

# THE WALL STREET JOURNAL.

This copy is for your personal, non-commercial use only. To order presentation-ready copies for distribution to your colleagues, clients or customers visit <http://www.djreprints.com>.

<https://www.wsj.com/articles/where-does-the-law-against-kickbacks-not-apply-your-hospital-1525731707>

OPINION | COMMENTARY

## Where Does the Law Against Kickbacks Not Apply? Your Hospital

The medical supply chain is a conflicted mess, and revoking its 'safe harbor' would save patients money.



PHOTO: DANIEL ACKER/BLOOMBERG NEWS

By Phillip L. Zweig and Frederick C. Blum

May 7, 2018 6:21 p.m. ET

Doctors have long struggled to care for patients amid artificial shortages of, and soaring prices for, hundreds of drugs—notably generic sterile injectable products, including saline, epinephrine, chemotherapeutic agents, anesthetics, painkillers, antibiotics, even sterilized water.

So when Amazon Business signaled last year that it planned to infuse competition into the marketplace for hospital supplies, clinicians were optimistic that scarce items would soon reappear. Wrong. Mighty Amazon has now backed away from the market. CNBC, which reported the news in April, attributed the decision partly to the barrier posed by hospitals' tight relationships with group purchasing organizations, or GPOs.

Amazon achieved its remarkable success by building a sophisticated e-commerce platform that promotes competition, transparency and low prices. In contrast, the GPO industry, which supplies doctors with hundreds of billions in medical products each year, rests on myriad conflicts of interest. The result is not only shortages but higher prices.

Four giant GPOs—Vizient, Premier Inc., HealthTrust and Intalere—control purchasing for most of the supplies used by thousands of hospitals, outpatient clinics and nursing homes. These buying cartels literally sell market share, taking money from drugmakers and other vendors in

exchange for exclusionary supply contracts.

Hospitals sometimes even get a cut of the GPOs' fees. The industry is very secretive, but when Premier was considering an initial public offering in 2013, Thomas Finn, an analyst at HCMatters.com, explained: "As a member-driven enterprise, it is common knowledge that Premier and other GPOs 'share back' with their members and owners. In fact, many hospital executives who are part of the Premier alliance have learned to rely on that share back as an integral part of their annual compensation."

In turn, GPOs primarily use three big "authorized distributors": McKesson, AmerisourceBergen and Cardinal Health. The supply chain is set up so that only authorized distributors, which pay fees to the GPOs, are entitled to manufacturers' rebates for products covered by the contracts. Since smaller wholesalers can't get the rebates, they're effectively frozen out.

The results of this anticompetitive system are higher costs and inevitable supply breakdowns. For example, the GPOs would have the public believe that Hurricane Maria triggered shortages of sterile IV solutions by damaging Baxter International's Puerto Rican plants. In fact, shortages of saline and other solutions have existed for years, forcing the U.S. to import them from several countries. The deeper reason is that GPOs have relied almost exclusively on Baxter for these products, concentrating production and discouraging potential competitors. Although information on contract terms is confidential, a Baxter press release touting a 2007 deal with Novation (now Vizient) describes the terms as "an extended single source award for IV solutions."

What's more, the fees that manufacturers pay to GPOs can be exorbitant, as demonstrated during a 2003 federal whistleblower case filed by a former employee of Novation. Documents in the case showed that in 1998 Ben Venue Laboratories, an Ohio company that produced the heart medication diltiazem, paid GPO fees that exceeded half its sales on the drug. The case was eventually settled. Ben Venue shut down after failing FDA inspections in 2011, making supplies of its products even tighter.

GPOs didn't always operate this way. The first was founded in 1910 when several New York City hospitals banded together to buy supplies in bulk. Members paid dues to cover administrative expenses. This nonprofit "co-op" model worked for decades. What perverted the system was a rule that began to allow cash to flow from manufacturers to the GPOs. In the mid-1980s, Congress gave GPOs a "safe harbor" by exempting them from the laws against taking kickbacks from suppliers.

A 2010 report by the Senate Finance Committee found no independent empirical evidence that GPOs save hospitals money. In 2002, however, the Government Accountability Office studied purchases of safety needles and pacemakers in one metropolitan area and found hospitals that negotiated on their own often obtained lower prices. Our estimate, based on accumulated evidence including interviews with former GPO contracting officers, is that the current system may inflate costs by 30% or more. Still, most administrators are enculturated to the GPO system, and the web of rebates and fees helps keep it in place.

Making matters worse, in 2003 the Department of Health and Human Services advised drug makers that the safe harbor would protect rebates paid to pharmacy benefit managers. This has created an upward spiral in the cost of drugs sold through these middlemen, as drugmakers compete for placement on PBM formularies by offering ever-larger rebates.

Without Amazon, the best hope for ending this travesty remains congressional repeal of the safe harbor. That goal has long eluded the bipartisan handful of lawmakers who have endorsed the idea, but thankfully outrage is mounting. The 36,000-member American College of Emergency Physicians adopted a resolution last year calling for repeal. Just last week, the commissioner of the Food and Drug Administration, Scott Gottlieb, suggested re-examining the safe harbor as a way to disrupt the system of drug rebates “that’s driving higher and higher list prices.”

If Washington is truly interested in lowering medical costs, here’s a straightforward idea: cancel the safe harbor and force the middlemen feeding at the health-care trough to compete on the merits.

*Mr. Zweig, a former Journal reporter, is executive director of Physicians Against Drug Shortages (PADS). Dr. Blum is an associate professor at the West Virginia University School of Medicine, a past president of the American College of Emergency Physicians, and a co-chair of PADS.*

Copyright &copy;2017 Dow Jones & Company, Inc. All Rights Reserved

This copy is for your personal, non-commercial use only. To order presentation-ready copies for distribution to your colleagues, clients or customers visit <http://www.djreprints.com>.