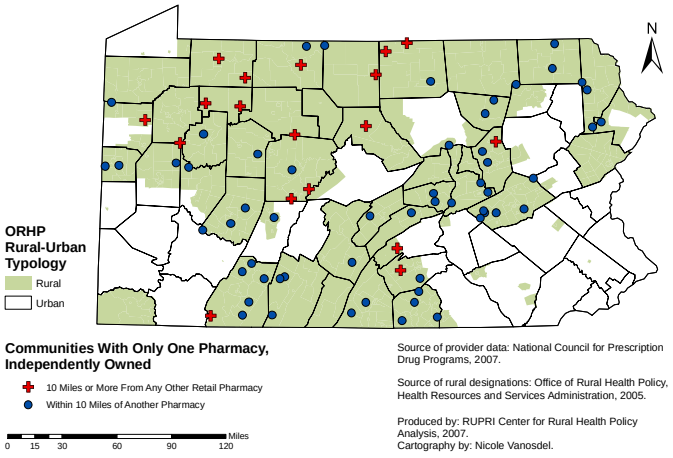


Figure 3. Pennsylvania Communities With Only One Pharmacy, Independently Owned



Discussion

This policy brief provides data and maps to help researchers and policy makers consider access to pharmacy services in rural communities served by independently owned pharmacies. In over 2,000 rural communities, the only local pharmacy is independently owned, and in 1,044 of those communities, there is no other pharmacy within 10 miles. There have been major changes in recent years in how all pharmacies are paid by three principal sources—commercial insurance, Medicaid (with changes in national policy scheduled in January 2008), and now Medicare. Rural independently owned pharmacies may be particularly vulnerable to payment formulas intended to reduce program costs. Knowing which pharmacies may be critical for local access is a first step toward dealing with unintended consequences of new policies.

Implications

Enrollment of Medicare beneficiaries into Part D plans (both those that are stand-alone and those that are part of Medicare Advantage plans) is entering its third year. Enrollment in rural areas has been increasing each year (McBride et al. 2007), which will influence revenues for rural independently owned pharmacies. This policy brief identifies those rural pharmacies that should be the first focus for research and policy activities, which should include addressing these questions about them:

- How has Part D enrollment affected their financial sustainability?
- Have they changed their service offerings as a result of Part D (e.g., servicing local providers such as hospitals and nursing homes)?
- What are potential service options for communities that lose the local pharmacy, for any reason?

Note

[1]We use the federal Office of Rural Health Policy's definition of rural, based on rural-urban commuting area (RUCA) codes, which includes portions of some metropolitan areas as rural.

References

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Funded by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services (Grant #1U1C RH03718).