SAN DIEGO — With signs of strain appearing throughout the nation’s health care system, retail pharmacy has arrived at a pivotal moment in its history. Efforts to control expenditures for prescription drugs have helped give rise to a whole host of challenges — everything from the proliferation of mandatory mail-order programs to drug importation and proposals to cut Medicaid reimbursement rates. At the same time the federal government is moving ahead with plans to implement a drug benefit for senior citizens, and pharmacists are being called upon to help improve the overall quality of health care.

To better understand those issues and what they mean to the industry, Chain Drug Review recently brought together a group of retailers and suppliers to gain their insights. The focal point of the roundtable, which was held in conjunction with the National Association of Chain Drug Stores Pharmacy & Technology Conference, was community pharmacy, but the discussion extended to related areas, particularly pharmaceutical manufacturing and pharmacy technology.

The retailer participants were John Fegan, vice president of pharmacy at Ahold USA; Dave Fong, corporate vice president of pharmacy at Safeway Inc.; Craig Fuller, president and chief executive officer of NACDS; and Carlos Ortiz, vice president of government affairs at CVS Corp.

Representing the supplier community were Mike Coughlin, president and chief executive officer of ScriptPro; Brad Cunningham, executive vice president of sales and marketing at Clay-Pack Labs Inc.; Monica Gilbert, executive director of health care systems marketing at Wyeth Pharmaceuticals; Linda Pinney, chief business officer of Asters Inc.; and George Stevenson, vice president of the generics business unit at Endo Pharmaceuticals Inc.

Extended excerpts from the discussion, which was moderated by CDR editorial director Jeffrey Woldt, follow.

WOLDT: The overriding issue in health care today is rapidly escalating costs and efforts to control them. Most of the major problems the pharmacy industry faces stem from that question. What are retailers and suppliers doing to meet the challenge?

ORTIZ: Clearly, from a government point of view — whether you’re looking at Medicaid or state employee prescription drug plans — everybody is trying to drive down costs. There seems to be a perception on the part of some policy makers that, regardless of what they do to community pharmacy, somehow the safety net of community pharmacies is always going to exist.

But that safety net and the infrastructure of community pharmacy are being eroded by the constant emphasis on bringing down costs, without taking into consideration the value pharmacy delivers.

FEGAN: We constantly focus on cost, but has anyone really done a good job of looking at the benefit that expenditures on prescription drugs bring to the equation? Yes, we’re spending more on pharmaceuticals, but that is what is done in terms of admissions to hospitals, stays in hospitals and the number of surgeries performed?

That’s the factor that’s missing. Different organizations have looked at it, but no one’s really done a good job of bringing that to the table.

GILBERT: John’s right. An integrated look is critical for interpreting the value of investments in health care and the such questions as, Are we driving people into the emergency rooms and spending really, really big dollars?

However, I do think there is some sign at the federal level that they are recognizing the consequences of not taking more attention to the larger picture. The discussion that we have been having during some of the meetings here at our pharmacy and technology conference on medication therapy management is a direct result of the fact that government, as a payer, has begun to realize that it really ought to go back at those areas in health care where most of the money is spent, and you cannot do it just by trying to hold down the costs of medication.

You really need to understand the whole therapy regime if you want to help patients do a better job. That really is what we’ve gotten through with some of our message. But it’s been tough, because people tend to look at these issues in silos.

ORTIZ: They also tend to take a shorter-term view. The federal government is the one that has the biggest vested interest in making sure that the people, as they reach the later stages of their life, are healthier. The view of most employers and most insurance companies is that people are switching jobs frequently, they’re switching health care coverage, so that nobody has a long-term interest in keeping people healthy. And that’s for the federal government.

CUNNINGHAM: A number of shifts have occurred over the last 12 months, and because of them we have these different focuses that we must take into consideration. From the standpoint of a generics manufacturer cost containment is a very, very key factor. There is a lot of differentiation from year to year, but 2003 probably marked the lowest increase of generics costs over the last four years. The average cost of a generic medication went up about 7% last year, compared with about 12% or 13% in recent years.

There’s been a tremendous focus on the PBMs [pharmacy benefits management companies] bringing in step programs to encourage utilization of less-expensive generics instead of the higher-cost branded products.

Last but not least, one of the changes that has really affected the cost of therapy has been a general shift in the therapeutic classes, where cholesterol-lowering drugs are now the No. 1-selling products, and they’re very expensive compared with the gastrointestinal products, which have a tendency to be less expensive. So as these factors shift from quarter to quarter and from year to year, we need to concentrate on lower-cost generics.

COUGHLIN: I would like to go back to something that Carlos said regarding the fraying of the community pharmacy safety net. The industry is in a state of economic vulnerability right now. Look at the rate of the move toward mail order: By the end of the year 24% of employers will have some form of mandated mail order.

Look at the targets of the mail-order industry: They think they’re going to go from 16% or 17% of the market to 40% in two years. And they’re going to try to move out of the maintenance therapies into the acute therapies. This is a very aggressive beast we’re dealing with.

In light of that, community pharmacy needs to look at a new economic model to deal with this vulnerability, to compete and to offer the convenience that mail order offers. There are ways to compete, and not just delivery.

What the industry needs to do is to investigate technological solutions. We’ve already progressed from filling scripts by hand to filling them robotically. We’ve come from systems that were character-based to graphics. There are a lot of exciting new technologies out there. They need to be fused with a better business model, a more comprehensive business model, to come up with a solution that will ensure the continued strength of community pharmacy.

CUNNINGHAM: One of the things that I noticed over the last few months is that the amount of money that goes into lobbying efforts at the federal level. Lobbying on the Medicare Modernization Act cost about $109 million, and there were approximately 526 lobbyists on the brand-side versus 80 for the generics side. Out of that $109 million only $4.4 million was spent on generics.

So when you talk about cost containment and where the focus is for profitability, these are some key areas that would substantiate what you’re saying regarding the importance of technology.

PINNEY: I’d like to comment on what Michael said about mail order. In looking at mail order in terms of total health care dollars spent, I’m wondering what’s going to happen to recidivism into the hospital. For instance, when you consider the portion of the population who are getting maintenance medications for CNS [central nervous system] disorders, are you going to give a patient 90 days’ worth of a CNS medication? Is that an intelligent thing to do? I don’t think so.

And the same thing applies to initial medications. Many physicians want to start with a two-week or a three-week or a four-week supply, and then test blood lev-
get to good policy.” So what we’re dealing with is short-term budget demands, but at the same time we need to be working with the policy makers in developing the right policies for the future.

So if you take a look at pharmacy specifically, technology has a place, mail order has a place and the care that is provided at each and every one of our locations by our professionals has a place. The trick is finding the right economic model that provides value so at the end of the day public policy makers and consumers feel good that we have a product and a service that’s meeting their needs.

WOLDT: Can that be accomplished by just looking at pharmacy or does the entire health care system really need to be reengineered?

FONG: Too often, we as pharmacy practitioners are tactical in the way we address the challenges in our profession and business. We need to be more visionary and strategic and be willing to work more closely with each other.

STEVenson: I agree that we tend to take a tactical view. The product we’re focused on is pain medication, but the press tends to emphasize its addictive properties rather than its ability to provide cost-effective pain relief for millions of people in this country.

We always seem to be behind as an industry, behind this tactical eight ball. We don’t see the strategic objective as far as what the American public believes. We’ll have to deal with that as an industry.

PineNy: I’d like to get back to the business model for pharmacy that we were discussing before. First of all, pharmacists are some of the most underutilized health care professionals we have. Who is more knowledgeable about the total medication regimen of a patient these days than the pharmacist? Nobody. With the demands of managed care physicians are not able to collaborate with each other in the prescribing process. So you have got a cardiologist prescribing one thing and a psychiatrist another and a GP another, and unless one of those is being a totalarian of care, coordination is not happening. In looking at the business model going forward, anything that we can do to value add the pharmacist is going to be important. There are some initiatives in certain states potentially to allow pharmacists to prescribe. That’s a very good idea.

The other way to value add, of course, is an expansion of services inside the pharmacy. I know a lot of folks are doing this already. In most places you have to drive one place for lab work and another for community services. Bringing those services into the pharmacy will drive up not only the pharmaceutical dollar sales but also, we hope, the other dollars that are being spent in the stores. It will provide more of a central place to go for health care.

FULLer: The question Jeff asked is an interesting one in terms of reform of the health care system as a whole. There is a lot of discussion now in Washington regarding that subject, and we predict that no matter who wins the election, the issue will remain on the front burner. This is an area where retail pharmacy should be applauded for the number of things it has done.

I really appreciate what Dave said. Dave’s part of a group, as are others, that formed and helped develop SureScripts. SureScripts today has been enormously successful at bringing retailers together with the physician community and even the manufacturers to provide real electronic connectivity for prescribing that is going to eventually provide a foundation for a number of reforms.

Some people in Washington have been approaching it as a big bang theory: They theorize that one day we’re going to wake up and we’re going to have electronic medical records in every physician’s office and we’re going to get rid of paper. That’s not going to happen. But today the biggest impediment to more rapid adoption of electronic prescribing is getting the physician to adopt it. Even so, it’s really beginning to happen.

Because it has invested in technology for electronic prescribing and in technology for automating the whole dispensing process, retail pharmacy has the ability — once the physician and the patient have agreed on a medication — for that prescription to travel electronically through an automated system that will go into a queue to be filled and be ready for the patient when he or she walks through the door. John and his team have been doing this for some time now at [Ahold’s] Giant-Landover stores.

In this case retail pharmacy has been a leader in reform that will eventually encourage greater participation by physicians in hospitals. But the reform has to occur in an evolutionary way. Each step must be evaluated. We have actually been encouraged by some of the people inside the [Bush] administration now who are looking at what actually has been done in the marketplace for the last couple of years regarding electronic prescribing.

WOLDT: Carlos, have you perceived that the thinking of people in Washington is changing on health care?

ORTz: I’ve been thinking about Alan Greenspan’s comments yesterday, which I found very interesting and a bit chilling with regard to Medicare, the fact is that the senior population isn’t filling or taking 25% to 30% of their medications. If they are forced to use it. It also presents the reasons everyone here is suggesting.

It’s become apparent that the model we’re used to today, but the whole population with a Medicare-endorsed dish rate might be different from what we see today. And a lot of reformers are thinking about how to reform prescription. Thus we’re going to see a very high recidivism rate into the hospital.

A study really needs to pinpoint people buying long-term care insurance.

GILBERT: A number of themes have been brought up here. Regarding a change in the business model just in pharmacy, I would suggest that it’s an entire market reform that’s needed on all fronts. It is a function of misalignment of incen-
to wait for the problem to be solved in Washington.

But, as Monica said, we can seize opportunities in dealing with this issue. If you look at the likely elements in the new business model, they are largely within the grasp of pharmacy. One of them is efficient prescription filling, bringing down the cost of filling scripts at retail to a competitive level. Right now they range from slightly not competitive to way, way out there. The $4 range is competitive in my view.

Achieving that involves good systems and 100% pharmacist utilization. What Linda was saying about pharmacist utilization is absolutely important; that is the key cost element. The model needs to also include a number of other elements to make pharmacies dispensing 250 scripts a day competitive with a huge factory that is filling tens of thousands of scripts a day.

Community pharmacy has to have systems that allow it to participate in manufacturer rebate flows, and the only way it’s going to be able to do that is to demonstrate that it has the metrics to affect branded drug market share. If pharmacy cannot do that, it will never participate in the rebate flows and a huge cost gap is going to be there. And just as Greenspan said yesterday, that cost gap is going to have to be reconciled somehow.

Retail pharmacies need to be able to promote patient persistence and patient compliance, and they need to systematically get compensated for that. They need to offer mail at retail for the convenience factor. But as Craig says, even if it is offered a lot of people don’t want to use it, and that’s been demonstrated. But it’s better to offer it and keep the customer in your store rather than say we don’t have it and lose that customer.

They need to be able to promote patient persistence and compliance and systematically compensated for doing this. They have to get revenues from cross-selling and copromotions. They should be promoting safety and accuracy. The fact is that mail-order operations have said a lot more about safety and accuracy than retail pharmacy. Mail-order operations have promoted pharmacist availability and customer service more aggressively than retail pharmacy.

Those are elements of an overall system model, and they’re all within the control of community pharmacy — not working alone, but in the context of working with system vendors, payers (such as regional health plans) and pharmaceutical manufacturers.

FEGAN: As advanced technology becomes more readily available we have the opportunity as operators to bring that into our pharmacies and to allow our pharmacists to do things differently. That’s part of the strategy. In addition, I applaud NACDS for reaching out to the FMIs [Food Marketing Institute] and NCPAs [National Community Pharmacists Association] of the world and forming coalitions.

With the creation of SureScripts we’re beginning to work with doctors. So now we have coalitions that are connecting with other health care sectors, and then, internally, we as operators are beginning to use the best technology available.

Are we there yet? Absolutely not, but from my perspective we’re making tremendous progress. But we’ve been behind for so long that we still have an enormous challenge in front of us.

WOLDT: George, as a supplier how do you view the retail pharmacy business and the progress it’s made?

STEVenson: At the end of the day we need the retailers to buy our products. We’re proud of the fact that we ship at a 100% service level. That’s been our goal from day one, because what we don’t want is a patient to walk into an an Ahold store or a Safeway store and not have that pain relief medication available. That wouldn’t be servicing the retail pharmacy very well. So we rely on retail pharmacy to bring our products to the marketplace and provide that pain relief to those patients who need it.

WOLDT: One area that has been the subject of a lot of talk over the years, but not seen a lot of action, is closer cooperation between retail pharmacy and
I'd like to echo what Carlos
The subject of cost
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today, yes it is. And we have
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al reason to bring all the parties together
able, but they have to be explained and
used properly, and so there’s just a natur-
al reason to bring all the parties together
to get that message out.
We’ve achieved that with some of the
public policy issues. But it occurred to
a number of us recently that we need a
stronger communications program and a
 succinct common message about the real
value of using medications properly. The
Sarasota Group came together with that
objective in mind.
I’m very encouraged, because I think
it has been a real meeting of the minds.
The tactical approach Mike spoke about
is going to be, of necessity, the priority,
but I think we need to do a better job as
combined industries, helping the policy
makers and the consumer understand the
real value of medications used prop-
erly. If we’re successful in achieving that
then I believe the public will begin to
understand the cost issues.

STEVENSON: In my own experience
— and I think all of us would probably
agree — if you were to go to a neighbor-
hood gathering and ask people about the
pharmaceutical industry, you’d find that
most of them have no knowledge of the
way it works. They know what they hear
on television or what they read in the
paper, but they really have no idea of the
ments of how we, on a consistent
basis, can effectively communicate
with our consumers the value of our
message on good pharmacy care. As
was said earlier, at the end of the day
desires want to feel good about
their experience with pharmacy and
their health care, in terms of both
dispensed product and service; if they’re
definitely what they expect from us, then
our value to them will be
questioned.
The only concern I have is making
sure that we sustain that message
consistently over time so that we
make a significant and lasting impres-
sion on the consumer. We
don’t want to issue one mess-
with one next. When we’re
talking about pharmacy care and what
elements contribute to the high quality of
that care, want our message to be
forceful and systematic.
Another point I’d like to make is that
if we create a communications strategy,
we simultaneously create an expectation
on which we, as providers, will need to
deliver. If we don’t then that message will
mean very little. As was said earlier, con-
sumers want to feel good about their
experience with health care, in terms of
both product and service; if they’re not
getting what they expect from us they’re
going to have some doubts.

ORTIZ: If we don’t change the
debate from cost to value it’s a no-win sit-
tuation. As things stand, CVS is not just
competing against Safeway and Ahold,
we’re competing against the pharmaceu-
tical manufacturers.
That’s a competitive situation that we
probably can’t win and thus isn’t prof-
it able for us to engage in. So the only way
to eliminate that natural competition that
occurs between manufacturers and retail-
er is to make the debate about value.

GILBERT: I agree. The
discussion can no longer be
just about cost. There has to be
a value debate. At the core
of our business is the innova-
tion of our research, and
innovation is a key piece of
the value equation. You have
quality and you have cost and
value; but what does quality
mean and how do you
demonstrate quality improve-
ments? Where’s your base
line, and how does that
change over time?
Regarding the discussion of
a tactical versus a strategic
approach — you need both.
The Sarasota Group is a great
opportunity to get into an
appropriate discussion on
the role each will play. But the
group needs to be more inclusive. Because value
is made up of medical services and costs, as
well as drug costs.

WOULD: Brad, how do the generics
companies fit into this equation?

CUNNINGHAM: The subject of cost
versus value is a very pertinent one. From
a generics standpoint, there has been
a lot of pressure to try to maintain costs,
especially with the volatility of API inter-
nationally. It’s been quite critical, because
there is a variance of API costs when it
comes down to making a generic product.
The value that the generics bring to
the table really accentuates the relation-
ship with retailers, because they really are,
in a sense, the end-users. Our concern
with patients is important, but we get the
most extensive and honest feedback from
retailers. Because we understand that cost
alone will not increase market share. So
there’s an opportunity for us to value in
the manufacturing of generics through the
relationship with retailers.

FEGAN: I’d like to echo what Carlos
said. The manufacturer has become our
competitor. Further, how do we convince
the consumer that we as retailers and
manufacturers, in partnership, are bring-
ing them value when they’re looking to
Canada, mail order and reimportation for
their prescription drug need? That’s
the question the Sarasota Group needs to
answer.

GILBERT: Do you view the competi-
tion as a function of price?
FEGAN: Today, yes it is. And we have
to change that.

GILBERT: One of the most impor-
tant discussions for the Sarasota Group to
have been pricing differentials. It’s also
clearly an opportunity for the phar-
aceutical industry to talk about what
our business is all about, the risk involved
in pursuing innovative research and the
realities of market dynamics.
But then, as a group, we must decide
who will deliver the message. As Dave
was saying earlier, we need to craft a
strong message and then sustain it in a consis-
tent way over time in order to establish credibility with
the public.

FULLER: Monica raises a good
point. Through whom do we deliver the
message? Our members feel very strongly
that the pharmacist should be at least
one channel.
We became curious during the debates
on Medicare reform last year about what
people were asking pharmacists, so we
ran some focus groups with pharmacists.
We found out, of course, that patients
were asking questions about all the issues
we’ve been raising here — Medicare,
importation and mail order — because
they trust the pharmacist, even if it is
someone they don’t know.
We also learned two things: One, that
pharmacists are too busy to spend as
much time with patients as they’d like;
and two, that they weren’t getting as
much information from their own compa-
nies as they needed to be able to give
their customers fully informed responses.
Pharmacists, by nature, are empathetic
with that patient across the counter. They
want to be able to provide better informa-
tion. They want to be able to have a lot of
the tasks behind the counter taken care
of so that they can engage in a dialogue
with their customers. So the more we
enable our pharmacists to be the deliver-
er of our message, the better off we’ll be.

GILBERT: Craig touched on two very
important points. One is credibility: We
want our message delivered to the con-
sumer by someone he or she trusts, and
who better than their local pharmacist?
As we all know, pharmacists are consist-
tently rated one of the most trustworthy
professionals in the country.
The other point was education. There’s
going to have to be a concerted
effort to educate pharmacists, and
through them, the public about the real
cost of health care — not just drugs but
all aspects of the system.

Pharmacy needs to leverage its rela-
tionship with the consumers. That links
directly into medication therapy manage-
ment services and the potential policy
implications of that. We know that we
have the mentioned market share; I would suggest
it needs to be more granular, it needs to be
captured at the consumer level.

PINNEY: I agree that pharmacists
need to be pulled forward from
behind the counter. The fact that they spend 50%
of their time managing third-party payer
claims and dealing with all the issues
behind the counter is a major weakness in
the system. The pharmacist is the last
person with whom the consumer talk to before they
go home with their medication.

COUGHLIN: I agree with Monica’s
point about the need for market share to
be granular. If you analyze cost pressures,
the employers have to pay the bills, and so
you end up with multilevel rebates. But
patients are finding ways around higher
copays.

They arrive at the pharmacy with their
prescription, but when they find that the
copay’s high they ask the pharmacist
if there’s a less-costly alternative. It’s going
to be a different brand and a different
class. So the pharmacist has to go to a lot of
effort to meet that need. The physician
has to get involved. The drug manufactur-
er loses the sale of the drug that was origi-
nally prescribed. Every party in the
provider chain loses. The pharmacist and
the physician waste a lot of time, and the
drug manufacturer loses the sale.

We need systems in place that allow
those situations to be identified and
action to be taken on a granular level with
that patient — maybe it’s a coupon or a
copromotion — to save that prescription
at the point of sale.

That approach would be better for the
industry as a whole. It’s a very
healthy approach. What we are saying,
we have to be able to deliver on the
plan; we have to have a sustainable system
to show that this can be done. Manufact-
urers could redirect some of their
dollars spent on physician detailing and
focus them at the point of sale with much
better results.

CUNNINGHAM: I’d like to comment
on Monica’s point about education.
There’s an old retailer in New York that

Chain Drug Review/October 11, 2004
says that an educated consumer is its best customer. There’s a lot to be said for that because there is a general lack of understanding of pharmaceuticals and there are many assumptions made about them.

The general public doesn’t really understand how the system works. They look at it from a pocketbook perspective, and they assume that the product they’re getting is the product they need, no matter what they pay or where they obtain it. That’s simply not true. For example, they are probably not aware that there are no regulatory statutes covering reimported products. So we’re going to have to increase awareness levels through advertising and, to Linda’s point, by bringing pharmacists forward. But educating the consumer about all these issues will be a tremendous challenge.

WOLTD: This might be a good moment to shift to a discussion of more specific issues. Importation certainly is something that’s on the minds of everyone in the industry. Carlos, maybe you could talk a little bit about that.

Carlos Varner, president and CEO of CVS Caremark Corporation, has a different view of the subject than many people.

ORTIZ: I’d like to clarify Tom’s position because there has been a lot of misunderstanding of what he actually said. Tom’s point was that the discussion has been focused on the differentiation between the price of a given medication in the United States and in Canada, England or Ireland, and there’s no discussion about whether in fact it’s a fair price in Canada, or a fair price in England or Ireland versus the United States. What he would like to see is the pharmaceutical manufacturers — led, in part, by government trade negotiators — establish global pricing. Tom feels that the huge differentiation in the pricing structure between Canada and the United States cannot be sustained long term, and that it has probably to be sort of a new era of trade negotiations.

But until those trade negotiations occur, you have to take importation — which is essentially a crime — out of the shadows and bring it into the light, so that there can be some safety surrounding the delivery of pharmaceuticals. The only way to do that is to allow to the infrastructure that exists in the United States, with all its checks and balances, to have access to those prices rather than have people continuing to deal in the shadows with a less-than-open type of delivery system.

We need to equalize the pricing between the United States and the rest of the developed world. Maybe there’s a justification for having lower prices in third-world countries, but clearly, industrialized nations should not be paying a much lower price than the United States.

FONG: Regarding the importation issue, there has to be significant changes to the current pricing of drug manufacturers before there’s any kind of parity as described by Carlos. Clearly, internationalized nations should not be able to pay a much lower price than the United States.

WOLTD: Monica, let me ask you, as the only representative of a branded pharmaceutical company here, to comment on this question.

GILBERT: Importation is less about getting a drug from a different source than it is about importing the price. I agree that the largest issue is pricing differentials globally. There are a number of factors that influence price. That’s why education is so important. The United States, for all intents and purposes, is the last free market in the world; the government sets prices in most other developed countries.

Change should begin with the value debate. We have to make people aware of the quality of the product they receive from us, how that quality is achieved and the role drugs play in reducing the cost of health care — both for the individual and the health care system as a whole.

I’m encouraged by what I see of the government’s interest in getting feedback and engaging in a dialogue about issues within the industry, not the least of which is supply chain integrity. We need a candid discussion about all the implications of allowing importation.

FULLER: The importation phenomenon is a result of many people not having health insurance. Ninety percent of the people purchasing medications from retailers here in the room have some kind of coverage, be it private plans or government plans. The people who don’t have coverage, if they go to a retailer, have to pay full price — many times, a very steep price. So going to Canada or Mexico or purchasing drugs on the Internet becomes almost a necessity. One answer to this dilemma is to have manufacturers and retailers work together to build on the Medicare-endorsed discount drug card program and, in that way, perhaps reach the uninsured.

Importation as it’s practiced today is dangerous and illegal. It’s going to put an increasing amount of counterfeit drugs into the health care system in this country, and that’s not a good thing. So, if we’re going to find ways to reach the uninsured and offer them a more competitive price, some would stop buying drugs from other sources.

It’s not only important economically for us and for the safety of the population, but politically as well. We must demonstrate that we can step up to the table and come up with industry solutions to this problem.

Looking ahead, a Kerry-Edwards administration would probably lead the charge to allow importation, while a second Bush-Cheney administration would probably watch the charge from Capitol Hill and not be able to stop it. There’s no question the debate is going to occur. We also have to be honest with our policy makers that this is not in any way a viable long-term solution.

I suspect that we are going to have to figure out some kind of a mechanism to deal with this issue down the road, perhaps during the second cycle of the next congressional session. In the meantime, it would be very useful to see whether manufacturers and retailers could come up with ways to really directly benefit the uninsured. As I suggested earlier, backing the Medicare-endorsed discount card seems to me to be a temporary solution.

FEgan: There’s a pilot program going right now with Accenture and some of the retailers at table and two of the big pharmaceutical wholesalers.

PINNEY: There’s a lot we can do in terms of technology to help make the supply chain work more efficiently, and also to speed up the prescription-filling process so that the pharmacist can spend more time with the patient.

FEgan: But there’s one hurdle that has to be overcome. The boards of pharmacy are very restrictive in what they allow pharmacists to do. While the technology exists, we can’t implement the boards because of the boards’ set ways of doing things — the old-fashioned way.

PINNEY: Actually we’ve been out to about six boards to familiarize them with our ScriptCenter prescription drug vending machines and have been pretty well-received. I think it’s because they’re beginning to see how the technology frees the pharmacist to spend time with patients.

We’re working on technologies that deliver results to patients. Right now, we’re trying to find ways to bring an electronic prescription in, scan it and send it out to a central fill facility immediately so that it can start processing it through Mike’s machine. Then you wouldn’t have that gap of eight hours wondering what you’re going to see in the morning.

FONG: I’d like to make a couple of comments. First, with RFID what are we trying to achieve? We’re trying to ensure integrity of the product as it moves through the supply chain. We need to stop focusing just on RFID and think instead about what kind of technology would be optimal for accomplishing that goal. As an industry we have not done a very good job of educating the policy makers both at the legislative and the regulatory levels about the cost of doing it.

I’d also like to comment on the regulators and their perspective on updating pharmacy law to provide for the changing pharmacy landscape. I had the pleasure of meeting with several members of the California State Board of Pharmacy to see new technology that would enhance pharmacy care and service while protecting the safety of our customers. They were impressed and supportive that regulations should not discourage, but encourage contemporary pharmacy practice. Our industry and profession need to continue to work with the National Association of Boards of Pharmacy [NABP] on areas for regulatory change to enhance pharmacy care.

There is an opportunity in this coming year to reengineer the program. The time frame is short because we have enrollment starting in November. We need to learn from this past year and step up the information to provide more clarity on options for our senior citizens and to know what program works best for them.

ORTIZ: Pharmacy regulations often suffer from the law of unintended consequences. We have a situation in New Jersey and New York where, in order to cut down on Medicaid fraud, they are mandating a specific prescription form, which is taking us backward rather than forward. It’s nonreproducible, so we’re having trouble
scanning it into our system. In addition — getting back to e-prescribing — many state boards have problems with it. So we’re ready to move forward on these two fronts, but the states are moving backward.

WOLDT: Let me switch gears again and ask about the Medicare drug discount card program. Craig, would you like to comment?

FULLER: First of all, what retail pharmacy anticipated — that, after the Medicare Modernization Act was passed, the pharmacy would be the gatekeeper to what would go to get information about the cards — became the reality. For instance, the pharmacy-centered programs — the Pharmacy Care Alliance [a joint venture between NACDS and Express Scripts Inc.], the CVS card and the Walgreens card and others — together have attracted several hundred thousand customers. So it is important to make sure that policy makers understand that people who want to learn about a program, sign up for it and utilize it are likely to do it through their local pharmacy.

The discount card program was launched with the government saying — for both practical reasons, because the Department of Health and Human Services had problems with its web site, and for political reasons, because one political party didn’t want the other to get an advantage — go slow, take your time. That was the message at the very moment when all the voices should have been trying to explain to seniors how this was valuable.

If a senior who is eligible for transitional assistance under the program has not signed up for a card, he or she is missing out on $200 that they can use over the next 12 months on their medication, and they would be able to apply that to drugs that are sold at lower cost. So we very much want to see the people that we captured in Pharmacy Care Alliance re-up, and we want to push to get other people signed up.

We didn’t start the Pharmacy Care Alliance to have the most successful card; we did it to demonstrate that retail pharmacy could present an offering to seniors that would be beneficial to them. Additionally, we wanted to have real-world experience to help shape our input as the regulations for the government-funded prescription benefit that goes into effect in 2006 are written.

Seniors who utilize the card are saving millions of dollars. That’s a success story. Thousands of seniors have signed up through their pharmacies for the program, and that’s a success story. So, with all the confusion that was out there it’s no surprise that the numbers were smaller than we thought they would be, but we are continuing to see growth.

FONG: Knowing what we know now, do you think there’s an opportunity for us to reenergize the program before the 2006 benefit goes into effect?

FULLER: I think there is. The card programs that are pharmacy-centered are the successful ones for the most part, and we’ve been focusing on the message that $1,200 over 12 months is no small matter for eligible seniors, and that’s what’s available if they sign up before November. We are hopeful that, in conjunction with the efforts of CMS [the Centers for Medicare and Medicaid Services], retail pharmacy can help rekindle interest in this program, because the benefits are very real.

FONG: The only reason I asked that question is because there was a lot of vitality at the retail level when the Pharmacy Care Alliance came out with its card. Consumers benefited from what we shared with them about the value of the program. Unfortunately, they simultaneously received negative messages from the media and other interest groups.

The opportunity in this coming year to reenergize the program. The window is short because we have reenrollment coming up again in November. But, if possible, we’d like to have the opportunity to migrate the value and offer another option to seniors if they decide not to participate in the drug benefit program. Pharmacy ought to step up and provide that today instead of after the drug benefit takes place.

WOLDT: George, how do you view the Medicare drug card program?

STEVENSON: In the case of generics, there already exist other programs that are substantially lower than branded products. In our case we also have a branded business, so we are participating in the discount cards on that side of the business. So there’s really not much impact on generics, because they are already priced lower.

WOLDT: Carlos, going forward, what lessons do you hope CMS will take from the discount card programs as it finalizes the regulations for the federally funded drug benefit for seniors?

ORTIZ: One issue I would like to see address is the confusion on the part of seniors, particularly on the Medicare Advantage portion of the program. There’s going to be the same level of confusion there as exists with the discount card. There’s going to be a plethora of programs out there, and hopefully the government has learned that everyone’s going to have to make the message very simple and very consumer-friendly.

WOLDT: John, do you think the burden of delivering the message — whatever it turns out to be — will fall primarily on the pharmacist?

FEGAN: I do. In fact, in talking to representatives of the Pharmacy Care Alliance, the food store industry did a pretty good job promoting the card and enrolling people. We may not fill as many prescriptions as the traditional drug store, but we have had an awful lot of questions coming through our pharmacies every week, and that puts a burden on us and our daily operations. Not that we’re not willing to accept that responsibility, but it’s beyond the scope of what we traditionally do in the prescription-filling process.

GILBERT: The pharmacist needs detailed information, because there’s going to be a range of actual benefits. The government is just laying out what is a standard, but the actuarial equivalents may vary.

FONG: And then you layer on the coordination of benefits, depending on whether it’s a primary or secondary payer, and has complex implications which could affect workflow and service.

WOLDT: For retailers that would seem to be a distressing prospect.

FEGAN: Absolutely. Our pharmacists are confronted with this daily.

WOLDT: I’d like to switch the topic to the ongoing problem of efforts to cut Medicaid reimbursements. Dave, you’ve had experience with it recently in California.

FONG: The new governor wants to partner with the pharmacy community and has expressed his support of good policy for reasonable reimbursement for pharmacy product and service while recognizing the importance of containing health care costs in the state. We will work closely with the administration, and we are hopeful for this coming year that we can institute good policy.

WOLDT: Is the industry as a whole making an effective case to Medicaid administrators that pharmacy services are important?

ORTIZ: The battle is being fought on a state-by-state basis constantly. We still have a major ongoing conflict in Michigan. Medicaid costs are now approaching 30% of many state budgets; if Florida they just exceeded education as the No. 1 line item in the budget. And even though drugs are only a portion of that total, it’s going to continue to be an issue for a long time.

How much of the population should a state be expected to support? Twenty-five percent of Maine’s population is on Medicaid. How can it continue to sustain that level of support? I just don’t know.

FEGAN: In addition to the issue of more and more people becoming Medicaid recipients, in pharmacy we’re confronted by the state’s unwillingness to give us pertinent information in real time. For example, there’s the pharmacy and coinurance criteria that we don’t get timely data on, and then a year later the states are coming back to us and asking for repayments. We’re in constant discussions in New England about maintaining adequate technology to help us do our jobs.

FULLER: We’re very concerned about what’s happening with coinurance in Florida. The co-pay has gone from zero to 50 cents to a $1 to $3, so that now you have a situation in which, under the coinsurance requirements, the co-pay could go up to $7. The inability of people to fulfill or to honor their copay obligation is going to put the burden squarely on pharmacy. It’s a huge issue.

FONG: With the requirement that the pharmacy fills the script, Policy makers set this up with absolute predictability, but it’s not workable; retail pharmacy pays the price. We’re very concerned about it.

I agree with what Dave said about California, that the administration there is addressing this issue in a more comprehensive way. But at the end of the day policy makers really come after both manufacturers and retail pharmacies to drive us down to what it costs to process — actually below that. And then when a retailer says, “Well, we give, we’re not participating,” then they take a look.

The situation with hospitals should serve as a red flag to our industry, and to government as well, about the unintended consequences of policy that has not, perhaps, been completely thought through. When Medicare reimbursements changed, hospitals all over the country went out of business. The intent was not to drive rural hospitals out of business, but that’s what happened.

Unfortunately, the battle lines tend to be drawn on an issue-by-issue basis — whether it’s surviving completely, in the case of many independent pharmacies, or whether it’s maintaining the service levels that the chains want to provide. That’s all too often what the debate centers on. That’s why the value message has to be instilled more effectively in the public mind and brought into our discussions with policy makers, so that the states continue to be under the gun, and it’s going to be a very tough battle state by state.