

Managing wholesaler agreements in the fee-for-service era

Many health care providers have built their pharmacy operations on the premise that product distribution will be subsidized by manufacturers. However, changes in the manufacturer–wholesaler relationship signify that buyers are likely to face higher product-acquisition and product-distribution costs. Hospital pharmacists and their group purchasing organizations (GPOs) should monitor wholesalers closely to make sure manufacturers incorporate hospital pharmacy perspectives into channel-planning decisions.

The dynamics of the industry have created a situation in which hospital buying groups and large retail pharmacies effectively negotiate away their portion of the wholesaler's gross margin. Some buyers obtain cost-minus pricing structures in which the wholesaler also concedes a portion of its manufacturer-derived discounts to the customer.

In response to these discounts, manufacturers stepped in to support the costs of distributing their products to customers. Until four years ago, most drug makers compensated wholesalers by allowing them to purchase more products than near-term sales demand required. Wholesalers could earn as much as 40% of their margin by holding extra inventory and selling it when prices increased. Cost-minus pricing was ultimately profitable because the incremental profits from investment buying compensated for any lost sell-side margin. Wholesalers earned an additional 40% of their margins from manufacturers' prompt-pay discounts, providing them with interest income and a relatively cheap source of working capital from the float between customer receivables and manufacturer payables.

Manufacturer–wholesaler relationships have now been transformed by fee-for-service agreements. To avoid stockpiling, manufacturers pay wholesalers to not hold more than one month of inventory. Most fee-for-service agreements also provide wholesalers with additional compensation to offset revenues lost by discontinuing inventory investment. Net profits for wholesalers are lower but more predictable.

Looking ahead, hospitals will find themselves paying for a greater portion of product distribution costs. Wholesalers now share detailed order, inventory, and shipment data with manufacturers, making wholesalers increasingly unable to offer deep discounts as a way to gain volume for investment buying. The manufacturer's prompt-payment terms are also becoming less generous, due in part to upcoming Medicaid

changes that will disallow the deduction of prompt-pay payments from average manufacturer price calculations.

GPOs and hospital pharmacies should recognize that the new manufacturer–wholesaler agreements were negotiated without direct input from customers. GPO executives should demand full transparency to the computation of wholesaler performance incentives embedded in the new manufacturer–wholesaler agreements. Other improvements could include a specific definition of important metrics such as adjusted fill rate and the requirement that a hospital's payment terms reflect the cost of capital rather than an arbitrary industry standard.

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GPOs and hospital pharmacists must take care to monitor wholesaler fill rates for key products and even require transparency to raw fill rates throughout their inbound supply chain. According to my company's analyses, the largest three drug wholesalers now hold 24 fewer days of inventory in their warehouses and have avoided an incremental \$8.4 billion of inventory investment on their balance sheets. Hospital pharmacies, which rely on daily replenishment from wholesalers, are at great risk of inadequate product availability.

There is some anecdotal evidence suggesting that today's reduced inventory levels might be limiting a wholesaler's ability to maintain product availability during a supply disruption. Amerinet, a leading GPO, has determined that orders are not being filled as completely by wholesalers and identified fee for service as one cause of the performance decline.¹

Manufacturers, GPOs, and wholesalers could also work together with hospital pharmacies to evaluate the ASHP Drug Product Shortages list, determine if inventory agreements have contributed to shortage or limited availability either nationally or regionally, and take corrective actions to minimize any potential disruptions to patients or quality of care.

Even if channel inventory levels are adequate, GPOs should build better relationships with pharmaceutical manufacturers' key decision-makers to avoid distribution changes that disproportionately burden hospital pharmacies. A go-it-alone model is inappropriate for most hospital systems, making fair and transparent agreements more important than ever.

1. Basta N. GPO's data tracking reveals declining fill rates in pharmaceutical deliveries from wholesalers. www.pharmaceuticalcommerce.com/frontEnd/main.php?idSeccion=300 (accessed 2007 Apr 12).

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