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Pharmacists' Perspectives on Current Issues in Pharmacy and Medicare: Findings from 2026 Virtual Focus Groups

A report by NORC at the University of Chicago for the Medicare Payment Advisory Commission



The views expressed in this report are those of the authors. No endorsement by MedPAC is intended or should be inferred.

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Pharmacists' Perspectives on Current Issues in Pharmacy and Medicare:

Findings from 2026 Virtual Focus Groups

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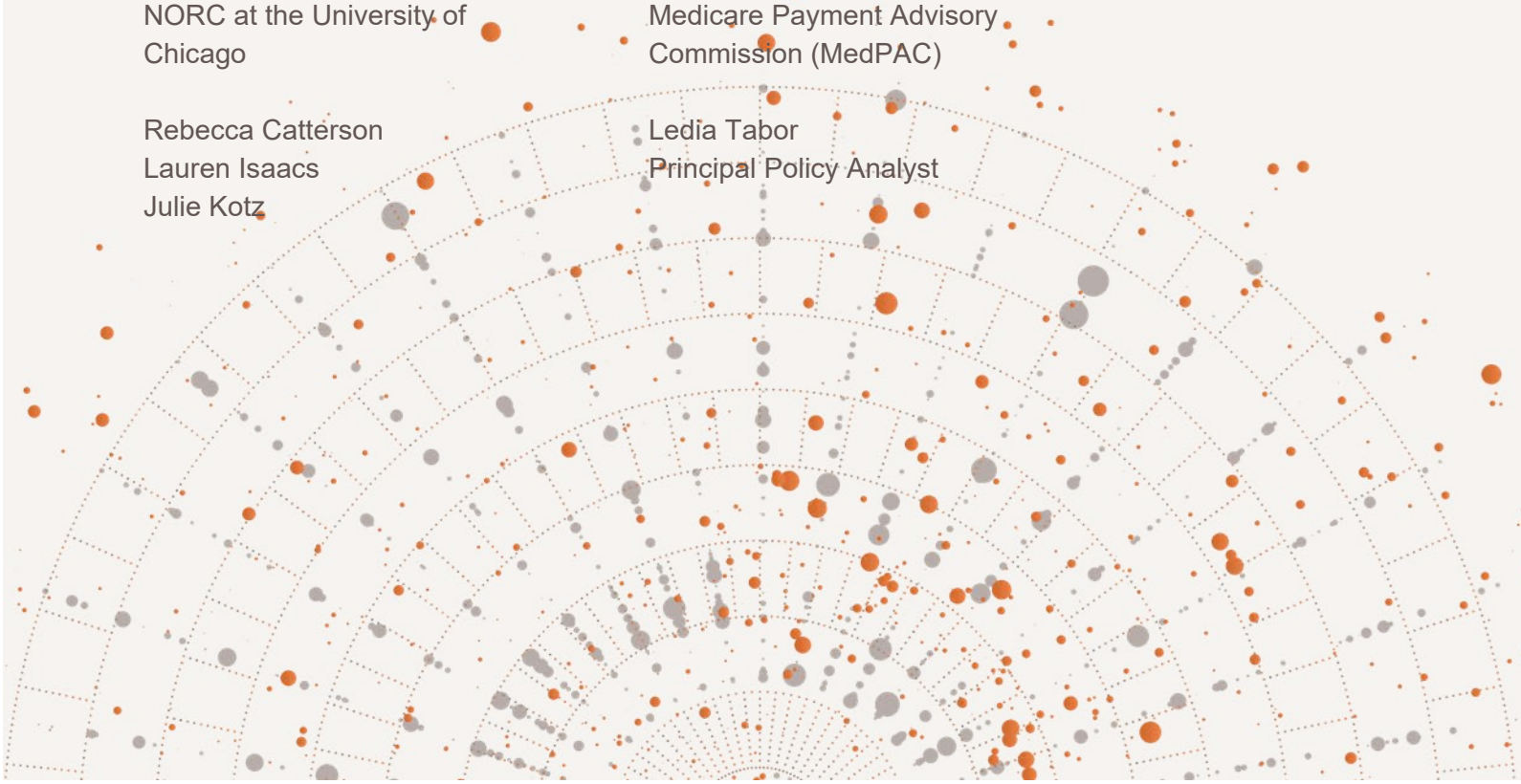


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Executive Summary

Introduction

Pharmacists are often the primary point of contact between Medicare beneficiaries and their medicines. In June and July of 2026, NORC at the University of Chicago (NORC) and the Medicare Payment Advisory Commission (MedPAC) conducted three focus groups with pharmacists across the United States who serve Medicare beneficiaries. Because pharmacists are an important part of Medicare beneficiaries' experience with the health care system, we aimed to learn their perspectives on a range of current issues in pharmacy and Medicare, and how things have changed in recent years. Discussions included pharmacists' insights into their daily responsibilities, insurance networks, prescription drug coverage and costs for Medicare beneficiaries, reimbursement rates, drug stocking and shortages, pharmacy closures, labor market conditions, and pharmacist well-being. Findings from the focus groups with pharmacists provide valuable context for policymakers considering issues that may affect the Medicare program and beneficiaries.

The pharmacist workforce has grown steadily in recent years, increasing faster than the overall U.S. workforce. However, this growth has been driven by jobs added in hospital and other inpatient pharmacy settings, while employment in outpatient pharmacy settings has declined in recent years. Still at least half of pharmacists in the United States work in outpatient pharmacy settings (e.g., chain, independent, outpatient specialty, and mass merchandiser pharmacies) rather than inpatient settings (e.g., hospitals, physicians' offices, and other health care settings).

A review of recent literature indicates that outpatient pharmacists are increasingly balancing longstanding responsibilities (e.g., dispensing medications and counseling patients on their medications) with an increasing demand for revenue-generating services (e.g., immunizations, Medication Therapy Management, testing and treatment services, health screenings, refill services, and home delivery). At the same time, new Medicare initiatives aimed at improving prescription drug affordability, such as the Medicare Drug Price Negotiation Program, the Medicare Prescription Payment Plan, and the GLP-1 Bridge Program, have implications for pharmacy operations and patient interaction.

Recent literature also suggests that outpatient pharmacies are facing insurance-related challenges that add to pharmacists' workload and create financial pressures, and pharmacists in the outpatient sector are navigating pharmacy closures and feelings of burnout. Claim denials add to administrative burden and can negatively impact patient experience. Declining PBM-negotiated reimbursement rates and low dispensing fees have caused financial strain, especially for rural and specialty pharmacies, in recent years. These financial pressures can influence drug stocking decisions, particularly for high-cost medications. More pharmacies have

closed than opened in recent years, and pharmacist burnout is increasing among many dealing with increased workloads. Professional pharmacy organizations have made well-being and burnout prevention a major priority in recent years.

Methods

Given that at least half of pharmacists in the United States work in outpatient settings rather than inpatient settings (e.g., hospitals, physician offices, and other health care settings), and our goal of speaking to pharmacists who interact with Medicare beneficiaries, Medicare drug plans, and other providers who serve the Medicare population, the team set out to recruit pharmacists who work in outpatient settings such as chain, independent, outpatient specialty, or mass merchandiser pharmacies. NORC recruited pharmacists for the virtual focus groups through a trusted market research organization using an online screener, developed in partnership with MedPAC, to assess eligibility and assign participants to groups. The screener assessed pharmacists' practice setting, professional experience as a pharmacist, experience serving patients enrolled in Medicare, familiarity with key topics that would be discussed in focus groups, and demographic characteristics to ensure diverse, knowledgeable participants.

In total, 17 pharmacists from 13 states participated in the focus groups. Nine pharmacists worked in chain pharmacies (e.g., Walgreens or CVS), four worked in independent pharmacies, two worked in specialty pharmacies, and two worked for a mass merchandiser (e.g., Walmart or Costco). Nine pharmacists worked in an urban area, four in a suburban area, and four in a rural area.

Topics discussed in the focus groups included how pharmacists spend their time, insurance networks, prescription drug coverage and costs for Medicare beneficiaries, the impact of reimbursement rates, shortages on product stock, pharmacy closures, the pharmacy job market, and pharmacist well-being. NORC researchers conducted a thematic analysis of the focus group content using NVivo. In this report, we summarize findings from the three virtual focus groups completed in 2026.

Key Findings from 2026 Focus Groups

How Pharmacists Spend Time Across Priorities

Time Allocation and Changes in How Pharmacists' Time is Spent

- All pharmacists who participated in our focus groups reported they spend at least some of their time interacting with patients, and several said most of their time is spent on patient interaction. Other responsibilities that some pharmacists spend significant time on are checking and filling prescriptions and managing technicians. Some pharmacists

said that delegating routine tasks to technicians and automated systems have enabled them to spend more time on patient care.

- Several pharmacists noted an increase in their workload following the onset of the COVID-19 pandemic. The increase in time spent interacting face-to-face with patients is in large part due to prioritizing vaccine administration, which is revenue-generating for the pharmacy.
- A couple of pharmacists spoke positively about spending their time administering immunizations. Some pharmacists who work with pharmacy technicians certified to administer immunizations had mixed views on how beneficial immunization-certified technicians are to a pharmacist's workflow.
- There was a consensus that providing care to patients is the most fulfilling part of being a pharmacist. Common challenges pharmacists reported related to having enough time and staff to complete all daily tasks. Limited staff and time make it difficult for some pharmacists to provide services such as Medication Therapy Management (MTM) and other ancillary services.

MTM and Polypharmacy

- Several pharmacists said that their pharmacies used to have a greater focus on MTM, but this focus has waned in recent years due to a lack of time or staff.
- A few pharmacists who provide MTM highlighted that, though it is time-consuming, it offers benefits to patients and the pharmacy. Some pharmacists pointed out that the time-consuming nature of MTM can result in abbreviated consultations as pharmacists need to help other patients waiting in line, and contacting patients for MTM services can increase demands on patients' time.
- In addition to MTM, several pharmacists described other mechanisms to identify and potentially reduce issues related to polypharmacy. Some pharmacists reported using their states' database of prescriptions for controlled substances, and some are alerted to potential polypharmacy issues by their computer systems or by insurance companies when a patient tries to fill a prescription.

Insurance Networks, Coverage, and Costs to Patients

Insurance Networks

- Pharmacists who work in chain pharmacies reported that their corporate leadership makes insurance contracting decisions. Several specialty or independent pharmacists said they work with a Pharmacy Services Administrative Organization (PSAO) for insurance contracting.
- When plan networks change, pharmacists described needing to explain to patients whether they are in-network, and if so, if they are a preferred pharmacy, and what this means for the patients' out-of-pocket expenses, which the pharmacists do not know until they run the claim.

- A couple of pharmacists in chain and independent settings detailed how contracting decisions and network changes have implications for retaining customers and create administrative burden. A pharmacist who works at an urban, independent pharmacy explained that the impact of their PSAO's decisions can include losing customers.

Coverage and Services

- Some pharmacists were not familiar with the differences between Medicare Advantage Prescription Drug plans and standalone Prescription Drug Plans and indicated that they are not aware of which type of Medicare prescription drug plan their patients have.
- Some pharmacists reported that prior authorization processes create bottlenecks that can delay patients' access to their prescriptions. Many pharmacists described their frustration with insurance claim denials, especially for patients with acute medical needs.
- A few pharmacists reported that some patients have changed to direct-to-consumer or online mail-order pharmacies. However, a couple of pharmacists noted that the availability of in-person consultations with a pharmacist is a benefit that a direct-to-consumer or mail-order pharmacy cannot provide.

Out-of-pocket Costs for Patients

- Several pharmacists noted that their patients enrolled in Medicare or other drug coverage are often unaware of how much their out-of-pocket costs for their medications will be until they fill their prescription. Several pharmacists said they have to educate Medicare beneficiaries about their out-of-pocket costs.
- Some pharmacists noted that a portion of their patients face high cost-sharing for certain drugs. For patients who fill high-cost drugs throughout the year, a couple of pharmacists recounted the difficulty they have had in explaining why the amount that the patients pay out-of-pocket is higher in the beginning of the year before they have hit their deductible. All pharmacists reported that they try to help patients afford their medications at their pharmacy through various means.
- In addition to pharmacists helping patients afford medications at their pharmacy, several pharmacists reported that some patients shop around at different pharmacies to find the lowest price per prescription.
- Many pharmacists agreed that they spend a significant amount of time checking prices across discount programs and tools, and these programs can lead to lost revenue for their pharmacy. Outside of the popular discount tools, few pharmacists discussed other programs that their pharmacies have for helping patients afford their medications at their pharmacies.
- Pharmacists reported limited use of the new Medicare Prescription Payment Plan that allows beneficiaries to spread out-of-pocket costs across the calendar year, citing low awareness among Medicare beneficiaries and challenges with patient education and enrollment. Several pharmacists said that the monthly out-of-pocket costs for beneficiaries with the Medicare Prescription Payment Plan are not transparent or clear to patients or pharmacists. One pharmacist specified that it did not make financial sense to

enroll in the Medicare Prescription Payment Plan for some patients who met their deductibles early in the year or whose out-of-pocket costs were too low to benefit from spreading payments over time.

- Many pharmacists were aware of and knowledgeable about the new Medicare GLP-1 Bridge Program, which offers select GLP-1 drugs to eligible Medicare beneficiaries for a $50 copay. Pharmacists described mixed experiences with patient access to GLP-1 medications through the GLP-1 Bridge Program to date.

Impact of Reimbursement Rates and Product Shortages

- Many pharmacists commented that reimbursement from public and private insurers for drugs and dispensing fees have decreased in recent years. Due to this, several pharmacists have had to find ways to make up for the losses their pharmacies accumulate on filling prescriptions.
- Several pharmacists discussed their pharmacy's approach to automatic refills, the implications for insurance companies' Star Ratings, and how this affects their pharmacy's reimbursement from these insurance companies.
- Several pharmacists reported that they do not do automatic refills and accept that this can lower their contracted insurance companies' Star Ratings, and in turn, the pharmacy's reimbursement.
- Several pharmacists reported minimizing on-hand inventory of high-cost medications by ordering them on an as-needed basis based on patient demand. Less commonly, pharmacists reported not stocking certain generic drugs.
- A few pharmacists explained that they had to make changes to their drug stocking decisions to avoid revenue loss. A chain pharmacist said their pharmacy has shifted many medications, especially brand-name drugs, to a centralized fulfillment center that delivers prescriptions in bulk the next day to the pharmacy to reduce their workload, and a specialty pharmacist noted that they no longer keep non-specialty medications in stock.
- Most pharmacists reported that they have dealt with drug shortages, and some commented that they have had to find workarounds to address drug shortages, such as compounding or coordinating with provider(s) to obtain another prescription for a similar drug.
- Awareness of the Medicare Drug Price Negotiation Program varied among pharmacists, and those familiar with the program reported some reimbursement-related challenges for negotiated drugs.

Pharmacy Closures in the Community

- Many pharmacists described recent closures of pharmacies in their area, which has resulted in an increase in patients seeking services at their pharmacy without a corresponding increase in resources.

- Few pharmacists reported that new pharmacies were opening in their area. A specialty pharmacist in a rural area said that they are opening new locations to meet the needs of people currently driving over 20 miles to their nearest pharmacy.

Pharmacy Job Market and Well-being

- Most pharmacists agreed that it is not difficult to find open positions in outpatient settings, but it is difficult to find attractive positions or hire pharmacists in outpatient settings. Several pharmacists reported that they are dealing with challenges in hiring technicians because it is difficult to offer competitive pay, which contributes to high turnover.
- Several pharmacists reported that the increase in their responsibilities without a commensurate increase in pay is causing burnout. Some pharmacists described still feeling the effects of burnout from the COVID-19 pandemic.
- A few pharmacists described efforts at both the state and organization levels to improve working conditions and reduce burnout, such as mandatory lunch breaks.

Introduction

Pharmacists are often the primary point of contact between Medicare beneficiaries and their medicines. In June and July of 2026, NORC at the University of Chicago (NORC), in partnership with the Medicare Payment Advisory Commission (MedPAC), conducted three focus groups with pharmacists from across the United States who serve Medicare beneficiaries in outpatient pharmacy settings.[i] Because pharmacists are an important part of Medicare beneficiaries' experience with the health care system, we aimed to learn their perspectives on a range of current issues in pharmacy and Medicare. Discussions explored a range of issues affecting pharmacist workload and patient access to pharmacy care, including pharmacists' daily responsibilities, insurance networks, prescription drug coverage and costs for Medicare beneficiaries, reimbursement rates, drug stocking and shortages, pharmacy closures, labor market conditions, and pharmacist well-being. These focus groups provided valuable qualitative insights into the experiences of pharmacists, helping to frame the factors that shape their work and the services they provide. By capturing personal perspectives, real-world examples, and the context underlying key challenges, the findings offer policymakers a deeper understanding of issues that may inform future considerations related to the Medicare program. In this section of

[i] In this report, outpatient pharmacy settings are defined as specialty and retail community pharmacies (e.g., independent, chain, supermarket, and mass merchandiser pharmacies) that are licensed by the State to dispense medications to the public at retail prices. For more information on the definition of retail community pharmacies, visit: https://www.law.cornell.edu/uscode/text/42/1396r-8#k_10.

the report, we provide background information on the topics discussed in the focus groups to provide context for the focus group findings presented in the following sections.

The Pharmacist Workforce

A pharmacist's role extends beyond dispensing prescription medications. Their role includes responsibilities such as reviewing prescriptions for safety and accuracy, assessing potential drug interactions and contraindications, counseling patients on medication use, administering vaccinations, collaborating with other health care providers on medication management, and supervising pharmacy technicians. Pharmacists typically complete a Doctor of Pharmacy degree, and every state requires that pharmacists are licensed to practice pharmacy.[1]

As of 2023, the U.S. Census Bureau's American Community Survey estimated that there were 337,400 pharmacists nationwide, representing 0.3 percent of the country's workforce. Between 2018 and 2023, the number of pharmacists increased each year, with a total increase of 17.8 percent over these five years. In contrast, the total number of U.S. workers aged 25 to 64 increased by 3.1 percent between 2018 and 2023.[2] While the overall pharmacist workforce has grown steadily and at a pace exceeding that of the overall U.S. workforce, this growth is attributed to increased employment in inpatient pharmacy setting. Employment in inpatient pharmacies grew by 3 percent in 2025 and decreased in outpatient pharmacy settings by 5 percent.[3]

At least half of pharmacists in the United States work in outpatient pharmacy settings rather than inpatient settings (e.g., hospitals, physician offices, and other health care settings).[3,4] Outpatient pharmacy settings include chain, independent, specialty, and mass merchandiser pharmacies. A chain pharmacy, for the purposes of this report, is a part of a group of four or more locations under common ownership; supermarket pharmacies are therefore categorized as chain pharmacies. An independent pharmacy is a standalone location or a part of a group of two or three locations owned by an individual or small group. Specialty pharmacies can be in a chain of pharmacies or independently owned and generally dispense a low volume of high-cost prescription medications to patients with chronic, complex, or life-threatening conditions.[5] A mass merchandiser pharmacy is a pharmacy operated within a large retailer that sells a broad range of merchandise in addition to pharmacy services, such as Walmart or Costco.

Under pharmacist supervision, pharmacy technicians perform a variety of daily activities to assist customers in accessing their medications. Responsibilities for pharmacy technicians can include answering phone calls from customers, entering patient information into the pharmacy's computer system, helping dispense medications, preparing and labelling prescriptions, managing inventory, and processing insurance claims. Pharmacy technicians typically have a high school diploma or equivalent and receive on-the-job training, or they may obtain postsecondary education in pharmacy technology. Most states regulate the pharmacy technician profession and may have requirements for formal education and certification. For

instance, pharmacy technicians may be trained and certified to administer vaccines under pharmacist supervision in many states.[6]

Based on projected trends, the pharmacy technician profession is growing. As of 2025, the U.S. Bureau of Labor Statistics estimated that there were 471,200 pharmacy technician jobs. The growth rate for pharmacy technician jobs is estimated to be 6 percent from 2025 to 2035, which is twice the average growth rate across all occupations (3 percent).[6]

Recent Trends in Pharmacy Services and Drug Affordability Initiatives

A review of recent literature reveals that pharmacists who work in outpatient settings are increasingly balancing longstanding pharmacy services, such as drug dispensing and medication counseling, with a growing emphasis on revenue-generating services, particularly immunizations and Medication Therapy Management (MTM). While pharmacists have a long history of administering vaccines, vaccinations became a larger focus for pharmacies following the COVID-19 pandemic when pharmacists were leveraged to improve access to COVID-19 vaccinations.[7] MTM often involves a comprehensive review of all prescription and over-the-counter products to identify polypharmacy[ii] issues or potential contraindications, personalized patient education and counseling, and collaboration with patients' health care providers to resolve medication-related issues. Since 2006, MTM has been a required benefit for eligible beneficiaries enrolled in Medicare Part D prescription drug plans and Medicare Advantage plans.[8]

Pharmacists who work in outpatient settings are also balancing their typical responsibilities with the increasing demand for more ancillary services, which many pharmacists noted are an increasingly important source of revenue for pharmacies. Ancillary services include immunizations and MTM, discussed above, but also include test-to-treat services (e.g., COVID, flu, and strep throat testing), refill reminders, blood pressure and glucose monitoring, and home delivery.[9,10] Home delivery services, which brick-and-mortar pharmacies can provide, differ from mail-order pharmacy services in that mail-order pharmacies only ship directly to patients, do not have brick-and-mortar locations, and are typically operated by a pharmacy benefit manager (PBM).[11,12]

With the aim of improving drug affordability for Medicare beneficiaries, Congress created the Medicare Drug Price Negotiation Program and the Medicare Prescription Payment Plan under the Inflation Reduction Act of 2022. The Centers for Medicare & Medicaid Services (CMS) implemented these programs in 2023 and 2025, respectively, as well as the GLP-1 Bridge Program demonstration in 2026. Through the Medicare Drug Price Negotiation Program, the Secretary of Health and Human Services negotiates with drug companies the price of select

[ii] Polypharmacy is commonly defined as the use of five or more medications by one patient. Issues related to polypharmacy include being prescribed multiple medications within the same drug class, which can increase the risk of a drug-drug interactions and adverse effects. For more information, visit: https://www.ncbi.nlm.nih.gov/books/NBK532953/

high-cost drugs covered by Medicare.[13] The Medicare Prescription Payment Plan is a voluntary program available through all Medicare drug plans that helps beneficiaries manage prescription drug costs by spreading their out-of-pocket payments over the calendar year, with payments made through monthly bills from their drug plan rather than at the pharmacy.[14] The GLP-1 Bridge Program, which launched on July 1, 2026, and is set to run through December 31, 2027, offers select GLP-1 drugs to eligible[iii] Medicare beneficiaries for a $50 copay.[15]

Current Challenges in Outpatient Pharmacy Settings

Based on a review of recent literature, pharmacists who work in outpatient settings report facing insurance-related challenges related to claim denials, reimbursement rates, and dispensing fees that have decreased in recent years. Claim denials add to administrative burden, reduce time available for patient interaction, and increase patients' frustration and confusion around getting their prescriptions.[16] Pharmacists report that PBM-negotiated reimbursement rates are resulting in low or below-cost reimbursement rates, and Medicare Part D dispensing fees are below the actual cost of dispensing medications, creating financial strain. Related to reimbursement issues, rural pharmacies risk closures due to their low volume of prescriptions, while specialty pharmacies contend with the high costs of handling complex medications and delays in reimbursement that can strain cash flow. These pressures also influence drug stocking decisions, with some independent pharmacies becoming more selective about carrying high-cost medications because of the financial risk associated with expensive inventory.[17]

The outpatient pharmacy sector is experiencing issues with pharmacy closures, workforce challenges, and concerns about burnout among pharmacists. Research has shown that more pharmacies have closed than opened in recent years, particularly among independent pharmacies, contributing to reduced pharmacy access in some communities.[18] Many pharmacists report burnout related to high prescription volumes, staffing shortages, expanding clinical responsibilities, administrative burdens, and pressure to meet operational performance metrics.[19,20] As a result, professional pharmacy organizations have made workforce well-being and burnout prevention a major priority, recognizing that sustainable working conditions are essential to the future of the profession.[iv]

[iii] The Medicare GLP-1 Bridge program is available nationwide. Eligible beneficiaries include those enrolled in standalone prescription drug plans or Medicare Advantage plans with drug coverage. Beneficiaries must meet specific clinical eligibility criteria, documented by their provider, and receive prior authorization. To qualify, beneficiaries must be age 18 or older, use a GLP-1 medication alongside ongoing lifestyle changes for weight management, and either have a BMI of at least 35, a BMI of at least 30 with certain serious conditions (heart failure, uncontrolled hypertension, or chronic kidney disease), or a BMI of at least 27 with specific cardiometabolic risk factors (prediabetes, prior heart attack, prior stroke, or symptomatic peripheral artery disease). For more information, visit: https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge/information-pharmacies

[iv] National Association of Boards of Pharmacy. July 8, 2025. Pharmacy organizations collaborate to prioritize pharmacy workforce well-being and Mental Health. Available at: https://news.ashp.org/news/ashp-news/2025/07/08/pharmacy-organizations-collaborate-to-prioritize-pharmacy-workforce-well-being-and-mental-health

Methods

The following bullets summarize the methods the NORC team used to conduct this qualitative research study. Additional details appear in the subsequent subsections.

- **Data collection approach**: Focus groups
- **Data collection timeframe**: June and July 2026
- **Number of focus groups**: Three
    - 17 pharmacists from 13 states participated in total
    - 9 worked in chain pharmacies, 4 worked in independent pharmacies, 2 worked in specialty pharmacies, and 2 worked for a mass merchandiser
    - 9 worked in an urban area, 4 worked in a suburban area, and 4 worked in a rural area
- **Participants**: Pharmacists who serve Medicare beneficiaries in a variety of settings, including chain, independent, specialty, and mass merchandiser pharmacies
- **Moderating**: NORC senior researchers moderated each focus group
- **Topics discussed**: How pharmacists spend their time, challenges with insurance networks, prescription drug coverage and costs for Medicare beneficiaries, the impact of reimbursement rates, shortages on product stock, pharmacy closures, the pharmacy job market, and pharmacist well-being
- **Length of focus groups**: Approximately 90 minutes each
- **Institutional review board (IRB)**: NORC's IRB reviewed and approved all focus group procedures, screeners, and discussion protocols

Recruitment

NORC partnered with a trusted market research organization with a nationwide database to recruit and host the virtual focus groups. In addition, NORC created a virtual flier with information about the focus groups and a link to an online screener and disseminated it to contacts at a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and a state pharmacists association. Pharmacists interested in participating provided information via the brief online screener that NORC used to determine their eligibility and placement in a focus group.

NORC worked with MedPAC to develop the screener and eligibility criteria for recruitment of pharmacists. Given that at least half of pharmacists in the United States work in outpatient settings rather than inpatient settings (e.g., hospitals, physician offices, and other health care settings) and the goal of speaking to pharmacists who interact with Medicare beneficiaries, Medicare drug plans, and other providers who serve the Medicare population, the team set out

to recruit pharmacists who work in outpatient settings such as chain, independent, specialty, or mass merchandiser pharmacies.[3,21] The screener included questions on:

- Pharmacy type, including chain, independent, specialty pharmacy, or mass merchandiser, to ensure pharmacists who work in each setting were included
- How long they had been working as a pharmacist to ensure participants would have sufficient experience to draw upon
- The share of patients they serve who are enrolled in Medicare or are dually eligible for Medicare and Medicaid, to ensure at least 25 percent of the participants' patients are Medicare beneficiaries
- Experience with key discussion topics (e.g., how their time at work is spent) to ensure groups would have participants who could speak to priority pharmacy topics
- Pharmacists' demographic information and the geographic area where they practice to recruit focus groups that included pharmacists from a mix of backgrounds and urban, suburban, and rural settings

We excluded pharmacists who reported that they do not serve Medicare beneficiaries since their experience is less relevant to the research questions of this project. In addition, we excluded pharmacists who have been practicing for fewer than two years or more than 30 years. We also ensured that we did not recruit more than one pharmacist per pharmacy location to protect participants' privacy during participation and to gain perspectives from pharmacists working in more locations.

When recruiting for focus groups, especially virtual focus groups with busy professionals, we often recruit more participants than needed for a discussion, as recruited individuals are often unable or unwilling at the last minute to participate. For that reason, we set out to recruit 10 pharmacists for each virtual focus group, with a goal of conducting groups with 8 pharmacists in each. In the end, these virtual groups ranged in size from 5 to 6 participants, with a total of 17 participants.

Focus Group Participants

We conducted discussions with a mix of pharmacists who work in outpatient pharmacy settings, including chain pharmacies (n = 9), independent pharmacies (n = 4), specialty pharmacies (n = 2), and mass merchandisers (n = 2).

Exhibit 1 presents demographic characteristics of participants in the virtual pharmacist focus groups. Diversity across demographic characteristics ensured that our focus group participants offered a range of perspectives.

Exhibit 1. Pharmacist participant characteristics

	Chain Pharmacy (n=9)	Independent Pharmacy (n=4)	Specialty Pharmacy (n=2)	Mass Merchandiser (n=2)	Total (n=17)
Race/Ethnicity					
Asian, non-Hispanic	2	0	0	2	**4**
White, non-Hispanic	7	4	2	0	**13**
Gender					
Female	6	2	1	1	**10**
Male	3	2	1	1	**7**
Years in Practice					
10–19	1	1	1	0	**3**
20–29	8	3	1	2	**14**
Geographic Area					
Urban	4	2	1	2	**9**
Suburban	4	0	0	0	**4**
Rural	1	2	1	0	**4**
Patients Covered by Medicare					
26%–50%	5	3	1	0	**9**
51%–75%	3	1	1	2	**7**
76%–100%	1	0	0	0	**1**

Data Collection

Focus groups were scheduled for 90 minutes, with one of three senior researchers from NORC moderating each discussion. A core set of research questions and topics of interest guided the development of discussion guides for all focus groups. Topics discussed in focus groups included how pharmacists spend their time, challenges with insurance networks, prescription drug coverage and costs for Medicare beneficiaries, the impact of reimbursement rates, shortages on product stock, pharmacy closures, the pharmacy job market, and pharmacist well-being.

Analysis

We performed our analysis using NVivo qualitative data analysis software. A summary of the analytic process is as follows:

- All focus groups were recorded and transcribed.
- NORC developed a list of topic codes based on the moderator guide for the focus groups. (The topic codes are generally reflected in the headers of the Findings section.)
- NORC loaded transcripts and codes into an NVivo project file.
- We coded each transcript in NVivo, tagging and organizing content based on the topic codes.
- NORC researchers conducted a thematic analysis of the content within each topic code to identify themes, such as areas of agreement and disagreement among participants, and compelling quotations illustrating the identified themes.

In some of the following sections, we highlight focus group findings by pharmacy type (e.g., mass merchandiser or chain, independent, or specialty pharmacy) and geographic area (e.g., rural, suburban, or urban area) to draw attention to any differences by setting. Due to the nature of focus group research, our sample was limited in number and is not representative of pharmacists across the country. Therefore, findings cannot be generalized either to the studied community or to the nation as a whole.

The benefit of the qualitative approach is that it allowed us to ask questions with answers that cannot be easily put into numbers to understand experience. In addition, it allowed us to understand the "how" and "why" of experiences, including deeper understanding of experiences and context, and provided personal narratives and real-life examples that policymakers may find useful as they consider potential changes to the Medicare program.

Findings

The following sections describe what we learned from our analyses of the three virtual focus groups with pharmacists. We begin by summarizing what we heard from pharmacists about how they spend their time at work and then discuss their perspectives on insurance networks, prescription drug coverage and costs for Medicare beneficiaries, reimbursement rates, and drug shortages. We end the report with pharmacists' experiences with pharmacy closures, the job market, and burnout.

How Pharmacists Spend Time Across Priorities

We asked pharmacists to estimate the share of time they spend on the following activities: interacting face-to-face with patients, interacting with other health care providers, filling or checking prescriptions, processing claims or dealing with insurance, and managing other staff in the pharmacy. We also asked about how their time spent interacting with patients may have changed in recent years. Pharmacists discussed changes related to providing ancillary services,

particularly administering immunizations. Pharmacists also discussed addressing polypharmacy issues primarily through MTM, which includes services such as comprehensive medication reviews, personalized education and counseling, and coordination with health care providers to identify and resolve medication-related issues.

Time Allocation

All pharmacists reported they spend at least some of their time interacting with patients, and several said most of their time is spent on patient interaction. Pharmacists explained that patient interaction largely includes explaining insurance coverage and out-of-pocket costs to patients, using various discount tools and programs to find the best price for each drug for their patients, counseling patients on their medication, providing MTM services, and providing ancillary services (e.g., immunizations; COVID, flu, or strep testing). Some pharmacists highlighted that providing immunizations accounts for a large part of their time during the annual flu season, in particular. One pharmacist noted that some of their time also involves helping patients find over-the-counter items. Many pharmacists noted that patient interaction is most rewarding when they can provide the prescriptions and immunizations their patients need and can afford and most frustrating when there are insurance coverage or affordability challenges.

Other responsibilities that some pharmacists spend significant time on are checking and filling prescriptions and managing technicians. Several pharmacists reported that about half or more of their time is spent checking and filling prescriptions. A few pharmacists reported that, out of all of their responsibilities, they spend the most time on managing technicians. Most others said they spend far less than half of their time on this responsibility. There was no pattern by type of pharmacy type or geographic setting in how much time pharmacists spent on managing technicians, though some noted their pharmacy hired dedicated pharmacy managers which allowed them to focus on other tasks. Several other pharmacists agreed that time spent managing technicians depends on how well trained their technicians are and how long they have been a technician.

Most pharmacists noted that they have many different responsibilities to manage and tasks to complete throughout the day, and the share of time spent on these activities varied by the pharmacists' particular employment setting. Activities that each account for a small share of many pharmacists' time included hiring staff, interacting with insurance companies to try to get prescriptions covered, interacting with health care providers to review prescriptions or obtain medical necessity letters for prior authorizations, providing ancillary services that do not involve patient interaction (e.g., sending refill reminders and coordinating home delivery services), making drug stocking decisions, and training pharmacy residents. Some pharmacists have technicians primarily interact with insurance companies and health care providers, but these pharmacists take on the more complex insurance issues themselves if a prior authorization or a dosage clarification was needed. One pharmacist who works at a suburban chain pharmacy described the difficulty in managing the competing priorities they have throughout the day: "We're asked to do so many initiatives and clinical [tasks], and you're

on the phone doing MTMs, and yet somebody—they're unhappy with their copay, [and] you have to call the insurance.… So, it's just trying to juggle all of that. We're constantly just trying to fix things."

Most pharmacists explained that they have limited staff to help complete daily tasks that consume a lot of their time at the expense of other activities, such as MTM. Several pharmacists explained that administering immunizations is very time-consuming due to the number per day they need to administer during flu season and the requirement to observe patients for at least 15 minutes following immunization. These pharmacists explained that whether technicians or pharmacists administer immunizations depends on the pharmacy; some pharmacists prefer to administer immunizations themselves so that their technicians can remain available to answer incoming phone calls and help walk-in patients.[v] However, one pharmacist who works at a suburban chain pharmacy highlighted that administering immunizations themselves can be challenging to balance with other competing demands: "[Administering immunizations] takes your time because you're pulled in all directions. We have three people waiting for vaccines. Can't, I'm stuck on a comprehensive medication review. They're on 20 drugs."

Overall, there was a consensus that providing care to patients is the most fulfilling part of being a pharmacist, and challenges related to having enough time and staff to complete all daily tasks is one of the most difficult parts of their job. Pharmacists described the fulfilling nature of the patient care they provide highlighting the satisfaction with helping patients broadly and supporting patients in getting affordable prescription drugs. One independent pharmacist said:

> *I would say helping patients, for sure, is kind of why we all do what we do, right? And then anyone in a retail setting knows the challenges that come with that. So, you could go on and on about the daily problems we have, but at the end of the day, if we help people, that's what we can go home happy about.*

Some pharmacists highlighted that they are being asked to do more non-patient-related tasks (e.g., licensing, accreditation, inventory) on top of their usual tasks, without increased compensation. One pharmacist who works for a mass merchandiser expressed the sentiment that many other pharmacists vocalized, as well: "I think the most challenging aspect is how much we have to do in a day. There's not enough time, and you want to do everything well, but you can't. The best part is connecting with the patients, knowing you're making a difference."

Changes in Time Allocation

Several pharmacists noted an increase in their workload following the onset of the COVID-19 pandemic, and more of their time spent interacting face-to-face with patients is

[v] Authority for pharmacy technicians to administer vaccinations is determined by the state. Most states have authorized pharmacy technicians to administer vaccinations. For more information, visit: https://naspa.us/resource/2024-pharmacist-immunization-authority/

in large part due to prioritization for administering vaccines. Several said they spend more of their time administering immunizations since the COVID-19 vaccines became available. Some noted that this has resulted in more face-to-face interaction with patients. A pharmacist who works at an urban independent pharmacy noted that pharmacists' workload across tasks involving patient interaction has increased, from immunizations to MTM to education on insurance: "It seems like a lot of things are falling on pharmacists' heads lately. It's our responsibility to save the world from a pandemic. So, we have to give all the immunizations. We have to do MTMs. I mean, we have to be insurance agents."

Some pharmacists said that delegating routine tasks to technicians and automated systems has enabled them to spend more time on patient care. These pharmacists reported that they are spending less time on the phone with patients and less time counting medication as their technicians and automated systems have taken on more of these responsibilities. Automated systems that pharmacists called out included a voicemail system, automated reminders and refills, online patient portals, and artificial intelligence phone identification and routing. These pharmacists said that shifting their tasks that technicians or automated systems can handle has allowed them to spend more face-to-face time with patients.

Immunizations and Other Ancillary Services

Several pharmacists indicated they are spending more time administering immunizations than they were prior to the COVID-19 pandemic, and this is partially because vaccines are revenue-generating. Some pharmacists emphasized that they spend more time administering vaccines during the annual flu season, with one noting that their personal record for number of vaccines administered in one day was about 70. A few pharmacists reported that the chain pharmacies they work for track metrics for administering immunizations, and one said these metrics' goals are higher during flu season. One pharmacist explained that the chain pharmacy they work for has benchmarks for contacting patients to come in for immunizations, with a target they are expected to reach on a quarterly basis. Another pharmacist who works at a suburban chain pharmacy described the recent change in the focus on immunizations:

> *We've had a really big push lately given the profitability of being a certified immunizer and immunizing that I've found that interacting face-to-face with patients has really increased. While I am very relational, as I like to practice that way, I would say I'm somewhere between 30 and 35 percent of the time I'm jumping over if only to ask are you up-to-date or would you like to schedule your flu shot if we're in season.*

A couple of pharmacists spoke positively about spending their time administering immunizations. They enjoyed connecting with and providing care directly to their patients. One pharmacist who works at an urban chain pharmacy described the magnitude of their time spent providing immunizations to Medicare beneficiaries: "I love giving immunizations. I give at least 30 to 40 shots every day because, like I said, we have senior buildings and a lot of seniors. We even go into their buildings and provide immunizations from all the different vaccines."

Some pharmacists who work with pharmacy technicians certified to administer immunizations had mixed views on how beneficial immunization-certified technicians are to a pharmacist's workflow. One pharmacist who works for an urban supermarket pharmacy expressed that, because she must carefully supervise her technicians and bears clinical responsibility for the patients' health, having technicians administer vaccines does not simplify her workflow. Another pharmacist highlighted the helpfulness of having immunization-certified technicians employed in the pharmacy with them. This pharmacist explained that immunization-certified technicians have the training to handle most of the steps for administering vaccines, which provides pharmacists more time to handle other responsibilities. This pharmacist who works at a chain pharmacy in both urban and suburban settings further explained:

> *One positive in retail chain is they gave a raise for technicians who became immunization certified. And so, it helps a lot when I'm at a store where there's one or two techs who are also immunization certified because there's a lot of them; there's only one of me. And so, for me to be able to check it, give it to them if I need to put it together, draw it up, whatever, and them to be able to step away helps me in workflow."*

A few pharmacists who work for chain pharmacies, including supermarkets, noted that they are offering more ancillary services in recent years, but this can be difficult to balance with their existing workload. These ancillary services included testing for illnesses such as COVID, flu, and strep throat; prescribing commonly used products, such as birth control and inhalers; and compliance packaging, whereby all a patient's prescription pills that must be taken at the same time on a given day are packaged together. A pharmacist who works at a suburban chain pharmacy explained the shift toward more ancillary services and the impact they can have on pharmacists' time and workload:

> *I think in more recent years, [pharmacies] across the board have been pushing less filling prescriptions and checking prescriptions. There's always that foundation that we have to meet on a daily basis. But at least at my company, there's been a large push for, A, immunizations, and then B, we also do a lot of testing services.… We do strep testing [and] flu.… We can do birth control prescribing, EpiPens. We can do inhalers. There's quite a few. Nausea medications. But again, it's letting people know that we offer these services, but also quite problematic because if somebody comes up and needs one of these, often with paperwork, turns into a 20- to 30-minute consultation, also very hard to get done with the way that the current pharmacy is set up.*

Medication Therapy Management (MTM)

Several pharmacists across pharmacy and geographic settings said that their pharmacy used to have a greater focus on MTM, but this focus has waned in recent years. These pharmacists explained that this is largely due to a lack of time and/or staff for MTM. Some also stated that MTM is not as revenue-generating as other services, such as immunizations. One pharmacist who works in both urban and suburban settings highlighted their belief that MTM is

not done at all in the areas they work due to financial reasons. Another pharmacist who works at a suburban supermarket pharmacy described the time-consuming nature of MTM:

> *We used to be really, really good at MTM, and that's kind of fallen through the cracks because there's just not enough staffing to do it, and there's not enough time…. On the outcomes platform, we used to be excellent rated, now we're not. We used to do appointments where patients would come in, we would schedule 30 minutes to one hour for them to come in, and now there's not enough pharmacist overlap to do those things, so the MTM tends to happen quickly, just quick points, like the overall checkup is not happening.*

Unlike other pharmacists, one specialty pharmacist explained that MTM is an important revenue source: "In my specialty world, we don't make any money dispensing any of the drugs. We make it all strictly on enhanced service on the MTMs. So, every single MTM service says so. Every drug we have has some sort of MTM service."

A few pharmacists who provide MTM highlighted that, though it is time-consuming, it offers several benefits to patients and the pharmacy. These pharmacists noted that it is a good way to build trust with patients, do a thorough review of their medication list to identify potential issues, check on needed refills, and receive some reimbursement. One pharmacist noted that reimbursement for MTM services can help offset financial losses incurred when dispensing medications whose reimbursement rates fall below their acquisition costs. This pharmacist, who works at a suburban chain pharmacy, detailed that:

> *It is another trust-building opportunity for us as pharmacists to call in, not trying to sell you anything, but here's ways that we can optimize your health. I see that you're taking two drugs within a class that typically is only treated with one. Would you like me to reach out and check with your physician? An opportunity to check adherence.… If a medication is past a refill date, are you still taking the medication? Was there something about it, whether it was side effects or an interaction where you've come across you just didn't like how your body was handling it? And again, it's just an opportunity to say, "Can you take a few minutes with me and let's just review things?" And then I know on the back end that if it's [specific insurer], then it's a way for the company to then submit the claim and get reimbursed. So, while we might be losing on dispensing the medication, we might be recouping it some in an MTM.*

Some pharmacists, however, pointed out that the time-consuming nature of MTM can result in abbreviated consultations, and contacting patients can increase demands on patients' time. A couple of pharmacists who work for supermarket pharmacies reported having to rush MTM services when their patient queue grew, resulting in less comprehensive consultations. Some pharmacists who work for chain pharmacies and one in specialty pharmacy described recurring experiences with patients who declined MTM services, citing mistrust in calls from unknown phone numbers or burnout from receiving too many calls from health care

providers, particularly among individuals with high health care utilization. A pharmacist who works for a rural supermarket pharmacy detailed these challenges further:

> *The challenging thing … with the number of MTMs and CMRs [Comprehensive Medication Reviews] and things like that that we're supposed to do—is keeping patients engaged with that. And they're getting sometimes burnt out, I guess—the patients are at times—because there are so many calls we have to make trying to keep them engaged. Maybe they're in poor health as it is, and they have so many appointments across the board from different specialists and things, and then we're trying to call them in for an appointment with the pharmacist or get their blood pressure checked and things. And they don't always seem excited about it.…*

Polypharmacy

Several pharmacists described MTM, computer system alerts (i.e., drug utilization review), and insurance claim rejection as mechanisms they use to identify and potentially reduce issues related to polypharmacy.[vi] Pharmacists who reported providing MTM consultations said this was their main method for identifying and addressing issues related to polypharmacy. One pharmacist who works at an urban independent pharmacy explained that they rely on insurance companies notifying them of potential polypharmacy issues after running a claim or patients telling them about their other prescriptions: "I mean, unless they're using their insurance and we're getting a DUR [drug utilization review] or something from the insurance [such as a] polypharmacy reject, there's no really other way to know."

At the same time, some pharmacists acknowledged limitations in identifying polypharmacy issues if patients fill prescriptions at multiple pharmacies. These pharmacists detailed that some patients have been prescribed multiple drugs in the same drug class for the same medical condition, and pharmacists may not always be able to ascertain this in a systematic and reliable way if patients are getting prescriptions from multiple, unrelated pharmacies. Some pharmacists raised the concern that they have limited visibility into some patients' full medication list if they use a discount program, which allows patients to shop for their prescription medications at different pharmacies to look for savings. In those cases, insurance companies may not have claims for all the patient's prescriptions, leaving them with one fewer resource for tracking prescriptions within the same pharmacological class. A pharmacist who works at a suburban chain pharmacy explained the challenges in polypharmacy that discount programs introduce:

> *I think the problem with the polypharmacy that we run into is, I mean, with GoodRx, we have patients who come to us for only two of their prescriptions. And we fully know that they—not like they're going to hide it—it's not a bad thing, but they go to [chain*

[vi] Polypharmacy is commonly defined as the use of five or more medications by one patient. Issues related to polypharmacy include being prescribed multiple medications within the same drug class, which can increase the risk of drug-drug interactions and adverse effects. For more information, visit: https://www.ncbi.nlm.nih.gov/books/NBK532953/. Notably, some conditions require multiple prescription drugs, but medications of different drug classes would typically be used.

pharmacy] for everything else. And then two of their prescriptions, it's too expensive, and we are cheaper, or after two months they're transferring out because the GoodRx price changed. And it makes it so much harder to just go to one pharmacy and be coherent, I mean, just because of pricing.

Some pharmacists explained that they check their states' database that tracks prescriptions for controlled substances and allows pharmacists to check for polypharmacy issues for these types of drugs. These pharmacists rely on their state's prescription drug monitoring program (PDMP) to track prescriptions for controlled substances among their patients. However, recent increases in polypharmacy for controlled substances have created increased challenges, as summarized by a pharmacist who works for a suburban chain pharmacy:

Where I see it the most, and it's been ratcheted up with this opioid crisis in our country, I live in a pocket that while it is suburban, I am tasked every day with logging into PDMP to check polypharmacy, not only drug use, but also did they just come from down the street? I need a certain amount of comfort that I'm dispensing within the guidelines and not just contributing to a problem. So, I feel like I'm equipped to handle oxycodone as well as I am amlodipine, but certainly while one is a little bit more publicized these days, I find myself having to be honest with people and trying to let them know that it's for their best interest to hold off on this, or that, or asking them why their tendencies are to use different pharmacies, and having to say 'no' a lot. And I'm comfortable doing that, because I'm not doing it for any other reason other than to help them, but it doesn't feel that way. So, the polypharmacy [issue] comes [up for] anything that I'm getting out of my safe these days.... [Those drugs are] what I have to watch.

Insurance Networks, Coverage, and Costs to Patients

We spoke with pharmacists about their perspectives on topics related to their pharmacy's insurance network decisions and how their patients who are enrolled in Medicare are affording their prescriptions. We talked to pharmacists about their experience with the Medicare GLP-1 Bridge Program,[22] the Medicare Prescription Payment Plan,[23] and other discount programs and tools that Medicare beneficiaries use to afford their prescriptions. Pharmacists also shared how their pharmacy is approaching mail-order or home delivery.

Pharmacy Insurance Network Decisions

Based on pharmacists' explanations, the process for insurance contracting decisions depends on the pharmacy type. Pharmacists who work in chain pharmacies reported that they do not participate in contracting decisions. Rather, their corporate leadership informs them of the plans they will be in-network with for the year. One specialty and two independent

pharmacists said they work with a Pharmacy Services Administrative Organization (PSAO)[vii] to negotiate contracts. These pharmacists described PSAOs as helpful in handling contracting and negotiations but said they can come with drawbacks in terms of delayed communication on changes from the PSAO and decision-making that may not always align with their pharmacy's interests. A specialty pharmacist who works in urban and suburban settings commented on these downsides: "It's nice if somebody can handle it for you, but it also, they're notoriously not very good at communicating quick changes or the decisions they make, especially when you're in a group, you can be outvoted if you're part of a group PSAO." Another pharmacist who works at a rural, independent pharmacy noted that they handle some contracts on their own, but their PSAO handles most of their contracts, for which they have no direct involvement:

> *There are a few contracts that we have applied for ourselves, but typically the PSAO … if we want them to, they'll take care of the contracting, and if it's not good, then they won't sign it. Or if something changes one year … and it was a plan that was good [but] was no longer good, [then] they did not re-up that contract. And then they usually have a nice list for me at the end of the year, but I don't know what all my people are signing up for until the beginning of the year.*

When plans change, pharmacists described needing to explain to patients whether they are an in-network and a preferred pharmacy and what this entails for the patients' out-of-pocket expenses, which the pharmacists do not know until they run the claim.[viii] One pharmacist who works at a rural independent pharmacy described the challenge with explaining this type of change to a patient: "I remember one year one of the groups got a letter, and everybody brought this letter in and said, 'Are you in the preferred network?' It's like, 'We're in-network, but we're not preferred.'"

A couple of pharmacists in chain and independent settings further detailed that contracting decisions and network changes have implications for retaining customers and administrative burden. One pharmacist who works for a chain pharmacy explained that having their pharmacy churn in and out of network for their patients sometimes results in losing longstanding customers and increases administrative burden with transferring patient files between pharmacies:

> *To me, it feels like a game of musical pharmacy, especially at the beginning of the year where my go-to trustworthy customers who have developed a relationship that I've spoken of a couple times here is, 'I'm sorry, but I have to transfer.' So, then my colleagues, not just within my company, but in others say, 'Hey, I need a profile transfer.' And then 12 months later, you're back in network, and now it becomes whether the*

[vii] PSAOs provide independent pharmacies and small chains with administrative, contracting, compliance, billing, performance monitoring, and PBM-related support services in exchange for a monthly fee. For more information, see: https://content.naic.org/sites/default/files/call_materials/The%20Role%20and%20Value%20of%20Pharmacy%20Services%20Administrative%20July%202022.pdf

[viii] Pharmacies may be in-network or out-of-network, and in-network pharmacies may be preferred or non-preferred. At in-network pharmacies, beneficiaries can fill prescriptions under their insurance coverage and pay the applicable cost sharing, while preferred pharmacies generally offer lower cost sharing than non-preferred pharmacies.

> *service that I can provide is enough to bring you back. Is there an incentive copay-wise? And then so from January till about mid to late February, we're transferring profiles in and out, in and out, in and out. So, while we're trying to meet our quota for filling in this, I'm governed by who I can take care of most of the time, because if I'm going to save $25 a script to go across the street, of course I'm going to do that, and I'll sacrifice the relationship that I had with my good old pharmacist to do it.*

Another pharmacist who works at an urban, independent pharmacy explained that the impact of the PSAO's decisions can include losing customers:

> *We lose customers if we're not preferred. I mean that's the reality, but we have no choice as an independent. We have no choice. [Our PSAO] does most of the negotiating for us. But I mean, if you're not preferred, again, it's like you have a customer of 20 years, and their plan tells them that it's going to be 20 more dollars per prescription at your pharmacy versus [chain pharmacy 1] or [chain pharmacy 2]. You lose the customer. I mean, it's just reality.*

One specialty pharmacist reported that vertically integrated organizations may favor affiliated specialty pharmacies in insurance networks. This pharmacist explained that vertically integrated organizations have been steering patients to their own affiliated specialty pharmacies and excluding smaller specialty pharmacies from their networks, particularly in commercial insurance plans but with Medicare as well. [ix] This specialty pharmacist who works in urban and suburban settings further explained this issue:

> *In specialty … you have a lot of third-party plans who want to use their own specialty pharmacy and don't give you the opportunity to do it. So, they lock us out.... And we do track that a little bit closer, especially to see if we can get into some of those plans. Medicare … [doesn't] have as many lockouts as some of the commercial plans do, but you still see them from time to time.*

Some pharmacists were not familiar with the differences between Medicare Advantage Prescription Drug plans and standalone Prescription Drug Plans and indicated they are not aware of which type of Medicare prescription drug plan their patients have. Several pharmacists reported no differences in the time they spend dealing with insurance or processing claims between patients who have Medicare Advantage Prescription Drug Plans versus those who have standalone Prescription Drug Plans. One specialty pharmacist noted that, because patients enrolled in Medicare have a choice in which specialty pharmacy they go to, they spend more time calling these patients who have already chosen another pharmacy, compared to patients enrolled in commercial or other insurance. Some pharmacists were not familiar with differences in out-of-pocket costs between types of plans or from one plan to another.

[ix] In July 2024, the Federal Trade Commission reported that "pharmacies affiliated with the three largest PBMs now account for nearly 70 percent of all specialty drug revenue." For more information, visit: https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

Insurance Coverage and Drug Costs for Patients

Coverage and Out-of-pocket Costs for Patients

Several pharmacists noted that their patients enrolled in Medicare or other drug coverage are often unaware of how much their out-of-pocket costs for their medications are going to be until they fill their prescription. A pharmacist who works for a suburban supermarket provided their perspective on the low awareness of out-of-pocket amounts among patients generally:

> *I think sometimes the patients, they're just out of the loop or they may get a letter, they don't read it, [and] they're just not informed.… I think they may get letters in the mail, and they don't open them or they just toss them in the garbage can. Then they come to the pharmacy and then they get a big surprise—your copay is $600.*

Several pharmacists said they have to educate Medicare beneficiaries about their out-of-pocket costs. These pharmacists emphasized that they spend a significant amount of time educating Medicare beneficiaries on their copay amounts and deductibles. A pharmacist who works for a chain pharmacy in an urban area described the challenging aspects of providing patient education on their out-of-pocket costs:

> *[The] only challenging part is explaining [to] them the deductibles…why they have to pay so much in the beginning of the year [and] why the copay jumps up. At the end of the year, it is like $40, and in the beginning, it is $300. So, explaining to them what is the difference and sitting down with them sometimes in the counseling room, that's a little challenging because they're seniors. We have to explain to them exactly because everything at the end of the day is the bills, and they need to be more patiently told about how it works, how the deductibles and everything works. So, that's a little challenging.*

Some pharmacists noted that a portion of their patients face high cost-sharing for certain drugs, and all pharmacists reported that they try to help patients afford their medications at their pharmacy through various means. A few said that many of their patients enrolled in Medicare have challenges with accessing their medication due to out-of-pocket costs and that this is becoming more common among Medicare beneficiaries. Another noted that deductibles seem to increase steadily, making affordability a growing issue. [x] One pharmacist, however, called out that some out-of-pocket costs have decreased for Medicare patients, including for insulin and inhalers. Methods that pharmacists reported using to help their patients afford their medication include finding alternatives if something is not covered, calling doctors to get

[x] In 2026, the standard Part D deductible is $615, and fewer plans, particularly MA-PDs, are offering enhanced plans with reduced deductibles, compared to before the recent benefit redesign. For instance, in 2023, 98 percent of enrollees in conventional MA-PDs had either a reduced deductible or none at all; in 2026, that share fell to 75 percent. For more information, visit: https://www.medpac.gov/wp-content/uploads/2026/07/July2026_MedPAC_DataBook_Sec10_SEC.pdf

prescriptions changed, identifying a discount program, or helping to resolve issues that led to an insurance claim denial.

For patients who fill high-cost drugs throughout the year, a couple of pharmacists recounted the difficulty they have had in explaining why the amount that the patients pay out-of-pocket is higher in the beginning of the year before they have hit their deductible. A chain pharmacist described the impact this can have on patients:

> *Instead of the coverage gap that everybody has [gotten] to "know and love" – and that's air quotes – the out-of-pocket [cost] for patients that are senior citizens is front-loaded where they have to meet their deductible first. And that was a real shocker to my suburban low-income people where they were covered up to a certain point, and now they're having to be responsible on the front end for it. And then the coverage is much better on the other end if they can just get there. And it's hard to... I've seen it take a large toll on them.*

In addition to pharmacists helping patients afford medications at their pharmacy, several pharmacists reported that some patients shop around at different pharmacies to find the lowest price per prescription. Methods that pharmacists reported patients use to shop for the lowest prices include comparing prices for each prescription across pharmacies, comparing between Medicare coverage and one or more discount cards at a given pharmacy, and combining these approaches and using Medicare coverage at one pharmacy and a discount card at another. Some pharmacists stated that shopping around for the lowest prices has resulted in patients getting prescriptions filled at multiple pharmacies. They explained that filling prescriptions at multiple pharmacies can cause difficulty with tracking polypharmacy and can result in revenue loss in cases when patients choose to fill higher-paying prescriptions (which pharmacies depend on to offset lower-paying prescriptions) at another pharmacy. A few pharmacists discussed their experiences with patients comparing their prices to prices at large chain pharmacies. One pharmacist who works at an independent pharmacy said:

> *Usually the patients will tell me… "Oh, if I go to [a large chain pharmacy] and I get [a] 90 day [supply], it'll be this copay, but I like your pharmacy better." Because patients, for whatever reason, they don't like [a large chain pharmacy] and the autofill and there's a whole list of reasons. So, they prefer to come to my pharmacy. But a lot of times, the patients tell me that…they can get a better copay at [a large chain pharmacy]…"*

Discount Programs or Tools

Many pharmacists agreed that they spend a significant amount of time checking prices across discount programs and tools, and using these can lead to lost revenue for their pharmacy. Though several focus group participants said the best part of their job is when they can find an affordable price for the medication someone needs, others emphasized that it is time-consuming, and they wish that patients would check prices themselves and tell the pharmacist which discount card to use. One pharmacist who works at a suburban chain

pharmacy explained that discount programs and tools result in revenue loss for the pharmacy and checking prices across platforms increases the wait time for other patients in line:

> *Ten drugs, and they want us to compare. Check Medicare, check my GoodRx. And the time that we spend, we barely make money off of this stuff. And then when they leave the doctor's office, it will ping their phone. It says, "The prescription is sent to [chain pharmacy]. Here are these discount cards." It automatically sends it there, and they show me on their phone. They're like, "I have these codes." I said, "Wait, I'm using your Medicare. It's $2. Why am I checking your GoodRx or whatever?" … I do it to help them save money because that builds the trust, but I don't have time to hold up a line to check your 10 drugs and compare which one's cheaper.*

Outside of the popular discount tools, such as GoodRx, few pharmacists discussed other programs for helping patients afford their medications at their pharmacies. A pharmacist who works at a suburban chain pharmacy mentioned their pharmacy offers a savings plan, but they do not advertise it widely. A specialty pharmacist noted that their pharmacy has a patient advocacy team dedicated to applying for grants to help patients pay for prescriptions.

In addition to the time-consuming nature of checking discount programs and tools, a couple of pharmacists described how some patients enrolled in a Medicare Part D plan attempt – but are not allowed to use – manufacturer discount coupons.[xi] One pharmacist who works for a suburban supermarket pharmacy provided an example of a patient who came in to pick up a prescription for an inhaler with a copay amount of about $600. The pharmacist reported that this patient tried to use a coupon they found on the manufacturer's website to reduce their out-of-pocket cost and became confused when the pharmacist tried to explain that they could not use the coupon with their Medicare Part D plan. Ultimately, the patient did not purchase the inhaler that the pharmacist had already filled, which the pharmacist indicated was not an uncommon occurrence. Another pharmacist who works for a rural supermarket pharmacy described the differences in being able to use manufacturer coupons by plan:

> *You have people that have commercial insurance [who] are able to use copay savings cards from manufacturers, but people with Medicare cannot, which people on Medicare are obviously the ones that need it the most. So, if they had some way of combatting the high copays, that would be nice, but the law gets in the way of that somehow.*

Medicare Prescription Payment Plan

Pharmacists reported limited use of the new Medicare Prescription Payment Plan, citing low awareness among Medicare beneficiaries and challenges with patient education and enrollment. Pharmacists were generally aware of the Medicare Prescription Payment Plan but

[xi] The Anti-Kickback Statute prohibits offering or receiving anything of value that may induce or reward the purchase of items paid for by a federal health care program; as such, the use of manufacturer coupons to reduce the cost of a drug (and possibly incent its use over that of another) is not allowed if a patient is using their Part D coverage for the claim. [42 U.S.C. § 1320a-7b(b)]

noted that many Medicare beneficiaries are not. Several pharmacists said that educating Medicare beneficiaries on the program and getting them to fill out the paperwork is difficult. Some pharmacists reported that few or no Medicare beneficiaries enrolled in this program; one specified that this was because it did not make financial sense for their patients who met their deductibles early in the year or whose out-of-pocket costs were too low to benefit from spreading payments over time:

> *I think we had maybe eight patients that ever signed up for [the Medicare Prescription Payment Plan]. Some of them reached their deductible so fast that it didn't make any sense for them to pay for it all year. They meet their deductible by February 15th, [and] they pay nothing the rest of the year. And then there's other people that aren't going to meet their deductible [so] it still doesn't make sense for them to pay over the year because they don't [have] enough [out-of-pocket costs]. Yeah, I think we had eight patients in the two years that program's been out that have actually used it.*

Several pharmacists said that the monthly out-of-pocket costs for beneficiaries with the Medicare Prescription Payment Plan are not transparent or clear to patients or pharmacists. A pharmacist who works at a suburban chain pharmacy detailed this issue further: "What's also deceiving is now with the Medicare payment plan option, they will always see zero, but they don't realize they're getting a bill that they have to pay. So, the copay is not transparent. I can't even see the copay."

GLP-1 Bridge Program[xii]

Many pharmacists were aware of and knowledgeable about the GLP-1 Bridge Program, which launched between the first and second focus groups. Almost all pharmacists who participated in the two focus groups after the launch of this program had started or were planning to start implementing the program to remain competitive in the market. One pharmacist recalled that a drug company representative came to brief their pharmacy on the GLP-1 Bridge Program to raise awareness and explain the process to their staff. A pharmacist who works at a mass merchandiser in a rural area described the need to participate in the program to avoid losing customers who may look to fill their GLP-1 prescription and other prescriptions elsewhere: "I think everybody's going to have to do it just to compete, because if you don't fill out one prescription, you're going to lose out on five or six others. They'll just transfer out. So, I think just to stay competitive, everyone's going to have to."

Pharmacists described mixed experiences with patient access to GLP-1 medications through the GLP-1 Bridge Program to date. Several already had successfully processed claims for GLP-1 medications through the Bridge Program. One pharmacist expressed their surprise at having claims processed and accepted within a day. Another pharmacist who had a

[xii] Under the Medicare GLP-1 Bridge Program, the out-of-pocket cost of certain GLP-1 drugs is $50 per month for Medicare beneficiaries. As the Medicare GLP-1 Bridge Program went into effect on July 1, 2026, we asked pharmacists in the two focus groups that occurred in July about their experience so far with the program.

drug company representative visit their pharmacy to inform them of the Bridge Program said that the prior authorization process seemed to be faster than the process for other medications. However, some pharmacists who work for chain pharmacies reported challenges with patients' awareness of the need for prior authorization for GLP-1 medications under the new GLP-1 Bridge Program. Some pharmacists explained that many patients are misinformed that they will automatically have their GLP-1 prescription covered through the program, when in fact they need to meet the program's eligibility criteria and receive prior authorization. One pharmacist noted that they had a claim rejected even after prior authorization was received. A pharmacist who works at a mass merchandiser in an urban area commented on patients being unaware of the process for prior authorization: "I've had a couple of denied claims, more than covered. I mean, obviously it's just starting, but yeah, I think [patients] are surprised that it's being denied, and it's the fine print that hasn't been read."

Prior Authorizations

Some pharmacists reported that prior authorization processes create bottlenecks that can delay patients' access to their prescriptions. One pharmacist who works for a specialty pharmacy said their biggest challenge with serving patients enrolled in Medicare is ensuring all the documentation is correct for prior authorization. Another specialty pharmacist explained that, during drug shortages, they try to help patients get the medications they need by working with their providers to obtain prior authorization for alternative medications, but they run into roadblocks with insurance companies that flag the new prescription for a similar medication:

> *If you can't find [the medication], then you maybe have to do another prior authorization for a different drug, and you have to go through the explanation [with the insurance company]. The insurance companies often are like, 'Well, why are you changing this drug?' because they don't understand the shortage.… I can't give the patient anything. That's why I'm trying to change. So, it's a very convoluted process, especially if prior authorization is involved.*

One specialty pharmacist noted that their workload has increased due to a change in who can handle prior authorizations. This pharmacist, who works in a suburban area, explained: "Techs used to be able to do prior authorizations. Now all the pharmacists have to do them. I don't understand why that's changed too. All the letters of medical necessity, all the pharmacists have to write them now. Why? The techs used to be able to do it. I don't understand why that has all changed."

Many pharmacists described their frustration with insurance claim denials, especially among patients with acute medical needs. A pharmacist who works at a chain pharmacy in urban and suburban settings described what it is like for patients to receive this type of information:

> *What is so sad is when someone comes after a recent hospitalization.… Something as serious as a stroke or a heart attack, they come to me and I say, "Oh, not covered. You*

> *have to wait." ... It's so hard because they're sort of like, "What do you mean I have to wait? I was clearly prescribed the medication because I need it." And so here I am with 30 things to do at work, telling someone like, "Oh, your Eliquis isn't covered until...." And then they'll say, "Well, when can I get it?" "We don't know." And it's just that whole process in pharmacy and in health care is the absolute worst part of my job, the having no answer for people who are very clearly sick and need medication.*

Mail-Order Pharmacy and Home Delivery[xiii]

Pharmacists sometimes used the terms "mail-order" and "home delivery" interchangeably, which may reflect that some pharmacies offer both services. One pharmacist who works for a chain specified that patients could use the chain's mobile app to order their medication and have it delivered by FedEx or DoorDash. Another pharmacist who works for a chain described the confusion that some patients have around ordering their medication through the pharmacy's mail order facility versus their local pharmacy location:

> *I know that it's an option because the patients call me and ask me, "Where's my medication?" I'll check in the system. I'm like, "It's already been routed to [another state]. You chose the mail order facility." I don't handle that. They select it on the app or on their email. As long as their insurance covers it, yes, it gets shipped from out of state to them. They get three months' supply, and the catch is it's free delivery, and they think it's coming from me as free delivery, but really it's going to a mail service facility.*

Some pharmacists reported that their pharmacies offer home delivery services, specifically. Couriers that these pharmacists described using included UPS and DoorDash. A couple of pharmacists noted that they do home delivery but do not have prescriptions mailed out automatically—they must speak with the patient first and get their approval. One pharmacist pointed out that home delivery is particularly helpful for an older population who may have limited mobility. Another specialty pharmacist noted that they do home delivery as a part of their "enhanced services," which brings in additional revenue.

Some pharmacists highlighted that home delivery services come with limitations and special considerations. For instance, one pharmacist pointed out that their pharmacy cannot mail controlled substances or medications needing refrigeration. Another pharmacist who works at an independent pharmacy described challenges around the financial sustainability of home delivery services. This pharmacy now charges for delivery and syncs multiple prescriptions so that they are all mailed once per month together, rather than mailing them in separate orders.

[xiii] CMS clarified in Chapter 5 of the Medicare Prescription Drug Benefit Manual that pharmacies that mail some, but not all, deliveries by common carrier are not considered mail-order pharmacies. Instead, these pharmacies are considered retail community pharmacies that offer delivery to a patient's residence (or "home delivery"). For more information, visit: https://www.cms.gov/files/document/chapter-5-benefits-and-beneficiary-protection-v92011.pdf. Most mail-order pharmacies operate through an insurance company's pharmacy benefit manager (PBM). For more information, visit: https://www.goodrx.com/drugs/medication-basics/5-things-to-consider-before-using-a-mail-order-pharmacy.

A few pharmacists (specialty, chain, and independent) reported that some patients have changed to direct-to-consumer or online mail-order pharmacies. The reason these pharmacists cited for this is that patients can have prescriptions mailed to them at no extra cost, which is a convenience that attracts some patients. A few called out Amazon Pharmacy, and one mentioned Mark Cuban Cost Plus Drugs.

However, a couple of pharmacists stated that coming in person to the pharmacy provides a patient benefit that direct-to-consumer or mail-order pharmacy cannot—in-person consultation with the pharmacists. One pharmacist noted that consulting with a pharmacist in person can improve medication adherence. A pharmacist who works at a suburban chain pharmacy commented that the move toward these platforms may be temporary, and in-person services are usually preferred:

> *It seems to be a hot button topic for a moment. And then I've transferred so many scripts out only to have them come right back in because it might be trendy for a second, but then most people would rather have the ability to talk and trust again as I fall back on that. So, I quickly get a lot of the prescriptions that go to Amazon or wherever the trendy marketplace is right now.*

Impact of Reimbursement Rates and Product Shortages

We asked pharmacists about recent changes in reimbursement rates for drugs filled by Medicare beneficiaries, drugs their pharmacy keeps in stock, and drug shortages. We also talked to pharmacists about their experience with the Medicare Drug Price Negotiation Program, which took effect for the first time in 2026.[xiv] Pharmacists commented on whether the Medicare Drug Price Negotiation Program has resulted in financial difficulty in dispensing negotiated drugs and other factors that have created financial challenges for their pharmacy.

Reimbursement Rates

Many pharmacists commented that reimbursement from public and private insurers for drugs and dispensing fees have decreased in recent years. Pharmacists reported that reimbursement rates for Medicare, as well as commercial plans, have declined. Two pharmacists also noted that dispensing fees across all plans, including but not limited to Medicare, have also decreased. Dispensing fees cover the costs of preparing the prescriptions, clinical review, and other operational costs.

[xiv] In August 2022, President Biden signed the Inflation Reduction Act of 2022 (P.L. 117-169) into law. The law provides Medicare the authority to directly negotiate the prices of certain high-expenditure, single-source drugs without generic or biosimilar competition. The Centers for Medicare & Medicaid Services (CMS) selected 10 drugs covered under Medicare Part D for the first cycle of negotiations for initial price applicability year 2026, 15 drugs for the second cycle of negotiations in 2027, and 15 drugs for the third cycle of negotiations in 2028. CMS engaged in voluntary negotiations with the drug companies for the selected drugs. For more information, visit: https://www.cms.gov/initiatives/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-negotiated-prices.

Given the reported decrease in reimbursement rates in recent years, several pharmacists across settings explained that they have had to find ways to make up for the losses they accumulate on filling prescriptions. One specialty pharmacist emphasized that as reimbursement rates have lowered, they have increased their "enhanced services," including MTM and immunizations, to make up the revenue. A pharmacist who works at a suburban chain pharmacy reported a similar focus at their pharmacy:

> *We lose money on so many prescriptions we fill. We can see the reimbursement rates where we're getting, even on a generic inexpensive medication, sometimes the reimbursement's negative $2. But across the board … no one's making money on prescriptions. And so the companies are having to brainstorm and expand what services we are able to offer, but they really have to focus on those services because that's what they're going to make money on."*

One pharmacist who works at an urban, independent pharmacy explained the difficult decisions they have had to make regarding filling patients' prescriptions, knowing they will lose money on them:

> *For me, the most challenging part, especially being that I work in an independent pharmacy, is these insurance companies: a lot of them do underpay the pharmacies, and I have to make tough decisions. A lot of times, I have to say, "Okay, I'm losing $100 on this prescription every month, and this prescription has 11 refills." But then I have to look at their other profile, their other medications and say, "Well, okay, I can make up for it with these other meds so I at least break even," because I don't really like to dismiss patients from the practice, but sometimes I've had to do that.*

MA and Part D Plan Star Ratings

A few pharmacists noted that the challenges they face in providing MTM services impact the Star Ratings of insurance plans and reimbursement from insurers. [xv] Because they are not doing MTM or cannot meet patient compliance metrics, a few pharmacists said their pharmacy's performance has fallen on metrics that contribute to the Star Ratings of plans that they contract with or are in-network with. These pharmacies accept this because they cannot offer this service with their current level of staffing. A pharmacist who works at an independent pharmacy in a rural area pointed out that MTM services can be reimbursed at a higher rate by meeting the metrics that contribute to Star Ratings but agreed with others that MTM services are too time-consuming for their pharmacy to provide:

[xv] CMS annually calculates Star Ratings for each Medicare Advantage Prescription Drug plan and Part D plan based on performance on various quality measures, some of which are related to prescription drugs. One measure is the rate of MTM program completion for comprehensive medication review. There are also three measures of medication adherence. An example of an adherence measure is the percentage of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are taking the medication. CMS publishes the Star Ratings on Medicare's Plan Finder website and Medicare Advantage Prescription Drug plans can receive bonus payments for high Star Ratings. For more information, visit https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf.

> *It was my understanding in the past that if you did well on your MTMs, then the insurance companies would pay better. So, we tried it: we try to get them done, but yeah, it's kind of like torture to get my staff to get them done because they're busy. They're busy checking prescriptions and on the phone, so it's not easy to.... Because there is no overlap.… To have somebody step out for 30 minutes [to conduct an MTM session], it's not feasible.*

Several pharmacists discussed their pharmacy's approach to refills, the implications for insurance companies' Star Ratings, and how this affects their pharmacy's reimbursement from these insurance companies. One pharmacist explained that their pharmacy sends automatic refills to maintain reimbursement associated with Star Ratings. This pharmacist, who works for a suburban chain pharmacy, said, "The only time I ship something out free is when you're on my adherence list, and you didn't pick up in 10 days. Let me send it to you for free so that I can meet [the] Star Rating [for the insurance company my pharmacy contracts with], and that adherence is met."

A couple of other pharmacists reported that they do not do automatic refills and accept that this can lower their contracted insurance companies' Star Ratings and, in turn, the pharmacy's reimbursement. One pharmacist who works for an urban independent pharmacy explained that their pharmacy does not do automatic refills because they want patients to authorize the refill before they charge the copay. However, this has resulted in patients not receiving their refills on time, which lowers their performance on a metric that contributes to contracted plans' Star Ratings and, in turn, their reimbursement rate:

> *The Star Ratings are basically for the maintenance meds, if they're refilling them on time. But like I said, we don't do auto-fills because a lot of my patients have copays, so we just don't autofill without their authorization. So, if you're not filling the maintenance meds like statins, blood pressure, diabetes, drugs on time, then your Star Ratings go down. And I believe your reimbursement also goes down.*

Another pharmacist who works for a rural supermarket pharmacy pointed out that receiving refills in the mail does not indicate the patient is adherent, which is the metric the Star Rating is intended to reflect:

> *Part of the problem with this whole thing too with adherence and these Star Ratings is you're measuring when a patient fills their prescription if they pick it up on time. I've had patients that have come in for a CMR, and they have bags of meds they got through the mail that they didn't even take, but they were still being sent so their Star Ratings probably look great. And it doesn't really measure adherence. I'm sorry, but unless you see the person put the pill in their mouth, you don't know if they took it. So, I just don't see where this is really going for making people healthier. You can't measure that all the time.*

One pharmacist described a situation in which a patient was taking a medication less frequently than prescribed. The patient told the pharmacist that the doctor had written the prescription for a different frequency because it was more cost effective to fill it this way. This resulted in the patient picking up refills less frequently than expected relative to the quantity prescribed, which hurt the Star Rating of the insurance plan due to the appearance of patient noncompliance. As the pharmacist explained:

> *I had a situation at one point where somebody was taking a statin and instead of taking it every day, doctor told them to take it three times a week, but the prescription was being sent in for one a day because they didn't want to pay. They were better getting 90 [pills] and just taking it every three times a week. I was like, "Well, I could change the quantity to 12 or whatever the number was, 36." But then they're like, "Well, I don't want to pay $10 for 36 [pills] when I can get 90 [pills] for $10." So, [this] throws off the Star Rating, but they're also concerned about their copay.*

Drug Stocking

Several pharmacists reported minimizing on-hand inventory of high-cost medications by ordering them on an as-needed basis based on patient demand. Some pharmacists indicated that they do not keep expensive medications and medications requiring refrigeration, such as injectable GLP-1 medications, in stock without confirmation that patients are going to fill their prescriptions and the pharmacy will receive payment for them. Several pharmacists who work for chain pharmacies reported that they call their patients to confirm that they will pick up their GLP-1 medication and can get it in stock within a few days or the next day. An independent pharmacist said that they stock very few maximum fair price[xvi] drugs and do not keep any expensive drugs on the shelf, even if multiple patients use it. They alert patients that they need to call ahead for these prescriptions to be filled, to which patients have not reacted negatively. Similarly, a specialty pharmacist keeps a limited stock of expensive drugs and orders them on a schedule according to their patients' needs, and a chain pharmacist does the same with brand-name drugs. Another chain pharmacist said they have an ordering system based on order history. If the drug has not been ordered before or the quantity or strength is different, they do not keep it in stock and instead order it on an as-needed basis. A third chain pharmacist reported that they check if one of the 20 locations in their pharmacy chain within a 30-mile radius have a drug in stock if their location does not have it.

Less commonly, pharmacists reported not stocking certain generic drugs. A pharmacist who works at an urban independent pharmacy described sometimes needing to make decisions about which generics to keep in stock due to price variations: "Well, because we do all of our own ordering. Every now and then, if you have five different generics, there will be a generic

[xvi] The prices negotiated by CMS and participating drug companies for selected drugs under the Medicare Drug Price Negotiation Program are referred to in statute as maximum fair prices. For more information, visit: https://www.cms.gov/initiatives/medicare-prescription-drug-affordability/overview/medicare-drug-price-negotiation-program/selected-drugs-negotiated-prices

that's for whatever reason, a heck of a lot more expensive than the other four. And that may be the only thing that's available, but you know you're going to lose money on it, so do you buy it?"

A few pharmacists explained that they had to make changes to their drug stocking decisions to avoid revenue loss. A chain pharmacist said their pharmacy has shifted many medications, especially brand-name drugs, to a centralized fulfillment center that delivers prescriptions in bulk the next day to reduce their workload. This has resulted in patients waiting an additional day for their prescription at times, which the pharmacist noted can create the perception that certain drugs are not stocked locally. A pharmacist who works at a suburban, specialty pharmacy noted that they no longer keep non-specialty medications in stock because these were a source of revenue loss: *"We used to keep auxiliaries, so anything like retail that would go with any sort of specialty drug. So, say they had Metformin and they needed Botox, and we would dispense that with that. We stopped keeping any auxiliaries just because we were losing money with it."*

Drug Shortages

Most pharmacists reported that they have dealt with drug shortages. Drugs that pharmacists noted have been affected by recent shortages include estrogen patches, dextroamphetamine, Creon, Solostar, and GLP-1s, including Mounjaro, for a brief time. One pharmacist who works at an independent pharmacy noted that they can usually find generic drugs but more often struggles to find brand-name drugs. Another pharmacist noted that they have lost patients to competitors during drug shortages.

Some pharmacists commented that they have had to find workarounds to address drug shortages. One independent pharmacist said they can compound some drugs, including Estradiol, while others said they do not compound drugs anymore. Other pharmacists reported that they try to get a different drug authorized if a shortage is impacting the availability of a prescribed drug, but they have received pushback on this from insurance companies. A specialty pharmacist who works in urban and suburban settings explained this issue further: "If you can't find it, then you maybe have to do another prior authorization for a different drug and you have to go through the explanation. And the insurance companies often are like, 'Well, why are you changing this drug?' Because they don't understand the shortage."

Medicare Drug Price Negotiation Program

Awareness of the Medicare Drug Price Negotiation Program varied among pharmacists, and those familiar with the program reported some reimbursement-related challenges. The Medicare Drug Price Negotiation Program gives Medicare the authority to directly negotiate prices for certain high-expenditure, single-source drugs without generic or biosimilar competition, beginning with 10 Medicare Part D drugs for voluntary price negotiations with manufacturers.[24] A few pharmacists were aware of the Medicare Drug Price Negotiation Program, including those who work for independent or specialty pharmacies, but several

pharmacists who work for chain pharmacies were unaware of this program. A couple of pharmacists who were aware of the Medicare Drug Price Negotiation Program noted that reimbursement for drugs negotiated under this program has come weeks to months after filling the prescription; they noted that this has resulted in challenges with accounting for the delayed reimbursement, including the additional administrative burden associated with tracking and validating reimbursements.[xvii] One pharmacist reported that the reimbursement rates for negotiated drugs have been lower than anticipated.

Pharmacy Closures in the Community

We asked pharmacists if there have been any closures of pharmacies or new pharmacies in their area in recent years. Pharmacists provided details on the impact of recent nearby closures on their pharmacy, patient volume, and patient access—particularly among older adults or Medicare beneficiaries. Pharmacists commented on how these recent changes have affected how they spend their working time.

Pharmacy Closures

Many pharmacists described recent closures of pharmacies in their area, which has resulted in their patient caseload increasing without an increase in resources to accommodate the change. Closures have included an entire chain of pharmacies, individual chain or supermarket pharmacy locations, and independent pharmacies. Reasons pharmacists provided for the closures included inadequate reimbursement, Drug Enforcement Administration fines for controlled substances, theft, expansion without adequate staffing, and a failed merger between supermarkets. Some pharmacists explained that they have been through mergers rather than full closures but similarly experienced challenges with an increased workload without increased resources. As a pharmacist who works at a suburban chain pharmacy put it: "Our company buys out grocery stores, so the files get transferred to the store. Influx of customers, still no increase in budget."

New Pharmacies

Few pharmacists reported that new pharmacies were opening in their area. A specialty pharmacist in a rural area said they are opening new locations to meet the needs of people currently driving over 20 miles to their nearest pharmacy. Another specialty pharmacist noted that health systems are increasingly establishing their own specialty pharmacies to retain

[xvii] Pharmacies must wait at least 21 days to receive the MFP refund from manufacturers. This timeframe exceeds the current 14-day pharmacy prompt-payment requirement for traditional Part D claims. (Payment for the plan's part of the selected drug claim is subject to the 14-day prompt-pay requirement, consistent with all other Part D-covered drugs.) For more information, visit: https://schaeffer.usc.edu/research/medicare-drug-prices-mfp-effectuation/

specialty prescriptions internally, respond to manufacturer lockouts and 340B Program[xviii] pressures, and capture the higher reimbursement opportunities associated with specialty medications.

Pharmacy Job Market and Well-being

We asked participants to describe what the job market is like in their area, including whether there are any challenges in hiring at their pharmacy. Pharmacists also discussed factors contributing to burnout and how experiences of burnout have changed recently.

Job Market

Most pharmacists who participated in the focus groups have been in their current positions for many years and have been working in pharmacy for over 20 years. Several used to work in other outpatient or inpatient pharmacy settings before settling into their current positions. Three pharmacists used to work in a hospital-based pharmacy and now work for a chain, supermarket, or independent pharmacy. A few now working in specialty or independent pharmacies had prior experience working in a chain pharmacy or a mass merchandiser. One pharmacist transitioned from working in an independent pharmacy to a chain pharmacy and noted that the independent pharmacy struggled to remain in competition with larger pharmacies. One pharmacist discussed being laid off from the chain pharmacy they now work for again due to budget constraints at the time; they worked for an independent pharmacy in between.

Most pharmacists agreed that it is not difficult to find open positions in outpatient settings, but it is difficult to find attractive positions or hire pharmacists in outpatient settings. Several of these pharmacists cited reasons including that compensation is not competitive with compensation in inpatient pharmacy settings or in other less skilled jobs in their geographic area and that working conditions are not desirable. One pharmacist explained in more detail that pharmacists in hospital settings have higher salaries than pharmacists working in outpatient settings, and pharmacists in outpatient settings are expected to do non-pharmacy tasks, making inpatient pharmacies more attractive. A pharmacist who works at a suburban supermarket pharmacy explained their observations of how pharmacists are approaching the job market: "I think in my area, there's plenty of pharmacists that are available, but they don't—they're more particular about the working conditions. They want to work where they're going to be well paid, where staffing is going to be adequate … where they're treated professionally, and they have breaks."

Some pharmacists commented on other issues with the job market in their area, affecting both pharmacists and technicians. Some pharmacists observed that some pharmacies in their area are hiring part-time or per diem staff, which from their perspectives is likely so the

[xviii] The 340B Program allows hospitals to buy outpatient drugs at reduced prices from manufacturers and can receive standard Medicare Part B reimbursements that are higher than their acquisition costs. For more information, visit: https://www.hrsa.gov/opa and https://www.cbo.gov/budget-options/60909

pharmacies do not need to pay benefits. However, one specialty pharmacy said they are hiring full-time pharmacists to staff the new pharmacies they are opening. Several pharmacists reported that they are dealing with challenges in hiring technicians because it is difficult to offer competitive pay, which contributes to high turnover.

Pharmacist Burnout

Several pharmacists reported that the increase in their responsibilities without a commensurate increase in pay is causing burnout. Several pharmacists who work for chain pharmacies agreed that they have feelings of burnout most during the autumn and winter when they are administering the most vaccinations. Two pharmacists highlighted that they would not recommend that someone starting a career go into pharmacy. A pharmacist who works at a chain with urban and suburban locations put into words the frustration several of the pharmacists felt about an increasing workload with stagnant compensation:

> *I feel like in retail pharmacy … the tasks keep increasing, the responsibility keeps increasing, with no money to show for it. If you're going to tell me to do another five things every shift, the least you could do is give me $10 to $20 more an hour. We're not even seeing a quarter more an hour.… We're seeing less money for more tasks. So, the burnout is very well and real for me: for everyone I know, for everyone in the area because of that.*

Some pharmacists described still feeling the effects of burnout from the COVID-19 pandemic. A pharmacist who works at a rural, independent pharmacy stated that: "During the pandemic, I was responsible for keeping our stores open. So, I think it actually hit me last year was when I'm like, 'I'm done. I'm done.'"

A few pharmacists described efforts at both the state and organization levels to improve working conditions and reduce burnout. One pharmacist at a chain pharmacy noted that the state boards of pharmacy have started to step in to improve the working conditions of pharmacists, and they have seen some limited improvements, such as a mandated lunch break in their state. One specialty pharmacist said that they help their staff prevent burnout by allowing them to switch tasks. For instance, pharmacists can adjust their role to have more patient interaction after working in the fulfillment center for a stretch of time, which they said helps to address burnout.

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