AN ANALYSIS OF GROUP PURCHASING ORGANIZATIONS' CONTRACTING PRACTICES UNDER THE ANTITRUST LAWS: MYTH AND REALITY©

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Group purchasing organizations (GPOs) play an important role in the provision of health care services in the United States. As hospitals and other health care providers have come under pressure to reduce expenses, they have turned increasingly to GPOs to reduce the costs of the products and services they purchase. Today, virtually every hospital in the U.S. belongs to at least one GPO. More than seventy percent of all hospital purchases are made through GPO contracts, and GPOs contract for purchases with an annual value in the range of $150 billion.[1]

The fundamental purpose of a GPO is to allow its members to join together to leverage their purchasing strength in order to purchase goods and services at lower prices, which in turn should enable them to lower their costs and become more competitive in the provision of their own services. In its basic form, a GPO is a cooperative of buyers. Over time, however, GPOs have evolved significantly to offer other competition-enhancing programs such as networking, benchmarking, and educational quality improvement programs.[2] These functions are procompetitive and consistent with antitrust policy – they offer GPO members increased efficiency, eliminate wasteful administrative duplication, and they increase competition between manufacturers/vendors, and within the hospital members' own markets, which translate into lower prices and higher quality for consumers.

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[1] *See* Muse & Associates, *The Role of Group Purchasing Organizations in the U.S. Health Care System*, at 3 (March 2000).

[2] *See* SMG Marketing Group, *2002 SMG MHS/GPO Market Report*, at 1 (2002) (hereinafter "SMG Report").

At a time when increasing health care costs are a major policy concern, one would expect GPOs to be seen as a major force in the health care industry for increased efficiency and cost containment. In fact, GPOs currently are under attack from several different directions. On the political front, GPOs have come under attack by some manufacturers of medical devices that claim GPO contracting practices, including "sole-source contracts," percentage of purchase or "market share" discounts, and multi-product or "bundled" discounts, favor large established manufacturers with the result that smaller companies with "innovative" products are effectively foreclosed from selling to a large number of the nation's hospitals.[3] These concerns have attracted the attention of the U.S. Senate, which held hearings last year scrutinizing GPO contracting practices;[4] the Senate may hold additional hearings on GPOs in 2003. Similarly, the Federal Trade Commission (FTC) held a workshop last fall at which GPO contracting practices were a topic of discussion, and the FTC, together with the Antitrust Division of the Department of Justice (DOJ), are holding health care hearings in 2003 at which GPO contracting practices also are being discussed.[5] Finally, a 2002 preliminary study by the General Accounting Office (GAO) raised questions about whether GPO contracts actually save hospitals money.[6]

GPO contracts also have been the subject of recent private litigation. In *Kinetic Concepts, Inc. v. Hillenbrand Indus., Inc.*, a jury awarded more than $500 million in treble damages against a manufacturer of hospital beds that allegedly was using GPO contracts to

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[3] *See*, *e.g.*, Medical Device Manufacturers' Association News Release, "GPOs Were Intended to be Anti-inflationary; Now They're Just Anticompetitive, According to Medical Device Manufacturers Association," www.medicaldevice.org.

[4] *See* Notice of Subcommittee Hearing, United States Senate Committee on the Judiciary, Subcommittee on Antitrust, Competition, and Business and Consumer Rights, "Hospital Group Purchasing: Lowering Costs at the Expense of Patient Health and Medical Innovation?" (April 30, 2002) (hereinafter, "Senate Hearings").

[5] Federal Trade Commission Workshop: Healthcare and Competition Law and Policy (September 9-10, 2002) (hereinafter "Health Care Workshop"); Notice of Public Hearings and Opportunity for Comment, Health Care and Competition Law and Policy, 67 *Fed. Reg.* 68672 (Nov. 12, 2002).

[6] *Group Purchasing Organizations: GAO Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices*, GAO-02-690T (April 30, 2002).

exclude plaintiff, its competitor.[7] In a suit more directly implicating GPO practices, *Retractable Technologies, Inc. v. Becton Dickinson, et al.*, a manufacturer of safety syringes sued the two largest manufacturers of standard and safety syringes along with the two largest GPOs, alleging, among other things, a conspiracy between the GPOs and manufacturers to monopolize the needle and syringe market.[8]

The important role GPOs play in the delivery of health care services, and the criticism that has been directed at them, raise important issues under the antitrust laws. Are GPOs the agents of efficiency they claim to be, or, as their critics charge, have GPOs become a vehicle for dominant manufacturers to achieve and/or maintain monopoly power? This article analyzes GPO contracting practices under the antitrust laws and whether these practices are likely to result in anticompetitive effects. As this analysis will show, in general, GPO contracts promote significant efficiencies and are unlikely to result in sufficient market foreclosure to injure competition. The policy implications of this conclusion are clear: instead of increasing competition, restrictions on GPO contracting practices are likely to result in less competition and higher prices for health care consumers.

I. History and Background of Group Purchasing Organizations

Hospital GPOs trace their history back to the late 1800s,[9] though the first known hospital GPO was the Hospital Bureau of New York, which appeared in 1910.[10] Over the next half century, the GPO concept grew slowly and by the early 1970s there were forty hospital GPOs in

[7] *Kinetic Concepts, Inc. v. Hillenbrand Indus., Inc.*, 95-CV-0755 (W.D. Tex., Aug. 31, 2000).
[8] *Retractable Tech., Inc. v. Becton Dickinson and Co.*, 01-CV-036 (E.D. Tex.). The authors of this article were counsel for VHA and Novation in this litigation.
[9] *See* Mark McKenna, President, Novation, LLC, Testimony Before the United States Senate Committee on the Judiciary, at 2 (April 30, 2002) (hereinafter "McKenna Testimony").
[10] *See* SMG Report, at 4.

the United States.[11] The next thirty years witnessed an explosion of GPOs. From 1974 to 1999, the number of GPOs grew from forty to 633.[12] Today, there are over 900 GPOs in the United States.[13] While some of these are "child" GPOs that rely on contracts negotiated by larger "parent" GPOs, it is estimated that approximately 200 GPOs contract directly with suppliers, and that twenty-six of these operate on a national level.[14]

It is not a coincidence that GPOs began to grow in popularity in the late 1970s and early 1980s. During this time, for-profit hospital chains began to expand and buy up not-for-profit hospitals, forcing not-for-profits to find ways to cut costs to remain competitive. In the early 1980s, Medicare instituted the Prospective Payment System through which hospitals were reimbursed a fixed rate based on a defined service rather than the cost to the hospital of providing that service. At the same time, growing pressure in the private sector to reduce health care costs in the form of Health Maintenance Organizations (HMOs) and other types of managed care also reduced hospital reimbursement. These external market factors made it important for hospitals to control costs. Part of this effort included forming or joining a GPO to lower the cost of goods and services that the hospitals purchased.[15]

In general, non-profit hospitals (which make up approximately eighty-five percent of all hospitals in the U.S.), have formed two types of GPOs in an attempt to contain costs. The first is for healthcare facilities to consolidate into Integrated Health Networks, or IHNs. SMG defines

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[11] *See id.*
[12] *Id.*
[13] *Id.* As discussed more fully below, there are different types of purchasing groups that can be characterized generally as GPOs. The two primary groups are Integrated Health Networks (IHNs), which are comprised of affiliated hospitals and healthcare facilities, and voluntary group purchasing organizations, which are comprised of unaffiliated hospitals that join together to form a GPO. Since the antitrust issues that arise in the IHN context are similar to those that arise in the voluntary GPO context, we do not distinguish between the two and refer to both generically as GPOs.
[14] SMG Report, at 5-6.
[15] *Accord id*. at 4.

an IHN as "an organization that, through ownership or formal agreements, aligns healthcare facilities in order to deliver integrated healthcare services by improving quality and reducing costs to a defined geographic area."[16] Increasingly, these IHNs have acted as their own GPOs. In fact, since 1991, the number of IHNs that perform their own group purchasing functions has grown from 100 to 441.[17]

For other hospitals and healthcare facilities that are not affiliated with a larger network of hospitals, the next best alternative is to form or join a voluntary alliance or GPO in which the hospital remains independent but engages in particular joint activities with other member hospitals through the hospital organization, including group purchasing. Indeed, the importance of group purchasing – whether through a traditional GPO or an IHN – to the survival of hospitals is evidenced by the fact that ninety-six percent of all acute-care hospitals in the U.S. use the services of a GPO and roughly seventy-two percent of all hospital purchases are made through a GPO contract.[18] Moreover, each hospital, on average, is a member of at least two and as many as four GPOs.[19]

With the large number of GPOs comes a wide variety of business models followed by different GPOs. For example, VHA and University Healthsystems Consortium (UHC), the parents of Novation, and Premier are alliances that provide many services in addition to group purchasing services, while newer GPOs, such as MedAssets, offer themselves as "pure play" GPOs focused on basic group purchasing services. Some GPOs attempt to offer the lowest possible prices by developing "committed" purchasing programs and emphasizing sole-source

[16] SMG Report, at 14.
[17] *Id.*
[18] Robert Betz, President and Chief Executive Officer, Health Industry Group Purchasing Association, Testimony Before the United States Senate Committee on the Judiciary, at 1 (April 30, 2002) (hereinafter "Betz Testimony").
[19] *Id. See also*, SMG Report, at 4.

contracts while other GPOs, such as AmeriNet, offer an alternative by providing a greater choice of vendors. In this way, the competitive GPO market offers hospitals a full range of contracting options.

Of course, the primary purpose and benefit of a GPO is to consolidate the purchasing power of its member hospitals. By consolidating their purchasing power, the hospitals as a group are able to negotiate better terms with suppliers, including price, than they could individually. This benefits both sides of the transaction, since the hospitals receive a better price and the supplier is guaranteed a larger volume. It is estimated that by using a GPO, hospitals save between ten and fifteen percent of what they otherwise would have paid if they contracted for the same purchases on their own.[20]

Critics of GPOs have questioned the validity of these claims by citing the 2002 GAO preliminary study finding that GPOs do not always provide the lowest prices to their members, who sometimes can do better contracting on their own.[21] There were at least two significant flaws in the methodology employed by the GAO. First, the GAO sampled GPO versus non-GPO prices for only two products in one city. Reliance on such a small sample pool to draw a general conclusion about GPOs is inappropriate. Second, the GAO study failed to consider the fact that hospitals that obtain better pricing outside their GPO often use the GPO contract as a starting point for their negotiations with vendors much in the same way that non-union workers may use union contracts as a benchmark for their own negotiations.[22] Indeed, JoAnne Bailey of the GAO,

[20] Betz Testimony, at 2; Muse & Associates, at 1.
[21] *See* Rebecca Simmons, "The Enhancement of Anticompetitive Activity Through Group Purchasing Organizations: A Case Study," at 4, fn.25.
[22] *See* Letter from Robert Betz, Ph.D., President and Chief Executive Officer, Health Industry Group Purchasing Association, to William J. Scanlon, Director, Health Care Issues, United States General Accounting Office, regarding Group Purchasing Organizations: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices (May 29, 2002).

who was involved in conducting the study, stated at the FTC Workshop last fall that the study was limited and preliminary, and that the GAO is expanding the study to include a broader sample of products and health care facilities.[23]

In addition to these flaws, the GAO study analyzed only one component of costs savings associated with GPO membership. Beyond direct savings on their purchases, GPO members also benefit from reduced overhead and administrative costs. Hospitals can outsource a significant portion of their contracting functions to their GPO. In other words, by using the services of a GPO, the individual hospital no longer needs to locate, negotiate and contract with numerous suppliers for many of its required supplies and services and can reduce substantially the number of employees and other resources devoted to these functions. These administrative savings are real efficiencies that help the hospital reduce its costs. It is estimated that it would cost on average $155,000 per hospital annually to replicate the functions performed by GPOs.[24] By providing savings on purchases and administrative costs, GPOs allow their members to contain the cost of providing health care to their patients.

II. Overview of GPO Contracting Practices

GPOs act as the purchasing agent of their member hospitals. They negotiate contracts for practically every need a hospital may have, including pharmaceuticals, surgical instruments, capital equipment, and office supplies. It is important to remember that GPOs do not actually buy anything. They simply negotiate a contract with a supplier that all members of the GPO can access. This guarantees the GPO member that it will receive a price no worse than the pre-

[23] Health Care Workshop, Session No. 2, at 55-56 (Sept. 10, 2002).
[24] Eugene S. Schneller, "The Value of Group Purchasing in the Health Care Supply Chain," at 6, available at http://wpcarey.asu.edu/hap/hap_novation.cfm.

negotiated price on the GPO contract. Of course, the members can always negotiate their own prices directly with the supplier.

Many GPOs use some form of competitive bidding for their contracts. For example, Novation uses a competitive bidding process because one of its owners, UHC, has members who are state universities that are required by various state laws to use a public competitive bidding process. The bidding process is open to any potential supplier. Novation posts a calendar of all bids on its website and all vendors are free to submit a bid.[25]

It also is important to realize that it is the members themselves who are largely responsible for contracting decisions. While the specific methods may vary, GPOs obtain member input into all decisions concerning product selection. Often this will take the form of member involvement (including through committees, task forces and councils) in developing requests for proposals, reviewing bids from competing manufacturers for a particular product, conducting clinical trials of the bidding manufacturers' products, and evaluating bids and the quality of the products in relation to the clinical needs of the member hospitals.[26] In this way, GPOs also provide a valuable network for member hospitals to discover and evaluate new medical technology. Ultimately, the GPO, usually on the strength of the recommendation of these internal groups, awards contracts. The ability of members to leave a GPO and join a new GPO – as hundreds of hospitals do every year[27] – insures that a GPO will keep members' interests in mind when making contracting decisions.

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[25] *See* McKenna Testimony, at 5.
[26] *See generally*, Betz Testimony, at 6-7.
[27] *See*, *e.g.*, "Changing the Rules," *Modern Healthcare* (Feb. 3, 2003) (article concerning Mount Sinai Medical Center's decision to leave Premier).

A. Sole-Source, Dual-Source and Multi-Source Contracts

The type of contract a GPO negotiates can take many forms as a GPO seeks to balance factors such as maximizing discounts against member demands for product choice. In some instances, a GPO may enter into a sole-source contract with a supplier in order to obtain a larger discount. Under a sole-source contract, the GPO or *buyer's agent* commits to contracting with only one supplier for that particular product or product group (*e.g.*, hospital beds). A sole-source contract is **not** an exclusive contract. In an exclusive contract, the purchaser commits to purchasing only from the contracted supplier and from no one else.[28] In the context of a Novation sole-source contract, for example, there is no commitment by the hospital (the actual party doing the purchasing) to buy from only one supplier since the member hospitals are completely free to use the GPO contract or not. Thus, by entering into a sole-source contract, a GPO may be selecting the best low bidders as "preferred" vendors that are available to member hospitals through that GPO, but it is not limiting the ability of any hospital to purchase any product it wishes.

A GPO also may enter into a dual or multi-source contract, allowing member hospitals to access through the GPO the products of two or more competing manufacturers. Despite what some critics suggest, dual or multi-source contracts are a common GPO practice. In the case of Novation, for instance, more than sixty percent of its contracts are dual or multi-source.[29] There may be many reasons for the GPO to contract with multiple vendors, but the primary reason is often the clinical needs or preferences of the member hospitals. Assume that in a given GPO,

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[28] *See*, e.g., *Omega Envtl., Inc. v. Gilbarco, Inc.*, 127 F.3d 1157, 1162-65 (9th Cir. 1997), *cert. denied*, 525 U.S. 812 (1998).

[29] Letter from Jody Hatcher, Vice President of Novation, to Donald S. Clark, Office of the Secretary, FTC (Sept. 30, 2002).

half of the members prefer product A over product B, while the other half prefer B. In this situation, the GPO may choose to contract with both vendors, thereby making both products available to its members. This often happens when clinical preference for the product outweighs the relative importance of obtaining the lowest possible price. In the case of commodities such as bed linens, hospitals may be fairly indifferent between manufacturers and more interested in obtaining the lowest possible price. As a matter of pure economics, the lowest price generally can be obtained when the purchaser or its agent can guarantee the largest volume. In the case of GPOs, that usually translates into a sole-source contract. But when the quality of a product can affect patient care, and there are differences in preferences or needs among the member hospitals or physicians, price quickly takes a back seat to the need to purchase the products that best suit the member hospitals' needs.[30] In these instances, the GPO usually will contract with two or more vendors.

B. Percentage of Purchase and Multi-Product Discounts

GPO contracts often provide member hospitals with multiple levels of discounts based on purchase volume and/or some form of committed purchasing. These too can take many forms, but among the most common are percentage of purchase and multi-product, or bundled, discounts. Percentage of purchase discounts provide the member hospital with rebates based on the percentage of the hospital's total volume that is purchased from that particular vendor. Percentage of purchase discounts differ from volume discounts in that the latter provides discounts based on the quantity purchased while the former is based on the percentage of a purchaser's total purchases. For example, take a hospital that normally buys one million bandages a year. Under a percentage of purchase discount program, the vendor may offer a two

[30] *See generally*, McKenna Testimony, at 5-6.

percent rebate if the hospital purchases eighty percent of its bandages from the vendor. The same effect would be achieved under a volume discount program if the vendor offered the same two percent rebate if the hospital purchases 800,000 bandages from the vendor. But if a smaller hospital only buys 500,000 bandages per year, that hospital will never qualify for the volume based discount. It will, however, qualify for the percentage of purchase discount by purchasing 400,000 bandages. In this way, a percentage of purchase discount allows both small and large hospital members to qualify for all the discounts offered through the GPO contract.[31]

Multi-product discounts provide the purchaser with additional discounts on the condition that the purchaser buy more than one product. They are a means by which a GPO can increase the likelihood that its members' purchases will achieve percentage of purchase or committed discount levels across multiple products, and therefore, are another tool by which a GPO can extract larger discounts from suppliers. In the GPO context, multi-product discounts can take at least two forms. The first is an offer by a manufacturer to provide a discount if the hospital buys some pre-determined combination of the manufacturer's products. The second type of multi-product discount can originate with the GPO itself. In this instance, the GPO can package products from different manufacturers and offer a member additional discounts if the member purchases a minimum percentage of its needs for those products from those manufacturers. Generally, the hospital member will be required to buy all or some fixed ratio (*e.g.*, three of the five) of the multiple products to qualify for the discount. For instance, take companies A, B and C, each of which make different products (products 1, 2 and 3) that are on contract with a GPO. The GPO negotiates an additional discount with companies A, B and C in return for a

[31] *See* IIIA Phillip E. Areeda and Herbert Hovenkamp, *Antitrust Law* ¶ 768b2 (2002) ("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").

commitment by a hospital to purchase a minimum percentage of its needs for those products from those companies. Thus, a hospital may qualify for an additional two percent rebate if it purchases ninety percent of its needs for products 1, 2 and 3 from companies A, B and C. Generally, the rebate will be available only if the hospital meets its commitment for all three products.

C. Commitment Levels

As the preceding discussion suggests, GPO contracts sometimes require a hospital member to commit to a certain level of purchases to qualify for additional discounts. Again, these commitments can take various forms, from requiring the hospital to commit to a minimum percentage of purchases to access the contract at all, to requiring commitments to purchase multiple products to be eligible for additional discounts or rebates beyond those offered under the "basic" contract for any individual product. Either way, the effects are the same, and they function much like a market share discount (*i.e.*, requiring the purchaser to achieve a minimum percentage of purchases in order to qualify for the discount).

Commitment levels are often necessary in the context of voluntary GPOs. Unlike a chain of commonly owned, for-profit affiliated hospitals (*e.g.*, Kaiser Permanente, Tenet or Columbia/HCA) where the parent can control the purchasing decisions of the entire chain, a voluntary GPO cannot force its members to utilize its contracts. Consequently, the GPO cannot guarantee any volume of purchases to a supplier. This fundamentally disadvantages the voluntary GPO because a supplier will be reluctant to offer its best price if it is unlikely to earn sufficient revenues through volume. Likewise, GPOs need to avoid the free-rider problem of having members use the GPO negotiated price as a ceiling for their independently negotiated

prices. If a GPO cannot generate a sufficient volume of sales through its contracts, it will be unable to effectively negotiate the best prices or value for its members in the long run and, therefore, will become ineffective as a cost-cutting vehicle for its members. This fact is a compelling, procompetitive motivation that causes GPOs to continuously search for innovative programs that bring value to their members so they remain competitive with other GPOs. Commitment levels can address this issue by requiring hospitals that choose to do so to commit to a minimum level of purchases before qualifying for additional discounts.

Depending upon the GPO, commitment levels do not necessarily mean, however, that hospitals are locked into purchasing products through a GPO contract. Rather, a hospital usually has the choice of purchasing a particular product outside of the GPO. In fact, this is more likely to be the case when the product at issue is highly differentiated (*i.e.*, a clinical preference product) as opposed to when the product is fungible. In the former instance, price is less of a factor, and if a hospital prefers a product that is not offered through the GPO it will be better off purchasing the product "off-contract." Conversely, in the case of fungible products (*e.g.*, linens), price is likely to be the most important factor and clinical preference is not. Thus, hospitals will simply be looking for the best price, which the GPO contract usually offers, and will have no problem committing to a minimum purchasing requirement to qualify for additional discounts.

D. Administrative Fees

GPOs fund their operations largely through the collection of administrative, or marketing, fees. Generally, these fees are charged to the vendor based on a percentage of sales made through the GPO's contracts. The standard fee averages between the range of two to three percent of sales on a given contract. In the case of Novation, for example, the average fee is 2.1

percent of sales.[32] The collection of administrative fees by GPOs from vendors has been exempted by Congress from the Anti-kickback laws.[33]

While some critics have suggested that allowing GPOs to collect administrative fees from vendors creates a conflict of interest,[34] and others claim that administrative fees are a means by which monopolist manufacturers conspire with GPOs by sharing their monopoly rents,[35] the fact is that allowing GPOs to collect administrative fees from vendors is the most efficient means of funding a GPO.[36] A GPO is like any business – it has operating expenses and someone has to pay them. One way would be for the hospitals themselves to pay the expenses. Of course, a GPO may have hundreds of members, each one of a different size and each utilizing the GPO to different degrees. Determining how much each member must pay to support the GPO – which would depend on factors such as the size of the institution, its revenues, and the volume of purchases through the GPO contracts – would be costly to administer and monitor. It is far more cost-effective to require the vendors to pay a fee based on the volume of sales that they make through the GPO contracts. This system achieves the same result but avoids the need to allocate utilizations among the various members to determine a fee.

Perhaps more important, if hospital members had to pay the full costs of operating GPOs today, many of the services GPOs provide that members want could not be offered, *e.g.*, benchmarking and educational programs, and member hospitals would have to duplicate the costs GPOs help eliminate. Moreover, the payment of administrative fees by vendors creates an

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[32] *See* McKenna Testimony, at 3.
[33] *See* 42 U.S.C. § 1320a-7b(b) and 42 C.F.R. § 1001.952(j).
[34] *See*, *e.g.*, MDMA, "GPOs Were Intended to be Anti-Inflationary; Now They're Just Anticompetitive, According to the Medical Device Manufacturers Association," www.medicaldevice.org.
[35] Einer Elhauge, "The Exclusion of Competition for Hospital Sales Through Group Purchasing Organizations," at 19-23 (May 2002).
[36] *See* McKenna Testimony, at 2.

incentive for members to support the GPO by using it if it is providing significant value to them. In addition, vendor fees represent additional value to GPO members. A substantial percentage of these fees is returned to GPO members in the form of patronage or cooperative dividends.[37] Fees returned to hospital members are, in effect, additional discounts on the products purchased.

III. Challenges to the GPO System

As discussed above, GPOs engage in a variety of contracting practices to attempt to secure larger discounts and increase value for their members, including using sole-source contracts, percentage of purchase discounts and multi-product discounts. These contracting practices enable the GPO to obtain greater value from a particular vendor by concentrating a greater percentage of its members' potential purchases for a particular product or service with that vendor. Obviously, this means that competing vendors are likely to obtain a smaller percentage of that GPO's members' purchases of the relevant product during the term of the contract. Given that GPO contracts account for seventy-two percent of hospital purchases, failure to win one or more GPO contracts may result in a significant loss of business to the losing vendor depending on the percentage of the total market for the product(s) represented by the purchasers of a particular GPO.

It is within this context that critics of the GPO system have arisen. Some suppliers to the medical device industry have complained that GPOs exclude and create barriers to entry for small, innovative suppliers. They claim that sole-source contracts, percentage of purchase discounts and multi-product discounts, individually and collectively, have the effect of

[37] In 2001, VHA returned approximately thirty-two percent of its revenues to its members and UHC returned approximately forty percent. McKenna Testimony, at 2.

establishing exclusive contracts between the member hospitals and the contracted supplier.[38] Competition is harmed, the argument goes, because the "exclusive" GPO contracts entrench further the contracted supplier, allowing it to gain a virtual monopoly and obtain all the rewards that a monopoly brings – *i.e.* higher prices and lower quality. In the case of health care, the critics argue, it is the patient who ultimately suffers both because the cost of health care continues to escalate and the patient does not have access to the latest, most advanced technology available.[39]

So vocal have these critics been that the U.S. Senate Committee on the Judiciary, Subcommittee on Antitrust held hearings into competitive issues relating to GPO contracting in April 2002.[40] The focus of the hearings was on the practices of sole-sourcing, commitment levels and multi-product discounts, the role of vendor payments to GPOs, and whether these practices may "reduce competition and innovation in health care and narrow the ability of physicians to chose the best treatment for their patients."[41]

For purposes of the antitrust laws, however, it is critical to distinguish between competitive bidding practices that result in certain vendors failing to win contracts, and suffering the consequent loss of business, and exclusionary practices that result in foreclosure of an entire

[38] *See*, *e.g.*, MDMA, "Proposed Code of Conduct for Group Purchasing Organizations," Submitted to the United States Senate on the Judiciary, available at www.medicaldevice.org. The MDMA has also attacked other practices of GPOs, including the receipt of administrative fees from the contracted manufacturer and alleged conflicts of interests between the GPOs and contracted suppliers. The focus of this paper, however, is on the antitrust issues surrounding GPOs contracts. *See also*, The Honorable Herb Kohl, United States Senator, Statement Before the United States Senate Committee on the Judiciary (April 30, 2002) (hereinafter "Kohl Statement").
[39] *See*, *e.g.*, Simmons, at 10.
[40] *See* Senate Hearings.
[41] Kohl Statement, at 1. *See also*, The Honorable Orrin Hatch, United States Senator, Statement Before the United States Senate Committee on the Judiciary (April 30, 2002); The Honorable Strom Thurmond, United States Senator, Statement Before the United States Senate Committee on the Judiciary (April 30, 2002).

market in which a particular product is sold, thereby reducing consumer welfare.[42] As the following analysis shows, GPO contracting practices may result in commercial disappointment for certain vendors, but are highly unlikely, in most instances, to injure competition.

IV. Framework for Assessing the Competitive Impact of GPO Contracts

Whether the focus is on sole-source contracts, percentage of purchase discounts, commitment levels, or multi-product discounts, attacks against GPO contracting practices boil down to one basic argument – the alleged exclusionary effect of these practices on competing suppliers for the goods at issue. The basic argument is that, given the importance of GPO contracts to the purchasing practices of hospitals, a sole-source contract is equivalent to an exclusive contract (notwithstanding the fact that, as discussed below, it does not bind the hospitals). Add to that, high commitment levels and the "golden handcuffs" of percentage of purchase and multi-product discounts, and the GPO – and contracted manufacturer – virtually guarantee that member hospitals will purchase their products through the GPO contract. The result, critics argue, is a degree of market foreclosure likely to drive competing suppliers from the market or otherwise render them ineffective to constrain the contracted supplier, who in the long run will be able to exercise market power by raising prices or reducing quality.[43]

Medical supply manufacturers who complain that they have been left out in the cold by the GPO contracting process may challenge GPO contracting practices under a variety of theories. First, in the case of a sole-source contract, a potential plaintiff can claim that the contract constitutes unreasonable exclusive dealing in violation of Section 1 of the Sherman

[42] *See Spectrum Sports, Inc.* v. *McQuillan*, 506 U.S. 447, 458 (1993); *Brunswick Corp.* v. *Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977).
[43] *See* Simmons, at 5.

Act.[44] If the GPO contract is with a supplier that has a large share of the sales of the product at issue, the plaintiff also can allege that the contract constitutes monopolization, an attempt to monopolize or a conspiracy to monopolize the market in violation of Section 2 of the Sherman Act.[45] Of course, these claims are not mutually exclusive, and plaintiffs challenging sole-source, percentage of purchase and/or multi-product discounts under contracts with vendors with large market shares may bring claims under all of these theories, each of which is discussed below.

A. FTC and Justice Department Guidelines Regarding Group Purchasing

Before assessing the GPO contracting practices at issue under the theories outlined above, it is important to note that, as a general matter, group purchasing arrangements between health care providers are evaluated by the FTC and the DOJ under their joint Statements of Antitrust Enforcement Policy in Health Care, Statement No. 7. Statement No. 7 addresses two potential anticompetitive effects of group purchasing—the exercise of monopsony power (monopoly power by a buyer), and the possibility that joint purchases by competing health care providers that account for a large percentage of their costs will result in standardized costs that facilitate collusion by the providers on the prices they charge for their services.[46]

While Statement No. 7 does not directly address the issue of whether GPO contracting practices could have exclusionary effects on vendors, the Statement's guidance regarding monopsony is relevant to the question of whether a GPO has market power. Statement No. 7

[44] Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce." 15 U.S.C. § 1. Section 3 of the Clayton Act also prohibits exclusive dealing. 15 U.S.C. § 14. However, Section 3 applies only to "sales" of goods. Since GPOs do not purchase or sell anything, Section 3 of the Clayton Act cannot apply to them. *See* Simmons, at 5, fn.37, *citing CDC Tech. v. IDEXX Labs.*, 186 F.3d 74, 77 (2d Cir. 1999).

[45] Section 2 of the Sherman Act provides that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony." 15 U.S.C. § 2.

[46] *See 1996 Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care*, No. 7 (1996), available at www.ftc.gov.

provides a safe harbor regarding monopsony: joint purchasing arrangements that account for less than thirty-five percent of purchases of a particular product in a given geographic market are unlikely to result in the exercise of market power.[47] Applying this standard to the GPO industry, it is highly unlikely that any GPO can exercise market power. Even Novation, the largest GPO in terms of total purchase volume, accounts for only approximately fifteen percent of total hospital purchases of supplies and equipment.[48] The figure for the next largest GPO, Premier, is only about twelve percent.[49] Even if this analysis is confined to purchases through GPOs, Novation accounts only for about thirty percent, while Premier accounts for twenty-four percent.[50] While the share of any given product purchased through the contract of any particular GPO could exceed these figures, these market shares suggest that no GPO is likely to have market power. Further, given the large number of GPOs, including 26 GPOs that offer contracts on a national basis, there is no credible argument that any GPO has market power. In the absence of such market power, no GPO contract with a vendor, exclusive or otherwise, can confer market power on that vendor. Exclusive contracts are evaluated under the Rule of Reason,[51] under which the contract's procompetitive benefits are weighed against its anticompetitive effects. Market power is an essential element of a Rule Reason claim.[52] The absence of GPO market power means that exclusive contracts with GPOs should not violate Section 1 of the Sherman Act.

B. GPO Contracts and Exclusive Dealing

[47] *Id*. *See also* Herbert Hovenkamp, "Competitive Effects of Group Purchasing Organizations' Purchasing and Product Selection Practices in the Health Care Industry," at fn.29 (April 2002).
[48] *Id*. at 2.
[49] *Id.*
[50] Elhauge, at 12.
[51] *See Business Elec. Corp. v. Sharp Elecs. Corp*., 485 U.S. 717, 724 (1988).
[52] *See Sports Ltd. Partnership v. National Basketball Ass'n*, 95 F.3d 593, 600 (7th Cir. 1996) (Easterbrook, J.) ("substantial market power is an indispensable ingredient of every claim under the Rule of Reason."); *U.S. Healthcare, Inc. v. Healthsource Inc.*, 986 F.2d 589, 593 (1st Cir. 1993).

A manufacturer seeking to challenge a GPO contract can argue that the contract constitutes illegal exclusive dealing. Generally, exclusive contracts are procompetitive and the courts have always recognized them as such.[53] When an exclusive contract forecloses a significant amount of the market to other competitors, however, it may constitute an unreasonable restraint of trade in violation of Section 1 of the Sherman Act.[54]

The fact that a contract between a GPO and a manufacturer has certain exclusive characteristics does not necessarily establish the relevant type of exclusivity for Section 1 purposes. It is important to remember that, in general, there are two levels of contracting when dealing with a GPO. The first is the contract between the manufacturer and the GPO. This is where exclusivity issues can arise and is often the source of attack by critics. However, the manufacturer-GPO contract does not generally bind the purchasing decisions of the member hospitals. It simply establishes a price schedule that member hospitals can access by virtue of their membership in the GPO. The second level of contracting is between the GPO and the member hospital. This is often nothing more than a membership agreement and these agreements also generally do not dictate purchasing decisions by the hospital. Generally, no contract exists between the member and the manufacturer. In some instances, the member may sign a letter agreement committing to meet certain purchase levels in return for additional discounts or rebates; the penalty for failing to meet these commitments is typically no more than the loss of the committed discount.

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[53] *See*, *e.g.*, *Standard Oil Co. v. United States*, 337 U.S. 293, 306-7 (1949) (Court highlighted some of the procompetitive aspects of exclusive contracts from both the buyer's and seller's point of view: an assured supply, price protection, known costs, reduced need for inventory, reduction in selling expenses, and a stable demand for the product).

[54] *See,* e.g., *Concord Boat Corp. v. Brunswick Corp.*, 207 F.3d 1039, 1059 (8th Cir. 2000).

Thus, a sole-source GPO contract, in the context of Section 1, is not the same as an exclusive contract. Even though a GPO has contracted with only one supplier for a given product, the hospitals are not bound to purchase from the sole-source supplier. GPO members always can turn to sources outside of the GPO contract. As noted above, most hospitals belong to more than one GPO, giving them access to multiple GPO contracts. Also, hospitals sometimes go to alternative vendors using their GPO's contract pricing as a benchmark to obtain better pricing in return for giving that vendor a large percentage of their business.

The fact that an agreement is not expressly exclusive, however, is not a complete defense to an exclusive dealing claim.[55] "Section 1 claims that allege only *de facto* exclusive dealing may be viable."[56] It is the plaintiff's burden, of course, to show that a contract that is not exclusive on its face is exclusive in fact. In *Concord Boat*, for instance, plaintiff boat builders attacked a percentage of purchase discount program offered by Brunswick, a manufacturer of engines, to boat builders.[57] Brunswick's program offered different levels of percentage discounts if the boat builder purchased a certain percentage of engine requirements from Brunswick.[58] None of the discount programs offered by Brunswick required the boat builders to buy engines from Brunswick, though the attractive discounts would be foregone if the boat builder did not buy at the specified levels.[59] Based on this, the plaintiffs alleged that the discount programs

[55] *See Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961); *Concord Boat*, 207 F.3d at 1058-59.
[56] *Id.* at 1058. *See also LePage's, Inc. v. 3M*, 2003 WL 1480498, at *14 (3d Cir. March 25, 2003).
[57] *Id.* at 1044.
[58] *Id.* For instance, one program offered a three percent discount if the boat builder bought eighty percent of its requirements from Brunswick, a two percent discount if it bought seventy percent of its requirements from Brunswick, and a one percent discount for purchasing sixty percent of its requirements from Brunswick. *Id.*
[59] *Id.* at 1045.

offered by Brunswick amounted to *de facto* exclusive dealing, enabling Brunswick to foreclose a substantial amount of the stern drive engine market and to charge higher prices for its engines.[60]

The Eighth Circuit rejected the boat builders' claim. The focus of the court's analysis was "the extent to which competition has been foreclosed in a substantial share of the relevant market, the duration of any exclusive arrangement, and the height of entry barriers."[61] Plaintiffs failed to produce any evidence that a substantial amount of the relevant market had been foreclosed.[62] Not only were there no requirements in the discount program that the purchasers commit to Brunswick engines for any period of time, but the discounts themselves were not so attractive as to effectively prevent purchasers from switching to other engine manufacturers.[63] Indeed, one witness testified at trial that it switched from purchasing eighty percent of its requirements from Brunswick to purchasing seventy to eighty percent of its requirements from a competing manufacturer, OMC, for a period of three years.[64] Moreover, the discounts did not constitute an entry barrier as they were sufficiently above cost to allow room for other manufacturers to enter the market.[65]

At a basic level, discount programs offered by GPOs are analogous to those analyzed in *Concord Boat* and generally do not amount to exclusive dealing. First, there is no contractual relationship between the member and the GPO or the member and the GPO-contracted supplier that requires the hospital to purchase through the GPO contract. The hospital can take advantage of the discounts offered through the GPO contract or it can seek a better deal elsewhere. For the

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[60] *Id.* at 1054.
[61] *Id.* at 1059, citing *Tampa Elec.*, 365 U.S. at 327; *Ryko Mfg Co. v. Eden Servs.*, 823 F.2d 1215, 1233-35 (8th Cir. 1987), *cert. denied,* 484 U.S. 1026, (1988); *Jefferson Parish Hosp. Dist. No 2 v. Hyde*, 466 U.S. 2 (1984).
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*

hospital, a better deal does not necessarily mean better prices. In a market of highly differentiated products, where price is not the most important factor, the hospital may choose to buy a more expensive "off-contract" product that it feels is of higher quality or more appropriately meets its needs.

Second, *Concord Boat* establishes a strong presumption against finding discount programs *de facto* exclusive under Sherman Act Section 1 absent clear evidence that the programs in fact foreclose a substantial amount of the relevant market by preventing purchasers from buying a competitor's product. This makes sense from an antitrust perspective, since even a firm with market power should be able to enter into an exclusive contract where the effect on the relevant market is small.[66] More "off-contract" purchases by member hospitals means that less of the market is in fact foreclosed. In the case of hospital GPOs, members purchase off-contract regularly, a fact that seriously undermines any complaint based on exclusive dealing.

Critics argue, however, that GPO contracting practices go further than the single product discounting programs analyzed in *Concord Boat*. They cite not only to the discount programs themselves, but the GPO practice of requiring commitment levels to receive certain discounts and offering discounts across multiple, unrelated products.[67] The existence of these programs, nevertheless, does not relieve the antitrust plaintiff from meeting the standard set out in *Concord Boat* for establishing an exclusive deal under Section 1 and proving antitrust injury (*i.e.*, injury to competition) as distinguished from harm to an individual competitor. The plaintiff still must

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[66] *See United States v. Microsoft Corp*., 253 F.3d 34, 70 (D.C. Cir. 2001).

[67] *See*, *e.g*., Medical Device Manufacturers' Association, "Proposed Code of Conduct for Group Purchasing Organizations," Submitted to the United States Senate on the Judiciary, available at www.medicaldevice.org. The Eighth Circuit briefly noted that cases such as *LePage's, Inc. v. 3M*, 1997 WL 734005 (E.D. Pa. Nov. 14, 1997), *SmithKline Corp. v. Elli Lilly & Co*., 575 F.2d 1056 (3d Cir.), *cert. denied*, 439 U.S. 838 (1978), and *Ortho Diagnostics Sys., Inc. v. Abbott Labs., Inc.*, 920 F. Supp. 455 (S.D.N.Y. 1996), all of which involved bundled discounts, were distinguishable from the case before it. *Concord Boat*, 207 F.3d at 1062.

show either that the programs were expressly exclusive – which they generally are not – or that they foreclosed a substantial portion of the relevant market.[68] Again, based on the court's analysis in *Concord Boat*, evidence that hospital members purchased off-contract regularly would seem to defeat such a claim.

Even if a plaintiff can show that most, if not all, members chose to stay within a GPO contract to take advantage of the offered discounts, there is still the fundamental question of whether there is market foreclosure. At the outset, it is important to keep in mind that many GPOs use some form of competitive bidding process. In this sense, competition for the GPOs' members' business is open to all vendors. Further, while a sole-source contract means that once the contract is awarded, there may be no further competition to be the GPO's preferred supplier during the term of the contract, there may have been very intense competition to be awarded the sole-source contract in the first instance, and such competition may take place again the next time the contract comes up for bid.[69] One reason exclusive contracts are usually procompetitive is that, because a large volume of business is at stake, competition for the contract is more intense than if a non-exclusive contract was being offered.[70] This same reasoning applies to sole-source contracts, particularly if it is argued, as GPO critics do, that they are essentially exclusive contracts.

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[68] *Concord Boat*, 207 F.3d at 1059.

[69] In addition, during the life of the contract, the losing vendor may still compete by seeking direct off-contract sales from the GPO's members.

[70] *See* XI Herbert Hovenkamp, *Antitrust Law*, ¶ 1811c (1998) ("Exclusivity contracts are often procompetitive ways of organizing the market to encourage more competitive pricing than might otherwise occur – alternatively, to get the benefits of more competition at a reduced price"); *Paddock Publ'ns, Inc. v. Chicago Tribune Co.*, 103 F.3d 42, 45 (7th Cir. 1996) ("Competition-for-the-contract is a form of competition that antitrust laws protect rather than proscribe, and it is common . . . Exclusive contracts make it harder to enter mid-year but cannot stifle competition over the longer run, and competition of this kind drives down the price . . . to the ultimate benefit of consumers").

Further, many GPO contracts are not long-term contracts (*e.g.,* seven to ten years); most last no longer than three years, and often contain provisions allowing the GPO to terminate the contract without cause on sixty to ninety days notice. An exclusive contract that can be terminated on such short notice does not result in any meaningful foreclosure because the business under the contract is always "at risk." For this reason, a number of courts have held that exclusive contracts terminable on short notice are not anticompetitive.[71] Some critics of GPO contracting practices have argued that these termination provisions are of little consequence because the incentives that cause a GPO to enter into an exclusive contract will make it highly unlikely that the GPO will terminate the contract before it ends.[72] The fact that GPOs do not generally exercise these provisions, however, does not mean they are ineffective. The ability to terminate the contract gives the GPO leverage to negotiate better prices or other modifications (such as allowing a GPO with a sole-source contract to add vendors to give members access to new technology) that will benefit its members even if the contract remains in place.

Even if it is assumed that competing vendors are truly foreclosed from GPO members, in most instances such foreclosure is unlikely to be sufficient to have anticompetitive effects. As is often the case, the definition of the relevant market is important. As noted above, no GPO accounts for more than fifteen percent of total hospital purchases of supplies and equipment or more than about thirty percent of total hospitals purchases through GPOs. Further, the purchase of many goods and services by members of all GPOs collectively, much less individually, often do not represent the entire relevant market; GPOs primarily represent hospitals and, to a lesser

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[71] *See*, *e.g*., *Roland Mach. Co. v. Dresser Indus., Inc.*, 749 F.2d 380, 395 (7th Cir. 1984) (exclusive contracts terminable in less than one year presumptively lawful); *Bepco, Inc. v. Allied Signal, Inc.*, 106 F. Supp. 2d 814, 829 (M.D.N.C. 2000) (noting the Fourth Circuit has held that "exclusive contracts terminable after thirty (30) days to one (1) year do not have substantial anticompetitive effects").

[72] *See* Simmons, at 6.

extent, non-acute care facilities. There are many purchasers of certain medical supplies that do not participate in GPOs. In fact, there are many health care facilities – for example, state health departments, prison systems, Veteran's hospitals, many non-acute care facilities and physicians' offices – that do not buy through GPOs. Where the manufacturer has other significant outlets besides those served by GPOs, the likelihood that a plaintiff will be successful in an exclusive dealing claim is significantly diminished; under such circumstances, the plaintiff may have difficulty showing that it was excluded from at least forty percent of the market, as the most recent court opinions are requiring as a precondition to sustaining a Section 1 claim.[73]

For instance, in the *RTI* case, RTI, a manufacturer of safety syringes and blood collection devices sued two of its principal competitors, Becton Dickinson and Tyco, as well as Novation and Premier on the grounds that Novation and Premier contracts with the defendant manufacturers had foreclosed RTI from a substantial portion of the relevant market. In particular, RTI claimed the sole-source contracts, percentage of purchase discounts and multi-product discounts constituted exclusive dealing and monopolization. While the *RTI* case has not been tried, one of the obstacles RTI will face is that a substantial percentage of the products at issue are sold outside of GPO contracts, including to clinics, laboratories, physicians offices and individuals. This will make it far more difficult to demonstrate the degree of foreclosure necessary to prevail under Section 1.

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[73] *See*, *e.g.*, *Microsoft Corp.*, 253 F.3d at 70; *Omega Envtl.*, 127 F.3d at 1162-65 (thirty-eight percent foreclosure not sufficient). This is true even if a plaintiff were to claim that GPOs represent the most efficient channel of distribution. First, the claim that GPOs are the most efficient distribution channel is suspect. Because GPOs do not buy or sell anything – indeed, they do not even handle the goods – a manufacturer must still incur the costs of marketing, selling and distributing its products. Second, a GPO contract does not foreclose any manufacturer from access to members that are always free to buy products off-contract or switch GPOs. Any viable alternate method for reaching purchasers of medical supplies will suffice to preserve competition. The antitrust laws are aimed at preserving competition, not in providing competitors with equally efficient channels of distribution. *See Omega Envt'l.*, 127 F.3d at 1163 ("[T]he antitrust laws were not designed to equip the plaintiff ... with [defendant's] legitimate competitive advantage").

This issue, of course, will turn to some extent on the nature of the product. Again, the main constituents of GPOs are hospitals. There are some products that are purchased primarily by hospitals. For instance, the *KCI* case involved the leasing of specialty hospital beds.[74] Plaintiff KCI alleged that Hill-Rom, a competing manufacturer of specialty hospital beds, entered into GPO contracts that offered discounts on its standard hospital beds on the condition that the hospital also exclusively lease Hill-Rom's specialty beds. Hill-Rom was the dominant supplier of standard hospital beds and KCI offered only specialty beds. KCI's complaint alleged, among other things, that Hill-Rom's practice of tying its specialty beds to its standard beds, where it faced competition from KCI and where it held a ninety percent market share, as well as offering a bundled discount, foreclosed a substantial portion of the specialty bed market and violated Section 1 of the Sherman Act.[75] A jury agreed and awarded KCI $520 million in damages – after trebling – based in part on its Section 1 allegations.[76]

The *KCI* case suggests that for products that do not have much of a market outside of hospitals, GPO contracts could be an important factor in whether a supplier with a large market share achieves market power. It is important to consider, however, that even for such products, no single GPO contract is likely to result in sufficient foreclosure to injure competition. Moreover, given the competition that exists for GPO contracts (*i.e.*, open competition through bidding), the ability of hospitals to purchase off-contract, and the fact KCI actually had two large

[74] *See* Second Amended Complaint, *Kinetic Concepts, Inc.*, No. SA-95-CA-0755.
[75] *Id.* at ¶¶ 96-98. The complaint also set out a count for exclusive dealing, *see* Count III of the Second Amended Complaint at ¶¶ 95-98, though the case went to trial on three theories – tying in violation of Sherman Act Section 1 and Clayton Act Section 3, unreasonable restraint of trade in violation of Sherman Act Section 1, and attempted monopolization in violation Sherman Act Section 2, *see* Simmons, at 3. Regardless of the nomenclature, and as the jury instructions reflected, the "unreasonable restraint of trade" count was essentially an exclusive dealing count. Notably, the plaintiffs did not sue any GPO.
[76] The parties eventually settled for $250 million. Sue Reisinger, "Dueling Bed Manufacturers Find Peace in Settlement," *Corporate Legal Times*, at 58 (April 2003).

GPO contracts at the time of trial[77] (including one with Novation), it is reasonable to question whether KCI truly was foreclosed from the market in a manner that should have resulted in antitrust liability.

Finally, in evaluating the alleged anticompetitive effects of GPO contracts, it is critical to keep in mind that GPOs are acting as agents of **buyers** whose interests are served by obtaining the best quality products at the lowest prices. This fact strongly suggests that the GPO contracting practices at issue promote consumer welfare and should not be condemned by the antitrust laws.[78] Critics of GPOs respond that GPO incentives to protect buyer interests are distorted by the fact that GPOs are funded largely by payments from vendors. This argument is flawed in several respects. First, as noted above, such payments are an efficient means of funding GPO activities and serve as a further discount to GPO members, particularly to the extent they are passed on to members in the form of patronage or cooperative dividends. Second, because these fees generally are based on purchases, GPOs receive them only if members use the contracts. Given the ability of members to purchase off contract and to access other GPO contracts through membership in multiple GPOs, a GPO that enters into an anticompetitive contract (*i.e.*, one that attempts to inflate prices or lock out better products) is at serious risk that members will not participate in the contract. Similarly, given the number of competing GPOs and the ability of members to leave and join other GPOs, a GPO that consistently enters into anticompetitive contracts would risk losing its members and the revenue they represent. All of these facts strongly suggest that it is in a GPO's interest to continuously insure that both its interest and those of its members are positively aligned. When they are

[77] *See* Simmons, at 3 fn.13.
[78] *See* Richard Steuer, "Customer-Instigated Exclusive Dealing," 68 *Antitrust L.J.* 239 (2000).

aligned, there will be high member satisfaction, continuous growth of membership, and growth of contract purchases, all of which are indicators that consumer welfare is being promoted.

B. Issues of Monopolization, Attempted Monopolization and Conspiracy to Monopolize

Those challenging GPO contracts as excluding smaller manufacturers have claimed that alleged GPO exclusivity not only raises issues under Section 1 of the Sherman Act, but also can form the basis for a monopolization claim under Section 2 of the Sherman Act.[79] This is true even if the foreclosure resulting from the contract is not sufficient to establish a Section 1 violation.[80] Of course, a GPO is not a seller of products; thus, no GPO has a monopoly. As a result, a GPO only will fall under the prohibitions of Section 2 if the GPO is found to have conspired to help maintain a monopoly or attempt to create a monopoly by virtue of entering into a contractual relationship with a manufacturer that independently violates Section 2.

To prove a claim of monopolization, the antitrust plaintiff must show two basic elements: 1) the possession of monopoly power in a relevant market; and 2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.[81] An attempt to monopolize requires proof that: 1) the defendant has engaged in predatory or anticompetitive conduct; 2) the defendant had a specific intent to monopolize; and 3) there existed a dangerous probability of

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[79] In *KCI* for instance, plaintiffs sued under Sections 1 and 2 of the Sherman Act. It is well established that exclusionary conduct can serve as a basis for a Section 2 claim. *See*, *e.g*., *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951); *LePage's, Inc.*, 2003 WL 1480498; *Microsoft Corp*., 253 F.3d 34; *Concord Boat*, 207 F.3d 1039; *SmithKline Corp*., 575 F.2d 1056; and *Ortho Diagnostics*, 920 F. Supp. 455.

[80] *Microsoft Corp*., 253 F.3d at 70 ("we agree with plaintiffs that a monopolist's use of exclusive contracts, in certain circumstances, may give rise to a § 2 violation even though the contracts foreclose less than the roughly 40% or 50% share usually required in order to establish a § 1 violation"). *See also*, *LePage's*, 2003 WL 1480498, at *14.

[81] *United States v. Grinnell Corp*., 384 U.S. 563, 570-71 (1966).

success.[82] An exclusive contract can constitute the "willful maintenance" or "predatory conduct" necessary to support either claim.[83]

In cases where an alleged exclusive contract forms the basis of a Section 2 complaint, the basic analysis as to whether the contract has the necessary exclusionary effect is similar to the analysis under Section 1. Claims that GPO contracts aid monopolization are likely to falter on the grounds that the contracts do not significantly foreclose competition. For GPOs, the particular aspect of the GPO contract that is alleged to be exclusionary is significant to the analysis. In *Concord Boat*, for example, the plaintiff boat builders argued in addition to their Section 1 claim that the market share discounts offered by Brunswick "were part of a deliberate plan to exclude competitors from the stern drive engine market."[84] The court quickly dispensed with this claim on grounds similar to those used to dismiss the Section 1 claim, namely, that the discounts did not appear to be below cost and that they did not effectively prevent customers from buying competing products.[85]

Based on this reasoning, it would be difficult to establish that market share discounts offered through GPO contracts, by themselves, constitute exclusionary conduct sufficient to establish a Section 2 claim. As the Eighth Circuit pointed out: "The Supreme Court 'has urged great caution and a skeptical eye when dealing with unfair pricing claims.' . . . This is because '[l]ow prices benefit consumers regardless of how those prices are set, and so long as they are above predatory levels [*i.e.*, above cost], they do not threaten competition.'"[86] Market share

[82] *Spectrum Sports*, 506 U.S. at 456.
[83] *Accord Conwood Company, L.P. v. U.S. Tobacco Co.*, 290 F.3d 768, 783 (6th Cir. 2002) ("'If a firm has been attempting to exclude rivals on some basis other than efficiency, it is fair to characterize its behavior as predatory [or exclusionary]'") *quoting Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 (1985).
[84] *Concord Boat*, 207 F.3d at 1060.
[85] *Id.* at 1062.
[86] *Id.*, at 1060.

discounts through GPO contracts benefit all the hospital members of the GPO by giving them equal access to the same discounts offered by the contracted manufacturer. Because a GPO is the buyer's agent, it is difficult to imagine a scenario in which a GPO that does not have monopsony power would or should be liable under Section 2 for striking a hard bargain with a manufacturer, even if the discounted pricing is below cost.

The Eighth Circuit in *Concord Boat*, however, was careful to point out that the case before it dealt only with the discounting practices of a single product line. Cases involving multi-product discounts present more complex issues and critics of GPOs are more likely to complain about the exclusionary effect of so-called "bundled" discounts, especially when commitment levels are part of the program. While multi-product discounts increase the likelihood that GPO members will choose to meet discount target levels, it is unlikely that these programs will result in foreclosure that can serve as grounds for a monopolization claim. The reasons for this are evident when one considers the Section 2 cases regarding multi-product discounts.

Multi-product discounts have long been recognized as a procompetitive means of competing by offering additional discounts. For example, in *Northern Pacific Railway Co. v. United States*, a Supreme Court case that set out a *per se* rule against tying, the Court stated "[o]f course where the buyer is free to take either product by itself there is no tying problem even though the seller may also offer the two items as a unit at a single price."[87]

A number of cases have held that under certain circumstances a multi-product discount, where at least one of the products is a monopoly product, can violate Section 2. The first such

[87] 356 U.S. 1, 6 n.4 (1958).

case was the Third Circuit's decision in *SmithKline*.[88] In that case, Lilly, the manufacturer of five different cephalosporin antibiotics, offered a three percent discount when any three of its products were purchased. Lilly was the dominant manufacturer of cephalosporins, controlling between ninety and 100 percent of the market during the relevant time period.[89] SmithKline had entered the market with a product, Ancef, that competed with one of Lilly's cephalosporins – Kefzol.[90] Two of Lilly's products – Keflin and Keflex – constituted seventy-five percent of hospital purchases of cephalosporins.[91] The district court found, and the Third Circuit agreed, that by providing a discount based on the purchase of any three of Lilly's five cephalosporins, Lilly was effectively bundling together sales of Kefzol – the product which faced competition from SmithKline's Ancef – with sales of Keflin and Keflex – the products in which Lilly held market power.[92] Without any significant discussion of the exclusionary effect of this practice, the Third Circuit found Lilly's discounting program to violate Section 2.[93]

The logic behind the *SmithKline* case was later followed in *Ortho Diagnostics*, a district court case, though the court arrived at a different conclusion. Similar to the facts that would arise in a GPO context, *Ortho* involved a claim that Abbott's contract with the Council of Community Blood Centers (CCBC), which performed group purchasing functions on behalf of a significant number of blood donor centers (BDCs) in the U.S., unlawfully excluded Ortho from the market for certain blood assays in violation of Section 2 by providing BDCs with certain beneficial pricing for buying a package of four or five different blood assay products from

[88] *SmithKline Corp.*, 575 F.2d at 1065.
[89] *Id.* at 1065.
[90] *Id.*
[91] *Id.* at 1061.
[92] *Id.*
[93] *Id.* at 1065.

Abbott.[94] Like all bundled discount cases, Abbott was deemed to have market power in some of the bundled products, and the plaintiff argued that by linking the monopoly product to the competitive product via discounts, Abbott was able to exclude competition in the market for the competitive product in violation of Section 2.[95]

The court eventually dismissed Ortho's allegations of Section 2 monopolization. In doing so, the court attempted to draw a distinction between pricing that was predatory and pricing that was simply competitive, a distinction that can be discerned in part by looking at the effect the alleged exclusionary conduct has on the plaintiff. The court held that such bundled pricing agreements can violate Section 2 under two conditions: 1) if the monopolist has priced below average variable cost; or 2) if the plaintiff is at least as efficient a producer as the monopolist, but the pricing program of the monopolist makes it unprofitable for plaintiff to continue to produce (*i.e.*, the pricing program excludes the competitor from the market).[96] This second possibility is very significant because it means that a plaintiff does not have to show that the bundled price was below cost.[97] Since Ortho had conceded that Abbott's prices were above cost, it could prove a Section 2 violation only if it showed that it was equally as efficient as Abbott, and that it could not sell its products at a profit. Ortho was unable to convince the court that it could not sell its product at a profit, even though there was evidence that its profitability

[94] *Ortho Diagnostics*, 920 F. Supp. at 458.
[95] *Id.* at 466.
[96] *Id.* at 469.
[97] The court followed the *SmithKline* court's lead and rejected the argument that *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209 (1993), a predatory pricing case involving one product, required a finding that prices be below cost in order to be considered exclusionary. This case differed from *Brooke Group* in that "the pricing at issue here involves the bundled pricing of a package of complementary products, in some of which the defendant has market power, as well as the unbundled prices of components of the package." *Ortho Diagnostics*, 920 F. Supp. at 466.

was harmed by Abbott's pricing program.[98] The court, therefore, granted summary judgment on Ortho's Section 2 claims relating to the pricing bundle.

The exclusionary effect of bundled discounts was again taken up by the Third Circuit in *LePage's, Inc. v. 3M*.[99] At issue was 3M's practice of offering multi-tiered, bundled discounts to customers of its Scotch brand transparent tape, the market leader. There were two primary aspects of the discounts challenged as unlawful by LePage's, a competing manufacturer of private label tape. First, 3M would offer discounts conditioned on the customer purchasing six different product lines: health care products, home care products, home improvement products, stationery products (which included transparent tape), retail auto products, and leisure time products.[100] Second, the size of the rebate depended on the customer meeting specific sales goals.[101] Each product line had its own sales target, and the customer was required to meet the sales target for each product line to receive the rebates. If the customer failed to meet the sales target for any one product line, the customer would lose its rebates for all product lines. The court found that these rebates could be considerable. For example, in one year Kmart received a rebate of $926,287; Wal-Mart received a rebate of $1.5 million; Sam's Club received a $666,620 rebate; and Target received a $482,001 rebate.[102]

The *LePage's* court held that the rebate programs offered by 3M constituted exclusionary conduct sufficient to sustain a Section 2 violation.[103] The court found that the anticompetitive effect of bundled rebates "is that when offered by a monopolist they may foreclose portions of the market to a potential competitor who does not manufacture an equally diverse group of

[98] *Ortho Diagnostics*, 920 F. Supp. at 470.
[99] 2003 WL 1480498 (3d Cir. March 25, 2003) (*en banc*).
[100] *LePage's,* 2003 WL 1480498, at *11.
[101] *Id.*
[102] *Id.*
[103] *Id.* at *19-20.

products and who therefore cannot make a comparable offer."[104] Like the *SmithKline* and *Ortho* courts before it, the *LePage's* court held that bundled rebates can violate Section 2 even if the bundled price is above cost.[105]

GPO contracts that contain multi-product discounts and commitment levels, even if they are with a dominant supplier, are unlikely to violate Section 2 under the standards described in these cases. Once again, the key to a plaintiff's claim is its ability to show an actual exclusionary effect from the multi-product rebates in circumstances where the program is either initiated or sought by a *buyer*. It is not enough just to prove that these discounts exist. In *Ortho*, the plaintiff was unable to show that it could not sell its product profitably in the relevant market. Even in *LePage's*, the bundled rebate program was not condemned outright. The court closely analyzed LePage's claims and the effects that the rebate programs had on its ability to compete. The type of evidence found relevant by the *LePage's* court was a drop in earnings as a result of the rebates (LePage's earnings dropped to below zero), a dramatic decline in demand for plaintiff's products, a loss of key accounts or large cut backs in purchases by accounts, and a precipitous fall in market share.[106] The bottom line is that to sustain an action under Section 2 based on the exclusionary effect of a GPO contract, a plaintiff will have to show that the effect of the contract is to "cut [plaintiff] off from key [ ] pipelines necessary to permit it to compete

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[104] *Id.* at *12.
[105] *Id.* at *8. The court did not address the *Ortho* court's second test for showing the anticompetitive effect of bundled prices, namely, that above-cost, bundled discounts can be exclusionary if an equally efficient firm cannot profitably sell its products in the relevant market. *Ortho Diagnostics*, 920 F. Supp. at 469. As part of its proof of injury, LePage's demonstrated that its efficiency, and therefore its ability to compete, had been damaged by 3M's rebate program. *LePage's,* 2003 WL 1480498, at *17. Nevertheless, there does not appear to have been a showing by LePage's, and the majority did not seem to require a showing, that it was an equally efficient competitor prior to 3M's rebate program. Indeed, as the dissent points out, LePage's economic expert conceded that LePage's was not as efficient a tape producer as 3M. *Id*. at 33 (Greenberg, J., dissenting).
[106] *LePage's,* 2003 WL 1480498, at *17.

profitably."[107] To the extent the plaintiff still has sufficient channels of distribution through which it can sell its products, even if they are not the most efficient ones, a claim under Section 2 should not survive.

At the outset, it is unlikely that most vendors, even vendors with a large market share, will price to a GPO below cost, placing the discount within the first prong of the *Ortho* test. GPO contracts are valuable to vendors because they represent a large volume of business and can last for three years. While these characteristics will likely encourage a vendor to compete vigorously for a GPO contract and offer its best price, it seems unlikely that most vendors would be willing to take a loss on large, multi-year contract.

There also are reasons to doubt that a GPO multi-product discount program will result in significant market foreclosure as appeared to be the case in *LePage's*. First of all, not all GPO members participate when a GPO offers such a program. In particular, where a significant percentage of a hospital's physicians prefer to use one or more products not included in the multi-product package, the hospital is unlikely to participate. For example, over the past several years, a significant percentage of Novation hospitals have consistently chosen not to participate in Novation's multi-product discount program, Opportunity. Where a significant percentage of purchasers (ten percent or more) choose not to participate in a multi-product discount, scholars have cautioned against finding that such discounts are illegal.[108] Second, as discussed above, many products purchased through GPO contracts also are sold to other purchasers.

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[107] *Id.*, at *16.

[108] *See* X Phillip E. Areeda, Einer Elhauge & Herbert Hovenkamp, *Antitrust Law* ¶ 1758b (1996) (suggesting a rule that multi-product packages be considered a *de facto* tie only when separate sales of the products in the package are below ten percent of total sales for those products). *See also Nobel Scientific Indus., Inc. v. Beckman Instruments, Inc.*, 670 F. Supp. 1313, 1325 (D. Md. 1986) (no de facto tie because 50-55 percent of the tied product sales were separate), *aff'd*, 831 F.2d 537 (4th Cir. 1987); *Robert's Waikiki U-Drive, Inc. v. Budget Rent-A-Car Sys., Inc.*, 491 F.

Third, if a court were to require that a GPO multi-product discount not foreclose an equally efficient competitor, it will be important to consider and examine closely whether a larger, more established company with which a GPO has a contract has achieved its cost savings and efficiencies on the merits, thereby distinguishing it from many smaller, newer companies that have not learned how to compete effectively. In these situations, a bundled discount that cannot be matched by a smaller company should not be grounds for a Section 2 violation. In this context, the *Ortho* standard stands for the proposition that the antitrust laws, which are concerned with consumer welfare, should not be used to protect inefficient competitors at the expense of higher prices to consumers.[109]

Finally, critics of GPO multi-product discounts sometimes fail to consider that even a small, single product company may be able to compete with a multi-product package by partnering with other companies. In the medical device and pharmaceutical industries, it is quite common for small, new companies to form marketing and distribution arrangements with larger, more established companies. Such alliances not only provide market access, but make it possible to offer alternative packages of products that can compete with the package offered by the GPO. Where the package offered under the GPO contract(s) contains a number of products that face competition from other products, it may be possible to construct alternative packages that match the GPO offer product for product, in which case no one competing vendor must meet the entire multi-product discount on its product to compete effectively with the GPO package.[110]

Supp. 1199, 1208 (D. Haw. 1980) (package discount might raise concern only if "no one would buy [the tied-in product] without the tied product"), *aff'd*, 732 F.2d 1403 (9th Cir. 1984).

[109] *Accord Omega Envt'l.*, 127 F.3d at 1163.

[110] At least one commentator has noted that it is not proper to allocate the discounts for each product in the package to the competitive product sold by plaintiff, thereby driving an otherwise above-cost discount to predatory levels. *See* III Philip E. Areeda & Herbert Hovenkamp, *Antitrust Law*, ¶749 (rev. ed. 1996). *But see*, *Ortho Diagnostics*,

Based on these considerations and principles taken from the *Ortho* and *LePage's* decisions, the following test should be used to evaluate a multi-product bundle under Section 2 1) where the GPO is not a monopsonist (*i.e.*, it has less than thirty-five percent of the GPO market and the product market at issue); 2) it offers unrelated products as a bundle and individually, some of which have a monopoly share of their respective product market; 3) the bundled price is deeply discounted and conditioned on a purchase requirement of eighty percent or more of each product in the bundle; and 4) a plaintiff, offering only one of the bundled products, claims it must effectively absorb the differential between the bundled and unbundled prices:

a) the incumbent supplier must have priced its monopoly product below average variable cost to the GPO which is passing it on;

b) the GPO must have forced its members to buy at these prices, leaving them no other practical alternative;

c) the plaintiff must be at least as efficient as the incumbent supplier of the competitive product; and

d) by virtue of this pricing scheme, the GPO must make it unprofitable for the plaintiff to stay in business.

If the plaintiff has not been foreclosed from a substantial portion of the market – at least forty percent – as a result of the pricing scheme, and if the plaintiff still has sufficient alternate channels of distribution – even if not the most efficient ones – then plaintiff's Section 2 claim must fail.

The underlying rationale of this test is that any alleged foreclosure or inability to compete must be directly tied to the bundling scheme and must affect competition in the market as a whole for the product at issue. If a rival is foreclosed because it is not as efficient or as

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920 F. Supp. at 467 (taking contrary view where party offering a package discount has market power in one of the packaged products).

competitive as the incumbent supplier, which may be caused, in part, by the bundling, the benefit of any doubt should go to the buyer and consumers. Or, as the 9th Circuit said in the *Omega Environmental* case "the antitrust laws were not designed to equip the plaintiff ... with [defendant's] legitimate competitive advantage."[111] Any other rule would entail a substantial risk that the antitrust laws would be used to protect an inefficient competitor – not of the GPO, but of the incumbent supplier – against price competition that would benefit consumers.

V. Conclusion

GPOs are important players in the fight to contain growing health care costs. In particular, GPOs have developed a number of innovative contracting practices that offer hospitals opportunities to achieve significant savings that reduce health care costs and benefit both third-party payers and patients.

Given the substantial benefits provided by GPO contracts, courts and government enforcement officials should proceed with caution in considering possible restrictions on GPO practices. While certain manufacturers that have failed to compete successfully for GPO contracts may feel aggrieved by practices such as sole-source contracting, percentage of purchase discounts and multi-product discounts, there are serious economic and policy reasons to doubt that such practices result in anticompetitive effects justifying intervention, or at the very least, that such intervention is justified absent very clear evidence that GPO practices are resulting in anticompetitive effects, not just lost sales to particular competitors. Rather, at a time when increasing health care costs continue to be a national priority, the better course is to allow the significant competition that exists in the GPO marketplace to continue to evolve in the

[111] 127 F.3d at 1163.

challenge to achieve further innovative solutions in creating a more cost-efficient, equitable health care system.