Group Purchasing Organization (GPO) Contracting Practices and Antitrust Law

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by

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I have been asked by the Health Industry Group Purchasing Association ("HIGPA") to respond to the testimony of David Balto, entitled *The Effects of Regulatory Neglect on Health Care Consumers*, in the *Competition in the Health Care Marketplace* hearing before the Consumer Protection, Product Safety and Insurance Subcommittee of the Senate Committee on Commerce, Science and Transportation that took place July 16, 2009.[2]

In his testimony, Mr. Balto alleges that the contracting practices of group purchasing organizations (GPOs) have foreclosed small and start-up medical device manufacturers from the market. Mr. Balto argues that the GPOs' contracting tools include "kickbacks," sole-source contracts, market share discounts and bundled discounts that act to exclude small device manufacturers and cause market inefficiencies that increase prices, distort demand and are not necessary for hospitals to obtain cost savings.[3]

In this paper, I address these accusations and recount the long-standing view of courts and antitrust regulators that GPOs are pro-competitive and enhance competition. I also review and describe the specific benefits and substantial cost savings that GPOs offer to their member-

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[2] *See* David Balto, *The Effects of Regulatory Neglect on Health Care Consumers*, testimony before the Consumer Protection, Product Safety and Insurance Subcommittee of the Senate Committee on Commerce, Science and Transportation (July 16, 2009) (hereinafter "*Balto*").

[3] *See Balto* at 16, 17.

hospitals, patients and the entire health care system. I examine Mr. Balto's superficial and unsubstantiated claims of growing consolidation and increasing GPO market power, and explain how GPOs are structured with inherent safeguards that protect competition, encourage market entry, and operate without market power in a dynamic and competitive landscape. I address Mr. Balto's allegations of anticompetitive contracting practices, and correct his mischaracterizations of the GPOs' contracting practices, to explain how, far from harming or excluding competition, these commonplace negotiating tools offer pro-competitive benefits that are essential for GPOs to contain costs and pass discounts and savings along to hospitals, patients and payors (including Medicare and Medicaid). Finally, I note that existing antitrust laws are available and actively used to police the market and prevent abuse.

I. Group Purchasing Organizations Play an Important Role in Reducing Health Care Costs

Courts and antitrust agencies have long recognized the pro-competitive, competition enhancing benefits of GPOs. In *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, the Supreme Court noted that "such cooperative arrangements would seem to be designed to increase economic efficiency and render markets more, rather than less, competitive,"[4] and noted that GPOs enable members:

> [T]o 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.[5]

In the health care context, the Department of Justice and Federal Trade Commission have each noted that "most joint purchasing arrangements … do not raise antitrust concerns," and that

[4] *See Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 295 (1985) (hereinafter "*Northwest Stationers*").

[5] *See Northwest Stationers* at 295.

GPOs' "collaborative activities typically allow the participants to achieve efficiencies that will benefit consumers."[6]

Indeed, for 100 years, hospitals and health care providers have used the pro-competitive benefits of group purchasing to combine their buying power and achieve discounts from vendors through high-volume sales and economies of scale.[7] Today, GPOs have expanded their role beyond simple discounting, to provide members with total supply chain management solutions. Today's GPOs routinely offer hospitals sophisticated inventory management and quality control systems, provide extensive training and education for purchasing department personnel, and offer benchmarking and product comparison services. GPOs offer hospitals important tools to reduce costs, increase efficiency, make better use of staff, and obtain better clinical outcomes—all of which result in savings to providers, patients and the entire health care system.[8]

The amount of savings GPOs offer health care providers, and in turn the nation, are substantial. Hospitals report saving 10 to 18 percent on purchases through GPOs, and human resource savings in excess of $350,000 per hospital through more efficient purchasing departments and assistance with product comparisons, benchmarking, and standardization.[9]

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[6] *See* DOJ-FTC Statements of Antitrust Enforcement Policy in Health Care, Statement 7, Joint-Purchasing Arrangements Among Health Care Providers (hereinafter "*Statement 7*").

[7] *See* Eugene S. Schneller, *The Value of Group Purchasing – 2009: Meeting the Needs for Strategic Savings* (April 2009) at 1 (hereinafter "*Schneller*"); *see also* Muse & Assoc., *The Role of Group Purchasing Organizations in the U.S. Health Care System* (March 2000) (hereinafter "*Muse & Assoc.*"); *see also* Herbert Hovenkamp, *Competitive Effects of Group Purchasing Organizations' (GPO) Purchasing and Product Selection Practices in The Health Care Industry* (April 2002) at 1 (hereinafter "*Hovenkamp*").

[8] *See Muse & Assoc.*

[9] *See Hovenkamp*; *see also Muse & Assoc.*; *see also* David E. Goldenberg and Roland King, *A 2008 Update of Cost Savings and a Marketplace Analysis of the Health Care Group Purchasing Industry* (July 2009) at ii (hereinafter "*Goldenberg*"); *see* Jody Hatcher, Comments Regarding Competition Law and Policy & Health Care, Submitted to the FTC (September 30, 2002); *see also* William J. Scanlon, Director, Health Care Issues, *Group Purchasing Organizations: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices,* Testimony before the Subcommittee on Antitrust, Competition Policy and Consumer Rights, Committee on the Judiciary, U.S. Senate (April 30, 2002) (GAO-02-690T) at 7 (hereinafter "*GAO Pilot Study*"); *see also Schneller* at 5 (At larger health systems, similar additional workforce expenditures of up to $600,000 per year would be necessary to replace those services currently obtained through GPO memberships).

Researchers estimate GPOs save the U.S. health care industry up to $64 billion in annual purchase price discounts, and over $2 billion in annual human resource savings.[10] The presence of a GPO in the marketplace lowers costs for all purchasers—even those that choose not to purchase through a GPO, because the availability of a GPO discounted price acts as a ceiling in off-contract negotiations.

Suppliers and medical device manufacturers also reap substantial benefits, including increased access to purchasing decision makers, more efficient sales and marketing activities, and a reduction in contracting costs.[11] Clearly, GPOs offer both substantial cost savings and qualitative benefits at all levels and to all participants in the healthcare industry.

II. Structure of the Market

A major premise of Mr. Balto's testimony is that "growing GPO consolidation and market power has increased the exclusionary potential of some of the GPO contracting practices."[12]

An examination of the marketplace reveals that health care providers and hospitals have abundant choice in the purchase of medical products. Purchasers of non-labor medical supplies, services and devices are diffuse, and manufacturers have ample opportunity to sell their products through many different distribution channels, including through GPO contracts, direct to GPO members, and to the many organizations that do not participate in GPOs. There are more than

[10] *See Schneller* at 5.

[11] *See GAO Pilot Study* at 7. Negotiating a single contract with a GPO can reduce the need to enter into thousands of individual contracts with hospitals and tens of thousands of contracts with alternative non-hospital providers.

[12] *See Balto* at 16.

600 GPOs alone in the United States, and more than two dozen that offer their members substantial discounts on a nationwide basis.[13]

Overall, GPOs account for no more than roughly 12% of all national health care expenditures,[14] and even for GPO purchases alone, no single GPO accounts for more than 15% of total GPO-enabled purchasing. Even the largest GPO is still small in relation to total purchasing volume and the large number of competing GPOs.[15] Additionally, because most hospitals are members of several GPOs and can pick and choose among their GPO networks to obtain the best value, and because hospitals can and often do make purchases outside of their GPOs, and can easily switch among the different GPO networks, GPOs exist within a competitive landscape that has virtually no chance of anticompetitive harm.[16]

The Justice Department and Federal Trade Commission both use the Herfindahl-Hirschman Index ("HHI") as a means of measuring market concentration. Under the agencies' Horizontal Merger Guidelines, a market is deemed "unconcentrated" when post-merger HHI is calculated below 1000.[17] For GPOs, the HHI is estimated to be less than half that—a mere 428.[18] In such an unconcentrated market, even a merger that eliminates *all the competition* between the merging parties is viewed as "unlikely to have adverse competitive effects and

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[13] *See* Knowledge Source, Inc., *HealthCare Market Overview: Group Purchasing Organizations* (Oct. 2009) at 8 (hereinafter "*Knowledge Source*"); *see also* Robert E. Bloch, Scott P. Perlman and Jay S. Brown, *An Analysis of Group Purchasing Organizations' Contracting Practices Under the Antitrust Laws: Myth and Reality* at 19 (hereinafter "*Bloch*").

[14] *See Goldenberg* at ii.

[15] *See* Modern Healthcare's 2009 GPO Survey (Aug. 31, 2009); Modern Healthcare's By the Numbers Supplement: 2008-2009 Edition (Dec. 22, 2008); and Healthcare Purchasing News: 2007 Annual Purchasing Volume.

[16] *See Hovenkamp.*

[17] *See* Department of Justice and Federal Trade Commission Horizontal Merger Guidelines §1.51 (1992) (hereinafter "*Horizontal Guidelines*").

[18] Herfindahl-Hirschman Index figures are estimated from market share data referenced at note 15, *supra.*

ordinarily require[s] no further analysis."[19] In fact, in contrast to some critics' statements,[20] the level of concentration in the GPO industry appears to have remained consistently "unconcentrated" over the past seven years.[21] All GPOs, even the largest, fall well within the antitrust safety zone established by the Department of Justice and Federal Trade Commission to encourage joint-purchasing activity.[22]

A. Pro-Competitive Features of GPOs

In addition to lacking market power and operating in a dynamic, competitive landscape, GPOs themselves have inherent pro-competitive features that ensure their interests remain aligned with those of their customers, encourages rivalry among the GPOs to attract and retain members, has low barriers to entry from new GPOs, and allows hospitals to "vote with their feet" by switching (or joining additional) GPOs and making off-contract purchases. These GPO features virtually eliminate all residual antitrust risk.[23]

1. Member-Focused Organizations

Although most GPOs are member-owned, *all GPOs* must be member-focused, for the simple reason that their members can and do switch groups in this highly competitive industry. GPOs act as purchasing agents for their members, and if they are to remain successful, must align their goals and interests with those of their owner-members. Since most hospitals belong to

[19] *See Horizontal Guidelines* at §1.51.

[20] *See Balto* at 16 n. 28 *citing Hospital Group Purchasing: Has the Market Become More Open to Competition?: Hearing Before the S. Comm. On the Judiciary,* 107th Cong. 3-4 (2003) (statement of Lynn James Everard).

[21] *See Hovenkamp* at 4 (calculating GPO concentration levels from 2001 market share data and obtaining HHIs in the range of 410-450, indicating an unconcentrated market). Current HHI estimates continue to fall within that range.

[22] *See Statement 7* (establishing an antitrust safety zone within which joint-purchasing arrangements will not be challenged, absent extraordinary circumstances).

[23] *See Statement 7* (noting that safeguards like those employed by the GPOs, substantially reduce, if not completely eliminate, antitrust risk).

several GPOs,[24] members have the ability to play one GPO off another—seeking to purchase wherever the best value can be found.[25] The ability for members to vote with their feet and transfer networks—as hundreds of hospitals do every year—ensures that a GPO will keep its members' interests in mind when making contracting decisions.[26]

2. Right to Make Non-GPO Purchases

In addition, almost all hospitals retain the right to make whatever "off-list" purchases they wish, from any vendor they choose. Indeed, hospitals frequently make such purchases and use GPO-contract prices as a price ceiling in their negotiations for off-list products. Thus, GPO-influenced savings extend far beyond actual purchase volumes, and help drive down prices for off-list products as well.[27]

3. Low Barriers and Active New Entry

Moreover, since GPOs own no specialized assets and do not purchase supplies or maintain inventories, there are no significant barriers to entry for new GPOs, or to adding new vendors or distributors. If a GPO were to earn a monopoly profit or advance vendor interests at the expense of its members, new GPOs would quickly form to take its place.[28] Indeed, new entry is already occurring—regional GPOs are increasing in popularity and flourishing.[29]

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[24] *See Knowledge Source* at 8.

[25] *See Hovenkamp* at 1, 2.

[26] *See Bloch* at 8.

[27] *See Schneller* at 5.

[28] *See Hovenkamp* at 1.

[29] Resource Optimization and Innovation, founded in 2002, has already grown from a regional GPO to become one of the top-10 GPOs in the nation. *See also* Shawn Rhea, *Above and Beyond: Regional GPOs work to offer value, services that their national counterparts often don't provide*, Modern Healthcare (Aug. 31, 2009).

B. Structure of Medical Device Market

Contrary to Mr. Balto's claims, there is scant evidence that GPOs' contracting practices (or anything else) are operating to exclude large numbers of small and start-up medical device manufacturers. To the contrary, the medical device industry is very innovative and highly competitive. In 2007, U.S. health care expenditures totaled over $2.3 trillion (approximately 17% of GDP), of which approximately $100 billion—roughly five percent—was spent on medical devices.[30] There are dozens of major international and domestic medical device manufacturers, each with sales in excess of $1 billion (*see* Table 1, below).[31] Medical device manufacturers continually innovate and bring new products to market: from stents and defibrillators, to artificial knees, new imaging modalities, diagnostic tests and surgical tools.[32] GPOs all have practices and procedures for understanding and evaluating these new medical technologies, innovations and devices—indeed this is one of the core benefits GPOs offer their member hospitals.

Historically, GPOs have been most impactful in contracting for commodity and bulk medical devices,[33] which has encouraged vigorous competition and resulted in unusually low price inflation in this category—over the past 18 years, overall device prices have increased by

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[30] *See Goldenberg* at ii; *see also* Jim Austin, Terry Fadem and Paul J. H. Schoemaker, *A Look Into the Future of the U.S. Medical Device Market*, Medical Device Link (January 2009) (hereinafter "*Austin*"); *see also* Gerald Donahoe and Guy King, *Estimates of Medical Device Spending in the United States* (May 2009) (hereinafter "*Donahoe*") (reporting 2006 figures).

[31] *See Austin*; Medical Product Outsourcing, *Still on Target* (July/August 2009) *available at*: http://www.mpo-mag.com/articles/2009/07/still-on-target (last visited Oct. 7, 2009).

[32] *See Donahoe.*

[33] Commodity medical devices such as bandages, cotton balls, swabs and tongue depressors are items for which few physicians express a brand preference and are usually purchased in large quantities.

only an average of 1.1% per year, compared to a 4.9% average annual increase in the Medical Consumer Price Index.[34]

However, GPOs can also have an impact when purchasing physician preference items—medical devices such as stents, pacemakers, artificial joints and hips—where surgeons and clinicians see a meaningful difference among products and must determine which particular brand of device is best suited to treat their patient's unique circumstance. There are a number of strategies employed by GPOs to drive best pricing value in these areas, depending on the category, including, but not limited to group buys, standardization, and data driven, outcomes-based conversion support. Although purchasing physician preference items through a GPO can result in significant discounts and savings,[35] oftentimes purchases are made "off list" and outside the GPO schedule. Such purchases are not usually subject to the same intensity of price competition that GPOs can provide for bulk and commodity devices. The result has been a rate of price inflation for physician preference items that far exceeds commodity device price increases.[36]

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[34] *See Donahoe* at 5 ("This relatively slow rate of price increase suggests the industry is highly price competitive.... It is also striking that, unlike most other areas of medicine, the prices of medical devices have actually been growing more slowly not only than the MCPI but than the CPI as a whole.")

[35] *See Schneller* at 12 ("[E]stimated savings are 15 percent for orthopedic implants ... and 17 percent for cardiology physician preference items... .")

[36] *See, e.g., Hip and Knee Implant List Prices Rise 6.3%,* Orthopedic Network News, Vol. 19, No. 1 (Jan. 2008) (noting that hip and knee implant list prices rose 6.3% from 2007 to 2008, and rose 5.8% from 2006 to 2007); *see also Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More*, McKinsey Global Institute (Dec. 2008) at Exh. 34 (noting 8% price increase in physician preference items between 2003-06) *available online at* http://www.mckinsey.com/mgi/publications/US_healthcare/pdf/US_healthcare_Chapter1.pdf (last visited Feb. 18, 2010).

Table 1: 2008 Medical Device Manufacturer Sales (in billions)		
Rank	Company	2008 Sales
1	Johnson & Johnson	$ 23.1
2	GE Healthcare	$ 17.4
3	Siemens Healthcare	$ 16.1
4	Cardinal Health	$ 13.7
5	Medtronic	$ 13.5
6	Baxter International	$ 12.3
7	Philips Healthcare	$ 10.7
8	Covidien	$ 8.9
9	Boston Scientific	$ 8.0
10	Abbott Labs	$ 7.2
11	Becton Dickinson	$ 7.2
12	Stryker	$ 6.7
13	B. Braun	$ 5.3
14	St. Jude Medical	$ 4.3
15	3M Healthcare	$ 4.2
16	Zimmer Holdings	$ 4.1
17	Toshiba	$ 3.9
18	Smith & Nephew	$ 3.8
19	Hospira	$ 3.6
20	Danaher	$ 3.3

Source: Still on Target, Medical Product Outsourcing (July/August 2009).

Likewise, the purchase of medical devices, goods and services is also extremely diverse and vibrant, with consumers that range from GPO members (*e.g.*, hospitals, nursing homes, etc.), to non-GPO members (*e.g.*, state health departments, prison systems, veterans' hospitals, some physicians' offices and other non-acute care facilities).[37] Recent estimates indicate that one segment alone (U.S. hospitals) accounts for more than $300 billion in annual non-labor healthcare purchases—much of which could theoretically be purchased through a GPO.[38]

C. GPOs do not Operate to Exclude Smaller Manufacturers, and GPOs Have Enacted Policies to Protect Against Abuse

The common, pro-competitive contracting practices used so effectively by GPOs to contain costs are found throughout the economy in a wide variety of industries and do not tend to exclude smaller manufacturers. Nevertheless, GPOs are sensitive to the concerns of all

[37] *See Bloch* at 25-26.

[38] *See Schneller* at 6.

constituents, and have voluntarily enacted a number of policies, in recognition of their member-hospitals' needs, to ensure that small, new and innovative device manufacturers can bring their products to market.

1. Online Technology Forums & Fast-Track Approvals

The Health Industry Group Purchasing Association (HIGPA) and participating GPOs have created web-based vendor exchanges where a small company not yet contracting with a GPO can nevertheless post information about its new and innovative products. These online exchanges help facilitate off-list sales to GPO members.[39] Additionally, most major GPOs are able to "fast track" the review and approval process for including new and innovative devices in the GPO contract for purchase by its members.[40] Moreover, hospitals are always able to contract "local," "direct," or "off-list" with any vendor they wish. This is extremely common in cases of new and innovative devices, as well as with clinical preference items (those devices where a physician expresses a preference for a particular brand or device).[41] Indeed, through sourcing and value-analysis committees, GPOs continuously seek their members' input—especially when making contracting decisions involving new and innovative products.

2. Group Purchasing Industry Codes of Conduct

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[39] *See Hospital Group Purchasing: How to Maintain Innovation and Cost Savings:* Hearing before the Senate Subcommittee on Antitrust, Competition Policy and Consumer Rights (Sept. 14, 2004) (Statement of Robert Betz) at 11; *see also Hospital Group Purchasing: Are the Industry's Reforms Sufficient to Ensure Competition:* Hearing before the Senate Subcommittee on Antitrust, Competition Policy and Consumer Rights (Mar. 15, 2006) (Statement of Mark McKenna) at 76 (hereinafter "*McKenna*").

[40] *See Group Purchasing Organizations: Use of Contract Processes and Strategies to Award Contracts for Medical-Surgical Products,* Testimony Before the Subcommittee on Antitrust, Competition Policy and Consumer Rights, Committee on the Judiciary, U.S. Senate (July 16, 2003) (GAO-03-998T) at 8.

[41] *See GAO Pilot Study* at 18 (71% of hospitals report purchasing clinical preference pacemakers off-list, whereas only 15% of hospitals report purchasing off-list commodity safety needles).

In 2002, the GPO industry began work on developing a set of code of conduct principles upon which GPOs' individual codes of conduct could be based. In 2005, the GPO industry formed the Healthcare Group Purchasing Industry Initiative ("HGPII") and adopted a set of principles upon which member organizations are required to base and implement a code of conduct. These principles and codes of conduct require adherence to high ethical standards, compulsory employee training, avoidance of conflicts of interest, participation in an annual Best Practices Forum, and provide public accountability. This voluntary industry initiative has worked to increase transparency and explain the GPO contracting process, particularly for smaller device manufacturers.

3. Annual Best Practices Forum

HIGPII hosts an annual Best Practices Forum at which industry leaders attend educational and training sessions to ensure that their organizations are in compliance with the HGPII code of conduct, and to ensure they are meeting the needs of all stakeholders—including small device manufacturers.

4. Annual Public Accountability and Transparency

Each member of HGPII is required to complete a detailed Annual Public Accountability Questionnaire that focuses on the development and implementation of strong ethical standards. Questionnaire topics include: the identification and mitigation of conflicts of interest, the proper handling of complaints, the evaluation of new and innovative medical technologies, and compliance with the organization's code of conduct and obligations as a HGPII member. A GPO's responses to the Annual Public Accountability Questionnaire must be reviewed and

signed by its CEO and is then reviewed and validated by the HGPII Coordinator. The full text of each questionnaire is posted online at the HGPII website for public review.[42]

Additionally, each year HGPII publishes an annual report that analyzes members' responses to the Annual Public Accountability Questionnaire, details the proceedings of the most recent annual Best Practices Forum, and identifies an agenda for the following year.

In sum, the GPOs have voluntarily implemented comprehensive measures that provide increased transparency and have enacted safeguards to further ensure small manufacturers are able to compete for GPO contracts and market new and innovative devices to GPO members, regardless of whether they currently hold a GPO contract.

III. The Contracting Practices Mr. Balto Condemns are Common, Lawful and Essential Tools Necessary for GPOs to Reduce Health Care Expenses

Mr. Balto accuses GPOs of using "kickbacks," "sole-source" contracts, market share discounts, and bundling of products in an effort to inflate prices, distort demand, deceive buyers, eliminate competition, and foreclose small manufacturers from the market.[43] His pejorative labels and broad accusations do little to address the fact that these are pro-competitive contracting tools that are commonly used across a wide array of industries to negotiate prices and contain costs. Although Mr. Balto argues that these contracting practices are "not necessary for hospitals to obtain cost savings,"[44] the fact is that without these tools, GPOs would be unable to negotiate the substantial discounts and savings that they currently obtain while helping to reduce the cost of health care for hospitals and other providers, payors, and patients.

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[42] *See* HGPII website at http://www.healthcaregpoii.com (last visited Oct. 9, 2009).

[43] *See Balto* at 16, 17.

[44] *See Balto* at 17.

1. "Kickbacks"

Mr. Balto pejoratively refers to the contract administration fees that vendors pay to fund GPOs' operations as anticompetitive "kickbacks," and suggests that this vendor-based funding deceives payers, distorts demand, artificially raises prices, undermines product selection and excludes competitors.[45] Mr. Balto's description of these payments as "kickbacks" is a mischaracterization: "kickbacks" are illegal payments commonly made pursuant to coercion or secret agreement.[46] The GPOs' vendor-based financing system relies on congressionally authorized, fully disclosed and transparent, written contract administration fees, and is nothing like an illegal "kickback."

Running a GPO isn't free—someone must pay to operate the GPO, and the fact is that it is easier, more efficient, and less burdensome to collect these administrative fees from vendors than from anyone else.[47] Mr. Balto's complaints simply seek to shift that funding obligation from vendors to the GPOs' member healthcare providers, and have no legal merit.

Congress recognized the economic benefits of collecting GPO administrative fees from vendors instead of hospitals and enacted legislation that distinguishes and exempts these payments, as well as discounts from the prohibitions of the Social Security Act.[48] Through this legislation and implementing regulations, Congress recognized such payments as a legitimate,

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[45] *See Balto* at 16, 17.

[46] See Black's Law Dictionary (8th ed. 2004) (kickback: "A return of a portion of a monetary sum received, esp. as a result of coercion or a secret agreement"); *see also* 1241 Webster's Third New International Dictionary (Merriam-Webster 2002) (kickback: "a usu. secret rebate of part of a purchase price by the seller to the buyer from such seller"); *see also* 786 Webster's New College Dictionary (Wiley 2007) (kickback: "a giving back of part of money received as payment, commission, etc., often as a result of coercion or an understanding"); *see also* 928 The New Oxford American Dictionary (Oxford 2d ed. 2005) (kickback: "a payment made to someone who has facilitated a transaction or appointment, esp. illicitly") *see also* Merriam-Webster's Online Dictionary (kickback: "a return of a part of a sum received often because of confidential agreement or coercion").

[47] *See Bloch* at 14.

[48] *See* 42 U.S.C. § 1320a-7b(b) (2009).

lawful funding source that benefits both providers and vendors.[49] Indeed, by requiring vendors to pay an administrative fee based on the volume of its GPO sales, purchasing organizations can avoid the expense and difficulty of allocating GPO operating expenses among members of varying sizes, profitability and utilization.[50] Vendor-based funding is especially pro-competitive because it lowers barriers to entry, promotes the establishment of additional GPOs, and encourages additional participation and purchasing by small institutions—especially rural and community-based hospitals that simply cannot command price discounts on their own.

Further, by collecting GPO administrative fees from as far upstream as possible, GPOs are able to align the manufacturers' interests with those of its members, because it incentivizes the vendor to keep costs down. By controlling and reducing costs, vendors keep their own contract administrative fees down as well. Moreover, assessing these fees on vendors ensures that all levels of the health care supply chain are helping to share the burden and reduce costs for patients. Vendor fees collected in excess of a GPO's operating costs accrue back to benefit its member-owners in many ways. . These include direct payments to members, which serve to further reduce their costs, and investments by the GPO itself in the provision of additional qualitative and value-added services.

Moreover, when Congress authorized vendor-based financing, it conditioned it upon compliance with an important safeguard—transparency. All contract administration fees must be in writing; and all fees must be disclosed to GPO members at least annually, and whenever requested by the Secretary of Health and Human Services.[51]

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[49] *See* 42 U.S.C. § 1320a-7b(b)(3)(C) (2009).

[50] *See Bloch* at 14.

[51] *See* 42 U.S.C. § 1320a-7b(b)(3)(C) (2009); *see also* 42 C.F.R. § 1001.952(J) (2009).

2. "Sole-Source" Contracts

Mr. Balto next accuses GPOs of using "sole-source" contracts to exclude smaller manufacturers from entering the market and states that such contracts are not necessary to obtain cost savings and can cause market inefficiencies.[52] Unfortunately, Mr. Balto has again mischaracterized the facts.

Very few GPO contracts are true "sole-source" agreements that obligate a hospital to purchase only from the contract supplier and no one else. In almost every case, GPO members always retain the right to purchase products off-contract from whomever they choose—including from vendors *other than* the GPO's "sole" or "exclusive" provider.[53] In fact, that is exactly what many hospitals do—they use the GPO contract price as a ceiling when negotiating with off-list vendors.[54]

Sole source contracts are common throughout our economy and offer important savings and advantages to both buyers and sellers. Sixty years ago the Supreme Court noted the substantial benefits that sole-source contracting can offer:

> In the case of the buyer, they may assure supply, afford protection against rises in price, enable long-term planning on the basis of known costs, and obviate the expense and risk of storage in the quantity necessary for a commodity having a fluctuating demand. From the seller's point of view, [sole source] contracts may make possible the substantial reduction of selling expenses, give protection against price fluctuations, and—of particular advantage to a newcomer to the field to whom it is important to know what capital expenditures are justified—offer the possibility of a predictable market.
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> *Standard Oil Co. v. United States (Service Stations)*, 337 U.S. 293, 306-7 (1949).

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[52] *See Balto* at 16, 17.

[53] *See Bloch* at 9.

[54] In the absence of a GPO, many providers would find it necessary to sign true "sole-source" requirements contracts with vendors in order to obtain discounts.

Antitrust law rarely condemns such pro-competitive arrangements because rival manufacturers can always compete for the contract business by matching the discount.[55] Judge Easterbrook explained that "competition-for-the-[sole-source] contract is a form of competition that antitrust laws protect rather than proscribe, and it is common … competition of this kind drives down the price … to the ultimate benefit of consumers."[56]

Additionally, GPOs follow contracting policies that help to avoid the potential for exclusion. GPOs have generally shortened the average duration of their vendor agreements, and many contracts are now terminable by either party without cause upon 60 or 90 days' written notice.[57] This increases the frequency with which contracts become available, and provides additional opportunities for rivals to compete for the GPOs' contract business. Of course, since there are virtually no true "sole source" agreements, nothing prevents vendors and GPO members from contracting "off-list" whenever they wish. By voluntarily shortening the average GPO contract duration and ensuring contracts are terminable without cause, upon 2 or 3 months' notice, additional opportunities are provided to include new and innovative devices from smaller manufacturers.

Like any contract, a sole-source contract could, in certain narrow circumstances, be misused to exclude competitors. However, in these rare cases, existing antitrust laws provide adequate relief.[58]

3. Market Share Discounts

[55] *See Hovenkamp* at 19.

[56] *Paddock Publications, Inc. v. Chicago Tribune Co.*, 103 F.3d 42, 45 (7th Cir. 1996).

[57] *See McKenna* at 78.

[58] *See, e.g., United States v. Grinnell Corp.*, 384 U.S. 563 (1966); *United States v. Microsoft Corp.*, 253 F.3d 34 (D.C. Cir. 2001); *LePage's, Inc. v. 3M Co.*, 324 F.3d 141 (3d Cir. 2003) (en banc) (hereinafter "*LePage's*"); *United States v. Dentsply Int'l*, 399 F.3d 181 (3d Cir. 2005).

Mr. Balto next alleges that large incumbent medical device manufacturers collude with GPOs to use market share discounts to exclude smaller rivals from the market and preserve incumbent vendors' market shares.[59] Although market share discounts can (under a very narrow set of circumstances not typically present here) be misused, courts and antitrust jurists agree that market share discounts generally are pro-competitive and beneficial practices that lead to cost savings for consumers.[60]

GPOs face a unique set of challenges that percentage of purchase discounts help them address. In order to provide value to its membership, a GPO negotiates with vendors to obtain substantial discounts in exchange for offering the certainty of a large volume of purchases. However, a GPO's membership is diverse in size and purchasing volume. To be successful, a GPO must offer benefits that appeal to both large- and small-volume members alike, and must overcome the free-rider problem of losing large-volume purchasers' business to off-list deals, by offering these larger members benefits comparable to what they could negotiate on their own.

Traditional volume-based discounts are problematic because many of the smaller GPO members may not qualify for the highest levels of price reductions, while larger members may see little (or no) additional benefit from what they could negotiate on their own. A percentage of purchase discount, on the other hand, is an effective tool that can help treat all buyers equally, by allowing members (even a small member) to qualify for the highest level of discounts in

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[59] *See Balto* at 16.

[60] *See* ABA Section of Antitrust Law, Antitrust Law Developments (5th ed. 2002) at 255 ("[I]t has been held that market share discounts (*i.e.*, discounts tied to the share of products purchased from the monopolist) generally are lawful so long as they are not below cost."); *see also Concord Boat Corp. v. Brunswick Corp.* 207 F.3d 1039 (8th Cir. 2000) *cert. denied*, 531 U.S. 979 (2000) (hereinafter "*Concord Boat*").

exchange for a minimum purchase commitment.[61] Likewise, such discounts also incentivize larger members to contribute their purchasing volume to the GPO (instead of going it alone) because they obtain discounts without needing to give up their ability to make "off-list" purchases.

Contrary to what Mr. Balto argues, GPOs use percentage of purchase discounts as pro-competitive glue—holding their large- and small-volume members together so that both may benefit from their combined purchasing volumes. It is for exactly this purpose that both the Department of Justice and Federal Trade Commission sanction GPOs' use of percentage of purchase discounts: "[m]embers can, however, be asked to commit to purchase a voluntarily specified amount through the arrangement so that a volume discount or other favorable contract can be negotiated."[62] Although exceedingly unlikely, any potential abuse of percentage of purchase discounts are already redressable under the existing antitrust laws.[63]

4. Bundling of Products

Mr. Balto has criticized the GPOs' use of bundled discounts as unnecessary and exclusionary and implies that GPOs collude with incumbent manufacturers to use bundled discounts to eliminate competition and preserve a supplier's market share.[64]

Bundling promotions (where a seller offers a discount if items are purchased together instead of separately) are part of the ordinary give and take of the bargaining process, occur in a

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[61] *See Bloch* at 11; *see also* IIIB Phillip E. Areeda and Herbert Hovenkamp, *Antitrust Law* ¶ 768b4 (3d ed 2008) ("Quantity discounts tend to discriminate against smaller buyers whose purchases are not large enough to qualify for the largest discounts; market-share discounts tend to treat all buyers in the same manner.").

[62] *See Statement 7.*

[63] *See e.g., Masimo Corp. v. Tyco Health Care Group, LP*, 2006 WL 1236666, 2006 U.S. Dist. LEXIS 29977 (C.D. Cal. March 22, 2006) (hereinafter "*Masimo*").

[64] *See Balto* at 16, 17.

wide variety of markets, and are virtually always pro-competitive.[65] Bundled discounts are ubiquitous throughout our economy and are a simple way to make products more attractive—customers receive what is in effect a discount and vendors can dispose of excess inventory.[66]

In the recent case of *Cascade Health Solutions v. PeaceHealth*, the Ninth Circuit reviewed the pro-competitive and pro-consumer nature of bundled discounts:

> Bundled discounts are pervasive, and examples abound. Season tickets, fast food value meals, all-in-one home theatre systems—all are bundled discounts. Like individual consumers, institutional purchasers seek and obtain bundled discounts, too … The varied and pervasive nature of bundled discounts illustrates that such discounts transcend market boundaries. On the one hand, the world's largest corporations offer bundled discounts as their product lines expand with the convergence of industries. On the other hand, a street-corner vendor with a food cart—a merchant with limited capital—might offer a discount to a customer who buys a drink and potato chips to complement a hot dog. The fact that such diverse sellers offer bundled discounts shows that such discounts are a fundamental option for both buyers and sellers … Bundled discounts generally benefit buyers because the discounts allow the buyer to get more for less. Bundling can also result in savings to the seller because it usually costs a firm less to sell multiple products to one customer at the same time than it does to sell the products individually.[67]

GPOs and medical device manufacturers negotiate bundled discounts to enhance output through increased volume (and lower prices), to dispose of excess inventory, to reduce transaction costs, and to introduce and market new and innovative devices to customers—all of which are pro-competitive. Far from excluding competition, bundled discounts offer an off-contract vendor the opportunity to compete for hospitals' business by offering an enticing discount that matches (or exceeds) that available under the GPO-contract. Likewise, the next time a GPO contract is up for bid, a rival manufacturer will be incentivized to offer a superior discount to win the business.

Like other contracting practices, bundling has the potential to be harmful in a specific set of narrow circumstances. However, Mr. Balto has provided no evidence that these

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[65] *See Hovenkamp* at 21-22.

[66] *See Hovenkamp* at 22. Given all the pro-competitive and efficiency enhancing benefits of bundled discounts, providers and vendors are likely to negotiate for bundled discounts, *even in the absence of GPOs*.

[67] *Cascade Health Solutions v. PeaceHealth,* 515 F.3d 883, 894 (9th Cir. 2008).

circumstances generally exist, or that bundling has been widely used to exclude competitors. Abuses involving bundled discounts are reviewable under existing antitrust law.[68]

IV. Existing Antitrust Laws Are Adequate to Prevent Anticompetitive Harm in the GPO Marketplace

Mr. Balto argues that a "gap in enforcement" exists under current antitrust law that allows GPOs' anticompetitive contracting practices to slip through the cracks, and urges the FTC to expand its use of Section 5 to condemn these practices—even though they violate no antitrust law and cause no antitrust harm. [69]

A. Existing Antitrust Laws Provide Adequate Remedies for Companies Injured by Anticompetitive Contracting Practices

Beginning in 2002, the Department of Justice and the Federal Trade Commission held a series of workshops, public hearings and investigations that examined competition in the healthcare industry and specifically evaluated whether the alleged anticompetitive GPO contracting practices Mr. Balto complains of were slipping through an enforcement gap in the current antitrust laws.[70] The DOJ and FTC reported that nothing would "preclude Agency action challenging anticompetitive conduct—such as anticompetitive contracting practices—that happens to occur in connection with GPOs," [71] and explained that the "Agencies will examine, on a case-by-case basis, the facts of any alleged anticompetitive contracting practices to

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[68] *See, e.g., Masimo; LePage's*; *SmithKline Corp. v. Eli Lilly and Co.*, 575 F.2d 1056 (3d Cir. 1978); *Avery Dennison Corp. v. ACCO Brands*, 2000-1 Trade Cas. (CCH) ¶ 72,882 (C.D. Cal. 2000).

[69] *See Balto* at 17.

[70] *See* Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition* (July 2004) at Ch. 4 p. 34 *et seq.* (hereinafter "*A Dose of Competition*").

[71] *See A Dose of Competition* at Ch. 4, p. 34 *et seq.*

determine whether the practice violates the antitrust laws."[72] The agencies stated that existing antitrust laws are adequate to prevent anticompetitive harm in the GPO marketplace:

> The Agencies, however, do not believe that it is appropriate or wise to amend *Statement 7*, because the statement and its safety zone thresholds do not prevent and should not be appropriately read as preventing antitrust challenges to any of the alleged anticompetitive contracting practices about which panelists and others have raised concerns.[73]

Although Mr. Balto states that there is an antitrust enforcement gap,[74] he also admits that existing antitrust laws are available and are successfully used to redress GPOs' alleged anticompetitive contracting practices: "[o]ver a dozen private suits have been brought, some successfully, by small innovative medical device manufactures against exclusionary practices by GPOs and device manufacturers."[75]

B. Use of Section 5 to Condemn GPOs' Contracting Practices is Inappropriate

It has long been a fundamental principle that U.S. antitrust laws protect competition, not competitors.[76] It would be a mistake to use Section 5 to condemn GPO contracting practices that do not violate the antitrust laws, because they do not harm *competition*, as opposed to *competitors*. Using Section 5 as Mr. Balto suggests to help smaller, less efficient manufacturers, would serve to protect a particular group of competitors, not competition as such, and would lead

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[72] *See A Dose of Competition* at Ch. 4, p. 46.

[73] *See A Dose of Competition* at Ch. 4, p. 46.

[74] *See Balto* at 17.

[75] *See Balto* at 16. Mr. Balto cites the Ninth Circuit case of *Forsyth v. Humana*, 114 F.3d 1467 (9th Cir. 1997) as an example of how existing antitrust law allows the GPOs' practices to slip through the cracks. Yet, that case didn't even involve a GPO, and didn't allow anything to slip through an "antitrust crack"—the court ruled *in favor* of the plaintiff's antitrust claims!

[76] *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977) ("antitrust laws ... were enacted for the protection of competition, not competitors").

to higher prices and increased healthcare costs, contrary to fundamental objectives of the antitrust laws.[77]

It would be particularly inappropriate to use Section 5 to condemn contracting practices that have been specifically authorized by Congress. The vendor-based funding of GPO operating costs through a transparent system of contract administrative fees is lawfully made pursuant to *explicit statutory authority considered and approved by Congress*.[78]

Moreover, expanding Section 5 to reach conduct lawful under the existing antitrust laws is fraught with uncertainty. The former Clinton-era head of the Department of Justice Antitrust Division, A. Douglas Melamed, notes that "if construed to reach beyond the antitrust laws, Section 5 would inevitably be too vague to send useful signals to the marketplace and to provide appropriate incentives for firms to conform their conduct to the requirements of the law."[79] Expanding Section 5 to reach contracting practices not in violation of current antitrust laws "would threaten the most basic objectives of sound competition policy—enabling markets to work efficiently without distortion."[80]

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[77] Senator Sherman sought to design legislation to promote "free and full competition," which he saw as naturally "increasing production [and] lowering ... prices." *See* Senate Resolution Directing the Committee on Finance To Inquire into Control of Trusts in Connection with Revenue Bills, 50th Cong. 1st Sess. (July 10, 1888), 19 Cong. Rec. 6041, *also reprinted in* Earl W. Kinter, The Legislative History of the Federal Antitrust Laws and Related Statutes 54-55 (1978).

[78] *See* 42 U.S.C. 1320a-7b(b)(3)(C) (2009).

[79] *See* A. Douglas Melamed, Comments Submitted to The Federal Trade Commission Workshop Concerning Section 5 of the FTC Act (October 14, 2008) (hereinafter "*Melamed*") at 6.

[80] *See Melamed* at 6.