The Pharmacist Activist

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"As a father has compassion on his children, so the Lord has compassion on those who fear him;" Psalm 103:13

Editorial

PBM Reform and Action

For many years companies that processed prescription claims for individuals with employer- or government-sponsored prescription benefit plans had a low profile and operated in a manner that was essentially invisible and unknown to most of the public. As a growing majority of prescriptions were being covered by third-party benefit plans, some of these companies were not satisfied to just process prescription claims, but saw an opportunity to expand their involvement and "manage" the programs and greatly increase their profits. Now identified as pharmacy benefit managers (PBMs), the three largest of these companies (Caremark, Express Scripts, Optum) now "manage" more than 80% of the claims for prescription medications. With little resistance at first, they have seized most of the authority for the medication distribution system, and now exercise more control over the selection of the medications being prescribed, the pharmacy from which the medication is dispensed (e.g., community, specialty, mail-order), the distribution, and the cost of medications than prescribers, pharmacists, prescription plan sponsors, and pharmaceutical companies. These PBMs do nothing that contributes to the effectiveness and safety of medications or achieving favorable therapeutic outcomes. Rather, their involvement is cost and profit driven. They claim to reduce drug costs at a time when drugs are becoming more costly to the point of being unaffordable. The PBMs and pharmaceutical companies engage in a blame-game in a mutually-enriching cycle of increased list prices established by the pharmaceutical companies and increased rebates for the PBMs.

The quality and safety of drug therapy for patients may be compromised by delays in providing medications for which the PBMs require prior authorization, denying coverage or requiring high co-pays for medications that the prescriber considers the best treatment for the patient but are not on the PBM formulary, or shipping medications that are temperature/humidity-sensitive from mail-order pharmacies without adequate protection and resultant deterioration and loss of potency of the medications.

Pharmacists are expected to agree to the terms of non-negotiable contracts with egregious terms and abysmal compensation that is often less than the cost of the medication paid by the pharmacy. If pharmacists do not agree with the contracts, they risk being excluded from the pharmacy network of the PBM. More than any other factor, the largest PBMs are responsible for closures of thousands of independent and chain pharmacies because they could not survive financially. This has resulted in the continuously increasing number of "pharmacy deserts" and increased challenges and delays for patients in obtaining needed medications.

As a consequence of their rapid growth, influence, and dominance of the medication use and distribution system, the largest PBMs have become highly visible to the public and legislators. They are greatly concerned about what they have learned about the PBMs usurping the authority and autonomy of prescribers and pharmacists, and the profits they have

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acquired for "managing" an increasingly dysfunctional drug use and distribution system that is incurring costs that are not sustainable. There is bipartisan legislative support for PBM reform.

Reform and action

The "management" and control of the medication distribution and use system by the large PBMs is damaging to the effectiveness and safety of drug therapy for patients and the financial survival of community pharmacies. Their intrusion into the healthcare system adds substantial costs that are not necessary. They can be replaced by much less costly systems for processing prescription claims. Bipartisan legislative support and extensive media coverage that is highly critical of the PBMs provide an unprecedented opportunity to achieve PBM reform. Some of the actions that have already been initiated are identified below, as are additional recommendations.

1. On May 22 the House of Representatives passed a budget reconciliation bill that includes language that would eliminate PBM spread pricing and require transparent and fair reimbursement (Medicaid fee-for-service-rate) in state Medicaid managed care programs. It is essential that the Senate retain this language or support even stronger reforms as it considers the bill. It is also necessary that President Trump support and approve the PBM reforms in the bill. His statements identify his awareness of the concerns that pharmacists and others have voiced and suggest his intent to take appropriate actions. We must not underestimate the wealth and political influence of the large PBMs, and it is very important that pharmacists and others continue to urge our legislators and the President and those who advise him of the urgent need for reform.

2. At the urging of state pharmacist associations and NCPA, legislators and governors in an increasing number of states are enacting PBM reforms. Examples include the following:

   a. Ohio officials successfully sued several PBMs and also enacted a single PBM program (SPBM) for the Medicaid program that resulted in net savings of nearly $140 million over the first 2 years.

   b. Arkansas has approved legislation that prohibits state permits to pharmacies that are owned by PBMs.

   c. Alabama has approved legislation that will require PBMs to reimburse independent pharmacists at least at the state Medicaid rate for prescription drugs.

   d. In addition to Ohio, Kentucky, Louisiana, Mississippi, and Virginia have enacted legislation to use just a single PBM to administer the states' Medicaid programs.

   e. North Dakota has enacted strong PBM licensure legislation.

   f. Indiana has enacted legislation to establish minimum pharmacy reimbursement levels in the commercial market.

   These actions are excellent and the pharmacists, pharmacy associations, legislators, governors, and others who persevered to achieve this progress are to be highly commended! However, most of these laws address one component of the egregious PBM programs. If it is not under development already, the NCPA should develop model legislation that addresses all of the policies/terms of PBM programs that should be reformed.

3. The profession of pharmacy should explore the establishment of a profession owned and operated program for the adjudication of prescription claims.

4. Independent pharmacists that have not already done so should explore membership/affiliation with the Community Pharmacy Enhanced Services Network (CPESN).

5. Approximately 80% - 90% of prescriptions dispensed in community pharmacies are for medications that are available generically at relatively low cost. Independent pharmacists should consider declining participation in PBM controlled programs that do not provide equitable compensation, and only dispense generically-available medications on a cash basis that includes the product cost and a professional fee that is sufficient to provide a reasonable profit. Some pharmacists have successfully implemented such a practice model, and their experiences should be identified and shared with those who are in a position to consider such changes.

6. Pharmacists who are currently employed at Rite Aid, Walgreens, and CVS stores that will be closed, and who are in a financial position to do so, should consider purchasing the prescription files and necessary inventory, renovate the building to include the prescription department and other healthcare products and services, and rent the remaining unoccupied space.

Daniel A. Hussar
DanH@pharmacistactivist.com

Chain Chaos

During much of the last 50 years the number of chain pharmacies significantly increased while the number of independent pharmacist-owned pharmacies has declined. Walgreens, CVS, and Rite Aid dominated the growth of "traditional" chain stores by opening new stores and acquiring smaller regional chain stores and independent pharmacies. At the peak of their growth Walgreens and CVS each operated about 10,000 stores, and Rite Aid operated approximately 5,000. In addition, some national (e.g., Kroger) and numerous regional grocery stores opened pharmacies, as did "big-box" retailers (e.g., Walmart, Costco, Amazon). Specialty and mail-order pharmacies also emerged.

The closures of independent pharmacist-owned pharmacies have greatly accelerated during the last decade resulting in a large number of "pharmacy deserts." The increasing dominance of the largest PBMs and health insurance companies with their egregious and anticompetitive policies and inequitable compensation for pharmacists has made it extremely difficult for community pharmacies, particularly independent pharmacies, to survive financially. I have voiced my strong concerns about these situations and the implications for the entire profession of pharmacy in numerous issues of *The Pharmacist Activist.*

The chaos in the community pharmacy marketplace also extends to the corporately-owned chain stores such as Rite Aid, Walgreens, and CVS. Their circumstances differ and are considered individually.

Rite Aid

The demise of Rite Aid started years ago because of the greed and fraud of its then CEO, Martin Grass, son of the founder of Rite Aid. He betrayed his family, his company, and its employees, and was prosecuted, convicted, and served a prison term. A parade of subsequent CEOs has failed to rescue the company, and efforts to sell it (i.e., to Walgreens and Albertsons) were not successful. Through the sale of some of its stores and the closure of others that were "underperforming," the number of its stores declined from approximately 5,000 to about 1,250. Rite Aid filed for bankruptcy and developed a plan for reorganization but, not surprisingly, failed to do even that successfully. Most recently, it has filed for bankruptcy again and all of its remaining locations will be closed or sold.

Rite Aid pharmacists, some of whom have been with the company for decades, are victims of the company's failed management, as are other employees. Executives will fare well financially for "managing" the bankruptcy and beyond, whereas most other employees will receive little or no financial assurances while coping with the termination of their employment and the need to find other employment in a tight job market.

Patients will be greatly inconvenienced as their prescriptions will be transferred to another pharmacy which may not be in close proximity to the Rite Aid store they have been using. The profession of pharmacy will be challenged in helping Rite Aid pharmacists and technicians identify other pharmacy employment opportunities in a volatile marketplace.

In a Reuters article on May 21 titled, "Court approves fire sale of most of Rite Aid's pharmacy assets" (Sabrina Valle and Dietrich Knauth), it is reported that Rite Aid sill sell prescription files for about 8 million customers to 13 buyers. It has buyers for the files at 810 of its stores but does not yet have buyers for the files at more than 200 others. CVS is the largest buyer and has agree to acquire 64 store locations and the prescription files at 650 other locations.

Walgreens

In my editorial, "The Walgreens Disaster," in the March issue of *The Pharmacist Activist*, I address the financial challenges the company has experienced that have resulted in its sale to the private equity company Sycamore Partners. I also recommend actions for Walgreens' pharmacists, NCPA, and APhA to consider. Walgreens has been closing hundreds of its underperforming stores, but its sale is not associated with the same abruptness and urgency as the second bankruptcy proceedings of Rite Aid.

I have serious concerns about what I consider to be potentially damaging consequences of its sale. However, in a recent discussion with one of the highest-ranking pharmacists at Walgreens, I was pleased to hear his optimism about both the professional and financial future for the company. I hope he is right!

A CNBC commentary (Annika Kim Constantino) on May 11 is titled, "Walgreens doubles down on prescription-filling robots to cut costs, free up pharmacists amid turnaround." It is noted that the number of its retail stores served by its micro-fulfillment centers will be increased to cut costs and free up time for pharmacy staff so they may interact directly with patients and perform more clinical services such as vaccinations and testing. It quotes Walgreens chief pharmacy officer as stating, "It gives us a lot more flexibility to bring down costs, to increase the care and increase speed to therapy – all those things."

I have often heard statements like these from Walgreens and other corporate pharmacies but have not seen the outcome fulfilled of freeing up the time of pharmacists so that they can spend more

time with patients. The primary, if not the single, purpose of increased automation/robotics is to reduce costs, and it is probable that some of the cost reductions will result from reduced pharmacist staffing in the stores. More pharmacist time with patients in providing counseling and services is a myth in these companies.

CVS

Of the three largest traditional pharmacy chains, CVS is the best positioned financially. However, it is not without challenges that have resulted in the recent replacement of its CEO, numerous lawsuits regarding alleged fraudulent or otherwise inappropriate activities, harmful medication errors, extensive negative publicity, and walk-outs of its pharmacists to protest understaffing and intolerable stressful working conditions. Of all pharmacy-related companies, it is the most reviled within the profession of pharmacy and by many of its own employees. This is due in large part to its ownership of a large health insurance company (Aetna), a PBM (Caremark), and mail-order pharmacies that enable it to engage in anticompetitive programs that jeopardize the survival of independent and smaller chain pharmacies, as well as the understaffing of its stores and the very stressful working conditions for its pharmacists and other employees.

CVS pharmacists and presumably other employees are expected to complete company-developed educational modules. One of these modules focuses on the CVS Health Code of Conduct that includes a message from the recently appointed President and CEO of CVS Health. He states: "We have a clear opportunity to position CVS Health as the leading health care innovator…" I agree that opportunity exists, but it will not happen unless there are dramatic changes in company and management priorities. He goes on to note: "..let's make sure our actions and decisions always reflect the spirit of the Code and align with our purpose 'of bringing our heart to every moment of your health.' By embracing these principles, we can make CVS Health a place where our work is built on trust, integrity and a shared commitment to improving health care for all Americans."

These could be fine statements but they are not credible because they do not reflect either the workplace culture or the actions and decisions of company executives/management. My observation is that the company will terminate pharmacists and other employees for policy violations that may be minor or accidental, whereas executives and other decision-makers appear to escape any discipline when government agencies and other organizations file lawsuits for alleged illegal and/or fraudulent/harmful actions of the company. Financial settlements up to billions of dollars mean never having to admit wrongdoing or even apologizing.

The comments of former CVS pharmacist Katie Forbes in a recent WISHTV (Indiana) interview (Danielle Zulkosky) stand in stark contrast to those of the CVS CEO. She left CVS because she felt that the staffing levels were unsafe and led to frequent medication errors. She reported many of her concerns to the Board of Pharmacy and subsequently left CVS when she felt intimidated by management because of her decision to speak up. The following are excerpts from her interview:

- "Medication errors are out of control at every pharmacy. It's not just an isolated incident. Patients are getting the wrong medications, they're getting other people's meds, and I just don't know how CVS has gotten away with this for so long."
- "The purposeful understaffing. They kept perpetuating this issue that there's a staffing issue, there's a pharmacist shortage, there's a technician shortage. There's no shortage at all. We have enough technicians. We have enough pharmacists. They're not allowing us the hours."
- After noting that trusting CVS with a prescription could be dangerous, she noted: "Absolutely. I would not recommend picking up scrips at CVS. You don't know if you're getting the right pills in the bottle, you don't know if it's somebody else's drug, you don't know if it's been mislabeled, you don't know if you're missing some."

Which is the real CVS? The one described by its CEO or the one experienced by Katie Forbes? We know the answer, and that it would be confirmed by a large percentage of current CVS pharmacists if they could do so anonymously. Although she left CVS, Katie Forbes is to be commended for her courage in publicly sharing her experience and alerting current and potential customers of the risks. CVS is addicted to profits and positive changes can't be expected. Business will continue as usual with harmful errors and resultant lawsuits and settlements viewed as a "cost of doing business."

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, 756 Billy Drive, Lancaster, PA 17601
E-mail: info@pharmacistactivist.com

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