The Pharmacist Activist

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"Do not be overcome by evil, but overcome evil with good." Romans 12:21

Editorial

PBMs – Pharmacy Needs New Strategies: Or a DOPAE!

One of pharmacy's highest legislative priorities during most of 2024 was PBM reform. Although progress was made in some individual states, at the national level we were NOT successful! The unprecedented media coverage has exposed how the PBMs control the selection, distribution, use, and cost of prescription medications – the PBMs are invisible no longer. Examples of their greed and policies, and the resultant reduction of the quality and safety of drug therapy for patients, and medication errors, are abundant. Outcomes also include the closure of thousands of community pharmacies and the rapidly growing number of "pharmacy deserts." The Federal Trade Commission (FTC) and the Department of Justice (DOJ) sued the largest PBMs regarding their monopolistic practices and published reports that include specific examples. Pharmacists have initiated class-action lawsuits. National pharmacy associations (primarily NCPA and APhA) secured bipartisan support for legislative proposals for PBM reform, and were assured that that they would be approved in the final legislative session following the election. Pharmacy has NOT been successful!

Current strategies

Legislative PBM reform initiatives and lawsuits against the largest PBMs have momentum and should be continued and strongly supported by our profession. There will be an opportunity as soon as next month to include PBM reform in budget proposals to be developed by Congress and quickly implemented. Will PBM reform be included as it was in the fall, or will it be omitted?

The three largest PBMs (and their corporate health insurance company collaborator) are CVS Caremark (Aetna), Express Scripts (Cigna), and Optum (UnitedHealth), and these companies are estimated to "manage" 80% of the prescription claims in the U.S. Even if legislative PBM reform is approved and lawsuits are successful, can pharmacy and our associations prevail against these three dominant organizations that have much greater wealth, strength, and legislative influence? Pharmacists are well aware that when their profits are threatened, these PBMs will challenge/delay, violate, and/or otherwise circumvent laws and litigation that restrict them. When caught, no one is held personally accountable and financial settlements can be attained.

In a recent discussion with a pharmacy leader, he was excited about the approval of PBM reform legislation in his state, but was lamenting that the provisions were not being enforced, as well as questions as to if and how funding would be available to provide pharmacists with equitable compensation. Thus, approval of PBM reform legislation does not provide assurance that patients and pharmacists will be well-served. The three largest PBMs will not change and the battle requires new strategies.

New strategies

I don't have answers for the current challenges but can provide recommendations and strategies for consideration by pharmacy leaders. I would also request interested readers to become Pharmacist Activist Investigators (badge not

included) who will provide me with pertinent information that I do not know.

1. The profession of pharmacy should construct a "model" prescription claims administration program.

Perhaps a model program has already been designed and I am not aware of it. However, I don't rule out the possibility that, because pharmacy has been in a defensive position for so long and is so threatened by the dominant PBMs, a model program with criteria pharmacists consider essential hasn't been prepared.

2. Existing prescription claims adjudication programs that are viewed favorably by patients and pharmacists should be identified.

One would hope that there are prescription claims administrators with programs that enable positive therapeutic outcomes for the patients served, and also recognize the professional and financial value of the services of participating pharmacists. It is my understanding that some pharmacists have worked with employers in their communities to develop prescription benefit programs for their employees. We need to identify successful programs of this type and determine how they can be supported/revised/adapted to serve much larger patient populations and many more pharmacies.

3. The profession of pharmacy should consider establishing its own pharmacy care administrator (PCA).

In 2017, I wrote a 5-part series of editorials on the topic, "Our Profession's Own Pharmacy Care Administrator (PCA)," (www.pharmacistactivist.com; May – September 2017). I received numerous supportive comments from pharmacists, but none from leaders of the profession at that time. Perhaps I should refresh and recycle those recommendations as "new," to see if there is interest among the current leaders.

I recognize that establishing a new PCA would require monumental effort and resources. A few years back, a group of very capable pharmacists established Indy Health, a PCA that provided programs in five states in which its programs could be most quickly implemented. This was a visionary and costly initiative but, unfortunately, was short-lived and not successful. I strongly suspect that its failure was a result of strategies and sabotage of the largest PBMs that viewed it as a threat, and exploitation by some greedy pharmacists whom the program was attempting to assist.

I hold the pharmacists who established Indy Health in the highest regard. They were committed to provide patients with high-quality pharmacy services and advance the professional roles and compensation for pharmacists. They were courageous and bold, and willing to risk, as were other pharmacist investors, their personal financial resources. In my view their vision and plans continue to provide the best opportunity for our profession to pursue now. We must learn from their experience and develop a stronger PCA, the value of which will be recognized and widely adopted. But are our profession and its leaders ready for that challenge? I will quickly accept rejection of my recommendations for the purpose of supporting better strategies that our profession would identify. However, other than PBM reform and seeking provider status for pharmacists that will continue to be strongly challenged by powerful entities, I am not aware of other strategies that have been proposed, and fear that there is not even a planning process in place.

4. Collaboration with other programs/partners with similar goals should be explored.

In addition to the programs identified in #2 above, are there larger prescription benefit plans with which collaboration can be explored? I am aware that some pharmacy leaders have had discussions with Mark Cuban regarding the program he has established, and I urge continuing discussions to evaluate the potential for mutually beneficial outcomes. Although the ideas and concepts exchanged can be very important, I consider it essential that the program be owned by an association of pharmacists to reduce the risk of subsequent sale of the program to investors or others whose interests are economically motivated.

5. Identify the individuals and organizations that are at greatest risk if current threats continue to worsen.

My initial list includes:

a. Patients and the public who will have even less access to the expertise and services of pharmacists;
b. Independent pharmacists/pharmacies;
c. Chain pharmacists/pharmacies;
d. The entire profession of pharmacy and its associations;
e. Colleges of pharmacy.

Large chain stores and mail-order companies are becoming the public identity of pharmacy for much of the public.

If that trend is not quickly reversed, the stature of pharmacy as a healthcare profession is in jeopardy!

6. Identify the specific prescription benefit plans/companies that the pharmacy associations and colleges of pharmacy provide for their employees.

If any organizations would be expected to provide prescription plans for employees that promote optimum drug therapy outcomes for patients and the professional roles and services of pharmacists, it would be the pharmacy associations and colleges of pharmacy. But which prescription plans do they use? I don't have a research group and this is a question for which I need the assistance of the Pharmacist Activist Investigative team. Please help identify this information and provide it to me for inclusion in a subsequent issue of *The Pharmacist Activist.*

Let's start by identifying the prescription plans provided for employees of the largest pharmacy associations (e.g., APhA, ASHP, NCPA). We would like to assume, but need to confirm, that our associations are providing prescription plans that promote pharmacy services of a standard that the associations are advocating and provide equitable compensation for pharmacists, and are NOT using plans/companies against which the associations are seeking legislative reform and supporting litigation.

The prescription plans provided by colleges of pharmacy for their faculty and other employees should also be identified (contact your alma mater to learn what one they use). Some colleges will respond that they are not involved in these decisions, and that it is the university or a consortium of organizations that collaborate to make these decisions. However, who within these organizations has more awareness than the colleges of pharmacy regarding the quality of the prescription plans and the PBMs and other entities that administer them?

7. Follow up on responses from pharmacy associations and colleges of pharmacy.

There will be some pharmacy associations and colleges that are using CVS Caremark, Express Scripts, Optum, or another similarly egregious plan. What possible explanation can the leaders of the associations provide for patronizing the PBMs of which they are so critical? Is it because the programs are less costly? If so, find a better plan and pay more! Is it because there are so few options? If so, establish a better one or work with a company that can! Do leaders of the pharmacy associations confer with each other in an effort to identify the best possible prescription plan for its employees? If not, why not? This is one of the many efficiencies that could be achieved if pharmacy associations collaborated more and/or merged.

The deans and faculty of colleges of pharmacy usually have no role in the selection of benefits for the employees of its university. However, what if the university selects a prescription plan that is administered by CVS Caremark, Express Scripts, or Optum? These companies have caused most of the destruction of the professional roles of community pharmacists, and have decimated the pool of applicants who might pursue a career in pharmacy. The most important concerns for most colleges of pharmacy at the present time are the declining number of applicants and enrollment. So how can the leadership of most colleges of pharmacy remain silent or refuse to challenge their university's selection of a PBM that prevents or suppresses the professional roles for which the colleges are preparing their students?

8. Identify the specific prescription plans/companies that the largest pharmaceutical companies provide for their employees?

It would seem that practicing pharmacists and our associations, and pharmaceutical companies would be natural allies in the provision of programs and services that provide the best possible drug therapy outcomes. However, such an alliance does not exist, for which I fault the pharmaceutical companies which even utilize distribution programs for their drugs that circumvent the involvement of local pharmacists and the profession that provided the foundation from which the companies evolved.

The large pharmaceutical companies (PhRMA) and PBMs are strong antagonists in faulting each other for the high cost of drugs. The PBMs extort huge rebates from the companies for placing select drugs in a favorable tier on their formularies. Even with the resources and influence of the pharmaceutical companies, the PBMs are prevailing in that battle as there are few substantive changes in the prescription programs and drug costs continue to increase. Thus, like the pharmacy associations and colleges, the PhRMA companies have a very compelling reason to avoid using one of the most destructive PBMs to administer the prescription benefit plan for its employees. We need to learn about the prescription plans they provide for their employees and how they are administered. The shared need of the pharmacy associations, colleges, and pharmaceutical companies for prescription benefit

programs that give priority to positive drug therapy outcomes and advocacy and appropriate compensation for the professional roles and services of pharmacists should be a powerful incentive to work together to develop a model prescription benefit program. However, do these three large entities even speak with each other about the threats imposed by the PBMs?

9. Promote a better prescription benefit program to large employers.

There should be no question that the profession of pharmacy can design a prescription benefit plan that is far superior to those now provided by CVS Caremark, Express Scripts, and Optum. The to-be-established plan would provide:

a. more comprehensive and personalized services for patients;
b. improved drug therapy outcomes for patients;
c. advocacy for the professional roles and services of pharmacists;
d. equitable compensation for pharmacists, and;
e. transparency of operations.

The greatly improved quality and services of the plan will also be associated with a substantial increase in costs. However, I would argue that these increased costs will be more than offset by the savings achieved from eliminating the very costly and profitable administrative involvement of the PBM middlemen, as well as the rebates they receive from the pharmaceutical companies that may be as much as 50% or more of the cost of certain drugs. Therefore, in addition to the improved quality, services, and outcomes of the plan, as well as equitable compensation for pharmacists, the plan would have the potential to be less costly than those provided by the PBMs. It is unacceptable that PBMs and their health insurance company colleagues which provide no more than administrative services continue to be so profitable when pharmacists who are actually providing the medications and services can't financially survive and are closing their pharmacies.

When/if the pharmacy associations and pharmaceutical companies establish and implement a prescription benefit program that is superior to the existing ones, the program should be promoted to large employers and government agencies that pay for prescription medications (e.g., Medicaid, Medicare) and provide a prescription benefit plan for their employees. An extensive promotional/marketing program should actually not be necessary because, once it becomes known that a superior and cost-effective prescription plan is available, large employers and government agencies will quickly learn about it and seek participation.

There will be pharmacy leaders who will continue to ignore and reject my recommendations for reasons I've already heard (e.g., I'm naïve, I'm not practical, I have never run a business, my ideas are impossible to achieve, the PBMs are too powerful, the system is too large to change, I'm nostalgic for the independent pharmacies that were prevalent when I was young, all of the above and more). In addition to the outdated observation, "Sticks and stones…," my response is "I would be pleased to review your ideas and recommendations for responding to the current threats." Other than PBM reform and litigation, the results of which are determined by those who are not pharmacists and may take many more years to be resolved, I have not observed or heard of other promising initiatives. Our profession can not depend on others to resolve our problems! We must assume that responsibility and the need to do that is urgent! In the event that my recommendations are not acceptable to pharmacy leaders and better ideas are not forthcoming, the profession should move to #10.

10. Establish the DOPAE (Department of Pharmacy Association Efficiency)!

If substantial progress does not occur by July 4, 2025, applications for the position of "Czar" will be requested.

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