

**Group Purchasing Organizations and Antitrust Law:
Recent Developments**

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Throughout the United States, hospitals rely on group purchasing organizations (GPOs) for procurement. This includes procurement of basic supplies such as shoe coverings and complex medical devices such as pacemakers. Hospitals may benefit from lower product prices and from reduced administrative costs associated with procurement personnel and infrastructure. Nearly all U.S. hospitals use GPOs for procurement.¹ GPOs account for more than 70% of hospital purchases.² GPO practices thus affect a substantial volume of U.S. commerce across a wide range of products.

Past concerns over GPOs focused on the possibility that GPOs would lead to undue leverage by purchasers over suppliers, also known as the exercise of monopsony power. While antitrust law has focused on harm to consumers through higher prices, the exercise of monopsony power resulting in low pricing may also raise concerns. According to the Statements of Health Care Antitrust Enforcement Policy, joint purchasing arrangements in some circumstances “might be able to drive down the price of the product or service being purchased below competitive levels.”³ The 2010 Merger Guidelines state that “[e]nhancement of market power by buyers, sometimes called ‘monopsony

¹ GAO, Group Purchasing Organizations: Services Provided to Customers and Initiatives Regarding Their Business Practices, GAO-10-738, at 4, Aug. 2010 (citing study of Health Industry Group Purchasing Association).

² *Id.* (citing research paper).

³ Federal Trade Commission and Justice Department, Statements of Healthcare Antitrust Enforcement Policy, Statement 7.

power,' has adverse effects comparable to enhancement of market power by sellers."⁴

The concern that GPOs will lead to monopsony power or excessively low supplier pricing has waned. This may be because of the fact that there are several national GPOs, and none has a share of purchasing typically associated with monopsony power. GPOs are now under heavy scrutiny for a different reason. The new concern is the opposite of the previous concern: it is that GPO compensation arrangements may lead to higher supplier prices, potentially leading to supplier monopoly or market power.

GPO compensation arrangements, and the possibility of unduly high supplier pricing, has been the subject of some government attention over the past year. The U.S. Government Accountability Office (GAO), a research arm of Congress, completed a review of GPO practices and issued a factual report in August 2010.⁵ This is the second GAO report issued in 2010, as GAO published a research report earlier in the year on the pricing impact of GPOs.⁶ In September 2010, the Senate Finance Committee issued a report.⁷ In October 2010, economists commissioned by the Medical Device Manufacturers Association published an empirical study and policy analysis.⁸

This Member Briefing provides an overview of these recent developments. Legal and regulatory oversight of GPOs has immediate impact on hospitals as customers and medical device manufacturers as suppliers. The underlying competition policy issues may have broader impact, extending across the healthcare sector.

⁴ Federal Trade Commission and Justice Department, Horizontal Merger Guidelines, 2010, at §§ 1, 12.

⁵ See GAO-10-738, *supra* note 1.

⁶ GAO, Group Purchasing Organizations: Research on Their Pricing Impact on Health Care Providers, GAO-10-323R, Jan. 29, 2010.

⁷ Minority Staff Report, Senate Finance Committee, Empirical Data Lacking to Support Claims of Savings with Group Purchasing Organizations, Sep. 24, 2010.

⁸ Litan & Singer, Do Group Purchasing Organizations Achieve the Best Prices for Member Hospitals? An Empirical Analysis of Aftermarket Transactions, Oct. 6, 2010.

Prior Legal and Regulatory Scrutiny of GPOs

GPOs receive administrative fees paid by suppliers. For example, a stent supplier pays the GPO 2% of the revenue earned for products sold to hospitals under the GPO's contract. The administrative fee represents a distribution cost to the supplier. An alternative approach would be for hospitals to pay the GPO a membership fee (e.g., an annual fee) or to pay the GPO based on some measure of savings realized by the hospitals.

In the early 1990s, the U.S. Department of Health and Human Services provided a "safe harbor" from the Medicare Anti-Kickback Statute to allow GPOs to receive payments from suppliers.⁹ This has been the major regulatory action affecting the funding or compensation of GPOs. This modification to the Anti-Kickback Law permits hospitals to benefit from GPO services without having to pay a membership fee or some similar charge.

This safe harbor has reduced regulatory risks associated with kickback claims, but antitrust claims have taken their place. Most recently, the Ninth Circuit affirmed a \$140 million jury verdict that Tyco's sole source and bundling contracts with GPOs violated the Sherman Act.¹⁰ Two leading GPOs and an incumbent medical device supplier settled an earlier antitrust lawsuit for \$150 million.¹¹ Various private antitrust lawsuits have been filed against incumbent suppliers or GPOs based at least in part on GPO contracting practices.¹²

⁹ 42 U.S.C. § 1320a-7b(b)(3)(C)(i); 42 C.F.R. § 1001.952(j).

¹⁰ *Masimo Corp. v. Tyco Health Care Group, LP*, 2009 WL 3451725 (9th Cir. 2009); *Masimo Corp. v. Tyco Health Care Group, LP*, 2006 WL 1236666 (C.D. Cal. 2006).

¹¹ Litan & Singer, *supra*, note 8 at 9 (citing press reports).

¹² *Id.* at 30-36; see *Catchitoches Parish Hospital Serv. Dist. v. Tyco International, Ltd.*, Complaint, No. 1:05-CV-12024 (D. Mass. 2005) (hospital challenging GPO sole source and dual source contracts with medical device container manufacturer); *Rochester Medical Corp. v. CR Bard*, Complaint, No. 5:04-CV-060 (E.D. Tex. 2004) (catheter manufacturing challenging sole source and dual source contracts as exclusionary); *Retractable Technologies, Inc. v. Becton Dickinson & Co.*, Complaint, No. 5:01-CV-036 (E.D. Tex. 2003) (syringe manufacturer challenging sole source and dual source contracts as exclusionary).

In some of the cases, a supplier brought an antitrust suit against GPOs as co-conspirators with the leading supplier.¹³ The smaller supplier alleged: (1) that GPOs required member hospitals to purchase a significant portion of their medical devices through the GPOs; and (2) that the GPOs entered into agreements with the leading supplier that were sole source or incited the member hospitals to use the leading supplier.¹⁴ The alleged anticompetitive effect was to foreclose the marketplace from smaller suppliers, thereby harming or threatening to harm consumers.

Despite repeated private antitrust litigation, there have been no court judgments calling into question the antitrust legality of GPOs or enjoining core functions of GPOs. Nor have there been any Federal Trade Commission or U.S. Department of Justice enforcement actions directed at GPOs.

Federal government attention has come in other forms. Congress held hearings in 2002 and 2003 focusing on GPOs¹⁵ In which some Congressional representatives raised concerns that GPOs collect excessive fees from suppliers and questioned other GPO business practices.¹⁶ GPOs responded with self regulation or by adopting codes of conduct.¹⁷ These codes of conduct address a range of matters, including GPO investments in suppliers, sole-source contracts, bundling, contract administrative fees, potential conflicts of interest, and transparency.¹⁸

Recent Developments

The past year has been active for analysis of the competitive impact of GPOs. This has been a sensitive subject in part because of the significant amount of

¹³ *Rochester Medical Corp. v. CR Bard*, Complaint, No. 5:04-CV-060 (E.D. Tex. 2004); *Retractable Technologies, Inc. v. Becton Dickinson & Co.*, Complaint, No. 5:01-CV-036 (E.D. Tex. 2003).

¹⁴ *Id.*

¹⁵ Group Purchasing Organizations: Use of Contracting Processes and Strategies to Award Contracts for Medical-Surgical Products, U.S. Senate Judiciary Comm., Subcomm. on Antitrust, 2003; Hospital Group Purchasing: Lowering Costs at the Expense of Patient Health and Medical Innovation, U.S. Senate Judiciary Comm., Subcomm. on Antitrust, 2002.

¹⁶ GAO-10-738, at 2.

¹⁷ *Id.*

¹⁸ *Id.*

commerce attributable to the supply of medical devices. Contracting practices that result in dual or sole sourcing, or heavily favor one manufacturer over others, may be questioned as exclusionary. Such charges may be more likely when enormous sales of medical device are affected. Recent analyses have not focused on exclusionary contracting practices but have questioned whether funding arrangements may lead to monopolization among suppliers. Major recent reports are summarized below.

GAO Report, January 29, 2010

GAO published a report that “summarizes the peer-reviewed and nonpeer-reviewed literature on the impact of GPOs on pricing for hospitals and other health care providers that we identified in our literature review.”¹⁹ It identified a single peer-reviewed study. This peer-reviewed study, based on a national survey of hospital procurement managers, concluded that GPOs can contain rising healthcare costs by reducing product prices and reducing transaction costs through commonly negotiated contracts.²⁰ GAO also identified numerous nonpeer-reviewed studies, characterizing them as “anecdotal” and lacking empirical foundation.²¹

GAO Report, August 2010

GAO issued a second report in 2010 after conducting interviews and collecting data from industry participants. GAO received written responses to structured questions from the six largest national GPOs and interviewed their representatives.²² It also interviewed representatives from hospitals and medical product suppliers. The report followed Senate Finance Committee inquiries about the types of services GPOs provide, the funding of GPO services, the initiatives GPOs have implemented since 2002, and the impact of GPOs’ codes of conduct.²³

¹⁹ See GAO-10-323R, *supra*, note 6.

²⁰ *Id.* at 2, citing L.R. Burns & J.A. Lee, Hospital Purchasing Alliances: Utilization, Services, and Performance, Health Care Management Review, 2008.

²¹ GAO-10-323R, at 2.

²² GAO-10-738, at 3.

²³ *Id.*

The data collected by GAO showed that the six largest GPOs together accounted for about 90% of all hospital purchases made through GPO contracts.²⁴ These six GPOs purchased about \$108 billion in supplies in 2008.²⁵ The largest GPO accounted for 33% of that volume and the second-largest GPO accounted for 27%.²⁶

The report describes some of the contracting practices GPOs use to obtain deeper discounts. This includes sole-source contracting and various bundling and incentive discount practices.²⁷ GAO also reported that the main source of revenue for GPOs is administrative fees paid by suppliers.²⁸ These fees are based on a percentage—typically about 2%—of the purchase price of the product obtained through GPO contracts.

This GAO report reviews the codes of conduct GPOs adopted as part of their self regulation. According to GAO, the codes of conduct strengthened prohibitions against conflicts-of-interest terms and enhanced transparency of information relating to pricing and administrative fees. The GPOs instituted employee education or compliance programs. The GPOs also formed the Healthcare Group Purchasing Industry Initiative to adopt principles of ethics and business conduct. GAO studied additional GPO services—that is, services beyond procurement of supplies. These additional services include benchmarking, customized contracting, technology assessments, and equipment repair.²⁹ There are various approaches used by GPOs for pricing or funding these services.³⁰

GAO did not attempt to measure product cost savings or the extent to which GPOs obtain reductions in product prices relative to independent hospital procurement. Nor did GAO attempt to measure transaction cost savings or the savings hospitals realize by lower procurement personnel costs or other reductions in expenses associated with procurement.

²⁴ *Id.* at 4-5.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.* at 5.

²⁸ *Id.* at 6.

²⁹ *Id.* at 9-11.

Senate Finance Committee, Minority Staff Report, September 24, 2010

The Senate Finance Committee has authority over the Medicare and Medicaid programs. The Committee views GPO activities as significant to overall federal healthcare spending. Earlier Committee work led to the introduction of the Physician Payments Sunshine Act, which became incorporated into the recently enacted healthcare reform legislation. This will require drug manufacturers, medical device manufacturers, and others to report on any gifts or payments provided to physician groups. Some Committee members have raised concerns about payments or administrative fees GPOs receive from hospital suppliers,³¹ but such payments are not covered by the new legislation.³²

A Minority Staff Report—entitled *Empirical Data Lacking to Support Claims of Savings with Group Purchasing Organizations*—complains that GPOs operate under an inherent conflict of interest. The conflict arises, according to the report, because GPOs earn greater per-unit administrative fees when product prices are higher.³³ The higher the prices, the greater the administrative fees; thus, the key theme of the report is that GPOs' financial incentives may align more with "the dominant supplier" than with the consumers or hospitals.

Before issuing the report, the Finance Committee staff collected documents from seven GPOs and interviewed device manufacturers, trade association personnel, and others.³⁴ The report contains empirical analyses of the range of administrative fees charged by GPOs and the extent to which GPOs pass on the administrative fees to hospitals.³⁵ It also contains data on how additional GPO services (e.g., benchmarking or e-commerce services) are priced or funded.³⁶

While the report's title focuses on "data lacking to support claims of savings," the Committee did not prepare any cost-savings analysis or attempt to measure the

³⁰ *Id.*

³¹ Minority Staff Report, *supra*, note 7 at 1.

³² *Id.*

³³ *Id.* at 2.

³⁴ *Id.* at 4.

³⁵ *Id.* at 10.

³⁶ *Id.* at 12.

extent to which GPOs provide savings to hospitals either through lower product prices or through lower administrative operating costs. Rather, the report focuses on the potential conflict arising from the fact that GPOs obtain administrative fees from suppliers rather than charge some form of a membership fee to hospitals.

Economic Report (Medical Device Manufacturers Association), October 6, 2010

The Medical Device Manufacturers Association commissioned an economic paper highlighting the theme raised in the Minority Staff Report of the Senate Finance Committee. This paper, by economists Robert Litan and Hal Singer, also contains an empirical analysis of product cost savings.³⁷

The economists start with a theory: a purchasing intermediary may be incented to allow the winning bidder to price at monopoly levels. This condition may hold when the intermediary is paid a fixed percentage of the product price. A monopoly outcome may be more valuable to the intermediary than a competitive outcome.³⁸

The authors associate GPOs with real estate agents (representing the buyer but compensated more the higher the home price), insurance brokers (acting for insureds but paid commissions by insurers), or rating agencies (acting for investors but paid by debt issuers).³⁹ They conclude that “GPOs have been poor bargaining agents because they are compensated not by their principals, the member hospitals, but instead by medical suppliers.”⁴⁰

This “theory of monopoly concession,” according to the authors, applies to GPO contracts.⁴¹ The theory of monopoly concession describes a setting in which a purchasing intermediary controls access to a captured customer base. The customers do not have ready access to substitutes. The supplier makes “a side

³⁷ Litan & Singer, *supra*, note 8.

³⁸ *Id.* at 12-17.

³⁹ *Id.* at 42.

⁴⁰ *Id.*

⁴¹ *Id.* at 12.

payment” or shares some of its expected monopoly profits with the purchasing intermediary.⁴²

The incentive problem identified by the authors would still exist if the hospitals rather than the suppliers paid the administrative fee (e.g., 2%) to the GPOs. Thus, characterizing administrative fees as supplier “kickbacks” or as part of a “pay to play” scenario may be misleading. The issue is not where the GPO compensation comes from; rather, the issue is whether the method of determining the payment aligns the incentives of the GPOs with those of the hospitals. If their incentives are misaligned, does this in turn threaten any harm to consumers?

The economic report includes some empirical analysis purporting to show that that a monopoly concession has occurred. The empirical support is a comparison of pricing under GPO contracts to certain “aftermarket” or “off contract” pricing, which is from a database supplied by a firm that conducts auctions for hospitals seeking to improve upon prices offered by the incumbent suppliers on the GPO contracts.⁴³ The authors’ analysis of this data, on the other hand, shows that aftermarket pricing is typically lower than original GPO contract pricing and that the incumbent suppliers often lower pricing in the “aftermarket” or after initial GPO contract award.⁴⁴

Critics of this form of cost-savings analyses have emphasized that hospitals purchasing in the “aftermarket” or “off contract” often use the GPO contract as the starting point for their price negotiations just as non-union workers may use a union contract as the starting point.⁴⁵ Price discounting following the initial award may be unsurprising. An alternative analysis would compare GPO contract prices to contract prices for hospitals that do not use GPOs for procurement.

⁴² *Id.* at 13.

⁴³ *Id.* at 17.

⁴⁴ *Id.* at 18-28.

⁴⁵ Bloch et al., *An Analysis of Group Purchasing Organizations’ Contracting Practices Under the Antitrust Laws: Myth and Reality*, at 6, 21, Sep. 26, 2003, FTC Healthcare Hearings; *see also* GAO-10-738, at 3 (“In order to obtain lower prices, four customers and all five of the vendors told us that GPO customers negotiate contracts directly with vendors, with the majority noting that customers use GPO prices as the starting point of negotiations.”).

In addition, a broader cost-savings analysis would take into account the hospital savings in overhead and administrative costs. An economic study, commissioned by a GPO group, estimated that this equated to about \$370,000 in recurring annual cost savings for each hospital.⁴⁶

Conclusion

When analyzing joint or group purchasing, antitrust law worries most about monoposony or power to lower supplier pricing.⁴⁷ This does not appear to be a concern with GPOs as recent critics are not raising monoposony concerns. They hold the opposite concern—that GPOs allow suppliers to maintain unduly high prices. These critics argue the funding mechanisms—administrative fees set as a percent of the product price—may incent GPOs to allow monopoly pricing or high pricing by suppliers.

There seems to be little doubt that GPOs have resulted in substantial administrative cost savings for hospitals. This is a procompetitive benefit of GPOs. The issue likely to continue to attract antitrust or regulatory scrutiny is whether the current funding or compensation approach makes GPOs ineffective as purchasing agents and facilitates monopoly pricing by suppliers.

⁴⁶ Schneller, *The Value of Group Purchasing – 2009: Meeting the Needs for Strategic Savings*, at 23, Apr. 2009.

⁴⁷ Federal Trade Commission and Justice Department, *Statements of Healthcare Antitrust Enforcement Policy*, Statement 7.

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