The Pharmacist Activist

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"Praise the Lord! Oh, give thanks to the Lord, for He is good! For His mercy endures forever."

Psalm 106:1

Editorial

Drug Prices are Too High! – The CMEIDPAR

The prices in the United States for single-source prescription medications and some off-patent generically available medications are far too high. This challenge has persisted for decades in spite of increased coverage for medications by government agencies and private health insurance programs, more extensive use of formularies, importation of drugs from Canada and other countries where the prices of medications are much lower, high utilization rates of less costly generic medications, and online purchases of medications (at greater risk!).

The pharmaceutical companies (PhRMA) that develop and obtain marketing approval for medications establish the list (purchase) prices for medications, and these companies are the primary targets for the criticisms of high drug prices. However, the high list prices are both the consequence and beginning of a highly secretive process that involves the large pharmacy benefit managers (PBMs) that administer most prescription benefit plans in the U.S., as well as the pharmaceutical companies. The PBMs request and receive rebates from the pharmaceutical companies for coverage of their drugs in their plans and placement in a preferred tier in their formularies. The percentage rebates for particular drugs are not disclosed but can vary widely and significantly exceed 50% for some medications in highly competitive therapeutic classes. It is in the interest of both the PBMs and pharmaceutical companies to consider the details of the negotiations and the specific rebates as highly confidential and protected information "for competitive reasons," and the information is not publicly disclosed as it would result in even greater criticism from the public, employers, government agencies, and legislators regarding drug prices. These circumstances are the basis for the "blame game" among the participants regarding the prices of medications.

The PBMs fault the pharmaceutical companies for the high drug prices and claim that they (the PBMs) are the only advocates for patients and the sponsors of prescription plans which can negotiate with the pharmaceutical companies to obtain lower more affordable prices for medications. The pharmaceutical companies fault the PBMs for high drug prices because they demand substantial rebates that the companies must anticipate and factor into the determination of the list price for a drug if it is to receive favorable coverage by the PBMs. Because terms of negotiations and financial details are not disclosed, those who challenge the high prices are faulted for not having evidence or documentation to support their allegations.

The continuing war of words

At first glance, it would appear that PhRMA and the PBMs are strong adversaries in faulting the other for high drug prices, and this is reflected by their self-promoting battle in wide-

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ly-read publications such as *The Wall Street Journal* (WSJ), some of which I have discussed in recent issues of *The Pharmacist Activist*. The following are more recent examples:

From PhRMA (WSJ; October 9, 2024; p. A6A):

- "Doesn't matter what you intended. I will pay for meds."
- Seniors are feeling the true cost of drug price "negotiations."
- Instead of saving money, some Medicare patients will pay more for medicines.
- Others may not be able to get their medicines – 89% of insurers and PBMs say they plan to reduce access to medicines in Medicare Part D because of the Inflation Reduction Act.
- Higher costs and less access.
- Not what seniors were promised.

From Express Scripts (WSJ; October 15, 2024; p. A16):

- First to cap insulin at $25 per month before any federal mandate.
- That's not a middleman.
- That's an advocate.
- We're 18,000 advocates who take pride in being the primary line of defense for millions of Americans against rising health costs. Fighting every day to make the health system better and people better.

Who is winning this advertising battle? The most obvious winners are the media organizations which receive substantial revenues from the purchase of advertising space and time, which also includes revenue from direct-to-consumer advertising of prescription medications from PhRMA companies (which also is a major factor in high drug prices). Less obvious is the recognition that the PBMs and PhRMA are BOTH winners for the reasons discussed below. The losers are the patients, payers, and the public who pay the excessive prices for medications but who don't understand and can't resolve the debacle that has victimized them. Pharmacists are also losers because of the draconian programs and abysmal compensation imposed by the PBMs without the opportunity for negotiation. They understand the problems but have not been able to resolve them.

The CMEIDPAR

The secretive and baffling system through which high drug prices persist must be defined, exposed, understood, and corrected. I suggest that this onerous and costly system be designated, "The Cyclic Mutually-Enriching Increases in Drug Prices And Rebates," which, of course, needs an acronym (CMEIDPAR). Although the PhRMA companies and PBMs can claim to be adversaries in the drug pricing system, they both benefit financially. When a company receives approval to market a drug, it establishes an initial list price which includes an estimate of the rebate it might be expected to provide, as well as the desired profit. A company typically increases the price of its widely-prescribed drugs every year, and sometimes twice or more each year. A price increase would be accompanied by increased rebate revenue for PBMs, creating a cyclic pattern from which both the companies and PBMs financially benefit while blaming the other for the increased prices.

For many years, the role, influence, and financial strength of the PBMs was unrecognized by most of the public and legislators. However, the recent and extensive media coverage of the operations of the PBMs has exposed their role in increasing drug prices, reducing the quality and timeliness of drug therapy for patients by denying or delaying (e.g., prior authorization) coverage of prescribed medications, denying equitable compensation to pharmacies that has resulted in the closure of many, and reducing access/convenience for patients in obtaining needed medications.

Alternative strategies

It would be naïve to think that the PhRMA companies and PBMs would voluntary pursue actions that give priority to other than those that are in their own self-interest. As an example, some companies (e.g., Lilly, Pfizer) have established programs that provide certain of their medications directly to patients in a manner that avoids the financial and other interventions of PBMs, but also bypasses the local pharmacies used by the patients. These self-serving company programs further fragment the provision of medications and healthcare services for patients, and increase the risk of medication-related problems. Pharmacists and physicians should demand that programs of this type should be discontinued, or decline to prescribe and dispense any of the medications from these companies for which therapeutically equivalent medications from other companies are available.

Although I have been critical of the high cost of medications in the U.S. and certain practices of the companies such as the advertising of prescription medications directly to the public, I also believe the companies have an essential role in conducting the research programs that are necessary to develop new medications that are more effective and safer for patients. Therefore these roles, and the motivation for appropriate profitability must be preserved, while concurrently

taking actions that will reduce the cost of drugs.

The PBMs *could* have provided a helpful role in the management of prescription medications and improving the quality of drug therapy. However, the largest and most dominant PBMs (Caremark, Express Scripts, Optum) have failed to do so and have exploited patients, healthcare professionals, and corporate, union, and government sponsors of prescription plans for the purpose of increasing the profitably of their own companies. These PBMs have demonstrated that they can't be trusted to initiate reforms on their own, and it should be anticipated that they will find ways to escape legislative and other reforms and policies developed by others. They have established a system that enriches themselves without incurring risks and costs such as unsuccessful research programs of the pharmaceutical companies and maintaining inventories of expensive drugs in pharmacies.

Unlike the pharmaceutical companies that I consider important and necessary, the exploitative PBMs such as those identified above are not necessary, and those who have been their victims should join forces in identifying other strategies to provide necessary administrative services. Consideration can be given to having smaller companies currently involved in the adjudication/administration of prescription claims assume greater responsibility. However, such programs must be provided with integrity and transparency in a manner that can be monitored by health professionals and other stakeholders.

Pharmacists, prescribers, and other health professionals *know* what the problems are, but we and our professional organizations have not been successful in resolving them. If we continue to fail to do so, any remaining control of our professional destiny will be lost!

Daniel A. Hussar
DanH@pharmacistactivist.com

The Failures of CVS, Rite Aid, and Walgreens – Implications for our Profession

Rite Aid declared bankruptcy but survived following a reorganization that resulted in the closure of hundreds of "underperforming" stores.

Frequent turnover of executives and changes in economic strategies at Walgreens have failed to prevent the closure of hundreds of stores.

In spite of horizontal, vertical, and other acquisitions, CVS has closed hundreds of stores and its CEO was replaced.

Thousands of pharmacists at these three chain organizations experience understaffed and stressful working conditions with physical and mental health consequences that result in their active pursuit of other pharmacy opportunities or leaving the profession.

For these situations to exist at companies that are the largest employers of pharmacists is dangerous for the patients served and disastrous for our profession. However, very few pharmacy leaders will publicly identify and actively address the importance of this reality. What do they think will be gained by their failure to do so, or do they deny that there are problems that threaten the future of our profession?

The common denominator of the failures of the three large chain organizations is that their executives/decision-makers are not pharmacists. They presumably have business/management experience and expertise (which many pharmacists do not have) that results in exclusive priority for revenues and profits. However, without the integration of the commitment to provide healthcare services to patients which has motivated most pharmacists to enter our profession, they put their customers/patients at risk and alienate their pharmacists and other employees.

These three large retail pharmacy corporations have very different histories. Charles Walgreen, Sr. was a pharmacist who purchased the pharmacy in which he was working in 1901. He opened/purchased additional pharmacies and his son and grandson succeeded him in leadership roles in the family's company. In recent years there have not been family members or pharmacists in decision-making positions within the company. Rite Aid was initially a discount center selling health and beauty products that subsequently added and acquired pharmacies. Throughout its approximately 60 years of operation, no pharmacists have served in leadership/decision-making position, and its recent history has been characterized by scandals, frequent turnover in its

leadership, and bankruptcy.

CVS (Consumer Value Stores) also started as consumer products stores in the 1960s and subsequently added and acquired pharmacies. There was a period of time in which pharmacist positions at CVS and the professional role of pharmacists were strongly supported by the company and were valued and sought by pharmacists wanting to practice in a chain pharmacy. Pharmacist Tom Ryan served as President and CEO for a period of 17 years. Following his retirement in 2011, another pharmacist succeeded him in these roles for the next decade. Many of the longer-serving pharmacists and other employees of CVS identify this transition as the beginning of the decline of the culture, morale, and staffing at CVS stores that also increases the risk of medication errors for patients. Although the company grew during his 10-year tenure as CEO, he betrayed his employees and profession and placed customers at greater risk. His successor lasted only three years before being replaced in October by the President of Caremark, CVS's PBM. I am not optimistic that the experiences of employees and customers in CVS stores will improve.

Walgreens, Rite Aid and CVS, as well as others, have been sued and have agreed to large financial settlements for their alleged role in opioid overdosage deaths.

The executives/decision-makers at grocery and big-box stores that include pharmacies are also not pharmacists. However, the cost of operating the pharmacy is usually only a small fraction of the total costs of operating the large retail organization. Therefore, the continuing costs of having a pharmacy that is not profitable can often be offset by other departments/retail merchandise that is profitable. The experience of Target stores is an exception in which management could not operate the pharmacies profitably and made the decision and financial arrangements to have CVS operate the pharmacy departments in Target stores. This course of action not only reduced the quality of pharmacy services for customers and working conditions for pharmacists, but also fell short of profit expectations in many locations. The consequence is that the CVS pharmacies in some Target stores are now being closed.

For different reasons, pharmacists who own independent pharmacies are the most vulnerable of all to the financial forces that make it extremely difficult to operate a pharmacy profitably. These pharmacists are typically motivated by a commitment to provide healthcare products and services to their patients and communities in what has become a financially unsustainable marketplace controlled by pharmacy benefit managers and health insurance companies. These smaller practices/businesses do not have the economies of scale or negotiating position of the large chain or big-box stores, and thousands of them have not survived financially. If anything, many independent pharmacists have kept their pharmacies operating long after they were no longer profitable.

The issues identified in this commentary have not developed suddenly or recently, but rather have evolved over a number of years and are well recognized within the profession. However, serious questions exist as to whether our professional organizations and leaders are even discussing strategies that can enable community pharmacies to survive. Seeking provider status for pharmacists and PBM reform are positive initiatives, but the funding for pharmacist services and the enforceability of reforms are outside of our profession's control and may not be provided. Similarly, the promotion of immunizations for which there is a better financial return than for dispensing prescriptions, or establishing/selling niche services/merchandise, may be of value, but often only on a seasonal or short-term basis.

The leaders of our profession have informed us that we now have the best opportunity to achieve the long-sought goals of provider status for pharmacists and PBM reform, and that there is bipartisan support for passage of needed legislation in the brief legislative session following the election. If these goals are achieved, what steps are planned for implementation? If they are not achieved, what alternative strategies have been identified for our profession to move forward?

Daniel A. Hussar
DanH@pharmacistactivist.com

Author/Editor/Publisher – Daniel A. Hussar, Ph.D.
Dean Emeritus and Remington Professor Emeritus at
Philadelphia College of Pharmacy
Assistant Editor – Suzanne F. Hussar, B.Sc. (Pharmacy)

The Pharmacist Activist, 1 Boulder Creek Lane, Newtown Square, PA 19073
E-mail: info@pharmacistactivist.com

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