

GPOS AND THE HEALTH CARE SUPPLY CHAIN: MARKET-BASED SOLUTIONS AND REAL-WORLD RECOMMENDATIONS TO REDUCE PRICING SECRECY AND BENEFIT HEALTH CARE PROVIDERS

Carl A. Johnston, Ph.D. * and *Curtis D. Rooney, Esq.* **

In *An Empirical Analysis of Aftermarket Transaction by Hospitals*, the authors Robert E. Litan, Hal J. Singer, and Anna Birkenbach suggest public policy changes to the law governing hospital group purchasing organizations (GPOs).¹ Their recommendations, however, appear to be based on a common fallacy and on selective data. Therefore, their conclusions are questionable. In response, we address their arguments, raise questions about the data used, and make our own public policy recommendations that promise to save the health care industry billions of dollars without disrupting the current system. We strongly believe Congress should pursue our important recommendations.

In the spirit of public debate, we asked the authors to provide us the data on which they based their published conclusions, so that we could empirically test the veracity of these figures for ourselves. Confidentiality clauses in the authors' contract with the company providing the information

* Carl A. Johnston, Ph.D. is Research Associate Professor at Chapman University's Economic Science Institute, a senior fellow at the National Center for Policy Analysis and a visiting post-doctoral research fellow at the Interdisciplinary Center for Economic Science at George Mason University (ices.gmu.edu) where he studies electricity and health care market reforms. He received his B.A. from Stanford. More on his work is available at www.economicssystemdesign.com.

** Curtis D. Rooney, Esq. is President of the Healthcare Supply Chain Association (HSCA) (formerly the Health Industry Group Purchasing Association (HIGPA)), the leading organization that advocates on behalf of health care group purchasing organizations (GPOs) in Washington, D.C. He received a Bachelor of Arts from The George Washington University and a Juris Doctor from The Catholic University of America, Columbus School of Law.

1. Robert E. Litan, Hal J. Singer & Anna Birkenbach, *An Empirical Analysis of Aftermarket Transactions by Hospitals*, 28 J. CONTEMP. HEALTH L. & POL'Y 23, 37-38 (2011).

reportedly prohibit dissemination of the relevant data.² As a result, our options were to either: (1) invest considerable resources to purchase the data from its purveyor to review, verify, or disprove the accuracy of the data by observation or experiment; or (2) attempt to rebut the findings of the study without the benefit of the data. Lacking the requisite resources, we undertake the latter course.

As a result, we provide an analysis of the authors' arguments and suggest that both the aftermarket and GPO market offer hospitals and other health care providers important alternatives for cost-reduction strategies. Rather than enacting the potentially disruptive public policy prescriptions of the authors—changes that would only benefit medical device manufacturers to the detriment of hospitals, patients, physicians, and taxpayers—we offer a market-based public policy alternative regarding the secrecy of medical device product pricing, from which hospitals and other health care providers would benefit.

Published in the most recent edition of this *Journal*, the original article contains the following Editor's note: "A 2010 unpublished study by the authors addressed the topic of group purchasing organizations ("GPOs") and their effect on health care costs. The following article presents new methodology and data to support the authors' views."³

It should be noted, however, that two of the authors did publish a similar work based on economic and antitrust arguments containing a nearly identical title, theories, and conclusions. The report is entitled *Do Group Purchasing Organizations Achieve the Best Prices for Member Hospitals? An Empirical Analysis of Aftermarket Transactions*.⁴

This piece, funded by the Medical Device Manufacturers Association (MDMA), has been used in conjunction with the group's efforts to alter public policy in favor of the \$200 billion medical device industry. Moreover, questions remain regarding the data used in the aforementioned study and how it was obtained and funded. These questions are all the more important in light of MDMA's longstanding opposition to GPOs, including various tactics such as public relations, litigation, and financial support for non-peer reviewed academic studies of questionable value.

The earlier report by Litan and Singer, in summary, is based on two claims: (1) GPO compensation through vendor payments gives a strong

2. *See id.* at 29 n.29.

3. *Id.* at 23 ed's n.

4. Press Release, Med. Device Mfrs. Ass'n, GPOs Fail to Secure the Best Prices for Patients and Hospitals (Oct. 6, 2010), *available at* www.medicaldevices.org/node/795.

incentive to hospitals and GPOs to overpay for medical devices to the detriment of Medicare and Medicaid, forcing competitors out of the market; and (2) that so-called *aftermarket* transactions conducted after completion of a GPO agreement yield prices that are substantially lower, showing that GPOs do not achieve cost-savings.

The first argument was summarily dismissed by the 8th Circuit Court of Appeals' holding in *Southeast Missouri v. C.R. Bard, Inc.*⁵ In fact, the court described one of the authors' expert reports in this case as lacking any empirical support.⁶ The report was also rejected as "unbelievable" by practitioners in the field, including the Mayo Clinic, New York-Presbyterian, BJC Healthcare, Memorial Hermann, and other large hospitals.⁷

The second argument, unfortunately, falls prey to a *post hoc ergo propter hoc* fallacy. Specifically, the authors come to their public policy conclusion based *solely* on the order of events, rather than taking into account other factors that might rule out the connection. In other words, any cost savings found in the aftermarket studied here are based on the fact that the selected items have already been subjected to the rigors of the GPO market. Rather than disabling the GPO market through public policy changes, as the authors and the medical device community suggest here, the more prudent course is to celebrate and support cost containment methods.

The authors' conclusion, that the GPO funding mechanism of supplier-paid administrative fees should be changed because the aftermarket auctions provide greater savings than the GPO market, fails to take into account the reported experience of the nation's purchasing professionals. In fact, purchasing professionals from many of the largest health systems in the United States rejected the authors' public policy prescriptions in a letter stating: "changing the current GPO funding mechanism would mean

5. *Se. Mo. Hosp. v. C.R. Bard Inc.*, 642 F.3d. 608, 616-17 (8th Cir. 2011).

6. *Id.* at 616-18 (affirming a district court's grant of summary judgment dismissing a hospital's claim that a medical device company's contract with a GPO violated antitrust laws. The plaintiffs' expert asserted that GPO purchasing power could allow GPOs to impose a small but significant non-transitory increase in price, but the Court found that plaintiffs' expert had failed to provide any facts—or even anecdotal evidence—to support the plaintiffs' claims).

7. Letter from fourteen of the nation's largest hospitals (including Mayo Clinic, New York-Presbyterian Hosp., Mem'l Hermann, *et al.*) to Eamonn P. Hobbs, Chairman of the Board, Med. Device Mfr. Ass'n (Dec. 13, 2010) (on file with author).

additional costs for hospitals and other health care organizations, thus driving health care expenditures even higher.”⁸

In the *Journal* article, the authors’ thesis is summarized as follows:

If a GPO is receiving an administrative fee equal to a percentage of the proceeds, the GPO’s incentive to seek out the lowest prices for hospitals is weakened. Moreover, in the presence of administrative fees, medical suppliers might be induced to bid less aggressively on price, as some of their resources are shifted towards competing for the largest administrative fee. The resulting diminution of competition might raise net costs for hospitals and government—which reimburses hospital expenses through Medicare, Medicaid, and other programs—despite the savings in transaction costs and consolidation of purchasing power made possible by GPOs.⁹

In response, we take on these arguments in turn and address its conclusions below. Before we address these matters, however, we must first accurately describe the complicated work of the GPO.

I. HOW GPOS WORK

For purposes of illustration, *St. Francis Med. Ctr. v. C.R. Bard, Inc.*, a federal court case, provides a detailed review of how hospitals utilize GPOs to purchase supplies and services and how GPOs work:¹⁰

A GPO is a purchasing intermediary that negotiates contracts for medical supplies on behalf of its member hospitals . . . Hospitals voluntarily belong to GPOs to obtain (i) better prices and services from the vendors on contract, (ii) lower expenses associated with having to negotiate and administer purchasing contracts, (iii) assistance with resolving product failures, . . . [etc].¹¹

GPOs provide cost-saving methods to hospitals and other health care providers by aggregating their purchasing power. GPOs aggregate hospital supply demands to achieve lower prices similar to more familiar consumer-oriented services, such as Groupon or LivingSocial. Often owned by their

8. *Id.*

9. Litan, Singer & Birkenbach, *supra* note 1, at 25.

10. *See St. Francis Med. Ctr. v. C.R. Bard, Inc.*, 657 F. Supp. 2d 1069, 1079-1105 (E.D. Mo. 2009).

11. *Id.* at 1078.

hospital members, the function of the GPOs is to drive down rising health care costs in a highly disaggregated market. Congress, the courts, and antitrust agencies have long recognized the competitive benefits of group purchasing arrangements.¹² Although the price benefits of GPOs are an important feature, their business model is more broadly based.¹³

GPOs serve numerous functions, both organizational and economic, that allow hospitals to use purchasing power to resolve unique challenges in the health care market.¹⁴ GPOs do not take title to the supplies purchased by their hospital or health care provider members or customers. Rather, GPOs create portfolios of contracts, often with 3-year term durations (with 60 to 90 day termination clauses),¹⁵ that include relationships with wholesaler-distributors. The wholesaler-distributor takes title to the product and is responsible for the delivery of the product to the facility.¹⁶ These portfolios of contractual relationships are offered to hospitals and other health care providers. Because GPO members and/or customers are most often its owner and/or shareholder, its interests and incentives are aligned.

A. Bids and Requests For Information

The contract process begins when the typical GPO posts a “bid calendar” on a website to announce the time frame that they will be entertaining offers from suppliers of goods and services. Interested suppliers are invited to

12. See Robert E. Bloch, Scott P. Perlman & Jay S. Brown, *An Analysis of Group Purchasing Organizations' Contracting Practices Under Antitrust Laws: Myth and Reality*, Sept. 26, 2003, FTC Healthcare Hearings, available at <http://www.ftc.gov/ogc/healthcarehearings/docs/030926bloch.pdf>; see also *Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co.*, 472 U.S. 284, 295 (1985); D.O.J. & F.T.C., STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, STATEMENT 7- JOINT PURCHASING ARRANGEMENTS AMONG HEALTH CARE PROVIDERS 66 (Aug. 1996).

13. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-738, GROUP PURCHASING ORGANIZATIONS: SERVICES PROVIDED TO CUSTOMERS AND INITIATIVES REGARDING THEIR BUSINESS PRACTICES 2 (2010) [hereinafter GAO-10-738].

14. Eugene S. Schneller, *The Value of Group Purchasing in the Health Care Supply Chain*, ARIZ. STATE COLL. OF BUS., SCH. OF HEALTH ADMIN. & POLICY. 1-3 (2000), <https://www.novationco.com/media/industryinfo/GroupPurchasing.pdf>.

15. See *St. Francis Med. Ctr. v. C.R. Bard, Inc.*, 657 F. Supp. 2d 1069, 1081 (E.D. Mo. 2009).

16. *Id.* at 1105.

participate in the bid process during that period. GPOs commonly send out a Request for Information (RFI) to gather other market and utilization data for their hospital members and customers. They then use a member, client, or customer committee comprised of clinicians to evaluate the products gathered based on agreed-upon criteria.

B. Request for Proposal

The clinical committee, which is convened by the GPO, will then review the compiled information and develop contract requirements. Contract terms may specify whether the agreements will be sole source, dual source or multi-source.¹⁷ Based on this feedback, the GPOs then go to the suppliers with a Request for Proposal (RFP). During the RFP process, the GPOs gather more information, make comments on the contract, and request pricing information. They then receive the bids on behalf of their members and customers. GPOs screen non-compliant bids and begin an in-depth round of talks that include negotiations with suppliers that have responded to the RFP. The process is entirely voluntary, conducted between highly sophisticated parties, and may take months to complete.

C. Evaluation and Scoring

GPOs have diverse methods for evaluating GPO contract offers to determine who will participate in the contract award process. A GPO may use a scoring process in which about half of the score is influenced by price.¹⁸ Non-financial criteria determine the other half of the score, including: the breadth of similar products offered by the supplier, the number of field agents to service contracts, product and patient safety considerations, the quality of manufacturing facilities, and the amount of product that is outsourced to third-party manufacturers.¹⁹ GPOs permit the clinical committee to determine if any suppliers do not meet the requirements to proceed. Some products may get special scoring because hospital staff prefer these items. Even when clinicians decide to place a product on contract, however, they remain free to purchase “off contract” even when products are included on a “sole source” basis.²⁰

17. *St. Francis Med. Ctr.*, 657 F. Supp. 2d at 1079.

18. *Id.* at 1083.

19. *See id.*

20. *Id.* at 1079-81.

Additionally, hospitals may also compete directly with GPOs. For example, a large hospital or system might organize what is called a “bulk buy.”²¹ In a bulk buy, hospitals that have a budget and are willing to purchase certain volumes may make a spot purchase, thereby obtaining a better price point for a volume specific product purchase. GPOs will often coordinate among multiple members and/or customers to increase the value of the spot purchase. But other non-GPO businesses serve this market, too.²²

D. Terms and Conditions

It is during this negotiation process that all terms and conditions are worked out, including pricing, administration fees, legal matters (e.g., indemnification, regulatory compliance, confidentiality, etc.), and basic business terms (e.g., failure to supply clauses, performance requirements, etc.). GPOs and members negotiate whether the contract includes a tiered pricing structure, which encourages members and customers to purchase a greater product volume in exchange for a better per unit price.²² For example, a contract could include a commitment to buy 85% of a hospital’s supplies from a given supplier in order to become eligible for a better price than if it committed only 60%.²³ Buyers frequently choose lower commitment tiers, despite having to pay higher prices. Finally, all hospitals and health care providers are free to make purchases “off contract.”²⁴

E. Best and Final Offer

At the end of the negotiation process, the GPO requests best-and-final price offers from suppliers. For example, some GPOs have a second client committee, the Executive Steering Committee, (ESC) made up of the supply chain heads of members or clients in large health care systems, and which determines business strategy and awards the contracts (with the input and recommendations from the clinical committees). In this example, the GPO takes the completed contract to the ESC, with an analysis of key terms,

21. *Id.* at 1080.

22. ANDREW L WILSON, PHARM.D, AM. SOC’Y OF HEALTH SYS. PHARMACISTS, FINANCIAL MANAGEMENT FOR HEALTH-SYSTEM PHARMACISTS (2009).

23. *Id.* at 1081 n.19.

24. See EUGENE S. SCHNELLER, THE VALUE OF GROUP PURCHASING-2009: MEETING THE NEED FOR STRATEGIC SAVINGS 11-12 (2009) [hereinafter SCHNELLER 2009], https://www.novationco.com/media/industryinfo/value_of_gpo_2009.pdf.

pricing impact based on historic utilization, and the ESC determines which contracts will be awarded. At the end of the process, the hospital has a complete schedule of prices and terms of sale for most, if not all, of the products it uses for the next three years. The hospital can then order those products at its convenience, subject to the terms and conditions of the contract based on its level of commitment, without having to negotiate each purchase individually. Since the agreements are long-term, the amount of work saved is substantial, and the hospital can rely on the GPO to meet fiduciary obligations to keep costs down. Researchers have found that GPOs save between 10-15%.²⁵

F. Reduced Personnel Costs

In addition to cost savings derived from discounts, GPOs reduce the need for hospitals to maintain separate supply staff. A typical hospital may have only a handful of people to handle all their contracting requirements. However, in order to operate, they need tens of thousands of items of equipment, medical devices, diagnostics, therapeutics, imaging, pharmaceuticals, food services, and bulk products, to mention a few. Large hospital systems would have to spend as much as \$600,000 per system, or \$2 billion nationally, to replace GPOs with in-house staff.²⁶ In-house hospital material management personnel focus on the highest priority products and services. For most other products, they rely on what they can get from distributors or from the supplier directly with a minimum of negotiation. Using a GPO, one purchasing order can be issued where, without it, 150 to 200 purchasing orders would be required.²⁷ GPOs are designed to bring the attention of competent personnel to all areas of contracts.²⁸

25. Lawton R. Burns & Andrew Lee, *Hospital Purchasing Alliances: Utilization, Services, and Performance*, 33 HEALTH CARE MGMT. REV. 203, 205 (2008) (finding savings of 10% to 15%); see also SCHNELLER 2009, *supra* note 24, at 12 (purchasing PPI's though GPOs gave hospitals an estimated savings of 15% for orthopedic implants).

26. SCHNELLER 2009, *supra* note 24, at 5.

27. *See id.*

28. *Id.* at 4-5.

G. Manage Complex Pricing and Products

GPOs may consider the Total Cost of Ownership (TCO) rather than the price of a particular component, when reviewing bids for more complicated purchases. For some products, prices may have more than one component and the desirability of a product may be linked to factors besides price. For example, a hospital buying x-ray equipment may also require a service contract and pay separately for the hardware, software, and service. Another device may have unique features that make it hard to compare to other products. The hospital product device market is fractured into myriad segments, with significant diversity, even within narrow product categories. For example, there are numerous kinds of catheters, and selecting the right product requires expertise. Over time, new segments emerge because of product or technology innovations. Moreover, changing technology adds to competitiveness and product change. Product safety, manufacturing consistency, and a track record for consistency are other factors that a hospital has to consider given its legal liability, regulatory concerns, and need for long-term operational stability and quality control.

H. “Share-Backs”

At the end of the year many GPOs will often divide up the money that is left over after expenses and distribute it to members and/or shareholders.²⁹ The members are often the GPO’s member owners or customer hospitals. Hospitals must report these distributions to the government as an additional reduction in the price of the product paid by the hospital. This is covered under the discount safe harbor, which protects passing along those savings to hospitals as long as the federal health care programs get the benefit of the savings.³⁰

I. Strategic Use of GPO for Benchmarking

GPO agreements do not bind their hospital members or customers to any single supplier. Usually, GPO agreements set terms for multiple suppliers of competing devices. In cases where GPOs contract with a single supplier, the hospital has at least five options for buying outside of the agreement. The hospital can (1) work through another GPO—the average hospital has two to four GPOs; (2) transact directly with the supplier; (3) re-offer the RFP through a specialized reverse-auction firm; (4) use internal staff to organize

29. GAO-10-738, *supra* note 13, at 6.

30. *Id.* at 12 (“The six GPOs combined reported distributing a total of \$1.1 billion in 2008, which is 53% of the total amount of revenue reported by the six GPOs.”).

a special purpose group of hospitals to make a bulk-purchase of the item outside of the GPO setting; and, (5) buy off the shelf of a retailer or wholesaler making an acceptable offer.³¹

GPOs are flexible in how they work with clients. For example, Schneller and Smeltzer identify four different types of hospital/GPO engagement, where the hospitals use GPOs: (1) heavily for product selection and contracts; (2) as a starting point for negotiation either directly with suppliers or with another GPO; (3) to negotiate a special price for them; and (4) for additional services such as data-mining, among others.³²

Additionally, there are “regional GPOs and national GPOs. There are product specific GPOs and hospital systems that perform the role of GPOs. Each GPO offers a different set of services.”³³ GPOs “are also helpful in establishing the market price for a particular product and a starting point for negotiations for lower-priced commodity products.”³⁴ Additionally, hospitals can have different ownership links to GPOs, as it might be a sole owner, part of a consortium or system, or the GPO might be entirely independent of the hospital.

J. The CAF Transaction Fee

Vendors pay Contract Administration Fees (CAFs), or a fixed percentage paid by the supplier to the GPO as part of closing a specific sale between supplier and hospital. The average contract administrative fees paid by vendors in 2008, weighted by purchasing volume, ranged from 1.22% of customer purchases to 2.25% of purchases.³⁵ These fees defray the GPOs’ cost of overhead, deal negotiation, advertisements to clients, and other activities. The CAF offsets the cost of GPOs for: (1) maintaining staff and offices; (2) research on products; (3) promoting products to their

31. See EUGENE S. SCHNELLER & LARRY R. SMELTZER, STRATEGIC MANAGEMENT OF THE HEALTH CARE SUPPLY CHAIN: PROGRESSIVE PRACTICES FOR HEALTH SYSTEM LEADERS (2006) [hereinafter SCHNELLER 2006].

32. See *St. Francis Med. Ctr. v. C.R. Bard, Inc.*, 657 F. Supp. 2d 1069, 1078 (E.D. Mo. 2009).

33. SCHNELLER 2006, *supra* note 31.

34. *Id.* at 1079.

35. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-12-126, MEDICARE: LACK OF PRICE TRANSPARENCY MAY HAMPER HOSPITALS’ ABILITY TO BE PRUDENT PURCHASERS OF IMPLANTABLE MEDICAL DEVICES (2012), <http://www.gao.gov/assets/590/587688.pdf>.

membership; and (4) advising hospitals on the most economical way to use the products.

The CAF payment is collected by the GPO only after a supplier and hospital enter into a fixed-quantity transaction under the terms of an existing GPO-negotiated contract. Thus, the CAF can be understood as a kind of transaction fee that becomes due only when an invoice is paid, sometimes 90 days after the underlying transaction, and perhaps years after the “umbrella” contractual agreement was executed. Depending on GPO ownership structure and terms of membership agreements, some or all of the CAF may be returned to the hospital as a distribution.³⁶ These distributions must be reported to Medicare and other government payors as they reduce Medicare’s reimbursement to the hospital.³⁷

This system forces the GPO and supplier to negotiate an agreement, including CAFs, that attracts the most clients through lower prices and better terms and conditions. If the umbrella agreement is not attractive, GPO clients have the option to shop around for a better deal. Most hospitals use two or more GPOs, and therefore, clients usually are able to shop between GPO portfolios for better prices.³⁸ The CAF value generated for the GPO is a direct effect of its negotiated contracts and their attractiveness to clients. The willingness of a supplier to pay a higher CAF is based on the credibility of the GPO in getting clients to use its contracts. A GPO that has members or clients that do not use its contracts will obtain neither competitive prices nor fees. The actual quantity of goods transacted is not known at the time that the overall agreement is negotiated, and the fee amount is set and paid only after a GPO client actually places an order with the supplier. Any uncompetitive offers made by one GPO will be an opportunity for another GPO to take its business.

II. THE LITAN, SINGER, BIRKENBACH STUDY

The authors rely on data gathered by a medical device auction provider that offers reverse auctions to hospitals seeking to purchase durable

36. *St. Francis Med. Ctr.*, 657 F. Supp. 2d at 1083.

39. Interestingly, the CAF also serves an economic function. As discussed in recent literature, transaction taxes tend to reduce price volatility in a market by restraining speculation. In the GPO market, the extra cost of the transaction fee may prevent hospitals from attempting to “arbitrage” their discounts by, for example, re-selling products bought under their GPO umbrella agreements to “free-riders” outside of the GPO system.

38. *St. Francis Med. Ctr.*, 657 F. Supp. 2d at 1079.

equipment and capital goods.³⁹ The items sold at auction were generally high value items known as capital equipment that make up approximately 20% of the total GPO market. The database consists of “approximately 8,100 aftermarket transactions,” in which the winning GPO price was put up for bid after the initial GPO auction.⁴⁰ The report then states several claims based on this research. The transactions data suggest that, when exposed to competition in the aftermarket, “hospitals were able to achieve average savings of approximately 10 to 14 percent across the entire database (2001 through 2010) and a savings of 15 percent on average for 2010 data.”⁴¹

One major methodological concern with the authors’ work is that the GPO baseline numbers appear to be inaccurate. For example, the data does not appear to include information about GPO “sharebacks” to hospital members that affect the end-cost of the product. In fairness, this would probably be impossible to do because of the inherent difficulty of properly attributing “sharebacks” to a specific device purchase. Without accounting for “sharebacks,” however, there is a substantial probability that the GPO baseline is too high.

A. Lack of Randomization

The data compiled here are vulnerable to bias against GPOs for several reasons. The auctions are based on transactions of large, high-value products, which, as previously stated, make up only a fraction of the GPO market, for which prices are typically more negotiable. Even if the data were accurate, however, it is unsurprising that suppliers would give a better price negotiating directly with a hospital that is 100% committed to buy the device. By contrast, GPOs typically negotiate on behalf of a number of hospitals for more indefinite quantities. Also, the aftermarket transactions in the paper occur in a segment of the market where quantities tend to be definite by nature (i.e., as with big-ticket imaging items). In a single-unit quantity after-market transaction (e.g., MRI scanner, etc.), the commitment to the supplier is always 100% and hence, a lower price would be expected. Think of selling a house. The purchaser typically pays the seller less than the public offer amount advertised by the broker. It is rarely the case that the buyer pays more, and that usually happens during a speculative bubble before brokers have reset their pricing method to account for a “hot” market. The motivation for the seller to reduce price for an eager, qualified buyer is

39. Litan, Singer & Birkenbach, *supra* note 1, at 28 n.27.

40. *Id.* at 29.

41. *Id.* at 28-29.

to reduce their own opportunity costs while waiting for a higher bid. Another factor to consider may be the intensity of the bidder. A definite quantity contract with a specific hospital might have substantially more private value to a supplier trying to “break in” to a new hospital market than an umbrella agreement with multiple hospitals.

B. Bidders and Offerors are Self-Selected

Since the aftermarket auction always occurred after the GPO negotiation, it is reasonable to assume that neither the prospective buyer nor the supplier would make an aftermarket bid unless they both thought they could surpass the GPO benchmark. Therefore, both the buyers and suppliers are self-selecting in the sense that they all believe they can do better than the benchmark and are committed to the trade. Conversely, the population that bids in the GPO market did not have a benchmark or special commitment from which to begin negotiations. Consequently, a GPO benchmark bid for an expensive piece of imaging equipment might be high since it is made without a firm commitment to purchase a specific package of gear, maintenance coverage, and technical support. By getting down to specifics in the aftermarket negotiation, there is plenty of room for supplier and buyer to get better terms by shifting the many variables in play. The same dynamic would not apply to simpler equipment and supplies. In summary, the statistics provided are comparing two entirely different types of market participants in a way that is biased against GPOs.⁴²

C. Generalization of the Data

Because the authors do not provide the data used in this paper, we assume the data presented here is the same as the authors’ previous work. The regressions displayed in the Appendix of that paper appear to show that price reductions were significant in only five out of twenty categories of products in the auctions.⁴³ As noted before, the auctions covered a range of high-end products that make up only about twenty percent of the GPO market.⁴⁴ Because the data include only a particular type of product category, which constitutes only a small portion of the GPO market, the data presented are not representative of the whole GPO market.

42. Schneller documents cases where hospitals appear to “cherry-pick” those transactions when they want to use GPO contracts versus when they prefer to negotiate their own deals and use the GPOs terms as a ceiling.

43. Litan, Singer, & Birkenbach, *supra* note 1, at 49.

44. See Press Release, Med. Device Mfrs. Ass’n, *supra* note 4.

D. The Economic Critique

The authors' economic critique is that GPOs benefit from uncompetitive markets. We posit, however, that the opposite is true because competitive markets generate more income for GPOs. It has been established that a monopoly or uncompetitive market is less profitable for an agent, because the agent shoulders the cost of the deadweight loss generated by the uncompetitive market as well as the excess profit.⁴⁵ It is worth noting that the excess profit does not compensate for lost sales, due to lack of competition and excessively high prices. The market for hospital goods is a fiercely competitive market. If a GPO does not offer good product at price, hospitals can: (1) use another GPO (hospitals usually belong to two or more GPOs); (2) hire another GPO; and (3) complete a transaction outside of the GPO market.

To test the logic of this argument, we posit the reverse case: assume GPOs have an incentive to negotiate higher prices as Litan and Singer have claimed. If a GPO gets three dollars for a 3% fee on a \$100 purchase, the GPO will want to get six dollars by negotiating a price of \$200. However, this argument assumes that purchase patterns are entirely static and that a hospital will always purchase X number of units from Supplier Y and has no opportunity or incentive to purchase fewer units from Supplier Y or to purchase more units from Supplier Z. From the GPO perspective, under the old contract, they sold 100,000 units at \$100 each, and received fees of \$300,000. If the GPO negotiates an additional 5% reduction in the unit price, from \$100 to \$95, it can attract more contracts usage. If clients purchase the same amount of units, then the GPO will be down \$15,000. If the clients increase their usage by 10%, to 100,000 units, then the GPO will receive \$313,500 in fees. In other words, the volume of sales determines the level of fees paid to a GPO just as much as the size of the fee. By negotiating an additional 5% discount, the GPO's clients need only increase their utilization by 5.3% for the fees generated to remain the same for the GPO.

E. Deadweight

The idea that GPOs could profit from encouraging a product market that is uncompetitive, as the authors have suggested here, is theoretically and mathematically improbable. A GPO that takes a fixed percentage of revenues will earn more from a competitive market operating at competitive equilibrium levels than it could from an uncompetitive market. Such markets have high prices and create big pools of unmet demand called

45. See generally GAO-10-738, *supra* note 13.

“deadweight loss.”⁴⁶ This deadweight loss is shouldered by intermediaries who profit by taking a fixed percentage from each transaction, similar to the GPOs. Otherwise, higher prices always mean less quantity sold, *ceteris paribus*, and hence less profit for the GPO.

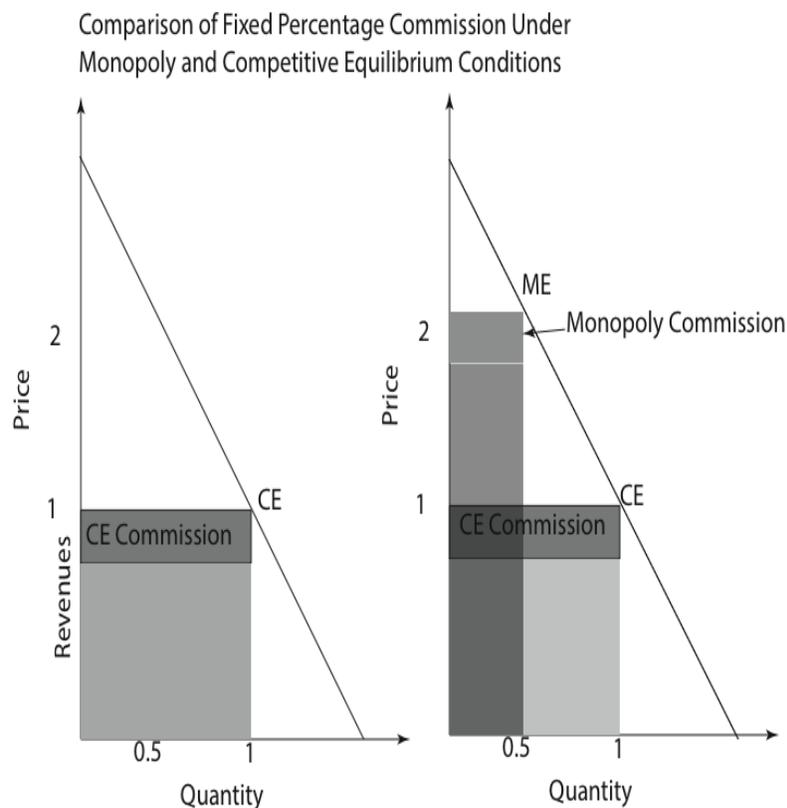


Figure 1: Under a competitive market, revenue is maximized at the competitive equilibrium price and quantity (CE) in the left hand graphic. In a monopoly market (the most extreme uncompetitive market) represented on the right hand side as a darker area with equilibrium price ME the constant percentage Monopoly Commission is smaller than the CE Commission in the competitive scenario on the left. This is because the quantity supplied at the monopoly price level is smaller than the quantity supplied at the CE. The left graph represents

46. HAL R. VARIAN, MICROECONOMIC ANALYSIS 229 (3d ed. 1992).

a competitive market where CE represents a competitive outcome: $Q=1$ and $P=1$ for total revenue of 1. In the right-hand box, the underlying gray area is, in fact, equal to the left-hand box. The CE Commission area represents a 20% on the old revenue, or about 0.2 currency units profit. In the ME area, the monopolist has curtailed production to $Q=0.5$, and the price has gone up to ME price of 2. This means revenue is now 0.5 currency unit, and the 20% profit has shrunk to 0.1 currency unit.

III. A PUBLIC POLICY ALTERNATIVE WORTH INVESTIGATING

A recent report by the U.S. Government Accountability Office (GAO) shows that medical device pricing secrecy impedes the ability of hospitals and GPOs to achieve the best possible prices. The report states that the medical device industry has successfully inserted “gag clauses” into their sales contracts with hospitals related to physician preference items. These gag clauses mask the true cost of medical devices. The report suggests this practice results in higher costs across the board, as hospitals routinely overpay for equipment because medical device prices are not disclosed. As a result, some hospitals unnecessarily pay thousands of dollars more than others for high-cost medical devices, such as defibrillators, stents, and hip replacements. Because of these contract provisions, and some additional factors such as the supplier-physician relationship, neither GPOs nor an aftermarket auction provider is able to provide the best value for their hospital customers. Therefore, at a time when all parties to the health care system are trying to rein in spending, Congress should take steps to enact a pro-market solution to this problem and prohibit contractual gag clauses in order to increase price transparency in the medical device marketplace.⁴⁷

IV. CONCLUSION

The authors do not meet their burden of proof because they do not offer an adequate opportunity for the examination of the data used in their study—an opportunity we would have gladly pursued. We also believe that the authors are hasty in providing their public policy suggestions. Cost pressures on hospitals will only increase in the future as the baby boomer generation ages and promises to place more pressure on the nation’s health care system. The new health care reform bill is funded, in part, by a \$500 billion-plus reduction in Medicare services paid to hospitals and health care providers. Other related reforms will require hospitals to pay more attention to the cost-effectiveness of their operations. GPOs are well-positioned to do so.

47. See generally *id.*

Aftermarket auctions may also provide value to hospitals looking for additional cost containment strategies. These strategies are not mutually exclusive and do not require public policy changes as have been suggested. Congress should, however, examine the implications of the GAO's recent findings related to the lack of price transparency in the implantable medical device market. It is clearly in the interest of all parties to the health care delivery system to have our health care markets work as competitively as possible.