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MERGERS THAT HARM OUR HEALTH

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We are currently facing a new wave of healthcare mergers in the United States. More and more health insurers, such as Aetna, have started merging with powerful drug suppliers, such as CVS. What do these companies hope to achieve by merging? They want to increase their access to our health data. They want to know our individual biology, our medical history, our level of well-being; they want to know where we go, what we buy, how much we sleep; if we can resist sugar, junk food or nicotine; if we exercise and how often we exercise. In other words, they aim to shape our digital health ID. *Why?* On one hand, health insurers aim to reduce their risks and therefore their costs by improving our level of well-being. On the other, health insurers aim to reduce their costs by discriminating against us. Indeed, by allowing health insurers to gain access to consumers' prescription history and health habits, these data driven mergers can create substantial barriers to entry for high-risk consumers who want to enter the health insurance services market. Can the U.S. antitrust enforcers address the harm that these mergers create? Specifically, reduced access to health insurance services for a specific segment of consumers? And, if so, how? This article identifies three potential ways in which the U.S. antitrust enforcers could address the harms that these mergers impose on high-risk consumers. First, the U.S. antitrust enforcers could contend that the vulnerable, high-risk consumers constitute a separate relevant market. Second, they could argue that the proposed merger's negative impact on high-risk consumers should weigh more heavily than its positive impact on low-risk consumers, notwithstanding that the net effect of the merger should be assessed. Third, the U.S. antitrust enforcers may argue that these mergers facilitate a health insurer's efforts to violate the Affordable Care Act and should, therefore, be prohibited. Thus, this article is the first to address the need for the U.S. antitrust enforcers and the courts to confront the harm that

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these data driven mergers pose to high-risk consumers. If not, they risk applying antitrust law in a way that further exacerbates the existing health disparities in the United States.

INTRODUCTION

Since the early 1980s antitrust enforcement in the health care sector has significantly increased. The Department of Justice and the Federal Trade Commission (the Agencies) have devoted valuable resources to challenge myriads of hospital mergers, physician cartels, mergers between health insurers and "reverse payment settlements" in the pharma sector.[1] This precedent may partially explain the new wave of vertical mergers we are currently facing in the United States: Express Scripts merged with insurer Cigna; insurer Aetna recently merged with the drug supplier, CVS.[2] Albeit vertical, these mergers can considerably hurt consumers. As this article illustrates, they can facilitate health insurers' efforts to discriminate against vulnerable populations, leaving them without meaningful access to care. They can also widen the existing health disparities in the Unites States and perpetuate the inequities. *How?*

[1] T. L. Greaney, *The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply?* 46 J.L., MED. & ETHICS 918, (2018).
[2] *Id.*

Health insurers, such as Aetna, merge with drug suppliers, such as CVS to increase their access to consumers' prescription history and health-related habits and data.[3] Retail pharmacies, such as CVS, "issue loyalty cards and offer discounts in exchange for data" on consumers' purchasing history and health related habits.[4] A merger between Aetna and CVS, thus, allows Aetna to gather detailed and sensitive information about us that we may not want our health insurers to have: whether we prefer vitamin water over coke; whether we are happy or depressed; whether we drink more beers and desire sweets when we are stressed.[5]

Health insurers may harness this type of health-related information to shape "consumers' body score", a new type of credit score.[6] By shaping consumers' body score health

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3 Erica Fry, *Tech's Next Big Wave: Big Data Meets Biology* FORTUNE (March 19, 2018) Clinton Leaf, *Why you are the reason for those healthcare mergers*, FORTUNE (March 19 2018), https://fortune.com/2018/03/19/cvs-aetna-healthcare-mergers-big-data/; Gary Bloom, *Disrupting Health Care: From Amazon To CVS, Data Is At The Heart Of It*, FORBES (July 6 2018), https://www.forbes.com/sites/forbestechcouncil/2018/07/06/disrupting-health-care-from-amazon-to-cvs-data-is-at-the-heart-of-it/#70675d1d1c06, Reed Abelson, Katie Thomas, *CVS and Aetna Say Merger Will Improve Your Health Care. Can They Deliver?* NYTIMES (December 4, 2017), https://www.nytimes.com/2017/12/04/health/cvs-aetna-merger.html; David Anderson, *Aetna, CVS Data Thoughts*, BALLON JUICE (December 4, 2017) https://www.balloon-juice.com/2017/12/04/aetna-cvs-and-data-thoughts/ (arguing that although "Aetna has a kick-ass data team… there are always serious holes in the Aetna list. Either someone has never been on Aetna before or there was a major change in health status when that person was covered by someone else. This is where CVS comes in. There is a good chance that CVS has filled some prescriptions for people who do not show up in Aetna's data banks…This will influence plan design, marketing materials, and whether or not Aetna enters or leaves a market or bids for certain contracts").

4 *See* Anderson, *supra* note 3 (noting that "the biggest data bonanza is the CVS non-prescription data that is tied to the loyalty card that almost everyone carries on their keychain. This should give a massive predictive edge to the Aetna data geeks. Combined, the insurer and the retailer would have a massive amount of data… This may not always be in the patients' best interest. A clever insurer for instance could probably tell whether a customer was planning a pregnancy based on his or her birth control purchases – and then try to induce the customer to switch plans so that some other payer could bear the cost."); For a similar discussion *see also* Nicolas Terry, *Big data and Regulatory Arbitrage in Healthcare* 58 in BIG DATA, HEALTH LAW, AND BIOETHICS (I. Glenn Cohen, Holly Fernandez Lynch, Effy Vayena & Urs Gasser eds., 2018), Nicolas P. Terry, *Regulatory Disruption and Arbitrage in Health-Care Data Protection*, 17 YALE J. HEALTH POL'Y L. & ETHICS 178-179 (2017); Robert Hart, *Don't share your health data with insurance companies just for the perks*, (11 September 2018) QUARTZ, https://qz.com/1367202/dont-share-your-health-data-with-insurance-companies-just-for-the-perks/ (arguing that "You may have told your doctor, or insurer, that you stopped smoking, started eating more healthfully, and joined a gym, but unless you use cash -which is pretty much the only way to truly opt out of this monitoring) they might be able to see the cigarette and fast-food-fuelled lifestyle you actually lead by reading the records kept by your loyalty and credit cards"); David Pittman, *The Big Data Potential of the CVS-Aetna Deal*, POLITICO, (December 5, 2017), https://www.politico.com/newsletters/morning-ehealth/2017/12/05/the-big-data-potential-of-the-cvs-aetna-deal-040437

5 *Id.*

6 Marshall Allen, *Health Insurance Hustle, Health Insurers Are Vacuuming Up Details About You — And It Could Raise Your Rates*, PROPUBLICA (17 July 2018) https://www.propublica.org/article/health-insurers-are-vacuuming-up-details-about-you-and-it-could-raise-your-rates. (arguing that Aetna has obtained "personal information from a data broker on millions of Americans. The data contained each person's habits and hobbies, like whether they owned a gun, and if so, what type. The Aetna data team merged the data with the information it had on patients it insured. The goal was to see how people's personal interests and hobbies might relate to their health care costs"). *See also* FRANK PASQUALE, THE BLACK BOX SOCIETY, 26 (2015). Nicolas Terry, *Big data and Regulatory Arbitrage in Healthcare* 58 in BIG DATA, HEALTH LAW, AND BIOETHICS; PBS Network, *Lifestyle choices could raise your health insurance rates*, (21 July 2018), https://www.pbs.org/newshour/show/lifestyle-choices-could-raise-your-health-insurance-rates; Bloom, *supra* note 3 (arguing that when announcing the Aetna deal CVS CEO Larry Merlo said: "With the analytics of Aetna and CVS Health's human touch, we will create a health care platform built around individuals").

insurers are able to sort consumers into general health related categories: the ones that are expected to remain healthy and the ones that might soon get sick; the diabetics that avoid sugar and the ones that cannot resist candies; the obese that love junk food and the obese that religiously adhere to a healthy diet. By analyzing consumers' drug store visits, shopping habits and prescription history, health insurers can identify "the diabetic–concerned" and "the depression–concerned" consumer groups.[7] They can also classify patients "by reference to their adherence to medication or their likelihood to face complex medical procedures".[8]

Health insurers may use this type of information to reduce their costs in various ways. For instance, they may attempt to nudge customers that love sugar or junk food towards healthier behaviors. United Healthcare already offers its customers four dollars per day in healthcare credits if they attain "three daily fitness goals: frequency, intensity and tenacity".[9] To meet these goals and receive the healthcare credits, subscribers must walk at least six sets of 500 steps and complete each set in no more than seven minutes.[10] They must also "space the sets out throughout the day at least one hour apart (frequency), take 3,000 steps in a single 30-minute period (intensity), and take a total of 10,000 steps each day (tenacity)".[11] Oscar, a New York-based health insurer also offers generous Amazon vouchers to its customers if they meet the health insurer's "daily fitness goals".[12] John Hancock, a Boston-based health insurance

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[7] Pasquale *supra* note 6 at 148 (2015), Terry, *supra* note 4 at 199, Nicolas P. Terry, *Protecting* Patient *Privacy* in the. *Age of Big Data*, 81 UMKC L. REV. 2, Mason Marks, *Emergent Medical Data*: *Health Information Inferred by Artificial Intelligence*, U.C. IRVINE LAW REVIEW 3 (forthcoming, 2021) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3554118. *See also* Alice E. Marwick, *How Your Data Are Being Deeply Mined*, N.Y. REV. BOOKS, (Jan. 9, 2014), Sharona Hoffman & Andy Podgurski, *Artificial Intelligence and Discrimination in Health Care*, 19 YALE J. HEALTH POL'Y L. & ETHICS 10, 11 (2020), W. Nicholson Price II, *Black Box Medicine*, 28 HARV. J.L. & TECH. 419, 421 (2015), Kate Crawford & Jason Schultz, *Big Data and Due Process: Toward a Framework to Redress Predictive Privacy Harms*, 55 B.C.L. Rev. 93, 98, 102 (2014), Michael J. Rigby, *Ethical Dimensions of Using Artificial Intelligence in Health Care*, 21 AMA J. ETHICS 121 (2019), Bonnie Kaplan, *Seeing through health information technology: the need for transparency in software, algorithms, data privacy, and regulation*, J.L. & THE BIOSCIENCES 8-9 (2020), G.M. Weber, K.D. Mandl, I.S. Kohane, *Finding the missing link for big biomedical data*, 24 JAMA 2479 (2014), Will Douglas Heaven, *Israel Is Using AI to Flag High-Risk COVID-19 Patients*, MIT TECH. REV. (Apr. 24, 2020), https://www.technologyreview.com/2020/04/24/1000543/israel-ai-prediction-medical-testing-data-high-risk-covid-19. (arguing that one of Israel's largest health maintenance organizations used AI to help identify which of the 2.4 million people it covers are most at risk of severe covid-19 complications.)

8 Terry, *supra* note 4 at 58. *See also* Hart *supra* note 4 (arguing that "rather than relying on a set of preprogrammed rules to process data, machine learning allows AI to learn from the data itself. As a result, we are now able to get meaningful insights from massive datasets that would have previously been unmanageable. With the processing power of AI, these data open up a panoply of opportunities: creating deeply personalized medicine, helping determine whether you will respond to certain medications, indicating your disease risk, and developing new treatments").

9 Hart, *supra* note 4.

[10] *Id*.

[11] *Id*.

12 *Id*.

company, also incentivizes its customers to wear Fitbits in order to monitor their physical activity and gain access to their health habits and data.[13]

Health insurers also try to reduce their risks and thus, their costs, by identifying risky patients who suffer from chronic conditions that are not being properly treated. They use, for instance, patients' health data to "identify high-risk asthma patients who have not yet been prescribed inhalers and manage their care before they end up in emergency rooms" with life threatening asthma episodes.[14] They steer high-risk customers to primary care doctors or specialists who can offer care that is "better coordinated and more consistent" than the sporadic and high-cost treatment a patient would receive in an emergency department.[15] They also monitor whether high-risk patients take their medication properly or encourage them to watch their weight or reduce sugar consumption through targeted texts and emails.

But, health insurers may also use our data to discriminate against us.[16] This risk is real. Health insurers already use "data-mined prescription drug data" to discriminate against high-risk consumers.[17] They use big data analytics to identify the type of customers they are likely to attract.[18] Then, they move the drugs associated with treating those customers to a higher cost sharing tier.[19] If, for instance, health insurers are able to identify that they are likely to attract a large number of patients with HIV/AIDS, they may move antiretroviral drugs to a higher tier aiming to dissuading them from applying for health insurance coverage.[20]

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13 *Id*.

14 Natasha Singer *When a Health Plan Knows How you Shop* NYTIMES (June 28, 2014) https://www.nytimes.com/2014/06/29/technology/when-a-health-plan-knows-how-you-shop.html.

15 *Id*.

16 Allen, *supra* note 6 (claiming that "Optum owned by UnitedHealth Group, has collected the medical diagnoses, tests, prescriptions, costs and socioeconomic data of 150 million Americans going back to 1993, according to its marketing materials. The company uses the information to link patients' medical outcomes and costs to details like their level of education, net worth, family structure and race. Using unverified, error-prone lifestyle data to make medical assumptions could lead insurers to improperly price plans — for instance raising rates based on false information — or discriminate against anyone tagged as high cost."). For a similar discussion, Hoffman & Podgurski, *supra* note 7, at 117, Nathan Cortez, *Substantiating Big Data in Health Care*, 14 I/S: J.L. & POL'Y FOR INFO. 61, 66 (2017), Crawford & Schultz, *supra* note 7, at 109; Sara Gerke, Timo Minssen, I. Glenn Cohen, *Ethical and Legal Challenges of Artificial Intelligence-Driven Health Care* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3570129; Frank Pasquale, *Redescribing Health Privacy: The Importance of Health Policy*14 HOUS. J. HEALTH L. &. POLICY 95, 101 (2014).

17 Terry, *supra* note 4, at 181, Terry, *supra* note 4, at 58; Jordan Robertson, *The Pitfalls of Health-Care Companies' Addiction to Big Data*, BNA BLOOMBERG HEALTH IT L. & INDUSTRY REP. (Sept. 23, 2015), https://www.bloomberg.com/news/articles/2015-09-23/the-pitfalls-of-health-care-companies-addiction-to-big-data.

18 *Id*.

19 *Id*.

20 *Id*. Jacobs, Douglas B., and Benjamin D. Sommers *Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace* 372 N.ENGL.J.MED 399–402 (2015); See *also* Harvard Center for Health Law and Policy Innovation, *CHLPI launches groundbreaking campaign to enforce healthcare rights for people living with HIV in seven states, Landmark Complaints Filed with the Federal Office for Civil Rights*, CHLPI BLOG, HEALTH LAW AND POLICY NEWS (September 6, 2016) http://www.chlpi.org/chlpi-launches-groundbreaking-campaign-enforce-health-care-rights-people-living-hiv-seven-states/ (arguing that seven insurers including Cigna and

Importantly, the Affordable Care Act (ACA) prohibits "discriminatory premium rates" and any type of exclusion on the basis of citizens' preexisting conditions.[21] The ACA has also implemented a "risk adjustment policy" to limit health insurers' ability to practice cream skimming.[22] Specifically, insurers with sicker subscribers receive financial assistance from insurers with healthier subscribers.[23] Risk adjustment disassociates enrollees' profitability from their expected costs because sicker enrollees may yield higher revenues.[24] It also forces health plans to offer several "Essential Health Benefits" (EHBs) including prescription drug coverage.[25] This policy aims to ensure that health plans meet adequate quality standards.

Risk adjustment, however, "is far from perfect".[26] Hence, health insurers are still incentivized to screen unprofitable consumers. In fact, as noted, health insurers discriminate against high-risk consumers on the basis of drug coverage. [27] Although EHB regulations compel health plans to "cover at least one drug in each therapeutic category and class of the United States Pharmacopeia, there is no requirement regarding how the drugs should be tiered within a formulary."[28] This, in turn, allows health insurers to design the benefits of their health plans to be attractive to "profitable" consumers and less attractive to the high-risk "unprofitable" ones.[29]

Indeed, a growing body of literature demonstrates that "drug classes used by less profitable consumers appear higher on the formulary tier structure (implying higher out-of-pocket costs for consumers) or are subject to non-financial barriers to access, such as prior authorization."[30] An official complaint that was filed with the Department of Health and Human

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Anthem, are discriminating against people with HIV/AIDS by "refusing to cover key medications and requiring high cost sharing."); S. Rose, S. L. Bergquist, T. J. Layton, *Computational health economics for identification of unprofitable health care enrollees* 18 BIOSTATISTICS 682, 683 (2017).

[21] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1201, 124 Stat. 146 (2010), Price II, *supra* note at 455; Wendy Netter Epstein, *Private Law Alternatives to the Individual Mandate* 104 MINN. L. REV 1436, 1437 (2020) (explaining that "prior to 2010, the individual health insurance market was predicated on an actuarial fairness model". While the young and low-risk individuals could obtain coverage at relatively low rates, the older and higher risk individuals either paid higher premiums or were denied coverage entirely. As a result, millions of Americans lacked health insurance. In an attempt to address this problem, the ACA "marked a move from an actuarial fairness approach towards a social solidarity approach. A social solidarity system makes no attempt to match risk and rate. Rather, it spreads cost evenly over the covered population.") See *also* Valarie K. Blake, *Ensuring an Underclass: Stigma in Insurance*, 41 CARDOZO L. REV. 1441, 1446-1448 (2020).

[22] Rose et al. *supra* note 20 at 683.

[23] *Id.*

[24] *Id.*

[25] Michael Geruso, Timothy Layton, and Daniel Prinz *Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges* 11 AMERICAN ECONOMIC JOURNAL, ECONOMIC POLICY 64, 71 (2019).

[26] S. Rose, S. L. Bergquist, T. J. Layton, *supra* note 20 at 683.

[27] *Id.* Geruso et al, *supra* note 25 at 104.

[28] *Id*. at 71.

[29] *Id*. at 104.

[30] *Id.* See *also* Rose et al *supra* note 20 (arguing that "If consumers who use drugs in a given therapeutic class are unprofitable on average, then the insurer will want to weaken coverage for drugs in that class, either by placing

Services (HHS) in May 2014 illustrates these concerns. The complaint demonstrates that "Florida insurers offering plans through the new federal marketplace (exchange) had structured their drug formularies to discourage people with HIV from selecting their plans."[31] Those insurers "categorized all HIV drugs, including generics, in the tier with the highest cost sharing."[32] Arguably, these practices can reduce access to health insurance services for high-risk consumers, leaving them without meaningful access to care.[33]

However, this is not the only strategy health insurers employ to exclude high-risk consumers. Health insurers often attempt to prevent high-risk patients from applying for health insurance by failing to provide clear and accurate information about which drugs their health plans cover.[34] They also avoid cooperating with specific healthcare providers that have a strong reputation for curing patients with HIV or hepatitis C or other diseases that require costly care.[35] They can increase consumers' copayment[36] for a type of care, after consumers have enrolled or after they have failed to meet the fitness goals health insurers often require in order to benefit from more advantageous insurance terms.[37]

But, these data driven mergers may not only facilitate health insurers' efforts to discriminate against vulnerable populations. They may also exacerbate the existing health and social inequalities among different socio-economic groups. Clinical evidence indicates a strong link "between social determinants of health and health disparities among certain populations."[38]

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those drugs on a formulary tier with high cost sharing or by removing most drugs in the class from the formulary altogether".); *See also* Martin Andersen, *Constraints* on *Formulary Design Under* the *Affordable Care Act*, 26 HEALTH ECONOMICS 160, 161 (2017).

[31] Jacobs & Sommers, *supra* note 20, at 401.

[32] *Id*.

[33] Harvard Center for Health Law and Policy Innovation *supra* note 20. *See also* Victor Laurion, Christopher T. Robertson, Victor Laurion, Christopher T. Robertson, *Ideology Meets Reality: What Works and What Doesn't in Patient Exposure to Health Care Costs* 15 IND. HEALTH L. REV 43, 64 (2018) (arguing that "designers of insurance contracts have keyed-in on consumers' RAND-proven sensitivity to cost and have increasingly sought to reduce health insurance coverage accordingly").

[34] Allen, *supra* note 6 (quoting Harvard Professor Robert Greenwald, faculty director of Harvard Law School's Center for Health Law and Policy Innovation). Pasquale, *supra* note 16 at 105- 107 (claiming that "even though the Patient Protection and Affordable Care Act's (PACA's) guaranteed issue provisions and exchanges will help deter underwriting practices, there are many other tactics that insurers can use to try to avoid particularly costly members. For example, "narrow networks" may be surreptitiously pushed on the vulnerable as a way of limiting insurers costs." The author adds that "although the insurer cannot use health status information to raise an individual's premiums based on the ACA the insurer could foreseeably use the information to determine single-pool risk factors related to ACA or overall plan premiums").

35 *Id*.

[36] Laurion & Robertson, *supra* note 33, at 44 (explaining that "A co-payment is the amount a patient must pay out-of-pocket at the time of service").

[37] Allen *supra* note.6.

[38] Sarah E. Malanga, Jonathan D. Loe, Christofer T. Robertson, and Kenneth S. Ramos, *Who's left out of big data? How Big Data Collection, Analysis and Use Neglect Populations Most in Need of Medical and Public Health Research and Interventions*, in BIG DATA, HEALTH LAW, AND BIOETHICS 99 (I. Glenn Cohen, Holly Fernandez Lynch, Effy Vayena & Urs Gasser eds., 2018).

Indeed, decades of research demonstrate that "the relationship between social advantage and health is incremental—with less advantaged groups experiencing a disproportionate burden of poor health and even relatively advantaged groups showing a deficit."[39] In addition, the most vulnerable populations are more likely to suffer from obesity[40] and alcohol addiction,[41] and face higher structural barriers to adopting a healthier life style.[42] Racial and ethnic minorities in the United States are also at greater risk for certain diseases including cancer[43], hypertension, diabetes[44], and COVID-19.[45] Moreover, being healthy or fit is neither easy nor costless. If you suffer from depression, it is often harder to exercise or adopt healthy eating habits. If you are poor, things can be even more challenging. Most poor people live in neighborhoods in which even walking around the block feels unsafe.[46] For them, doing 10,000 steps per day is not a question of will. Doing those 10,000 steps might actually be dangerous.

Others cannot afford the luxury of arranging childcare to free up the time needed to frequently exercise and meet health insurers' fitness goals.[47] Also, the poorest are the ones least able to afford healthier meals.[48] Indeed, a hormone-filled fried chicken is cheaper than grass-fed organic beef. In other words, no matter how much less-advantaged social groups may try to

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[39] Michael Marmot, *The richer you are the healthier you are and how to change it* THE GUARDIAN (September 11, 2015) https://www.theguardian.com/books/2015/sep/11/health-inequality-affects-us-all-michael-marmot. *See also* Ana Penman-Aguilar, Dr Makram Talih, Dr David Huang, Ramal, Moonesinghe, Dr Karen Bouye, Gloria Beckles, *Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity*, 22 J PUBLIC HEALTH MANAG PRACT 33 (2016); Gilbert C. Gee, Katrina M. Walsemann, and Elizabeth Brondolo, *A Life Course Perspective on How Racism May Be Related to Health Inequities* 102 AMERICAN JOURNAL OF PUBLIC HEALTH, 967 (2012), Hoffman & Podgurski, *supra* note 7 at 17.

[40] Susan Mayor, *Socioeconomic disadvantage is linked to obesity across generations, UK study finds* BMJ 356 (2017), M. Pigeyre et al, *How obesity relates to socio-economic status: Identification of eating behavior mediators* 40 INTERNATIONAL JOURNAL OF OBESITY, 1794 (2016).

[41] Cerdá, Magdalena et al. *The relationship between neighborhood poverty and alcohol use: estimation by marginal structural models*." 21 EPIDEMIOLOGY, 482 (2010); KJ Karriker-Jaffe, SC Roberts, J. Bond *Income inequality, alcohol use, and alcohol-related problems* 103 AMERICAN JOURNAL OF PUBLIC HEALTH 649-656 (2013).

[42] Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571, 616 (2014).

[43] David R. Williams and Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health* 24 HEALTH AFFAIRS, 325, 326 (2015).

[44] Sarah E. Malanga, et al *supra* note 38 at 104-105, Elizabeth Brondolo, *Race, Racism and Health: Disparities, Mechanisms and Interventions* 31 J. BEHAV. MED, 1, (2018).

[45] Don Bambino Geno Tai, Aditya Shah, Chyke A Doubeni, Irene G Sia, Mark L Wieland, *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States*, 72 CLINICAL INFECTIOUS DISEASES, 1 (2020), CDC, *Health Equity Considerations and Racial and Ethnic Minority Groups*, https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html; *See also* Christen Linke Young *There are clear, race-based inequalities in health insurance and health outcomes* BROOKINGS (February 19 2020) https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/02/19/there-are-clear-race-based-inequalities-in-health-insuranceand-health-outcomes/.

46 Neighborhood Safety and the Prevalence of Physical Inactivity—Selected States, 1996, Morbidity and Mortality Weekly Report 48 143–146 (1999) Hart, *supra* note 4.

47 *Id*.

[48] J. Harrington, J. Lutomski, M. Molcho, IJ Perry *Food Poverty and Dietary Quality: Is there a relationship?* 63 EPIDIMIOL COMMUNITY HEALTH 16 (2009).

meet the health insurers' fitness goals or adopt a healthier life style, they may fail to do so for reasons related to their socio-economic conditioning.[49]

Hence, instead of increasing high-risk consumers' access to health insurance, — data-driven mergers between health insurers and drug suppliers may actually make access easier for those who need it the least—the low-risk consumers who eat healthier and live healthier lives.[50] This could definitely defeat the risk-pooling purpose of insurance.[51] The same may happen if health insurers choose to increase their access to our health data by merging with giant tech companies such as Facebook or Twitter. Facebook, for example, has already explained how it collects medical data from its users.[52] Considering that numerous consumers use Facebook for peer-to-peer healthcare support, there is plenty of health-related data that can easily be harnessed.[53]

Nonetheless, the social costs of health disparities are high. They include significant healthcare costs, premature deaths and illness-related lost productivity.[54] Additionally, diseases that are more prevalent in poor neighborhoods "eventually spread into affluent communities".[55] Hence, health disparities affect not only the most vulnerable populations but the well-being of a society as a whole. Given these risks, this article asks: Can the U.S. antitrust enforcers ban data driven mergers in the healthcare field on the basis that they may reduce access to health insurance services for "unprofitable" consumers?

This question is not easy to address. It requires further thought by both antitrust scholars and policy makers. First, because the more tech companies such as Facebook, Google,

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[49] Hart *supra* note 4 (arguing that "an insurance system that obscures these complexities serves to discriminate against people that are already worse-off").

[50] *Id*. (Arguing that "data-driven insurance policies promise incentives to the privileged while further discriminating against those most in need of support and this type of discrimination is hidden.")

[51] Jacqueline R. Fox, *Healthism, Intersectionality, and Health Insurance: The Compounded Problems of Healthist Discrimination*, 18 MARQ. Benefits & Soc. WELFARE L. REV. 279, 282 (2017) (explaining that each subscriber "pays money into a pool of funds that is used to cover any costs the members have if an insured event occurs. Similarly, the insurance company calculates, in advance, the amount of money that must be in the pool by determining the likelihood of any particular illness or injury occurring in the covered population, and how much it will cost to provide care for that illness or injury. Individuals purchasing insurance, by contributing to this pool, agree to cross-subsidize each other if these events occur." *See also* Blake, *supra* note 21 at 1447.

[52] Mason, *supra* note 6 at 9-10, Raina M. Merchant, David A. Asch, Patrick Crutchley, Lyle H. Ungar, Sarath C. Guntuku, Johannes C. Eichstaedt, Shawndra Hill, Kevin Padrez, Robert J. Smith, & H. Andrew Schwartz, *Evaluating the Predictability of Medical Conditions from Social Media Posts*, 14 PLOS ONE (2019); Kirsten Ostherr, *Facebook knows a ton about your health. Now they want to make money off it* THE WASHINGTON POST (April 18, 2018) https://www.washingtonpost.com/news/posteverything/wp/2018/04/18/facebook-knows-a-ton-about-your-health-now-they-want-to-make-money-off-it/?noredirect=on. *See also* Crawford & Schultz, *supra* note 7 at 93,97, Kaplan, *supra* note 7, at 7.

53. *Id.*

[54] John Z. Ayanian, *The Costs of Racial Disparities in Health Care*, HARVARD BUSINESS REVIEW (October 1 2015), https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care.

[55] Woodward A, Kawachi *Why reduce health inequalities*? 54 JOURNAL OF EPIDIMIOLOGY& COMMUNITY HEALTH, 923-929 (2000).

or Amazon are moving into the digital health market, the more mergers we may see between health insurers and digital platforms. And the more mergers between tech giants and health insurers, or between drug retailers and health insurers increase, the more opportunities there will be for discrimination against vulnerable populations. Second, the Health Insurance Portability and Accountability Act (HIPAA), the privacy law that aims to protect health information in the United States, is extremely limited in its reach.[56] For instance, although health insurers are covered by HIPAA, "the rule does not govern deidentified data and many big data sources are deidentified, at least to some extent."[57] Additionally, HIPAA covers only "protected health information" and thus non-medical data that may be used by health insurers to shape consumers' body score are not subject to the rule.[58] Third, health disparities in the United States have been continuously escalating.[59] In the land of dreams and opportunity, the difference in life expectancy between the wealthy and the poor exceeds close 10 to 15 years.[60]

Hence, this article also asks: Can the U.S. antitrust enforcers and the courts ban mergers between health insurers and drug suppliers on the basis that they may allow health insurers to inhibit the ACA's mission that aims to ensure access to health insurance services for all citizens irrespective of their preexisting health conditions, social, racial or economic background?[61]

The answer is not straightforward. This is because antitrust law is primarily concerned with the overall welfare of society—it does not distinguish between different groups.[62] From an antitrust law perspective, both high-risk and low-risk consumers, count equally.[63] Indeed, although the use of a consumer welfare standard treats the same people unequally in their roles as workers and producers, it treats all consumers as equally deserving

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56 Sharona Hoffman, *Big data's New Discrimination's Threats* in BIG DATA, HEALTH LAW, AND BIOETHICS 90 (I. Glenn Cohen, Holly Fernandez Lynch, Effy Vayena & Urs Gasser eds., 2018).
57 *Id.* Terry, *supra* note 4 at 162-163, Gerke, Minssen, & Cohen, *supra* note 16 at 33, Kaplan, *supra* note 7 at 8.
58 *Id*.
59 Theodosia Stavroulaki, *Mind the Gap: Antitrust, Health Disparities and Telemedicine* 45 AM. J. L. & MED. 171 (2019).
60 *Id*. Gessica Glenza, *Rich Americans live up to 15 years longer than poor peers studies find*, THE GUARDIAN (April 6 2017), https://www.theguardian.com/us-news/2017/apr/06/us-healthcare-wealth-income-inequality-lifespan.
61 Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination based on race, color, national origin, sex, age, or disability in particular health programs or activities. Elaborating on the protected classes, the statute refers to individuals protected by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (addressing sex discrimination), Section 504 of the Rehabilitation Act of 1973 (addressing disability discrimination), and the Age Discrimination Act of 1975. Sharona Hoffman, Andy Podgurski, *supra* note 7, at 27.
62 K J Cseres, *The Controversies of the Consumer Welfare Standard*, 3 COMP. L. REv. 12, 124 (2007).
63 Joseph Farrell & Michael L. Katz, *The Economics of Welfare Standards in Antitrust*, 2 COMPETITION PoL'Y INT'L 3, 11(2006)

with respect to consumption.[64] Thus, if a merger between a health insurer and a drug supplier leads to an increase in the cost of treatment for high-risk consumers but to a reduced cost for lower-risk ones, the antitrust enforcers might accept the merger even though it could harm the most vulnerable populations.

This is antitrust law's blind spot. By aggregating consumers into one group without weighing the circumstances and the interests of different consumer groups, antitrust law often fails to consider "the effects on different classes or types of consumers that are affected by the conduct or the transaction."[65] If, however, in the case at issue, the Agencies failed to consider the interests of high-risk consumers, the Agencies could apply antitrust law to healthcare in a way that contributes to the existing health disparities. Hence, this article also asks: Do the Agencies have the analytical framework to adequately assess the impact of vertical mergers on a specific segment of consumers?

This article proceeds as follows. Part I explores the history of the American vertical merger law. It examines the 1984 Non-Horizontal Guidelines and the 2020 Vertical Guidelines (2020 VMG) that were recently published by the Agencies. Part II identifies the main competitive concerns vertical mergers between health insurers and drug suppliers, such as Aetna-CVS, generally raise. It also shines a light on a significant harm these mergers pose on high-risk consumers that so far has evaded antitrust scrutiny: higher drug coverage costs and increased non-financial barriers to drug utilization. Part III examines whether the Agencies can in fact confront this harm. Focusing on this question, Part III delves into the 2010 Horizontal Merger Guidelines (2010 HMG) and the relevant case law. In so doing, it identifies three potential ways in which the Agencies could address the barriers to entry to health insurance services these mergers may raise for the high-risk, "unprofitable" consumers. First, the Agencies could contend that the vulnerable, high-risk consumers constitute a separate relevant market. Second, they could argue that the proposed merger's negative impact on high-risk consumers should weigh more heavily than its positive impact on low-risk consumers, notwithstanding that the net effect of the merger should be assessed. Third, the Agencies could argue that the proposed merger might facilitate a health insurer's efforts to evade the ACA. The last part concludes.

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[64] *Id*. at 48.

[65] Michal S. Gal, *The Social Contract at the Basis of Competition Law: Should we Recalibrate Competition Law to Limit Inequality?* in RECONCILING EFFICIENCY AND EQUITY: A GLOBAL CHALLENGE FOR COMPETITION POLICY 95, 103 (D. Gerard, I. Lianos eds., 2019).

I. BACK TO BASICS: HOW HAS THE AMERICAN VERTICAL MERGER LAW BEEN SHAPED SO FAR?

The Agencies assess three types of mergers: horizontal, vertical, and/or conglomerate.[66] Irrespective of the type of merger that the Agencies examine, the goal of each merger assessment remains the same: The Agencies seek to identify and ban any transactions that may produce market power or facilitate its exercise.[67] Increased market power can be manifested in both price and non-price terms.[68] The latter includes reduced variety, product quality or reduced service. Non-price effects "can coexist with price effects or arise in their absence".[69] Nonetheless, competition authorities rarely analyze solely— or even primarily— a merger's effect on non-price competition parameters such as innovation or quality".[70] Indeed, "price is king" in antitrust enforcers' merger analysis.[71] This is because non-price terms, such as innovation, or reduced service are elusive concepts that cannot be easily evaluated.[72] For this reason, antitrust enforcers prefer to devote their valuable resources to what can, in fact be more easily assessed: short-term price effects or reduced output.

Antitrust scholarship increasingly indicates that even though the Agencies often condemn horizontal mergers, they rarely challenge vertical and conglomerate mergers.[73] This, however, was not the case in the 1950s when Congress extended Section 7 to include vertical and conglomerate mergers.[74] In fact, the Supreme Court's ruling in *Brown Shoe* reveals that earlier vertical merger cases were subjected to high levels of scrutiny by the Agencies and the courts.[75] In *Brown Shoe,* the Court examined the merger between Kinney and Brown Shoe. Kinney was a shoe manufacturer as well as one of the "largest independent chains of family shoe stores" in the United States. Brown Shoe was another retailer and large shoe manufacturer.[76] The Court concluded that the merger should be banned on the basis that it

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[66] DANIEL CRANE, ANTITRUST,140 (2014).
[67] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES §1, Herbert Hovenkamp, *Markets in Merger Analysis*, 57 Antitrust BULL. 887, 888 (2012).
[68] Theodosia Stavroulaki, *Integrating Healthcare Quality Concerns into the US Hospital Merger Cases, A Mission Impossible?* 39 WORLD COMPETITION, 593, 597 (2016).
[69] *Id*. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* 67 at 2.
70 MAURICE STUCKE, ALLEN GRUNES, BIG DATA& COMPETITION POLICY 7.01-7.02 (2016), Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation under the Clayton Act*, 91 WASH. L. REV.199, 201 (2016).
[71] STUCKE & GRUNES *supra* note 70, at 7.04-7.06.
72 *Id*. at 7.03.
[73] *Id*. at 8.02.
[74] CRANE, *supra* note 66; Hovenkamp, *supra* note 67, at 890.
[75] Greaney & Ross, *supra* note at 70, at 202.
[76] Brown Shoe Co. v. United States, 370 U.S. 294 (1962).

would foreclose the competitors of either party from a segment of the market.[77] In shaping its conclusion, the Court took into account Brown's past conduct and testimonies indicating that Brown might "use its ownership of Kinney to force Brown shoes into Kinney Stores."[78] The Court's assessment was also influenced by increasing vertical integration in the shoe retail market in the United States.[79] Specifically, the Court pointed to "the tendency of acquiring manufacturers to become the primary sources of supply for their acquired outlets."[80] In the Court's opinion, this tendency would lead to the foreclosure of independent manufacturers from markets that would be open to them absent the merger.[81]

In *Brown Shoe,* the Court admitted that vertical mergers between manufacturers and retailers may benefit consumers by leading to lower prices.[82] The Court also emphasized that such mergers should not be considered anticompetitive merely because they are likely to harm small retailers. While the goal of the Clayton Act is "*to protect competition and not competitors*", Congress' desire to protect competition through the protection of small, viable and independent stores should be taken into consideration.[83] Despite the fact that Congress acknowledged that the maintenance of fragmented industries may inevitably lead to higher prices for consumers, Congress resolved these competing values "in favor of decentralization".[84] Because the proposed deal would foreclose competition from a substantial share of the shoe retail industry without yielding any countervailing social, economic or competitive benefits, the Court held that the merger should be prohibited.[85]

The Court's ruling in *Brown Shoe* was severely criticized by the Chicago School's prominent thinkers, such as Bork.[86] Chicagoans rigorously maintained that rather than leading to foreclosure, vertical mergers "realign vertical relationships."[87] Chicagoans confirmed that after the merger, Brown Shoe would sell more shoes to Kinney and less to rival shoe retailers.[88] Kinney may also purchase more shoes from Brown Shoe and fewer from competing shoe manufacturers. Nonetheless, Chicagoans alleged that the shoe retailers no longer buying from Brown Shoe, could benefit from shoe manufacturers no longer selling their products to

[77] *Id*. at 324.
[78] *Id*. at 332.
[79] *Id.*
[80] *Id.*
[81] *Id*.
[82] *Id*. at 373.
[83] *Id*.at 344.
[84] *Id*.
[85] *Id*. at 334.
[86] Steven C. Salop, *Invigorating Vertical Merger Enforcement*, 127 YALE L. J. 1962, 1966 (2018).
[87] *Id.*
[88] *Id*. at 1967.

Kinney[89]. To Chicagoans, this implied that vertical mergers may not necessarily lead to foreclosure.[90]

Chicagoans also maintained that unlike horizontal mergers, vertical mergers should not necessarily be subject to antitrust scrutiny on the basis that "an unregulated monopolist can obtain only a single monopoly profit."[91] To Chicagoans this meant that a monopolist may not necessarily increase its market power as a result of market foreclosure.[92] Chicagoans also pointed to the strong procompetitive benefits vertical mergers tend to create. For instance, they claimed that vertical mergers may lead to the "elimination of double marginalization."[93] Essentially, they maintained that after the merger "the upstream firm will transfer its input at marginal cost" and not at the "higher premerger price."[94] Following the merger, therefore, the downstream firm would reduce, rather than increase its output price. In other words, consumers would benefit.

The Chicago School's theories were, undoubtedly, influential. In fact, their main arguments are reflected in the 1984 Non-Merger Guidelines (the 1984 Guidelines)[95] which seem to support the idea that vertical mergers should be challenged only to the extent that some specific conditions are met.[96] For instance, when identifying vertical mergers' anticompetitive effects, the 1984 Guidelines highlight that integration stemming from these types of transactions may yield significant barriers to entry.[97] Nonetheless, they also emphasize that barriers to entry can create competitive concerns only when certain factors are present.[98] First, the "degree of vertical integration between two markets must be so extensive that a firm could enter one market (primary) only if it entered another one (the secondary) simultaneously".[99] Second, "the requirement of entry at the secondary level must make entry at the primary level substantially more difficult and less likely to occur".[100] Third, the structure and the main

[89] *Id.*
[90] *Id.*
[91] *Id.* at 1968.
[92] *Id.*
[93] *Id.* at 1970, ROBERT H. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF, 226-227, (1978).
[94] Bork, *supra* note 93 at 219, Salop *supra* note 86, at 1970. *See also* Gerard Gaudet & Ngo V. Long, *Vertical Integration, Foreclosure, and Profits in the Presence of Double Marginalization*, 5 J. ECON. & MGMT. STRATEGY409 (1996).
[95] U.S. DEP'T OF JUSTICE, 1984 NON-HORIZONTAL GUIDELINES (1984), https://www.justice.gov/atr/page/file/1175141/download?mkwid=c.
[96] Salop *supra* note 86, at 1963.
[97] U.S. DEP'T OF JUSTICE, 1984 NON-HORIZONTAL GUIDELINES *supra* note 95, at 4.21.
[98] *Id.*
[99] *Id.*
[100] *Id.*

characteristics of the primary market "must be otherwise so conducive to noncompetitive performance that the increased difficulty of entry is likely to affect its performance."[101]

When the potential anticompetitive effects of vertical mergers are being evaluated, the 1984 Guidelines also state that any efficiencies stemming from vertical integration will definitely be considered.[102] Specifically, the 1984 Guidelines highlight that while the Agencies may give less weight to efficiency claims in the context of horizontal mergers, they are more likely to consider them in the case of vertical mergers.[103] Nonetheless, the 1984 Guidelines also emphasize that "an extensive pattern of vertical integration" may constitute adequate evidence that vertical mergers produce substantial economies and, therefore, benefit, rather than harm consumers.[104] In other words, the 1984 Guidelines seem to echo Chicagoans' main claims that instead of harming competition by leading to market foreclosure, vertical mergers promote competition and increase competitive rivalry due to the efficiencies they generally create.

Over the past several years, prominent Post-Chicago scholars as well as members from the FTC have been raising the concern that the 1984 Merger Guidelines are out of date and that new guidelines should be issued so that vertical merger enforcement becomes a key priority for antitrust enforcers again.[105] Professor Steven Salop, for instance, has extensively delved into the reasons why the main theories regarding vertical integration, introduced by Chicagoans, are flawed and no longer reflect modern economic thinking. First, Professor Salop indicates that the "single monopoly theory" rarely, if ever, applies in reality.[106] This is because vertical mergers rarely involve entities that enjoy monopoly power protected by high barriers to entry.[107] In the absence of monopoly power, the single monopoly profit theory does not constitute sound economic reasoning that can justify a more lenient vertical merger policy.[108]

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[101] *Id*. The 1984 Guidelines also state that a vertical merger may create competitive concerns when it leads to the elimination of a disruptive buyer. According to the Guidelines, if firms in the upstream market consider a particular buyer as a vital commercial partner, they may deviate from the terms of a collusive agreement in order to secure their partnership with this buyer. A merger, therefore, between a disruptive buyer and an upstream firm may weaken firms' incentives to abstain from collusive agreements. Although the 1984 Guidelines recognize that these types of mergers may pose a threat to the competitive rivalry, they also highlight that antitrust enforcers are unlikely to challenge these types of mergers unless two conditions are met: 1) the overall concentration of the upstream firm is 1800 HHI or above and 2) the disruptive firm significantly differs in terms of volume or other relevant characteristics from its rivals in the relevant market.

[102] *Id*. at 4.24.

[103] *Id.*

[104] *Id*.

[105] For instance, C. Salop and Daniel P. Culley, *Revising the US vertical merger guidelines: policy issues and an interim guide for practitioners* 4 J. OF ANTITRUST ENFORCEMENT 1 (2016), Greaney & Ross *supra* note 70 at 201, Steven C. Salop, Daniel P. Culley *Revising the U.S. Vertical Merger Guidelines: Policy Issues and an Interim Guide for Practitioners,* 4(1) J. ANTITRUST ENFORCEMENT 1 (2015).

[106] Salop and Culley s*upra* note 105, *at 5.*

[107] *Id*. at 6.

[108] *Id*.

Instead, Professor Salop and other Post-Chicago scholars put forward the claim that vertical mergers increase the risk of collusion among rival firms, facilitate harmful price discrimination or evasion of price regulation, and lead to foreclosure.[109] These potential harms to competition and consumers, they contend, may not necessarily be outweighed by the efficiencies Chicagoans presume vertical mergers yield. Hence, Post-Chicago scholars allege that the Agencies should devote their resources to challenging vertical mergers especially in markets in which high barriers to entry and network effects pervade.[110]

The Agencies did not remain deaf to Post-Chicago scholars' claims. In response, they recently published the 2020 VMG with the aim of informing the antitrust community about the main principles underlying vertical merger enforcement in the United States.[111] The 2020 VMG state that when examining a vertical merger, the Agencies primarily consider the "effects on the actual and potential direct customers of the merging parties, and, if different, the final consumers of firms that utilize the goods or services of the merging parties."[112] In so doing, the 2020 VMG maintain that the Agencies seek to prevent "*harm to competition, not to competitors*."[113]

When evaluating vertical mergers' anticompetitive effects, the 2020 VMG stress that the Agencies take into consideration both the merging parties' market shares and their level of concentration in the relevant markets.[114] The 2020 VMG also focus on vertical mergers' (a) unilateral effects, namely market foreclosure and access to competitively sensitive business information[115] (b) coordinated effects (e.g. due to the elimination of a maverick firm that would otherwise prevent collusive behavior in the relevant market).[116] Nonetheless, the 2020 VMG explain that these potential anticompetitive effects may be mitigated if the envisaged vertical merger leads to the "elimination of double marginalization" and they may be surpassed by the likely cost or qualitative efficiencies vertical mergers often create.[117] To adequately assess a

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[109] *Id*.
[110] Salop *supra* note 86, at 1963.
[111] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, VERTICAL MERGER GUIDELINES (2020), https://www.ftc.gov/system/files/documents/reports/us-department-justice-federal-trade-commission-vertical-merger-guidelines/vertical_merger_guidelines_6-30-20.pdf.
[112] *Id*. at 2.
[113] *Id.*
[114] *Id.* at 3.
[115] *Id.* (Specifically, the 2020 VMG Guidelines raise the concern that in cases where the merged entity gains access to rival's competitive business information, it may use this information to 'react quickly to a rival's procompetitive business actions.' In such cases, rivals may be disincentivized from taking competitive actions. They may refrain from establishing a collaboration with the merged firm, rather than 'risk that the merged firm would use their competitively sensitive business information.')
[116] *Id.* at 10.
[117] *Id.* at 11.

merger's anticompetitive effects, the 2020 VMG state that the Agencies should apply the analytical framework that the 2010 HMG set forth.[118] Thus, for the efficiencies to count in favor of the merger, they should be (a) merger specific or, in other words, attained only through the proposed merger (b) verifiable, which means efficiencies that are not vague or speculative (c) not resulting in output restrictions.

By weighing the alleged efficiencies against the potential anticompetitive harm, the 2020 VMG highlight that the Agencies aim to measure the vertical mergers' "*likely net effect on competition in the relevant market*."[119] For instance, the 2020 VMG say that the merged firm may attempt to foreclose its rivals or raise their costs by dealing with them on less advantageous terms. However, as already noted, after the merger, the merged entity may also reduce its output price in the downstream market due to "the elimination of double marginalization".[120] In these cases, the 2020 VMG state that, "the likely merger-induced increase or decrease in downstream prices would be determined by considering their impact of both these effects, as well as any other competitive effects."[121]

What are the likely competitive concerns a vertical merger between a health insurer and a drug supplier may in fact raise? Can they hurt competition and consumers? And, if so, in what way? Thoroughly examining the Aetna-CVS deal, the section that follows sheds some light on these questions.

II. A DEEP DIVE INTO THE AETNA-CVS DEAL: WHAT ARE THE LIKELY ANTICOMPETITIVE EFFECTS?

A vertical merger between a health insurer and a drug supplier can harm competition and consumers in several ways. To start, a merger between Aetna and CVS can reduce competition in the health insurance services market. Aetna is the third largest health insurer in the Unites States. CVS is "the largest retail pharmacy chain" and one of the most powerful Pharmacy Benefits Managers (PBMs).[122] PBMs offer two main services to health

[118] *Id.*
[119] *Id.* at 5.
[120] *Id.* at 11-12.
[121] *Id*. at 11.
[122]. American Antitrust Institute (AAI), *Letter to US Department of Justice re. Competitive and Consumer Concerns Raised by the CVS-Aetna Merger*, 1 (March 28, 2018) https://www.antitrustinstitute.org/work-product/aai-calls-on-doj-to-block-the-merger-of-cvs-aetna-vertical-integration-will-restructure-important-healthcare-markets-to-the-detriment-of-competition-and-consumers/

insurers, managed care organizations, and employers.[123] First, they "negotiate rebates with drug manufacturers in exchange for preferred formulary placement (e.g. lower co-payment) for the manufacturer's drugs compared to the drugs offered by rival manufacturers." PBMs either retain these rebates or pass them on to health insurers. [124] Second, PBMs negotiate contracts with drug retailers and choose if the latter will be in a health insurer's network. They also decide the amount of compensation a drug retailer will receive "for dispensing drugs" to the insured consumers.[125]

Importantly, before the merger takes place, CVS is incentivized to offer its PBM services to all health insurance companies.[126] However, after the merger, CVS may be incentivized to sell its PBM services to Aetna's rivals under less favorable terms.[127] For instance, CVS may charge competing health plans higher prices for its PBM services. CVS may also refuse to pass the rebates it receives from drug manufacturers on to rival health insurers.[128] This is a legitimate risk because health insurers "have scant information about the rebates supposedly negotiated on their behalf," given that contracts between PBMs and drug manufacturers are considered trade secrets.[129] These practices can further reduce competition in the highly concentrated health insurance services sector and harm consumers.

CVS might also foreclose rival health plans by refusing to provide them access to its "must have retail pharmacies".[130] Competing health plans that lack access to CVS' pharmacy network may be less attractive to consumers, especially in markets where CVS enjoys market power.[131] Alternatively, CVS may offer rival health insurers access to its retail pharmacy network at higher prices. If competing health insurers accept the higher prices, their input costs will increase.[132] Hence, they may pass on these increased costs to their customers in the form of higher insurance premiums.

A vertical merger between a health insurer and a drug supplier may also lead to customer foreclosure.[133] Before the merger takes place, Aetna has strong incentives to

[123] American Medical Association (AMA), *Letter re. The Acquisition of Aetna, Inc. by CVS Health Corporation*, (August 7 2018) 6.
[124] AAI, *supra* note 122, at 6.
[125] *Id.*
[126] *Id.*
[127] AMA, *supra* note 123, at 2.
[128] *Id*. at 6.
[129] *Id*. at 7.
[130] *Id*. at 18.
[131] *Id.*
[132] *Id.*
[133] AAI, *supra* note 122, at 7.

cooperate with all retail pharmacies.[134] Post-merger, however, Aetna's incentives may change. CVS-Aetna may deny retail pharmacies access to Aetna, thus restraining competition in the PBM and retail pharmacy markets.[135] Because the health insurance services market is highly concentrated, "the number of alternative customers that rival retail pharmacies and PBMs could seek out post-merger" is limited.[136] Consequently, competition in the highly concentrated retail pharmacy sector will be decreased.[137]

In addition, the Aetna-CVS deal may also further increase "the barriers to entry into both the PBM and the health insurance services markets." Indeed, "following the CVS-Aetna and Cigna-Express Scripts mergers, the vertical integration between the PBM market and the market for health insurance would become so extensive" that a firm could enter into either market only if it entered the other market simultaneously.[138] Considering that both PBM and health insurance markets are characterized by significant barriers to entry, a two-level entry requirement would further restrain competition in these markets. [139]

A merger between Aetna and CVS may also give rise to coordinated effects by facilitating collusion among downstream rival health insurers that deal with CVS.[140] Anthem, for instance, a major health insurer in the United States, has already signed a contract with CVS.[141] Thus, CVS deals both with Aetna and rival Anthem. Because CVS can collect information on both Aetna and Anthem subscribers, it can facilitate information exchange between rival health insurers. This kind of information exchange increases the likelihood of "anticompetitive coordination" in the health insurance services market, "including price fixing and market allocation".[142]

But, the Aetna-CVS merger might also harm competition and consumers in other non-visible ways. As previously noted, the Aetna-CVS deal would allow Aetna to expand its access to consumers' prescription history, health habits and shopping data. Thus, post-merger, Aetna would be better able to identify the "unprofitable consumers" that is likely to attract and remove the drugs associated with treating those customers to a higher cost sharing tier. Hence, a merger between a drug supplier and a health insurer may lead to increased drug coverage costs for the higher risk, "unprofitable" consumers.

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[134] *Id.* at 9.
[135] *Id.*
[136] *Id.*
[137] *Id.*
[138] AMA *supra* note 123, at 2.
[139] *Id.*
[140] AAI, *supra* note 122, at 9.
[141] *Id.*
[142] *Id.*

A merger between Aetna and CVS may also facilitate the health insurer's efforts to detect the "high-risk" consumer groups that is likely to attract and increase their non-financial barriers to drug utilization. These barriers include prior authorization, quantity limits or step therapy.[143] Prior authorization requires that consumers purchase a drug only after receiving approval from their health plan.[144] Quantity limits reduce the number of pills of a given drug a patient may receive at a time.[145] Step therapy is "a weaker form of prior authorization" in that patients are required to use alternative drugs before they are able to use other, more expensive drugs.[146] Research demonstrates that these kinds of policies reduce access to healthcare services and increase the rates of treatment discontinuation. Hence, they can harm population health. They can also undermine an important dimension of the quality of health plans: "patient-centeredness".[147] According to the Agency for Healthcare Quality Research, this specific dimension measures the "rates of health plan member complaints or appeals over coverage decisions."[148] To the extent that a merger between Aetna and CVS may help the merged firm to increase the non-financial barriers to drug utilization, the Agencies may allege that this merger may harm the quality of the health insurance services offered to consumers, and, thus, should be banned.

Indeed, if a merger between a health insurer and a drug supplier leads to higher drug coverage costs or lower quality health insurance services for all consumers, the Agencies may contend that it violates section 7 of the Clayton Act. If, however, the proposed merger positively impacts the lower-risk healthier group of consumers, and negatively "the likely to get depressed", the diabetic or the chronically ill, the Agencies may not necessarily prohibit this merger. This is because, as noted, antitrust law is primarily concerned with the overall welfare of society—it does not distinguish between different groups.[149] From an antitrust law perspective, both high- and low-risk consumers, whether healthy or chronically ill, count equally.[150]

This begs the question: Can the Agencies ban data-driven mergers that facilitate the merged entity's efforts to increase the barriers to entry to health insurance services for the high-risk, vulnerable consumers? Surprisingly, when it comes to this question, the 2020 VMG

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[143] Andersen, *supra* note 30, at 161.
[144] *Id.*
[145] *Id.*
[146] *Id.*
[147] AGENCY FOR HEALTHCARE QUALITY RESEARCH, *Examples of Health Plan Quality Measures for Consumers*, https://www.ahrq.gov/talkingquality/measures/setting/health-plan/examples.html.
[148] *Id.*
149 K J Cseres, *supra* note 62.
[150] Farrell &. Katz, *supra* note 63.

remain silent. However, the 2020 VMG indicate that they "should be read in conjunction with the Horizontal Merger Guidelines." In light of this, the section that follows examines whether the 2010 HMG would give insight to the analytical tools under which the Agencies and the courts can assess the impact of vertical mergers on a specific group of consumers.

III. A PUZZLE WORTH EXPLORING: CAN THE U.S. ANTITRUST ENFORCERS PREVENT VERTICAL MERGERS THAT MAY HARM VULNERABLE CONSUMERS?

A. VULNERABLE CONSUMERS CONSTITUTE A SEPARATE PRODUCT MARKET

Any merger analysis usually starts with the definition of the relevant product and geographic market in which competitive effects are likely to be felt.[151] The 2010 HMG state that "the Agencies will normally identify one or more relevant markets in which the merger may substantially lessen competition." [152] The 2010 HMG clarify that when the Agencies define relevant markets, they mainly focus on demand substitution factors, i.e. "the ability and willingness of customers to substitute one product for another in response to a price increase or a corresponding non-price change, such as a reduction in product quality or service".[153] Although the 2010 HMG explain that both a price increase and a reduction in quality can be a demand substitution factor in a relevant product market definition test, they do not specifically explain how a reduction in quality can actually play a role in the definition of a relevant product market.[154] Nonetheless, the 2010 HMG do explain the methodological framework for defining the relevant product market on the basis of customers' responses to price increases.[155] The methodological framework is the Hypothetical Monopoly Test (SSNIP).[156]

The Agencies apply the SSNIP to identify "the smallest set of products for which a hypothetical monopolist could profitably raise a price" by a significant percentage (usually five per cent) "above the competitive level for a sustained period of time".[157] Thus, a potential

[151] Theodosia Stavroulaki, *supra* note 68, at 598.
[152] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* note 67.
[153] *Id.* at 7.
[154] Theodosia Stavroulaki, *supra* note 68, at 599.
[155] *Id.*
[156] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* note 67 at 8-9.
[157] *Id. See* J. Hausman, G Leonard, C. Vellturro, *Market Definition Under Price Discrimination*, 64 ANTITRUST L. J., 367,368 (1996), Jonathan Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L. J. 129, 144, L. Sean P. Sullivan, David Glasner, *The Logic of Market Definition*, 83 ANTITRUST L. J, 293, 324.

market definition is extremely narrow if, in the case of a five per cent price increase, "the number of customers who turn to products outside the market is large enough to make the price increase unprofitable".[158] Economists refer to the group of consumers who will stop purchasing the product (or will reduce consuming it) in light of the price increase as "marginal customers".[159] The majority of customers, however, are not marginal ones. Indeed, the majority of customers "will continue to purchase the product despite the price increase."[160] Essentially, this is because "their willingness to pay for the product outweighs the price increase".[161] Economists call this group of customers "nframarginal."[162]

Importantly, in certain cases, the hypothetical monopolist may be able to "distinguish inframarginal customers from marginal customers".[163] If so, the hypothetical monopolist would be able to "charge customers different prices according to their willingness to pay for a product".[164] Specifically, the hypothetical monopolist "could charge each customer a price above the competitive price, but just below what the customer is willing to pay for the product".[165] Hence, even if in some cases the hypothetical monopolist may find it unprofitable to raise a price five per cent "above the competitive level uniformly for all customers", the monopolist may still find it profitable to raise the price by this percentage only for a specific segment of customers.[166] This specific group of customers constitutes a separate product market, according to the 2010 HMG.[167]

Indeed, the 2010 HMG stress that if a hypothetical monopolist can "profitably target" a group of customers for price increases, the Agencies can "identify relevant markets defined around those targeted customers."[168] These markets are also known as "price discrimination markets."[169] However, as the 2010 HMG also say, "the Agencies identify price discrimination markets only in cases where there is a realistic prospect of an adverse

[158] J. Hausman, G Leonard, C. Vellturro *supra* note 157, at 368.
[159] *Id*.
[160] *Id.*
[161] *Id.*
[162] *Id.*
[163] *Id* at 369.
[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* note 67 at 12.
[168] *Id.*
[169] *Id.* Jonathan Baker, *supra* note 157 at 151, L. Sean P. Sullivan, David Glasner, *supra* note 157 at 324, Terrell McSweeny, Brian 'O'dea The *Implications of Algorithmic Pricing for Coordinated Effects Analysis* and *Price Discrimination Markets* in *Antitrust Enforcement*'32 ANTITRUST, 75, 77 (2017).

competitive effect" on a specific group of consumers.[170] "When price discrimination is reasonably likely", the 2010 HMG say, the Agencies will "*evaluate competitive effects separately by type of customer*."[171] But when is price discrimination "reasonably likely"? When two conditions are met. The 2010 HMG state: First, when the firm is able to classify consumers in different groups on the basis of "observable characteristics" and charge these groups different prices.[172] Second, when arbitrage is unlikely to occur either because the firm can prevent it or because it is "inherently impossible" for the firm's products or services.[173]

The FTC relied on price discrimination markets to challenge the proposed merger between *Sysco* and *U.S. Foods*, the two largest foodservice distribution companies in the United States.[174] *Sysco* and *U.S. Foods* sell and deliver a wide range of food items to restaurants, hospitals, hotels and other customers with locations dispersed across the country.[175] The FTC found that the relevant product market was "broadline food service distribution."[176] "Within this broader product market", the FTC maintained that there was a distinct product market for "broadline foodservice distribution services sold to national customers."[177] To substantiate its claim, the FTC relied on two specific facets. First, the FTC argued that national customers have a nationwide footprint and, therefore, they typically deal with broadliners that have geographically dispersed distribution centers.[178] Second, national customers tend to purchase goods "under a single contract that offers price, product and service consistency across all facilities".[179]' These customers, the FTC argued, "may be subject to a post-merger selective price increase due to their inability to switch to local suppliers."[180] Because the District Court agreed with the FTC, that national broadline customers constituted a separate product market, it granted a preliminary injunction.[181]

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[170] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* note 67, at 12.
[171] *Id*. at 6. L. Sean P. Sullivan, David Glasner, *supra* note 157, at 325. The authors clarify that "if the theory of harm is market-wide price elevation, it is unnecessary to specify the customer component of the market. If the theory of harm is price elevation to a subset of customers, then this should be reflected in the relevant market.'
[172] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* note 67 at 6. *See* also I. Simmons, S. Zaslavski, L. Freeman, *Price Discrimination Markets in Merger Cases: Practical Guidance from FTC v. Sysco*, 31 ANTITRUST 40 (2016); Jonathan Baker, *supra* note 157, at 151.
[173] *Id*.
[174] FTC v. Sysco Corp., 113 F. Supp. 3d 1 (D.D.C. 2015).
[175] *Id.*
[176] *Id.*
[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] *Id.*
[181] *Id.*

In *RR Donnelley*, a case that involved the merger of two large publication printers, Donnelley, which provided both gravure and offset printing services, and Meredith, "the third largest gravure printer in the United States," the counsel complaint tried to rely on price discrimination markets to prevent the proposed merger.[182] Specifically, the complaint counsel attempted to show that the relevant product market was "high volume publication gravure printing".[183] To substantiate this claim, the complaint counsel submitted several print buyers' testimonies arguing that "they would not or might not switch from gravure to offset if the price of all gravure printing services was raised by five percent."[184] To the counsel, this meant that "the merged entity could exercise market power with respect to high-volume publication customers who would not switch to gravure in the face of a 5% increase.''[185] The Administrative Law Judge agreed.

The Commission, however, was not convinced. In shaping its conclusion, the Commission identified the conditions under which a profitable discriminatory price could realistically be charged. First, the Commission said that the hypothetical monopolist should be able to identify the inelastic gravure customers. [186] Second, the hypothetical monopolist should be able to profitably charge this group of consumers higher prices.[187] Third, arbitrage of gravure printing (resale by elastic customers to targeted inelastic customers) should not be sufficient to offset the price increase.[188]As arbitrage could not take place in this case, the Commission focused on whether the first two conditions were met.[189]

The Commission rejected counsel's assessment "that price discrimination, with respect to the targeted customers, was likely."[190] To support the claim that the merged entity could detect and "target inelastic gravure customers with a discriminatory price increase, the complaint counsel had applied a breakeven analysis that estimated the production volume at which offset printing would become a less viable alternative to inelastic customers as the number of copies increased."[191] The Commission, however rejected this type of analysis.

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[182] R.R. Donnelley, 120 F.T.C. at 159–60.
[183] *Id.* (Complaint counsel and their expert Dr. Hilke thought that high-volume publication gravure printing "is approximated by gravure jobs of at least 5 million copies, of at least 16 pages, and with less than 4 four-color versions (or the equivalent in single color versions").
[184] *Id.* According to the findings "some print buyers" had showed "a distinct preference for the gravure process and they usually "did not switch between processes for a particular printing program."
[185] *Id.*
[186] *Id.*
[187] *Id.*
[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] *Id.*, I. Simmons, S. Zaslavski, L. Freeman, *supra* note 172, at 40.

Specifically, it thought that "a break-even analysis was not an effective means of differentiating customers based on the elasticity of demand because "increased productivity and efficiency" of offset printing made it difficult to detect at what point (if at all) offset printing can become a less viable alternative to gravure printing."[192] In light of these findings and other evidence indicating vigorous competition between gravure printing services and offset printing services in response to a supra-competitive price increase, the Commission refused to adopt the view that "high volume publication gravure printing' constituted a separate product market."[193]

As the previous section illustrated, a vertical merger between a health insurer and a drug supplier may lead to reduced costs of drug coverage for a certain group of consumers—the less risky ones, but higher costs for the "unprofitable" and more "vulnerable" ones. The merged entity may achieve this goal by increasing the out-of-pocket costs for drug coverage for high-risk consumers. If, for example, after a merger, the health insurer is better able to predict that it will attract a large number of consumers "that are likely to get depressed, be diabetic or obese", it may move the drugs that are vital for their treatment to a higher tier. Thus, high-risk consumers may pay higher out-of-pocket costs for drug coverage following a merger. They may also face higher non-financial barriers to drug utilization, such as step therapy, prior authorization or quantity limits. This segment of consumers may comprise a separate product market under the SSNIP test.[194]

However, in this case the Agencies may not necessarily ban the proposed merger because of the discrimination itself.[195] They may decide to prohibit the merger because it would allow Aetna to exercise its pre-existing market power.[196] Post-merger successful entry into the health insurance market would also require entry into the retail pharmacy market. Indeed, unless a potential entrant gained access to consumers' prescription history and health related data, it may be unable to compete in the health insurance services market. This is because without ensuring access to consumers' health data and prescription history, a firm may be less able to

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[192] *Id.*

[193] *Id.* ('No evidence in the record appears to suggest that high volume customers using offset are inframarginal, economically irrational, or otherwise irrelevant to market definition. Complaint counsel offer no explanation for the existing use of offset. The record as a whole shows substantial existing competition between gravure printing services and offset printing services, particularly in publication printing for print jobs with volumes between one million and ten million copies, but the margin (with the versioning parameter appropriately evaluated) appears to extend into even higher volumes.')

[194] Terrell McSweeny, Brian 'O'dea *supra* note 169, at 75, 76 (2017) (arguing that "algorithm-enabled price discrimination could significantly influence the merger review process in the near future by creating narrower product markets.") See *also* Steven C. Salop and Daniel P. Culley, *supra* note 105 at 32.

[195] Salop & Culley *supra* note 105 at 32.

[196] *Id.* (arguing that "in the case of a merger, the agencies would be challenging the merger that facilitates the exercise of market power through price discrimination, not the price discrimination itself.")

target the "healthier" low-risk consumers and avoid "the high risk, unprofitable" ones. This may further deter entry into the health insurance services. Ultimately, competition in the health insurance services market and consumers would be hurt.

B. DEFENDANTS' REBUTTAL: THE NET HARM TO ALL CONSUMERS SHOULD BE ASSESSED

While the U.S. antitrust enforcers may try to prohibit the merger between a health insurer and a drug supplier because it could lead to increased costs for health coverage or reduced quality of health insurance services for a specific segment of consumers, "the likely to get depressed" or "the diabetic concerned", the merging entities may put forward the claim that their envisaged merger does not necessarily hurt competition and consumers in light of the significant efficiencies it is likely to yield. First, the defendants may argue that the harm the proposed merger would cause to high-risk consumers should be outweighed by the benefits it may bring to the lower risk ones. Such benefits may be lower out of pocket costs for drugs utilization and increased access to health insurance services. Second, the merging parties may say that the envisaged merger may also yield cost and qualitative efficiencies in the relevant market(s). In other words, the merging parties might assert that unless the Agencies measure the net harm on competition in any relevant market, they cannot challenge the proposed merger. What are the likely efficiencies the merging entities may try to demonstrate to support this claim?

In their public statements CVS and Aetna maintained that the proposed merger would help them "pool complementary assets and leverage existing capabilities."[197] For instance, CVS has 1,100 Minute Clinics in its pharmacies.[198] These are walk-in clinics that treat minor health conditions, perform health screenings, and provide vaccinations at much lower prices than a hospital.[199] Post-merger, CVS-Aetna would route customers requiring urgent but basic care to these Minute Clinics. These retail clinics, Aetna-CVS said, would become mini-community health centers that facilitate access to lower-cost healthcare services.[200] This may

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[197] Burns, Lawton R. *Limits on Consumer Benefits from Proposed Merger of Aetna Inc. into CVS Health Corporation.*8 https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-8-7-Letter-to-Delrahim-CVS-Aetna-Merger.pdf.

[198] *Id*.

[199] CVS Health, Minute Clinic, https://cvshealth.com/our-services/health-and-wellness-services/minuteclinic.

[200] CVS Health to Acquire Aetna; *Combination to Provide Consumers with a Better Experience, Reduced Costs and Improved Access to Health Care Experts in Homes and Communities Across the Country*.

improve coordination of care, patients' experiences and health status. It may also reduce costly hospital emergency room visits.[201] Therefore, at least in theory, a merger between a health insurer and a drug supplier may reduce health expenditures and promote population's health.[202]

As discussed, a merger between Aetna and CVS would also allow Aetna to improve its access to patients' purchasing history, health habits and data.[203] Aetna-CVS would be able to identify the patients that are not being properly treated and ensure their access to healthcare. For instance, the merged entity could "identify the high risk asthma patients who have not yet been prescribed inhalers and manage their care before they end up in emergency rooms" with life threatening asthma episodes.[204] It may also steer high risk patients to primary care physicians or specialists who can provide care that is better coordinated and more consistent than sporadic and costly treatment in emergency departments.[205] It may also induce consumers to seek care, or change their health habits to prevent complications in the future.

Can the merging parties' alleged efficiencies rebut the Agencies' prima facie illegal case? The answer to this question is not straightforward. Under the 2010 HMG approach, efficiency considerations can be factored into a merger analysis in two ways: First, as Professor Herbert Hovenkamp explains "certain categorical assumptions about efficiencies are made in determining where the line for prima facie illegality should be drawn."[206] Second, according to the 2010 HMG, an efficiency defense is also available once the Agencies have established a prima facie illegal case.[207] The defendants bear the burden of proving an efficiency defense. However, once a prima facie case is established, it is highly unlikely that the defendants will successfully raise an efficiency defense.[208] Additionally, the U.S. Supreme Court has never recognized an efficiency defense to a section 7 claim.[209] In *FTC v. Procter & Gamble Co.*, the Supreme Court said that, "possible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies, but it struck the balance in favor of protecting competition."[210]

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https://cvshealth.com/news-and-insights/press-releases/cvs-health-to-acquire-aetna-combination-to-provide-consumers-with. Burns, Lawton R. *supra* note 197, at 8-9.

[201] *Id*.

[202] *Id.*

[203] *Id.* Burns, Lawton R., *supra* note 197, at 24.

204 *Id.* Natasha Singer *supra* note 14.

205 *Id*.

[206] Herbert J. Hovenkamp, *Appraising Merger Efficiencies*, 24 GEO MASON L. REV. 703, 704 (2019).

[207] *Id*.

[208] *Id.*

[209] Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 789-780 (9th Cir. 2015) AMA *supra* note 123, at 24.

[210] FTC v. Proctor & Gamble, 386 U.S. 568, 580 (1967); *See also* AMA *supra* note 123, at 24.

However, the possibility that an efficiency defense can rebut a prima facie case cannot be excluded. Consider *U.S. V. Anthem.*[211] This case involved the merger between Anthem and Cigna, the second and third largest companies of medical insurance in the United States.[212] Anthem and Cigna sell health insurance services to large national firms. Anthem had about 41% of the market and Cigna had 6%.[213] In light of the high market concentration, the government easily established a prima facie case.[214] Specifically, it banned the proposed merger on the basis that the fees it would charge to large employers for health insurance services may significantly increase.[215] The merging parties tried to rebut the government' s prima facie case. Specifically, they claimed that the merger should be allowed in light of the medical cost savings it was expected to create.[216] First, the merging parties claimed, Cigna would be able to access Aetna's lower rates through rebranding.[217] Second, by increasing its bargaining power, the merged firm would be able to renegotiate lower rates with providers. Although the court, by Judge Rogers, was unsure whether efficiencies could ever rebut a prima facie case, the court was willing to at least consider the possibility that they could.[218] However, the court easily dismissed the efficiencies alleged by the powerful health insurers on the basis that they were non-cognizable.

Nonetheless, in the case at issue, the merging parties' claimed efficiencies may not rebut the Agencies' prima facie case. This is because the merging entities' alleged efficiencies "must occur in the specific market" in which the merger is expected to hurt competition and consumers.[219] Importantly, the 2020 VMG and the 2010 HMG do not specifically articulate whether the harm a merger may create in one relevant market can be outweighed by gains to another one. However, the 2010 HMG say that "the Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential harm to consumers in

[211] United States v. Anthem, Inc., 855 F.3d 345 (D.C. Cir. 2017)
[212] *Id*. at 350.
[213] *Id*. at 372.
[214] *Id* at 351.
[215] *Id.* at 352.
[216] *Id.*
[217] *Id.*
[218] *Id.* (arguing that "despite, however, widespread acceptance of the potential benefit of efficiencies as an economic matter, see, e.g., Guidelines § 10, it is not at all clear that they offer a viable legal defense to illegality under Section 7").
[219] Terrell McSweeny, Brian 'O'dea *supra* note 169, at 76. As the authors explain the HMG "do not net out consumer welfare gains in one market against losses in another. If a targeted group of customers will be harmed by a loss of competition, that in and of itself is sufficient grounds to justify blocking the trans-action… Under the Guidelines, the agencies normally will not simply abandon particular groups of consumers to a post-merger exercise of market power by trading off potential gains and losses across different relevant markets." *See also* AMA *supra* note 123, at 27.

the relevant market, e.g., *by preventing price increases in that market.*"[220] Additionally, the 2010 HMG convey that the Agencies consider the anticompetitive effects "in each relevant market affected by a merger independently."[221]

However, the 2010 HMG also provide that "the Agencies may consider efficiencies not strictly in the relevant market, but so inextricably linked with it that a partial divestiture or other remedy could not feasibly eliminate the anticompetitive effect in the relevant market without sacrificing the efficiencies in the other market(s)."[222] According to 2010 HMG, "inextricably linked efficiencies are likely to make a difference when they are substantial and the likely anticompetitive effect in the relevant market(s) is small."[223] Put simply, to the extent the alleged efficiencies in one market are significant and the harm to competition in another one relatively small, the Agencies may accept the merger on the basis that the cognizable efficiencies in one market surpass harm to competition in another one.

Nonetheless, the Guidelines are not law. Additionally, the notion that the harm a merger may cause in one relevant market can be outweighed by the benefits it may bring to another, is not line with Supreme Court's ruling in *Philadelphia National Ban*k.[224] This antitrust case centered around the merger of the second and the third largest commercial banks in the Philadelphia metropolitan area.[225] The proposed transaction would result in Philadelphia's largest commercial bank. To rebut the government's findings of anticompetitive effects, the merging parties raised an efficiency defense. Specifically, they alleged that following the merger, the resulting bank "with its greater prestige and increasing lending limit would be better able to compete with large out of State (particularly NY) Banks, would attract new business in Philadelphia and in general would promote the economic development of the metropolitan area."[226] The Supreme Court was not convinced. The Supreme Court took the stance that "if anticompetitive effects in one market could be justified by procompetitive justifications in another, the logical upshot would be that every firm in an industry could, without violating the Clayton Act, embark on a series of mergers that would make it in the end as large as the industry leader."[227] Hence, the Supreme Court banned the proposed merger.

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[220] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES *supra* note 67 at 30-31.
[221] *Id*. at ft 14.
[222] *Id*.
[223] *Id*.
[224] *US* v. *Philadelphia National Ban*k 374 U.S. 321 (1963). *See also* Michael Katz & Jonathan Sallet, *Multisided Platforms and Antitrust Enforcement*, 127 YALE L. J. 2142, 2171 (2018).
[225] *US* v. *Philadelphia National Ban*k *supra* note 224, at t 330.
[226] *Id*. at 334.
[227] *Id* at 370.

In an analogous manner, the Agencies may argue that the welfare gains enjoyed by one group of consumers comprising one relevant market, the healthier, low-risk consumers, cannot outweigh the welfare losses suffered by the higher risk ones.[228] Moreover, they may contend that even if the proposed merger facilitates access to low cost care and improves coordination of care, those efficiencies would take place in the market for primary care and not the health insurance services market. In line with the Court's precedence in *United States v. Philadelphia National Bank,* the Agencies may therefore put forward the claim that the vertical merger between a health insurer and a drug supplier violates section 7 of the Clayton Act and, as a result, should be prohibited.

However, if the story ended here it would be incomplete. The merging parties may try to rebut the Agencies' findings of anticompetitive effects by raising some additional concerns. For instance, they may try to show that the high-risk consumers do not constitute a separate product market under the SSNIP test. They may also try to support a more ambitious claim. Specifically, they may allege that the health insurance market is a two-sided platform and, therefore, in line with Supreme Court's ruling in *Ohio V. American Express* ("Amex")*[229]*, the Agencies should perform "a net-effect" and not "a separate effects" analysis.[230] Put differently, the merging entities may claim that unless the Agencies assess the net harm across all consumer groups, both high-risks and low risks, they have not established a prima facie case.[231]

Amex arose because the federal government and 17 states challenged the anti-steering provisions that *Amex* imposed upon merchants accepting its credit cards.[232] These provisions banned merchants from inducing customers to use credit cards that charge merchants a lower fee.[233] On their face, Amex's anti-steering provisions reduce price competition on the merchant side of the credit card platform.[234] Competing credit card networks, such as Visa and Mastercard, cannot boost their profits by lowering the fee they charge merchants.[235] Consumers may not recognize the differences between merchant fees, and *Amex* prevents merchants from steering their customers towards rival credit card networks that offer lower cost credit cards.[236]

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[228] Terrell McSweeny, Brian 'O'dea, *supra* note 169, at 77.
[229] Am. Express Co., 138 S.Ct. 2274 (2018).
[230] For a similar discussion, *see also* Michael Katz & Jonathan Sallet, *supra* note 224, at 2145.
[231] For a thorough analysis of the *Amex* case and how it altered the plaintiff's burden of proof under the rule of reason, John B. Kirkwood, *Antitrust and Two-Sided Platforms: The Failure of American Express*, 41 CARDOZO L. REV. 1805, 1817 (2020).
[232] *See* Am. Express Co., 138 S. Ct *supra* note 229, at 2280.
[233] *Id.*
[234] John B. Kirkwood, *supra* note 231, at 1810.
[235] *Id.*
[236] *Id.*

In other words, Amex's anti-steering provisions undermine credit card networks' incentives to reduce merchant fees. Centering its legal analysis around this harm, the District Court maintained that the relevant market was "credit card services provided to merchants."[237] The District Court concluded that the Government had established its prima facie case and that *Amex* had failed to rebut it.[238] The Second Circuit reversed the District Court's ruling on the grounds that the market was two-sided: card-holders on one side and merchants on the other.[239] Since Amex card-holders receive significant rewards because of the higher fees *Amex* charges merchants, the plaintiff must demonstrate the net loss for the merchants and the cardholders to establish a prima facie case.[240]

The Supreme Court agreed. Specifically, the Supreme Court alleged that "evidence of a price increase on one side of a two-sided transaction platform cannot by itself demonstrate an anticompetitive exercise of market power".[241] To show anticompetitive effects on the two-sided credit-card market, the Supreme Court said, the Government must show that "Amex's antisteering provisions increased the cost of credit-card transactions above a competitive level, reduced the number of credit-card transactions, or otherwise stifled competition in the credit-card market." [242] Since the plaintiff had failed to consider both sides of the market, the Supreme Court took the view that the government had failed to demonstrate the anticompetitive effects.

"Credit card networks", the Supreme Court held, are "a special type of two-sided platform" or else "a transaction platform."[243] A two-sided platform offers different products or services to two different groups of users that both "depend on the platform to intermediate between them".[244] Transaction platforms, the Supreme Court stated, cannot make a sale unless "both sides of the platform simultaneously agree to use their services".[245] For instance, no credit-card transaction can take place "unless both the merchant and the cardholder simultaneously agree to use the same credit card network."[246] The Supreme Court argued that transaction platforms also differ from traditional markets because "they exhibit more pronounced indirect network effects and interconnected pricing and demand."[247]

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[237] *See* Am. Express Co., 138 S. Ct *supra* note 229 at 2283.
[238] *Id*.
[239] *Id.*
[240] *Id.*
[241] *Id.* at 2278.
[242] *Id.*
[243] *Id*. at 2277.
[244] *Id.*
[245] *Id.* at 2278.
[246] *Id.* at 2280.
[247] *Id*. at 2278.

Indirect network effects, the Court maintained, "exist where the value of the two-sided platform to one group of participants" highly depends on the volume of the participants of "a different group."[248] In fact, the value of the services that a two-sided platform offers "increases as the number of participants on both sides of the platform increases".[249] A credit card, for instance, is more valuable to merchants the more cardholders use it and more valuable to cardholders the more merchants accept it.[250] However, to ensure adequate participation, "two-sided markets must be sensitive to the prices that they charge each side".[251] This is because charging a higher price on one side of the platform (side A) may lead to lower participation on that side which may decrease the value of the platform on the other side of the platform (side B).[252] If members on side B leave the platform because of the loss in value, "then the platform has even less value to side A." Because of these indirect network effects two-sided platforms often charge a higher price on one side of the platform than the other.[253] The Supreme Court held that "striking the optimal balance of the prices charged on each side of the platform is essential for two-sided platforms to maximize the value of their services and to compete with their rivals." [254]

Relying on *Amex*, Aetna and CVS may put forward the claim that the health insurance services is a two-sided platform. Hence, the Agencies should show a combined net loss for the high-risk and low-risk consumers to establish a prima facie case. The merging parties could claim that the health insurance services market is a two-sided market because the value of the health insurance services increases as the number of participants on both sides of the platform increases. Health insurance is more valuable to high-risk consumers when more low-risk consumers subscribe and is more valuable to low-risk consumers when more high-risk consumers subscribe. High-risk consumers benefit when more low-risk consumers enroll because the higher the expected cost of the risk pool, the higher premiums will be.[255] Low risk consumers also benefit when high-risk consumers are enrolled because of externalities: costs that are likely to bear if high-risk consumers lack health insurance. These include "physical externalities from communicable diseases" (high-risk people are more likely to get an infectious

[248] *Id.* at 2280.
[249] *Id.*
[250] *Id.* at 2281.
[251] *Id*.
[252] *Id*.
[253] *Id*.
[254] *Id.*
[255] Wendy Netter Epstein, *supra* note 21, at 1431.

disease and spread it to others) and "financial externalities from uncompensated care".[256] Additionally, to the extent that high-risk consumers lack adequate coverage, health disparities in the United States will further increase. Ultimately, this would not only affect the high-risk consumers, but the well-being of the society as a whole.

Would the merging parties' argument succeed? The answer should be a negative one. This is because as the Supreme Court highlighted in *Amex*, only "platforms that facilitate a single, simultaneous transaction between participants" fall within its single market rule.[257] Unlike the case of credit cards markets, health insurers do not facilitate a simultaneous transaction between high-risk and low-risk consumers. Hence, under the Supreme Court's ruling in *Amex*, the health insurance market would not be considered a two-sided market.

However, one cannot ignore the possibility that the merging entities may successfully allege that the merger's impact on both high-risk and low-risk consumers should be considered. For instance, even if the merging parties failed to prove that the health insurance services market is a two-sided market, they might show that the "vulnerable consumers" do not constitute a separate product market. If so, the merger's net effect on both high-risk and low-risk consumers would be assessed. However, if the merger's positive impact on low-risk consumers is outweighed by its negative impact on the high-risk ones, the Agencies would approve the proposed merger. In this case, however, the U.S. antitrust enforcers may risk applying antitrust law in a way that disregards one of the fundamental goals of the ACA: access to health insurance for all citizens, irrespective of their pre-existing conditions and socio-economic status.[258]

What are the alternatives? The U.S. antitrust enforcers may take the stance that although the net effect of the proposed merger on all segments of consumers should be considered, the merger's negative impact on the high-risk consumers should weigh more than

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[256] Jonathan Gruber, *Covering the Uninsured in the U.S*. (NBER Working Paper 13758) (2008). Research demonstrates that "imposition of cost-sharing causes poorer patients to not consume healthcare that would have been beneficial to them" and that "copayment increases led to increased use of emergency department visits and hospital days". *See also* Victor Laurion, Christopher T. Robertson, *supra note* 33, at 58, 61, Wendy Netter Epstein, *supra* note 21 at 1455 (claiming that many individuals that end up in emergency rooms consume care at a high cost that they cannot afford to pay. Inevitably, these costs are incurred by the insured population and the government.). *See also* Ricardo Alonso-Zaldivar, *How Much Do Health Insurance Subsidies Cost Taxpayers?* INS. J. (Dec. 19, 2016), https://www.insurancejournal.com/ news/national/2016/12/19/435878.htm [https://perma.cc/VA3M-2KFL]; Maureen Groppe, *Who Pays When Someone Without Insurance Shows Up in the ER?*, USA TODAY (July 3, 2017), https://www.usatoday.com/story/news/ politics/2017/07/03/who-pays-when-someone-without-insurance-shows-up-er/ 445756001/ [https://perma.cc/XZ2N-549H].

[257] Herbert Hovenkamp, *Platforms and the Rule of Reason: The American Express Case*, COLUM. BUS. L. REv. 35, 82 (2019).

[258] One of the main goals of the ACA is to expand access to health insurance services, Victor Laurion, Christopher T. Robertson, *supra note* 33, at 43.

its positive impact on the low-risk ones. However, conducting this balancing exercise may be a tough road for the Agencies. This is because under the consumer welfare standard, both high-risk and low-risk consumers count equally.[259] Therefore, unless the Agencies adopted an alternative notion of consumer welfare standard, one that specifically encompasses distributive concerns, they may clear the proposed merger despite its negative impact on the vulnerable populations that need access to health insurance services.

Although the U.S. antitrust enforcers and the courts have not adopted this alternative notion of consumer welfare thus far, they have good reasons to consider adopting it in the case at issue. First, because their analysis would be in line with the policy objectives of the ACA that aims to facilitate access to health insurance services for the vulnerable consumers.[260] Second, because, as noted, low-risk consumers benefit if high-risk consumers gain access to health insurance services. This is because of the high costs low-risk consumers incur when vulnerable populations lack any meaningful access to healthcare. Third, because although the reduction of inequality or the pursuit of other distributive concerns are not part of the antitrust agenda, the U.S. antitrust enforcers and the courts in the past have applied antitrust law in a way that considers the interests of the less advantaged. The *Long Island Jewish*[261] case, in which a Federal District Court examined the merger between two non-profit hospitals, echoes this claim. Although the FTC challenged the envisaged hospital merger on the basis that it could have led to increased market power in the relevant market, the court took a different view.[262] The court's assessment was bolstered by an agreement completed by the merged hospitals and the Attorney General of the State of New York who foresaw that the merged entity would pass a substantial part of the cost savings achieved through the merger to the community by providing high quality healthcare "to economically disadvantaged and elderly members of the community".[263] In others words, the court decided to accept this merger on equity grounds: because ultimately, it would not hurt the less privileged.

[259] Joseph Farrell & Michael L. Katz *supra* note 63.
[260] Victor Laurion, Christopher T. Robertson, *supra note* 33, at 43.
[261] United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997).
[262] *Id.*
[263] *Id*. at 149.

C. THE MERGER MAY FACILITATE THE MERGED ENTITY'S EFFORTS TO VIOLATE THE ACA

A central question that also deserves attention is whether the U.S. antitrust enforcers may ban data driven mergers between drug suppliers and health insurers on the basis that they facilitate health insurers' efforts to evade the ACA, which aims to prohibit pre-existing condition exclusions and discriminatory premium rates. Again, the answer to this question is not straightforward. Specifically, a closer look at the most recent hospital merger cases reveals that when the merging entities try to support the claim that their proposed merger should not be banned on the ground that it will facilitate the merging parties' efforts to expand access to healthcare services for the less advantaged populations, the U.S. antitrust enforcers and the courts retell the story that the pursuit of policy goals, such as access, cannot enter the equation. Consider *FTC v. St. Luke's Health System*, a case that involved St. Luke's acquisition of Idaho's largest independent multi-specialist physician group, *Saltzer Medical Group*.[264] To rebut the FTC's assessment that the proposed hospital merger would lessen competition in the relevant market, the merging parties attempted to show that their merger would generate qualitative efficiencies. The merging entities maintained "that the acquisition of Saltzer would enable it to move away from fee for service ("FFS") and towards "risk-based" care."[265] Under FFS, physicians are compensated "for each procedure they perform."[266] Thus, FFS incentivizes physicians to increase the volume of the procedures they perform rather than provide cost effective care.[267] However, when the care provided by physicians is risk-based, they are motivated to improve the quality of the services they offer and reduce the cost of care.[268] The merging parties claimed that moving away from providing FFS care, would allow Saltzer "to increase access to medical care for the significant population of Medicaid and Medicare patients in Canyon County."[269]

The District Court easily rejected the defendants' alleged efficiencies on the basis that they were not merger-specific.[270] Crucially, the court also dismissed the merging parties' claim that the proposed transaction would enable the merging entities to expand their services

[264] Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd, Findings of Fact and Conclusions of Law, No-0560, DkT, No.14-35173, at 150.
[265] *Id*.
[266] *Id*.
[267] *Id*.
[268] *Id*.
[269] *Id*. at 46.
[270] Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd., Reply Brief of Appellants St. Luke's Health System, Ltd., et al., No. 14-35173 (9th Cir. 2 Sep. 2014), at 18.

to the most disadvantaged groups of the population in Nampa, the poor and the uninsured. To the court, "there was no shortage of access to medical care for Medicaid patients in Nampa."[271] Emphasizing also that "even if policy considerations could trump the Clayton Act, they would not do so on this record" the court did not allow health policy considerations to alter its conclusions.[272]

The FTC aligned with the District Court's reasoning. While elaborating on whether the pursuit of improved quality or access to care can surpass the harm to competition, the FTC emphasized that "the Clayton Act contains no healthcare exception."[273] Citing *National Society of Professional Engineers v. United States* case,[274] the FTC maintained that "Congress declined to provide an exemption from the antitrust laws for specific industries because it rejected the notion that monopolistic arrangements will better promote trade and commerce than competition."[275] The Appellate Court confirmed.

In *Penn State Hershey Medical Center*.[276] the FTC also adopted a similar approach. This antitrust dispute involved the merger of the two largest hospital systems in the area around Harrisburg, Pennsylvania, Hershey and Pinnacle.[277] Taking the view that the proposed merger would hurt competition and consumers, the FTC sought a preliminary injunction to stop the transaction. The defendants insisted that the merger should be consummated, arguing that the merger would create qualitative and cost efficiencies.[278] However, the FTC insisted that "*No court ever has found, without being reversed, that efficiencies rescue an otherwise illegal transaction*".[279] The FTC concluded that defendants' efficiency claims were overstated, speculative, and not merger-specific.[280] Federal District Court Judge Jones dismissed the FTC's request for an injunction on the basis that "the government had failed to properly define the relevant geographic market."[281] Although Judge Jones did not in fact delve into the defendants' alleged efficiencies, he reflected on the defendants' claim that the proposed merger would improve healthcare. Diverting from the FTC's core findings, Judge Jones alleged that the proposed merger could actually benefit consumers. To the court, this finding was informed by the "growing need" for hospitals "to adapt to an evolving landscape" of health care "*that also*

[271] *Id*., 58 -59.
[272] *Id*., at 59.
[273] *Id.*
[274] Nat'l Soc'y of Prof'l Engineers v. United States, 435 U.S. 679 (1978).
[275] Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd., *supra* note , at 20.
[276] In the Matter of Penn State Hershey, Medical Center, a corporation, et al., Complaint, Docket No. 9368.
[277] *Id.*
[278] *Id*. at 72.
[279] *Id*.
[280] *Id*. at 75.
[281] FTC et al. v. Penn State Hershey Medical Center et al., No. 1:15-cv-02362-JEJ 9 May 2016.

included the institution of the ACA".[282] Nonetheless, in its appeal the FTC refused to embrace the lower court's analysis. In line with *FTC v. St. Luke's Health System*, the FTC once again said that "the Clayton Act contains no healthcare exception" and that "the antitrust laws apply to hospitals in the same manner that they apply to all other sectors of the economy."[283]

Importantly, the Agencies and the U.S. courts remain faithful to the narrative that the pursuit of policy goals cannot outweigh the harm caused to competition. However, they seem to consider those goals when they evaluate the anticompetitive effects of regulations adopted by medical boards with respect to Section 1 of the Sherman Act. The antitrust enforcers' analysis in *South Carolina State Board of Dentistry* reflects this point. In *South Carolina State Board of Dentistry*, the core antitrust issue centered around the complaint that the FTC issued against the State Board of Dentistry in South Carolina ("the Board").[284] The FTC claimed that the Board harmed "competition in the provision of preventive dental care services" by unreasonably restraining "the delivery of dental cleanings, sealants, and topical fluoride treatments in school settings by licensed dental hygienists".[285] Despite the fact that the South Carolina Assembly ("the legislature") had previously passed legislation "eliminating a statutory requirement that a dentist examine each child before a dental hygienist may perform cleanings or apply sealants in school settings", the Board later adopted an emergency regulation that "re-imposed the very examination requirement that the legislature had eliminated".[286] The FTC argued that, due to the Board's action, thousands of school children—particularly the poor— were deprived of access to preventive oral health care services.[287] The FTC concluded that the Board's actions violated the antitrust mandate.

In the case at issue, the Agencies may contend that the envisaged merger should be prohibited on the basis that it may facilitate the merged entity's efforts to evade the ACA that aims to prevent discriminatory premium rates and any discrimination on the basis of citizens' preexisting health conditions. So far, the U.S antitrust enforcers and the courts, have not relied on this argument to ban a merger. However, prominent scholars in the United States have

[282] *Id.*
[283] FTC et al., Appellants, v. Penn State Hershey Medical Center et al. Appellees, Reply Brief, No 16-2365.
[284] South Carolina State Board of Dentistry, Docket No. 9311, 1 (Fed. Trade Comm'n Sept. 11, 2007) (opinion and order), https://www.ftc.gov/sites/default/files/documents/cases/2004/07/040728commissionopinion.pdf.
[285] *Id.* at 3.
[286] South Carolina State Board of Dentistry, Docket No. 9311 (complaint), https://www.ftc.gov/sites/default/files/documents/cases/2003/09/socodentistcomp.pdf.
[287] *Id.* at 1.

claimed that a vertical merger that "may facilitate harmful price discrimination or the evasion of price regulation violates section 7 of the Clayton Act."[288]

The Agencies have not rejected this approach. In 2006, the FTC challenged the proposed Fresenius "acquisition of an exclusive sublicense from Luitpold Pharmaceuticals."[289] Fresenius is a dominant provider of "end-stage renal disease (ESRD) dialysis services in the United States."[290] Fresenius "would supply the intravenous iron drug Venofer to dialysis clinics in the United States".[291] The FTC claimed that the proposed deal would violate Section 7 of the Clayton Act because it would allow Fresenius "to report higher prices for Venofer used in its own clinics to Center for Medicare & Medicaid Services (CMS)".[292] Because this would result in "a higher average selling price," Fresenius would receive "a higher Medicare reimbursement rate for Venofer."[293]

In an analogous manner, the Agencies may allege that the proposed deal should be subject to antitrust scrutiny on the basis that it would facilitate the merged entity's efforts to evade the ACA that precludes discriminatory premium rates. As discussed, the Agencies have not thus far embraced this approach. However, the Agencies may have good reasons to examine, specifically in the case at issue, whether the proposed merger would facilitate the merged entity's efforts to evade the ACA on the basis of two concerns. First, adopting this approach would allow the Agencies to apply antitrust law in a way that considers the policy goals of the ACA. Second, it would allow the Agencies to avoid the difficult task of weighing the circumstances and interests of different consumer groups: the low-risk and the high-risk consumers. To the extent that the Agencies showed that the envisaged merger may facilitate the merged entity's efforts to discriminate against people with preexisting conditions or apply discriminatory premium rates, they could prohibit the envisaged merger. However, because the

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[288] Steven Salop and Daniel Culley, *supra* note 105, at 6, Michael H. Riordan; Steven C. Salop, *Evaluating Vertical Mergers: A Post-Chicago Approach*, 63 ANTITRUST L.J. 513, 561-562 (1995).
[289] *Id.*
[290]FTC Challenges Vertical Agreement Between Fresenius and Daiichi Sankyo, (September 15, 2008) https://www.ftc.gov/news-events/press-releases/2008/09/ftc-challenges-vertical-agreement-between-fresenius-and-daiichi.
[291] In the Matter of Fresenius Medical Care AG & Co KGaA and Daiichi Sankyo Company, Ltd, No 081- 0146 (15 September 2008), https://www.ftc.gov/news-events/press-releases/2008/09/ftc-challenges-vertical-agreement-between-fresenius-and-daiichi.
[292] *Id.*
[293] *Id.* However, a consent order settled the Commission's charges and allowed the companies to consummate the transaction. The consent prevented "Fresenius from reporting intra-company transfer prices higher than certain levels specified in the order") https://www.ftc.gov/news-events/press-releases/2008/09/ftc-challenges-vertical-agreement-between-fresenius-and-daiichi.

Agencies have not so far adopted this novel approach, it may not necessarily be an easy choice for them.

CONCLUSION

This article asked: Can the Agencies ban a vertical merger between a health insurer and a drug supplier on the grounds that it may allow the merged firm to increase the barriers to entry to health insurance services for high-risk consumers? Delving into this underexplored question, this article identified three potential ways in which the U.S. antitrust enforcers and the courts could address the harms that these mergers impose on high-risk consumers. First, the U.S. antitrust enforcers could contend that the vulnerable, high-risk consumers constitute a separate relevant market. Second, they could argue that the proposed merger's negative impact on high-risk consumers should weigh more heavily than its positive impact on low-risk consumers, notwithstanding that the net effect of the merger should be assessed. Third, the U.S. antitrust enforcers may argue that these mergers facilitate a health insurer's efforts to violate the ACA and should, therefore, be prohibited. This article illustrated the need for the U.S. antitrust enforcers and the courts to confront the harm that these data driven mergers pose to high-risk consumers. If not, they risk applying antitrust law in a way that further exacerbates the existing health inequalities in the United States.