

# **Defining and Measuring Product-Based Cost Savings in the Health Care Supply Chain**

**Research and Report By**

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## Introduction

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U.S. hospitals continue to face enormous financial pressures. According to a survey of hospital CEOs conducted by the American College of Healthcare Executives, seventy-one percent of hospital CEOs reported that financial challenges are their top concern.<sup>1</sup> Therefore, it is necessary and prudent to continually assess options available to hospitals to reduce their costs of doing business. Labor costs, making up roughly fifty-five percent of a typical hospital's operating budget, continue to grow because of a shortage of nurses and other clinicians that drives up those costs. Non-labor expenses including supplies, equipment, pharmaceuticals and purchased services make up the bulk of the remaining forty-five percent and continue to grow as well.

For decades hospitals have relied on Health Care Group Purchasing Organizations (GPOs) to keep their supply, equipment and pharmaceutical costs in check. During that time GPOs have reported that they produce significant product cost savings for their members. On the basis of those claims Congress passed a Safe Harbor to grant GPOs the unusual power of being able to collect fees from the suppliers to whom they award contracts.

Almost twenty years have passed since the Safe Harbor was enacted. Yet, in all that time no scientific, in-depth studies have ever been done to substantiate the claim that GPOs actually save hospitals money. The only report, a government review regarding pricing, was conducted by the General Accounting Office in April 2002. They found that "GPOs' prices were not always lower and were often higher than prices paid by hospitals negotiating with vendors directly."<sup>2</sup> There have been a number of opinion surveys put forth to "prove" that GPOs save money and to suggest the amount of costs possibly saved by GPOs. But surveys are best used to gauge opinion rather than to establish public policy. At the same time, hospitals and hospital organizations are reporting sharp increases in the cost of medical supplies and pharmaceuticals as a major factor in the cost burden borne by hospitals. The Massachusetts Hospital Association reported this in a September 28, 2004 press release<sup>3</sup> and Tenet made a similar statement in a December, 2004 press release<sup>4</sup>. Are these cost increases and concerns an early warning sign that GPOs have lost their ability to leverage lower prices or mitigate the rate of pricing escalation?

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<sup>1</sup> ACHE, Research Survey: Top Issues Confronting Hospitals: 2004, ACHE web site, [www.ache.org](http://www.ache.org).

<sup>2</sup> "Group Purchasing Organizations: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices", United States General Accounting Office Report, April 30, 2002, p4.

<sup>3</sup> Massachusetts Hospital Association, Press Release, September 28, 2004, Massachusetts Hospitals Still Navigating Rough Financial Waters

<sup>4</sup> Tenet Healthcare, Press Release, December 13, 2004, Tenet Says Fourth Quarter and 2005 Results Will Remain Under Pressure

The time has come to substantiate or refute GPO cost savings claims. If GPOs do produce valid and verifiable cost savings beyond what hospitals could do on their own and they do not slow the introduction of new technology or unnecessarily create supplier monopolies, then they should be given the full support of the government and the health care community. If, on the other hand, GPOs do not produce such cost savings or did once but no longer do so, or if they slow the introduction of new technologies or create supplier monopolies, then their future role in the health care supply chain must be questioned and the government protections afforded to them must be re-evaluated. The first step in substantiating GPO claims of cost savings is to define what a product cost savings is and create a widely accepted yardstick against which all cost savings claims can be measured. That is precisely the purpose of this research.

### **Current and Historical Use of the Term “Cost Savings”**

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At first it might seem strange to even discuss the concept of cost savings since the term itself would seem to be quite self-explanatory. After all, hospitals, GPOs and suppliers have been doing business together for decades and given the pre-eminence of product cost in negotiations one would expect that this area would be thoroughly nailed down. Unfortunately, that is not the case. Early supply chain relationships were relatively uncomplicated. There was little in the way of value added and product complexity and deal complexity were relatively limited. Hospitals purchased on the basis of price, even if they did not have sufficient volume or leverage to get the best pricing available. A cost savings was the difference between the old price paid and the new price paid for the same item.

As time went by and hospitals began joining GPOs, the aggregation of volume proved to bring lower product prices to members. But manufacturers quickly saw that this new reality would be their worst nightmare if they did not adjust their own thinking and approach to customer relationships. The goal of manufacturers was and still is to gain or maintain market share while improving or maintaining profit margins. (To some extent this would be necessary to continue to invest in costly research and development and to withstand the financial rigors of clinical trials and FDA approval.) This would prove to be more challenging because of the apparent new found clout of the GPOs. New tactics would have to be developed and these tactics would have to make hospital buying decisions more complicated. Out of the complexity would rise protection for margins and market share. These new tactics included bundling of products and/or divisions by manufacturers, extraordinarily high commitment levels and sole source contracting. It should be noted that the recent attention placed on these tactics has focused on their use by GPOs but it is more likely that, with the exception of the corporate bundling programs of Novation, and more recently, MedAssets, most of these tactics would seem to be the inventions of the manufacturers themselves. (Manufacturers have a fiduciary duty to their investors to maximize their profits and should be expected to develop tactics that

effectively support that end. But, if GPOs represent their members, as they claim, they should be expected to thwart such manufacturer tactics and maintain leverage for their member hospitals.) Each tactic can be implemented directly with customers or through a GPO. The important thing about each of these tactics is the level of complexity that is added to the buying decision. It is much more difficult to determine which supplier and which combination of products and services will produce the lowest cost for the hospital. All too often it becomes almost impossible to effectively determine which supplier offers the best deal. And this creates significant leeway for GPOs to be able to use their own self-devised, and perhaps more speculative, methods to determine the winner of a bid and the “value” that a supplier would bring to the GPO and/or its hospitals. These methods may also rely more heavily on the financial impact of supplier fees in the bid evaluation process. This complexity has also been used by GPOs to increase hospitals’ dependence on GPOs to look out for their interests. Hospitals are led to believe that the complexity makes it all but impossible for them to protect their own interests. Ironically, the complexities also make it exceedingly difficult for the Congress to determine if GPOs are still doing today what they claimed to do when the Safe Harbor was granted.

Over the past decade total cost has emerged in most industries as being a more important yardstick of cost analysis than line item product cost. But the challenge for GPOs is that the unique buying patterns and operational needs of each of its members would likely produce a different supplier winner and loser for each of those members, effectively limiting the benefits or perceived benefits of volume aggregation. A focus on line item pricing would produce a clearer picture of product cost savings but would also fail to account for the financial impact of value-adds and the various forms of bundling. It is interesting to note that many of these tactics would seem to minimize the impact of line item pricing, which itself was the very bedrock of the GPO’s existence. If simple aggregation of volume is the magic behind the early successes of GPOs, these newer tactics would seem to significantly dilute the value of aggregation. On that basis one must ask if bundling and other tactics are enhancing the value of volume aggregation or replacing it?

Historically, a hospital’s capital purchasing decision was made up of two main components: pricing and financing terms. The goal was to get the best deal possible on the equipment and then go to a bank or leasing company to get the best financing deal. Today many, if not most, capital equipment sellers also happen to conveniently be in the leasing and financing business as well. Of course, if one adds in repair, preventative maintenance and insurance to the picture, a hospital can cover all of its equipment needs with the same supplier who makes the equipment. Such an arrangement is clearly more efficient but it is not likely to improve the hospital’s chances of getting the best deal. Instead of making a profit off of the hospital on just equipment or just repair, the supplier now can earn significant profits from each and every aspect of the product life cycle. And the hospital is faced with an ever growing complexity in its financial decision making; thus increasing the odds that the hospital will choose the path of least resistance in its capital equipment procurement decisions.

A number of GPOs regularly report on the “savings” they create for their members. Some, like Novation, report the “value” of their work to their members. But to the GPO, value is not necessarily cost savings. It is, rather, a combination of all of the “economic benefits” created by the GPO collectively for its members. [Note: The fact that there is no

standard definition of cost savings means that GPOs are free to create their own definitions as they see fit.] The alleged savings or value numbers are quite impressive. But there is some question as to how much of this value is offered versus how much is actually realized by the members and could actually be claimed as legitimate cost savings. What savings opportunity is created and how much of that is actually produced for the members? However, the key question to ask in any cost savings analysis is this: savings off of what? How is an organization like Novation able to report savings/value in the area of one billion dollars per year, year after year, while line item prices appear to be steadily increasing and supplier contracts contain price escalators and list prices, which often form the basis for constructing a contract price, continue to rise without impediment? What is the basis of the savings and where does it come from? Is it savings over last year? Is it savings off of a manufacturer's established list price that moves higher and higher? Do the current complexities of supplier contract offerings really lower costs or do they simply hide the fact that prices are going up? Are the savings true or a half-truth?

HIGPA often cites research that claims that GPOs save hospitals fifteen percent off of product costs. This number has been cited so many times by HIGPA and others that it is now widely considered to be fact. Yet the origin of this savings number is quite fascinating. In a report prepared for HIGPA in March of 2000<sup>5</sup> Muse and Associates states that one of the goals of the study is to estimate the dollar savings to the U.S. health care system that is produced by GPOs through their purchasing practices. On page 2 of the 65 page report the authors state that providers report that GPOs save them between ten and fifteen percent on their purchases. What then follows is a compelling arrangement of facts and figures that work well together, **but only if** GPOs actually save hospitals money. The information vital to the report is virtually buried and anecdotally presented in a single paragraph. The source of the cost savings "proof" is a survey in which hospital purchasing managers were asked how much money they saved by using GPOs. The surveyors accepted the 10-15% claim without question and without any point of reference that would answer the question "savings off of what?" And just in case anyone had any doubts about the survey's validity, the report writers were sure to point out that the purchasing managers interviewed stated that they conduct internal studies and detailed cost comparisons. No science. No proof. No trended studies of product price movement over a fixed period of time. No baseline. The most critical component of the report is simply glossed over and accepted as true because it is what the authors of the report and the funding source already had concluded. ("That GPOs save money for their customers, and therefore for the entire health care system, was never an issue.") For the next four years this cost savings "proof" was cited as fact in a number of papers and studies on GPO cost savings. The Safe Harbor remains in full force because of the five year old opinions of hospital purchasing managers who barely have enough staff to get by, let alone conduct internal studies and detailed cost comparisons. Ironically, if the hospitals actually had the resources necessary to do the internal studies and detailed cost comparisons, they may have discovered that the "proof" of GPO cost savings claims is anything but conclusive.

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<sup>5</sup> Muse and Associates, The Role of Group Purchasing Organizations in the U.S. Healthcare System, March, 2000, p. 22

GPOs were afforded the Safe Harbor because they convinced Congress that without their existence, prices would go up and hospitals would go out of business. Yet prices are going up and have been for some time and hospitals appear, in many cases, to be far worse off financially today than twenty years ago when the Safe Harbor took effect. GPOs do not report the basis on which they calculate cost savings. Hospitals do not demand such reporting and the Federal government has never addressed the issue of what exactly constitutes a cost savings that would be deserving of special allowances for GPOs. It is time to go back to basics and attempt to reconstruct a product cost savings definition and use that definition to measure the effectiveness of GPOs in producing product cost savings for hospitals.

## Research Design and Methodology

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In order to address this important issue, a plan was developed to solicit input from hospital Directors of Materials Management, supply chain consultants, health care supply chain experts and the GPOs themselves as well as their trade association, in order to create a widely accepted definition of a product cost savings. Finally, expertise from outside of health care, including procurement leaders from some of the nation's Fortune 500 companies, was sought to provide a baseline of how industry views issues related to procurement and cost savings. Resources included academic writings such as procurement and supply chain management textbooks used at the college level, written works from purchasing industry trade publications and writings produced by and for the Institute for Supply Management (ISM), the world's foremost experts in procurement and the organization that awards widely recognized standard in procurement excellence, the Certified Purchasing Manager (C.P.M.) designation.

The first Data Collection Tool was developed and sent via email to almost four hundred hospital Directors of Materials Management. It was designed to elicit the opinion of a cross section of the individuals who most hospitals place in charge of their product cost savings efforts. The most important questions in the survey were as follows:

1. *Do you believe that your GPO saves you money?*
2. *Do you know how much money your GPO saved you in 2003?*
  - a. *If yes, how do you know*
  - b. *If your GPO told you, could you validate that information on your own?*
3. *How do you define a cost savings?*
4. *Do you view cost savings and cost avoidance equally?*

The second Data Collection Tool was a question designed to elicit a definition of what constitutes a valid cost savings in the eyes of almost thirty supply chain consultants and industry experts. That question is as follows:

*Last year a hospital had a contract price of \$25.00 for a product that had a list price of \$40.00 (no one paid list) and an average market price of \$32.00. This year the contract price is \$27.00 while the list price has gone to \$45.00 (still no one pays list) and the market average price is now \$35.00. Assuming no change in purchase volume and that rebates and other supplier incentives remain constant from last year to this year, from last year to this year is there a:*

*Cost Savings? If yes, how much?  
Cost Avoidance? If yes, how much?  
Neither?  
Both?*

The third Data Collection Tool was the same question as above sent to the senior leadership of the eight largest GPOs as well as to the leadership of HIGPA, the Health Industry Group Purchasing Association.

The fourth Data Collection Tool was the same question as above sent to close to fifty procurement leaders in some of the nation's Fortune 500 corporations.

## Research Results and Discussion

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*The key question at work in the research is this: Is the economic value of cost avoidance equal to that of cost savings? In other words, is maintaining a gap between the current cost and the ever-increasing manufacturer's list price equivalent to achieving a new cost that is actually lower than the previous cost?*

### Hospital Director of Materials Management Survey Results

The Director of Materials Management responses to the key questions are as follows:

1. *Do you believe that your GPO saves you money?* **94 percent said yes.**
2. *Do you know how much money your GPO saved you in 2003?* **29 percent said yes.**  
*If yes, how do you know?* **80 percent of those who answered yes to question 2 said they knew how much they saved because their GPO told them how much they saved.**  
*If your GPO told you, could you validate that information on your own?* **60 percent of those said they could validate the savings on their own without the help of the GPO.**
3. *How do you define a cost savings?* **58 percent defined a cost savings as a lower price than last year, 18 percent defined a cost savings as a discount off of list and the rest of the respondents either did not answer the question or had unique answers.**

4. *Do you view cost savings and cost avoidance equally?* **35 percent view cost savings and cost avoidance equally while the rest either did not or did not answer.**

There is a significant disconnect between the Directors of Materials Management's answers to questions one and two. An overwhelming ninety-four percent of respondents believe that their GPO saves them money. Yet only twenty-nine percent said they knew how much money their GPO actually saved them. So while the vast majority believed their GPO saved their hospital money less than a third actually knew how much. The answers to question one suggest that GPOs have been highly successful in getting out their message that they save money for hospitals. But the fact that so few actually knew how much they saved suggests that their answers to question one might be based more on conditioning than on fact. If the majority of the people charged with managing their hospital's supply contracting function did not know how much they saved, it opens serious doubt about the validity of their belief. Furthermore, over three quarters of those who said they knew how much they saved said that they knew because their GPO told them. That means that only six percent of the respondents who said they believed their GPO saved their hospitals money had actually validated their GPO's savings claim on their own, although sixty percent of those who said their GPO told them how much they saved said that they would be able to do the analysis on their own.

In the critical area of defining what a cost savings is, fifty-eight percent of the Directors of Materials Management who responded defined a cost savings as a lower price this year than last year. Only eighteen percent considered a discount off of a list price to be a cost savings. The balance of respondents to that question either did not answer or offered a unique perspective.

Finally, thirty-five percent viewed cost savings and cost avoidance equally. Interestingly, the majority of those were from smaller hospitals.

### **Industry Experts and Consultants Survey Results**

A number of industry experts, consultants and academicians were asked to respond to the following scenario:

*Last year a hospital had a contract price of \$25.00 for a product that had a list price of \$40.00 (no one paid list) and an average market price of \$32.00. This year the contract price is \$27.00 while the list price has gone to \$45.00 (still no one pays list) and the market average price is now \$35.00. Assuming no change in purchase volume and that rebates and other supplier incentives remain constant from last year to this year, from last year to this year is there a:*

*Cost Savings? If yes, how much?*

*Cost Avoidance? If yes, how much?*

*Neither?*



*Both?*

None of the respondents saw a cost savings in the scenario while forty-two percent did see cost avoidance. Those who saw cost avoidance reasoned that an increase in the market average price provided the basis for the cost avoidance. By taking aggressive action to keep their company's pricing below the market average they reasoned that they could track a cost avoidance. However, this market does not use an average market price and most organizations, if they track anything, are looking for the lowest market price so they can attempt to co-opt it for themselves. Note: The market average price was added to the scenario to gain an understanding of the thought processes each respondent used to arrive at their answer. The only "market average price" used in the health care industry is the "average wholesale price or AWP" used in the pharmaceutical segment by pharmacy providers to bill insurance companies and insurance companies to use as a basis for reimbursement of pharmacy providers.

### **GPO Survey Results**

This same question was posed to the senior leadership of the eight largest health care GPOs and their trade association, HIGPA. Surely this group would provide significant insight into how product cost savings are defined since producing product cost savings is their primary reason for existing. Yet only one GPO, Broadlane, responded to the question. HIGPA at first cited schedule conflicts for its failure to respond. It was offered more time but declined. These organizations regularly report on their cost savings and lobby Congress to maintain the Safe Harbor on the basis of those cost savings but would not, or perhaps could not, answer a question that, for them, should be exceedingly easy to answer.

Broadlane responded that there would be both cost savings and cost avoidance in the example. In their response Broadlane suggested that the reason there would be a cost savings, even though the contract price actually went up by \$2.00 per unit, was that "due to poor information systems and lack of resources many hospitals do not get the contract price and overpay without realizing it". Broadlane also said that there would be cost avoidance because the "average price" went up at a higher rate than the contract price. In other words, the spread between the average price and the contract price had increased. Broadlane also looked to the contrived "market average price" to explain its calculation of cost avoidance.

If Broadlane's response would be considered a typical GPO response, it may provide an interesting window into how GPOs calculate cost savings. First, GPOs claim to save their members money but they do not answer the question, "savings off of what?" A contract announcement press release by Novation from November 17, 2003<sup>6</sup> states that a private label agreement for patient footwear will produce an estimated one million dollars in annual savings for members. Yet in the next paragraph it states that "Utilizing the NOVAPLUS private label brand can help save members save approximately 35 percent

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<sup>6</sup> Novation, Press Release, November 17, 2004, "Novation Signs Agreement With Albahealth(R) and Principle Business Enterprises for NovaPlus ® Patient Footwear"

*over typical name brand prices* for patient footwear.” The release claims savings of one million dollars but does not state that prices went down. In stating that members save approximately 35 percent over typical name brand prices, Novation is not claiming that it lowered patient footwear prices by 35 percent. What it is saying is that its members will pay 35 percent off of list pricing. It is critical to note that using this logic it is possible to claim significant annual savings in a market in which prices are actually rising year over year. From a technical procurement standpoint it becomes obvious that neither a true 35 percent cost savings nor a true million dollar cost savings was created. Rather Novation appears to have measured the spread between the current contract price and the current list price. That is not a cost savings and is not cost avoidance either. Now, if the market were such that its members would have no alternative but to pay the going list price for patient footwear without a Novation contract in place, the cost avoidance claim would carry more weight. But, apart from a pure monopoly on the part of a patient footwear supplier, the assumption of its members paying list price but for Novation’s intervention is an unlikely scenario.

On the very next day Novation announced a contract on surgical gloves<sup>7</sup> claiming savings of fifteen million dollars on an annual spend of seventy-five million dollars. Yet gloves are a virtual commodity whose price should be affected by raw material shortages. A fixed price on such an item carries significant potential risk of overpayment if raw materials supplies stay constant but could be a bargain if raw materials become in short supply. Either way the claim of a fifteen percent savings on such a product is at best a weak example of cost avoidance.

Second, Broadlane’s response also suggest that while GPOs can offer members lower contract prices they do not guarantee that the member will actually pay the contract price. While Broadlane claims to make certain that its members get the correct pricing, such a practice is not an industry standard and hospitals are often left on their own to make certain they get the contract price. This trap door has been the lifeblood of Accounts Payable audit firms who work with hospitals to identify instances of overcharging and gain refunds from suppliers. Yet, if GPOs made certain that their members got the right price, accounts payable audit firms would not have enjoyed the success they have had. There would seem to be a factual contradiction between the GPO claims of cost savings and the business success of Accounts Payable audit firms. The fact that GPOs typically play no role in making certain that members receive the correct pricing should prevent them from making bold claims about how much money they saved members in the first place, since the members would only save that money if they actually paid the correct contract price on each purchase.

This situation may provide GPOs with an opportunity to sell against other GPOs by pointing out that the hospital is not actually getting the contract price, while not taking any steps to insure that the hospital would get the contract price if it changed GPOs. Since GPO administrative fees appear to be paid on the basis of what hospitals actually spend, not what they should have spent if contract pricing were used, there would seem to

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<sup>7</sup> Novation, Press Release, November 18, 2004, “Novation Announces Multi-Source Awards for Surgical Gloves”

be no incentive for the GPO to insure that hospitals actually get the right price. Making certain that hospitals get the right price would create a loss of revenue for GPOs, creating, at the very least, a potential conflict of interest for the GPO.

### **The Industry Procurement Professionals Survey Results**

The same question was also posed to a number of procurement professionals, many from Fortune 500 companies. None saw a cost savings while only 18 percent saw cost avoidance and those who saw cost avoidance were clear on the standard they would use to allow a cost avoidance to be claimed. If, and only if, the buyer negotiated the contract price and if the “average price” was real, could the buyer claim cost avoidance. It is clear that industry procurement professionals have a very clear set of standards in determining what constitutes a product cost savings.

### **Are Cost Savings and Cost Avoidance of Equal Value?**

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Procurement experts from outside the health care industry make it quite clear that the creation of a cost savings requires that the net price paid for a product in the current contract period must be less than the net price paid in the previous contract period. This logical and time tested approach focuses only on actual invoice cost and does not factor in changes in list price. In fact, for most manufacturing organizations, the raw materials they purchase do not have list prices. Clearly, paying a lower price for a product this year than last year is an essential component of cost savings.

A small but significant percentage of hospital Directors of Materials Management expressed their belief that a cost savings and cost avoidance were of equal value. Their viewpoint, however, was wrapped very tightly in their simultaneous belief that without the assistance of GPOs their (smaller sized) hospitals would be forced to pay list price for the products they purchase. They clearly believed that they had no market leverage whatsoever and that any discount from a list price, no matter how arbitrary, was a real benefit to them. However, the only way for their belief to be true would be in a market environment in which there was no competition and suppliers had monopoly power to use at their discretion. But such a market would seem to strongly contradict the GPO assertion that their existence actually increases market competition. Such a belief also fails to take into consideration the fact that the vast majority of products where GPOs exert their influence are commodities. Yet the very definition of a commodity is grossly at odds with the notion that there can be commodity monopolies and the only way in which such monopolies could exist would be through collusive behavior on the part of GPOs and manufacturers or manufacturers with one another.

Like the earlier discussion of cost analysis complexity, too much attention paid to an arbitrary and frequently rising list price can blind buyers to what specific price is

desirable or achievable. The notion of the list price increase presents with it an air of inevitability that can effectively disarm the buyer and move him to a defensive position, in which he takes what he can get, versus an offensive position, in which he has identified a fair price for the product in question, and marshals his leverage points to achieve that price.

The relevance of a list price is a critical issue in this discussion. While a list price can serve as a cost marker it generally seems to be more reflective of a supplier's profit motive rather than providing insight into a particular product market. In health care, list prices bear little relevance to the market and the current contract discounts offered on surgical sutures would seem to bear this out. Discounts approaching the fifty percent mark suggest that list prices are used to create value for a product while significantly discounted contract pricing would seem to detract from that value. There are no controlling factors that would prevent a manufacturer from raising its list price to a point that even a substantial discount would still result in monopolist-like profits. For that reason a list price is a poor point of comparison when attempting to understand the impact of GPOs on product pricing.

The tracking of the spread between list pricing and contract pricing would seem to show a widening spread which some might be tempted to label as cost savings. However, such thinking would suggest that any manufacturer's list price increase should produce an automatic increase in cost savings produced by the GPO. The problem is that manufacturers can raise their list prices any time they want and as much as they want. There is simply nothing stopping them from doing so. In that scenario, achieving a larger discount than before can still result in a higher net price paid. For that reason any relationship between a list price and a contract price is not a reliable means of measuring the contracting effectiveness of a GPO or a hospital.

According to procurement experts Joseph L. Cavinato and Ralph Kauffman in their book, "The Purchasing Handbook: A Guide for the Purchasing and Supply Professional"<sup>8</sup>, in order to claim a cost avoidance there are a number of factors that must be true. First, rules for quantifying cost avoidance must be established in advance. In the case of hospitals and GPOs this would mean that all involved would know and agree on how cost avoidance would be quantified and reported. Second, there must be an actual cost increase. In other words, the buyer must be notified in writing that the price he pays is going up. A change in a list price has no relevance unless the buyer already pays the list price. Third, the buyer (or his representative, i.e. his GPO) must take specific action to reverse the price increase. This action must be active, not passive. It would likely require a serious negotiation or application of leverage on the part of the buyer. Fourth, strict documentation must be kept through the entire process. Fifth, credibility for the cost avoidance must be clearly established between the buyer's organization (including senior management acceptance) and the seller's organization.

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<sup>8</sup> Joseph L. Cavinato and Ralph Kauffman in their book, "The Purchasing Handbook: A Guide for the Purchasing and Supply Professional", McGraw Hill, c. 1999

On December 13, 2004<sup>9</sup> Neoforma, the E-commerce company of Novation, reported that it had documented over eighty million dollars in value in 2004 for hospitals using its service. In the press release, Neoforma defines value as a combination of savings and cost avoidance but when it reports results from specific hospitals it does not break down how much of the “value” came from cost savings and how much came from cost avoidance. But judging by the case studies on the Neoforma web site, it is likely that the vast majority of the reported value is being derived from cost avoidance. Unlike the GPOs, where cost avoidance plays a role in estimating member savings, Neoforma’s cost avoidance is focused on process improvement. But the key issue here is whether process improvement-based cost avoidance can be claimed if no employees were eliminated or redeployed or if there is was no measurable impact on the hospital’s income statement. Otherwise, anyone could claim unlimited cost avoidance for almost anything, anytime they desired to do so. For example, in the hospital purchasing department, following up on orders and dealing with problems does not in itself produce value. But if parts of that process were automated through e-commerce and the result allowed the hospital to capture product cost savings or reduce overcharges that it would have otherwise missed, then there is a legitimate savings that can be attributed to the use of the e-commerce technology. The problem for most hospitals, and companies like Neoforma, is that baseline analysis is typically not done. The minute the technology is deployed everything changes and the baseline can no longer be measured. Most of the case studies and savings claims would have to be built on what if scenarios because the baselines were never established and the desire to demonstrate savings is an afterthought when a technology company is under pressure to show savings results.

E-commerce was supposed to create significant process cost savings for hospitals but Neoforma learned otherwise several years ago when it received the results of the e-commerce value report it commissioned the now defunct Arthur Andersen to create. The problem was that, of all the links in the health care supply chain, hospitals were actually shown to have the least potential for value creation in the process management area and even those estimates were based on a fully deployed, mature e-commerce solution, which still does not exist. This is further complicated by the fact that the brand of e-commerce currently available is only a few clicks better than the EDI that has been in place for decades.

Because the industry has lacked any kind of generally accepted cost savings standards virtually anyone can construct a compelling argument for savings even if no savings exists, and they are unlikely to be challenged in their analysis. Neoforma’s attempt to legitimize its own existence by creating questionable estimates of value or savings is just the latest example of the risks faced by hospitals on a daily basis. An industry standard for measuring and reporting cost savings and legitimate cost avoidance would protect the financial interests of hospitals and the communities they serve.

What do purchasing professionals outside of health care think about cost avoidance? In an article called Cost Reduction versus Cost Avoidance on the Institute for Supply

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<sup>9</sup> Neoforma, Press Release, December 13, 2004, “VHA and UHC Member Hospitals Document More Than \$80 Million in Value Using Neoforma Solutions Through Marketplace@Novation”

Management web site<sup>10</sup>, Jack Porter, manager of central purchasing at Caterpillar, Inc. states, “I’d never talk to my CEO about cost avoidance. You want to talk about what you bring to the bottom line. Cost avoidance doesn’t bring anything. It’s ‘funny money’. Your CEO is not interested in ‘funny money’.”

At the end of the day cost avoidance is a poor substitute for real hard dollar cost savings. It seems that all too often in the health care supply chain, those who cannot offer real cost savings offer cost avoidance and hope that the customer will not know the difference.

### **Is There A Statute of Limitations On A Product Cost Savings?**

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In industry, procurement professionals are held to very strict standards regarding how long they can claim a cost savings. According to authors Cavinato and Kauffman, cited earlier, and the industry procurement professionals contacted for this study, purchasing can take credit for a product cost savings only for the first year it is achieved. After that full year the new price becomes the standard cost or norm. In order to take any future credit for a cost savings for that product, the purchasing department must negotiate a new price that is lower than the standard cost.

The claim made by HIGPA that GPOs save their members ten to fifteen percent has no temporal frame of reference. But since the figure is cited on a regular basis one can only assume that HIGPA intends to create the belief that GPOs are creating new savings of fifteen percent each and every year. If that were true, then an item that had a contract price of \$1.00 twenty years ago when the Safe Harbor was passed would now have a contract price of \$0.037 (less than four cents!). Yet, given the fact that so many GPO contracts have price escalators built in or are discounted from steadily increasing list prices and given the fact that hospitals continue to cite rising supply costs as one of their greatest challenges, it is much more likely that the same item now costs well above that \$1.00 standard cost of twenty years ago, an outcome that would call GPO cost savings claims into serious question.

On the other hand, if the savings number is a flat fifteen percent, then it would have to be fifteen percent off of something; either the current price at the time the survey was done or off of the list price, which rises regularly. Of the two, only the fifteen percent off of the list price makes sense. But if that is the case, a set percentage off of a rising list price means that actual contract prices are increasing, making it hard to claim any kind of savings, let alone substantial savings.

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<sup>10</sup> Purchasing Today Magazine, Published by the Institute for Supply Management, January 1, 1996, “Cost Reduction vs. Cost Avoidance”

## **A Proposed Product Cost Savings Definition**

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Without a clear cut definition of what constitutes a product cost savings hospitals will remain entirely too open to untested and unsubstantiated claims of cost savings while their costs of doing business continue to rise, unabated. As a first step in resolving this situation the following cost savings definition is presented for consideration by the entire health care supply chain.

**Definition:** A product cost savings is defined as obtaining and realizing a lower unit price on the same item than the unit price was in the last contract period. An offer of a lower price is not a cost savings. Rather a true cost savings can only be determined at the end of a contract period. A cost savings can only be verified and accounted for on a retrospective basis, once all of the purchases and actual paid prices can be validated. This should apply to GPOs savings claims as well as to hospitals accounting of their GPO savings.

**Term:** A cost savings is valid for as long as the comparative that generated the savings is but not to exceed the end of the contract period in which the savings was produced. On the first day of the next contract period the old price becomes the standard cost and the baseline against which any future cost savings is measured.

**Basis:** The basis for any cost savings is the actual price paid.

**The Role of List Prices:** List prices are irrelevant in determining if a product cost savings has occurred. Only actual current and previous prices paid by the hospital may be used to calculate a cost savings.

**Value:** For any service or offering to have financial value the hospital must have been willing to pay for it out of pocket or must have already been paying for it in a way that can be measured on the hospital's income statement. This definition should be a requirement for any discussion of a limited number of legitimate cost avoidance scenarios.

## **Understanding the Belief Structures That Foster Confidence in GPO Cost Savings Claims**

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Clearly, there is a difference in how product-based cost savings are viewed outside of health care providers. Purchasing professionals outside of health care understand that their ability to drive down costs is one of their most compelling strategic competitive advantages.

The majority of hospitals seem to use a vastly different approach. Most either have little leverage or have not developed the ability to use it effectively and the supply chain is

viewed as a low level function with little strategic importance. There is also widespread acceptance of the relevance of artificial manufacturer list prices. Most hospitals, instead, choose to rely on third parties, who are compensated by their suppliers, to negotiate contracts with those same suppliers, with seemingly little concern for potential conflicts of interest on the part of GPOs. They seek larger discounts off of a list price even if the list price moves higher at a much faster pace than the discounts they are offered. According to the American Hospital Association, approximately one third of the nation's hospitals are operating in the red. Given how many hospitals seem to treat their supply chains, their financial challenges should come as no surprise.

Hospitals have a unique culture and a number of questionable beliefs. The most questionable of those beliefs may be that the hospital industry is unique and cannot be compared to anything other industry. There is comfort in such a belief and from a clinical standpoint there is some truth to it. But from a supply chain perspective, hospitals are not all that unique. In fact, there are many similarities with other industries. The hospital supply chain itself has its own set of questionable beliefs. One is the importance of list prices. List prices make a great base on which a hospital can build its own list price for its dealings with payers. But list prices should have little or no role in determining what a hospital will pay for the products it purchases. Another is the belief in the relevance of cost avoidance; a belief that the GPOs themselves have helped to promote with their frequent reminders to hospitals to wonder just how bad things might be if not for their GPOs. GPOs and HIGPA constantly instill fear into their members that if GPOs went away or their work was somehow regulated, that manufacturers would instantaneously raise all of their prices to list. Yet, as was discussed earlier, such an outcome would only be possible in a market with limited competition. But GPOs claim to be the real drivers of competition. One wonders how they could have it both ways and why hospitals have not been more aggressive in taking them to task over their claims.

But perhaps the most troubling hospital supply chain belief is that it is possible to get something for nothing. Hospitals have been convinced by GPOs that the services of GPOs are free. But there is a world of difference between something being truly free and an environment in which suppliers cover the cost of the fees they pay to the GPOs (so hospitals don't have to pay) by either charging hospitals higher prices or limiting the size of the discounts they offer. Some home equity loan company advertising entices borrowers with the notion that they can become debt free. But if one looks at the fine print, it explains that debt free really means credit card debt free. The home equity loan transaction is simply a transfer of debt from one lender to another. It is not an elimination of the debt. At the end of the transaction the borrower still has their debt but with another lender. Both debtors and hospitals need to understand that there is no such thing as a free lunch and that every business decision has risks and consequences.

Hospitals have an enormous fiduciary responsibility to stay financially solvent so they can continue to provide health care services. Part of that responsibility should be to hold their GPOs, indeed all of their supply chain partners, to the highest standards and demand that they produce real hard dollar proof of the savings they claim to deliver. If anything, hospitals should demand that GPOs be held to the same standard that any Fortune 500



company would hold its suppliers to and reject the validity of cost avoidance claims except under the strictest of conditions.

## **Some Thoughts on GPO Shareholder Distributions**

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Hospitals are like every other type of company in that cash is king. A hospital's supply chain can produce cash in one of two ways. Hospitals can receive cash rebates from manufacturers as a reward for meeting purchase volume commitments. Hospitals, who are also GPO shareholders, can receive a share of excess fees paid by manufacturers to the GPO. While these cash distributions from GPOs provide a way to reward shareholders, they also present well-intentioned hospitals with a potential Medicare reporting problem. Distributions of excess fees have the same net impact as lower unit costs and therefore should be reported to Medicare as a part of Medicare cost reporting. However, a number of factors including timing of the issuance of the checks and the form those distributions take can run hospitals afoul of the strict Medicare reporting guidelines. A federal investigation is now underway to determine the impact of unreported distributions.

A number of GPOs have two classes of membership: owners (shareholders) and members (non shareholders). By virtue of their ownership, owners have the ability to receive dividends but these dividends are funded by supplier fees. But if supplier fees are the direct result of specific purchase activity by specific members, then all of those fees should go to the member whose purchase activity generated them and none of those dollars should be redirected to shareholders. Surely, the Congress, in passing the Safe Harbor, would have wanted the excess fee distributions to go to the hospitals who earned them.

Novation returns only a portion of hospital earned excess fee distributions to their members in the form of cash. The balance is kept on account in the form of Patronage Equity Certificates, which are essentially coupons that can be used to buy services but only from Novation or Novation approved business partners. While Novation may argue that such an arrangement benefits its members, it would seem to benefit Novation much more. It provides Novation with the opportunity to keep its members' earned distribution money by creating a pretense of allowing the member to get something for nothing. By using certain Novation services the hospital can appear to forego actually paying for them out of its own pocket. Yet would it not seem more beneficial to the hospital to simply give all of the earned distribution money back to the hospital instead of creating a form of double jeopardy for as much as half of the money? By accepting the PEC, the hospital risks not getting their money's worth by overpaying for services or not getting their money back at all, by not using the offered services. Either way this arrangement forces the hospital to place half of their distribution dollars at risk. It is hard to understand how that practice benefits hospitals.

Novation's use of the PEC may create an unfair competitive advantage for its own consulting operations. By allowing hospitals to use PEC dollars to pay for the services of its consultants it presents the hospital with a skewed purchasing decision. Should the hospital use Novation consultants virtually for "free" or pay out of its own pocket to hire non-Novation consultants? It would seem obvious that generally hospitals will choose to use services that they do not have to pay for. Therefore, even if a non-Novation consulting company has better ideas or superior services, the PEC dollars give the Novation consultants a significant edge and gives Novation the opportunity to keep more of its hospitals' money, even if their services or results did not measure up to what was available on the open market.

One of the problems with GPOs controlling these fee distributions is that they tend to place the GPO in a position of authority over its members, when the opposite is supposed to be true. Why would a hospital join a GPO and then empower the GPO to exact financial penalties on it? If the mission of GPOs is to help their members, should they not use every means possible to put more money back into the pockets of their members? And if GPOs produce real value for their members, then the members should be eager to fairly compensate their GPO for the value they produce. If GPOs are saving their hospitals so much money, why don't GPOs trust their members enough to value their services enough to pay them out of their own pockets for the value they produce? Could it be that hospitals really don't see the value for themselves after all?

Finally, in order to fully understand the role of cash distributions one must evaluate the significance of the annual distribution check as a percentage of the total actual cost savings produced by the GPO for the hospital member. There would appear to be some reason for concern that the annual distribution check hospitals receive from their GPOs is being misinterpreted by the hospitals as a cost savings when it may simply be that the cash distribution is a portion of the hospital's own money being returned to it in lieu of actual product cost savings. What if these checks were merely the GPO refunding a small percentage of the hospital's membership dues or cost of becoming a shareholder? These distributions are the direct result of fees paid by suppliers to the GPO and most certainly are included in the cost that hospitals pay for the product they purchase. In other words, the hospital may be prepaying its own distribution by paying higher product prices and the additional margin gained by the manufacturer would be used to offset the fees paid to GPOs.

## **Conclusion**

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As the Congress seeks to address health care supply chain competition and GPO business practices, it, the GPOs, and the entire health care supply chain, must work to establish a standard for what constitutes a legitimate product cost savings. This issue was so important nearly twenty years ago that Congress literally changed the rules of business to

allow GPOs to legally collect fees from the suppliers to whom they award contracts, a practice that in almost any other industry would often be considered illegal and at the very least, unethical. While the fees may be legal, their full impact on the GPOs' business dealings with manufacturers may never be fully known. Yet their effect on the health care supply chain is becoming all too apparent. The real results of the Safe Harbor must now be studied again and in serious depth and in surgical detail. This study must trend the pricing of not less than 1000 medical technologies and commodity line items over a period of not less than ten years. It must be real research, not opinion surveys. It must be determined beyond a shadow of a doubt precisely what role health care GPOs play in the health care supply chain and if they are justified in claiming to reduce product costs. If it is found that they do not reduce product costs, Congress must revisit the Safe Harbor. If it is proven that they do reduce costs while not harming innovation or the quality of care, the Safe Harbor should stay in full effect and the work of GPOs should continue.

In order to assist Congress in its task this report has presented a definition of a product cost savings. It was drawn from years of research and study and comments from respondents to this survey project.

Some readers may wonder why this paper does not address the business practices of manufacturers. While some manufacturers may engage in questionable business practices vis a vis the GPOs and some of the recent antitrust case settlements would suggest that some of these practices may be illegal, the real issue here is that the GPOs were given the Safe Harbor in order to lower healthcare costs and limit the power of large manufacturers. The information in this paper and others suggests that GPOs may have failed at both and any move by the Federal Government to investigate manufacturers would need to begin with the realization that GPOs have indeed failed in their mission to protect the financial interests of the hospitals they represent. Consequently, GPOs and some contracted manufacturers are effectively business partners sharing in profits derived from purchases of GPO members, creating enormous conflicts of interest that give credence to concerns regarding market access and harm to competition, innovation, caregivers and patients.

In creating the Safe Harbor the Federal Government intervened in the affairs of commerce related to the health care supply chain. Should valid analysis determine that GPOs do not produce the cost savings and value they purport or if they prevent access to innovative technologies, the Federal Government should act to remove their previous interference, to restore the competitive market forces that result in lower prices and increased innovation. The ailing health care industry and the American people who depend on a thriving and competitive health care system deserve nothing less. Resolving the GPO dilemma will not, in and of itself, solve the problems of health care. On the other hand, it is doubtful an effective solution can be reached without addressing the role of GPOs in the health care supply chain.

**About the Author**

Lynn James Everard, C.P.M., CBM is a twenty-three 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 six 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.” He can be contacted at 954-647-3554 or [leverard@bellsouth.net](mailto:leverard@bellsouth.net).