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[00:00:08] **Speaker 1** So, easy questions to start. Just tell me a little bit about yourself as a pharmacist and the owner of this business.

[00:00:22] **Speaker 2** Yeah, thanks for letting me be here today. I'm Nicole Schreiner. I am a pharmacist for over 25 years and I am the current owner and CEO of Strews Pharmacy in Green Bay, Wisconsin.

[00:00:36] **Speaker 1** And how long has shrews been around?

[00:00:40] **Speaker 2** Strews has been serving their community for over 70 years and it's been kind of passed down through different families and generations and now embarking on a new generation with me and another business partner as we move into this part of the you know the 2025.

[00:00:58] **Speaker 1** So tell me a little bit about what you personally like the most about being an independent pharmacist.

[00:01:07] **Speaker 2** The part that I really enjoy is really making a difference in patients' healthcare decisions and helping them navigate some of those decisions, helping them be compliant with medications and just being a part of a total healthcare team. I've described to some of my staff and colleagues that medicine has become very specialized. Patients might have a neurologist, a cardiologist, a behavioral health physician. And a primary care provider, and I feel like sometimes I talk about them being tiles on the wall. And I feel pharmacy is that grout that holds it all together and keeps it all from falling off the wall, and because we're the ones who are kind of doing a lot of that communication back and forth between the providers and the patients because we see them on a regular basis.

[00:01:58] **Speaker 1** Um. So, very broadly, what are some of the biggest issues facing local independent pharmacies?

[00:02:10] **Speaker 2** Yeah, the broad answer to that is the reimbursement that we're getting from PBNs or pharmacy benefit managers has made it a very challenging environment to be able to properly staff and be a viable business in the community.

[00:02:26] **Speaker 1** And tell me a little bit more about reimbursements.

[00:02:29] **Speaker 2** Sure, so I've got to give you just a little bit more history from my perspective at least on pharmacy benefit managers, or PBMs, in that they existed, they did exactly what they were called to do, or what their name means, is they managed the pharmacy or the medication portion of a patient's health plan. And they were looking to control costs by deciding on formulary and negotiating prices with drug companies. That made them. It was very competitive when they first came out. In the 60s and 70s, there was, at their peak, I think they were well over 50 different PBMs that existed. Now, currently, there are three PBM that control 89% of the lives in the United States. So it's become very powerful, and independent pharmacies like myself have no negotiating power anymore with these PBM's. And so the contracts have become basically take it or leave it. They've continued to erode year after year after a year. And it's estimated that independent pharmacies, depending on your particular location in the country, can have anywhere from 20% to 40% of their claims are actually reimbursed below cost.

[00:03:48] **Speaker 1** And so what is the end product of that then?

[00:03:54] **Speaker 2** Meaning.

[00:03:55] **Speaker 1** What are the consequences?

[00:03:57] **Speaker 2** Oh yeah, the consequences are, well one, NCPA estimates that one independent pharmacy closes every single day. So one, just the feasibility of having an independent pharmacy is becoming very challenging. Pharmacies that are doing, are hanging in there or trying to weather the storm, are having to cut staffing and resources. Less able to do some of the wonderful services that we do, such as device training, coaching on chronic disease state management, whether that be diabetes, high blood pressure, other types of interventions. We offer things like delivery service and medication packaging to help people be more compliant with their medications. It's endangering those services that pharmacies provide oftentimes at no charge to patients.

[00:04:55] **Speaker 1** Are independent pharmacies very different from chain pharmacies.

[00:05:01] **Speaker 2** I believe so, which is why I chose to become an independent pharmacist. I believe that we are able to offer a personalized service. We pride ourselves. I oftentimes don't even like to use the word retail because I don't want to be associated with the product or just the dispensing of the medication. I want to a member of the patient's healthcare team and I want it to be an essential part of that healthcare team in helping patients understand their medications and being compliant with their medications. So I believe, because we are independent and answer mostly to ourselves, we have the ability to be nimble and change more quickly and adapt to the needs of the patients on a regular basis.

[00:05:44] **Speaker 1** Um so talking a little bit more specifically about some of what is in this piece of legislation um it covers a lot of different things um there are some things that are very specific to pharmacies yes so one of them is reimbursements what would it do

[00:06:06] **Speaker 2** So a couple things with the reimbursement. One is it would address that there would be a minimum requirement for a dispensing fee. So right now, dispensing fees can be $0.50 under $1. And that's supposed to cover your label, your bottle, your labor, all of the other things for your fixed cost. And we all know that $0,50 to $1 doesn't go anywhere near. Especially when we're not even getting the ingredient costs to cover the cost of the medication itself. So it would have a minimum dispensing fee associated with that. In addition, that bill also would allow patients to allow the manufacturers that have copay cards that would allow patience to utilize those and allow those to go towards their deductible. The bill also in terms of reimbursement would allow me to deny service or to say to patients that this particular product is not, is reimbursing under my cost of my, my purchase price of the medication. Right now I have to treat a patient as a whole, meaning that if I, I have that patient's entire medication profile at my pharmacy and I'm losing money, I can't just say I'm not going to dispense this medication. So I have a couple examples. One is a class of medications that is being commonly used to treat diabetes called GLP-1s. Those, some pharmacies are just choosing not to carry them because they get reimbursed below their cost and they can't say that I'm not gonna dispense just that one medication. So they just don't carry them because they can afford to. And I had an example this last year with patients that I had one patient, I added up all of her medications. She had 10 or 11 medications, and I ended up owing the PBM over $50 at the end of each month because I was taking losses when you totaled up all of her prescription reimbursement, my margins on all of meds. So it's just not a feasible model for independent pharmacy to continue to operate.

[00:08:13] **Speaker 1** Does that leave the patient in a difficult position if their medications are so expensive that pharmacies might not want to dispense to them?

[00:08:25] **Speaker 2** Absolutely, it's creating an access issue for patients. Whether the pharmacies choose not to carry them because of the losses that they're taking, where's that patient gonna go? The pharmacies going out of business is creating shortages for patients in particular areas. We oftentimes talk about in rural areas, patients having to travel perhaps 20 miles to find a pharmacy that would be able to provide their medications. And, but we're having that even in urban city areas where patients who don't have access to transportation other than public transportation having difficulties finding a pharmacy that's gonna be able to serve them, take their insurance. Some pharmacies are choosing not to carry particular plans because of the poor reimbursement. For instance, our pharmacy did an analysis of our major payers. And we decided not to sign contracts with two of the major PBMs in our area and that was just because of the poor margin that we were taking and we tried to renegotiate those contracts and we basically got a reply that was this is what we have to offer and at this time we are not adjusting any of our our contracts so it's it's take it or leave it you get what you get and that unfortunately, is, is... We have no power to negotiate anything better.

[00:09:57] **Speaker 1** We spoke a little bit about Kolschmitnik and how there was a service that he didn't get that his father got from a local pharmacy. Can you describe what you think is the benefit of this legislation? And not speaking to coal specifically, but in general, that it would provide.

[00:10:32] **Speaker 2** So, in general, I believe every pharmacist wants to do what's right by their patient. And unfortunately, sometimes metrics and being able to stay afloat makes you make choices that you wouldn't otherwise make in a place of freedom. And so, this bill would, first of all, allow us to have proper reimbursement that would hopefully allow them to have an adequate amount of labor. That when you get these confusing rejections or even a paid claim when we run them through the computer system, but higher co-pays, sometimes those require a degree of research. Is the patient deductible? Is this no longer the preferred product? What is the preferred project? Do we need to get a therapeutic interchange or an alternative product for that patient? That is all very time consuming. And not reimbursed. And so if you're not even making a reasonable margin on your product that you are able to dispense, it certainly doesn't allow for time to be able to do these above and beyond the routine.

[00:11:47] **Speaker 1** With these systems being so complicated, how likely is it that we can be proper consumers if we're not experts in all this stuff?

[00:12:02] **Speaker 2** Yeah, that's a good question. I think what we're trying to make people aware, actually at just one of my recent meetings, someone asked the question at a pharmacy meeting, what tells you that something is changing in the world of community pharmacy? And I said that more people actually even know what a PBM is. So I think we're tying to educate. I think patients oftentimes think that because the medication is costly. That the pharmacy is the one that is pocketing that money. And it's just, it's not the case as we gave the statistics of every, all these pharmacies closing across the nation, other pharmacies filing bankruptcy. We know that it's, it not in the pharmacy's model that is making all of the money. And yet we see PBMs becoming. In the top Fortune 50 companies in the United States. And they're doing it because they have the power to be able to do this now because of the amount of lives that they control with the top three PBMs.

[00:13:12] **Speaker 1** Um, I don't think we covered it here yet, um, can you share again the chain pharmacies that...

[00:13:22] **Speaker 2** Yeah, I don't have the exact numbers, but it's public information. Walgreens made an announcement. I believe they're closing over 2,000 stores nationwide, which I believe they had just over 8,000, so coming close to a quarter of their stores nationwide are closing. Rite Aid, I believe it was earlier this week, just filed bankruptcy. So it's very difficult if these change that have thousands of stores can't make it go. Because they lack the power to negotiate with these PBMs. It's very concerning how someone like me, who owns one location, is going to have any negotiating power.

[00:14:03] **Speaker 1** Why can't manufacturers who, to some degree, are probably also frustrated with PBMs and pharmacies circumvent PBM?

[00:14:17] **Speaker 2** Oh, that's a convoluted story. So we haven't even talked about wholesalers and buying groups, which are also part of that. Very few products are purchased directly between a pharmacy and a pharmaceutical manufacturer. They have to go through this whole chain of which I believe there is a lot of waste in there. We have wholesalars who are also on the Fortune 500 company, on the fortune 500 list. And then you have a buying group, which everybody has to take their little piece of the pie, as well as the pharmacy benefit managers. So sometimes if we could be able to purchase these drugs more directly from manufacturers or get rebates from them, I'm not going to say that manufacturers are innocent in this whole thing either. Some of their products are quite costly. But also the United States is, in their defense, one of the highest innovators in research and development in the world. And so that's part of you have to pay for a lot of medications that don't make it to market. And a lot that goes to that. And I believe, as we did briefly mention with the copay cards from manufacturers, they tried, in my opinion, to make baby steps towards trying to help patients be able to afford their medications with these patient assistance cards. And then PBMs took it as a way to say, well then it can't apply towards your deductible. And so it took that baby step away from the manufacturer even trying to help the patient to make that happen.

[00:15:58] **Speaker 1** Can you briefly describe how vertical integration is something that also ends up harming local source.

[00:16:10] **Speaker 2** Yeah, so that's been a challenge to vertical integration, meaning that sometimes health plans own their own PBM. Sometimes PBMs own their pharmacy. And so they restrict or require patients if they're on that particular health plan to utilize their pharmacies or utilize their PBM So just for example, like CVS Caremark is a is a PBM. And they prefer patients to use their pharmacies or CVS. So that becomes very challenging because either patients are restricted and not able to use an independent pharmacy or if their plan allows them to use independent pharmacy, they may be paying higher call pays. So that's just one example of vertical integration. Optum and United Health is another example of a vertical integration So it just becomes more challenging because the power then becomes even bigger and again doesn't allow us to have that negotiating power and the ability to

[00:17:17] **Speaker 1** What does Felskowski's bill address then?

[00:17:20] **Speaker 2** It does not, as far as I know, it does not address any vertical integration, however, Arkansas just passed PBM reform in their state, I believe at the beginning of the month, that does not allow any PBM to operate a pharmacy within their state if they have financial.

[00:17:39] **Speaker 1** Okay, so I thought maybe the networks piece of the bill addressed that, but that's-

[00:17:44] **Speaker 2** It wouldn't make it inappropriate to have or illegal to have vertical integration, but it would allow access. So I apologize for not understanding the question appropriately. Yes, the bill does allow patients to have freedom of choice, so they would not be required to use either a mail order or a chain pharmacy or any one particular pharmacy. It would be any willing provider would have the ability to be able to provide care for that patient.

[00:18:14] **Speaker 1** Um... Anything about... Other fees like claim processing, performance-based, network participation, accreditation, are those things that are also any particular pain for pharmacies or is it death by a thousand cuts?

[00:18:47] **Speaker 2** Exactly, it is because there we do pay a switch fee meaning so because we send the claim through electronically through the computer every time you process the prescription the PBM and the switch all take a fee out of those. They're small but when you're talking about processing potentially 30,000 claims in a year or in a month that adds up very quickly and so you're losing another portion of that reimbursement for those fees that are paid. In addition, there used to be what was called DIR fees that were meant to help pharmacies be higher performing pharmacies, making sure patients were compliant, they had certain disease states, that they were on certain medications and that they taking them appropriately. And what would be these fees would then be assessed to us. Retrospectively, meaning that I might not get that fee taken back. So I would get paid a certain amount today, and then that fee would be taken back two to three months later in what was called a DIR fee. Well, we were able to get not that DIR fees went away, but the fees went to being assessed at the time of the claim. However, with even certain PBMs, they take a chunk. Whether that be 10%, 11%, 8%, they take a percentage of that claim, and even if you are a great performing pharmacy, your chance of earning something back is 1%. So those are other fees that, again, get assessed. Some people call them pay to play. It's basically you have your contract, and then you also have these additional fees that go above and beyond on those contracts.

[00:20:36] **Speaker 1** Yes.