



**Empirical Data Lacking to Support Claims of Savings
With Group Purchasing Organizations**

Minority Staff Report

111th Congress

**Senate Finance Committee
Sen. Charles E. Grassley, Ranking Member**

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Background

The United States Senate Committee on Finance (Committee) has jurisdiction over, among other things, the Medicare and Medicaid programs. As Ranking Member of the Committee, Senator Chuck Grassley has an interest in conducting oversight to ensure that taxpayer dollars are spent appropriately in the Medicare and Medicaid programs to provide beneficiaries with quality care and access to safe and effective drugs, medical devices, and other medical supplies.

Since 2005, as Chairman and then as Ranking Member of the Committee, Senator Grassley has been examining various operations and activities of the pharmaceutical and medical device industries, including payments made to physicians for speaker bureaus, payments for continuing medical education and conferences, and funding for research.

The Senator's inquiries led to the introduction of the bipartisan Physician Payments Sunshine Act, which he co-authored with Senator Herb Kohl. The Act requires pharmaceutical and device manufacturers to disclose to the Secretary of the Department of Health and Human Services (HHS) anything of value given to physicians, such as payments, gifts, honoraria, or travel, above certain minimum thresholds. Companies are also required to report the name of the physician, the value and date of the payment or gift, and its purpose, among other information. The Secretary of HHS would then make this information available to the public on a searchable website. This bill was incorporated into the recently passed health care reform legislation, the Patient Protection and Affordable Care Act,¹ which was signed into law by President Obama on March 23, 2010. Beginning in March 2013, pharmaceutical, device, biologics and medical supply manufacturers will be required to report annually payments they made to physicians nationwide.

The new legislation, however, does not cover all entities in the health care industry that receive industry payments, including group purchasing organizations (GPO), pharmacies, health plans, and others. As purchasing intermediaries, GPOs play a major role in the availability and cost of medical devices and supplies sold to hospitals and other health care providers throughout the country. According to the Government Accountability Office (GAO), the six largest national GPOs accounted for more than \$108 billion of the purchasing volume of hospital purchases made through GPO contracts in 2008.²

GPOs were initially formed by groups of hospitals in an attempt to improve their negotiating strength and buying power.³ Many of these GPOs eventually merged in the mid-

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §6002, 124 Stat. 119, 689-696 (2010).

² U.S. Government Accountability Office, *Group Purchasing Organizations: Services Provided to Customers and Initiatives Regarding Their Business Practices*, GAO-10-738, Aug. 2010.

³ See Walt Bogdanich, "Medicine's Middlemen; Questions Raised of Conflicts At 2 Hospital Buying Groups," *N.Y. Times*, Mar. 4, 2002; S. Prakash Sethi, *Group purchasing organizations: An evaluation of their effectiveness in providing services to hospitals and their patients*, July 20, 2006, available at http://www.icca-corporateaccountability.org/PDFs/HGPPII_Report07-20-06.pdf.

1990s to form larger organizations.⁴ According to the GAO, “a relatively small number of GPOs dominate the market for products sold through GPO contracts. Although there are over 600 GPOs in the United States, in 2007, the six largest national GPOs by reported purchasing volume together accounted for almost 90 percent of all hospital purchases nationwide made through GPO contracts.”⁵

The purpose of GPOs is to contain health care costs and save money for hospitals and other health care providers by negotiating better prices with manufacturers.⁶ However, the question of interest to the Committee is whether or not GPOs successfully achieve that purpose, since GPO activities have implications for federal health care spending. In addition, it is the responsibility of the Committee to conduct oversight into entities and activities that could affect the quality of care received by Medicare and Medicaid beneficiaries. GPOs determine what medical products are on GPO contracts for purchase by GPO hospitals and other members and customers. Even though the GPOs report that members and customers can purchase off contract, GPOs still play a significant role in the availability and cost of the medical products to their members and customers. Thus, they can have an impact on the quality of care delivered to Medicare and Medicaid beneficiaries.

In 1986, Congress passed legislation that provided a statutory safe harbor for GPOs under the Anti-Kickback Statute, 42 U.S.C. 1320a-7b. This safe harbor allows GPOs to receive fees from manufacturers without violating antitrust and anti-kickback laws. *The New York Times* reported that the GPO industry convinced Congress that more health care dollars could be saved if manufacturers paid the group purchasing costs.⁷ However, in providing GPOs the safe harbor Congress also created an inherent conflict of interest. Although GPOs represent the interests of their members and customers—the purchasers of medical supplies—many are funded by the manufacturers through administrative fees collected as a percentage of the cost of products purchased under the GPO contract. Manufacturers pay these fees in return for administrative services and the ability to sell to a GPO’s purchasing members and customers.⁸

During contract negotiations with manufacturers, GPOs may negotiate their own administrative fees. Some have argued that because GPO fees are based on sales to members and customers, there is a built-in incentive not to seek the lowest price because higher prices will yield higher fees.⁹ Increased prices also indirectly translate into increased cost to taxpayers, because Medicare pays more when hospitals receiving financial distributions from GPOs fail to

⁴ See Statement for the Record by William J. Scanlon, Director, Health Care Issues, U.S. Government Accountability Office, *Group Purchasing Organizations: Pilot Study Suggests Large Buying Groups Do Not Always Offer Hospitals Lower Prices*, Before the Subcommittee on Antitrust, Competition, and Business and Consumer Rights, Committee on the Judiciary, U.S. Senate, GAO-02-690T, Apr. 30, 2002.

⁵ U.S. Government Accountability Office, *supra* note 2.

⁶ For purposes of this report, the term “manufacturers” refers to manufacturers, vendors, and suppliers.

⁷ Bogdanich, *supra* note 3.

⁸ See Scanlon, *supra* note 4.

⁹ See Pablo Lastra, “Hijacking at the Hospital,” *Fort Worth Weekly*, Nov. 23, 2005, available at <http://www.fwweekly.com/content.asp?article=3419>; S. Prakash Sethi, *supra* note 3; Scanlon, *supra* note 4; Testimony of Mark B. Leahey, Executive Director, Medical Device Manufacturers Association, “Hospital Group Purchasing: Are the Industry’s Reforms Sufficient to Ensure Competition?” Before the Subcommittee on Antitrust, Competition, and Business and Consumer Rights, Committee on the Judiciary, U.S. Senate, Mar. 15, 2006, available at http://judiciary.senate.gov/hearings/testimony.cfm?id=1808&wit_id=5164.

report these appropriately as offsetting supply costs. Thus, “the contracts that were intended to protect the customer from increased prices are now protecting the dominant supplier from deflated prices.”¹⁰ According to the HHS Office of Inspector General (OIG),

Cost reports play an important role in determining Medicare payments to hospitals that do not participate in the prospective payment system (PPS) [such as psychiatric and cancer hospitals], as well as those that do... Medicare reimburses these hospitals based on their actual costs of providing services. Therefore, failure to reduce costs by GPO net revenue distributions or rebates will result in larger Medicare payments.

* * *

Medicare-certified institutional providers, such as hospitals, are required to submit an annual cost report to a fiscal intermediary... Medicare contractors use these data to compute some elements of Medicare reimbursement, such as inpatient outlier payments.¹¹

Nevertheless, GPOs claim that under the current system, they achieve the goal of saving money for their hospitals and other health care providers.¹² For example, the GPO Novation reported that it saves American hospitals \$1 billion each year.¹³

Some GPOs are owned by hospitals or health systems and others do not have an ownership relationship with their customers. Hospitals contract with a GPO or with several GPOs to negotiate with manufacturers of medical supplies ranging from bandages to pacemakers.¹⁴ As part of that negotiation, the GPOs may secure rebates to be paid by the manufacturers to the GPO or directly to the hospital.¹⁵ In addition to rebates, the GPO may also distribute some of the administrative fees received from manufacturers to hospitals that are members or customers¹⁶ of the GPO. Not every hospital contracting through a GPO, however, receives these financial distributions.¹⁷ In addition, a hospital may negotiate prices directly with a manufacturer for specific medical devices, such as heart valves and pacemakers, commonly referred to as “physician preference” items.¹⁸

¹⁰ Statement of Said Hilal, President and Chief Executive Officer, Applied Medical Resources Corporation, Joint FTC/DOJ Hearings on Health Care and Competition Law and Policy, Sept. 26, 2003, available at <http://www.ftc.gov/ogc/healthcarehearings/030926ftctrans.pdf>.

¹¹ Office of Inspector General, U.S. Department of Health and Human Services, *Review of Revenue from Vendors at Three Group Purchasing Organizations and Their Members*, A-05-03-00074, Jan. 2005.

¹² See Michael Hiltzik, “Supply Middlemen May Leave Hospitals Ailing,” *L.A. Times*, Apr. 14, 2005, available at <http://articles.latimes.com/2005/apr/14/business/fi-golden14>; Sethi, *supra* note 3; Press Release, Health Industry Group Purchasing Association, HIGPA Supports Health Care Reform Bill’s Increased Transparency Measures That Would Improve Patient Care and Prevent Conflicts of Interest in Healthcare Sector, Mar. 19, 2010.

¹³ See Pablo Lastra, “Putting the Bite on Hospitals,” *Fort Worth Weekly*, Oct. 4, 2007, available at <http://www.fwweekly.com/content.asp?article=6344>.

¹⁴ See Statement for the Record by Marjorie Kanof, Director, Health Care—Clinical and Military Health Care Issues, U.S. Government Accountability Office, *Group Purchasing Organizations: Use of Contracting Processes and Strategies to Award Contracts for Medical-Surgical Products*, Before the Subcommittee on Antitrust, Competition Policy and Consumer Rights, Committee on the Judiciary, U.S. Senate, GAO-03-998T, July 16, 2003.

¹⁵ See Office of Inspector General, U.S. Department of Health and Human Services, *supra* note 11.

¹⁶ The terms “members” and “customers” include equity and non-equity members, customers, and clients.

¹⁷ See Bogdanich, *supra* note 3.

¹⁸ See U.S. Accountability Office, *supra* note 2. According to the GAO, customers and manufacturers said that some GPOs may still receive administrative fees for customer-negotiated purchases.

Once contracts are in place, members and customers can use them to make purchases from the manufacturers on the GPO contracts. According to the Health Industry Group Purchasing Association (HIGPA), the trade association representing GPOs:

- About 72 percent of purchases that hospitals make are done using GPO contracts.
- 96-98 percent of hospitals in the U.S. utilize GPO contracts.
- On average, hospitals in the U.S. use between 2 and 4 GPOs.¹⁹

In addition to the conflict of interest concerns related to the statutory safe harbor protection for GPOs, there has been a lack of transparency in the types of payments made to GPOs by manufacturers and others and the services that these payments fund, in addition to the administrative costs associated with negotiating lower prices for members and customers. In the summer of 2009, representatives of HIGPA, Premier, Inc., and VHA, Inc. met with Committee staff regarding their concerns that any adjustments or modifications to the safe harbor provision would, in their opinion, limit the important services that GPOs currently offer to their members, beyond the negotiation of better prices for drugs, devices, and medical supplies. These services they said include quality of care and patient safety initiatives.

To better understand the fees and other payments GPOs receive and the services that they provide, Senator Grassley, along with Senator Kohl and Senator Bill Nelson, sent letters to seven major GPOs in August 2009: Amerinet, Broadlane, Consorta, Inc., HealthTrust Purchasing Group, MedAssets, Premier, Inc., and Novation.²⁰ Senator Grassley also asked the GAO to report on the literature available concerning the impact of GPOs on pricing.

The following report presents the Finance Committee Minority staff's findings to date, based on: (1) a review of documents provided to the Committee by the seven GPOs; (2) a review of publications the staff received and collected through literature searches; (3) a review of GAO and HHS OIG reports on GPOs; and (4) interviews with device companies, distributors, trade associations, and attorneys examining group purchasing practices.

Findings

A. Limited Data Available on Whether GPOs Achieve Cost Savings

In 2002, the GAO conducted a pilot study, examining the extent to which hospitals in one metropolitan area buying pacemakers and safety needles saved money by using a GPO contract.²¹ In that study, the GAO found that a hospital's use of a GPO contract did not guarantee that the hospital saved money and that the GPOs' prices were not always lower and, in

¹⁹ Health Industry Group Purchasing Association, *A Primer on Group Purchasing Organizations: Questions and Answers*, available at www.higpa.org/assets/1/workflow_staging/AssetManager/230.PDF.

²⁰ According to Consorta, in 2007, it acquired an equity interest in HealthTrust Purchasing Group. While Consorta is still a separate GPO, Consorta stated that a vast majority of the contracting and a large proportion of other GPO operations are handled by HealthTrust.

²¹ See Scanlon, *supra* note 4.

fact, were often higher than prices paid by hospitals negotiating directly with manufacturers. This study, however, had its limitations. GAO noted that it was “exploratory, testing the feasibility of collecting price and purchase data for medical devices” and that the agency would follow with a broader study.

In addition, in their analysis of GPOs, critics of the report raised concerns regarding the GAO findings:

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...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.

* * *

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.²²

The GAO did not conduct a broader study after testifying in 2002. As a result, in 2009, Senator Grassley asked GAO to examine 50 or more medical devices and supplies to evaluate the impact of GPO contracting on pricing. The GAO informed Committee staff that it could not conduct that study. The GAO stated that it was unable to establish a methodology that would address the concerns raised about its 2002 pilot study.

Senator Grassley then asked the GAO to identify and review the literature available on the impact of GPOs on pricing. In January 2010, the GAO reported that “GPO and other trade associations have funded studies on the impact of GPOs. However these studies have limitations.”²³ The GAO searched literature published between January 2004 and October 2009 and identified one peer-reviewed article published during that period. According to the GAO, although the article concluded that GPOs can contain health care costs by reducing prices, reducing transaction costs, and increasing hospital revenues through rebates and dividends, “the article identified some limitations to the analysis, including that the findings rely on the perceptions of materials managers identified through a survey and do not include empirical

²²Robert E. Bloch, Scott P. Perlman, and Jay S. Brown, *An Analysis of Group Purchasing Organizations' Contracting Practices Under the Antitrust Laws: Myth and Reality*, Sept. 26, 2003, available at <http://www.ftc.gov/ogc/healthcarehearings/docs/030926bloch.pdf>.

²³U.S. Government Accountability Office, *Group Purchasing Organizations: Research on Their Pricing Impact on Health Care Providers*, GAO-10-323R, Jan. 29, 2010.

analyses of hospital cost savings.”²⁴ Materials managers are responsible for the purchases of medical supplies made by the hospitals. The GAO also identified nonpeer-reviewed articles, but again these studies did not include the results of empirical analyses and they provided mainly anecdotal information.

According to a HIGPA-commissioned study,

...in Calendar Year 2008, GPOs saved the nation up to \$64 billion – with savings to public health care programs ranging from \$16 billion to \$36 billion. The study also estimates that Medicare realized savings of between \$8 billion and \$17 billion in CY 2008 with savings to Medicaid ranging from \$5.7 billion to more than \$12 billion.²⁵

However, as GAO noted in its report, this study applies “varying assumptions to national expenditure data to model the effects of GPOs on providers or federal expenditures.”²⁶ GAO also noted that one of the other industry funded studies “relies on estimates of savings reported by hospitals in a survey, but does not report the survey response rate or how the respondents were selected.”²⁷

Based on GAO’s findings and the study constraints identified in the available literature, there is limited data on the actual savings that may or may not be achieved through GPOs. In April 2010, the publication *Hospitals & Health Networks* and the Association of Healthcare Resource & Materials Management conducted a nationwide survey of hospital vice presidents, directors of materials management, and chief financial officers to find out, among other things, the value of the goods and services hospitals purchase through their GPOs. The study, published in July 2010, found that 90 percent of the respondents were satisfied or very satisfied with their primary GPO and GPOs received the highest scores for pricing, savings, and customer service compared to the other services provided. Nevertheless, according to the article, the consultant who helped develop the survey questions noted that “many areas where hospitals reported savings, improvement and satisfaction are really based on estimates and perceptions, rather than hard data.”²⁸

B. Payments to GPOs and Distributions to Members and Customers

Administrative fees from manufacturers are understood to be the main source of GPO revenue, covering operating expenses and services. Based on the information provided to the Committee by the GPOs, about 80-100 percent of total GPO revenue comes from manufacturer and distributor administrative fees. The HHS OIG has noted, however, that “GPOs’ revenues

²⁴ *Id.*

²⁵ David E. Goldenberg and Roland “Guy” King, *A 2008 Update of Cost Savings and a Marketplace Analysis of the Health Care Group Purchasing Industry*, July 2009, available at http://www.higpa.org/assets/1/workflow_staging/AssetManager/226.PDF; see also Eugene S. Schneller, *The Value of Group Purchasing – 2009: Meeting the Need for Strategic Savings*, April 2009, available at www.higpa.org/assets/1/workflow_staging/AssetManager/235.PDF.

²⁶ U.S. Government Accountability Office, *supra* note 23.

²⁷ *Id.*

²⁸ Chris Serb, “Does Your GPO Deliver the Goods?” *HHN Magazine*, July 2010.

from vendor fees substantially exceeded operating costs.”²⁹ In its 2005 review of three GPOs, OIG found that the GPOs collected administrative fees of \$1.8 billion for the time periods reviewed. Of this amount, the OIG found that “\$1.3 billion, or 72 cents of every dollar collected, represented net revenue **in excess of operating costs**. The remaining \$487 million, or 27 cents of every dollar collected, was used to cover the GPOs’ operating costs.”³⁰ [Emphasis added] About 70 percent of the excess revenue was distributed to members and the rest was retained by the GPOs “to provide reserves and venture capital for new business lines.”³¹

In addition to contracting with manufacturers and with hospitals, GPOs contract with distributors of medical supplies. Only distributors with a GPO contract are allowed to sell and distribute products to the GPO members and customers. As part of the arrangement, GPOs may collect fees from the distributors, typically a percentage of the total invoice price. Thus, “buying groups often collect twice on the same product—from the manufacturer and from the company that delivers the product to hospitals.”³²

In addition, six of the GPOs offer additional services to their members and customers that are beyond the traditional GPO functions related to the negotiation and administration of GPO contracts. These additional services may be paid for entirely or in part by the members and customers in the form of fee-for-service or subscription payments. Although most of the fees that GPOs receive from manufacturers are administrative fees for GPO contracts, six of the GPOs reported that a small percentage of their revenue comes from sponsorship or exhibition fees paid by manufacturers for annual or periodic conferences and educational programs offered to members and customers. Two of the GPOs also mentioned educational grants; one of these GPOs reported that the educational grants go directly to the members or customers.

In their responses to the Committee, none of the GPOs reported investments or equity interest in manufacturers as a source of revenue. In October 2002, a report requested by the Audit Committee of the Board of Directors of Premier identified relationships between GPOs and manufacturers that raised significant ethical concerns and made recommendations for best ethical practices.³³ Some of the relationships the report identified include: (1) joint investments with manufacturers; (2) GPO executives investing in, serving on the boards of, and receiving compensation from manufacturers; and (3) GPO use of advisory groups composed of member hospital employees who have equity interest in or receive compensation from manufacturers. The GPOs informed the Committee that they have adopted conflicts of interest policies, such as prohibitions on equity ownership in manufacturers for individuals who are in the position to influence GPO contracting decisions, to prevent or reduce these types of relationships that GPOs and their members had with manufacturers.³⁴ Figure 1 shows the relationships and interactions between the various stakeholders and the GPOs, including revenue flow, based on the information the seven GPOs provided to the Committee.

²⁹ Office of Inspector General, U.S. Department of Health and Human Services, *supra* note 11.

³⁰ *Id.*

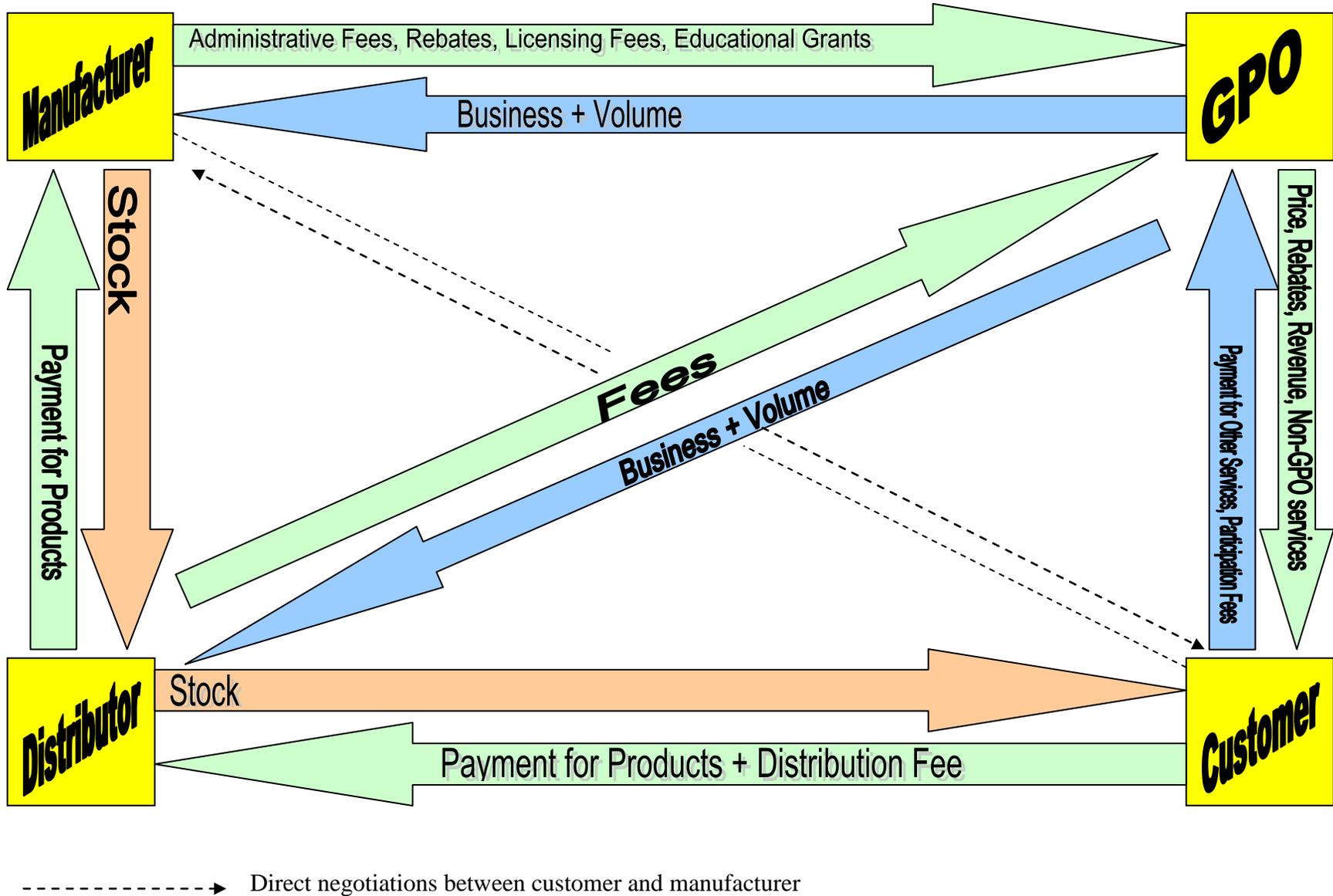
³¹ *Id.*

³² Bogdanich, *supra* note 3.

³³ Kirk O. Hanson, *Best Ethical Practices for the Group Purchasing Industry*, Oct. 2002, available at <http://www.premierinc.com/about/mission/ethics-compliance/publications.jsp>.

³⁴ Senator Grassley also asked the GAO to examine the impact of the GPOs’ codes of conduct on GPO practices. See U.S. Government Accountability Office, *supra* note 2.

Figure 1. Diagram of GPO Relationships with Manufacturers, Distributors and Customers



The GPOs reported that all of the rebates paid by manufacturers and distributors are distributed to the GPO members and customers either directly or through the GPOs. They also reported that a share of the manufacturer and distributor administrative fees (minus GPO operating costs, overhead and/or other related expenses) is distributed to their members and customers. However, not every member or customer receives these financial distributions.

Whether or not members and customers receive these payments and how much may depend on their: (1) relationship with the GPO; and (2) the contract terms with the GPO. Some GPOs are owned by their member hospitals or large health systems; others are comprised of non-equity members that may pay participation or membership fees to receive the services offered by the GPOs. One GPO, for example, reported that its members could negotiate contracts that include the receipt of a share of the administrative fees; others can choose not to include those terms in their contracts. Another GPO stated that smaller hospital members may not receive a share of the administrative fees because the GPO incurs higher administrative costs for these members. A third GPO stated that if the administrative fees from a member or customer's purchases are not enough to cover the cost of the service to the GPO then the service is paid in part by the member or customer.

Table 1 below summarizes the information the seven GPOs submitted to the Committee on the range of administrative fees received by each of the GPOs each year from 2005-2009, the percentage of revenue paid to members and customers, and some of the other sources of GPO revenue. Five of the GPOs reported that they do not accept administrative fees greater than three percent. Two of the GPOs reported that they charge fees for use of their "private label," which allows a manufacturer's products to be sold under the GPO's brand name.

Table 1. Payments to GPOs and Distributions to Members and Customers

	Percentage Range of Administrative Fees Paid to GPOs³⁵	Percentage of Total Administrative Fees Distributed to Members/Customers	Other Fees and Payments to GPOs
GPO #1	From manufacturers: up to 3% (about 80-90% in 2-3% range) From distributors: up to 3%	About 50%	From manufacturers: transaction fees From members/customers: management fees, consulting fees, savings bonuses, other service fees
GPO #2	From manufacturers: up to 3% (about 75% in 2-3% range) From distributors: up to 2%	About 40-75% based on contract terms	From manufacturers: exhibition and sponsorship fees From members/customers: licensing fees, service fees, subscription fees From other third parties: fees for non-GPO services
GPO #3	From manufacturers: up to 9.9% (about 85% at 3% or less) From distributors: up to 1%	About 40%	From manufacturers: licensing fees, fees for not providing contracted products From members/customers: membership fees, consulting fees, educational services fees
GPO #4	From manufacturers: up to 10% (about 35% in 1-2% range and about 50% in 2-3% range) From distributors: up to 3%	About 80-85% (2005-2007) About 50% (2008)	From manufacturers: licensing fees, sponsorship fees, educational grants From members/clients: fee-for-service payments, participation fees
GPO #5	From manufacturers: up to 3% (more than 70% in 2-3% range) From distributors: up to 3%	About 85-95%	No other fees and payments
GPO #6	From manufacturers: up to 3% (about 85% in 2-3% range) From distributors: up to 3%	About 35%	From manufacturers: exhibit and sponsorship fees, educational grants From members/customers: membership fees/other service fees
GPO #7	From manufacturers: up to 3% (about 75% in 2-3% range) From distributors: up to 1%	0-100% based on fees generated by their purchases and contract terms	From manufacturers: conference and sponsorship fees, advertising fees

³⁵ Some of the GPOs reported that the total amount received from distributors is about 5-10 percent of the revenue they receive in the form of administrative fees.

C. Some Administrative Fees Pay for Non-Traditional GPO Activities and Services

In the letters to the seven GPOs, Senators Grassley, Kohl, and Nelson requested, among other things, information about all of the services GPOs provide, in addition to the traditional GPO contracting activities. Senator Grassley also asked the GAO to examine the services GPOs provide to their members and customers. The GAO collected data from the six largest GPOs. The activities reported to the GAO include product marketing, continuing medical education, patient safety services, and insurance services.

As several of the GPOs reported to Senators Grassley, Kohl and Nelson in September 2009, as well as to the GAO, a portion of the administrative fees may be used to finance other activities. The GAO presented a list of those services and the GPOs that reported offering each service in Table 2 and how those services are paid for in Table 3 of its report. Both tables are reprinted below.

Table 2. GAO Table on Services that Six GPOs Provided in 2008

Service ^a	GPO					
	A	B	C	D	E	F
Custom contracting	✓	✓	✓	✓	✓	✓
Clinical evaluation and standardization	✓	✓	✓	✓	✓	✓
Technology assessments	✓	✓	✓	✓	✓	✓
Supply-chain analysis	✓	✓	✓	✓	✓	
Electronic commerce	✓	✓	✓	✓	✓	
Materials management consulting	✓	✓	✓	✓	✓	
Benchmarking data	✓	✓	✓	✓	✓	
Continuing medical education	✓	✓		✓	✓	✓
Market research	✓	✓	✓	✓		
Materials management outsourcing	✓	✓			✓	
Patient safety services	✓	✓	✓			
Marketing products or services	✓	✓		✓		
Insurance services	✓	✓				
Revenue management	✓	✓				
Warehousing	✓					
Equipment repair	✓					
Other ^b			✓		✓	✓

Source: GAO structured data collection protocol.

Note: The six largest GPOs were selected based on their reported 2007 purchasing volume in Health Industry Distributors Association, *Group Purchasing Organization & Integrated Delivery Network: Market Brief* (Alexandria, Va., July 2009).

^aThis list includes services that may be offered through affiliates of the GPO.

^bOther reported services included, for example, contracting for environmentally friendly products, energy-related services and education, and public policy services.

Table 3. GAO Table on Funding Methods for Services Provided in 2008

Table 3: The Six Largest Group Purchasing Organizations' (GPO) Reported Funding Methods for Services Provided in 2008

Service ^a	Number of GPOs offering service	Number of GPOs funding only through administrative fees	Number of GPOs funding only through charges to customers	Number of GPOs using both funding methods
Custom contracting	6	2	2	2
Clinical evaluation and standardization	6	4	0	2
Technology assessments	6	5	1	0
Supply-chain analysis	5	1	1	3
Electronic commerce	5	2	0	3
Materials management consulting	5	1	1	3
Benchmarking data	5	1	1	3
Continuing medical education	5	4	0	1
Market research	4	2	2	0
Materials management outsourcing	3	0	3	0
Patient safety services	3	2	1	0
Marketing products or services	3	2	1	0
Insurance services	2	1	1	0
Revenue management	2	0	2	0
Warehousing	1	1	0	0
Equipment repair	1	1	0	0
Other ^b	3	2	0	1

Source: GAO structured data collection protocol.

Note: The six largest GPOs were selected based on their reported 2007 purchasing volume in Health Industry Distributors Association, *Group Purchasing Organization & Integrated Delivery Network: Market Brief* (Alexandria, Va., July 2009).

^aThis list includes services that may be offered through affiliates of the GPO.

^bOther reported services include, for example, contracting for environmentally friendly products, energy-related services and education, and public policy services.

According to the GAO, the GPOs offer the additional services in response to demand from their members and customers and to remain competitive in the GPO market. GAO also reported that the proportion of customers planning to use the service influenced some of the GPOs' decision whether or not to fund the service with administrative fees collected or fee-for-service payments from customers. Three of the seven GPOs told the Committee that only group purchasing services are paid for with administrative fees. One GPO informed the Committee that it funds all activities with administrative fees, but it does not offer any services beyond the activities related to the negotiation and administration of group purchasing agreements. Another GPO reported that it recently started charging some of its members and customers directly for the additional services rather than finance them with administrative fees; however, administrative fees continue to fund the same additional services for the remaining members and customers.

Conclusions

There seems to be general agreement that GPOs serve an important function. At issue is not the existence of GPOs but rather the incentive system under which they operate and whether or not they, in fact, achieve savings for the health care system. A major concern has been that the manufacturers essentially write the paychecks for GPOs since administrative fees are the primary source of revenue for GPOs. The GPOs evaluate and select the products that are placed on contract, but they are paid by the entities that make these products. Another issue is whether and how revenue distributed to the GPO's members and customers are reported to Medicare. If GPOs are driving up costs, then that has implications for federal health care spending, private insurance, and in 2014, tax credits under the recently passed health care reform legislation.

HIGPA told Committee staff that GPOs would not be able to operate without the administrative fees, although the OIG reported in 2005, from its review of three GPOs, that the administrative fees collected were in excess of operating expenses and used to finance business ventures. One GPO, however, reported that the administrative fees do not pay for all of its operating costs and some of that cost is covered by revenue from customers. Several GPOs stated that without fees from the manufacturers, they could not continue offering valuable programs to hospitals, beyond the basic contracting services. However, HIGPA's own informational materials on GPOs say that the purpose of the "safe harbor" is to "reduce costs and assist hospitals in their purchasing needs."³⁶

According to the recent *Hospitals & Health Networks* GPO survey, pharmacy and clinical service consulting and peer networking services, for example, are not important to many of the hospitals who responded to the survey.³⁷ The *Hospitals & Health Networks* article quotes the director of Texas Children's Hospital as saying, "Some GPOs try to be all things to their customers, and I'm not sure that's a good thing" and "I like some of the 'extras' like spend analytics, but I'm not too interested in the fluffy things."³⁸

Based on the Committee staff review and GAO's report, GPOs are offering many more services outside of the traditional group purchasing activities. Some of these activities are being funded with administrative fees, which appear to exceed the original intent of the safe harbor provision. A portion of the administrative fees may be distributed to the members and customers only to be funneled back to the GPO in the form of payments for other non-traditional GPO services. Not surprisingly, calculating the savings achieved by GPOs is complicated by the use of administrative fees to provide additional services that may or may not be of significant value to hospitals.

In addition, although five of the seven GPOs reported that they do not accept administrative fees greater than three percent, the administrative fees are not calculated based on what it actually costs the GPOs to perform their group purchasing functions. Interestingly, for example, the GAO table shows that one GPO uses administrative fees to finance insurance services provided to its customers, which begs the question, why are manufacturers supporting

³⁶ Health Industry Group Purchasing Association, *supra* note 19.

³⁷ Serb, *supra* note 28.

³⁸ *Id.*

these insurance services—or why are taxpayers indirectly paying for these services since manufacturers can always pass along extra costs in the form of higher product prices. The issue for the Committee to consider is whether or not legislation is required to clarify the safe harbor provision to ensure that fees collected are the reasonable cost of group purchasing activities.

Another matter of consideration is the expansion of the Physician Payments Sunshine Act to include all individuals and entities in the health care community that receive industry funding, such as gifts, travel, honoraria, consulting fees, and investment or ownership interests. The Medicare Payment Advisory Commission (MedPAC) recommended in a March 2009 report to Congress that Congress also require that pharmaceutical companies report their financial relationships with pharmacy benefit managers, health plans, and others.

Specifically, MedPAC said the following:

Given the potential benefits of public reporting, we recommend that the Congress mandate the reporting of comprehensive information on industry relationships with physicians and other health care entities and that the [HHS] Secretary post this information on a public, searchable website.³⁹

MedPAC then went on to say in Recommendation 5-1 that:

The Congress should require all manufacturers and distributors of drugs, biologicals, medical devices, and medical supplies (and their subsidiaries) to report to the Secretary their financial relationships with:

- physicians, physician groups, and other prescribers;
- pharmacies and pharmacists;
- health plans, pharmacy benefit managers, and their employees;
- hospitals and medical schools;
- organizations that sponsor continuing medical education;
- patient organizations; and
- professional organizations.⁴⁰

According to *The New York Times*, Curtis Rooney, the president of HIGPA, stated that the GPO industry “is probably the most transparent industry in the whole health care system.”⁴¹ He also added in a HIGPA press release dated January 18, 2010 that, “we support the tough transparency provisions in the Senate health care reform bill because all patients and hospitals have the right to know that physicians are not being unduly influenced by medical device and pharmaceutical manufacturer marketing and incentives when making critical decisions about patient health.”⁴²

³⁹ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 5, Mar. 2009.

⁴⁰ *Id.*

⁴¹ Mary Williams Walsh, “Senators Investigate Hospital Purchasing,” *N.Y. Times*, Aug. 14, 2009.

⁴² Press Release, Health Industry Group Purchasing Association, HIGPA Calls for Increased Transparency on Health Care Product Manufacturer Incentives to Physicians in Letter to Speaker Pelosi and Majority Leader Reid, Jan. 18, 2010.

The same can be said about payments made to other health care entities, including GPOs. Patients and hospitals should know if the availability and price of drugs, devices, and medical supplies are being unduly influenced by medical device and pharmaceutical manufacturers. In conversations with Committee staff, HIGPA expressed support for extending the reporting of payments by pharmaceutical and device manufacturers to GPOs, provided that all other health care entities, including distributors and pharmacy benefit managers, are also covered. Though the amounts of these payments are only one element of a more complex financial relationship, it is important that the federal government, the medical community, and Congress continue to better understand the relationships among GPOs, the drug and device industries, and the medical community, as well as the effects these relationships have on patients, prices, and federal healthcare spending.

Congress established the safe harbor provision for GPOs in 1986 on the presumption that these organizations would reduce costs for the health care system. Almost 25 years later, however, Congress and the American public do not have the data evaluating the success or failure of this provision. The GPO industry has evolved over the years, and in light of the lack of empirical data on GPO savings, Congress should consider legislation to provide HHS OIG with greater oversight. In this way, the OIG could conduct an independent and objective analysis and assess the true value provided by GPOs to hospitals, and in turn, to the Medicare and Medicaid programs.