Health Policy Statement Number Seven And Marketplace Competition In the Health Care Supply Chain:

A Market-based Analysis

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Introduction

On September 26, 2003 the Department of Justice and the Federal Trade Commission held a joint hearing debating the merits of revising Health Policy Statement Number Seven. That statement specifically provides for an antitrust safety zone for health care Group Purchasing Organizations provided they stay within a very broad set of criteria. Although the policy statement may have been appropriate at the time it was drafted the health care supply marketplace has undergone enormous change, much of which has eroded the relevance of the current statement.

At the hearing each witness was given only fifteen minutes to make its case. Unfortunately, the complexity and importance of this issue cannot be fully addressed in a fifteen minute presentation. For that reason I am submitting this paper to expand and supplement my oral presentation.

This paper will address the current realities of the health care supply marketplace, the impact of harmful GPO contracting practices, the impact of those practices on innovation and make specific recommendations for consideration in revising the policy statement and begins with the following statement:

Health Policy Statement Number Seven does not sufficiently protect patients and caregivers, nor does it adequately support competition and innovation.

Defining the Group Purchasing Organization

In order to effectively address issues related to health care Group Purchasing Organizations one must begin by defining GPO types.

In a **proprietary GPO** each of the members is also an owner. An owner is directly involved in decision making, is represented in all matters by employees who have a direct fiduciary responsibility to the owner hospital, and shares fully in the distribution of excess supplier paid fees including but not limited to administrative fees. In a proprietary GPO the management and employees of the GPO are fully accountable to the owners and it is expected that the owners will provide the necessary oversight over the business practices of the GPO. Proprietary GPOs tend to have a limited number of members/owners. Once a certain size would be reached it would be difficult, if not impossible, for each member to have a significant say in the decisions made by the group.

Consorta appears to be an example of a proprietary GPO. Integrated Delivery Networks (IDN) and the growing number of purchasing cooperatives also fall into this category.

In a **membership-based GPO** members are not owners. The GPO is owned by a third party and contracts are made available to members on a voluntary basis. Members are given some opportunity to participate in decision making but not every member participates equally. The strategic direction and operating priorities of a membership-based GPO are determined by the owners and not the members and there is no financial accountability to the members beyond what might be contemplated in a membership agreement. The membership-based GPO may distribute excess supplier fees but is not obligated to do so except as is defined in its relationships with specific members. MedAssets is an example of a membership-based GPO.

The **hybrid GPO** is a cross between a proprietary GPO and a membership-based GPO. There are both members and owners/shareholders. Both have access to contracts but owner/shareholders receive a larger share of the distribution of excess supplier fees. Like membership-based GPOs, these organizations can be very large and for the majority of members there is little to no participation in decision making. Corporate governance oversight is limited to executives and a small number of shareholder CEOs. Novation and Premier are examples of hybrid GPOs.

The proprietary GPOs would seem to have the best alignment of incentives and the most ongoing oversight, thus placing some limits on the kinds of business practices they would be likely to engage in on an ongoing basis. The membership-based GPOs and the hybrid GPOs would appear to have the least amount of serious corporate governance and therefore be most susceptible to engaging in business practices that would either impair competition or enrich the GPO at the expense of members and taxpayers.

HCA and Tenet are two hospital chains that own their own hospitals and have both the volume and commitment necessary to drive what arguably should be the best pricing in the industry. Yet each formed its own Group Purchasing Organization. The only logical conclusion one can draw from this move is that they wanted to create GPO revenue. Both organizations developed hybrid GPOs; HCA formed Healthtrust and Tenet created Broadlane. Understanding precisely why each organization formed its own GPO would add a great deal to the federal government's understanding of the real marketplace impact of both the Safe Harbor and the Antitrust Safety Zone.

Changing Economic Drivers in the Health Care Supply Chain

When the Safe Harbor legislation was passed by Congress in 1986 the hospital industry was reeling from a significant change in Medicare reimbursement that had been made just a few years earlier. The idea of permitting Group Purchasing Organizations to collect fees from suppliers was clearly sold on the basis of the expected results of group

contracting, namely lower product costs for hospitals which would then be passed on to the Medicare program creating a win-win for hospitals and taxpayers. The need for those cost savings results seemed to have pushed discussions of the appropriateness of allowing GPOs to collect fees from suppliers right off of the table. Once the Safe Harbor was passed it was clear that an Antitrust Safety Zone needed to be established to govern how joint purchasing arrangements would work. Again, this all seemed to assume that the end justified the means.

Years later the economic realities of the health care supply chain do not even remotely resemble what was believed to be in place when the Safe Harbor and subsequently, the Antitrust Safety Zone were created.

Reality Number One: At the time the Safe Harbor was passed the GPO landscape was made up of hundreds of small regional groups, performing bidding functions and negotiating their own contracts. Although the Health Industry Group Purchasing Association (HIGPA) claims that there are hundreds of GPOs, the reality is that the majority of these "groups" negotiate very few contracts, perhaps some local contract on perishable food items. For most, their primary role is to serve as regional marketing organizations, signing up hospitals to participate in contract portfolios negotiated by one of the handful of large national groups that actually negotiate national contracts. This handful of large national groups is the direct result of significant merger activity that started after the passage of the Safe Harbor and continues to this day. The HIGPA definition of a GPO is so broad that a small regional cooperative of just a few hospitals is considered a GPO. Yet there is a world of difference between a large national GPO composed of unrelated shareholders and members in that the vast majority of affiliated hospitals have little to no say in contracting matters and an owned cooperative where every member has a voice and a stake in every contracting decision. There are many regional marketing organizations and small Integrated Delivery Networks but there are less than ten national GPOs with any real market power.

Reality Number Two: There is no valid proof of the cost savings claims of GPOs. In fact, their fees, their so-called successes, and their proliferation in the marketplace have all taken place in spite of the fact that they provide no objective means of measuring whether they have accomplished their mission. One would be hard pressed to find a company in any competitive market that could survive with the same ability to prove their value. Hospital products and pharmaceuticals can be broken down into three general categories. The first is sole source products. Sole source products are only made by a single supplier, are protected by patents, and provide no real leverage opportunity to GPOs or individual hospitals. High cost physician preference items represent an area of little opportunity for GPOs but can produce significant savings for individual hospitals and IDNs skilled in strategic sourcing. The third area, commodities, is where the GPOs have had their greatest historical impact. Volume aggregation and commitment have traditionally been the levers that created reductions in commodity pricing. But if taken to their logical extreme, even volume and commitment lose their ability to create lower prices. Once economies of scale have been maximized and supplier profit margins are reduced to bare bones, there is no additional volume that can produce a corresponding

price decrease. A number of years ago GPOs reached the limit on how far they could lower prices for most commodities. Contracting leverage had reached the point of diminishing returns. But over the past ten years modern manufacturing methods have reduced the cost of manufacturing and yet those efficiency savings have not been passed on to end users. And even though most commodities are manufactured from plastic which comes from resins which come from oil, the decrease in world oil supply that led to rising gasoline prices at the pump had no impact on the cost of commodities to end users. Compare this to significant price fluctuations in the latex glove market during times of lower latex production such as in the late 1980s. So we are left with only two possible conclusions. Either commodities have reached their pricing nadirs or competition has been artificially slowed.

Reality Number Three: While GPOs have aggressively competed with each other to attract members, there is little variance in pricing from one GPO to the next. If GPOs acting individually have not produced much in terms of competition between suppliers to reduce commodity pricing, perhaps they could produce it amongst themselves. However, the existence of the most favored nations clause in GPO-Supplier contracts prevents one GPO from having any significant pricing advantage over another GPO.

Reality Number Four: The absence of real competition on commodity prices has led to an explosion in fees. For the last several years talk of fee revenue has been replacing discussions of pricing discounts. Since there is no valid proof of measurable pricing reductions on commodity products one must contemplate that the multiple kinds of fees are, in fact, selective discounts offered to improve compliance and encourage consumption while protecting the manufacturer's baseline line item pricing from competition-based erosion. If fees are the new discounts, then those fees must find their way back to the hospitals and be credited toward the costs of care.

Reality Number Five: One significant result of GPO merger activity is that what started out as scores of simple regional contracting organizations have blossomed into a handful of monolithic GPOs that offer large numbers of "services" that chew up fee dollars before they are able to be returned to members. The original purpose of permitting the collection of administrative fees was to fund contracting activities. Today those fees cover the costs of GPO organizations who have hundreds or even thousands of employees engaged in providing "services" that on their own would not have enough value to convince more than a few hospitals to pay for them out of pocket. These added services provide questionable value to the member hospitals and little or no value to Medicare or the public at large yet they are paid for out of dollars that should be used to reduce the cost of providing hospital care.

While union members' Beck rights protect their right to legally choose to receive a refund of the portion of their dues used to support candidates or causes that they personally do not support, hospitals who are GPO members have no such right to opt out of having their portion of GPO collected fees be used to provide services they do not need, want or use. In the Beck decision by the U.S. Supreme Court about fifteen years ago, the court ruled that rank-and-file union members can be required only to pay dues

and fees that are directly related to the cost of collective bargaining and contract administration. Surely hospitals should have the right to opt of GPO services that go beyond bidding and contracting. In this way hospitals would be able to receive a greater portion of supplier fees and use that money for their own priorities.

Reality Number Six: It is difficult to understand how competition is served when large GPOs regularly renew or extend contracts without conducting bids. It is also troubling that bid data is never disclosed. This raises questions about how the bids are analyzed and if the lower bidder actually wins. Immediately following the Senate hearings in 2002 the two largest GPOs began a flurry of entering into multi-source contracts with large numbers of small suppliers. These contracting activities did not enhance competition because while small suppliers were added to the contracts large dominant suppliers who had the advantages of strong bundling programs did not lose the contracts. Although the GAO cited a percentage breakdown of new suppliers awarded contracts compared to contracts being held by existing suppliers, the statistic was flawed by the addition of significant numbers of small suppliers who had received courtesy contracts. There is no proof that such awards actually moved significant volume or market share to smaller suppliers. It should also be noted that a number of those contracts were of a much shorter duration than was given to suppliers with market power.

Reality Number Seven: The Antitrust Safety Zone provides private companies with special privileges generally reserved for government entities. Providing such privilege effectively places GPOs out of reach in terms of antitrust laws and their application. This is precisely what Robert Bloch was pointing out in his paper when he stated that it would be virtually impossible for a GPO to violate antitrust laws. The problem is that GPOs are private entities that should not have such privileges bestowed upon them unless they are willing to submit themselves to regular ongoing oversight and provide transparency and accountability, at least to the government. Since the government has chosen not to provide suitable oversight, the Antitrust Safety Zone must be significantly narrowed to protect the interests of patients and taxpayers. Currently, providers cannot incentivize actual participants in their supply chains to assist in cost reduction but private businesses, namely GPOs, can make decisions predicated on pure self interest and there is no means of disclosure, scrutiny or governance, much less any governmental intervention.

Reality Number Eight: Size, scope and fiduciary responsibility matter greatly. While it is true that there are a number of GPO business models in place one cannot escape the fact that size, scope and level of fiduciary responsibility of are paramount importance. As has been shown there are very few GPOs that actually negotiate contracts of significance. In addition to that, many hospitals clearly do not believe that they have the expertise to negotiate contracts on their own or the hospital CEO has made the decision to rely on a GPO. So even if participation in a GPO contract is completely voluntary many hospitals have little perceived choice but to use a GPO contract for their purchasing. (This is not a legal problem but rather points to a lack of supply chain awareness on the part of providers.) In the end this means that a manufacturer with market power and the ability to pay significant fees only has to win a few significant GPO contracts to effectively foreclose the market to competition. If there were only one car model made in the United

States, being that this is a free country, everyone would have the right to buy that car or not buy it. But if someone wanted to buy a car they would ultimately buy that car. Because there are only a few GPOs that negotiate large contracts ultimately a hospital that perceives that it has little or no buying power on its own will choose to use a GPO contract negotiated by a one of those GPOs. And in many, if not most, cases that same hospital will buy products made by a manufacturer with market power. To a dominant supplier holding several major GPO contracts, having the pricing protection of most favored nations clauses firmly in place and its own bundling power at work on local, corporate and GPO levels, it matters little which GPO the sale is made through. Large volumes will be sold and profit targets will be met and any costs associated with working with a GPO, namely fees, are simply passed on to the hospital in the contract prices that were constructed to account for the cost of the fees. The dominant supplier wins and the GPO wins but does the hospital win and more importantly, do Medicare and other payors and the taxpayers win? Too often the answer to that question is no.

It is also clear that when GPOs require manufacturers to pay fees to the GPO just because the hospital who buys product from the GPO appears on the membership roles of the GPO not because the GPO played any role in negotiating the contract that the GPO is not delivering value to anyone and is enriching itself because it can. When it collects fees that it did nothing to earn a GPO is functioning as a toll collector on a toll road and nothing more.

Reality Number Nine: Commodity suppliers complain that they can't reduce prices any more but they are able to provide financial support to practically every institution in the industry with no apparent negative impact on their profitability. Practically every major event in this industry is funded in large measure by payments from suppliers in exchange for trade show booths or face time with attendees. Have hospitals traded away their contracting leverage in exchange for donations here and there? Do they not realize that everything a supplier gives them comes directly from their own pockets when they buy that supplier's products? A look at Johnson and Johnson's 2002 Consolidated Statement of Earnings shows that Selling, Marketing, and Administrative Costs as a percentage of Net Revenue is forty-seven percent! One wonders how much of that number is fees paid to GPOs and contributions made to industry events and organizations.

Reality Number Ten: In order to win new customers some GPOs are offering what they call guaranteed savings. If the hospital does not save what the GPO promised the GPO will write a check to make up the difference. The problem is that the money used to cover the check comes directly out of fees received from suppliers, money which should be returned to other members who earned those funds as a result of their compliance and participation. There has been some anecdotal information about hospitals receiving checks up front when changing GPO affiliations and this business practice, if true, must be closely scrutinized. Tenet executives in California are alleged to have done something similar to this and they are being criminally investigated.

The Impact of Specific GPO Contracting Practices

Although the following contracting practices are said to be GPO practices each clearly has significant benefits to suppliers. The fact that GPOs seem willing to go along with them may be an indication of a marketplace power shift in the making.

1. Long Term Committed Contracts – The use of long term committed contracts creates a significant barrier to survival for suppliers who do not win GPO awards. Apart from receiving at least one major award from a major GPO, a small supplier's odds of being able to survive until the next bid are questionable at best. This practice increases the market power of dominant suppliers and reduces competition. This situation is compounded in the light of a relatively small number of contracting organizations. A single hospital or IDN acting on its own simply does not have the power to foreclose competition in the way that a large national GPO can. Although GPOs will argue that there was significant competition and opportunity at the initial bid and award, that competition fades quickly in the absence of subsequent significant and frequent competitive events. Furthermore, any competition created at the bid is only valuable if it is the lower prices that actually gain contract awards. The fewer the competitive events the less opportunity there is for the benefits of competition. Prices will not drop without some competitive event causing them to do so. The issuing of any contract in excess of three years may be a clear indication on the part of the GPO of its recognition that the commodity in question is no longer open to market competition.

2. Sole Source Contracts – It must be stated that when used judiciously by individual hospitals or IDNs, sole source contracts are likely to produce superior cost savings results. But a sole source contract awarded by a large national GPO does have the ability to foreclose competition especially if the same supplier continues to win the bids with the same GPOs year after year. How long has it been since someone other than Ethicon won the suture contract with Novation? Surely, U.S. Surgical would have figured out how low they needed to bid in order to win that contract by now! How long have other manufacturers been with Novation and Premier and other GPOs? Are the people who run the companies that don't win the bids with these large GPOs simply unable to get it right time after time after time or is there something else going on? The extension of any sole source contract by a large national GPO in the absence of a competitive bid should be considered to be an anticompetitive act.

3. High Commitment Levels – High commitment levels are closely related to the concept of sole source. In both cases the goal is to create a compliance lever which gives the supplier more of the volume they had hoped to get in the contract arrangement. Both high commitment levels and sole source contracts also reduce competition when used by large national GPOs. If a small supplier cannot win the large contract and cannot even win enough left over business to allow them to create economies of scale then even if they last until the next bid they are sure to enter the bid process as a weak competitor making them a greater financial risk to the GPO and its members. This can become a

cycle in which competition is eroded or eliminated and all that is left to decide is the size of the fees that will be paid to the GPO by the dominant or sole supplier.

4. Bundling - Bundling has a variety of forms but each form is an attempt to foreclose market share to smaller competitors who cannot match the power of the bundle. Like the other strategies bundling has the power to make dominant suppliers even more powerful. There are essentially three variations of bundling. The first is the GPO corporate bundle and it is best demonstrated by the Novation Spectrum Opportunity Program. This bundle is created by the GPO in the hopes of driving volume over a long period of time resulting in periodic financial benefits with a large payoff at the end of the five year term. The Spectrum program is the Godzilla of contracting programs in that it actually includes aspects of each of the other contracting practices discussed here. The Spectrum program places a heavy emphasis on fees, which one can only hope find their way back to the hospital member participants. In the GPO corporate bundle hospitals who choose to participate must agree to buy a high percentage of their needs from a portfolio of selected suppliers for a period of time, often five years, in order to be eligible for rebates much of which will be paid at the end of the program. The second form of bundling is when a GPO gives its approval to a dominant supplier partner to use the leverage of its broad product line to form a bundle which prevents a member from switching to use another supplier's product, even though that supplier may also have a contract for a particular product line. Although the new supplier may have a better price and a better product the manufacturer with the bundle can inform the hospital that if it chooses to buy the product from the new supplier that its prices on the other items it buys from the large manufacturer will go up. Often the hospital will evaluate the total picture and decide that the new product is not worth the higher costs it would have to pay on its other items. In this way the GPO helps maintain the power of the dominant supplier. The third form of bundle is the same approach but without the tacit approval of the GPO. Bundles are designed to lock out the competition and the more business a hospital does with a multi-line manufacturer the more likely it is to experience the negative effects of bundling. If one were to add up the prices of the items in the bundle in almost every case they would be higher than what can be done on an individual basis. We would never allow such a thing to happen in the competitive merger appeal process but for some reason it is okay here? That seems very inconsistent.

5. GPO Private Label Programs – Although only two GPOs actively participate in private label programs they are nonetheless a questionable contracting practice and in one case play a significant role in corporate bundle program. Private label programs are used extensively in the retail market where a supplier wishes to expand its market share while protecting its pricing on its branded products. The program is effective because retail customers more easily identify with the label of their local grocery or discount department store chain. In the retail market, the brand of the private label has a value that will drive sales to consumers. But make no mistake: private label products have two distinct advantages to a consumer goods manufacturer. First, it provides the ability to create incremental revenue without sacrificing the profit margins of the brand products that actually sustain the company's profitability. Second, it serves as a defensive

leveraging technique by making it harder for a competitor to enter the market on the basis of price. Manufacturers have no intention or reason to cannibalize the value of their brands by increasing their sales of private label products at the expense of their sales of brand name products. Brand names carry tremendous value and the worth of many consumer products companies is intrinsically tied to the specific brands they sell.

Hospitals, however, are not household consumers. They do not shop the aisles of the nearby super-center. There is no need for a physician or nurse to ask for a private label product by brand and they do not, for the most part, care about the label on a box of cotton balls. There is no marketing advantage to be gained from a GPO selling private label products. The pharmaceutical and medical-surgical commodities that are the mainstays of GPO private label programs are widely available in generic form precluding the necessity of buying them from a branded manufacturer. If the issue is simply price there are many companies from which they can buy generic products. But for the medical or pharmaceutical manufacturer, private label offers the same advantages as it does to manufacturers of retail consumer goods. Manufacturers can gain market share and incremental profits without jeopardizing the value of the branded products they sell and at the same time prevent competitors from being able to enter the market on price. Both create significant advantage for the dominant suppliers but seem to offer little to the GPO or its members. So, if private label offers only minimal pricing reduction value to GPO members, and from a long term perspective it may reduce competition by making dominant suppliers more dominant, why would a GPO get involved in a private label program? The only possible reason could be that the GPO receives a combination of fees and a share of the supra competitive profits of the co-ownership of the private label brand with the manufacturer. If commodity product pricing is not as low as it can go and significant margin remains, the co-ownership of the private label brand provides a conduit for the manufacturer to reward the cooperation of the GPO by sharing in its supra competitive profits. This could be easily validated if one were in a position to compare the fee percentages of private label products of a GPO to the fees paid to the GPO by the same manufacturer for the same branded product.

6. Supplier Paid Fees – Although the Safe Harbor permits GPOs to collect fees from suppliers it creates a very dangerous situation that begs the very notion that such a permission would somehow improve competition. Money is one of the most powerful forces on the planet. In fact, one of the most enduring characteristics of our capitalistic society is that if one understands all the incentives, behaviors are clearly predictable. To expect that GPO contracting decisions would not be affected by their ability to collect fees from suppliers defies logic and completely ignores human foibles. The Safe Harbor should have demanded the most intense oversight possible. Instead, the current Antitrust Safety Zone is broad, vague and assumes that GPO officials are inherently above reproach and would be unable to engage in antitrust and/or self-indulgent behavior. Either the Safe Harbor must be repealed or the Antitrust Safety Zone must be narrowed sufficiently for it to be of any value in supporting enforcement actions and protecting competition.

If fees have largely replaced discounts, why is it that while Consorta reports it will return 71% of the fees it collects to its members, Premier will only return 40%, and Novation a mere 32% of which half is likely to be in cash and the other half in credits that can be applied to the purchase of Novation or VHA services? Recently, VHA voted to permit these credits to be applied to services provided by Neoforma, Novation's majority owned E-commerce company, that is also a public corporation. In Novation's case, does that mean that Novation keeps 68 cents out of every dollar it collects in fees? Where does that money go? How is it being used? Does any of that 68 cents ever make it back to the hospitals? How many programs do Novation and Premier have that are funded by fees? Do the hospitals on whose purchases much of those fees were generated, have the ability to opt out of funding those services (Beck rights) and take the much needed cash discounts instead?

The area of fees is a critical discussion because ultimately supplier fees paid to GPOs are passed on to hospitals in the prices paid for products. To the extent that any hospital receives Medicare reimbursement that is the extent to which Medicare and ultimately taxpayers are paying for the GPO fees. That fact alone cries out for greater oversight over the business practices of GPOs.

Unintended Consequences of GPO Contracting Practices: The Competitive Tipping Point

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When small regional contracting organizations ruled the GPO landscape it was highly unlikely that the actions of any single GPO could create market foreclosure to any single supplier or reduce competition in the marketplace as a whole. While the rapid growth of large national GPOs fueled by a plethora of mergers served to consolidate and aggregate purchase volume it also raised the stakes of each bid for the business of each GPO. Fewer but larger GPOs meant fewer opportunities for suppliers to make large market share gains. So the large national GPOs had more power and each supplier had more to lose on each bid opportunity. Longer contract terms had the exact same effect. With the GPOs having so much power and suppliers having so much to win or lose the stage was set for a change in the currency required to win a bid. While smaller GPOs with smaller contracts could only demand the standard three percent administrative fees, the larger groups found themselves in a position to demand or suggest an ever growing fee component to the overall supplier offering. During this same time pricing reductions on commodities began to slow and the fees could create additional value to the GPO and its members.

Over time each of the large national GPOs began to focus more of its efforts on fee revenues rather than on price reduction. All of the above contracting practices had played a significant role in enhancing the health care supply chain's "natural selection process". Suppliers with market power used fees to cement their dominant positions and in exchange GPOs directed more and more business to them.

But in their zeal to feed the ever increasing appetite for fees some GPOs may have made a tragic miscalculation. Instead of managing competition, many GPOs chose simply to manage a few critical relationships. The result of this was that the competitive tipping point had been reached with a number of suppliers and that trend continues today. When purchase volume reaches the point where additional purchase volume will not produce any significant value to the supplier and when competition has been eliminated or incapacitated and when the GPO has become overly dependent on supplier fees, the GPO is vulnerable to losing its leverage to the dominant supplier. When that happens the dominant supplier controls the terms of the relationship and the GPO becomes a passenger in a vehicle it is no longer driving.

How could such a situation happen? In the world of professional procurement short term tactical price improvements are almost always subject to the overall need to stimulate competition in any market or product area. Failing to promote competition ultimately decreases a buyer's leverage and harms his organization. Procurement professionals outside of the health care provider market are actively engaged in programs that develop their supplier base, ensuring that competition will be maintained or improved. Procurement professionals understand that it takes more than an occasional bid to maintain a competitive marketplace. Instead of using the aggregated volume of their members to lead the industry into its technological future some GPOs seem to have chosen to become partners with dominant suppliers. By failing to maintain a focus on fostering competition some health care GPOs may have squandered the market power of the purchasing volumes entrusted to them by their members. One notable example of how a GPO can prohibit competition through its contracting practices is found in the language of Novation's Spectrum II Opportunity Program where hospitals that join the program are prohibited from even evaluating new products that could compete with the Novation contracted supplier. The value of compliance in a purchasing contract is clear but when compliance requires the abandonment by a hospital of its responsibility to evaluate new products that could improve treatment for its patients or safety for its caregivers, something is terribly wrong and demands responsible action by those in a position to do so.

Recommended Contracting Practice Rules for GPOs Desiring to be Covered Under the Antitrust Safety Zone:

If the goal of the Department of Justice and the Federal Trade Commission is to safeguard competition in the medical supply industry the following recommended contracting practice rules for GPOs must be given serious consideration.

1. Prohibit the use of Evergreen clauses in GPO supplier contracts.
2. Replace the current Letter of Commitment document with a copy of the actual GPO-Supplier contract with an amendment to include the specific hospital as a participant in the contract. Furthermore, no hospital should be held accountable or

termination penalties found to be enforceable if their letter of commitment does NOT specifically disclose all of the terms and conditions of the core corporate agreement and all sub agreements.

3. GPO contracts should be for no longer than three years. In the case of disposables that are proprietary to a particular piece of capital equipment with a useful life that extends beyond the term of the GPO contract hospitals should be free to extend their contract for proprietary disposables through the expected useful life of the contract with the original supplier and a GPO should not be able to coerce a hospital to prematurely switch its capital and related disposable agreements.
4. Prohibit no bid contract extensions or renewals.
5. Require GPOs to publish and adhere to bid schedules.
6. Require GPOs to publish bid results to insure greater accountability and facilitate competition by explaining the factors that went into making the award including why the low bidder did not receive the bid if that were the case.
7. Prohibit GPOs from contractually preventing their members from exploring and evaluating new medical technologies.
8. Require GPOs to submit annual financial disclosure statements with the OIG HHS specifically accounting for all fees received from each supplier along with the total dollar volume of purchase pass through for each supplier and the calculation of an effective fee percentage.
9. Subject GPOs to periodic audits to evaluate business practices and sources and uses of fees.
10. Establish transparency and oversight in the bid process by appointing independent observers to be present when bids are opened.
11. Require Membership-Based and Hybrid GPOs to create and manage supplier development programs beyond current initiatives such as HUB programs and new technology review Programs.
12. Prohibit GPOs and their executives from any form of ownership of suppliers.
13. Prohibit any form of ownership of or investing in an e-commerce venture.
14. Require GPOs to return a minimum of 80% of all fees collected to their members within three months of the close of any fiscal year. Fees must be returned in the form of cash. Start at 50% and require the 80% threshold within three years. In light of the fact that GPOs have not been able to quantify their savings to their members, the return of anything less than 70% would strongly suggest that the cost of running a GPO is too high when compared to the results produced. By applying a Beck rights to GPOs an opt out provision could be created that would allow a hospital the ability to check off the amount of fees they will expect returned to them based on the number of GPO services they choose to use. (Ideally, all supplier fees would be paid directly to hospitals and included in their cost reports. Then GPOs would bill the hospitals for their services and be paid by the hospitals thus eliminating all incentives for self-dealing and self-interest.
15. Establish parameters for acceptable uses of supplier generated fees to match the original intended purpose of the fees, namely, to cover only the cost of legitimate contracting activities.
16. Prohibit use of the most favored nations clause in GPO contracts.
17. Prohibit GPOs from involvement in private label programs.

18. Prohibit GPOs from determining which distributor a hospital will use or collecting fees from distributors.
19. Prohibit GPOs from soliciting fees from suppliers on behalf of their owned E-Commerce companies.

Conclusion

In evaluating the role of GPOs in competition in the health care supply chain marketplace one cannot escape the conclusion that GPO decisions are significantly influenced by supplier fees. Although GPOs protest to the contrary, the secretive nature of their business dealings and the mysteries of their governance practices strongly suggest a different reality. Up to this point the government has been squarely against eliminating the Safe Harbor yet at the very least it must recognize the danger that supplier paid fees create in a totally unregulated environment. If it can be agreed that GPOs are not de facto government agencies with the protections thereof, then it is time to require full accountability, full disclosure and undisputable proof of their value. They consume too many dollars and control too much of the health care supply chain for them to continue to operate with the benefits of the Safe Harbor but apart from any mandatory government oversight.

About the Author

Lynn James Everard, C.P.M., CBM is a twenty-two year veteran of the healthcare industry. His work has spanned numerous segments of the healthcare provider side of the business. He is a Certified Purchasing Manager (C.P.M.) and a Certified Business Manager (CBM). Mr. Everard is a healthcare business educator, supply chain strategist and thought leader. He is the author of over seventy-five published articles and four white papers including “Blueprint for an Efficient Health Care Supply Chain” and “The Impact of Group Purchasing on the Financial Prospects of Health Systems: Changing Value Perceptions and Unintended Consequences.”

About the Foundation for Healthcare Integrity

We are committed to improving competition in the health care supply chain by realigning financial incentives and reforming questionable business practices that stifle innovation. Some of these questionable business practices also infringe on the prerogative of physicians to use the products that they believe will best treat their patients. Misaligned financial incentives can place hospital CEOs in the untenable position of having to chose between saving money and providing their nurses and other caregivers with safe and effective products that will minimize the workplace risks they face in caring for their

patients. The Foundation for Healthcare Integrity has applied for 501 (c) 3 status as a non profit organization. www.healthcareintegrity.org.