Federal Trade Commission's
Health Care and Competition Law and Policy Workshop

Panel 3: "Hospital Group Purchasing Organizations"
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10:30 a.m.

Submitted by
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Introduction

I am Robert Betz, Ph.D., President & CEO of the Health Industry Group Purchasing Association (HIGPA). HIGPA represents over 165 health care supply chain organizations, including nearly every major group purchasing organization (GPO) in the United States, and many of the vendors with whom they do business. Today's workshop offers both policy makers and the public the opportunity to gain insight into how group purchasing organizations (GPOs) operate, and the value they offer health care providers. I appreciate the opportunity to represent the members of HIGPA.

Role of Group Purchasing Organizations in the Health Care Supply Chain

Most Americans are unfamiliar with the process health care providers – such as hospitals, nursing homes, and home health agencies – use to purchase necessary medical products and services. Group purchasing organizations are entities that help these providers achieve savings and efficiencies by aggregating purchasing volume and contracting functions to negotiate discounts with manufacturers, distributors and other vendors. Of all acute-care hospitals in the country, 96 percent use GPOs to help reduce their purchasing costs, as well as improve their supply chain management and quality of care. On average, hospitals utilize the services of at least two, and as many as four, GPOs per facility, according to a recent report by SMG Marketing.

The vast majority of products that health care providers need are available at a discounted price through a GPO contract – from pharmaceuticals, to medical devices, to dietary resources, to telecommunications services, to janitorial supplies. Industry-wide, approximately 72 percent of all hospital purchases are made via a GPO-negotiated contract, according to a March 2000 study by Muse & Associates. This level of utilization shows that GPOs have proven their ability to offer hospitals a valuable service, while also illustrating the fact that hospitals and other providers have the freedom to make purchases outside of their GPO relationships. Indeed, at the end of the day, the preferences of individual physicians, nurses and other clinicians are what drive purchasing decisions. Hospitals must listen to their front-line health care workers on what products they need to provide the highest quality of patient care, and GPOs in turn listen to hospitals.

GPOs are the agents of providers, not suppliers. They operate at the request of their health care provider members, and negotiate contracts for products and services that those members desire. In many instances, GPOs are owned by their member-providers and in all instances are ultimately accountable to provide them with substantial value. If a GPO failed in this duty, it would not survive as a business. GPOs do not purchase products or force the purchase of a particular product. Their value is based solely on offering providers access to desired products at reduced prices, and because most hospitals belong to multiple GPOs, each with a unique set of contracts, hospitals have choices in deciding among GPO contracts, or going directly to the supplier to purchase a particular product.

Group purchasing organizations are not a new phenomenon. They date back to 1909, when the Hospital Superintendents of New York first considered establishing a purchasing agent for laundry services. In 1910 the first GPO was created, the Hospital Bureau of New York. During the last quarter of the 20th century, the importance of GPOs grew as hospitals were faced with rising expenditures due to advances in care and an aging population, as well as declining reimbursement from the government and private sector payers.

Importance of GPOs to hospitals

As an industry, GPOs save providers between 10 to 15 percent of what they would pay without the benefit of a GPO. Even when providers purchase directly from suppliers, they benefit from the GPO contracting process because suppliers have to price direct purchases to compete with annual GPO contracts. In an era when one-third of all hospitals have negative operating margins, reimbursements from private and public payers are falling, and overall expenditures are rising, this substantial cost saving is of critical importance. Quite simply, hospitals would be in far worse circumstances if GPOs did not exist. Very few hospitals could continue to properly serve their patients if GPOs did not empower them to purchase needed products at considerable discounts.

In addition to being able to get discounts in return for aggregating volume purchases, GPOs also reduce providers' administrative overhead costs, and offer supply chain efficiencies for health care providers in the procurement, standardization, and contracting functions. If group purchasing organizations did not exist, it would annually cost hospitals an average of $353,000 per facility to perform the same cost comparison and product standardization function as GPOs, according to a July 2000 study by a leading researcher at Arizona State University. This figure does not include the volume discounts GPOs provide, but rather benefits that result from taking out of the hospital much of the work that goes into identifying, tracking and performing due diligence on suppliers (*i.e.*, ensuring suppliers meet safety standards and can meet expected product demand), as well as negotiating, maintaining and updating contracts. Without GPOs, providers would have to increase the number of staff and resources to perform the same supply chain functions, essentially further fragmenting a sector of the economy that is already highly decentralized. Such a situation would have enormously harmful effects on providers, given that they do not have the luxury of adding non-clinical staff at a time when they are struggling to

afford a sufficient level of staff needed for the direct provision of health care, such as nurses, doctors, and other clinicians.

In addition to cost-savings that result from group purchasing, hospitals and other health care providers are increasingly relying on GPOs for sophisticated supply chain solutions to help manage and streamline the complex system of health care purchasing. Many GPOs offer providers e-commerce solutions that reduce widely recognized inefficiencies in the health care supply chain. The GPO community is also a leader in the effort to reduce medical errors, through such efforts as standardizing product use within a facility to reduce unnecessary variation, educating clinicians on best practices, and leading the drive to institute bar coding for medical products.

GPOs help counter the balance of power in the health care supply chain that includes some of the largest and most successful companies in the United States. With the largest health care manufacturers and distributors reporting more than $360 billion in revenue in 2001 and the largest GPOs representing approximately $55 to $60 billion in purchasing volume, GPOs are increasingly important tools for health care providers to help adequately represent themselves in the health care supply chain.

Benefits of the GPO Business Model

Fundamentally, GPOs are able to offer additional value to their provider-members because much of their operating revenue is generated through earning administrative fees paid by suppliers. This business model of sellers paying fees based upon sales is widely used in many sectors of the U.S. economy, such as the real estate industry. Moreover, buying cooperatives play an important role in other industries such as agriculture. This model has an established history of offering value to the ultimate recipient of a product or service. GPO administrative fees are earned only after providers utilize a contract and, typically, a substantial portion of this fee is returned to the provider-members after a GPO's administrative costs have been covered.

In the mid-1980s, Congress and the Department of Health and Human Services' Office of Inspector General recognized the value in allowing such fees, given that the alternative would be for hospitals to take money away from patient care. Indeed, in 1985 Richard P. Kusserow, the then HHS Inspector General said, "We [HHS OIG] believe the current practice of reimbursement by vendors to group purchasing agents should be permitted. The use of volume purchasing through group purchasing agents clearly reduces the cost of purchases by hospitals. Therefore, we would encourage use of such arrangements regardless of the reimbursement methodology."

What Mr. Kusserow and others recognized was that by allowing GPOs to earn administrative fees, hospitals and health care providers are able to dedicate more financial resources to the direct provision of patient care, such as employing additional doctors or nurses, purchasing the most advanced products, or a host of other goals to support patient care. In what could be the most supportive possible endorsement, the federal government uses many of the same

contracting practices as GPOs, including earning administrative fees, for a variety of government agencies, such as the Department of Defense, General Services Administration and Department of Veterans Affairs.

It is also important to note suppliers can realize benefits by working with a GPO. For example, group purchasing offers a consolidated access point to a large group of health care providers dedicated to a common goal. For suppliers, the alternative to negotiating one contract that a large group of providers can access would be to negotiate individual contracts with each provider. A likely result of this would be higher costs for both the purchaser and the supplier as a result of streamlining the contracting and contract administration process. Suppliers would likely have to increase their sales, marketing and legal staff to make contact with each individual provider and to administer multiple contracts, and hospitals would lose the ability to obtain volume product discounts.

Such a system – where GPOs were unable to adequately represent the best interests of providers, and hospitals had to deal directly with manufacturers – would, I believe, favor larger suppliers over both their smaller counterparts and providers themselves. Purchasing contracts would still exist, as they do for any business, but they would have to be negotiated thousands of different times with each individual provider. This would tilt the marketplace in favor of larger suppliers because they would have a greater ability than smaller suppliers to fund the necessary operations to maintain such an extensive number of contracts. I do not believe this option to be beneficial to any entity in the health care supply chain, be it provider, GPO, or manufacturer.

Antitrust Issues

Recently, allegations have been made that GPOs are anticompetitive and create circumstances that are unfair to health care suppliers. These allegations are baseless from both a legal and economic perspective. HIGPA asked one of the country's most respected antitrust scholars, Professor Herbert Hovenkamp, J.D., Ph.D., of the University of Iowa College of Law, to provide an antitrust analysis regarding GPOs. Professor Hovenkamp has detailed his arguments in the attached research paper [See Appendix A], but to quote from his analysis:

> "The buying market in which GPOs operate is highly competitive. The products purchased through GPOs are identical with those purchased by thousands of other buyers large and small. Approximately 800 GPOs collectively contract for about 45% of the supplies and equipment purchased by health care institutions. No GPO has a market share larger than 15%, and only two have shares exceeding 10%. The small size of GPOs in relation to the entire market, the large number of GPOs and intense competition with purchasers who do not use a GPO makes monopolistic practices or price-fixing among GPOs virtually impossible.

"This competitiveness in purchasing is enhanced by the fact that most hospitals are members of several GPOs and play them off against each other. If one GPO does not provide a hospital with desired products the hospital can turn to another GPO, or in some cases drop its membership altogether. As a result there have been significant shifts in the market shares of GPOs as they compete with each other to serve their members. Further, there are no significant barriers to entry because GPOs own no specialized assets. If a GPO were to earn monopoly profits, new GPOs would quickly be formed to take its place.

"GPO group purchasing is a socially beneficial, procompetitive activity that reduces costs by enabling sellers to bid for high volume sales. One characteristic of many goods sold to health institutions is production "economies of scale," meaning that it is much cheaper per unit to develop or produce a good if the seller can anticipate a large volume of sales. As a result, manufacturers typically bid significantly lower prices when they can be assured of a large volume.

"While the market for *purchasing* of health care supplies is fiercely competitive, many of the markets in which these products are sold are oligopolies; these markets may be more naturally prone to high prices. It is well known to economists that if buyers organize themselves into large groups they can force sellers in these markets to bid more aggressively for a particular buying group's trade.

"One result of group purchasing can be that fewer brands are purchased than would be the case in an atomized purchasing market. But such limitations are essential if economies of scale are to be achieved. In any event, GPOs give individual members considerable choice in purchasing. *First*, GPOs listen to their members' medical staffs before deciding what to buy. *Second*, individual members are largely free to purchase outside the GPO agreement at any price they can obtain. *Third*, since most members are in more than one GPO, they can choose their best product mix from among several GPOs. *Fourth*, in most cases a hospital unhappy with the offering of the GPOs in which it is currently a member is free to join a different GPO that meets its needs better. While GPOs do not "impose" products on their members, they do provide them with incentives to purchase a certain percentage of their products through the GPO's contracts. But such incentive arrangements are output enhancing. They have uniformly been found procompetitive under the antitrust laws.

"While GPOs are transaction facilitators rather than buyers, their activities resemble buying in nearly all economic respects. Procompetitive group purchasing produces scale economies that result from *increased* output. Typically the GPO places no limit on the amount of any product that individual

> members can purchase. Indeed, members are given incentives to continually increase their purchases of selected products.
>
> "In sum, there are many reasons for thinking that GPO group purchasing increases output, reduces prices, and is procompetitive. There are no reasons, either structural or behavioral, for finding their activities to be anticompetitive."

Clinical Input Into the Purchasing Process

In addition to the valuable cost savings that GPOs enable providers to achieve as a result of aggregating their purchasing power, GPOs play a critical role in drawing upon and consolidating the clinical expertise of hospitals across the country. To examine this issue of the clinical review processes conducted by GPOs and their provider-members, HIGPA invited The Lewin Group, a nationally known independent research firm, to conduct a study of the GPO decision-making process for purchasing health care technology.

What the researchers found was that, in working with GPOs, hospitals seek to make clinically informed, evidence-based decisions about which medical products will offer the highest quality of care to patients. Indeed, the study found that "GPOs and health systems conduct extensive and rigorous clinical reviews when deciding which health care technologies will be listed in purchasing contracts and made available for use."

GPOs provide a unique mechanism for a group of hospitals to coordinate not only their purchasing power, but also their brainpower. By drawing upon their broad-based memberships, GPOs give doctors, nurses, pharmacists, and other clinical experts a pathway for evaluating new products and their potential impact on the quality of care.

The Lewin Group study said, "the evidence suggests that the exact locus of the clinical review process can vary – sometimes more is done at the GPO level, and sometimes more is done at the health system level – but in any event these processes employ widely accepted methods for assessing the clinical value of health care technologies."

Additionally, the researchers found that GPOs and their provider-members "have established comprehensive committee structures and related processes to review new products. Committee members are generally drawn from the clinical, pharmacy and technical staff of GPO member institutions, supplemented by GPO staff and other outside experts…[C]ommittees are charged to evaluate clinical and related technical properties first. If these elements are consistent with expectations for quality, then the committees consider relevant economic and other impacts of a product."

What is clear from this study is that the clinical review process is of critical importance to GPOs for several reasons. I believe it is indisputable that GPOs are primarily interested in providing

their members with the most clinically appropriate products at the best possible prices. Assertions that suggest otherwise are simply not supported by the facts. GPOs exist to serve their members and if they did not contract for products that are clinically desired, they could not survive as businesses.

Indeed, there is considerable evidence that GPOs enhance the clinical review process and strengthen the quality of medicine. For example, GPOs typically have a wide variety of provider members. Some are leading-edge research hospitals, some are mid-size suburban facilities, some are small rural facilities, and some serve the most depressed urban areas of our country. By working with a GPO, providers with more limited resources are able to benefit from the clinical expertise that exists in hospitals engaged in teaching and research. That is, GPOs are able to bring together the most recognized experts within its membership when evaluating products. This benefit would not be available if GPOs did not exist, and all purchasing functions, including evaluation, were made by individual providers.

Response to Charges by Opponents of GPOs

There have been allegations recently made against GPOs and their member hospitals by a small group of manufacturers. I believe an underlying motive to the allegations is that these manufacturers believe they know what is best for hospitals and how those hospitals should provide patient care. This group of companies would like you to believe that hospitals are unable to make the most appropriate purchasing decisions because of GPOs, and therefore need the assistance of manufacturers—the very companies that are trying to sell them products. Although this is a convenient argument for those manufacturers, it is not based in fact. Under the current system of group purchasing, providers already have the ability to make these purchasing decisions. All GPOs are controlled by, and ultimately responsible to, hospitals and other providers. I believe those manufacturers who are unhappy with the current purchasing model are trying to disguise their arguments as being in the best interests of hospitals and their patients. In reality, their efforts are designed to benefit their companies and their shareholders.

Some manufacturers have claimed that allowing GPOs to earn administrative fees creates a conflict of interest for GPOs and reduces their responsiveness to their provider members. I do not believe this allegation to be true. The earning of administrative fees has no impact on the objectivity of GPOs because the fact remains that unless providers utilize contracts, GPOs could not succeed as businesses because administrative fees are only earned after a purchase is made. This fundamental underpinning of the GPO business model is of crucial importance. The government has repeatedly recognized this, both through their statements supportive of GPOs, and through their actions that in many instances mimic the GPO business model.

Another claim heard from some manufacturers is that specific contract structures create a situation where the best products are not available to providers. Again, I believe this allegation to be false. As the representative of the entire group purchasing industry, I am not in a position to advocate on behalf of specific practices of individual GPOs. However, the fact remains that

because GPOs are the agents of providers they must act in accordance with the wishes of those providers. Providers ultimately set the direction of a GPO and have the ability to modify that GPO's activities.

At the end of the day, it is up to individual providers whether to purchase products via a GPO contract, or whether to make purchases independent of a GPO. If a provider prefers a product that differs from what the GPO has negotiated for, or a provider believes that specific contract structures are not favorable, that provider has the ability to make purchases without the assistance of a GPO. No one is forcing providers only to purchase products that GPOs offer. Therefore, the value and appropriateness of specific contracts is ultimately determined by providers through their decision on whether to utilize a contract. The difference really boils down to two distinct actions: contracting and purchasing. GPOs only perform contracting functions, while providers are ultimately responsible for purchasing. This business model keeps the ultimate power of what products are used in a hospital squarely where it should be — in the hands of providers.

If the opponents of GPOs and health care providers succeed in abolishing or unnecessarily restricting administrative fees, providers will face added financial constraints and their ability to meet their patients' health care needs will be challenged. They would have to choose between diverting financial resources from the direct administration of patient care to fund the operations of GPOs, or they would have to stop using GPOs altogether, thereby losing volume discounts, and increasing the cost of health care. Neither of these options would ultimately serve patients. Both would have one and only one consequence: reducing the ability of hospitals to aggressively negotiate purchasing contracts with powerful suppliers. This would result in higher costs for hospitals at a time when they already face inadequate reimbursement, labor shortages, and rising expenditures.

It is also important to expose fully the motives of those that want to strip GPOs of their ability to secure the best products at the lowest price. A simple examination of public statements from these manufacturers shows that they seem to be making simultaneous, yet contradictory, remarks about their success as for-profit enterprises.

For example, one California-based manufacturer of pulse oximeters recently told a major newspaper that they could not sell their device to many hospitals. Yet at the same time, this company boasts that it has "grown by over 2,000%, with an average compounded growth rate of 122% since 1998," and that with their sales "more than doubling year after year, the demand on our manufacturing team to keep up with this level of customer demand has been tremendous."

At the same time this manufacturer's chairman & CEO says to the news media that it is doubtful that a company like his could ever secure proper funding, he also states that they have been "successful in raising close to $100 million" from investors.

I make these points not to criticize any particular company or cast aspersions on manufacturers in general. Many of the members of HIGPA are manufacturers or other health care suppliers that understand the value of group purchasing. Rather, I make these points to bring to illustrate that GPO practices have not prevented small manufacturers from successfully competing in the marketplace.

Code of Conduct Principles

HIGPA, with the support of its GPO members, developed a GPO Code of Conduct with the purpose of strengthening and improving the delivery of products and services to health care providers. The GPO contracting process was already highly transparent to health care providers that purchase through GPO contracts. Nevertheless, the industry wanted to assure that it met the highest ethical standards. In developing the Code of Conduct, HIGPA focused on several areas, including: eliminating the potential for conflicts of interests; ensuring open communications between members and vendors; establishing guidelines for the use of contracting tools; requiring full disclosure to members of all vendor payments; and, establishing reporting and educating programs, including surveys to quantify the value of GPOs.

The Code provides as follows:

Conflicts of Interest:
HIGPA's Code of Conduct Principles addresses conflicts of interest by:

- Prohibiting employees who are in a position to influence the GPO contracting decisions from accepting any gifts, entertainment, favors, honoraria or personal services payments (other than those of nominal value) from any participating vendor.

- Prohibiting employees who are in a position to influence the GPO's contracting decisions from having an equity interest in any participating vendor.

- Requiring GPO non-employees, officers, directors or advisors who are in a position to influence the GPO's contracting decisions to disclose any gifts, entertainment, favors, honoraria or personal services payments they receive from participating vendors and be recused from any negotiations or decisions relating to such participating vendor.

- Requiring GPO non-employees, officers, directors, or advisors to disclose any equity interests in any participating vendor and be recused from any negotiations or decisions relating to such participating vendor.

- Prohibiting a GPO from having a corporate equity interest in any participating vendor of clinical products or services, unless the acquisition of the equity interest demonstrably benefits the GPO's members by creating a source of a clinical product or service where there is no other source, or very limited sources.

In addition, if a corporate equity interest is obtained, the GPO must fully disclose the interest to its members and cannot impose an obligation, commitment or other requirement that in any way obligates a member to purchase goods or services from such participating vendor.

Contracting Practices:

HIGPA's Code of Conduct Principles addresses concerns about the impact of certain GPO contracting tools in a number of ways:

- Requiring each GPO to permit its members to (a) communicate directly with all vendors (b) assess products or services provided by all vendors and (c) purchase clinical preference products or services directly from vendors that do not contract with the GPO.

- Requiring that, to the extent contracting tools are used, either alone or in combination, in contracting arrangements, each GPO consider a set of specific factors — such as the occurrence of innovation in the product category and the market share of relevant vendors — to achieve a high quality of care and competitive pricing.

- Requiring each GPO to implement a contracting process that (a) informs potential vendors of the process for seeking and obtaining contracts with the GPO and (b) provides all interested vendors with the opportunity to solicit contracts.

- Requiring each GPO to individually engage in, or otherwise participate in, processes and programs that routinely evaluate, and provide opportunities to contract for, innovative clinical products or services.

- Requiring each GPO to adopt policies and procedures that endeavor to address vendor grievances related to access for innovative clinical products or services.

Cost Savings:

HIGPA's Code of Conduct Principles addresses the issue of the cost savings GPOs provide by:

- Committing to support the production of authoritative surveys and studies that will provide the public with reliable and up-to-date information on the value of GPOs.

In addition, the Code creates an oversight process as follows:

- Requiring GPOs to appoint a compliance officer who will be responsible for overseeing compliance with the Code and the fulfillment of the GPO's reporting requirements.

- Requiring each GPO member of HIGPA to certify annually to HIGPA that it is in compliance with the principles. HIGPA will publish an annual report identifying those

HIGPA members that have certified their compliance. This certification shall constitute a requirement for membership in HIGPA.

- Creating and supporting a web-based directory where vendors can post product information, including information about products that the vendors consider to be new and innovative.

- Requiring full disclosure to a GPO's members of all vendor payments, including those payments that are not allocable to the actual purchase of a member.

- Requiring GPOs to offer or participate in programs that promote diversity among vendors to include women and minority-owned vendors

The HIGPA Code establishes baseline principles that individual GPOs will adopt to improve the group purchasing industry, while also recognizing that a one-size-fits-all approach would be counterproductive to ensuring a competitive GPO marketplace. If all GPOs had the same essential business models—such as the same level of administrative fees, same contract length and same contract details—health care providers would be unable to benefit from competition among GPOs. Specifically, there were certain issues pertaining to individual GPO business practices—such as the level of administrative fees—that HIGPA could not address in the Code without being in violation of federal antitrust laws.

In a June 21, 2002 letter to HIGPA, Professor Hovenkamp details his concerns surrounding the GPO Code of Conduct in that it be lawful under the existing antitrust laws. Hovenkamp writes:

> "Agreements fixing prices and related terms of sales are unlawful per se. Importantly, this rule applies to maximum price fixing as well as minimum price fixing. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (physicians' agreement setting maximum fees in context of health plan unlawful per se); see also Ratino v. Medical Services of D.C., 718 R.2d 1260 (4th Cir. 1983); Tom v. Hawaii Dental Service, 606 F.Supp. 584 (D. Haw. 1985) (dental plan setting fees unlawful per se). It also applies to brokerage fees as well as outright sales. See, e.g., McLain v. Real Estate Bd., 444 U.S. 232 (1980).
>
> "The per se rule also governs agreements fixing collateral terms such as signing bonuses, limiting or regulating the size of rebates, or specifying other price-related terms. Catalano v. Target Sales, 446 U.S. 643 (1980) (agreement to eliminate various forms of credit unlawful per se); National Society of Professional Engineers v. United States, 435 U.S. 679 (1978) (condemning agreement to refrain from competitive bidding); United States v. Aquafredda, 834 F.2d 915, 917 (11th Cir. 1987), cert. denied, 485 U.S. 980 (1988) (agreement eliminating discounts; criminal violations); Int'l. Assn. of

> Conference Interpreters, 5 Trade Reg. Rep. ¶24235 (FTC, 1997) (agreement fixing travel reimbursement rates and collateral charges unlawful); Personal Protective Armor Ass'n, 5 Trade Reg. Rep. (CCH) P 23,521 (FTC Mar. 17, 1994, consent order) (same; agreement stipulating insurance coverage).
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> "For these reasons competition among GPOs, rather than collusion via Code of Conduct, must determine the existence or size of administrative fees, signing bonuses, rebates and other collateral fees that GPOs charge for their services. Any provision that stipulates or even suggests a limit on such fees or prohibits a certain type of fee would be subject to antitrust challenge.
>
> "This is not a situation where Congress or state law has granted GPOs an immunity from the operation of the antitrust laws. Cf. Gordon v. New York Stock Exch., 422 U.S. 659 (1975) (federal securities law immunized commission setting by stock brokers from antitrust attack); 1A P. Areeda & H. Hovenkamp, Antitrust Law ¶243b (2d ed. 2000); and see Southern Motor Carriers Rate Conf. v. United States, 471 U.S. 48 (1985) (joint rate making by trucking firms immunized by state law); 1 Areeda & Hovenkamp, id. at ¶224.
>
> "Nor is there any Noerr-Pennington immunity for petitions to the government. The petitioning immunity comes into play when joint actions are not instigated by private parties, but rather cast as a petition to the government for some action. Eastern R.R. Pres. Conf. v. Noerr Motor Freight, 365 U.S. 127 (1961); United Mine Workers v. Pennington, 381 U.S. 657 (1965). However, the immunity is invoked only when the joint action is proposed to the Government and contemplates government action, not when parties simply agree with each other to implement it on their own. See Superior Ct. Trial Lawyers Assn. v. FTC, 493 U.S. 411 (1990) (Noerr-Pennington immunity did not apply when lawyers simply set their own fees and imposed them.)
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> "In sum, if the GPOs acting without immunity agree to set maximum fees, rebates or other terms they would be incurring a significant risk of civil and perhaps even criminal violations of the federal antitrust laws."

By establishing baseline principles for all GPOs, the Code recognizes that both individual GPOs, and the industry as a whole, have important spheres of responsibility. HIGPA's Code of Conduct Principles and the implementation process will be updated and modified as necessary.

Closing

The fact that approximately 96 percent of hospitals use GPOs, including all of the top hospitals as ranked by *U.S. News & World Report* is a testament to the tremendous value GPOs offer providers. At the end of the day, GPOs are responsible to their member providers, not to for-

profit suppliers. It is the clinicians making decisions about the most appropriate medical devices to use – through the GPO process – that are the real advocates for patients.

Given that group purchasing empowers providers to negotiate discounts from suppliers at virtually no cost to those providers, GPOs are the real untold success story in health care, and there is no need for any change in the antitrust enforcement policy.

Thank you.

Appendix A: "Competitive Effects Of Group Purchasing Organizations' (GPO) Purchasing And Product Selection Practices In The Health Care Industry," April 2002, Professor Herbert Hovenkamp.

Appendix B: Lewin Group Analysis of GAO's April 30 Interim Report

Appendix C: HIGPA Code of Conduct Principles.

Appendix A
Submission by HIGPA

Competitive Effects Of Group Purchasing Organizations' (GPO) Purchasing and Product Selection Practices in The Health Care Industry

By Herbert Hovenkamp, Ph.D.
Professor of Law
University of Iowa

Prepared for:
The Health Industry Group Purchasing Association

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COMPETITIVE EFFECTS OF GROUP PURCHASING ORGANIZATIONS' (GPO) PURCHASING AND PRODUCT SELECTION PRACTICES IN THE HEALTH CARE INDUSTRY

EXECUTIVE SUMMARY

Herbert Hovenkamp

Group Purchasing Organizations (GPOs) negotiate for the purchase of medical goods and services on behalf of their members, which include hospitals, nursing homes and other health care provider organizations. GPOs have been very successful in obtaining lower prices than members can obtain by purchasing individually, with savings ranging from 10 to 15 percent.

The buying market in which GPOs operate is highly competitive. The products purchased through GPOs are identical with those purchased by thousands of other buyers, large and small. Approximately 800 GPOs collectively contract for about 45% of the supplies and equipment purchased by health care institutions. No GPO has a market share larger than 15%, and only two have shares exceeding 10%. The small size of GPOs in relation to the entire market, the large number of GPOs and intense competition with purchasers who do not use a GPO makes monopolistic practices or price-fixing among GPOs virtually impossible.

This competitiveness in purchasing is enhanced by the fact that most hospitals are members of several GPOs and play them off against each other. If one GPO does not provide a hospital with desired products, the hospital can turn to another GPO, or in some cases drop its membership altogether. As a result there have been significant shifts in the market shares of GPOs as they compete with each other to serve their members. Further, there are no significant barriers to entry because GPOs own no specialized assets. If a GPO were to earn monopoly profits, new GPOs would quickly be formed to take its place.

GPO group purchasing is a socially beneficial, procompetitive activity that reduces costs by enabling sellers to bid for high volume sales. One characteristic of many goods sold to health institutions is production “economies of scale,” meaning that it is much cheaper per unit to develop or produce a good if the seller can anticipate a large volume of sales. As a result, manufacturers typically bid significantly lower prices when they can be assured of a large volume.

While the market for *purchasing* of health care supplies is fiercely competitive, many of the markets in which these products are sold are oligopolies; these markets may be more naturally prone to high prices. It is well known to economists that if buyers organize themselves into large groups they can force sellers in these markets to bid more aggressively for a particular buying group’s trade.

One result of group purchasing can be that fewer brands are purchased than would be the case in an atomized purchasing market. But such limitations are essential if economies of scale are to be achieved. In any event, GPOs give individual members considerable choice in purchasing. *First*, GPOs listen to their members’ medical staffs

before deciding what to buy. *Second*, individual members are largely free to purchase outside the GPO agreement at any price they can obtain. *Third*, since most members are in more than one GPO, they can choose their best product mix from among several GPOs. *Fourth*, in most cases a hospital unhappy with the offering of the GPOs in which it is currently a member is free to join a different GPO that meets its needs better. While GPOs do not "impose" products on their members, they do provide them with incentives to purchase a certain percentage of their products through the GPO's contracts. But such incentive arrangements are output enhancing. They have uniformly been found procompetitive under the antitrust laws.

While GPOs are transaction facilitators rather than buyers, their activities resemble buying in nearly all economic respects. Procompetitive group purchasing produces scale economies that result from *increased* output. Typically the GPO places no limit on the amount of any product that individual members can purchase. Indeed, members are given incentives to continually increase their purchases of selected products.

In sum, there are many reasons for thinking that GPO group purchasing increases output, reduces prices, and is procompetitive. There are no reasons, either structural or behavioral, for finding their activities to be anticompetitive.

COMPETITIVE EFFECTS OF GROUP PURCHASING ORGANIZATIONS' (GPO) PURCHASING AND PRODUCT SELECTION PRACTICES IN THE HEALTH CARE INDUSTRY

Herbert Hovenkamp[1]

I. Introduction

Group Purchasing Organizations (GPOs) resemble buying cooperatives.[2] Their membership includes hospitals, nursing homes and other health care provider organizations. GPOs have been very successful in using product management techniques and volume aggregation to obtain lower prices for covered items than hospitals or other members can obtain by purchasing individually. Hospitals themselves report that GPOs save them from 10 to 15 percent on their purchases.[3] In addition to contracting, GPOs assist members in product selection, an activity that would otherwise use up large amounts of member staff time. Product information can be obtained and processed far more efficiently by the GPO, who can then disseminate the information to its numerous members, than by each individual member.[4]

II. Market Structure; General Competitiveness

The market in which GPOs contract is highly competitive in structure. The goods and services sold through GPOs are identical with those sold to thousands of other buyers large and small, as well as to institutions that may be GPO members but who purchase widely outside of their GPO contracts. As a result, GPOs compete with a substantial market for purchases of the same goods and supplies by other means than through GPOs. Further, alternatives have emerged that place even more competitive pressure on GPOs. For example, several companies now consolidate buyers and connect them with sellers over the internet. In addition, many integrated healthcare networks controlling large numbers of hospitals or other institutions now offer

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[2]GPOs differ from many buyers' cooperatives in that typically the GPO does not purchase the product for its own account and then resell to members. Rather, it acts more like an agent or intermediary, negotiating a transaction that then occurs directly between the manufacturer and the purchasing member, such as a hospital.

[3]Muse & Assocs., The Role of Group Purchasing Organizations in the U.S. Health Care System, introduction, pp. 16-17 (March, 2000).

[4]Id. at 17.

substantial competition.[5] The individual members of the nation's 800 GPOs[6] collectively purchase approximately 45% of the supplies and equipment purchased by health care institutions.[7] Because the products and services purchased from manufacturers outside of GPO contracts compete vigorously with purchases made through such contracts, there is a single relevant market for the products purchased through and outside GPOs.[8]

The numbers that best represent the market shares of the top ten GPOs are the percentages of their sales measured against the group of supply/equipment purchases made by health care institutions. Against this number the 2001 market shares of the top ten GPOs are approximately:[9]

Novation	14.6%
Premier	12.5%
AmeriNet	4.6%
MedAssets	4.5%
ManagedHealth	3.3%
Consorta	2.2%
HealthCare Purchasing Partners	1.1%
National Purchasing Alliance	.7%
AllHealth	.6%
Innovatix	.6%

Although the largest GPOs are substantial firms, the overall size of the market in which they purchase is very much larger. The Justice Department and FTC Merger

[5]See SMG Solutions, Multi-Hospital System (MHS) & Group Purchasing Organizations (GPOs) by City, State, 2001 Report & Directory at 15-18, 21 (2001).

[6]See id. at 1, identifying 684 GPOs that serve hospitals; many other specialized GPOs serve other institutional buyers. See id. at 5, noting that there are over 800 total GPOs in the United States.

[7]See 31 *Modern Healthcare* 28 (May 21, 2001).

[8]For example, the fact that dairy farmers or stationery suppliers organize into cooperatives to sell or purchase their products jointly does not create a separate relevant market for "goods sold through cooperatives."

[9]While data concerning the top ten GPOs are relatively easy to come by and produced annually, details concerning the balance of the market are more difficult to obtain. The individual members of the top ten GPOs, many of which are hospitals, account for the great majority of purchases of supplies and equipment made through GPOs. 1999 data indicates that the members of the top ten GPOs purchased approximately $39 billion during that year in equipment and supplies, while members of all GPOs purchased approximately 40.5 billion. See *Modern Healthcare* Supp., "By the Numbers" at 21 (Dec. 24, 2001).

Guidelines would regard this market as "unconcentrated," thus presenting the smallest danger of anticompetitive effects.[10]

A. The principal GPOs compete with each other by offering the same or similar products to their respective members, many of whom belong to more than one GPO. In addition a large number of specialty and regional GPOs serve specialized institutions, offer specialized product lists, or serve specific geographic regions rather than the entire nation. The market share numbers given above suggest that it would be structurally impossible for any single GPO to suppress significantly the output of any product. Manufacturers would and do bid aggressively to serve the needs of rival GPOs and hospitals for the products they prefer and offer competitive prices to encourage GPOs to switch to their products. Even the largest GPOs face the situation that nearly 90% of the purchasing in the market is done through competing GPOs or by other means.

B. Most hospitals belong to several GPOs.[11] As a result, hospitals are in a position to play GPOs off against each other. If one GPO does not provide a hospital with a product that it wants the hospital can turn to one of the others in which it has a membership, thus forcing the GPOs to compete with each other to provide hospitals with the optimal range of products. This ability of hospitals to shift their purchases makes the individual offerings of GPOs highly elastic and renders it virtually impossible that a GPO can impose an overpriced, unwanted or deficient product on its members.

C. The market share figures given above understate the degree of competitiveness in the GPO market in other important ways. Many GPOs are owned by their members, who sit on their boards, and are operated as cooperatives. These boards have no interest in procuring overpriced or substandard products in behalf of their own institutions. Many other GPOs have transient memberships. If the GPO is not serving a member's need adequately

[10]Department of Justice and Federal Trade Commission Horizontal Merger Guidelines §1.51 (1992). Briefly, the Guidelines use the Herfindahl-Hirschman Index (HHI) to estimate market concentration. The index equals the sum of the squares of the market shares of each firm. Thus a market with five identical size firms has an HHI of $20^2 + 20^2 + 20^2 + 20^2 + 20^2 = 2000$. The Guidelines regard a market with an HHI less than 1000 as "unconcentrated," one whose HHI falls between 1000 and 1800 as "moderately concentrated," and one whose HHI exceeds 1800 as "highly concentrated." While precise calculation of the HHI of the market for the sale of medical supplies and equipment is impossible, because that would require information about the market share of each of the thousands of firms in the market, the HHI appears to be in the range of 410-450.

[11]The average hospital belongs to 4.2 GPOs, although some of these may be interconnected. See SMG Solutions, Multi-Hospital System (MHS) & Group Purchasing Organizations (GPOs) by City, State, 2001 Report & Directory at 5 (2001). An increasingly common practice is that hospitals use a regional GPO for some purchases and a national GPO for others. See 29 *Modern Healthcare* 44 (Sep. 20, 1999).

the member can defect. As a result, some GPOs show much greater shifts in volume or market share than others. For example, from 1999 to 2000 Innovatix' and Consorta Catholic's transaction volumes increased by about 50%, while Allhealth, National Purchasing Alliance, and AmeriNet showed no growth at all or growth in the range of 5%.[12] In a cartelized market firms generally maintain stable market shares because production, or output, is assigned to each firm by the cartel.[13] The same is generally true of oligopoly, where firms tend to accept the output of other firms as given, and calculate their own output accordingly. As a result oligopoly is typically characterized by rigid, stable market shares and few efforts by one firm to pursue aggressively the sales made by other firms. By contrast, the non-parallel shifts in GPO purchasing market shares indicate that GPOs are competing to take business away from each other by offering better price and quality of product or service than their rivals.

D. There is also no evidence that the GPOs employ commonly used collusion "facilitators" to make their market more conducive to price-fixing. For example, there are no general programs of price information exchange among GPOs or their members. Indeed, individual GPOs are very reluctant to share such information with each other.

E. There appear to be no significant structural barriers to entry into the GPO market. GPOs control assets that consist mainly of general purpose office buildings, computer equipment, trained personnel, and an internet website. A new GPO can readily be created when market circumstances warrant. Consolidations and the formation of new GPOs are a frequent phenomenon. Groups of hospitals or other buyers can and have created new GPOs when they were dissatisfied with the performance of their existing GPO, and within the last few years many specialty GPOs have come into existence.[14] These facts

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[12]*Modern Healthcare* Supp., "By the Numbers" at 21 (Dec. 24, 2001).

[13]See Herbert Hovenkamp, Federal Antitrust Policy: the Law of Competition and its Practice §§4.1a, 4.6a (2d ed. 1999).

[14]See, eg., Health Works, formed in 1998, in New York. Modern Healthcare, 9-20-99 at 44. MedAssets entered in 1999 and grew substantially by acquisition and internal growth to one of the top four GPOs. See 31 Modern Healthcare 28 (5/21/2001). One powerful recent innovation is the shift to internet purchasing, which is not only paperless and quick, but enables hospitals to make quick comparisons of prices from the different GPOs in which they are members. Internet driven GPOs have grown rapidly, with some leveling off during the 2000-2001 recession years. For example, Innovatix entered the market in 1993 and now has a membership of 2300 health care providers located in all fifty states. See *http://www.innovatix.com*.

In addition, other organizations have entered the market in competition with GPOs. For example, in 1999 Tenet Healthcare formed its own procurement company called Broadlane. SMG Solutions, Multi-Hospital System (MHS) & Group Purchasing Organizations (GPOs) by City, State, 2001 Report & Directory at 22 (2001).

indicate that new entry is easy. In addition, currently existing specialty and regional GPOs, of which there are many, could readily expand their own domain into markets in which monopoly returns were being obtained. Under such circumstances it is highly unlikely that anticompetitive pricing or output restriction policies could be sustained.

F. The percentage of purchases of medical products made through GPOs has consistently increased over the past decade. This suggests that GPOs are competing aggressively against each other as well as against alternative supply channels for new trade, and that they are providing a procompetitive service health care organizations want. When a market is cartelized the almost immediate effect will be a loss of the cartel members' aggregate market share to outside (non-cartel) sales. This occurs because purchasers, with varying degrees of success, seek to substitute away from the cartel. By contrast, switches in purchases *toward* a particular group of firms suggests that these firms are offering prices or products that benefit buyers, a sign of healthy competition.

III. Competitive Effects of Group Purchasing

The principal business activity of the GPO is facilitation of group purchasing. In this activity the GPO's role resembles that of an agent or intermediary, not a purchaser-reseller. Ordinarily GPOs do not purchase medical goods and resell them to members. Rather, they respond to the aggregate member needs for certain goods or services by soliciting bids from manufacturers or other sellers. A supply contract is then negotiated with the winning bidders, and the GPO's members are entitled to purchase through that winning contract at the price and other terms so specified. Manufacturers are encouraged to bid aggressively for these contracts because they typically represent a very large quantity of sales to the GPO's members.

A. Group purchasing is a socially beneficial, procompetitive activity.[15] By organizing into groups firms can purchase or offer to purchase larger quantities of goods or services. Further, the group purchasing agent can test products for quality or appropriateness and make purchasing recommendations to its

[15]See *Northwest Wholesale Stationers v. Pacific Stationery & Printing Co*., 472 U.S. 284 (1985). As the Court observed, a group purchasing arrangement:

> ... permits the participating retailers to achieve economies of scale in both the purchase and warehousing of wholesale supplies, and also ensures ready access to a stock of goods that might otherwise be unavailable on short notice. The cost savings and order-filling guarantees enable smaller retailers to reduce prices and maintain their retail stock so as to compete more effectively with larger retailers.

Id. at 295.

members. Group purchasing can thus address the problem of brand proliferation by researching the appropriateness and price/quality features of individual brands and recommending one or a small number of brands to member institutions. In sum, the savings from group purchasing are numerous and varied.[16]

B. Group purchasing enables a larger amount of goods to be distributed over a single contract, thus reducing per unit transaction costs. In particular, by making an advance commitment to purchase large amounts of a particular product, the GPO can facilitate significant production cost reductions. Especially in product differentiated markets, group purchasing facilitates longer production runs, which can result in significant cost savings. This is true to a degree in all markets that have differentiated products, but it is particularly true in markets in which fixed costs are significant, and even more particularly true in markets in which research and development and the resulting protection of the intellectual property laws are a significant factor.

To illustrate, most R&D costs are both fixed and sunk. The costs are fixed because once R&D monies are invested and a product developed the amount of R&D monies spent does not vary with the number of units that are produced. This means that costs can be significantly lower for larger production runs. To illustrate, suppose that R&D for a particular product costs $1,000,000. If only 100,000 units of that product are sold the developer must receive $10.00 per unit in order to break even on its R&D investment. By contrast, if 1,000,000 units are sold the firm breaks even on R&D when it obtains only $1.00 per unit. Thus a larger anticipated production run enables a firm to charge significantly lower prices and still make a profit. A seller of such a product will therefore bid a significantly lower price if it anticipates that contract volume will be large. R&D costs are also sunk, which means that once the monies are expended the result often cannot readily be transferred to a different product if the primary product fails. As a result most R&D costs must be recovered through sales of the particular product at which the R&D was directed.

C. Medical goods such as pharmaceuticals and many types of medical hardware are particularly susceptible to scale economies that result from long production runs. For example, a prescription drug with a very large production run will have a significantly lower R&D cost component per unit than another drug with a similar cost structure but a shorter production run. The greater the proportion of fixed costs, including R&D costs, the more significant the economies that are generated from long production runs. Significant cost savings often result from GPO-brokered “group buys” of costly durable equipment such as CT scanners.

D. For all such products, group purchasing encourages or enables sharply reduced prices by inducing sellers to bid aggressively for larger quantities of potential sales. In an atomized market no seller can be assured of a large production run because each individual buyer makes on the spot decisions about

[16]See generally 13 Herbert Hovenkamp, Antitrust Law ¶2135b (1999).

what to buy. For example, if five firms have developed a version of product Alpha and each has expended substantial R&D and other development monies, each will have to set a price high enough to recover its costs over the anticipated production run. The smaller the anticipated production run, the higher this price must be. By contrast, if a group of buyers agree to purchase a specified minimum percentage of their needs over a defined time period from a particular seller, this seller can anticipate a longer production run and set a lower price. This is hardly an exercise of "monopsony power"; rather, it is simply recognition of the fact that producing certain specialized products in larger quantities facilitates significantly lower per unit costs.

E. Group purchasing does not reduce competition even though the result may be that the group selects only one or a small number of manufacturers among a larger number of alternatives. In the atomized market the five manufacturers of variants of product Alpha compete with each other, perhaps on a transaction-by-transaction basis, to make individual sales to individual buyers. Alternatively, an individual buyer such as a hospital might enter a supply contract for a single brand. Under GPO group purchasing contemplating a single contract with a single seller, manufacturers compete against each other *for* the right to be the preferred supplier to the entire GPO. That competition can be very intense. Even if only a single supplier is chosen by the GPO the result is no more anticompetitive than if a firm such as General Motors contracts to have its snow removed by a single firm for the entire season, rather than calling snow plowing firms each time it snows and striking a deal for that particular plowing job. Bargaining costs are significantly lower for the full term contract. In all events, such contracts almost never force GPO members to purchase from the winning bidder exclusively. In most cases members can and do continue to purchase competing goods from rival sellers who do not have a contract with their GPO.

F. Individually, the purchasers of medical hardware and supplies (hospitals, nursing homes and other health care facilities) are very small and numerous; the market contains many thousands of purchasers.[17] By contrast, many sectors of the selling, or manufacturing, market are highly concentrated and prone to oligopoly, and potentially, anticompetitive collusion. Organization of small purchasers into GPOs is particularly valuable to their members in dealing with markets that are highly concentrated on the sellers' side. It is well known that one way to combat the effects of structural oligopoly on the seller's side is to offset their power by creating larger, more powerful and sophisticated buyers. Such buying groups force oligopoly producers to bid aggressively against each other in order to obtain large volume sales at highly competitive prices, which is procompetitive. As *Antitrust Law* explains:

[17]For example, individual hospitals who are members in at least one purchasing organization numbered 6577 as of May, 2001. SMG Solutions, Multi-Hospital System (MHS) & Group Purchasing Organizations (GPOs) by City, State, 2001 Report & Directory at 12 (2001).

> Even where seller concentration is "high," the likelihood, scope, and persistence of non-competitive pricing is affected by the sophistication and size of buyers, as well as the size of their orders. The presence of large buyers, infrequency or irregularity of orders, and the ability to conceal price cuts at least temporarily, all operate to disrupt adherence to non-competitive prices and thus to drive prices down toward competitive levels....
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> When sellers are attempting to coordinate their output, the individual firm's decision whether or not to cut price below what has been actually or tacitly agreed upon depends on a balancing of short-run gains against the risk of rival reactions driving down prices generally. The larger the order, the greater the gains from securing it. Further, a price cut on a single large order is less likely to be interpreted by rivals as a general price move that must be met than would numerous departures on small orders. Thus, the large buyer is in a favorable position to persuade one or more sellers to offer a reduced price. Such a buyer may also be in a position to make all-or-nothing offers, or to threaten backward vertical integration in the event prices are maintained.[18]
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> Numerous markets for the *production* of health care equipment, pharmaceuticals and other supplies are highly concentrated, and in these markets organized group buying is able to have the pro-competitive effects just described. For example, as a result of GPO contracting the price of coronary stents, which is dominated by four

[18] 4 Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶943 (rev. ed. 1997). See also the Justice Department and Federal Trade Commission's Merger Guidelines. These Guidelines, which aid the government in identifying market structures and situations where competitive harm from mergers might occur, note that large and sophisticated buyers can put pressure on oligopoly sellers, forcing them to make concessions from adherence to their usual oligopoly prices. The result is a competitive market and lower prices for customers:

> In certain circumstances, buyer characteristics and the nature of the procurement process may affect the incentives to deviate from terms of coordination. Buyer size alone is not the determining characteristic. Where large buyers likely would engage in long-term contracting, so that the sales covered by such contracts can be large relative to the total output of a firm in the market, firms may have the incentive to deviate. However, this only can be accomplished where the duration, volume and profitability of the business covered by such contracts are sufficiently large as to make deviation more profitable in the long term than honoring the terms of coordination, and buyers likely would switch suppliers.

Merger Guidelines §2.12.

manufacturers,[19] fell by approximately one-third from 1999 to 2000.[20] By the same token, oligopoly suppliers can be expected to object to GPOs because GPO purchasing threatens the stability of their oligopolies and forces price reductions. Group purchasing is particularly effective in markets that may be prone to price-fixing, market division, or other anticompetitive price-enhancing restraints.[21] The natural tendency of such restraints is to reduce output and raise price; by contrast, the natural tendency of group purchasing is to force sellers to bid against each other aggressively for very large volume purchases.

IV. Limitations on Product or Brand Choices: Motives and Effects

One result of group purchasing can be that a smaller variety of brands are purchased than would be in an atomized purchasing market. If every hospital and nursing home made individual purchasing decisions then many variations of a product might find at least some purchasers, even if they are inferior or more expensive than alternatives. Many GPOs favor "dual choice" or a combination of "dual choice" and "sole source" purchasing, thus giving members choice in which brand or variation of a product to use. Further, because hospitals typically belong to several GPOs, they typically have a choice among products for which the GPO has facilitated buying arrangements.

A. While GPOs do some product research and make some buying recommendations, their product selection process is generally member driven. That is, they begin the product-selection process by soliciting advice and suggestions from their members' medical and nursing staffs. The GPO then selects the most desirable products based on member criteria, mindful of both cost and quality concerns. Product selection is always done with the heavy participation of the members, and products are not "imposed" on a membership that prefers a different product. If a GPO did so it would face immediate defections as its members either left the GPO or purchased outside the GPO contract or through a different GPO. Cost is always a significant factor in product

[19]Boston Scientific, Johnson & Johnson, Guidant, Medtronic.

[20]*Modern Healthcare* 26-28 (Oct. 29, 2001).

[21]Recent examples in markets for medical goods or supplies include *In re Brand Name Prescription Drugs Antitrust Litigation*, 186 F.3d 781 (7th Cir. 1999), cert. denied, 528 U.S. 1181 (2000) (denying summary judgment on claims of pharmaceutical price-fixing conspiracy); *Cook, Inc. v. Boston Scientific Corp*., 2002 WL 335314 (N.D.Ill. Feb 28, 2002) (refusing to dismiss restraint of trade claim in market for coated stents); *In re Lorazepam & Clorazepate Antitrust Litigation*, 205 F.R.D. 369 (D.D.C. Feb 01, 2002) (collusion, anti-anxiety drugs; settlement approval); *In re Cardizem CD Antitrust Litigation*, 200 F.R.D. 326 (E.D.Mich. 2001) (similar, certifying class).

selection, and GPOs are always under pressure to keep costs down. As a result they tend to select products that reflect the best, least costly variation of a product that is deemed acceptable to its membership. A more costly product that has a certain feature distinct from rival products may not be adopted unless the GPO and its membership believe that the product's special features are extraordinary and cost justified.

B. Even among brands of a good that are deemed equivalent in quality, features and price, a GPO tends to select a single brand for a purchasing contract. This is so largely because of the scale economies described above. For example, if a GPOs membership has aggregate anticipated needs for a certain product of 3,000,000 units per year, letting a single contract gives that seller an anticipated production run of 3,000,000 units. By contrast, if equivalent contracts were approved with three different manufacturers, then each could count on a production run of only 1,000,000 units. Anticipating the larger production run, the firm bidding on the single contract will bid significantly lower per unit than the firm bidding to obtain one out of three contracts.

C. Even though a relatively narrow range of product selections is completely justified by the GPO's concern with obtaining the best quality for a highly competitive price, in nearly all cases a particular member who is unhappy with the GPOs selection is free to make its own individual product choices. In most cases the institutional member will be permitted to purchase brands or products for which the GPO does not have a purchasing agreement. In other instances the institutional member may be required to purchase a specified minimum percentage of its needs through the GPO-approved contract, but may satisfy its own unique needs with separate purchases. Naturally, these purchases made outside of the GPO contracting process will not necessarily enjoy the quantity-generated cost reductions associated with purchases made through the GPO contract. If that were not the case, then the GPO would have no reason for existence. In fact, however, manufacturers compete aggressively for the opportunity to make sales to a member outside the member's GPO contract and frequently do so. This often occurs in situations where incumbent suppliers are displaced by new, winning suppliers, and the losing supplier tries to keep its old customers. As a result, even the prices of brands that have not been contracted through a GPO tend to go down and stay competitive.

D. Two factors make it virtually impossible for a GPO to pass off substandard or overpriced products to its members.

1. First, as noted previously, member institutions can readily shift either their membership or their purchases from one GPO to another, or their product selection from one GPO to another in which they are already members, if they feel that a particular GPO is not meeting their needs, and many institutional members have done so. As a result, GPOs compete for membership by offering the best services, and chief among these services is the offering of high quality products at competitive prices.

2. Second, for the great majority of members a broad range of purchasing decisions is made by staff physicians, nurses or other personnel who have a great deal of clinical experience in product selection, and are free to opt for alternative products if they dislike the GPO-selected product. Further, many of these personnel bear a significant portion of the legal responsibility that may result from selection of a defective or substandard product. For example, if a GPO tried to impose a substandard hip joint on a hospital, the orthopedic surgeon would not be bound to accept it, in almost all cases has discretion to make an alternative choice, and will state his or her objections to the GPO-selected device.

V. Anticompetitive Buyer Collusion Distinguished

While GPOs are transaction facilitators rather than buyers, economically their activities resemble the buying function in certain respects. Under certain circumstances buyers can organize cartels just as sellers can.[22] Such a buyers' cartel threatens competition and produces harmful results similar to those that result from a sellers' cartel.[23] These bad results include (a) suppression of the buying price to below the competitive level, forcing the manufacturer to limit its output; (b) reduced marketwide output; and (c) in many cases, higher prices in the output market.[24]

A. An anticompetitive buyers' cartel is ordinarily a "naked" agreement in which the buyers do not organize, consolidate or integrate their purchasing or any other functional purchasing activity. They merely agree to suppress the market price. For example, a group of buyers at an auction may tacitly agree not to bid against each other.[25]

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[22]On buyers' cartels generally, see Roger D. Blair & Jeffrey Harrison, Monopsony: Antitrust Law and Economics 41-45 (1993); 12 Herbert Hovenkamp, Antitrust Law ¶2011 (1999). See, e.g., *Mandeville Island Farms v. American Crystal Sugar Co*., 334 U.S. 219 (1948) (finding a naked price fixing agreement among buyers to be within the reach of the antitrust laws); *Petruzzi's IGA Supermarkets v. Darling-Delaware Co*., 998 F.2d 1224, 1246 (3d Cir.), cert. denied, 510 U.S. 994 (1993) (buyers' cartel purchasing fat and bone renderings from retail butchers); *City of Long Beach v. Standard Oil Company of California*, 872 F.2d 1401 (9th Cir. 1989), cert. denied, 493 U.S. 1076 (1990) (similar; oil rights); *Reid Brothers Logging Co. v. Ketchikan Pulp Co.*, 699 F.2d 1292 (9th Cir. 1983), cert. denied, 464 U.S. 916 (1983) (similar; timber rights).

[23]See, e.g., *Khan v. State Oil Co*., 93 f.3d 1358, 1361 (7th Cir. 1996), rev'd on other grds., 522 U.S. 3 (1997) (monopoly and monopsony produce similar anticompetitive results); *Vogel v. American Soc'y of Appraisers*, 744 F.2d 598, 601 (7th Cir. 1984) (Posner, J.). See also *Todd v. Exxon Corp*., 275 F.3d 181 (2d Cir. 2001) (buyers' cartels' and sellers' cartels equally unlawful under antitrust laws).

[24]Whether the buyers' cartel leads to reduced output and higher prices in the market in which the cartel members resell depends on whether they have market power in both their purchasing and their selling markets. For example, a local cartel of sugar processors purchasing sugar beets from nearby farmers would suppress the beet price and cause locally lower beet output. However, in contrast to the beets, the refined sugar is resold in a national market at a presumably competitive price. As a result, there would not be a measurable output reduction in the sugar market. See 12 Herbert Hovenkamp, Antitrust Law ¶2011b (1999).

[25]See, e.g., *Todd v. Exxon Corp*., 275 F.3d 191 (2d Cir. 2001) (refusing to dismiss complaint alleging possible price fixing by oil companies of certain employees' salaries); *United States v. Romer*, 148 F.3d 359 (4th Cir. (1998), cert. denied, 525 U.S. 1141 (1999) (cartel of purchasers of real estate at foreclosure auctions).

B. Buyer collusion is thus readily distinguishable from group purchasing. Characteristic of the latter is that the buyers' organization negotiates jointly on behalf of all of its members, thereby integrating the separate members' transactions, education and personnel through a single activity. In almost all these situations the sellers know that they are dealing with a group purchasing organization.[26] By contrast, in a secret buyers' cartel, the members do not purchase jointly; rather, they simply agree surreptitiously not to pay more than a certain price for the cartelized product. Such a restraint is "naked," in that it depends on market power for its success and is not accompanied by any integration of purchasing, product selection, or collateral services given to participants. The Supreme Court has consistently distinguished group purchasing from buyer collusion, and praised the former. The Antitrust Division of the Justice Department and the Federal Trade Commission recognize these significant differences:

> An agreement among purchasers that simply fixes the price that each purchaser will pay or offer to pay for a product or service is not a legitimate joint purchasing arrangement and is a per se antitrust violation. Legitimate joint purchasing arrangements provide some integration of purchasing functions to achieve efficiencies.[27]

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[26]Further, the buying cooperative is profitable whether or not its aggregate membership has market power in the market in which it purchases. As a result, cooperative buying is not a "naked" restraint under the antitrust laws, but is classified as ancillary. See 11 Herbert Hovenkamp, Antitrust Law ¶1906 (1998).

[27]Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. ¶13153 (1996), Statement 7, n. 17. The Statement also says:

Joint purchasing arrangements are unlikely to raise antitrust concerns unless (1) the arrangement accounts for so large a portion of the purchases of a product or service that it can effectively exercise market power in the purchase of the product or service, or (2) the products or services being purchased jointly account for so large a proportion of the total cost of the services being sold by the participants that the joint purchasing arrangement may facilitate price fixing or otherwise reduce competition. If neither factor is present, the joint purchasing arrangement will not present competitive concerns.

The Statement then establishes a "safety zone" of non-prosecution when these two conditions are met:

(1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement.

> In sum, group purchasing of the kind engaged in by GPOs is not even presumptively anticompetitive. Further, and as noted previously, there is no evidence that GPOs are agreeing with each other to suppress competition.

C. One significant difference between procompetitive joint purchasing and the anticompetitive buyers' cartel is the impact on the volume of purchases in the market for the purchased product. For example, a sellers' cartel suppresses competition by reducing the marketwide output of the cartelized product. The price rises in response to this output reduction. While selecting a target reduction in *aggregate* output may be easy for the cartel, it often faces difficult problems in allocating the output reduction among various members and then enforcing these output restrictions. Individual cartel members have a strong incentive to "cheat" on the cartel by surreptitiously producing more, and to the extent they do so the market price falls back to competitive levels.[28]

Buyers' cartels face the same set of problems. In order to suppress competition the buyers' cartel must suppress the amount its members purchase. Just as in the case of the sellers' cartel, the buyers' cartel must assign maximum purchasing quotas to its members and ensure that individual cartel members do not "cheat" by surreptitiously purchasing more at the infracompetitive price.[29]

In sharp contrast, the procompetitive joint purchasing organization obtains lower prices by *increasing* the volume of purchased product, thus leading to lower prices resulting from reduced transaction costs, economies of scale, and longer production runs. As a result, one way of distinguishing between procompetitive joint purchasing and the anticompetitive buyers' cartel is by examining the group's policy with respect to the quantities purchased by individual members. The anticompetitive buyers' cartel profits by suppressing purchases. Thus in the anticompetitive buyers' cartel arrangement one would expect to see managers continually forcing members to reduce their purchases, lest output reach too high a level. Strict limits would be placed on purchases, and those who purchased more would be disciplined. In sharp contrast, in socially beneficial joint purchasing arrangements no limits would be placed on the maximum amount that members purchase and they might even be encouraged to increase their purchases via discounts, rebates, or other incentives for large quantity purchases. In sum, the underlying strategies of anticompetitive buyer collusion are output decreasing; while the underlying

[28]See H. Hovenkamp, Federal Antitrust Policy: the Law of Competition and its Practice §4.1 (2d ed. 1999). A good example is OPEC, a cartel of oil producers. In order to keep the price of oil up, the cartel managers must continuously keep output down by assigning maximum output quotas to individual members. If members "cheat" on these quotas and produce more the price of oil falls.

[29]See Roger D. Blair & Jeffrey L. Harrison, Antitrust Policy and Monopsony, 76 Cornell L.Rev. 297, 312-313 (1991).

strategies of procompetitive joint purchasing are output increasing.[30] The output data given in successive annual reports in Modern Healthcare indicate that the volume of purchases made through GPOs has increased consistently and in some cases dramatically over the past ten years. This strongly suggests that GPOs have not been formed for and are not engaged in output reducing activity.

Typically the GPO places no limit on the amount of any product that individual members can purchase. On the contrary, they are typically given incentives to continually increase the amount of their purchases of products that the GPO has selected. This willingness of the GPO to place no limits on the amount purchased, coupled with the suppliers' willingness to increase output at the contracted price, indicates that the GPOs are not pursuing an anticompetitive strategy of suppressing market output in order to obtain infracompetitive prices. On the contrary, they are increasing output in order to decrease per unit costs of getting health care products from the manufacturer to the consumer.

VI. Practices Analogized to Exclusive Dealing

Exclusive dealing occurs when a firm agrees to purchase[31] all of its needs for a certain product from a particular supplier. The great majority of exclusive dealing agreements are procompetitive and lawful, particularly when exclusive dealing is initiated by customers as in the case of GPO group purchasing.[32] However, a small subset can be anticompetitive depending on such factors as the percentage market share foreclosed by the exclusive dealing arrangement, the duration of exclusive contracts or the presence or absence of early termination provisions, the existence of

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[30]See H. Hovenkamp, 12 Antitrust Law ¶2012b (1999). See also *All Care Nursing Svces. v. High Tech Staffing Svces*., 135 F.3d 740 (11th Cir. 1998), cert. denied, 526 U.S. 1016 (1999) (applying rule of reason and approving hospital joint purchasing of nursing services where individual hospitals were not required to limit the amount of services purchased); *Sewell Plastics v. Coca-Cola Co*., 720 F. Supp. 1196, 1217-19 (W.D.N.C. 1989), aff'd mem., 912 F.2d 463 (4th Cir. 1990), cert. denied, 498 U.S. 1110 (1991) (similar; bottlers' joint purchasing of bottles).

[31]As a threshold matter, to the extent that GPOs do not purchase or resell covered goods themselves, they cannot violate §3 of the Clayton Act, which reaches only to sales. 15 U.S.C. §14; see *CDC Tech. v. IDEXX Labs*., 186 F.3d 74, 77 (2d Cir. 1999) (Clayton Act provision does not apply to broker, or transactor). Cf. *FTC v. Curtis Pub*., 260 U.S. 568 (1923) (Clayton Act provision did not apply to consignment agent). The exclusive dealing proscription of Clayton §3 is generally regarded as more aggressive than that of §1 of the Sherman Act. See *CDC Tech*., 186 F.3d at 78; *United States v. Microsoft*, 253 F.3d 34, 69 (D.C.Cir. 2001); 11 Herbert Hovenkamp, Antitrust Law ¶1800c4 (1998) (likely majority of circuits apply more aggressive test under Clayton Act).

[32]See Richard M. Steuer, Customer-Instigated Exclusive Dealing, 68 Antitrust L.J. 239, 250-251 (2000).

alternative distribution channels and the ability of these channels to expand output in response to supracompetitive prices, and the presence of compensating efficiencies.[33]

A. Very few of the contract arrangements employed by GPOs can be described as exclusive dealing. Rather, they are incentive arrangements that encourage members such as hospitals to purchase larger volumes through a GPO's contract. For example, a contract might require a GPOs members to purchase at least a certain percentage of their needs for some product through the GPO contract, or give them cost incentives to do so.

B. In assessing the extent of exclusivity of purchasing requirements one must examine two different transaction levels. One is the set of agreements between the GPO and the various suppliers with whom it deals; the other is the set of agreements between the GPO and its various member hospitals. For example, suppose a GPO agreed to give Alpha Company a contract for the purchase of a large volume of bandages and agreed not to enter a similar contract with any other bandage supplier. Even if such an agreement was "air tight," it would not operate as exclusive dealing as long as the GPO's member institutions were free to purchase bandages "outside the contract" — that is, were free to continue buying bandages from alternative sources. Exclusive dealing would occur only if (a) the GPO and Alpha agreed that the GPO would enter a purchase agreement for these bandages from Alpha, to the exclusion of any rival brand of the same product; and (b) the individual members of this GPO agreed to purchase their bandages only through this particular contract. In other words, the GPO members would be affirmatively prohibited from purchasing from other suppliers. GPOs enter virtually no such arrangements.

C. Exclusive dealing agreements should not be confused with inducements given to firms to increase their purchases from the seller. These include rebates or discounts for a buyer's purchase of a specified share of its needs from the supplier. The simplest of these arrangements is the quantity discount, in which the seller offers a lower price if the buyer purchases a specified minimum number of units. An alternative is a discount, which gives the purchaser a lower price if it purchases a specified minimum percentage of its needs from the seller. Such arrangements are virtually always procompetitive, output increasing strategies. Their purposes are manifold. In some cases, they reduce transaction, transportation or processing costs by enabling a larger number of units to be covered by a single sale or delivery. In other cases they enable firms to make larger production runs which, as explained earlier, can yield significant cost reductions. Such arrangements are lawful even when the seller using them is a monopolist.[34] As noted previously, no GPO comes close to having monopoly

[33]See 11 Herbert Hovenkamp, Antitrust Law ¶1821 (1998).

[34]E.g., *Concord Boat Corp. v. Brunswick Corp*., 207 F.3d 1039, 1061-1062 (8th Cir.), cert denied, 121 S. Ct. 428 (2000) (approving market share discounts even when seller was a monopolist); *Barry Wright Corp. v. ITT Grinnell Corp*., 724 F.2d 227, 237 (1st Cir. 1983) (Breyer, J.) (approving quantity discount arrangement); cf. *Barr Labs. v. Abbott Labs*., 978 F.2d 98, 109 (3d Cir. 1992) (approving contracts requiring purchaser

power, and the market is not structurally suited to monopolization. In yet other cases they can permit firms to estimate future production needs by making it easier to predict how many units buyers will purchase.

D. Percentage or quantity discounts generally lack an important feature that has induced courts to condemn some exclusive dealing agreements. In the traditional exclusive dealing agreement the purchaser commits itself for a defined time period not to purchase anything at all from a rival. By contrast, in a percentage or quantity discount arrangement rival firms can almost always compete for the buyer's trade by matching the discount. For example, if a seller charges $10 for its widgets but gives a 10% discount to any firm who purchases at least 100,000 widgets in a year, a rival seller can compete for the trade simply by selling widgets for $9. Assuming the $9 price is not predatory, an equally efficient rival can always compete for the trade of the seller offering a quantity or percentage discount.[35]

> **Example 1**: suppose the GPO negotiates a contract with a manufacturer to supply Alpha to the GPO's members. The contract provides for a base price of $10.00 per unit, and progressive discounts (or rebates) which are maximized at 10 percent if the member purchases 1000 units per year. Thus the member who purchased at least 1000 units per year could earn the lowest possible discounted price of $9.00 per unit. Assuming that this price is not predatory,[36] any seller could compete against this contract simply by offering an equivalent product at the $9.00 price.
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> **Example 2**: suppose the GPO negotiates a contract with a manufacturer to supply Alpha to the GPO's members at a base price of $10.00, but with a progressive discount as the percentage share of the members' use of Alpha, as opposed to other brands, increases. A member gets the maximum discount of 10 percent when it purchases at least 90 percent of its needs of this product through the Alpha contract. Once again, assuming that the $9.00 price is not predatory any competing seller could compete against

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to buy covered product wherever legally permissible to do so; enabled manufacturer to reduce costs by guaranteeing high quantity outlets).

[35]See *Concord Boat Corp. v. Brunswick Corp*., 207 F.3d 1039, 1059, 1063 (8th Cir.), cert denied, 121 S. Ct. 428 (2000) (Brunswick's market share discounts did not cause competitive injury to rivals because rivals could take sales simply by matching the discounted price, and this price was not shown to be predatory); *Western Parcel Express v. United Parcel Serv. of Am., Inc*., 190 F.3d 974, 976 (9th Cir.1999) (similar; volume discounts).

[36]The structural and behavioral prerequisites for predatory pricing are severe and seldom met. See 3 Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law Ch. 7C (2d ed. 2002). In any event, the predator would be the manufacturer, not the GPO.

this deal simply by offering to sell an equivalent product at a price of $9.00.

In sum, a feature of quantity and minimum purchase percentage discounts that distinguish them from exclusive dealing is that they rarely lock in buyers, who are free to purchase elsewhere. Further, any equally efficient rival can steal the buyer simply by matching the discounted price. In fact, manufacturers that do not have a contract with a particular GPO continue to compete for sales to that GPOs members by offering to match the contract price, or by offering product variations that a particular GPO member might prefer. As a result the discounting practices induce more competition into the market.

E. Even absolute exclusive dealing is lawful unless the purchaser agrees not to buy from rivals for a lengthy period.[37] If a contract has an early cancellation provision the duration of the contract is typically measured by the notice time given in that provision, rather than by the length of the overall contract.[38] Likewise, even absolute exclusive dealing is unlikely to have anticompetitive consequences (reduced output and higher prices) when sufficient alternative distribution channels exist for the product in question.[39] Numerous alternative means of distribution exist for virtually every GPO contract. First, hospitals are almost always free to purchase a product they prefer notwithstanding that its GPO has contracted with a different supplier. Second, GPOs usually have little or no control over independent agents such as physicians, who can and do demand alternatives if they regard the GPO's selection as unacceptable. Third, because most hospitals are members of several GPOs they can purchase from whichever GPO contract best suits their needs. Finally, any supplier is continuously free to bid for the trade of a different GPO, which in turn can solicit members who are unhappy with their existing GPO.

F. Even if certain agreements facilitated by GPOs can be characterized as exclusive dealing, the practice is typically regarded as unlawful only when it

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[37]See, e.g., *Barry Wright Corp. v. ITT Grinnell Corp*., 724 F.2d 227, 237 (1st Cir. 1983) (two year contract term presumptively lawful); *Roland Machinery Co. v. Dresser Industries*, 749 F.2d 380, 395 (7th Cir. 1984) (contract durations of less than one year presumptively lawful).

[38]See, e.g., *Balaklaw v. Lovell*, 14 F.3d 793 (2d Cir. 1994) (approving exclusive hospital/anesthesiology contract with three year term but permitting cancellation upon six months' notice); *U.S. Healthcare v. Healthsource*, 986 F.2d 589, 596 (1st Cir. 1993) (similar); *Drs. Steuer & Latham v. Nat'l. Med. Enterprises*, 672 F. Supp. 1489, 1516 (D.S.C. 1987) (90 day notice provision guaranteed that exclusive medical provision contract was harmless).

[39]E.g., *CDC Tech. v. IDEXX Labs*., 7 F.Supp.2d 119 (D.Conn. 1998), aff'd, 186 F.3d 74, 80 (2d Cir. 1999) (exclusive dealing contracts by firm with 80 percent market share foreclosing 65 percent of distributor market lawful when rivals had alternative means of getting their products to customers).

foreclosures a significant portion of the market, with most courts identifying 40 percent of a properly defined relevant market as the minimum.[40] In the case of GPOs, the largest market share occupied by any GPO is on the order of 14.5%, and the general purpose GPOs largely sell the same products. As a general proposition a firm's percentage foreclosure of a product cannot exceed its market presence in that product.[41] For example, if a gasoline supplier accounted for 25 percent of the gasoline market and imposed absolute exclusive dealing on all of its dealers, the foreclosure rate would be 25 percent. In the present situation it is thus highly unlikely that any contract properly defined as exclusive dealing comes close to the minimum thresholds for illegality. In any event, one could find illegality only in the presence of the requisite foreclosure standards and a thorough analysis of possible anticompetitive effects and likely justifications in each case.

G. Finally, exclusive dealing is a "rule of reason" offense. Even when it exists and covers the qualifying minimum market share threshold, it is properly defended by showing reasonable business justifications for the practice. Among these are reduced costs resulting from higher volume transactions, and increased certainty about the future through assurance of reliable customers.[42] GPO purchasing arrangements are virtually always procompetitive when these rationales are taken into account.

VII. Tying and Related Product Bundling

Occasionally manufacturers supplying GPOs use "bundling" as an inducement to make their offerings more attractive. For example, a pharmaceutical manufacturer whose brand is about to go off patent may agree to give a GPO's members the anticipated "generic" price of the drug provided that the GPO also contracts to purchase one or more other products in that manufacturer's inventory. Alternatively, a manufacturer may have a large inventory of a certain product, which it then uses as an inducement to make a different product more attractive. For example, a manufacturer with a large surplus of bandages may attempt to clear its inventory by offering a free package of bandages along with each box of thermometers that a hospital purchases. Such promotions are part of the ordinary give-and-take of the bargaining process, occur

[40]See, e.g., *United States v. Microsoft*, 253 F.3d 34, 70 (D.C.Cir. 2001) (suggesting 40 percent).

[41]See Phillip E. Areeda & Herbert Hovenkamp, 2A Antitrust Law ¶570 (2d ed. 2001).

[42]See, e.g., *CDC Tech. v. IDEXX Labs*., 186 F.3d 74, 77 (2d Cir. 1999) (noting these justifications); and see 11 Herbert Hovenkamp, Antitrust Law ¶1811 (1998) (market assurance), id. at ¶1813 (risk management).

widely in a variety of markets, and almost never represent an anticompetitive exercise of market power.[43]

A. Tying is a seller's refusal to sell a desired product unless the buyer also purchases a second product, which it may prefer to purchase elsewhere.[44] Tying is common in our economy; for example, a car dealer may refuse to sell a car without its tires, or a hospital may insist that those admitted as patients use the hospital's nursing staff rather than bringing their own. Most such arrangements have no anticompetitive effects whatsoever and are perfectly lawful. Tying is condemned only when the seller has significant market power in the tying product market, with the threshold typically expressed as a share of at least 30% or 40% of a properly defined market.[45] Even then, a thorough analysis of possible anticompetitive effects and procompetitive justifications must be made under the rule of reason.

B. Bundling in GPO contracts is rarely or never an anticompetitive exercise of market power on the part of a product manufacturer. Quite the contrary, bundles such as those described above are simply ways of making products more attractive, effectively cutting price, or reducing costs by disposing of excess inventory. Indeed, in the two previously given examples — the drug whose patent is about to expire and the surplus inventory of bandages — it is the *absence* of power rather than its presence which explains the arrangement. The bundle is used as an inducement to make a relatively unattractive product more attractive, just as the car dealer who sells the year old model by throwing in a radio, or the computer manufacturer who sells a slightly outdated model by including some software.

[43]See 9 P. Areeda, Antitrust Law ¶1714, 1715d2 (1991).

[44]If the buyer does not wish to purchase the tied product at all, then there is no injury to competition because no one is foreclosed from the market. See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 16 (1984) ("... when a purchaser is 'forced' to buy a product he would not have otherwise bought even from another seller in the tied product market, there can be no adverse impact on competition because no portion of the market which would otherwise have been available to other sellers has been foreclosed").

[45]See *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984) (rejecting tying claim between hospital and anesthesiologist where hospital controlled only 30% of surgical admissions in defined market).

VIII. Competitive Effects of GPO's Role in Distribution Process

In an ordinary distribution market characterized by intermediary purchase and resale, the reseller's profits comes from the spread between the wholesale price it pays and the resale price it charges to its customers. Manufacturers might compete for this particular seller's trade in a variety of ways — by cutting the product's wholesale price, by offering collateral services such as "free" delivery or stocking, by paying for certain fixed cost components such as a costly display, training of employees, technical equipment needed for repair and maintenance, periodic rebates or other payments for highly successful resellers, and so on. The market accommodates an almost infinite variety of such inducements, and these are an important contributor to the great variety of retailing and other distribution mechanisms that our economy offers. The quality and variety of these inducements varies with the complexity and uniqueness of the product. For example, the farmer selling grain probably competes on little more than price, although he may offer free delivery or some other collateral service. By contrast, the manufacturer of automobiles, computers, various types of chemicals including pharmaceuticals, or complex machinery is likely to use a wide array of such inducements.

A. The GPO differs from the reseller in the traditional distribution scheme in that it does not actually purchase, own and resell the products that it negotiates on behalf of its members. Rather, it is more closely akin to an agent. But the incentives that operate on an agent in such a situation are similar to those that operate on any buyer; namely, the agent maximizes its principal's interests by obtaining the best price that it can for the contracted goods, and this "price" includes the full panoply of payments and other incentives that a particular manufacturer might offer the GPO's members for their trade. Such an agent has no greater incentive to accept a "bribe" from a manufacturer as an inducement for carrying an inferior or overpriced product, than an ordinary retailer would for accepting a bribe from a manufacturer to purchase that manufacturer's inferior or overpriced goods.

B. Any residual doubts one might have about the GPOs' incentives to enter anticompetitive arrangements with manufacturers is laid to rest upon examination of the market structure. There are many GPOs, and a member who is unhappy with the prices, product quality or other services that its current GPO is providing can readily switch to another. As a result GPOs are forced to compete with each other in the same way that any competitors are compelled to compete. Such competitors can be expected to pursue and consider every reasonable inducement that their suppliers make available to them because such inducements are effectively a decrease in the purchase price or, in other cases, a reduction in fixed costs.[46]

[46] An example of the latter would be a manufacturer's construction or subsidy of a costly showroom display, its supply of specialized racks or other display equipment, or diagnostics equipment for warranty work. These are all fixed rather than variable cost items. As a result, while they do not reduce the retailer's direct wholesale price, they do reduce its operating expenses.

IX. Conclusion

The potential anticompetitive threats posed by GPOs are negligible. First, the purchasing side of the market for the types of supplies, equipment and services that GPOs contract for has many players and no dominant firms. Given the ease of entry, and the fluidity of membership and product selection, collusion is highly unlikely; in any event, there is no evidence that it is occurring. When anticompetitive buyers' collusion is present, it is characterized by elaborate arrangements to suppress the purchasing volume of each member of the buyers' cartel. In the case of GPOs, by contrast, each member is typically encouraged to purchase as much as possible through the GPO. Such encouragement is absolutely inconsistent with anticompetitive buyer collusion.

Further, there are many reasons for thinking that the overall effect of GPOs is strongly procompetitive. GPOs encourage large volume transactions, which in the case of complex medical supplies and equipment, can yield significantly lower production costs and thus lower product prices. To the extent that non-GPO manufacturers compete to offer equivalent goods, competition is further enhanced. GPOs provide significant assistance to their members in identifying optimal products and suitable suppliers. Finally, by placing a portion of the buyer's side of the market in the hands of relatively large and sophisticated agents, GPO purchasing tends to destabilize oligopolistic markets on the selling side, forcing manufacturers to behave more competitively if they wish to win a GPO contract. The resulting price benefits accrue not only to GPO members but to other buyers in the market as well.

Review of United States General Accounting Office Study: *GROUP PURCHASING ORGANIZATIONS: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices*

Introduction and Background

A variety of sources have inquired about the ways group purchasing organizations (GPOs) operate and the value they bring to the health care industry. In response, and on behalf of its members, the Health Industry Group Purchasing Association (HIGPA) has undertaken a number of activities to provide insight into the purchasing process and the contributions that GPOs make to the industry.

HIGPA asked The Lewin Group to review and comment on the recent GAO report entitled "Group Purchasing Organizations: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices" (GAO-02-690T). The paper was submitted as testimony for the Senate Judiciary Subcommittee on Antitrust, Competition, and Business and Consumer Rights on April 30, 2002, and summarized results from a pilot study of hospital purchasing in an unnamed metropolitan area of the United States. The pilot study sought to determine whether hospitals in that market saved money by using GPO contracts for two particular types of products and whether the hospitals used small manufacturers as sources in purchasing them.

This review presents an analysis of the pilot study undertaken by the GAO, in order to provide the basis for improving the technique and process of a potential larger study, as appropriate. This review examines the methodology the GAO used, as well as the presentation of the data, methods, and findings.

Comment on Conclusions of the Pilot Study

The GAO qualified its report at the outset, in essence asserting that the findings ought not to be taken as meaningful:

> "This study was exploratory, testing the feasibility of collecting price and purchase data for medical devices, and will be followed by a broader study covering more areas, devices, GPOs and hospitals." (p. 2)

Notwithstanding this disclaimer, the GAO report went on to conclude that,

> "In summary, for the hospitals that we studied, a hospital's use of a GPO contract did not always guarantee that the hospital saved money: GPOs' prices were not always lower and were often higher than prices paid by hospitals negotiating with vendors directly." (p. 3)

The GAO's conclusion about whether hospitals "saved money" may not be warranted. The scope, methods, and data that the GAO used were too limited to lead to such a definitive

conclusion. Furthermore, consideration of price alone may not suffice to address the economic value that GPOs can bring to hospitals. The authors of the GAO study acknowledged some of these other factors, but did not incorporate them in the analyses described in the report.

Comments on the Study Methodology

The GAO pilot study had two aims: 1) to determine the extent to which hospitals in a single market saved money by using GPO contracts to purchase safety needles and pacemakers, and 2) to determine the relative amount of purchases of these devices from small manufacturers. GAO analysts obtained one year's data about purchases of pacemakers and safety needles from 18 hospitals in a single metropolitan area market. According to the GAO, pacemakers and safety needles were selected for examination "because they are two types of devices that are commonly purchased by hospitals." Prices for these two products through GPO-negotiated contracts were compared with prices hospitals were able to obtain by shopping on their own.

Detailed comments on the approach used in the pilot study follow.

- **Product Selection:** Pacemakers and safety needles are indeed commonly purchased by hospitals. Furthermore, inclusion of both types of products offers a look at two quite different types of products, each of which comprises a range of models whose characteristics may drive pricing distinctions. Safety needles represent a low cost, high volume, commodity type product (even though many variations of safety needles are produced), while pacemakers are complex , high cost, lower volume medical devices that are generally more differentiated and subject to particular patient indications and distinct physician preferences.

  The question posed by the GAO's selection of these two products is not whether they are among the kinds of products that hospitals buy, but whether they can possibly represent the broad array of items that hospitals purchase. A typical hospital buys many thousands of different products over the course of a year, both directly from suppliers and through GPOs. The products that hospitals purchase include not only those in the medical/surgical category that encompasses safety needles and pacemakers, but also pharmaceuticals, capital equipment, food and other nutrition items, office and cleaning supplies, and many other categories.

  In order to reach valid conclusions regarding the economic value that GPOs may bring to hospitals, analysts should consider a more complete "market basket" that represents the broader selection of the types of purchases that hospitals make. And, as will be discussed below, such a market basket comparison should consider the volume of purchases of different types of products, to explore whether a hospital buying through a GPO or outside of a GPO can save money overall, not just on a select few items.

- **Volume of Purchases:** In limiting its analysis to price differences among selected models of the two products chosen for analysis, the GAO report ignores the impact of the combination of price and volume on savings.

While the GAO report cites price differences for particular product models, it gives no data on the numbers of models purchased at their respective prices, some of which are higher as negotiated via GPOs and some of which are lower as negotiated via GPOs. Savings for a particular item accrue not from unit price alone, but from the product of price and volume of purchases. For example, suppose a hospital bought a total of 40 units of a particular product—models A, B and C—at GPO-negotiated prices and 40 units at direct-from-manufacturer pricing, with the prices and volumes shown below.

	Model A		Model B		Model C		Total Outlay
	Price	Units	Price	Units	Price	Units	
GPO	$1,100	10	$900	9	$990	21	$39,890
Direct	$1,050	11	$850	10	$1,100	19	$40,950
Advantage	Direct	-	Direct	-	GPO	-	GPO

Here, the non-GPO pricing is favorable on two of the three models, but the total outlay for all purchases is lower via the GPO because the high-volume product was priced lower in the GPO contract. Therefore, it may be insufficient, and perhaps misleading, to report prices of product models in the absence of information about quantities bought.

- **Product and Hospital Sample Size:** As a group, the 18 hospitals in the GAO pilot study sample purchased a total of 121 models of pacemakers and a total of 196 models of safety needles. However, price comparisons were only possible for subsets of these models, since not every hospital purchased each model, and not every model was purchased using a GPO-negotiated price as well as a non-GPO price. This need for direct comparison resulted in comparisons of 42 models of pacemakers and 23 models of safety needles. The ultimate comparison, however, between GPO prices and prices hospitals negotiated on their own was among only 41 pacemaker models and 6 safety needle models.

  The report is not entirely clear about the minimum number of observations that were required to make a price comparison. One footnote says, "Price comparisons include instances in which only the purchases of two or three hospitals could be included." A legend used for several figures reads, in part, "Median prices were calculated and used in comparisons that included more than one GPO-negotiated price or hospital purchasing on its own." In any case, these appear to reflect very few observations.

  These price comparisons included instances in which only very small numbers of hospitals purchased a particular model of a product. Clearly, the need to establish a subset of product models purchased via both the GPO route and the non-GPO route among the sample of hospitals in one metropolitan area severely limited the data points that could be analyzed, including the number of product models and the number of hospital purchases, bringing into question the validity of the study's conclusions.

  With regard to the number of hospitals sampled, many variables affect what constitutes a reasonable sample size. One version of a test that would generate statistically reliable results would require a sample of some 400 hospitals.

- **Potential Reporting Artifact in Price Comparisons:** The report does not say whether the large drop-offs from the numbers of models purchased by any hospital—121 for pacemakers and 196 for safety needles—to the number of models for which comparisons were actually made—41 for pacemakers and 6 for safety needles—was due to the absence of GPO purchases or non-GPO purchases. If comparisons for many models were not possible because most models were purchased only via GPOs, this would indicate that hospitals prefer this avenue of purchasing compared to non-GPO purchasing. Such instances where hospitals could not find lower non-GPO prices, and therefore did not purchase models outside the GPO contract, would not have been included in this study. It is also possible that some of the drop-offs from the number of models purchased to those for which comparisons were possible were due to instances where a model was not included in a GPO contract, but was purchased independently by a hospital from a manufacturer. In any case, the prevalence of instances in which GPO prices were lower than non-GPO prices among all models purchases is unknown.

- **Use of Median Price:** When more than one hospital purchased a particular device, the GAO used median price as a measure. Median price (i.e., the middle price, above which and below which there are an equal number of price observations) may not reflect the distribution of actual prices paid, especially when the sample number of prices is small. A median price does not account for the relative magnitude of the prices above and below it. Mean (average) price would be a more useful measure, since it accounts for the volume (number) of purchases at each price, and thus would enable comparing actual expenditures for the items purchased via GPOs and independently of GPOs.

- **Hospital Size:** The GAO study took into account the size of the hospital in determining savings in purchasing through GPO contracts, and found that small (<200 beds) and medium (200-499 beds) hospitals did better with GPO contracts (i.e., saved more on GPO-negotiated prices relative to prices they negotiated independently) more often than larger (>500 beds) hospitals. This is consistent with the expectation that hospitals that are not large enough to generate economies of scale, with respect to the volumes of products they purchase and to the ability to maintain sufficient dedicated purchasing staff and infrastructure, stand to benefit from buying through GPO contracts.

- **GPO Size:** The GAO study sought to discern a relationship between GPO size and price for the two types of products studied. According to the report,

  > "The advantage or disadvantage of GPO prices varied by the model purchased and size of hospital – but lacked a clear relationship to size of GPO.... Hospitals of all sizes using a large GPO's contracts almost always saved money on safety needles but often paid more for pacemakers, compared to those using smaller GPOs' contracts. Large GPOs would be expected to achieve price savings consistently." (p. 11)

  This mixed result may have nothing to do with the size of the GPO, but rather with the nature of the purchasing process. It seems likely that savings would be more often seen in GPO pricing of products with more standard models, including commodities such as safety needles, rather than with more differentiated products, such as pacemakers. In particular,

manufacturers may be less willing to give price breaks to GPOs on novel, top-line devices than for commodity products. Hospitals buying opportunistically on the spot market may well do better in these instances. Indeed, such opportunistic buying may be facilitated when hospitals can "shop" a known GPO-negotiated price as a starting point in negotiating an independent price. However, this does not mean a manufacturer will always make the lowest price available to any hospital on any day.

- **Manufacturers' Administrative Fees to GPOs:** The GAO study mentioned in a footnote, but did not take into account quantitatively, manufacturers' administrative fees to GPOs. Generally, GPOs pass along a significant share of these administrative fees to their member hospitals. A large hospital that regularly buys through a GPO contract could realize hundreds of thousands of dollars in such fees. These fees returned to hospitals may significantly offset the instances where there is an apparent price advantage of purchasing outside of a GPO contract. That would be particularly true vis-à-vis the GAO's findings concerning safety needles, where deviations in median prices for different models ranged between only one and five percent.

- **Savings in Operating the Purchasing Function:** The GAO analysis acknowledges that GPOs may produce savings for hospitals in ways other than the price of goods, but does not take these savings into account. The report states,

> "According to GPOs and a GPO trade organization, benefits that GPOs provide to member hospitals include, in addition to lower prices, reduced costs due to hospitals being able to reduce the size of purchasing departments, as well as assistance with product-comparison analysis and standardization of products." (pp. 6-7)

Indeed, a recent university study that looked at this question found that typical hospital could save approximately $150,000 per year on its costs of purchasing administration.*

- **Volume-dependent Prices:** The report cites both GPO-negotiated prices and non-GPO prices without reference to anticipated or actual purchase volumes of the various product models. In practice, the price for any given model of a product is often tied to the volume purchased of that model. The report acknowledges, yet ignores in its analysis, the role of volume in setting prices:

> "The more of a product that a hospital purchases, the lower the price per unit it may pay the manufacturer. A hospital's price may also vary depending upon the share of a product it purchases from a manufacturer. For example, a hospital that buys only 25 percent of its cardiac stents from one manufacturer may pay nearly three times more per stent than one that purchases all its stents from that manufacturer." (p. 7)

* Eugene S. Schneller, Arizona State University School of Health Administration and Policy, "The Value of Group Purchasing in the Health Care Supply Chain," April 2000.

Price also is subject to other market conditions (e.g., higher supply or higher demand at the time of the price negotiation). Such within-model price variations may apply whether the purchase price is negotiated via a GPO or directly between a hospital and a vendor. Further, the price structure for volume purchases by hospitals through GPOs may be different than the price structure on the spot market at any given time. Quoting prices out of the context of purchase volume and other market conditions provides an incomplete picture of savings within, as well as across, models of any given product.

- **Quality-dependent Prices:** One of the factors affecting the magnitude of price discounts is the range of technical quality among product models. As noted above, while some pacemaker models may be regarded as having similar attributes, other models possess considerable ranges in technical attributes to address various patient indications and physician preferences. Manufacturer willingness to agree to a lower price may depend on the qualities of particular device models. For example, a manufacturer may be willing to give sizable spot market discounts on a large number of commodity models, but less willing to commit to similarly large discounts for its top-line pacemakers with a large GPO. Thus, comparing the magnitude of price differences from one model to another does not account for quality differences among these models or willingness of manufacturers to provide smaller or larger discounts from one model to another.

Comments on the Presentation of Data, Methods, and Findings

Several issues arise when considering the presentation of the results and data collected for the pilot study. These issues concern the language used in the report as well as the explanation of the use of the data.

- **Summary of Results:** Within the text of the report, results are presented in terms of outliers (e.g., " … up to 26 percent lower … up to 39 percent higher…" on p. 3). The distributions of the observed price differences are not discussed in the text. Certain figures display price differentials in the form of bar graphs, although many readers may interpret these as representing the number of times there is a price differential. Instead, the number of bars simply represents the number of product models for which any comparative price data was available for a GPO-negotiated price and a price negotiated directly by a hospital and a manufacturer.

- **Magnitude of Savings and Costs:** Because the report does not account for purchase volume, its bar charts only reflect median observed price differences for models for which comparative data was available. As such, these bar graphs provide no information regarding the net savings for a product realized through GPO-negotiated prices. Indeed, no graphical representations are given for price differentials among models of safety needles; only results for pacemakers, which demonstrated much greater price variation, are displayed.

  On p. 12, the report notes, "For different safety needle models, median GPO-negotiated prices exceeded prices negotiated by a hospital buying on its own by from 1 percent to 5 percent." However, when discussing the opposite result—savings from GPO pricing—on p. 14, the report minimizes results in a similar range: "…the GPO-negotiated price was not

much lower—from 1 to 6 percent—than what they [small hospitals] paid on their own." This subtle difference in characterization ("…not much lower…") favors non-GPO pricing results.

- **Small vs. Large Manufacturers:** The report states, "Regardless of whether a GPO contract was used, hospitals bought pacemakers and safety needles predominantly from large manufacturers. " (p. 18) This indicates that factors other than the influence and buying power of GPOs affect the selection of a small manufacturer versus a large manufacturer, and that there are many avenues open to manufacturers to market to hospitals, which make the ultimate buying decision.

Conclusion of This Review

There are a number of mainly methodological issues that call into question the report's general finding that , "a hospital's use of a GPO contract did not always guarantee that the hospital saved money…." As was readily acknowledged by the authors, the study was based on a very narrow set of information, and was really intended just to "[test] the feasibility of collecting price and purchase data for medical devices."

In examining comparative prices of the selected products, the study did not make important calculations that might have shown what hospitals' total outlays would be based on the mix and volume of products actually purchased. Moreover, the study findings did not consider the interplay of price with other factors that contribute to the economic value that GPOs can bring to hospitals. A more comprehensive analysis of a larger data set might well lead to a different conclusion.

Appendix C
Submission by HIGPA

Adopted Unanimously by the HIGPA Board of Directors - July 24, 2002
Delivered to the United States Senate - July 29, 2002

HEALTH INDUSTRY GROUP PURCHASING ASSOCIATION

CODE OF CONDUCT PRINCIPLES

INTRODUCTION

Hospitals and other health care providers have one principal objective: providing high quality care at an affordable price. Achieving this objective is always difficult, but it is particularly challenging now given a steady rise in the costs of health care items and services, and a sharp decline in payor reimbursement levels.

Group purchasing organizations (GPOs) — which enter into contracts with suppliers on behalf of their provider-members — help providers achieve their objectives of providing quality, affordable health care. GPOs do this in several ways. Most importantly, GPOs leverage purchasing power. That is, GPOs represent large numbers of providers and, as such, are able to negotiate lower prices with suppliers for a particular item than most individual providers, acting on their own, generally could.

GPOs also help their members avoid certain costs. For example, the process of procuring items and services — defining institutional needs, identifying quality products, preparing requests for proposal, analyzing responsive bids, and negotiating contract terms — requires specialized personnel, and is both time consuming and costly. GPOs, which are funded in large part by the fees that they receive from suppliers, are able to furnish those procurement services to their members at a minimal, or no, cost.

The services GPOs provide are of critical importance, especially during an era when providers are faced with a wide-range of challenges that put added constraints on the financial well-being of providers. The challenges include:

- More than 40 million Americans without health coverage;
- Severe hospital and health facility workforce shortages;
- Increasing administrative and regulatory burdens;
- Serious challenges in health care liability insurance;
- Skyrocketing costs for many critical new health care products and services;
- The increasing need for standardization of care and product use to improve patient safety, eliminate adverse events and reduce supply costs;
- Reimbursement systems that erect barriers to full deployment of new drugs and technologies;
- Rising costs and declining reimbursement; and
- A new emphasis on readiness in the wake of September 11.

In rising to these challenges, health care providers have pursued strategies to assure the highest level of uninterrupted care for their patients. At the same time, health systems have an obligation

— imposed by public and private payers of care — to deliver such services in the most efficient, cost-effective manner possible. In recognition and appreciation of this obligation, now more than ever before, health systems need access to the cost-saving tools and resources of group purchasing to manage growth in health care costs.

The Health Industry Group Purchasing Association (HIGPA) — in consultation with its member organizations — has prepared these Code of Conduct Principles to help ensure that providers have access to group purchasing organizations that offer necessary services at the lowest possible cost.* The principles cover several areas, including legal compliance, disclosure of vendor payments, conflicts of interest, product innovation, and a diverse manufacturer base with access to the GPO contracting process.

The organizations within HIGPA recognize that cooperation among health care providers is critical to ensure that patients' best interests are always served. Therefore, we collectively affirm our commitment to the following initiatives aimed at assuring patients' receipt of the highest quality care.

HIGPA's GPO Members are committed to observing these Principles, and to implementing company-specific compliance policies and procedures based upon each GPOs unique business structure and relationships. The Principles set forth below underscore the group purchasing industry's commitment to improving health care and advancing technological innovation at the most manageable cost to providers of care and their patients. These initiatives are designed to assure the operation of a thriving, innovative and competitive health care marketplace. Each GPO shall, at a minimum, incorporate these principles into its own Code of Conduct. Further, each GPO shall be committed to the full implementation of these Principles and shall not take any action that would be contrary to the intent and purpose of these Principles.

* These principles were developed through collaboration of HIGPA members and other trade association and industry members. The adoption of these principles affirms the best practices within the industry. Adoption of these principles reflects each GPO's commitment to the highest standards and is not a reflection upon any individual company's past actions or programs.

I. Principles

A. Compliance with Applicable Laws

Each GPO shall comply with applicable laws. Each GPO shall stay abreast of changes and new developments in the law and provide compliance training, guidance and education regarding applicable laws for directors, officers and employees.

B. Conflict of Interest Policies

1. *GPO Employees*

a. Each GPO shall implement internal policies to require that employees who are in a position to influence the GPO contracting decisions do not accept any gifts, entertainment, favors, honoraria or personal services payments (other than those of Nominal Value) from any Participating Vendor.

b. Each GPO shall implement internal policies to require that none of its employees who are in a position to influence the GPO contracting decisions for Participating Vendors have an Individual Equity Interest in such Participating Vendors.

2. *GPO Non-Employee Officers, Directors, or Advisors*

a. Each GPO shall implement internal policies to require that any non-employee officer, director, or member of an advisory board of a GPO, in a position to influence the GPO contracting decisions, who accepts any gifts, entertainment, favors, honoraria or personal services payments (other than those of Nominal Value) from any Participating Vendor discloses such transactions to the appropriate governance body and is recused from any negotiations or decisions relating to such Participating Vendor.

b. Each GPO shall implement internal policies that require that any non-employee officer, director or member of an advisory board or body of a GPO discloses Individual Equity Interests in any Participating Vendor to the appropriate governance body and is recused from any negotiations or decisions relating to such Participating Vendor.

3. *GPO Corporate Equity Interests*

a. Each GPO shall implement internal policies ensuring that the GPO does not have any Corporate Equity Interest in any Participating Vendor of Clinical Products or Services, unless the acquisition of such Corporate Equity Interest demonstrably benefits the GPO's Members by creating a source of a Clinical Product or Service where there is otherwise no other source, or very limited sources.

b. Each GPO that has a Corporate Equity Interest in a Participating Vendor shall disclose such equity interests to Members in writing. Each GPO in which a Participating Vendor has a Corporate Equity Interest shall disclose such equity interest to Members in writing. Such disclosure should be made (a) at the time the Corporate Equity Interest is obtained if the GPO already has a contract with the Vendor or (b) at the time the GPO enters into a contract with the Vendor if the GPO does not already have a contract with the Vendor, and in each case, at least annually thereafter. GPOs shall also publicly disclose such Corporate Equity Interests.

c. Each GPO that has a Corporate Equity Interest in a Participating Vendor will impose no obligation, commitment or other requirements or restrictions that in any way obligates any Member to purchase goods or services from such Participating Vendor.

C. Member Relations, Product Evaluation & Vendor Grievances

GPOs shall be committed to identifying and making available to Members innovative products and technologies in order to promote high quality and cost-effective health care, and to the free exchange of information relating to clinical, safety and technological and other innovations within the industry. Toward that end, each GPO shall incorporate the following principles in its contractual and business relationships with Vendors and Members:

1. *Member Communications & Relationships with Vendors*

a. Each GPO shall implement its policies and contracts in a manner that permits its Members to (a) communicate directly with Vendors, including Vendors that do not have current contracts with a Member's GPO, (b) assess Products or Services provided by a Vendor that does not have a contract with the GPO, and (c) purchase Clinical Preference Products or Services directly from Vendors that do not contract with the GPO.

b. Each GPO shall implement a contracting process that (a) informs potential Vendors of the process for seeking and obtaining contracts with the GPO and (b) provides any and all interested Vendors with the opportunity to solicit contracts, including but not limited to posting such information on a GPO's website and promptly responding to Vendor inquiries regarding contract opportunities.

2. *Innovative Product Evaluations*

Each GPO shall individually engage in or otherwise participate in processes and programs that routinely evaluate and provide opportunities to contract for innovative Clinical Products or Services.

3. ***Vendor Grievances***

Each GPO shall adopt policies and procedures that endeavor to address Vendor grievances related to access for innovative Clinical Products or Services.

D. Use of Contracting Tools

The goals of the GPO contracting process include promoting quality of patient care and achieving price savings and cost reduction for Members. In order to better achieve those ends, GPOs seek to foster competition among Vendors. To that end, GPOs have contracting tools that include sole source contracting, commitment level requirements, contract length and multi-product line discount arrangements. GPOs should use these tools either alone or in combination only in contracting arrangements that achieve the foregoing goals. These goals are most important in relation to Clinical Preference Products or Services. To the extent that multiple contracting tools are used in the contracting process, each GPO shall consider the following factors in each contractual arrangement to achieve the aforementioned goals: market share of the Participating Vendors, the size of the GPO, the number of Vendors available to provide the relevant product or service, ability of the Participating Vendor to meet the needs of the GPO's Members, and the occurrence of innovation in the relevant product or service category.

E. Compliance, Certification & Implementation

1. ***Compliance Officer***

Each GPO shall designate a compliance officer who will be responsible for overseeing compliance with the Code of Conduct adopted by the GPO and the fulfillment of the GPO's reporting requirements.

2. ***Certification***

The management of each GPO member of HIGPA shall certify annually to HIGPA that they are in compliance with the principles. HIGPA will publish an annual report identifying those HIGPA members that have certified their compliance. This certification shall constitute a requirement for membership in HIGPA.

3. ***Implementation, Transition & Updating***

a. Each GPO shall adopt a transition plan supervised by its compliance officer in keeping with these principles in the event (a) an entity becomes a Participating Vendor to a particular GPO, (b) an employee (i) is in a position to influence the contracting decision for Participating Vendors and currently has an Individual Equity Interest in such Participating

Vendors or (ii) is hired or transferred to a position in which the employee would influence the contracting decision for Participating Vendors and has an Individual Equity Interest in such Participating Vendors, or (c) other situations arise to which these principles apply. Each GPO shall seek regular, periodic and timely disclosure of information covered by these conflict of interest principles by directors, officers, employees and advisors.

b. HIGPA shall assess and update the principles consistent with newly identified best practices and as business practices change to ensure that the goals of avoiding conflicts of interest and promoting competition continue to be achieved.

F. Reporting & Education

1. *Industry-Wide Survey*

To promote competition and to evaluate on an ongoing basis the benefits of group purchasing, HIGPA will evaluate and implement, consistent with the antitrust laws, periodic surveys and aggregate reporting of industry-wide information relating to value through cost savings and administrative efficiencies of GPO relationships.

2. *Web-Based Vendor Directory*

In order to foster innovation, HIGPA, with the support of its GPO members, shall make available a web-based directory where Vendors can post product information, including information about products that the Vendors consider to be new and innovative.

3. *Educational Programs*

HIGPA shall coordinate the development and implementation of industry-wide educational programs focusing on new developments related to clinical innovations, contracting processes and programs, patient safety, public policy, statutory and regulatory requirements and best practices regarding compliance and Code of Conduct principles. As part of this process, the industry will draw upon representatives of GPOs and any Vendors to promote processes and programs to assure availability of new and innovative products to Members through the GPO contracting process.

G. Disclosure of Vendor Payments

1. *Written Agreement*

Each GPO shall have a written agreement with each Member or Member's agent that authorizes the GPO to act as a purchasing agent to negotiate contracts with Vendors to furnish goods or services to each Member.

2. ***Disclosure of Acceptance of Payments***

Each GPO shall disclose in writing to each Member or Member's agent that it receives Payments from Participating Vendors with respect to purchases made by or on behalf of such Member.

3. ***Disclosure of Payments Related to Purchases***

Each GPO shall annually report, or cause to be reported, to each Member or Member's agent the amount of all Vendor Payments received with respect to purchases made by or on behalf of the Member.

4. ***Disclosure of Payments Not Allocable to Actual Purchases***

Each GPO shall annually report, or cause to be reported, to each Member or Member's agent the amount of Payments received pursuant to a Vendor contract that was utilized by that Member, but is not allocable or otherwise reported with respect to the actual purchases of that or any other Member.

H. **Safety, Cost-Reduction & Clinical Comparability**

GPOs shall support programs and processes, such as displaying Universal Product Number ("UPN") or machine-readable bar codes at the unit-of-use level, or other programs and processes, that provide for clinical comparability and improve and promote patient safety and supply-chain cost reduction.

I. **Diversity**

GPOs shall offer or participate in programs that promote diversity among Vendors to include women and minority-owned Vendors.

II. Definitions

A. **"Clinical Preference Products or Services"** shall mean those Clinical Products or Services which require substantial training to learn to use and which have a demonstrable effect on patient care outcomes. Accordingly, they are products or services for which a provider has a particular preference based on factors such as the provider's training and experience, the performance or functionality of such products in a clinical setting and patient clinical outcomes.

B. **"Clinical Products or Services"** shall mean products or services used by providers directly in the provision of health care services to patients.

C. **"Corporate Equity Interest"** shall mean securities, options, warrants, debt instruments (including loans), or rights to acquire any of the foregoing.

D. **"GPO"** shall mean any entity that as all or part of its business activities is authorized to act as the agent of a provider of health care services to enter into contracts with Vendors ("Vendor Contracts"), pursuant to which Vendors agree to sell or furnish goods or services consistent with the terms set forth in the Vendor Contracts. GPOs do not typically take title to products.

E. **"Individual Equity Interest"** shall mean securities, options, warrants, debt instruments (including loans), or rights to acquire any of foregoing, provided, however that the term shall not include: (a) interests in mutual funds or (b) interests held in a blind trust in which all investment decisions are independently managed by a third party and the existence and trust terms are fully disclosed to the appropriate governing body to ensure that the neutrality of the GPO contracting decisions are protected.

F. **"Members"** shall mean any provider of health care services to patients that has an agreement (directly or through an authorized agent) which authorizes the GPO to act as the provider's purchasing agent to negotiate contracts with Vendors to furnish goods or services to the provider.

G. **"Nominal Value"** shall mean any item, service or other thing of value (not including cash or cash equivalents) that does not exceed $50 per instance or $100 in any given calendar year. Any item, service or other thing of value that costs $10 or less shall not be counted toward the $100 annual limit.

H. **"Participating Vendor"** shall mean, with respect to a particular GPO, a Vendor that has a contract or submits a formal bid or offer to contract with such GPO to provide goods or services to the GPO's members.

I. **"Payments"** shall mean all payments by a Vendor of goods or services to a GPO as part of any agreement to furnish goods or services to Members.

J. **"Vendors"** shall mean manufacturers, distributors, suppliers or other entities that sell goods or services to Members.