BY THE COMPTROLLER GENERAL

Report To The Chairman, Subcommittee On Health, Committee On Finance United States Senate

OF THE UNITED STATES

Hospitals In The Same Area Often Pay Widely Different Prices For Comparable Supply Items

GAO surveyed prices of supplies routinely purchased by 37 hospitals in six cities and found wide differences in prices paid for similar items. The most frequent explanation was that hospitals don't share price information with each other.

Since Medicare and Medicaid payments to hospitals include payments for these supplies, HEW and its contract intermediaries can assist hospitals to avoid paying excessive prices for routine purchases. By compiling price information and communicating it to hospitals, HEW could assist them in controlling costs.

HRD-80-35
JANUARY 21, 1980

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-197201

The Honorable Herman E. Talmadge
Chairman, Subcommittee on Health
Senate Committee on Finance
United States Senate

SEN04105

Dear Mr. Chairman:

At your request, we have reviewed the procurement practices of certain hospitals to determine (1) the prices paid for selected routine hospital items and (2) whether there are significant variations in prices paid for the same or similar hospital items within the same geographical area. The cities covered by this review were Atlanta, Georgia; Cincinnati and Columbus, Ohio; Miami, Florida; Pittsburgh, Pennsylvania; and Seattle, Washington.

As discussed with your office, we obtained comments on this report from the American Hospital Association, American Surgical Trade Association, Health Industry Manufacturers Association, and the Department of Health, Education, and Welfare (HEW). All parties provided written comments, and these were considered in finalizing the report.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from its cover date. At that time, we plan to make copies available to the various congressional committees interested in hospital costs reimbursed under Medicare and Medicaid; the Secretary of Health, Education, and Welfare; and the Director, Office of Management and Budget.

Sincerely yours,

Elmer B. Staats
Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
SENATE COMMITTEE ON FINANCE

HOSPITALS IN THE SAME AREA OFTEN PAY WIDELY DIFFERENT PRICES FOR COMPARABLE SUPPLY ITEMS

HCFA — AGC00624

D I G E S T

The Department of Health, Education, and Welfare (HEW) (AGC00022) and its Medicare intermediaries have devoted scant attention to the costs of items routinely purchased by hospitals. Both HEW and the intermediaries believe that scrutiny of the prices of thousands of such items would not be cost effective.

GAO disagrees. It reviewed prices paid for the same or similar routine supply items at 37 hospitals in six cities--Atlanta, Georgia; Cincinnati and Columbus, Ohio; Miami, Florida; Pittsburgh, Pennsylvania; and Seattle, Washington--and found significant differences in prices. For example, in Seattle one hospital paid $2.42 for a cylinder of oxygen while another paid $5.37. In Cincinnati one hospital paid $3.19 for irrigating solution that another got for $1.17. (See p. 4.) In some instances, the highest price for an item was more than 300 percent higher than the lowest price. (See p. 31.)

NO CONCRETE REASONS FOR PRICE DIFFERENCES

Overall, there appeared to be no rhyme or reason for price variations noted. The most plausible explanations were

--purchasing agents did not share or exchange price information and

--the higher prices for some items were due to other services furnished by vendors. (See p. 8.)

Other explanations, such as volume or group purchasing arrangements resulting in lower prices or differences in product quality, were not consistent with GAO's findings.

While some differences between the highest and lowest prices of individual items were extreme, the overall weighted impact of the differences in terms of total annual usage was a moderate 10 percent. (See p. 15.)

FEDERAL MONITORING COULD ASSIST HOSPITALS TO AVOID EXCESSIVE PRICES

GAO believes there is a role for Medicare intermediaries in assisting hospitals to avoid paying excessive prices for routinely purchased items where the potential for cost savings appears the greatest. (See p. 19.) GAO identified five such items which offered potential aggregate savings of about $150,000, or 4 percent aggregate volume of these items, for hospitals in two or more cities.

GAO's review was limited to less than one-half of one percent of the hospitals participating in the Medicare program. The results of the review cannot be statistically projected. However, considering the lack of a system for routinely providing price information to hospital purchasing agents and the limited Federal involvement in monitoring the cost of supply items, GAO believes that the potential savings on the five items alone could amount to millions of dollars. The role of the intermediary in this situation should be to

--gather price information on the selected items from hospitals in an area,

--communicate the information to the hospitals it services, and

--periodically monitor the hospitals' purchases of such items. (See p. 21.)

RECOMMENDATIONS

The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to instruct Medicare intermediaries to gather and compile price information in various

areas on the five items GAO identified that appeared to offer the greatest potential for cost savings and to communicate such information to the hospitals they service.

The intermediaries should be instructed to periodically monitor their hospitals' purchases of these items and report back to the Health Care Financing Administration so it can

--assess whether monitoring prices may result in cost savings and

--determine whether it should be expanded to include other hospital supply items.

AGENCY COMMENTS

HEW agreed, in part, with GAO's recommendation. It will conduct an experimental project at one intermediary. The test is expected to take 1 year. At the end of the experiment, the results will be evaluated, and recommendations will be made as to the feasibility of creating a national supply price monitoring and information system.

The American Hospital Association and two trade associations commented on the report. Generally, they questioned its validity based on the six cities and 37 hospitals and saw no basis for regulatory or legislative control over the purchase of hospital supplies.

GAO believes an objective review of the report should include consideration of the following facts.

--There are 66 metropolitan areas in the country with populations of more than 300,000 which represent about one-half of Medicare's $20 billion reimbursement to hospitals; this review covered six areas--(9 percent).

--There are 170 hospitals in areas covered by this report. If GAO had surveyed all

170 hospitals instead of 37, the price variations could not have been smaller--they could only have been greater, or the same.

GAO believes its recommendation should be viewed as a form of assistance to hospitals in controlling costs. The fact that Medicare and Medicaid pay about 40 percent of hospital costs provides the Government with a strong interest in this subject.

Contents

ABBREVIATIONS

AHA	American Hospital Association
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
MAC	Maximum Allowable Cost
SMSA	Standard Metropolitan Statistical Areas

CHAPTER 1

INTRODUCTION

At the request of the Chairman, Subcommittee on Health, Senate Committee on Finance, we reviewed the procurement practices of certain hospitals to determine (1) the prices paid for selected routine hospital items and (2) whether there are significant variations in prices paid for the same or similar hospital items within the same geographical area.

As agreed with the Subcommittee, we limited our review to 43 routine hospital items. (See app. 1.)

FEDERAL GOVERNMENT INVOLVEMENT IN FINANCING HEALTH CARE COSTS

Titles XVIII and XIX of the Social Security Act established the Medicare and Medicaid programs to help eligible persons meet the cost of health care.

Under Medicare, eligible persons generally 65 and over, or disabled, may receive two basic forms of protection:

--Part A, hospital insurance benefits, generally financed by special social security taxes, covers inpatient hospital services and certain post-hospital care in skilled nursing facilities and patients' homes.

--Part B, supplementary medical insurance benefits, is a voluntary program, financed by premiums of enrollees and Federal contributions covering physician services and many other medical and health benefits.

The Federal Government is responsible for administering Medicare.

Under Medicaid, a grant-in-aid program, the Federal Government and the States share the costs of providing medical assistance to persons--regardless of age--whose income and resources are inadequate to pay for health care. The States are primarily responsible for administering their Medicaid programs.

During fiscal year 1979, Medicare and Medicaid payments to hospitals on behalf of beneficiaries for inpatient hospital services were $19.6 billion and $5.2 billion, respectively, of which about $4.3 billion represented supply costs. The

Federal share under Medicaid for inpatient hospital services totaled about $3 billion. Overall, Medicare and Medicaid payments represent about 40 percent of total inpatient hospital costs.

MEDICARE ADMINISTRATION

The Secretary of Health, Education, and Welfare (HEW) has delegated administration of the Medicare program to the Administrator of the Health Care Financing Administration (HCFA). HCFA is responsible for operating the program, establishing policy, and developing operating guidelines.

To help administer part A of Medicare, HEW has contracted with about 77 public and private insurance companies called intermediaries. Among other things, intermediaries are responsible for reimbursing hospitals for those costs which are reasonable and related to patient care.

SCOPE OF REVIEW

We examined hospital price information on routine supply items at 37 hospitals in Atlanta (5), Cincinnati (5), Columbus (5), Miami (5), Pittsburgh (7), and Seattle (10).

The relationship of these cities to the 66 large metropolitan areas in the country is discussed on page 17 in connection with our evaluation of agency comments.

We selected the hospitals to include a cross-section of sizes (large, medium, and small) and of various types (municipal, voluntary nonprofit, and proprietary).

In selecting the items for price comparison, we provided a list of 73 potential candidates to the Director, Hospital Shared Services--a Seattle group purchasing association. He examined our list and identified those most likely to be purchased by all hospitals and to be comparable irrespective of the brand name.

From each hospital, we obtained copies of invoices to identify item brand, unit price, and vendor (who serviced the hospital) for 43 routine supply items which included drugs, food, surgical items, medical gases, and various solutions. Estimated annual usage and purchasing methods used in acquiring the items were provided by hospital officials. The prices used were the most recent as of July 31, 1978.

In addition to the hospitals, we contacted group purchasing associations, intermediaries for each hospital reviewed, vendors who serviced the hospitals, and HEW's regional office for each area. (See app. III.)

We reviewed regulations, Federal and State laws, and other pertinent data on hospital material management which deal with the procurement of routine supplies.

We requested comments on this report from the American Hospital Association (AHA), American Surgical Trade Association, Health Industry Manufacturers Association, and HEW. We understand AHA's comments had been coordinated with the 37 hospitals reviewed. All the parties provided written comments, and these were considered in finalizing the report and are included in appendixes IV through VII.

CHAPTER 2

PRICES HOSPITALS PAY VARY WIDELY

Hospitals are paying significantly different prices for the same or comparable routine supply items. For example, in Seattle one hospital paid $2.42 for a cylinder of oxygen while another paid $5.37. In Cincinnati one hospital paid $3.19 for irrigating solution while another paid $1.17. In Pittsburgh one hospital paid $4.20 for a roll of recording chart paper while another paid $1.12. In Atlanta one hospital paid $1.22 for a fluorescent lamp while another paid $.59. These examples are some of the conditions we noted in comparing prices paid by the various hospitals.

We obtained price information on 43 common routine supply items. (See app. I.) Our analysis showed:

--Some hospitals paid more than double the price paid by other hospitals. For several items some hospitals paid more than three times the price paid by another hospital in the area.

--Some vendors sold the same item to different hospitals in the same area at different prices.

The general consensus of the hospital officials we talked to was that the wide variations in prices might be the result of volume purchases, differences in product quality, brand preference of medical staff, discounts, or "loss leader" items (products that are offered at a low cost by vendors as a means of obtaining additional business with the hospitals). Also, group purchasing directors attributed the wide price variations to hospitals' participation under the group contract on a selective basis.

Price variations for comparable items were not only within cities but were also prevalent between cities. The table below shows typical differences between the lowest, median, and highest price for selected items. As can be seen, the differences between the highest price and the lowest price were sometimes over 300 percent.

Prices Paid by Hospitals for Selected Routine Items in Six U.S. Cities

Item	Highest price	Median price (note a)	Lowest price	Percent difference between highest price and lowest price (note b)
Blade, surgical #11 detachable sterile, stainless steel; per blade:				
Cincinnati	$ .165	$ .159	$ .152	9
Columbus	.177	.163	.158	12
Atlanta	.160	.150	.112	43
Miami	.159	.128	.117	36
Seattle	.241	.150	.140	71
Pittsburgh	.170	.159	.132	29
Medical gas, oxygen cylinder size "H":				
Cincinnati	$ 2.75	$2.75	$2.75	0
Columbus	5.78	4.41	3.44	68
Atlanta	5.00	3.13	2.65	89
Miami	2.70	-	2.57	5
Seattle	5.37	2.42	2.42	122
Pittsburgh	4.50	3.16	3.16	42
Needle, hypodermic, sterile disposable 18 ga., 1-1/2 inches, box of 100:				
Cincinnati	$ 5.16	$3.74	$3.22	60
Columbus	4.40	3.84	3.10	42
Atlanta	4.73	3.73	3.15	38
Miami	4.73	3.33	2.75	72
Seattle	5.21	3.24	2.99	74
Pittsburgh	3.06	2.09	2.09	46
Lamps, 48 inches 40W fluorescent cool white, each:				
Cincinnati	$ .71	$ .65	$ .65	9
Columbus	.95	.93	.76	25
Atlanta	1.22	.99	.59	107
Miami	1.90	1.09	.65	192
Seattle	1.41	1.23	.67	111
Pittsburgh	1.17	.75	.64	83
Penicillin VK tablets, 250 mg tablets-bulk, per 100 tablets:				
Cincinnati	$ 2.39	$ 1.95	$1.95	23
Columbus	8.90	8.02	1.95	356
Atlanta	3.75	-	1.59	136
Miami	4.50	-	2.79	61
Seattle	8.90	2.85	1.90	368
Pittsburgh	9.13	7.33	1.85	394
Penicillin VK tablets, 500 mg tablets-bulk, per 100 tablets:				
Atlanta	$18.52	$ -	$3.92	372
Miami	10.25	7.50	7.46	37
Seattle	17.27	6.69	3.66	372
Intravenous solution D5W 1,000cc, each:				
Cincinnati	$ 2.92	$ 1.14	$1.02	186
Columbus	1.21	1.05	.74	64
Atlanta	1.34	.94	.75	79
Miami	1.07	.85	.67	60
Seattle	2.48	.95	.75	231
Pittsburgh	.83	.82	.73	14

a/The lack of data precluded computing a median in some cases.

b/Expressed as a percent of the low price.

Price data for those items we surveyed which could be compared in three or more cities is shown in appendix II. In summary, the data show that the price difference between the highest and lowest price exceeds 100 percent for 22 percent of the cases.

In commenting on our report (see app. V), AHA maintained that subtle functional differences often result in significantly different prices for a product and questioned our basis for comparability. We recognize that subtle functional differences may account for some differences in prices; however, we believe that a price range of more than 600 percent for aspirin, 100 percent for trash can liners, or 100 percent for fluorescent lamps represents more than subtle functional differences. We did not conduct a value analysis on each item. As previously stated, we relied on the director of a hospital group purchasing association to help us identify items which were suitable for comparison.

SOME EXPLANATIONS FOR THE VARIATIONS

We contacted hospital purchasing agents, vendors, group purchasing directors, and others to obtain explanations of the causes of or reasons for the price variations. Plausible explanations for the differences in prices included (1) lack of exchanging price information among purchasing agents to find out what other hospitals were paying and (2) higher prices because of other vendor services. Other explanations for the differences, such as the relationship between lower prices and higher volume by individual order or annual usage, the differences in the quality of an item, and the lower prices obtained by group purchasing arrangements, were not consistent with the findings of our review.

Purchasing agents do not share price information

Most purchasing agents in the hospitals visited said they were unaware of what other hospitals were paying for routine supply items. Several hospital purchasing agents said that traditionally purchasing agents do not exchange information on what they pay for supplies. Several group purchasing association directors said that purchasing agents do not divulge the prices they pay because they may be obtaining supplies at prices higher than what others pay, and this could cost them their jobs. The directors also said purchasing agents do not tell others of the prices they pay because the vendors instructed them not to do so.

Hospital administrators were also not aware that prices paid for certain items were higher than those that other hospitals were paying. For example, we asked hospital officials in Seattle why they paid the highest prices for selected routine items. In about 50 percent of the cases, hospital officials stated they were unaware that they were paying more than the other hospitals for an item.

Some hospital officials stated that there is a pressing need for some type of system for exchanging information on the cost of supply items. They stated that a computer information system should be established for hospital purchasing agents. This system could provide data about the prevailing price of routine supply items and ultimately result in reduced hospital costs.

The need for sharing price information was also pointed out in a recent two part GAO study 1/ which was done in cooperation with the American Hospital Association, several purchasing groups, and 21 participating hospitals. The study states:

> "Hospitals and purchasing groups need to share information. Openness protects against favoritism and profiteering. It also gives all parties concerned an opportunity to learn how suppliers bid on hospital requirements. The principles of openness, however, did not appear to be widely observed among hospitals and purchasing groups we visited. An exchange of information can begin on such readily available data as prices of common supplies and sources and later extend to more sophisticated data, such as results of value analysis and standardization.
>
> "A regular flow of information between hospitals and between various purchasing groups, even geographically dispersed, would permit each to take advantage of the other's experiences. To the extent practical, information should be shared on matters such as * * * the prices paid for specific goods and services."

1/Part I--Study of Purchasing and Materials Management Functions in Private Hospitals (PSAD-7-58A) (Apr. 1979).

Part II--Checklist and Guidelines for Evaluating Purchasing and Materials Management Functions in Private Hospitals (PSAD-79-58B) (Apr. 1979).

In commenting on our report, AHA stated it did not agree that purchasing agents do not share price information. We found this somewhat difficult to believe ourselves, but we were told by hospital purchasing agents in the six cities that price information was not being shared except possibly through the dissemination of the prices under group purchasing contracts. This seemed to be a plausible explanation of the price differences because it would be illogical for one hospital to deliberately pay twice as much for the same item as another if the purchasing agent knew it.

Possible method for providing hospitals needed price information

After completion of our fieldwork, we contacted two hospital service organizations--the Washington State Hospital Association and the Seattle Area Hospital Council--to determine if they would undertake a program to survey member hospitals to establish what hospitals pay for specific supply items. The price information collected could then be furnished member hospitals so purchasing agents would know what other hospitals pay for various items.

According to the Association's President, if given enough time, the Association could survey hospitals to determine what they pay for specific items. This information could then be made available to all member hospitals for use by the purchasing agents. The President said that the Association already performs wage surveys at the hospitals to establish salaries for various skilled jobs, and the price surveys would be similar.

The Council's Executive Director stated that if given time it could also survey member hospitals for the necessary price information and make the information available to all member hospitals. However, this official felt the council should defer action on the matter until it is definite what action will be taken by the Washington State Hospital Association. Most of the council's member hospitals are also members of the Hospital Association.

Higher prices due to prime vendor arrangements

Hospital officials and vendors said that the high cost of certain items was often due to extra services provided under prime vendor arrangements. Under these arrangements, vendors provide services, such as financing, inventory management, warehousing, and emergency or fast delivery,

which are included in the price charged for the items. However, because hospitals do not share price information, purchasing agents may not be in a position to assess the reasonableness of the additional amounts paid for such services.

We identified several cases where prime vendor arrangements contributed to the higher prices paid for an item, for example, one hospital in Seattle had prime vendor contracts on five items, and in each instance, the hospital's costs were the highest of any hospital visited. A conservative estimate of the additional costs for these items is shown in the following table.

Item	Prime vendor price	Next highest price	Difference	Annual volume	Estimated additional cost
	(a)	(b)	(a-b)	(c)	(a-b) X (c)
Intravenous solution-D5W, 1,000cc each	$ 2.48	$ 1.21	$ 1.27	144	$ 183
Irrigating solution 1,500ml water	3.49	1.61	1.88	1,560	2,933
X-ray film 14 inches by 17 inches	563.65	509.69	54.00	20	1,080
Needle, hypodermic sterile disposable 21ga., 1-1/2 inches, box of 100	5.21	3.81	1.40	52	73
Wrapper, sterile autoclave 30 by 30 disposable sheet	.26	.11	.15	6,500	975
Total					$5,244

Although hospital officials did not know the extent of the additional cost, they realized that the prices paid for the above items were high but maintained that the prime vendor relationship was cost effective. They said that the operating room supervisor was responsible for some purchases, and

she did not have the time to deal with more than one vendor for a specific item or to constantly monitor items to determine when to reorder; the prime vendor contracts were to save her time.

According to vendors in Atlanta, Miami, and Pittsburgh, price differences were attributable to the extent that they had to finance some hospitals because of late payments. Vendors in these cities said that late hospital payments adversely affected their cash flow; therefore, chronic late payers were charged higher prices.

Lack of relationship between lower prices and higher volume

Although several purchasing agents and vendors attributed the price variances to high-volume purchasing either on an individual order basis or on an annual volume, this was not consistent with the findings of our study. 1/ For example, we identified several cases in Cincinnati, Columbus, and Seattle which showed that high-volume users were not obtaining items at prices lower than low-volume users. In Columbus two hospitals bought the same brand of intravenous solution for $1.05 and $.74, with respective quantities of 10,452 and 6,000 units. In this instance the product was manufactured by the same company and serviced through the same vendor. The table below shows similar examples where the lowest prices were not obtained by the higher volume users whether in terms of invoice quantity or annual usage.

1/Overall the highest volume purchaser obtained the lowest price in about half the cases where comparisons could be made.

Location/item	Price (note a)	Invoice quantity	Annual usage
Cincinnati			
Bandage, elastic 6 inches wide by 5 yards long	$ .95	120	948
	1.02	288	3,356
Blade, surgical #11 detachable, sterile, stainless steel	$ .16	300	7,200
	.17	1,500	10,500
Tape, adhesive (1 inch by 360 feet) non-water-repellent	$ .44	72	1,152
	.53	144	5,040
Morphine tubex disposable 10mg/1cc, each	$ .41	300	3,500
	.47	600	17,600
Seattle			
Bread, 22-1/2 ounce round loaf--fresh, white, enriched	$ .34	10	7,280
	.35	10	2,288
	.35	8	3,000
	.36	15	2,533
	.36	12	6,749
	.36	75	10,400
	.38	8	1,596
	.54	13	3,285
Morphine sulfate 10mg/cc ampule injection	$ .45	500	8,000
	.45	3,000	50,000
	.47	200	1,050
	.47	400	2,650
	.47	560	8,000
	.47	1,200	14,600
	.50	200	2,800

a/Prices rounded to the nearest penny.

Simply stated, the hypothesis that the higher volume purchasers would obtain the more favorable prices was not supported by the data obtained in our survey.

Differences in quality do not explain price variances

Hospital officials also asserted the differences in quality of the items purchased was a reason for the differences in prices. However, we noted that the same vendors were charging different hospitals different prices for identical items. In our opinion this situation is not consistent with the hypothesis that differences in the quality of the selected items caused the price variances. For example, two hospitals in Seattle purchased the generic drug penicillin VK in a tablet 250mg form from the same vendor. One hospital with an annual usage of 2,000 paid about 3 cents, and another hospital with an annual usage of 2,400 paid about 9 cents.

Three vendors in Miami charged two hospitals the following prices for the same items:

Item	Hospital (note a) A	Hospital (note a) B	Difference
Bandage, elastic 6 inches wide by 5 yards long	$.93	$ .81	$ .12
Blade, surgical #11 detachable, sterile, stainless steel, each	.16	.13	.03
Catheter, 100 percent silicone foley, 5cc, 16 fr, two way, each	3.21	2.97	.24
Glove, examining latex nonsterile, box 50	2.38	1.90	.48
Intravenous solution D5W 1,000cc, each	1.07	.84	.23
Irrigating solution 1,000ml water	4.00	1.26	2.74
Radiopaque, barium sulfate	1.23	.88	.35
Tape, adhesive 1 inch by 360 feet, non-water-repellent	.58	.43	.15

a/Prices rounded to the nearest penny.

The vendors cited different purchase volumes and competition as the reasons they charged different prices. We noted, however, that in six of the eight cases cited above, there was an inverse relationship of what one might expect between price and volume; that is, the higher the volume, the higher the price.

In Atlanta the same vendor was charging one hospital $1.18 for 48 inch fluorescent lamps and another 59 cents. Other examples involved

--hypodermic needles where the vendor's price for a box of 100 was $4.33 to one hospital and $3.90 to another,

--intravenous solutions where the vendor's price for 1,000cc was $1.34 to one hospital and $1.21 to another, and

--an ECG recording chart where the vendor's price per roll was $1.65 to one hospital and $1.05 to another.

Deviation from group purchasing association price

Although hospital officials and group purchasing directors attributed low prices to group purchasing arrangements--which was true for about 40 to 63 percent of the items where comparisons could be made--group arrangements did not necessarily result in the lowest price in an area. Frequently, (1) unsuccessful bidders on group contracts often attempt to undercut the group's price and (2) member hospitals negotiate directly with vendors for prices equal to or below the group's price. Conversely, some member hospitals pay more than others because they did not participate in group purchasing efforts because of personal preferences by medical or nursing staffs which also tended to erode the groups' ability to obtain the lowest price.

Group purchasing associations

Group purchasing associations are a composite of small and large nonprofit hospitals voluntarily banding together to seek cost savings through volume purchases. The basic theory regarding group purchasing is that increased negotiating power, quantity discounts, and other purchasing advantages accrue more to a group of institutions rather than to a single hospital. Such purchasing advantages in turn can result in lower costs.

Group associations' price not the lowest

In five of the six cities surveyed, membership in group associations did not necessarily result in hospitals achieving

the lowest price available in the area. 1/ For example, in Cincinnati and Columbus, when the groups' prices for the items we surveyed were compared to the prices paid by hospitals in the area, only about 40 percent of the items obtained by groups were acquired at the lowest price. Conversely, about 5 percent of the items contracted by the groups had the highest price. In Seattle, group purchasing arrangements resulted in the lowest price for about 45 percent of the items.

Several other examples where group purchasing arrangements did not result in the lowest price are shown below.

Location/item	Group price (note a)	Lowest price (note a)	Difference
Atlanta			
Paper, toilet 1 ply 1,000 sheet/roll	$ .22	$ .19	$ .03
Penicillin VK tablets 500mg tablets-bulk	.07	.04	.03
Ampicillin, oral suspension 100ml bottle, 250mg/5cc	1.28	1.19	.09
Miami			
Electrodes, monitoring pre-jelled, disposable ICU or OR, each	.33	.28	.05
Medical gas-oxygen cylinder size "H"	2.70	2.57	.13
X-ray film 14 inches by 17 inches	497.10	412.40	84.70

a/Prices rounded to the nearest penny.

Group purchasing directors told us that unsuccessful group bidders would undercut the groups' prices to obtain or retain a hospital's business. We do not know the extent of this practice; however, if it is widespread, the advantages

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1/The exception was Pittsburgh, where except for penicillin, the prices surveyed tended to cluster around the group price which was the lowest price for 63 percent of the items where comparisons could be made.

attributed to group purchasing associations would be eroded accordingly. Several group directors said that a member hospital can obtain short-term gains by purchasing from a nongroup vendor, but such a practice can detract from the long-range effectiveness of the group.

In Cincinnati, one hospital negotiated prices independent of the group but used the group's price as a basis for negotiating an identical price for oxygen cylinders from a vendor who had unsuccessfully bid on the group contract.

Member hospitals often do not participate in group purchasing efforts even when the groups' prices are favorable because of personal preferences by medical and/or nursing staff. In Miami, the group's prices for particular brands of intravenous solution and irrigating solution were $.67 and $1.00, respectively. At one hospital physicians preferred a different brand and, therefore, the hospital purchased intravenous solution and irrigating solution at $.85 and $1.35, respectively, at an additional cost of about $1,735.

To discourage price undercutting or other nonuse of the group contracts, group purchasing associations in Seattle, Cincinnati, Columbus, Atlanta, and Miami have plans for using members' precommitment as a means of legally binding members to the contract, thus giving potential vendors an incentive to offer their best prices. Precommitment requires each hospital to identify the quantity to be obtained under a particular group contract and then to buy at least that quantity under the group contract.

WEIGHTED IMPACT OF PRICE DIFFERENCES

Although the differences between the highest and lowest prices for individual items were quite extreme, the overall impact of the differences in terms of total annual usage at the related prices paid by the hospitals was much more moderate. Based on the reported prices and the annual usage for those items where comparisons could be made (e.g., more than one hospital in an area purchased a specific item) and using the lowest price as the base, the weighted impact of the price differences was about 10 percent. However, this ratio varied between cities, as shown on the following table.

Location	Actual cost and actual prices	Computed cost and lowest prices	Difference	Percent difference Col. 1 ÷ Col. 3
		(000 omitted)		
Seattle	$1,714	$1,482	$232	14
Atlanta	1,208	1,068	140	12
Miami	1,552	1,377	175	11
Columbus	1,226	1,093	133	11
Pittsburgh	1,971	1,818	153	8
Cincinnati	1,277	1,184	93	7
Total	$8,948	$8,022	$926	10

CONCLUSIONS

There was little rhyme or reason to the variations in prices noted in the six cities because (1) there was often little correlation between the volumes purchased and the prices paid, (2) the same vendors were charging different hospitals different prices for identical items without regard to the volume purchased, and (3) group purchasing arrangements did not necessarily result in the lowest prices in an area. One of the explanations for the wide variations that seemed to consistently apply was that hospital purchasing agents simply did not know what other hospitals were paying for similar items and, thus, could not know whether the prices paid were reasonable.

In at least one of the cities visited (Seattle), local hospital association officials have indicated their interest in dealing with the issue of lack of communication of price information among hospitals by making price surveys for selected items and making such information available to their member hospitals.

AHA AND TRADE ASSOCIATION COMMENTS AND OUR EVALUATION

In commenting on our report, AHA expressed concern regarding the limited data base for the report. It questioned whether the six cities and the 37 hospitals were selected by a rigorous random sampling technique. AHA stated that it had difficulty understanding how such a limited data base can support conclusions representative of the entire U.S. health care industry.

Although we are not attempting to draw conclusions with regard to the entire U.S. health care industry, we believe a more objective view of the scope and data base for this review should include consideration of the following facts:

--There are 66 Standard Metropolitan Statistical Areas (SMSA) in the Continental United States with populations of more than 300,000. These areas include about 50 percent of the Nation's population, about 26 percent of the hospital beds, and about 50 percent of Medicare's total amount of reimbursement to hospitals.

--Five of six cities (or SMSAs) included in this review ranked in the top 20 in terms of population and the six cities represented about 3 percent of the Nation's hospital beds and 4 percent of total national Medicare reimbursement. Although the cities were not selected on the basis of random sampling, they were located in four of the nine census divisions (Middle Atlantic, East North Central, South Atlantic, and Pacific) in the country, and thus geographically dispersed.

--The six cities (or SMSAs) included 170 hospitals. If we had surveyed all 170 hospitals, the weighted impact of the price differences could have been different but it would not be possible for the difference between the highest and lowest price in each city to be smaller--the difference could only be greater or the same.

In addition, we do not believe it is reasonable to assume that the conditions discussed are limited to the six cities included in this report. Preliminary work done by us in Washington, D.C.; and Baltimore, Maryland; as well as studies reported in the media in Chicago, Illinois; Norfolk, Virginia; and New York City tended to parallel the findings of this report in that there were also wide differences in the prices paid by hospitals for routine supply items. The fact that the Medicare and Medicaid programs are paying about $4.3 billion a year for hospital supplies indicates to us that such differences should be a matter of concern to HEW as well as the hospital industry.

AHA also expressed concern regarding the 43 items for which price comparisons were attempted. AHA does not believe that our list of products represented the most significant cost-intensive supply items routinely purchased. We cannot disagree with AHA's position. As discussed previously, the principal criteria for selecting items for the review was to

facilitate price comparisons. The Director of a Seattle group purchasing association examined a preliminary list of about 73 routine supply items and identified which of the items were most likely to be purchased at all hospitals and where valid price comparisons could be made in terms of comparability. If our preliminary list included high-dollar, high-volume items, and they met the criteria, the items were included, if not, high-dollar items were dropped in order to focus on comparable routine supply items.

In retrospect, a number of items turned out to represent relatively low-cost-intensive purchases across the board. For example, total purchases of aspirin tablets, phisoderm, ampicillin, morphine sulfate, and certain penicillin products amounted to less than $3,000 for all the selected hospitals in at least five of the six cities.

The Trade Associations generally said that there was insufficient information in the report to explain the price differences and questioned whether the overall 10-percent weighted difference was statistically significant when product and service variations among vendors are given proper consideration.

As discussed in this chapter, we obtained various explanations for the price differences from hospital and vendor personnel in the cities visited; but on analysis, most did not prove to be valid. While we agree that the statistical significance of the 10-percent weighted difference is uncertain, as discussed in the following chapter, we believe significant potential savings are available through greater involvement by HEW and intermediaries in cost containment for selected routine supply items.

One Association said we should not have looked at the prices of specific items but should have reviewed hospitals' overall supply costs including purchasing, inventory, and distribution costs.

In the first place, this was not what the Subcommittee asked us to do. Secondly, the lack of uniformity in accounting for hospital costs on a functional basis makes the feasibility of such an approach doubtful, and thirdly, the consideration of overall supply costs which could include a wide mix of items would make comparisons extremely difficult.

CHAPTER 3

FEDERAL INVOLVEMENT IN COST CONTAINMENT FOR ROUTINE SUPPLY ITEMS

With the exception of limiting reimbursement for the prices paid by hospitals for certain drugs, HCFA and its intermediaries have done little to monitor the reasonableness of the costs of routine hospital supply items because, in their view, such activities would not be cost effective. Further, even where specific program requirements have been established with respect to drugs, intermediaries have not adhered to them for the same reason. We disagree and believe that there is a role for Medicare intermediaries to play in assisting hospitals to avoid paying excessive prices for routine supply items where the potential for cost savings appears the greatest.

MEDICARE REIMBURSEMENT REGULATIONS AND THE PRUDENT BUYER CONCEPT

Implicit in Medicare cost reimbursement regulations is the principle that the program will only pay reasonable costs. As part of this principle, in November 1971 HEW added to the reasonable cost rules the "prudent buyer concept." 1/ Briefly stated, this rule provides that (1) the program expects that a provider, like any prudent and cost-conscious buyer, will not only refuse to pay more than the "going" price for an item or service but will also seek to economize by minimizing costs and (2) intermediaries should not reimburse providers for costs that exceed those that a prudent buyer would incur unless there is evidence that the higher costs were unavoidable. However, except for certain drugs, 2/ the prudent buyer rule did not impose specific limitations on reimbursable provider costs or duties on the intermediaries for its implementation.

1/This was not incorporated into the reimbursement regulations but was included in the Provider Reimbursement Manual, which elaborates on the regulations.

2/The maximum allowable cost (MAC) limitation placed on certain multiple source drugs, such as penicillin and ampicillin. These limitations were incorporated into the regulations.

Although the prudent buyer concept has been applied in several reimbursement decisions to uphold an intermediary's disallowances of alleged, excessive, or unreasonable costs for physical therapy services, administrative salary increases, and consulting fees, we identified no situations where the rule has been applied to disallow the costs of routine supply items. Further, none of the Medicare intermediaries in the six cities reviewed were making reviews to determine whether hospitals were paying more than the lowest generally available prices for routine supply items under the prudent buyer concept. Their reasons for not doing so were that

--they did not believe HCFA expected them to make such reviews and

--in view of the thousands of items involved, they did not believe such reviews would be cost effective.

HCFA officials have echoed these views as to the probable cost effectiveness of intermediaries monitoring the prices paid by hospitals for routine supply items under the prudent buyer concept.

Intermediaries do not enforce the maximum allowable cost limit for drugs

As previously indicated, HCFA has not imposed specific cost limitations on providers or duties on its intermediaries under its prudent buyer concept rules except for limiting the amount reimbursed for certain multiple source drugs (the MAC program), which rules were published as final regulations in August 1975. Under the regulations, as explained in the Provider Reimbursement Manual, reimbursement to hospitals is limited to the lowest of

> "* * * (1) the actual cost, (2) the amount which would be paid by a prudent and cost-conscious buyer for the drug if obtained from the lowest-price source that is widely and consistently available within a provider's source area, or (3) the MAC."

The MAC is set at the cost of the lowest priced, generally available source (nationwide) of a given generic drug at a given point in time.

According to HCFA instructions, intermediaries are supposed to (1) make "ongoing surveys" for evaluating

the providers' cost of drugs and "related medical supplies" including MAC drugs and (2) record and retain on a provider-by-provider basis the results of the cost evaluation. In the cities visited, the intermediaries were not doing this because they believed

--such surveys would not be cost effective and

--the MAC limits were set so high that it was improbable that any hospital would exceed them.

Four drug items (or subitems) listed under the MAC program were also included in our selected supply items. These represented about .06 percent of the total cost of $8.9 million of comparable items reviewed. (See p. 14.) Six of the 37 hospitals did, in fact, pay more for three items of penicillin than the applicable MAC. Based on these six institutions' annual usage, the excess costs subject to disallowance under the regulations totaled only about $1,100, which tended to support the intermediaries' rationale as to why they were not adhering to program requirements in this area. 1/

CAN THE APPLICATION OF THE PRUDENT BUYER CONCEPT TO ROUTINE SUPPLIES BE WORTHWHILE?

On the basis of our review, we believe that the application of the prudent buyer concept to routine supply items could be cost effective if it is focused on those items that offer the highest potential for cost savings. Although the number of items meeting this criteria varied from city to city, we identified five such items in the review of six cities, which offered potential aggregate savings of about $150,000 for hospitals in two or more of the cities, if (1) the hospitals' personnel in these areas were aware of what the other hospitals were paying and (2) the intermediaries applied the prudent buyer concept to those hospitals that persisted in paying more than the other hospitals. Because our review was limited to less than one-half of one percent of the hospitals participating in the Medicare program, it is likely that potential savings for these items alone could amount to millions of dollars. The role of the intermediary

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1/We have currently underway a broad review of the MAC program which covers the procurement of both inpatient and outpatient drugs. Therefore, we are drawing no conclusions as to the cost effectiveness of this phase of the program based on this review involving six cities.

in this situation should be to (1) gather price information on the selected items from hospitals in an area, (2) communicate the information to the hospitals it services, and (3) periodically monitor the hospitals' purchases of such items.

GAO's hypothesis on potential savings

We developed a hypothesis to the effect that it could be worthwhile if the availability of price information would help one or more hospitals save $1,000 or more a year each for a specific item. Under this hypothesis we compared the prices paid by the various hospitals with the lower prices that at least two hospitals in the same area were paying. For example, if only one hospital in an area was paying the lowest price of $.76 for 1,000cc of intravenous solution and the next lowest price paid by at least one other hospital was $.95, we used the latter price as the base. If the combination of the unit price differences and the annual usage by the remaining hospitals in an area produced a total difference of $1,000 or more for any other hospital, we concluded that the application of the prudent buyer could be worthwhile. Despite the wide variance in unit prices for most of the items compared, surprisingly few items met or qualified under this criteria. Because we looked at more hospitals in Seattle and the price differences in that city were the largest, 11 of the 40 comparable items in Seattle produced a potential savings at one or more hospitals of $1,000 or more for a total of $57,600. For the other cities, however, the number of items qualifying under our hypothesis was much lower.

Location	No. of qualifying items
Miami	6
Columbus	5
Cincinnati	5
Pittsburgh	4
Atlanta	3

Also there was a high degree of commonality of the qualifying items in each of the cities. For example, the pre-jelled disposable electrode (item 8 in app. I) qualified in all six cities and represented a potential savings for 10 of the 37 hospitals of about $39,500. The 1,000cc of intravenous solution (item 13 in app. I) qualified in five of

the six cities and represented a potential savings of about $39,400 for 9 of the 37 hospitals. X-ray film (item 30) also qualified in five cities and represented a potential savings of $38,100 for 11 hospitals. Medical gas (item 17(1)) qualified in four of the six cities with a potential savings of $24,700 for five hospitals and irrigating solution (item 14) qualified in two cities with a potential savings of $8,400 for three hospitals.

Overall, the total cost for these five items represented about 40 percent of the $8.9 million total costs of comparable items in the six cities. Accordingly, we believe that if judiciously applied to the high volume, high-cost items in an area, the application of the prudent buyer concept to routine supply items could be cost effective.

Proposed role of the intermediary

We believe that an appropriate role for the Medicare intermediaries would be to gather and compile price information from hospitals in an area for those routine supply items offering the greatest potential for cost savings and to communicate such information to the hospitals they service.

Inasmuch as the benefits to the Federal Government and the public generally would be maximized by helping hospitals avoid paying more than the lowest generally available prices for routine supply items, we believe that the intermediaries' role should be initially focused on communicating price information to the hospitals as opposed to retroactively disallowing the excessive costs of items that have already been purchased.

On the other hand, we believe that the intermediaries should periodically monitor hospitals' procurements of the selected supply items and should disallow for reimbursement the excessive costs associated with those hospitals that persist in paying more than the "lowest" generally available prices for the selected items unless it is unavoidable.

CONCLUSIONS

Although the prudent buyer concept has, for about 8 years, been a part of the provider reimbursement manual, which elaborates on Medicare's cost reimbursement regulations, HCFA and its intermediaries have done little to monitor or contain the costs of routine hospital supply items. In fact,

the intermediaries in the cities surveyed had not complied with specific program requirements pertaining to hospital drug purchases because they believed that such compliance would not be cost effective. Although our findings did not contradict their rationale, we believe this situation does reflect the low priority afforded the costs of routine supply items in HEW's cost-containment activities, even though such items represent about 17 percent of total hospital costs.

We believe the application of the prudent buyer concept could be cost effective if it is focused on those items that offer the highest potential for cost savings. We identified five items which seemed to meet this criteria in two or more cities. Also, we believe that the intermediaries' role under the prudent buyer concept should be initially directed to providing price information to hospitals to help them avoid paying more than the lowest available prices as opposed to disallowing costs for Medicare and/or Medicaid reimbursment purposes.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary direct the Administrator of HCFA to instruct the Medicare intermediaries to (1) gather and compile price information in various areas on the five items we identified that appeared to offer the greatest potential for cost savings and (2) communicate such information to the hospitals they service. We also recommend that the intermediaries be instructed to periodically monitor their hospitals' purchases of these items and report back to HCFA in order to (1) assess the extent that this activity may result in cost savings and (2) determine whether it should be expanded to include other hospital supply items. This could be accomplished by comparing the cost of the monitoring activities with any price reductions realized by the hospitals as a result of the exchange of price information. The items to be added could be determined by identifying those items which represent the more significant dollar value of total purchases based on price and volume. For the five items we identified, 60 percent of the hospitals reviewed had an aggregate volume of over $3.5 million.

HEW, AHA, AND TRADE ASSOCIATION COMMENTS AND OUR EVALUATION

In summary, HEW agreed, in part, with our recommendations; however, before HEW issues specific instructions to its Medicare intermediaries, HCFA will conduct an experiment

with at least one intermediary. This test is anticipated to take 1 year from its inception (about mid-November 1979). At the end of the experiment, the results will be evaluated and recommendations will be made as to the feasibility of nationwide implementation of a price monitoring and information system.

Although we believe it would be preferable to proceed immediately on a broader basis, at least with respect to the five items we identified as having the greatest potential for cost savings, HEW's comments represent a step in the right direction.

AHA and the Trade Associations disagreed with the proposal. Their primary concern appeared to be that this report could be instrumental in bringing about additional Federal involvement or regulations in controlling hospital costs. AHA also said that it disagreed with our assessment that there is a role for the Medicare intermediaries to play in helping hospitals avoid paying excessive prices for routine supplies. AHA said that positive progress in this area was being made by virtue of the efforts of group purchasing programs and through voluntary cost containment efforts.

As discussed on page 7, after completion of our fieldwork, we contacted two hospital service organizations in the Seattle area to find out whether they would be interested in surveying member hospitals to find out what the hospitals were paying and then disseminating that information. These organizations indicated such a program was feasible but deferred comments on the actual implementation.

To the extent that hospital service organizations actually do implement such a program, we would expect that the Medicare intermediaries' role would be modified accordingly to avoid duplication.

Further, we believe that our recommendation should be viewed as a form of assistance to hospitals in controlling or reducing costs. In our view, the fact that Medicare and Medicaid are paying about 40 percent of hospital costs provides the government with a strong interest in this objective.

APPENDIX I

LIST OF ROUTINE SUPPLY ITEMS FOR WHICH PRICE AND ANNUAL USAGE DATA WERE REQUESTED

	Description of item	Unit issue
1.	Aspirin 5 grain, plain, bulk (a) unit dose	btl (500)
2.	Bag, bedside Flame, and moisture resistant	100
3.	Bandage, elastic 6 inches wide X 5 yards long	each
4.	Blade, surgical #11 Detachable, sterile stainless steel	each
5.	Bread (a) 22-1/2 ounce round loaf--fresh, white, enriched (b) 24 ounce round loaf--fresh, white enriched (c) 22-1/2 ounce round loaf, day-old, white, enriched (d) 24 ounce round loaf, day-old, white, enriched	
6.	Catheter, nasal, oxygen 14FR Disposable, transparent, individual package, with connector and tapered end	each
7.	Catheter, 100 percent silicone foley 5cc, 16FR, two way	each
8.	Electrodes monitoring pre-jelled, disposable ICU and OR. Electrode for use in operating and recovery room	each
9.	Electrodes, monitoring, pre-jelled, disposable For use in ECC monitoring procedures	each

APPENDIX I

Description of item	Unit issue
10. Enema, sodium phosphate, premixed 6 ounces Ready to use, disposable (a) 4-1/2 ounce	each
11. Fuel oil (a) No. 2 diesel (b) No. 3 diesel (c) No. 4 diesel	gal.
12. Glove, examining latex nonsterile	box (50)
13. Intravenous solution--D5W	1,000 cc each
14. Irrigating solution (a) 1,500ml water (b) 1,000ml water	each
15. Lamps, 48 inches 40W, fluorescent Cool white	each
16. Milk Individual 1/2-pint HUD	each
17. Medical gas--oxygen, bulk (a) with tank cost (b) without tank cost	100 cu. ft.
18. Medical gas--oxygen, cylinder Size "H"	each
19. Needle, hypodermic, sterile Disposable 18ga., 1-1/2 inches (a) Disposable 19ga., 1-1/2 inches	box 100
20. Needle, hypodermic, sterile Disposable 21ga., 1-1/2 inches (a) Disposable 22ga., 1-1/2 inches	box 100
21. Paper ECG recording chart Single channel 50MM X 150 feet	roll
22. Paper toilet (a) 2 ply, 500 sheet/roll 4.5 X 4.5 (b) 1 ply, 1,000 sheet/roll (c) 1 ply, 1,500 sheet/roll	roll

APPENDIX I

Description of item	Unit issue
23. Phisoderm (a) Phisohex	gal.
24. Radiopaque, barium sulfate	lb.
25. Syringe, disposable sterile with needle, 3cc, 21ga. X 1-1/2 inches (a) with needle, 3cc, 22ga. X 1-1/2 inches	each
26. Syringe, disposable irrigating Asepto 3 ounce bulb	each
27. Tape, adhesive 1 inch X 360 feet (910 yards) Non-water repellent	roll
28. Tape, adhesive, water repellent 1 inch X 180 inches (5 yards)	roll
29. Wrapper, autoclave (a) 30 X 30 disposable (b) 24 X 24 disposable	sheet
30. X-ray film 14 inches X 17 inches	case (500)
31. Ampicillin, oral suspension (a) 100ml bottle, 250mg/5ml (b) 200ml bottle, 250mg/5ml	btl
32. Morphine sulfate 10mg/1cc	amp
33. Morphine tubex, disposable 10mg/1cc	each
34. Penicillin VK tablets (a) 500mg tablets--bulk (b) 250mg tablets--bulk	100 tablets
35. Penicillin VK liquid 100mc- bottle 250mg/5ml	btl

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Description of item	Unit issue
36. Penicillin, G procaine, 300,000 units/1cc Disposable syringe	each
37. Meperidine, ampule (a) 100mg/1cc (b) 100mg/2cc	amp
38. Meperidine, tubex 100mg/1cc	each
39. Underpad, disposable, polyethylene	each
Select one most used by individual hospitals:	
a. 23 inches X 24 inches Following judged comparable:	
Parke Davis	30-6138-1
Will Ross	103122
AHS	16520
Scherer	16520
b. 23 inches X 24 inches Following judged comparable:	
Parke Davis	30-1038-200
Will Ross	10-1122
AHS	50474-223
Scherer	321
c. 17-1/2 inches X 24 inches Following judged comparable:	
Parke Davis	30-949-1
Will Ross	10-1122
AHS	50474-217
Scherer	311
40. Trash can liner--mobil	
Select size most used by individual hospital:	each
a. 1 mil 15 X 9 X 24 (24 X 24)	
b. 1 mil 15 X 9 X 33 (24 X 33)	
c. 1-1/4 mil 16 X 14 X 37	
d. 1-1/2 mil 23 X 10 X 40	

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Description of item	Unit issue
41. Crystalline amino acid solution 8.5%	
a. Kit includes 500ml bottle at 50% dextrose	bottle (500ML)
b. 500ml bottle amino acid solution only	
42. Cephradine	
a. 500mg capsules--bulk	each
b. 250mg capsules--bulk	
43. Dexamethasone	
4mg/cc vial	each

APPENDIX II

PRICES PAID BY HOSPITALS FOR ROUTINE SUPPLY ITEMS (note a)

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Aspirin, 5 grain plain bulk bottle of 500:				
Cincinnati	$ .43	$ -	$ .33	30
Atlanta	2.67	.89	.38	603
Miami	1.92	1.29	.43	347
Seattle	1.84	1.48	1.20	53
Pittsburgh	1.49	1.48	1.32	13
Bag, bedside flame, and moisture resistant, box (100):				
Cincinnati	$2.37	$ -	$1.33	78
Columbus	1.89	1.83	1.64	15
Miami	2.04	-	1.70	20
Seattle	2.14	1.69	.96	123
Pittsburgh	2.37	2.19	1.81	31
Bandage, elastic 6 inches wide X 5 yards long, each:				
Cincinnati	$1.29	$1.02	$ .95	36
Atlanta	1.78	1.05	.87	105
Miami	1.21	.85	.62	95
Seattle	2.15	.95	.72	199
Pittsburgh	1.44	.97	.97	49

APPENDIX II

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Blade, surgical #11 detachable sterile stainless steel, per blade:				
Cincinnati	$ .165	$ .159	$ .152	9
Columbus	.177	.163	.158	12
Atlanta	.160	.150	.112	43
Miami	.159	.128	.117	36
Seattle	.241	.150	.140	72
Pittsburgh	.170	.158	.132	29
Medical gas-oxygen bulk without tank cost 100 cubic feet:				
Cincinnati	$ .335	$ .229	$ .229	46
Columbus	.840	.420	.290	190
Atlanta	.400	.390	.255	57
Miami	.670	.460	.264	154
Seattle	.860	.740	.320	169
Pittsburgh	.385	.340	.320	20
Electrodes monitoring pre-jelled disposable ICR and or electrode for use in operating and recovery room, each:				
Cincinnati	$ .560	$ .531	$ .320	75
Columbus	.653	.450	.252	159
Atlanta	.583	.450	.360	62
Miami	.550	.325	.280	96
Seattle	.550	.390	.270	104
Pittsburgh	.584	.500	.360	62

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Fuel oil No. 2 diesel, gallon:				
Cincinnati	$ .413	$ .406	$ .387	7
Columbus	.473	.469	.373	27
Seattle	.537	.434	.399	35
Pittsburgh	.480	.399	.376	28
Miami	.394	-	.394	0
Enema, sodium phosphate premixed 6 ounces, ready to use disposable, each:				
Atlanta	$ .325	$ .240	$.216	51
Miami	.390	.249	.240	63
Pittsburgh	.340	.230	.220	55
Cincinnati	.339	-	.238	42
Glove, examining latex non-sterile, (box 50):				
Cincinnati	$3.06	$2.35	$2.12	44
Columbus	2.91	2.48	2.28	28
Atlanta	2.41	2.26	1.83	32
Miami	2.38	1.95	1.00	138
Seattle	4.70	2.57	1.90	147
Pittsburgh	2.52	1.89	1.89	33
Intravenous solution D5W 1,000cc, each:				
Cincinnati	$2.92	$1.14	$1.02	186
Columbus	1.21	1.05	.74	64
Atlanta	1.34	.94	.75	79
Miami	1.07	.85	.67	60
Seattle	2.48	.95	.75	231
Pittsburgh	.83	.82	.73	14

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Irrigating solution 1,500ml water, each:				
Atlanta	$1.40	$1.36	$1.23	14
Miami	4.00	1.30	1.05	281
Seattle	3.49	1.33	1.05	233
Pittsburgh	1.15	1.14	1.14	1
Irrigating solution 1,000ml water, each:				
Cincinnati	$3.19	$1.80	$1.17	173
Columbus	1.30	1.22	.72	81
Pittsburgh	.86	.82	.80	8
Lamps, 48 inches 40W fluorescent cool white, each:				
Cincinnati	$ .71	$ .65	$ .65	9
Columbus	.95	.93	.76	25
Atlanta	1.22	.99	.59	107
Miami	1.90	1.09	.65	192
Seattle	1.41	1.23	.67	111
Pittsburgh	1.17	.75	.64	83
Medical gas--oxygen cylinder size "H", each:				
Cincinnati	$2.75	$2.75	$2.75	0
Columbus	5.78	4.33	3.44	68
Atlanta	5.00	3.25	2.65	89
Miami	2.70	-	2.57	5
Seattle	5.37	2.66	2.42	122
Pittsburgh	4.50	3.16	3.16	42

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	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Needle, hypodermic sterile disposable 18ga., 1-1/2 inches, box of 100:				
Cincinnati	$5.16	$3.74	$3.22	60
Columbus	4.40	3.84	3.10	42
Atlanta	4.33	3.73	3.15	38
Miami	4.73	3.33	2.75	72
Seattle	5.21	3.24	2.99	74
Pittsburgh	3.06	2.09	2.09	46
Paper, ECG recording chart single channel 50mm X 150ft. roll:				
Cincinnati	$2.50	$1.48	$1.05	138
Columbus	1.78	1.50	1.05	70
Atlanta	1.65	1.25	1.05	57
Miami	2.00	1.29	1.18	70
Seattle	2.41	1.82	1.05	130
Pittsburgh	4.20	1.12	1.12	275
Radiopaque barium sulfate, pound:				
Cincinnati	$1.00	$1.00	$ .91	10
Columbus	1.58	-	.89	78
Atlanta	1.21	1.06	.67	81
Miami	1.78	1.09	.88	102
Seattle	1.89	1.37	1.16	63
Pittsburgh	1.37	1.37	.99	38
Syringe, disposable irrigating asepto 3 ounce bulb, each:				
Cincinnati	$ .642	$ .613	$ .445	44
Columbus	.710	-	.561	27

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Tape, adhesive 1 inch X 360 feet (910 yards) non-water-repellent, roll:				
Cincinnati	$ .527	$ .447	$ .431	22
Columbus	.444	.429	.423	5
Atlanta	.453	.421	.300	51
Miami	.583	.421	.415	41
Seattle	.453	.418	.329	38
Pittsburgh	.396	.323	.323	23
Needle, hypodermic sterile disposable 21ga., 1-1/2 inches box 100:				
Cincinnati	$ 5.16	$ 3.61	$ 3.22	60
Columbus	5.19	3.84	3.10	67
Atlanta	4.33	3.27	3.11	39
Seattle	5.21	3.25	2.99	74
Pittsburgh	3.06	2.90	2.90	6
X-ray film 14 inches X 17 inches case of 500:				
Cincinnati	$491.75	$491.70	$461.77	7
Columbus	599.70	491.75	491.70	22
Atlanta	504.89	491.70	483.90	4
Miami	497.09	497.09	412.40	21
Seattle	563.65	497.69	463.60	22
Pittsburgh	503.75	503.69	449.96	12
Morphine sulfate 10mg/cc ampule-injection, per ampule:				

APPENDIX II

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Morhpine tubex disposable 10mg/1cc, each:				
Cincinnati	$ .523	$ .497	$ .405	29
Columbus	.497	.469	.446	11
Miami	.523	-	.469	12
Seattle	.497	.469	.452	10
Pittsburgh	.469	.452	.446	5
Penicillin VK tablets 500mg tablets bulk, per 100 tablets:				
Atlanta	$ 18.52	$ -	$ 3.92	372
Miami	10.25	7.50	7.46	37
Seattle	17.27	6.69	3.66	372
Penicillin VK tablets 250mg tablets bulk, per 100 tablets:				
Cincinnati	$ 2.39	$ 1.95	$ 1.95	23
Columbus	8.90	8.02	1.95	356
Atlanta	3.75	-	1.59	136
Miami	4.50	-	2.79	61
Seattle	8.90	2.85	1.90	368
Pittsburgh	9.13	3.50	1.85	394
Penicillin VK liquid 100ml bottle 250mg/5ml, bottle:				
Cincinnati	$ 1.40	$ .93	$ .90	56
Columbus	1.98	1.91	.92	115
Atlanta	.94	-	.92	2
Miami	1.60	1.37	.86	86
Seattle	2.09	.96	.92	127
Pittsburgh	2.09	.90	.89	135

APPENDIX II

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Meperidine, tubex 100mg/1cc each:				
Cincinnati	$ .409	$ .357	$ .312	31
Columbus	.409	.388	.361	13
Miami	.409	.409	.353	16
Seattle	.409	.388	.372	10
Pittsburgh	.388	.372	.369	5
Ampicillin, oral suspension 100ml bottle, 250mg/5ml, per ml:				
Cincinnati	$1.45	$ -	$1.26	15
Columbus	1.93	-	1.42	36
Atlanta	1.35	-	1.19	13
Seattle	1.93	1.36	1.19	62
Pittsburgh	1.28	-	1.15	11
Bread, 24 ounce round loaf--fresh, white, enriched:				
Cincinnati	$ .590	$ .590	$ .575	3
Columbus	.450	-	.450	0
Atlanta	.520	-	.470	11
Catheter, nasal, oxygen 14FR, disposable, transparent, individual package, with connector and tapered end, each:				
Cincinnati	$ .239	$ -	$ .050	378
Columbus	.327	.262	.169	94
Seattle	.475	.475	.450	6

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Electrodes monitoring, pre-jelled, disposable for use in ECG monitoring procedure, each:				
Atlanta	$ .500	$ -	$ .072	594
Seattle	.550	.357	.104	429
Pittsburgh	.550	.550	.420	31
Milk, individual 1/2-pint HUD, each:				
Cincinnati	$ .119	$ .088	$ .083	43
Columbus	.088	.088	.085	4
Atlanta	.115	.104	.088	31
Miami	.160	.103	.102	57
Seattle	.101	.098	.092	10
Pittsburgh	.145	.130	.130	12
Paper, toilet, 2 ply, 500 sheet/ roll:				
Atlanta	$ .213	$ -	$ .205	4
Seattle	.352	.225	.200	76
Pittsburgh	.199	.199	.199	0
Syringe, disposable sterile with needle, 3cc 21ga. X 1-1/2 inches, each:				
Cincinnati	$ .060	$ -	$ .056	7
Atlanta	.068	.052	.041	66
Miami	.046	.045	.044	5
Seattle	.057	.051	.047	21
Pittsburgh	.065	.045	.045	44
Tape, adhesive, water repellent, 1 inch X 180 inches, roll:				
Atlanta	$ .663	$ .357	$ .357	86
Seattle	.829	.814	.521	59
Pittsburgh	.481	.452	.430	12

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Penicillin, G procaine, 300,000 units/1cc disposable, syringe, each:				
Cincinnati	$ .484	$ -	$ .473	2
Atlanta	.532	-	.473	13
Miami	.444	-	.350	27
Seattle	.576	.520	.473	22
Pittsburgh	.587	.545	.508	16
Meperidine, ampule, 1pp mg/1cc, amp:				
Cincinnati	$ .171	$ -	$ .119	44
Atlanta	.121	.119	.108	12
Miami	.175	.134	.118	48
Seattle	.288	.231	.112	157
Pittsburgh	.226	.226	.119	90
Trash can liner, mobil, each:				
Cincinnati	$ .017	$ -	$ .017	0
Columbus	.021	-	.018	17
Miami	.022	-	.017	29
Seattle	.028	.021	.014	100
Pittsburgh	.028	.019	.017	65
Crystalline, amino acid solution, 8.5 percent bottle (500ml):				
Miami	$16.65	$16.65	$10.98	52
Seattle	14.65	13.79	10.85	35
Pittsburgh	14.15	13.73	13.44	5
Dexamethasone 4mg/cc vial, each:				
Cincinnati	$ 1.27	$ .99	$ .90	41
Columbus	1.47	.87	.85	73
Miami	.90	.61	.59	53
Seattle	1.38	.62	.51	171
Pittsburgh	.52	.48	.46	12

	Highest price	Median (note b)	Lowest	Percent difference between highest price and lowest price
Wrapper, sterile autoclave, 24 X 24 disposable, sheet:				
Atlanta	$ .120	$ -	$ .110	10
Miami	.115	-	.074	55
Seattle	.259	.114	.075	245
Cephradine, 250mg capsules, bulk, each:				
Cincinnati	$ .318	$ -	$ .263	21
Miami	.348	.318	.256	36
Seattle	.540	.463	.314	72
Pittsburgh	.319	-	.258	24
Underpad, disposable polyethylene, 17-1/2 inches by 24 inches:				
Cincinnati	$ .063	$ -	$ .057	11
Columbus	.078	.052	.051	53
Atlanta	.062	-	.057	9
Miami	.097	.065	.048	102
Seattle	.070	.063	.058	21
Pittsburgh	.065	.062	.047	38

a/Price information compiled on 2 of the 43 (items 7 and 23 in app. I) was not sufficient to make comparisons.

b/A lack of data precluded computing a medium in some cases.

APPENDIX III

LIST OF ORGANIZATIONS CONTACTED

Hospital Associations

American Hospital Association; Chicago, Illinois
Greater Cincinnati Hospital Council; Cincinnati, Ohio
Hospital Shared Services Incorporated; Columbus, Ohio
Georgia Hospital Association; Atlanta, Georgia
Georgia Hospital Shared Services Incorporated; Atlanta, Georgia
South Florida Hospital Association; Miami, Florida
Hospital Shared Services Incorporated; Seattle, Washington
Seattle Area Hospital Council; Seattle, Washington
Washington State Hospital Association; Seattle, Washington
Washington State Hospital Commission; Seattle, Washington
Hospital Council of Western Pennsylvania; Pittsburgh, Pennsylvania
Health Industry Manufacturers Association; Washington, D.C.
American Surgical Trade Association; Washington, D.C.

Intermediaries

Hospital Care Corporation (Blue Cross); Cincinnati, Ohio
Blue Cross of Central Ohio; Columbus, Ohio
Blue Cross of Western Pennsylvania; Pittsburgh, Pennsylvania
Blue Cross Association; Jacksonville, Florida
Aetna Life and Casualty; Seattle, Washington
Blue Cross of Washington and Alaska; Seattle, Washington

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEW Region V:	Cincinnati, Ohio
	Columbus, Ohio
HEW Region X:	Seattle, Washington
HEW Region IV:	Atlanta, Georgia
	Miami, Florida
HEW Region III:	Pittsburgh, Pennsylvania

APPENDIX IV

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

Mr. Gregory J. Ahart
Director, Human
Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Prices Paid By Hospitals For Routine Supply Items Vary Widely." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Acting Inspector General

Enclosure

APPENDIX IV

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED, "PRICES PAID BY HOSPITALS FOR ROUTINE SUPPLY ITEMS VARY WIDELY"

Overview

GAO has identified problems in the application of Medicare's reasonable cost regulations to the costs of routine supply items obtained by hospitals. More specifically, GAO has cited the failure of Medicare's fiscal intermediaries to apply the "prudent buyer principle" to the costs of routine supply items in the determination of reimbursable costs. While we believe that the audit of each and every element of a provider's costs would not be cost-effective, we agree with GAO that the Health Care Financing Administration (HCFA) does have a role to play in helping providers overcome the existing barriers to making the most prudent choice of source of supply.

As a general observation, the draft report describes the "prudent buyer principle" as part of the "reasonable cost rules" (page 24) or the "cost reimbursement regulations" (page 32). It should be understood that this principle is not part of reimbursement regulations published in the Code of Federal Regulations. It is issued only in various administrative manuals and instructions.

GAO Recommendation

We recommend that the Secretary of Health, Education, and Welfare direct the Administrator of the Health Care Financing Administration (HCFA) to:

> Instruct the Medicare intermediaries to gather and compile price information in various areas on the five items identified in our review which appeared to offer the greatest potential for cost savings and to communicate such information to the hospitals they service.

We also recommend that:

The intermediaries be instructed to periodically monitor their hospitals' purchases of these items and report back to:

(1) assess the extent that this activity may result in cost savings, and

(2) determine whether it should be expanded to include other hospital supply items.

This could be accomplished by comparing the cost of the monitoring activities with any price reductions realized by the hospitals as a result of the exchange of price information. The items to be added could be determined by identifying those items which represent the more significant dollar value of total purchases based on price and volume.

APPENDIX IV

Department Comment

We agree with the GAO report that hospitals may be paying excessive prices for routine supply items. However, before issuing specific instructions to HCFA's Medicare intermediaries to compile the prices of routine supply items, inform the hospitals and monitor the use of the information, HCFA will first conduct an experimental test with at least one intermediary. This test is anticipated to take one year from its inception (approximately mid-November). At the end of the experiment, the results will be evaluated and recommendations will be made as to the feasibility of national implementation of a supply cost monitoring and information distribution system. The following are some of the areas that will be addressed during this experiment:

--levels of administrative costs incurred by the intermediary in compiling and distributing the information

--determining costs to hospitals which have prime vendor arrangements with suppliers

--time frames for collection and distribution of new prices to providers

--processing changes which are brought about between the intermediary and providers, and providers and suppliers

It should be noted that providers nominate their own intermediaries, so that hospitals in a particular area may be serviced by several intermediaries. Collecting area-wide data may, therefore, require additional administrative costs to effect the necessary data not contemplated by GAO.

As mentioned in the overview, the "prudent buyer principle" is not explicitly included in the reasonable cost regulations, but rather is included only in various administrative manuals and instructions. HCFA has already begun action to incorporate the "prudent buyer principle" into the cost regulations and plans to publish a Notice of Decision to Develop Regulations on this subject by the end of the first quarter of fiscal year 1980. We expect that this expansion of the reasonable cost regulations will serve to strengthen the regulations as applied to all elements of a provider's costs.

APPENDIX V

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-645-9400
6626
TO CALL WRITER, PHONE 312 645-

October 1, 1979

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart

This letter conveys the comments of the American Hospital Association (AHA) on the draft of a proposed report prepared by the Human Resources Division of the United States General Accounting Office entitled "Prices Paid by Hospitals for Routine Supply Items Vary Widely." We understand that this report was requested by the Chairman of the Subcommittee on Health of the Senate Finance Committee to determine (1) the prices paid for selected routine hospital items and (2) whether there are significant variations in prices paid for the same or similar hospital items within the same geographical area. The report has been carefully reviewed by AHA staff and others in the industry. Our comments follow.

The AHA has a serious concern regarding the limited data base for the report. As the GAO indicates, the 37 hospitals audited represent less than one-half of one percent of all U.S. hospitals. In addition, we question whether the six cities and the 37 hospitals were selected by a rigorous random sampling technique. Therefore, the AHA has difficulty understanding how such a limited data base can support conclusions representative of the entire U.S. health care industry.

The AHA also has concerns regarding the listing of products for which prices were obtained. We do not believe that the listing is representative of the most significant cost-intensive supply items routinely purchased by U.S. hospitals. Therefore, in our opinion, the resulting data does not identify the best potentials for impacting total operating cost. Purchasing managers in U.S. hospitals have been applying their major efforts to those items which offer the greatest potential for overall cost reduction and any report which does not examine these cost-intensive items cannot convey the total progress made in this area.

With regard to the audit of prices paid for the items on GAO's listing, we note that GAO obtained prices for "the same or similar" (page 1) or "the same or comparable" (pages i and 4) items. "Comparable" or "similar" supply items may have subtle functional differences which may impact on the efficient delivery and quality of patient care. These subtle functional differences often result in significantly different prices that can be compared only after the value of the functional differences has been analyzed. Since, to our knowledge GAO did

APPENDIX V

not conduct a value analysis on each "comparable" or "similar" product, we challenge the data for any price comparison made on other than the same or identical product.

While we suspect that many of the variances identified by GAO are the result of invalid comparisons of "similar" or "comparable" items, we do not dispute the apparent variances in prices paid for the same or identical items. We are concerned, however, that GAO provides no basis for comparison of these variances in other contexts and therefore we cannot assess their meaning. We suspect that if this study were replicated in another U.S. industry, the results would reflect similar variances indicative of normal marketing practices in a competitive environment.

There is considerable concern that this isolated, instantaneous picture of hospital supplies purchasing does not reflect the positive progress made in this area over a period of time. It should be noted that in recent years the rate of increase for prices paid for routine hospital supplies has significantly lagged behind the rate of inflation for the economy as a whole. Much of the credit for this result can be given to individual hospital purchasing managers in their efforts to contain costs and reduce prices.

The positive progress resulting from group purchasing activity is also inadequately addressed in the GAO report. Many group purchasing organizations were initiated by purchasing managers who wanted to reduce the variances in prices being paid for the same or identical items. While GAO did identify some of the incidental short term effects which may temporarily confound the market during a group's formative years, GAO does not address the positive effect of a group over a period of time. Ample evidence is available which indicates that group purchasing contracts reduce prices by a significant percentage over those obtainable by the individual hospital purchasing alone. Also, the existence of a group purchasing program in an area has resulted in the additional advantage of reducing the variances in prices being paid for the same or identical items.

With regard to the sharing of information, AHA does not agree that purchasing managers do not exchange pricing information. Information of this nature is being shared, especially among members of group purchasing organizations. In fact, at least one regional group is sharing approximately 200,000 prices each year. It may be productive to increase the activity of sharing pricing and vendor information, providing certain limitations on this activity are clearly recognized. Since the hospital industry is not exempt from legal responsibility regarding restraint of trade, price fixing, and antitrust, it is unclear as to when information sharing activities violate these legal parameters. It is important that GAO consider these parameters when encouraging information sharing activities.

The AHA agrees with GAO that the application of the prudent buyer principle to routine hospital supplies can be worthwhile. However, AHA is concerned about the cost-effectiveness of a rigorous implementation of the prudent buyer principle as a reimbursement limitation methodology. The AHA believes that it is more cost-effective to pursue voluntary conformance to this principle.

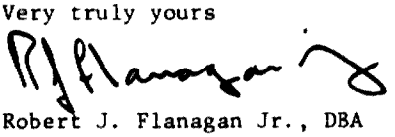
APPENDIX V

The AHA does not agree with GAO's assessment that there is a role for Medicare intermediaries to play in assisting hospitals to avoid paying excessive prices. Positive progress in this area is being made by virture of the efforts of group purchasing programs throughout the country. We believe that expansion of these efforts will have a more cost-effective impact than additional federal regulatory involvement.

In summary, the American Hospital Association believes the GAO report to be an inconclusive and an inadequate assessment of current hospital purchasing practices. Voluntary measures in this area have been productive and effective; there exists no need for additional federal regulatory involvement as an inducement or incentive to reduce prices and costs in the acquisition and management of routine hospital supplies.

We thank you for the opportunity to review and comment on this proposed report.

Very truly yours



Robert J. Flanagan Jr., DBA
Vice-President

paw

APPENDIX VI

President
Harold O. Buzzell

Health
Industry
Manufacturers
Association

1030 Fifteenth St., N.W.
Washington, D.C. 20005
(202) 452-8240

September 20, 1979

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Health Industry Manufacturers Association (HIMA) herein submits its comments on the Comptroller General's Report to the Subcommittee on Health of the Senate Finance Committee on Prices Paid by Hospitals for Routine Supply Items. We understand this report was requested to support possible legislative or regulatory initiatives concerning routine hospital supplies.

The Health Industry Manufacturers Association is a trade association comprised of over 275 companies and their subsidiaries and divisions who are engaged in the manufacture and sale of medical devices and diagnostic products. The Association has been actively involved in efforts to properly reform Medicare and Medicaid practices that lead to a waste of public funds. We agree that it is appropriate to examine how Medicare-Medicaid funds are employed for the purchase of routine supply items, but HIMA does not believe that the data developed justifies any further imposition of regulatory or legislative controls on such purchases. As described below, the Association maintains that the cause of, and justification for, the variations found are not adequately developed. The real cost of routine supplies has not been studied and it is therefore impossible to determine whether the findings are representative, or whether the price differentials noted are statistically significant. Furthermore, the report errs by isolating the prices of individual items without reviewing a hospital's overall annual supply costs.

HIMA does not believe that the elements which make up the real cost of a routine supply item have been properly considered. The report does discuss briefly the fact that price is only one item to consider in determining cost, but this important consideration is never developed. Variations in product quality, different indicated uses of a similar product and additional services (equipment servicing, delivery service, management and inventory control) provided by a vendor which reduce overall costs are all considerations which are necessary in determining a hospital's total supply costs. In the absence of such information, it is impossible to determine whether the pricing comparisons offered in the report deal with truly comparable products.

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Furthermore, to properly evaluate the prices paid, it is necessary to review a hospital's overall supply costs. It is essential to know on what date each price was quoted and for how long the price applied; as well as the size and type of the hospital making the purchase and what other supply items were bought at the same time. Spot checks of prices paid for only a few hospital supplies are not meaningful especially since the prices could reflect fill-in orders, one-time or irregular purchases. To properly evaluate the supply purchasing practices of a hospital, the government would have to look at prices paid on total supplies on an annual basis as well as the accompanying purchasing, inventory, and distribution costs associated with those supplies.

There are other factors unrelated to product which can also readily account for pricing variations. If a hospital habitually is late in paying its bills, a vendor may have to sell product to that hospital at a higher cost to cover carrying charges. Whether freight charges are included could also be significant. Distance, method of delivery, and responsibility for freight charges are factors that need to be considered. Problems such as this are not mentioned in the document.

HIMA contends that it is impossible, based on the data presented in the Report, to draw any conclusions concerning the prices paid by hospitals for routine supply items. Even if such conclusions could be drawn, however, we believe that the overall weighted difference of 10 percent would not be statistically significant when product and service variations among vendors are given proper consideration.

The Association cannot ascertain from the Report that the six cities chosen are representative of conditions throughout the United States, because no rationale for selection is mentioned. Also concerning methodology, the Report does not attempt to in any way distinguish direct sales by manufacturers from sales by dealers, which makes it impossible for us to analyze in any detail the reasons for possible pricing variations.

To summarize, the Association believes that while the Federal government should periodically audit how its funds are being spent, nothing in this Report would warrant imposition of further regulatory or legislative restrictions on the purchase of routine hospital items. The study may not be representative because of the sample size and location chosen, and the weighted differences do not appear to be statistically significant. The Report does not reveal any attempt to ascertain the real cost of product involved, it does not consider extra-product conditions which could justify variable pricing, and it fails to deal with a more realistic measurement of cost -- annual total hospital supply costs.

The Association appreciates the opportunity to comment on this Report, and if we can be of further assistance, please contact me.

Sincerely,

Harold O. Buzzell
President

mrl

AMERICAN SURGICAL TRADE ASSOCIATION

October 1, 1979

Mr. Gregory J. Ahart
Director
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

This is in response to your request for comments on the draft report on prices paid by hospitals for routine supply items. There are a number of reasons why prices paid by hospitals for routine supply items will vary between cities, between suppliers, and between different transactions. A useful analysis of the variations must consider a large number of variables -- including the size of hospital, the size of the order, the length of time covered by the contract, the nature of services included in the purchase price, the individual competitive situation which existed at the time the contract was signed, the length of time required for payment, and other costs involved in servicing the contract.

The American Surgical Trade Association and its members have provided considerable information to the General Accounting Office and its field investigators in their study. We have, for example, provided the General Accounting Office with information on the average profit margins of surgical supply distributors (consistently less than three percent before taxes); and members have met with local G.A.O. auditors to provide them with the background necessary to understand why individual prices, despite these consistently low margins, will vary from one transaction to another. Unfortunately -- whether because the sample was too small or because the time available for the study was too short -- most of the information presented to the G.A.O. auditors on this subject has been omitted. For this reason, the final study is disappointing in its failure to assess this information and its relevance to the differences in prices found in the statistical phase of the study.

Group Purchasing

The statistical phase of the study correctly punctures the pervasive myth that group purchasing usually saves hospital money. As reported in the study, "in five of the six cities surveyed, we found that membership in group associations did not necessarily result in hospitals achieving the lowest price avialable in that area." This finding is all the more important when one considers that 1) group purchasing organizations typically provide none of the services

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of warehousing, delivery, quick order servicing, billing, and financing of receivables provided by private distributors; and 2) that a large number of group purchasing organizations, particularly in the Eastern half of the United States, require volume-based rebates, typically at two percent, from their suppliers. Since the rebate is usually not passed on to the hospital (in violation of Medicare regulations) but is instead used to underwrite the group's administrative costs, this two percent should be added to the true costs of the supplies obtained by hospitals through these group purchasing operations.

The G.A.O. study also reports the desire of some group administrators to require committed volume purchasing -- that is, mandatory purchasing through the group. This, of course, would serve only to commit hospitals, particularly large institutions, to group prices which will often, considering both price and service, be inferior to the price/service which the hospital can obtain from direct contracting with local distributors. Trying to bind members to a group contract would be, in fact, an admission by the group that its price and/or service was not sufficiently attractive to hold the members' commitment.

Reasons for variations among costs

Further analysis by the General Accounting Office should have provided greater understanding of many of the variances in prices. Different prices are part of the ebb and flow of competition in American commerce. The study in some places seems to suggest that if all purchasers pay the same price, all will pay the lowest price. This does not logically follow. A regulation which prevented a distributor from offering a low price to one customer would hardly help that customer.

The G.A.O. field auditors -- presumably because of their pledge of confidentiality to hospitals -- interviewed surgical supply distributors only in the most general terms, without seeking to elicit information which would bear directly upon the specific transactions included in their statistical tabulations. Unfortunately, this problem in methodology severely limited the ability of the field auditors to develop meaningful information.

The confidentiality promised to hospitals by the G.A.O. has also made it impossible to check or to re-analyze the data presented. There are probably some errors in compilations, due to the fact that the auditors were not familiar with medical products (in Seattle, it appears that two different types of adhesive tapes, one of them produced for specialty use in the operating room, were mistakenly assumed to be comparable); and there are a few cases where prices appear misrecorded. But more important are the reasons for variations in prices, which require considerable further analysis.

It is important to look at these variables jointly, not one at a time. The study too often assumes that where one or two atypical examples contradict a general hypothesis, the hypothesis is disproven. It is easy to find individual cases where any one of the variables is contrary to what might be expected: for example, where a large quantity sale was at a higher price than a lower-quantity sale by the same supplier. What is important in this case is to find out what did explain the difference in prices, not just to stop with the observation that the difference is not attributable to the quantity. The finding

of exceptions does not invalidate a general explanation which may often (if not always) be true.

Among the variables which affect pricing are:

1) Differences in product quality and services. Health care providers have the option of ordering different types and different quality of products. Such services as immediate delivery are important, as in some cases is the frequency or distance involved in delivery. The differences will not always be indicated on the invoice or be obvious to the auditor not familiar with the product.

2) Differences in the size of the order (as noted above, this will often but not always, explain price differentials) or differences in the amount of business placed over a period of time by the customer. Even if the order is small, the total business done by the customer in the course of the year (covering all products, not just the one product line) may affect prices.

3) The time frame covered by the contract. Obviously, at the current pace of inflation, a hospital purchasing under a contract signed one year ago will usually be paying less than the hospital which is buying under a new contract signed last month. Conversely, a hospital which enters today into a one-year price-guaranteed contract may pay more on an individual transaction next week than the one which places a single order, yet be making a prudent decision for the longer run.

4) Differences in the habitual payment terms of the hospital. At the current cost of money, a hospital which routinely makes its suppliers wait 90 to 120 days for payment will usually not obtain the same price as the hospital which customarily pays within 30 days.

5) Differing competitive situations. A supplier now has the discretion to provide individual customers with advantageous prices, either to hold business or to gain introduction to a new customer. To require a supplier to lower prices to every customer, on every transaction, whenever he did this for one customer, on one transaction, would be to discourage price competition. This would be unlikely to increase efficiency or reduce costs; more likely, the stifling of price competition would have the opposite effect.

As noted above, gross mark-ups and profit margins within the surgical supply industry are extremely low, with profits before taxes averaging less than three percent. The obvious conclusion is that competition, within the industry, is doing what economic theory says it should do -- holding down prices and leading to sharp competition for hospitals' business between private suppliers.

The American Surgical Trade Association continues available to assist the General Accounting Office in this study. If time is available for additional analysis, we would welcome the opportunity to contribute further to the work of the General Accounting Office and its auditors.

Sincerely,

Thomas Bloor
President

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WASHINGTON, D.C. 20548

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