The Pharmacist Activist

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Editorial

Independent Pharmacies and the Fight for Survival

On numerous occasions I have voiced my opinion that the extent to which the profession of pharmacy will be able to thrive is inextricably linked to the extent that independent pharmacies are able to thrive. Independent pharmacists are the face and identity of our profession to the public, and the admirable way in which these pharmacists have fulfilled this role has been of great value for our entire profession. However, the number and strength of the threats to the survival of independent pharmacies continue to increase, and many long-standing pharmacies have been sold or closed (please see my editorial, "After 124 Years and Four Generations of Family Pharmacists, Hinkle's Pharmacy Closed on October 25," in the October 2017 issue of *The Pharmacist Activist*).

My January editorial is titled, "The FTC Must Prevent CVS from Acquiring Aetna, and Require CVS to Divest Caremark!" I sent a letter to the Acting Chairman of the Federal Trade Commission (FTC) to urge these actions and included a copy of my editorial. I find myself wondering how many of our pharmacy associations and individual pharmacists have communicated with the FTC and others regarding these matters and, if not, why not? Are the implications of this proposed CVS acquisition and its prescription benefit programs not important enough to take a position on and respond accordingly? Are circumstances considered to be so dire that we don't have a chance to be successful in voicing our concerns and, therefore, do not do so? Are our pharmacy associations and individual pharmacists sufficiently comfortable and complacent with the *status quo* that the increasing issues are viewed as annoyances rather than threats?

There is some hope! On February 1, the Department of Justice/FTC requested CVS and Aetna to provide additional information regarding their proposed merger, just as the 30-day waiting period under the Hart Scott Rodino Act expired. This request extends the waiting period for another 30 days. CVS and Aetna have scheduled shareholder votes for the purpose of approving the deal for March 20. Our associations and individual pharmacists must urgently communicate our concerns and pertinent examples! To illustrate the anticompetitive practices of CVS Caremark and other PBMs and insurance companies, I consider the following situations to be particularly convincing:

> If a large, experienced, and successful retail organization such as Target can't identify a way in which to be financially successful in operating its pharmacies, with the result that it sold them to CVS, it is all the more difficult for an independent pharmacy to be successful in contending with the nonnegotiable, egregious terms and inequitable compensation imposed by current prescription benefit programs.
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> If a chain pharmacy organization as large as Rite Aid with almost 5,000 stores identifies its best hope as

selling itself to Walgreens, it is all the more difficult for an independent pharmacy to be successful in the current anticompetitive marketplace. (It is encouraging that the prospect of the FTC not approving the planned acquisition of the entire Rite Aid organization resulted in a much smaller number of Rite Aid stores being sold to Walgreens.)

As important as these questions are, it is essential that pharmacists also communicate their own experiences and the extent to which they threaten the survival of their pharmacies.

Outrageous actions continue

I received responses to my January editorial from many individuals, including current and former CVS pharmacists. They validated and supported the concerns I voiced and provided additional examples of inappropriate situations of which I had not been aware. I also just participated in meetings of two state pharmacy associations. Although some of the concerns experienced by independent pharmacists have existed for years, the current level of frustration, outrage, and concern for survival of their pharmacies is unprecedented. CVS and certain other PBMs are stealing their patients, they are being excluded from prescription plan networks, compensation is being reduced and DIR fees imposed, and terms of their "agreements" restrict them from sharing pertinent cost information with their patients.

What can be done? In a 5-part series of editorials (May, June, July, August, September 2017 issues of *The Pharmacist Activist*) I urged that the profession of pharmacy establish our own Pharmacy Care Administrator (PCA) that would provide prescription benefit programs that would be superior to and competitive with the programs currently available from PBMs and insurance companies. In my October 2017 editorial I urged that our profession convene an Independent Community Pharmacy Summit on Strategy, Structure, and Survival that would bring together representatives of our national organizations that have a large membership of independent pharmacists, representatives of national/regional wholesalers, buying groups, and other organizations with which independent pharmacists are affiliated. Although I consider these actions to be very important for independent pharmacists and our profession, there has been little to no support for these initiatives from the leaders of our profession and national associations whose involvement would be essential for successful planning, development, and implementation.

In responding to the current challenges that confront independent pharmacists, we do not have the luxury of time to engage in discussion and debate that are not accompanied by urgently needed actions. Therefore, I am now recommending specific actions for independent pharmacists to consider for implementation as feasible in their individual pharmacies.

Strategies for survival

I do not have experience in owning or managing a community pharmacy, or in developing or analyzing economic models. Accordingly, I acknowledge the limitations of my personal expertise with respect to predicting the viability and practicality of certain of my recommendations. I do fully understand, however, the most basic requirement for successfully operating a pharmacy – If a pharmacy is not profitable, it will not continue to exist and provide medications and the accompanying counseling and professional services that I and others advocate. The current situation in which pharmacies are compensated for many medications in amounts that are much lower than the actual cost of the medications is not equitable or sustainable, and places the survival of the pharmacy at risk. If I owned an independent pharmacy, I would give priority attention to the following actions.

1. I would communicate with the prescribers from whom I received the most prescriptions to promote the maximum utilization of medications for which generic equivalent products are available. Multisource generic equivalents are already provided for a large majority of prescriptions dispensed in community pharmacies (some data indicate 80% or higher), but this percentage can be further increased when prescribers are made more aware of the cost savings that could result. Many generic medications may be purchased at relatively inexpensive prices. The cost of a 30-day or 90-day supply of a generic medication plus a fair/profitable fee for professional services will often be less than the amount of the co-pay patients would be required to provide under the terms of many prescription benefit plans. For example, the prescription benefit plan provided by my employer requires a co-pay of $20 for a 30-day supply of a generic medication from my local pharmacy, or a co-pay of $40 for a 90-day supply of the medication from a mail-order pharmacy (that I refuse to use).

The generic medications that I take on a maintenance basis are relatively inexpensive and would permit my local pharmacist to provide them to me, and receive a fair professional fee, for less than the co-pay I would be expected to provide, if the terms of the prescription plans in which the pharmacy participates would permit them to do that.

These generic medications offer the best opportunity for pharmacists to provide medications and professional services in a profitable manner, and these are the products that would comprise the vast majority of the inventory of medications I would maintain. I would also maintain a limited inventory of brand-name medications with which treatment must be initiated as soon as possible (e.g., certain antibiotics, certain analgesics). I would not regularly stock most expensive trade-name medications with the resultant large investment in inventory, but rather would order them at the time I receive a prescription for which I would receive fair/profitable compensation. At the time the prescription is received, the medication can be ordered from the wholesaler and provided to the patient in much less time than if the patient was to obtain it from a mail-order pharmacy.

If there is criticism for not maintaining a large inventory, my response would be that I can't afford to dispense prescriptions in programs in which I am losing money, and that it is unfair to expect patients who pay cash or obtain their prescriptions in a plan that is equitable to subsidize patients in prescription plans that do not provide sufficient compensation to cover costs. Current drug distribution systems actually often impose restrictions that prevent local pharmacies from obtaining certain medications because of the increasing extent to which pharmaceutical companies only supply many costly medications through specialty pharmacies.

2. I will refuse to purchase brand-name medications at list price when the companies supplying those medications are providing substantial discounts/rebates to other purchasers such as PBMs and insurance companies. In a current message to consumers, pharmaceutical companies are trying to shift the blame for high drug prices to PBMs and insurers by stating that "one-third of the list price of a brand medicine is rebated back to payers and the supply chain…who do not share these discounts with patients." My patients and my pharmacy should not have to subsidize these rebate games from which we are excluded. Because the pharmaceutical companies set the list prices and provide the rebates, their figure of one-third of the list price being rebated back must be accurate. I would rather not play the rebate games at all but, if rebates are provided to some purchasers, they must also be provided in a manner in which my patients are treated fairly and my pharmacy will be provided equitable compensation, or I will not purchase and dispense the medication.

   In certain prescription benefit plans, pharmacists will not be compensated in an amount that is greater than their "usual and customary" fee/compensation. This same principle must be applied to the arrangements in which pharmaceutical companies provide medications to pharmacies – that is they should not be compensated in an amount that is greater than their "usual and customary" charge of list price less a rebate of one-third.

3. I would refuse to participate in the prescription benefit plans of PBMs and insurers that disrespect and insult my patients and my pharmacy, and do not permit me to participate on a profitable basis. I will not subject myself to the nonnegotiable, inequitable, and deceptive terms of the plans, stealing my patients, DIRs and clawbacks, and unfair audits. Not only do these prescription plans make it very difficult, if not impossible, to operate a pharmacy on a profitable basis but they also discourage initiatives for increasing communications with patients and professional services, and deny us the professional fulfillment that we should be able to enjoy from practicing in a manner that is of optimum benefit for our patients.

4. I would implement a medication synchronization program (i.e., appointment-based model) that would enhance communications and therapeutic outcomes for patients, and also increase the efficiency in providing professional services and inventory planning and management.

5. I would participate in the Community Pharmacy Enhanced Services Network (CPESN; www.cpesn.com), an initiative that is committed to providing expanded professional services and documentation of their value that will provide the foundation from

which equitable agreements with payers may be established.

6. I would be an ambassador for the profession of pharmacy in my community and beyond, and be a source of valued information and advice regarding public health and medication-related issues and questions. I would be an active participant in programs of the National Community Pharmacists Association and the American Pharmacists Association.

7. I would include compounding of medications as an integral part of my practice. Commercially available formulations in a small number of potencies will not provide optimum treatment for many patients. One size/dose doesn't fit all. Compounding is the original "personalized medicine" and provides the opportunity to develop formulations that include the medications and doses that are best suited for the needs of individual patients.

8. I would include a self-care center in my practice that would encourage patients to ask questions, and would recommend, as appropriate, the selection and appropriate use of my "pharmacist's choice" of nonprescription medications.

9. I would establish one or more "niche" services/centers depending on the needs and interests of my patients and community, that would become recognized as a primary source of authoritative expertise and valued services. Examples could include smoking cessation and/or other public health initiatives, respiratory therapy, pharmacogenomic services, eye care/contact lenses, complementary and integrative therapies/ dietary supplements, nutrition, travel health services, and medical equipment/supplies.

10. I would "tell the world" about the value of the services I provide, starting with my patients but also including the "high prescribers" for the purpose of identifying areas of collaboration and service for the benefit of our patients, civic and business leaders who are making the decisions regarding healthcare/prescription benefits for their employees, and the community in general through media public service commentaries and/or advertisements. I would encourage my patients to ask questions about their medications including the prices of their prescriptions, and I would be fully transparent in identifying the costs of the medications provided, the amount of my professional fee for services and other operating costs, and the reasons for which I do not participate in prescription benefit plans that result in substantial profits for PBMs and insurers who do nothing to contribute to the quality and scope of health care for patients, and who are unwilling to provide fair conditions of participation and equitable compensation for pharmacists.

The strategies identified are not provided with guarantees. Given the realities of the concerns about prescription and other healthcare costs, it is possible that they will not provide financial success. But if it would turn out that my strategies are not financially successful, that situation would be a consequence of well-motivated decisions that I personally made, rather than my becoming a victim of unfair and inequitable prescription plans in which I have no input or control, that are dictated by companies that add layers of cost and their own profits to the economics of the healthcare system, but do not contribute benefit or value. HOWEVER, I am very confident that the strategies I have recommended will have positive outcomes, and will be professionally successful and financially successful. I welcome the opportunity to learn from your experiences and recommendations.

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