The Pharmacist Activist

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"The Lord is my shepherd, I shall not want." Psalm 23:1

Editorial

The Future of Pharmacy Practice

Which of the following do you consider to be best positioned to address the topic, "The Future of Pharmacy Practice?

a. American Pharmacists Association (APhA)
b. American Society of Health-system Pharmacists (ASHP)
c. National Community Pharmacists Association (NCPA)
d. American Association of Colleges of Pharmacy (AACP)
e. American College of Clinical Pharmacy (ACCP)
f. Joint Commission of Pharmacy Practitioners (JCCP)
g. National Association of Boards of Pharmacy (NABP)
h. None of the above

The AACP is holding its annual meeting this month and approximately 2,000 deans, faculty, and other members/friends of the "Academy" are convening to attend plenary and educational programs, to participate in roundtable and poster sessions, and to conduct the business of the Association. I perused the program to view the topics that have emerged as the most important and timely since I retired from my faculty position. Dozens of topics are to be considered in presentations I am confident will be excellent and informative. However, there are a few topics I consider of importance that I was not finding until I located one toward the end of the scheduled programming – "The Future of Pharmacy Practice."

To return to the above question, the correct answer suggested by AACP programming is "h" – none of the above. Although the topic is presented at the AACP meeting, the full title of the presentation mentioned above is, "The Future of Pharmacy Practice: Innovation in Action at CVS Health." There are three CVS pharmacists (presumably in mid-level management positions) who are the speakers in what is designated as a "sponsored session." Are there no deans or faculty who have the vision and boldness to address the topic of the future of pharmacy practice, or to provide a counterpoint or alternative view to what CVS will present? Are AACP and most other national pharmacy organizations defaulting on this topic and allowing CVS to define and implement what it wants the future of pharmacy practice to be? In my opinion, CVS Health is the worst organization to which AACP could provide a platform to voice its views about the future of pharmacy practice. The reasons for this opinion include:

- CVS makes decisions based on their profit potential, and not on the welfare and safety of its customers and employees. It is not a healthcare provider; it is a healthcare "pretender," and should be exposed as such.
- CVS ignored and tried to suppress information about the suicides of FIVE CVS pharmacists and technicians within a 5-month period in eastern Pennsylvania last year.
- CVS understaffs its stores, creating a stressful and dangerous workplace environment that increases the risk of errors and mental and physical health challenges for pharmacists and other staff, and anger and criticism of customers.
- CVS considers errors and settlements of dozens of lawsuits in the amounts of billions of dollars as costs of doing business.
- CVS has committed fraud in numerous prescription benefit programs that has been discovered and partially recovered by federal investigations and investigations in numerous states.
- CVS steers customers in its plans to use its stores or its Caremark mail-order pharmacies.
- CVS cheats independent and other pharmacies by paying them less than its own pharmacies for dispensing prescriptions for patients covered in its prescription plans.
- CVS is an anticompetitive predator that has acquired many independent and smaller chain pharmacies, or created

Contents

pressures that have made it impossible for them to survive financially. CVS is alleged to have had a major role in the bankruptcy of Rite Aid and the closure of all of its pharmacies. Rite Aid investors have filed a lawsuit against CVS.

- CVS has threatened to close all of its 134 stores in Tennessee because of legislation recently approved that prevents a company from owning pharmacies and a PBM (Caremark). There are several messages in this threat. Caremark is more profitable for CVS than its 134 stores in Tennessee, and it will not consider closing or divesting Caremark. If its lawsuit is rejected, how does the CVS threat to close 134 stores in one state reconcile with its future of pharmacy practice. Would its plan be to steer its prescription customers in its 134 stores to its Caremark mail-order pharmacies?
- The Florida Attorney General has issued a subpoena to CVS Health Corporation and Caremark for alleged anticompetitive practices harming Florida families.
- CVS in-store pharmacists are among the company's strongest critics. One pharmacist has stated, "I feel I am a danger to the public working at CVS." A former CVS employee who was a friend of one of the Pennsylvania CVS pharmacists who committed suicide stated, "CVS management has blood on their hands."
- CVS is destroying the profession of pharmacy. I have stated this opinion and my reasons in previous issues of The Pharmacist Activist. Many readers have voiced their agreement but most pharmacy leaders have been silent.
- CVS wants to reduce the number of pharmacists it employs by understaffing its stores, providing financial incentives for its customers to use its mail-order facilities, and by increasing its use of central-fill facilities, robotics, artificial intelligence, and other technologies. In addition, the toxic culture and negativity in its stores is a deterrent for its college-bound employees to want to study for and pursue a career in pharmacy, thereby reducing the pool of applicants for colleges of pharmacy. What could be of greater concern for the many colleges of pharmacy that are already not meeting enrollment goals?
- Experience has demonstrated that CVS can't be trusted.

I have not heard or read the CVS presentation on the future of pharmacy practice, but can anticipate much of its content. I will read it if and when it is available. If AACP or deans and faculty feel that any of my observations are inaccurate, I welcome hearing from them. If AACP and other pharmacy organizations continue to be silent on important issues, is the CVS plan the one we want our student pharmacists to hear and embrace?

But wait! Maybe I have misjudged AACP and its members. Perhaps providing CVS a platform to discuss the future of pharmacy practice and CVS "innovations," is part of an AACP strategy to learn CVS's plans, and to then provide an appropriate rebuttal/response. We should know soon.

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Dr. Who?
Opportunities for Colleges of Pharmacy

The title is the beginning of a longer title of a first-page article, "Dr. Who? The Nurse Practitioner Will See You Now," in *The Wall Street Journal* (May 18, 2026: Te-Ping Chen). The commentary identifies nurse practitioners as the fastest-growing field in health care, and involving responsibilities such as examining patients, making diagnoses, and prescribing medications, "just like a physician." However, the nurse practitioners whom the writer interviewed do not hold the title of "Doctor." Although Doctor of Nursing Practice (DNP) and PhD degree programs in nursing are available, nurse practitioners typically complete advanced nursing programs that qualify them for certification for the role/credential of nurse practitioner.

Medical practice groups typically include physicians, physician assistants, and nurse practitioners. Each of these individuals has the authority to diagnose medical problems and prescribe medications, but only physicians hold the title of "Doctor." Approximately 30 states have provided nurse practitioners with the authority to practice without physician oversight, and about 10 states permit physician assistants to practice independently. It is noteworthy that there is growing momentum to change the designation Physician Assistant to Physician Associate.

Some medical practice groups also include pharmacists. An increasing number of states have permitted pharmacists to diagnose certain medical problems and prescribe medications to treat them. However, this prescribing authority is much more limited than that of physician assistants and nurse practitioners. Pharmacists have had far more extensive coursework and experience with respect to the properties and use of medications than physicians, physician assistants, or nurse practitioners. The drug therapy knowledge and expertise of pharmacists would be an important and valued addition to medical group practices, but steps in this direction are evolving slowly.

In the January, February, and March issues of *The Pharmacist Activist*, I and others urged reconsideration of pharmacy degree and licensure requirements. An additional option that was identified was the establishment of a combined dual-degree program in which students would earn both a Doctor of Pharmacy degree and a degree in Physician Assistant Studies. Several colleges of pharmacy have developed such programs but, to my

knowledge, no college of pharmacy offers a dual-degree program in which students earn a Doctor of Pharmacy degree and a Nurse Practitioner degree. Participation in such an integrated program would not only extend the expertise of the students, but would also increase the roles, responsibilities, and opportunities of the graduates.

Many of the didactic and experience components of the current Pharmacy and Nursing programs overlap, and efficiencies can be attained by designing an integrated program that would meet the licensure requirements for both pharmacists and nurse practitioners. Many colleges of pharmacy are in universities that also offer nursing degree programs, and this would facilitate the consideration of establishing a combined program.

I urge the colleges of pharmacy that are in a position to do so to actively explore the development of an optional dual-degree program that would enable participants to earn both Doctor of Pharmacy and Nurse Practitioner degrees. I recommend that an initial goal be to construct a combined program that students can complete in seven years (post-high school), and that would include a pharmacy PGY-1 residency and the equivalent experience now required in Nurse Practitioner programs.

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The Tennessee Pharmacy Ownership Law (continued)

In the May issue of *The Pharmacist Activist*, I discussed the recently approved law in Tennessee that would prohibit companies from owning pharmacies and PBMs. Soon thereafter CVS challenged the law in federal court and Express Scripts and the Pharmaceutical Care Management Association (PCMA) have subsequently filed lawsuits. The court has not yet provided a response.

CVS wants the legislators and the public to believe that the law will require that it close its 134 stores and certain other facilities in Tennessee. This is blatant deception! The law provides CVS with the choice to either close/divest its pharmacies or close/divest its Caremark PBM. CVS has not even mentioned divesting Caremark as an option which sends a message in itself that Caremark's value, profits, and lack of transparency are of far greater value to the company than its stores. CVS's threat to close its stores is accompanied by its disingenuous concerns that customers will be disadvantaged, and that Tennessee employees in the stores will lose their jobs. But that choice and decision would be made by CVS and not made or forced by anyone else or a law.

Express Scripts also resorts to threats and scare tactics in challenging the Tennessee law. Unlike CVS, Express Scripts does not own local community pharmacies, but it does own Accredo Specialty Pharmacies, one of which is in Memphis. The designation, "specialty pharmaceutical," was initially applied to medications that were very expensive and used for the treatment of rare and complex diseases, and which required special storage, handling, and/or complex instructions for preparation and administration for optimal use. Almost all of these medications are sent by mail or other delivery services to patients. However, as PBMs, health insurance companies, and pharmaceutical companies recognized that this limited distribution system could be profitably exploited by restricting distribution and manipulating supplies and costs/revenues, many specialty pharmacies significantly increased the number of medications they dispense based only on their high costs but not the other criteria by which medications were initially considered to be specialty pharmaceuticals. Examples include orally, topically, and self-administered subcutaneously injected medications that are very expensive but require no special instructions or other measures for appropriate use. These medications could be more conveniently and safely dispensed by a local community pharmacy but are only available from one or more specialty pharmacies.

A news release on June 12, 2026 is titled, "Express Sxcripts Sues to Preserve Access to Care for Tennesseans and Prevent Closure of Major Memphis Specialty Pharmacy." The lawsuit requests that the court strike down a state law that will reduce access to prescription medications and health care for hundreds of thousands of Tennesseans. Other statements include:

> "The law….will force hundreds of pharmacies to shutter or relocate—including Accredo Specialty Pharmacy's Memphis facility."
>
> "Accredo Specialty Pharmacy shipped over 168,000 prescriptions that treat complex diseases to more than 132,000 patients in 2025."
>
> "Many of these patients critically need these medications and cannot get them anywhere else. More than 20 different medicines treating a range of conditions including certain types of cancer and spinal muscular atrophy are available to dispense only through Accredo."

It is ironic that the statements of Express Scripts essentially acknowledge what has been one of the strongest criticisms of the PBM that it operates in a monopolistic, anticompetitive manner. Why should certain medications be "available to dispense only through Accredo," and patients who need them "cannot get them anywhere else?" Is this not monopolistic control over the distribution of medications for which patients have a "critical need?" Is the Federal Trade Commission (FTC) investigating this anticompetitive control over the availability of such important medications?

Express Scripts fails to acknowledge in its statements that there are numerous Accredo Specialty Pharmacies throughout the

country, and it attempts to scare patients and legislators into thinking that if the Memphis facility closed or relocated that patients with critical needs would not be able to obtain their medications. However, medications dispensed by Accredo are almost always sent to patients via mail or another delivery service. It makes no difference to a patient whether their medication is sent from Memphis or Missoula!

Other Actions Against PBMs

In Florida, the Attorney General has issued a subpoena to CVS Health Corporation and Caremark for alleged anticompetitive practices harming Florida families. The news release includes the following statements:

> "The probe examines whether CVS/Caremark steers patients to its own locations, reimburses its affiliated stores more generously than independent pharmacies for identical prescriptions, imposes burdensome audits that claw back payments, and enforces restrictive contracts that threaten small businesses. Such practices allegedly contribute to pharmacy closures and 'pharmacy deserts,' leaving families and seniors with fewer options and higher costs."
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> "The Civil Investigative Demand requires thousands of documents and sworn testimony on reimbursement rates, pharmacy contracts, patient steering, audits, rebates, differential treatment of own versus independent stores, and expansion plans. Compliance is required by July 28, 2026."
>
> "This action requires fair play so no company harms Florida families by limiting choice and inflating the cost of essential medications."

In 2023, the National Community Pharmacists Association (NCPA) formed TRUST, LLC to support pharmacies in investigations and potential litigation to recover direct and indirect remuneration (DIR) fees charged to the pharmacies. Representing almost 5,000 independent pharmacies, on July 2, TRUST, LLC filed a federal antitrust lawsuit against Prime Therapeutics alleging that it colluded with Express Scripts to fix prices. Because the three largest PBMs (CVS/Caremark, Express Scripts, and Optum) exercise such dominant control (approximately 80% of prescriptions) over the prescription distribution and use system, smaller PBMs that also engage in anticompetitive and unfair business practices often escape attention. However, the prescription marketplace is so large and profitable for those who exploit it that even much smaller PBMs like Prime Therapeutics can use similar practices to operate very profitably with a much smaller share of the overall "market."

Because of its huge market share, Express Scripts is able to provide lower compensation/fees to pharmacies and impose higher DIR fees than much smaller PBMs like Prime Therapeutics. Citing a 2019 agreement between Prime Therapeutics and Express Scripts, the TRUST, LLC lawsuit alleges that Prime adjusted its rates to match the rates of Express Scripts with consequences that reduced payments and increased costs for pharmacies, but further enriched Prime and also had financial benefits for Express Scripts. Although Prime and Express Scripts are competitors, they still find ways to collude for their own financial advantage, but to the great disadvantage of pharmacies, many of which have closed because they cannot survive financially. The TRUST, LLC lawsuit states: "The Agreements allow Prime to effectively rent Express Scripts' substantial market power to impose lower Reimbursement Rates and higher Fees on independent pharmacies, including Plaintiffs, than the pharmacies would otherwise accept." The lawsuit requests the courts to award damages and costs related to the antitrust violations, as well as damages resulting from Prime's breach of contract. Although collusion is alleged, Express Scripts is not named as a defendant. Presumably, this is the first action in a more comprehensive strategy, and one which the profession of pharmacy should strongly support.

In a separate recent case initiated by the AIDS Healthcare Foundation, an arbitrator ruled against Prime last year, determining that Prime violated antitrust laws by price-fixing with Express Scripts. The AIDS Foundation was awarded $10.3 million, and Prime was barred from continuing the arrangement.

Prime's response to the TRUST, LLC lawsuit includes the standard refrain employed by PBMs which are accused of unfair, deceptive, and/or illegal operations:

"Prime Therapeutics has played an integral role in bringing down prescription drug costs, and we always strive to balance cost savings for patients with equitable reimbursement for pharmacies. By offering more network options for savings as part of our approach, we've driven lower costs at the pharmacy counter for tens of millions of Americans, while delivering billions of dollars in savings for the patients, health plans and other clients we serve."

The Prime response contradicts the overwhelming experience and opinions of the public, federal and state agencies, and other organizations that provide/sponsor prescription benefit plans, which contend that drug costs in this country are far too high. When Prime or other PBMs provide responses like this, they should be requested to identify specific patients and full financial documentation of the lower prescription costs they claim!

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