

The value of group purchasing organizations in the United States



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ABSTRACT: This article examines the valuable role of group purchasing organizations (GPOs) in hospital purchasing in the United States. For over 100 years old GPOs have helped hospitals and other health care providers realize savings and create contracting efficiencies by aggregating purchasing volume to negotiate discounts with manufacturers, distributors and other vendors. The US has recently enacted a series of healthcare reforms to correct some of the historical concerns regarding cost, quality and access. GPOs are expected to continue to play a critical role in the business of hospital purchasing and may potential export that other countries may wish to examine.

The rising cost of healthcare goods and services in the United States is an issue with enormous consequences for policymakers and patients alike. For example, the US federal government spends approximately 25% of its annual budget on health care matters. This figure is only expected to grow in the future due to the increasing costs associated with medical technology and an aging population. These factors combined likely ensure that cost containment will become and remain a key policy objective for both public and private sector health care supply chains. This article will examine one aspect of this enormously important and complicated issue: the valuable role of group purchasing organizations (GPOs) in the hospital purchasing supply chain in the United States.

Background

In the US, GPOs have long helped hospitals (and other healthcare providers including nursing homes, ambulatory care facilities, etc.) realize savings and create contracting efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors. The US GPO industry is over 100 years old. The first GPO was created in 1910 by the Hospital Bureau of New York and consisted mostly of laundry and other shared services. The use of GPO contracts has grown and accounts for approximately 73% of non-labour purchases a hospital makes¹. A survey by Burns and Lee (2008) revealed that nearly 85% of US hospitals route 50% or more of their commodity-item spending, and 80% route 50% or more of their pharmaceutical spending through GPOs².

The US has approximately 5000 hospitals. Most of these institutions are not-for-profit. A smaller number of hospitals and health systems are investor-owned, while still fewer are public facilities run by either state or local government. The physicians that provide medical services are either employed by the hospital

or have “privileges” to see patients in that facility. The number of physicians in “private practice” is expected to continue to decline with declining reimbursement rates. US healthcare expenditures totaled over US\$2.3 trillion (approximately 17% of GDP) in 2007³. Medicare and Medicaid spending was US\$749.8B in Fiscal Year (FY) (October) 2009 compared to US\$333.9 billion in federal healthcare spending in FY 2002⁴.

There are two basic types of healthcare GPOs⁵. The first is comprised of an existing network of healthcare providers often called an “Integrated Delivery/Health Network,” which centralizes its purchasing activities into one place. The other type of GPO, which is more prevalent, is the “voluntary GPO,” whose members participate in the benefits of leverage contracting but often buy “off-contract” (i.e., negotiating with and buying directly from manufacturers or distributors). Buying “off contract” is especially common in connection with “physician preference items” such as implantable medical devices and specialty pharmacy drugs⁶.

Voluntary GPOs do not guarantee specific purchase volumes to a manufacturer. The extent to which a given hospital buys “on-contract” (i.e., completes purchases under terms negotiated by its GPO) is called “compliance” or “participation.” The compliance or participation level of a GPO’s members is an important determinant of the GPO’s power in negotiating prices for its provider-members. The key reason hospitals join a GPO is that it will incur a lower total purchasing cost. The voluntary GPO model is so common that approximately 90 to 96% of all US hospitals belong to 1 or more GPOs in the US⁷. In fact, hospitals use an average of 1.6-2.6 GPOs per facility to achieve their purchasing goals⁸.

GPOs do not purchase supplies, member hospitals do, under the terms of GPO-negotiated contracts. To choose the most appropriate products, GPOs create value analysis teams of clinicians and experts from member institutions that evaluate,

analyze and make recommendations. Contracts with suppliers typically last 3-5 years (and may be terminated by either side, with notice). In addition, innovative products are typically allowed to be added to a contract at any time. GPOs charge vendors, rather than health care providers, an administrative fee⁹, which is only earned after a hospital purchases the item under contract. While this arrangement is meant to primarily benefit hospitals it also creates contracting efficiencies for vendors that no longer have to negotiate the terms and conditions of individual agreements with thousands of hospitals from across a geographically vast nation.

The US GPO market

There are approximately 600 GPOs in the US¹⁰. In 2008, 6 GPOs made up nearly 90% of the total GPO contract volume (US\$108B in 2008). Recently there has been a slight increase in consolidations in the GPO market. For example, MedAssets Inc. successfully combined with The Broadlane Group in 2010, while HealthTrust also completed its three-year planned acquisition of Consorta. This trend, however, does not suggest that the GPO market is overly concentrated. In fact, the US GPO market remains highly competitive and free from anti-trust concerns¹¹. The following are the largest GPOs and the corporation under which they are organized:

- + Novation (a cooperative owned by VHA and UHC).
- + Premier (Limited Liability Corporation owned by approximately 2200 shareholders and members).
- + HealthTrust Purchasing Group (owned by Health Corporation of America).
- + MedAssets Inc. (publicly traded stock corporation).
- + Amerinet Inc. (privately held investor owned: InterMountain Healthcare and Administrative Resources, Inc.)

Not included above are federal and state public GPO programs managed by the US Department of Defense, the Department of Veterans Affairs and numerous state and local programmes.

It is worth noting that the estimated net revenue for the entire GPO industry is rather modest – approximately US\$1.9 billion, compared to the US\$200 billion medical device industry. In addition, this figure does not reflect (i.e., subtract) those amounts that are commonly referred to as “share backs” which are a percentage of revenue returned to GPO owner and member hospitals. Share backs are often characterized as being a type of dividend. They are valued because they represent a return on investment. It is not uncommon for hospital-owned GPOs to return more than half of all net revenue collected by the GPO.

Hospitals are required to report these earnings on reports to the federal government on an annual basis. The GPO industry has voluntarily taken additional measures to ensure greater transparency by creating the Healthcare Group Purchasing Industry Initiative (HGPII). HGPII includes all of the major GPOs, whose Chief Executive Officers attest to the correctness of an annual questionnaire regarding their firms’ business practices. For example, the most recent questionnaire stated that, on average, the weighted contract administrative fee ranged from 1.22% to 2.25% for all GPOs. This report and the answers to individual GPO questionnaires are available to the public at www.healthcaregpoii.com.

As indicated above, the GPO industry is highly competitive. A recent report by the US General Accountability Office (GAO) stated

that in addition to contracting with manufacturers, other GPO services include:¹²

- + custom contracting;
- + clinical evaluation and standardization;
- + technology assessment;
- + electronic commerce;
- + materials management consulting;
- + benchmarking data;
- + market research;
- + clinical Medical Education;
- + materials management outsourcing;
- + patient safety;
- + marketing products or services;
- + revenue cycle management;
- + insurance services, etc.

The future of group purchasing in the US

The US has recently embarked on a series of health care reforms that attempt to correct some of the historical problems concerning cost, quality and access. Although the politics surrounding health care reform continue to be litigated, the primary goal of the Affordable Care Act is to increase coverage and reform the health insurance market. Taken together, all of the changes included in that law, as well as other recently enacted measures, are just a first step toward setting the regulatory process on a path to:

- + incenting prevention and primary care;
- + aligning incentives in payment;
- + increasing transparency;
- + increasing efficiency and investment in Information Technology;
- + rewarding value-based services.

The next phase of reform will inevitably be real cost-cutting, because the US government, as well as many governments around the world, are simply broke. With such a high percentage of the federal budget going toward health care, the government’s best hope is to align incentives, invest in prevention and primary care and hope the wave of baby boomers doesn’t completely swamp the nation’s future fiscal picture. GPOs provide a time-tested private sector method of proven cost containment.

A recent study of over 200 hospital executives found that a majority of respondents plan to increase GPO usage as a primary method of dealing with cost increases¹³. In fact, the study states that these executives expect GPO utilization to increase 20 percent by 2015¹⁴. The reasoning is simple: GPOs save money and – as this study asserts – will continue to be a vital component of healthcare reform implementation. Although medical manufacturers have used the political process to attempt to weaken the GPO industry by proposals that suggest taxing GPOs and diluting the ability of GPOs to continue to work under the Medicare statute, they are not likely to be successful.

Conclusion

The supply chain will need to move swiftly to keep up with its health care provider customers. The “new normal” will likely be based on Medicare (government) rates. Private-sector cost containment efforts will be critical in helping hospitals and other health care providers adjust. To make economies of scale work in an environment featuring lower reimbursements, the health care

supply chain will include further consolidations at every level. In addition, vendors will need to rethink how their products fit into the new processes being developed for disease management and care coordination. GPOs will need to marry their data services to real-time clinical and quality situations for their hospital customers. Wholesaler/distributors will need to harness their existing data to new clinical requirements as well. Survivors of consolidation will be bigger, more efficient, leaner, meaner and data-driven. GPOs are expected to continue to play a critical role in the business of hospital purchasing. In fact, the US GPO model may be an exciting export that other countries may wish to examine in the future. □

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Prior to becoming President of HIGPA, Mr Rooney was the Senior Associate Director and Counsel, Federal Relations, for the American Hospital Association (AHA) from 1999 to 2006. He was responsible for a number of issues including disaster preparedness, Medicare payment issues, medical liability reform, mental health services, telemedicine and ERISA.

Mr Rooney was an attorney with the law firm of Arent Fox Kintner Plotkin & Kahn, practicing in the Health Law Group in Washington, DC. He has also been Washington Counsel to the American Medical Association (AMA) in the Division of Legislative Counsel and Counsel to the Association of Private Pension and Welfare Plans (APPWP) (now the American Benefits Council).

Mr Rooney has written and spoken extensively on politics, Medicare, telemedicine, ERISA and health care reform. He sits on a number of boards including the Healthcare Industry Supply Chain Institute. He is Chairman of the Children of Kibera Foundation which creates educational opportunities for underprivileged children in Nairobi's (Kenya) largest slum. He received a Bachelor of Arts from The George Washington University and Juris Doctor from The Catholic University, JD. He is married and has two children.

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- ¹ David E. Goldenberg, Ph.D. and Roland "Guy" King, F.S.A., M.A.A.A. "A 2008 Update of Cost Savings and a Marketplace Analysis of the Health Care Group Purchasing Industry", July 2008 at p.2.
- ² L.R. Burns and J.A. Lee. "Hospitals purchasing alliances: Utilization, Services and Performance." *Health Care Management Review*, July-September, 33: 203-215, 2008.
- ³ David E. Goldenberg, Ph.D. and Roland "Guy" King, F.S.A., M.A.A.A. "A 2008 Update of Cost Savings and a Marketplace Analysis of the Health Care Group Purchasing Industry", July 2008 at p. 2.
- ⁴ Id.
- ⁵ R.E. Bloch, S.P. Perlman, and J.S. Brown. "An Analysis of Group Purchasing Organizations' Contracting Practices Under the Antitrust Laws: Myth and Reality." White Paper. Mayer, Brown, Rowe & Maw, 2006.
- ⁶ Eugene Schneller, "The Value of Group Purchasing – 2009: Meeting the Need for Strategic Sourcing." Health Sector Advances Inc., April 2009 at 8.
- ⁷ See Burns and Lee at p.204.
- ⁸ See Burns and Lee at p.204.
- ⁹ The "Medicare and Medicaid Patient Protection Act of 1987" created GPO "Safe Harbor" which requires:
 - ¹⁰ The GPO must have a written agreement with each hospital or healthcare provider, that provides for either of the following agreements:
 - (a) The vendor from which the hospital or healthcare provider will purchase goods or services will pay a fee to the GPO of 3% or less of the purchase price of the goods or services provided by that vendor, and
 - (b) In the event the fee paid to the GPO is not fixed at 3% or less of the purchase price of the goods or services, the agreement specifies the exact percentage or amount of the fee.
 - 2) The GPO must disclose in writing to the hospital or healthcare provider at least annually, the amount received from each vendor with respect to purchases made by or on behalf of the hospital or healthcare provider. See, 42 U.S.C. § 1320a-7b(b)(3)(C)(i); 42 C.F.R. § 1001.952(j) (2009).
- ¹¹ Report to the Ranking Member, Committee on Finance, U.S. Senate, United States Government Accountability Office. "GROUP PURCHASING ORGANIZATIONS: Services Provided to Customers and Initiatives Regarding Their Business Practices (GAO-10-738)" at p.4, September 2010.
- ¹² William Kolasky, "Group Purchasing Organization (GPO): Contracting Practices and Antitrust Law." White Paper, Wilmer Cutler Pickering Hale and Dorr LLP, November 2009.
- ¹³ See GAO-10-738 at p.9.
- ¹⁴ Stuart Jackson and Bob Lavoie. "Healthcare Reform Shifts Hospital Priorities, Creates New Opportunities for MedTech Companies", *L.E.K. Consulting*, Volume XIII, Issue 4, February, 2011.
- ¹⁵ Id at p. 4.