Independent pharmacies struggle
By Linda Baker
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Bob Coulter, an independent pharmacist in La Grande, is bucking industry trends. Between 2009 and May 2011, the number of independently owned pharmacies in Oregon dropped from 161 to 97. During that same period, Coulter, who already owned two drugstores in La Grande, decided to open another one, the Olive Branch in Enterprise.

Collectively, the three stores are on track to gross $6 million this year, up 20% from the year before. “There are potential rocky roads ahead,” says Coulter, referring to uncertainty over health care reform legislation. “But with the baby boomers, it’s a good time in history to be in the pharmacy business,” he says. “As independents, we can compete.”

In 2011, those are fighting words, not just in Oregon, but around the country, where many independent pharmacies are struggling to stay afloat. Nationwide, there were 22,728 independent pharmacies in 2009, down from 24,345 in 2005. Although the number of independents nationally did increase by a few hundred last year, market share for community pharmacists continued to decline. According to an analysis by Adam Fein, a Philadelphia-based pharmaceutical consultant, independents filled 6.3 million fewer prescriptions in 2010, making them the only pharmacy format to shrink last year. In Oregon that format been shrinking for quite some time. In 2006, there were 221 independents in Oregon, more than twice as many as exist today.

“The neighborhood pharmacy is not so different from the neighborhood hardware store, which became Lowe’s and Home Depot,” says Gary Schnabel, executive director of the Oregon Board of Pharmacy. “Our business model promotes bigger ones eating the little ones.”

The plight of the independent drugstore is a reflection of larger retail trends. But as health care providers, independents are also subject to larger political and market forces. Fifty years ago, consumers paid for about 90% of all prescription drugs. Today only 20% of all prescriptions are paid out of pocket, with the balance paid for by private insurance plans or government programs such as Medicare or Medicaid. At the mercy of third-party reimbursement rates and payment schedules, independents also face
growing competition from mail order pharmacies — dispensing facilities that are owned by pharmacy benefit managers (PBMs), huge corporations that manage more than 90% of prescription drug plans in this country.

“It takes a lot more effort to stay in business today,” says Gary Balo, the proprietor of Paulsen’s Pharmacy in Portland, a store that has been in operation since 1918. “There’s more paperwork and the big insurance companies make the rules.” But other market conditions, such as an aging population, are more promising. Competing as an independent, Balo says, requires carving out a niche and banding together with fellow owners to boost purchasing power and political clout. In an era of health care reform, it also means convincing consumers and legislators that neighborhood drugstores are not relics of the past, but instead play a role in containing costs and improving patient outcomes. “We provide a service that cannot be matched,” says Balo.

Fein, who writes a well-known industry blog, DrugChannels, puts it more bluntly. “I have a tough-love message for independents,” he says. “Get big, get focused or get out.” The independent pharmacy industry represents a $94 million marketplace and employs about 62,000 pharmacists, according to the National Community Pharmacists Association (NCPA). Although there are no official figures on the value of the Oregon market, there are about 624 retail pharmacies in Oregon, including independents, chains such as Rite-Aid and mass merchants such as Walmart.

To understand why so many independent pharmacists in Oregon chose to “get out” last year, start with the fact that many of the owners were in their 60s or 70s. “It was a huge slide,” acknowledges Diana Courtney, owner of Lake Shore Pharmacy in Lake Oswego and a member of the board of directors for the Oregon State Pharmacy Association. But according to Courtney, many of the pharmacies didn’t close for lack of business; they closed because the owners were retiring and there was no one to take over. David Swenson, the former owner of Bandon Pharmacy in Bandon, one of the 64 that closed over the past two years, is a case in point. Swenson, 73, spent the last eight years trying to sell his store — to no avail, although he did manage to sell his inventory to another Bandon pharmacy, Tiffany’s. “There’s a glut of us on the market,” he says.

Why? Certainly, the economy played a role. So did the workplace benefits, or the lack thereof, according to Swenson. “If you work for a chain, you get time off and paid vacations,” he says. “With independents, you don’t get that.”

Bob Coulter didn’t get out — he got big and got focused. Nevertheless, his story also helps explain why community pharmacies are on the decline in Oregon.

In 1983, Coulter purchased Red Cross Drug in La Grande, then 18 years later opened Red Cross Institutional Pharmacy, which exclusively serves assisted living and retirement homes — totaling 250 beds. Coulter says he opened Olive Branch, the Enterprise store, because of the “unmet need” in Wallowa County, which has a population of 7,000 people but only one other pharmacy, located in the Enterprise Safeway. It takes about 3,000-4,000 people to support a single pharmacy, says Coulter,
adding that Olive Branch broke even after three months — “a short time for a startup.”

According to the NCPA, about 65% of all independents are in rural areas, and the average owner of an independent pharmacy owns about 2.5 stores. A poster child for independent drugstore owners, Coulter is also quick to identify the rural location as a potential drawback for next-generation pharmacy school graduates. “A lot of it is that people don’t want to live a rural lifestyle,” he says. “This is a geographically isolated county.”

The 21st century desire to live in cities is one of the macro forces bearing down on the community pharmacy industry. The health care marketplace is another. In 2006, for example, the federal government began subsidizing prescription drugs for Medicare recipients under Medicare Part D, replacing what had been a cash business for pharmacies. Twelve months later, 1,500 independents around the country went out of business. Most pharmacists have weekly wholesale drug bills to pay, explains Balo. So in the early days, when Medicare plans took about six to eight weeks to reimburse, pharmacies went under. “For the independent, it’s all about managing cash flow,” he says. Today, most Medicare plans take about two weeks to reimburse.

Like many independent pharmacists, Balo belongs to a wholesale provider group, in his case the Good Neighbor Pharmacy, a brand that gives members access to private-label purchasing, marketing materials and managed care networks. The store’s niche products and services include free home delivery, specialized “bubble packing” that allows seniors to keep track of medications in their homes, and customized drug preparations that range from cancer medications to veterinary antibiotics. Hard-to-find skin care creams, Medicare-approved “durable medical supplies,” and an old-time soda fountain featuring $2.75 root beer floats add to the offerings.

Like most independents, the bulk of Paulsen’s annual pharmacy sales, about 85%, come from prescription drugs — the national average is around 94%. Chain stores, by contrast, rely more on “front end” merchandise such as food and toiletries that can be marked up to compensate for flat rate drug reimbursement or dispensing fees.

Market diversification gives the Rite Aids of the world an edge. Nevertheless, in the David vs. Goliath tale community pharmacists like to spin about themselves, the giant is not so much the chains — or the government — as the pharmacy benefit managers. Most independents have contracts with the three biggest PBMs — Medco Health Solutions, Caremark and Express Scripts — but typically have little control over the terms. “The medicine might cost $200 and the contract pays us $202,” says Ann Murray, who, with her husband, John, owns two Murray’s Drugs, one in Condon and another in Heppner. “Most businesses have to make 20% to cover overhead,” Murray says. “You can’t expect pharmacies to survive by giving it away.”

The biggest problem with PBMs is they push consumers toward their own mail-order pharmacies, says John Murray. When the PBMs sell direct, they are able to negotiate better rates with drug manufacturers, and offer deals such as a three-month supply of medication for the cost of one. In the last few years, Murray estimates he’s lost about
20%-50% of his prescription business to mail order.

Aimed at reducing costs, mail order actually increases waste, Murray and other pharmacists contend, because patients change prescriptions before 90 days or because people take the medicine improperly. PBMs counter with their own studies saying that people are more likely to take medicines when by ordered by mail — and that mail order saves consumers and health plan sponsors money. “Independents always argue that we’re squeezing them out of business,” says Thom Gross, a spokesperson for Express Scripts, adding that independents are actually more profitable than other drug channels, including PBMs.

The National Community Pharmacists Association is engaged in an ongoing battle with the PBMs, an effort that includes lawsuits related to deceptive practices and unfair competition. Pennsylvania and New York are also considering legislation prohibiting PBMs from mandating their customers use mail order.

In Oregon, independent pharmacies are tackling other political and economic issues with varying degrees of success. The sector scored a big win in 2009 with the creation of a “critical access” pharmacy category under the Oregon Prescription Drug Program, which provides coverage to people without insurance, as well as thousands of teachers through the Oregon Educator Benefits Board. After community pharmacists in rural counties complained the program’s reimbursement rates were too low, Rep. Greg Smith (R-Heppner) helped lobby for the new category, defined as the “sole pharmacy in a community within a 10-mile radius of other pharmacies.” Such pharmacies, including Murray’s Drug in Condon — the only store within a 90-minute drive — receive a higher dispensing fee.

People in rural areas often have to drive 20-30 miles or rely on mail order, says Scott Eklad, director of the Oregon Office of Rural Health. “Particularly for emergent conditions, that is not good health care.” The critical access program, Eklad says, recognizes the value of rural pharmacies and the importance of helping them become financially viable.

The budding “Entrepreneurial Academy” at Oregon State University’s College of Pharmacy is another effort to shore up the struggling sector. The program aims to get a new generation of students excited about working in non-hospital settings, says Courtney, who is helping organize the curriculum. The academy will “focus on the business and marketing knowledge” needed to run a stand-alone pharmacy, instead of working as an employee, Courtney says.

Whether these initiatives will compensate for health care reform efforts is unclear. In January, for example, Oregon adopted a new benchmark for Medicaid pharmacy reimbursement, a move experts agree will lower reimbursement rates and profitability for independent drug stores. Community pharmacists also oppose a bill that would allow physicians’ assistants under certain circumstances to dispense medications, a policy shift favored by one-stop medical and urgent care clinics such as ZoomCare, a Hillsboro-based company. “We want to make sure we’re not being kept out of the loop,”
Today, the independent pharmacist, like the health care system itself, is at a crossroads. On the one hand, more people are buying more prescriptions. Balo, for example, is filling more prescriptions than in previous years, an increase he attributes to an aging population and the tendency for doctors to prescribe multiple medications for a single condition, such as high blood pressure. And at a time when many doctors spend less than 10 minutes with patients, Balo says his clients appreciate the personal service and medical advice. Portland’s neighborhood-based buy-local ethos also bolsters his business, Balo says. But Portland’s buy-local sensibility didn’t help the iconic neighborhood drugstores that have closed in the past 10 years: Dickson’s in Montavilla, Phoenix on Foster, and NW Portland’s Nob Hill, featured in the Gus Van Sant movie Drugstore Cowboy.

These retail and demographic trends are up against what Coulter describes as “a health care system we can’t afford.” And to reduce health care costs, many businesses will have to make less money, be it doctors, mail-order conglomerates or independent pharmacists.

What distinguishes the independent drugstore is that its fate intersects with other key issues of our time: how to balance big-box affordability with the values of neighborhood enterprise, and how to preserve rural America. Of course, all of these debates have been unfolding for a long time. Amid the latest wave of closures, Oregon’s surviving pharmacies remain upbeat — perhaps out of necessity. “People have been predicting our demise for 50 years,” says Courtney. “But 50 years later, we’re still here.”