Harvard Business Review

GOVERNMENT

Broken Compensation Structures and Health Care Costs

by Robert E. Litan and Hal J. Singer

OCTOBER 06, 2010

In recent years, a series of situations have come to light where, thanks to compensation structures, perverse incentives were created, and terrible consequences ensued. At the heart of the 2008 financial crisis, for example, there were ratings agencies being compensated for their work by the very firms whose securities they were assessing, leading to unreliable ratings that led investors astray. Bankers, meanwhile, were driven by their incentive structures to pursue investment strategies that were too risky. Prior to the recession, the best-selling *Freakonomics* revealed the incentives that could drive real-estate brokers to act contrary to the best interest of home sellers.

Sadly, we seem to be looking at another such situation. **Broken compensation structures in health care are likely leading to bad outcomes for U.S. consumers.**

In the health arena, group purchasing organizations (GPOs), which consolidate the buying power of hospitals, play a huge role in the health care industry. There is no question that they save their member hospitals money by relieving them of some of the transaction costs associated with procuring medical supplies on their own. Relative to a world without GPOs, the total outlays by U.S. hospitals for medical equipment would presumably be greater. But how much greater? The answer we have heard to date is gratifying — it amounts to billions of dollars per year — but unfortunately, that answer comes from studies funded by GPOs themselves. Last week, those studies came under scrutiny by both Senator Grassley and the GAO for lacking a sound empirical basis.

The question therefore arises: are GPOs saving hospitals as much as they should? Or is their ability to secure the lowest possible prices for member hospitals undermined by a broken compensation structure?

Ostensibly, GPOs seek the best products at the lowest prices through a competitive bidding or auction process in which vendors bid for the right to supply an entire network of hospitals. To cover their operating expenses, GPOs currently charge vendors "administrative" and other fees based on a percentage of the proceeds generated by the auction. The anti-kickback statute of the Social Security Act makes it illegal knowingly and willfully to offer, pay, solicit, or receive any compensation to induce referrals of items or services reimbursable by federal health care programs.

But to get around that Act, the GPOs convinced Congress in 1986 that federal health care expenditures could be reduced if *medical suppliers* paid the GPOs' costs. This meant they were exempted from the general statutory ban on kickbacks where the *government* covers health care costs. As a result, since the early late 1980s, GPOs have been paid a percentage of the total outlays by their

member hospitals to preferred medical suppliers on the GPO contracts. The higher the expenditures, the higher the GPO compensation.

The obvious problem with this arrangement is that it reduces incentives for GPOs to bargain for the lowest prices. The less their hospital members pay, the less GPOs receive in administrative fees. In a 2006 report, one of us estimated that if this GPO safe-harbor provision were removed, GPO-member hospitals would keep an additional 21 to 32 percent of the administrative fees (net of operating expenses) currently paid to GPOs but not passed through to member hospitals. This saving would have been substantial – roughly half a billion dollars per year. The report also estimated the overcharges to the federal government relating to Medicare reporting problems; relative to direct payment of rebates by manufacturers, hospitals tend not to credit indirect, lump-sum payments of rebates from GPOs to individual medical device purchases on their cost reports, leading to cost overruns.

In a new study on GPOs, we estimated the anticompetitive impact on medical supply prices attributable to the GPO safe harbor. To assess whether GPOs are in fact securing the lowest possible prices for hospitals, we analyzed "aftermarket" transactions for medical supplies – that is, we examine the prices of medical supplies that are rebid by hospitals after the GPOs have supposedly secured the "best" price. If the original GPO auctions are designed efficiently, then there should not be significant room for price improvement in the aftermarket.

Our findings clearly are inconsistent with the notion that GPOs are securing competitive prices for their member hospitals. When exposed to competition in the aftermarket, hospitals enjoy an average price reduction of 10 percent from 2001 through 2010, and an average price reduction of 15 percent in 2010. When incumbent device makers are induced to bid against their GPO bid (which occurs in roughly 52 percent of the auctions), they reduce their prices by seven percent on average; in 10 percent of these occasions, the incumbent dropped its own price by 15 percent or more. These systematic and significant savings would not be possible if GPOs secured competitive prices for their member hospitals.

One clear policy implication of these findings is to modify the incentives that limit the intended pro-competitive objectives of GPOs – namely, by changing the method of compensation of GPOs to reduce conflicts of interest. **This could be achieved by reinstating the application of the existing anti-kickback statute of the 1986 Social Security Act, thereby prohibiting vendors from paying GPOs.** This exemption has allowed GPOs to retain an equity interest (or its functional equivalent) in their contracts with those with whom they are to negotiate for lower prices.

So long as GPOs are compensated this way, they have an inherent conflict that limits their ability to negotiate the best prices for their member hospitals and those hospitals (and their payors, including the federal government) will likely continue to overpay for medical devices. Changing the incentive structure by reapplying the anti-kickback statutes would reduce private U.S. health care expenditures by up to $37.5 billion annually, and would reduce federal health care spending by up to $17.25 billion annually.

Repealing the safe harbor would not threaten the existence of GPOs; they would have to secure funding from their principals, as they should. But this reform would help "bend the cost curve" in a dramatic way for U.S. health care consumers. And it would unleash a new wave of innovation in medical technology, as entrants would be encouraged to take new risks knowing that their products would be judged on the merits of their designs, and not on side payments to GPOs.

Robert E. Litan is Vice President for Research and Policy at the Kauffman Foundation in Kansas City and a Senior Fellow in Economic Studies at the Brookings Institute. He has served in a number of federal government positions, including Associate Director of the Office of Management and Budget (1995-96) and Deputy Assistant Attorney General in the Justice Department's Antitrust Division (1993-95). Hal J. Singer is a Managing Director at Navigant Economics and has served as adjunct professor at the McDonough School of Business at Georgetown University. The views expressed here are those of the authors and should not be attributed to their employers.

Robert E. Litan is Vice President for Research and Policy at the Kauffman Foundation in Kansas City and a Senior Fellow in Economic Studies at the Brookings Institute. Hal J. Singer is a Managing Director at Navigant Economics and has served as adjunct professor at the McDonough School of Business at Georgetown University.