A Framework for Evaluating Vertical Integration Among Payers and Providers

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A VERTICAL MERGER TYPICALLY INVOLVES two non-competing companies, one of which provides a necessary input for the product/service of the other. In contrast to horizontal mergers, the potential anticompetitive effects of vertical mergers are often less intuitive, and this is especially true within the payer-provider marketplace. In order to understand the context of these vertical mergers, it is important to first understand the significance of health financing and delivery integration. Vertical integration involves both network construction to merge clinical and health plan operations along with risk distribution throughout the healthcare delivery supply chain.[1] The Centers for Medicare and Medicaid Services (CMS) has begun to favor this type of integration in its policy making, forcing many healthcare executives to examine the sustainability of their current business models.

The public policy push into risk-based contracting naturally may lend itself to increased vertical integration in healthcare, and we will outline a framework that the Federal Trade Commission (FTC) and Department of Justice (DOJ) (collectively, the Agencies) can use to evaluate vertical mergers in healthcare, specifically payer-provider mergers and affiliations, balancing potential pro-competitive efficiencies against potential anticompetitive effects specific to these transactions. The 2020 Vertical Merger Guidelines (now withdrawn) recognized that vertical mergers have the potential to generate efficiencies through the elimination of double marginalization (EDM).[2] In contrast, in 2023 the Agencies released a new version of Merger Guidelines that reflects a far more skeptical view of vertical integration.[3] This paper presents a framework that seeks a balanced approach to address the complex and specific nature of vertical payer-provider transactions in the healthcare marketplace, warns against foreclosure tactics and anticompetitive strategy, and highlights the potential for enhanced coordination and improved outcomes.

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Antitrust Enforcement and Healthcare Transactions

Horizontal healthcare mergers provide important context for understanding the competitive effects of vertical healthcare mergers. Horizontal mergers in healthcare most often occur between hospitals or physician practices looking to pool resources and expand footprint, often with the result of increased bargaining leverage against payers. From 1998 through 2017, there were nearly 1,600 hospital mergers in the United States, and most of these mergers involved direct competitors.[4] This large number of mergers has permitted extensive research into the consequences of horizontal transactions in healthcare, with many researchers concluding that these mergers often lead to higher prices for consumers.[5]

One important type of vertical healthcare merger is between payers and providers broadly.[6] UnitedHealth Group (UHG) has been the subject of much scrutiny over several vertical transactions in recent years. UHG has two primary subdivisions relevant here: UnitedHealthcare, its payer division, and Optum, its health services division. UHG has grown Optum significantly since its inception in 2011, with over 28 physician group acquisitions to date.[7] More recently, UHG has also moved to acquire assets elsewhere along the patient care continuum. In 2021, UHG proposed the acquisition of Change Healthcare, a data analytics and health information technology company. After receiving a letter from the American Hospital Association in protest, the DOJ sued to block the $7.2 billion deal in 2022 on grounds that it would give UHG an unfair advantage over its payer competitors, along with access to competitively sensitive information. The DOJ ultimately lost its challenge in federal court.[8]

In 2022, UHG also moved to acquire LHC Group, a firm focused on home health, for $5.4 billion.[9] That transaction went unchallenged by antitrust authorities. In June of 2023, UHG announced plans to expand its home health footprint through the acquisition of another firm, Amedisys.[10] On November 12, 2024, the DOJ and four state Attorneys General filed a complaint challenging the Amedisys acquisition. The DOJ's theory of harm, however, focuses only on the horizontal overlapping businesses of LHC and Amedisys. Notably, the complaint does not allege harm based on the vertical integration of UHG as an insurer and Amedisys as a provider group.[11] The only mention of UHG's dual role as an insurer and provider is discussed in the context of how the transaction would result in two major integrated

entities: "the nation's three largest home health providers would be owned by the nation's two largest Medicare advantage insurers—UnitedHealth, through LHG and Amedisys, and Humana, through Kindred (which Humana purchased in 2021)."[12]

Other players that have been active in the payer-provider space include Kaiser Permanente and Geisinger Health with their venture, Risant. Headquartered in Oakland, California, Kaiser is at the forefront of integrated care delivery, insuring and providing care for more than 12 million members across eight states and the District of Columbia as of 2023.[13] In many states, Kaiser owns providers responsible for nearly all aspects of patient care—outpatient to inpatient, including ancillary lab and imaging services. Similarly, Geisinger operates in Pennsylvania and owns its own health system serving 1 million lives, with approximately half covered under their health plan.[14] In April of 2023, Kaiser announced plans to launch a new non-profit entity, Risant, that subsequently acquired Geisinger,[15] followed by a subsequent announcement of another cross-market merger with the proposed acquisition of Cone Health in North Carolina. It is notable that the FTC has yet to take action on a cross-market theory of harm in this sector.

Because empirical research has shown that many horizontal mergers of providers have resulted in higher prices, the Agencies have engaged in extensive enforcement against horizontal transactions. The sheer number of transactions occurring over the past three decades has provided the Agencies with ample evidence as to the economic and anticompetitive harms that may occur in horizontal transactions. After years of increased enforcement, the DOJ withdrew the 1996 health care enforcement statements, which had historically offered protections for transactions and collaborations between healthcare entities. The withdrawal of those protections, as well as the issuance of the updated Merger Guidelines in 2023, were in line with the Agencies' competition policy and broader enforcement agendas under the Biden administration.[16]

In contrast to the enforcement history and the extensive legal and economic literature on competitive effects of horizontal transactions, vertical transactions lack this body of evidence and policy template. Vertical mergers will likely represent the next wave of health care consolidation, but the relatively few Agency enforcement actions provide only limited guidance on some of the nuances of vertical healthcare transactions.

Though not strictly payer-provider, an adjacent example is the CVS/Aetna merger in 2017, in which a major payer merged with a major retail pharmacy chain, pharmacy benefit manager (PBM), and retail clinic provider. The DOJ allowed the transaction to proceed with the requirement that Aetna spin off its Part D plan due to concerns over horizontal effects. The DOJ did not address input foreclosure, including exclusivity or refusal to contract with other pharmacy chains in its construction of networks.[17]

Healthcare Policy as a Driver of Payer-Provider Vertical Integration

Financial risk in health insurance is unique because, in addition to the calculus surrounding the probability of a member/patient getting a certain illness, there is also significant variability in how that illness might be treated. Logically, a payer would find it appealing to have control over that added variability—as an example will illustrate.[18] Payer A provides coverage to a population of 10 people. Each of the 10 beneficiaries provides Payer A $1,000 in annual premiums, so Payer A has a total of $10,000 with which to pay the health care costs of its 10 beneficiaries. Seven of the 10 covered lives incur no medical expenses, and the remaining three undergo total knee replacements. Each surgery is performed by a different provider at Healthcare System B, with significant variation in cost: Surgeon X bills $3,000, Surgeon Y bills $3,500, and Surgeon Z bills $4,000, which leads to $10,500 in total medical expenses on Payer A's income statement, a loss of $500. If all three surgeons had billed the lowest rate ($3,000), then the payer would have had a surplus of $1,000.

In risk-based contracting, the payer and provider agree that rather than the gain or loss being borne solely by the payer, it will instead be shared. In a risk-bearing environment, it is the payer who is primarily incentivized to vertically integrate, though the provider may also become motivated if there is substantial upside to be captured. This practice is similar to capitated models, in which the government or the payer allocates a certain amount of money for each patient for a defined period of time (typically per patient per month for an annual contract), and the next level in the supply chain will either retain whatever is not spent or be responsible for overbudget spending. Both scenarios would motivate the provider to shift its practice towards value over volume, so as to curb spending. Vertical integration between payers and providers lies at the extreme end of the spectrum that begins with risk-based contracting.

Public policy is driving risk-based contracting forward through the Centers for Medicare and Medicaid Services' (CMS) initiatives. For instance, policymakers have mandated that all Medicare patients and a significant majority of Medicaid patients be covered under contracts attached to risk by 2030[19]—a transition supported across administrations. Coverage under Medicare Advantage (MA) plans, which are capitated risk-based plans, has risen from 19% of Medicare lives in 2009 to 51% in 2023, and it is expected to continue rising.[20] As of December 2020, 67.8 million Medicaid enrollees received their benefits through some form of managed care, Medicaid's risk-based arm, with 58.5 million of that subpopulation (72.4% of total enrollees) enrolled in comprehensive, risk-adjusted, capitated Medicaid Managed Care Organizations (MCOs).[21] This push towards risk-adjusted, capitated models encourages vertical integration, because both payers and providers will find it increasingly attractive to improve their ability to manage risk through the

operational integration of healthcare financing and delivery whether via organic growth, joint ventures, or M&A.

Application of Traditional Merger Analysis to Payer-Provider Transactions

The 2010 Horizontal Merger Guidelines issued by the Agencies were supplemented by a revised set of Vertical Merger Guidelines in 2020.[22] Just over a year later, the FTC voted to withdraw the Vertical Merger Guidelines to ensure that a new set of guidelines would be "appropriately skeptical of harmful mergers."[23] In December 2023, the Agencies published consolidated Merger Guidelines that replaced both the horizontal and vertical guidelines.[24]

The FTC's challenge of the recent Illumina/Grail merger provides a window into the Agency's analysis of vertical healthcare mergers.[25] Illumina offers the premier Next Generation Sequencing (NGS) platform available in the United States. In 2021, Illumina sought to acquire Grail, a company that utilized Illumina's technology in the development of multi-cancer early detection tests. The FTC raised concerns that Illumina and Grail would have *the ability and incentive to foreclose rivals* in the multi-cancer early detection space through Illumina's control of NGS. The Fifth Circuit affirmed the Commission's opinion on the issue of whether Illumina would have the ability and incentive to foreclose rivals.[26] This decision is consistent with the 2023 Merger Guidelines that discusses the analytical framework by which the Agencies have and will analyze vertical mergers going forward.

There have been few examples of large-scale payer-provider M&A to provide insights into the Agencies' current views, but decisions in private-plaintiff cases can help fill the void. For example, *Omni Healthcare Inc.* vs. *Health First Inc.* provides a glimpse of what potentially anticompetitive activity among payer-provider entities may entail, but it does not paint a full picture, because the case was settled before completing a full trial. Omni, a consortium of medical providers in Southern Brevard County, Florida, sued Health First, a dominant regional hospital system that also offered insurance products, for alleged violation of antitrust laws. Omni alleged that Health First engaged in exclusionary activity designed to keep patients within the Health First network by requiring Health First physicians to accept only Health First Medicare Advantage Plans and to refer their patients only to other Health First providers.[27] Though the case settled just one day into the trial, the judge had ruled on a motion for summary judgment that the facts presented raised triable issues of fact.[28]

In the context of vertical mergers between payers and providers, the end-product is provider services sold and rendered to payers and their enrollees. We posit that the Agencies should view these transactions from the perspective of whether a potential pro-competitive effect would offset any theoretical anticompetitive effects. All things being equal, an increase in the value of care provided to a higher number of patients should be prioritized over the status quo if there is no threat to competition.

A Proposed Framework for Evaluating Payer-Provider Transactions

Following is a framework for evaluating vertical integration between payers and providers, identifying specific harms and benefits from these types of deals. Despite their withdrawal, the 2020 Vertical Merger Guidelines provide a structure from which to construct examples (both concrete and theoretical) of the potential anticompetitive and pro-competitive outcomes of vertically integrative transactions.[29]

1. *Market Definition, Related Products, Market Shares, and Concentration*

   Example 1: Relevant markets can involve related payers, providers, and hybrid organizations

   Situation: A hospital system (downstream) merges with a payer (upstream).

For market definition, the Vertical Merger Guidelines relied on the 2010 Horizontal Merger Guidelines. Sections 4.1 and 4.2 of the 2010 Guidelines provide ample guidance for this purpose when evaluating a potential merger.[30] A vertical transaction can have effects in either the hospital market or the payer market (or both). For instance, a hospital system with significant presence in an geographic area may be a key provider for all payers in the area, and once it is owned by one payer, that integrated system may have the incentive and ability to foreclose other payers. Alternatively, a payer may have significant presence in an area or line of business, and once it is owned by one hospital/provider, that integrated system may have the incentive and ability to foreclose other hospitals/providers from serving its insured members.[31] At a minimum, this transaction will produce effects in the competition between health systems in the regional provider market, and the reach of this effect will be directly related to the size of the hospital system seeking to merge with the payer. Systems can vary widely in terms of lives-served, which may be limited to a single city or be spread across several states. Even more granularly, downstream effects in the provider market will vary by the specific lines of business contained within the health system—primary care, specialty care, acute care, post-acute care, for example. The transaction will also produce competitive effects between payers in upstream markets, with the affected geographic market depending upon the line of business affected (e.g., Medicare Advantage analyzed at a county level).

2. *Unilateral Effects*

   Example 2: Exclusion of rival providers via marketed insurance products

   Situation: Hospital System A merges with Payer B and is now able to create gradations of exclusion for rival provider groups across Preferred Provider Organization (PPO), Point-of-Service (POS), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO) products, among others.

Within PPO and POS health insurance products, this merged entity can disadvantage rival providers by deeming

them non-preferred, though the plan will still cover services at a less favorable rate. Those less favorable rates may drive demand away from the rival provider, causing foreclosure. Within EPO and HMO plans, this merged entity could exclude rival providers from coverage altogether, again resulting in foreclosure.

In a scenario where most of the population in a market was covered under one payer-provider group, it might become difficult to enter at either the payer or provider level, as a prospective entrant may be forced to attempt entry at both levels if it wishes to enter at all.

Example 3: Exclusion/raising rivals' cost (e.g., of rival payers)

Situation: Hospital System A is the dominant provider organization within a market and merges with Payer B, creating Payer-Provider AB. Payer C is considering market entry. In hospital rate negotiation with Payer C in markets with medical loss ratio regulation for insurance products, Payer-Provider AB may be disincentivized from offering hospital rates lower than what it is accounting for internally as passing between the now-combined Hospital System A and Payer B—i.e., its cost as measured by internal transfer pricing—and the size of this effect will be inversely related to the size and health of Payer C's covered lives. If Payer C has not attracted significant membership, the ultimate rate negotiated will likely be higher than what would have been negotiated between A and C had the merger not occurred (i.e., C will have to pay more for a particular medical service to be performed for its members by Payer-Provider AB). Medical loss ratio regulation can magnify the value of vertical integration for Payer-Provider AB in order to maintain regulatory compliance; Payer A can increase the amount it pays to its now-owned and -operated Provider B, raising overall premiums while raising barriers to entry for Payer C.

Hospital systems negotiate with payers their reimbursement rates for that payer's covered lives. The greater the number of hospital options available to payers, the lower the bargaining leverage those hospitals will have in their negotiations with payers. However, a dominant hospital system, like Hospital System A, may become incentivized to disadvantage rival payers if it becomes vertically integrated with a payer. Medical loss ratio regulation could be a mechanism by which Payer-Provider AB increases costs to rival payers. The potential exclusion of firms like Payer C will need to be weighed against the potential elimination of double marginalization and improved patient care.

Example 4: Potential foreclosure of complementary lines of business

Situation: Hospital System A has some degree of market power (e.g., 30% market share) and recently launched a new division, Homecare Firm A. The market for homecare is quite competitive, and Homecare Firm A has had difficulties in gaining market share. Hospital System A then merges with Payer B, which also has some degree of market power (e.g., 30% market share) in the payer market. As Payer-Provider AB, the integrated system may have the ability and incentive to foreclose other homecare firms.

As is the case for many hospital systems, Payer-Provider AB has decided to enter a complementary market through organic growth—though it should be noted that it could have also entered via joint venture or acquisition. As a new entrant into a competitive marketplace, it will need to differentiate itself from other players, and it has opted to do so on price. Payer-Provider AB could attempt to foreclose other homecare competitors through mechanisms such as predatory pricing or self-preferencing behavior.

3. *Coordinated Effects*

Example 5: Use of non-public claims data to detect whether a pricing agreement is being adhered to

Situation: Hospital System A has an agreement with Hospital System X that they will not price their bundled Total Knee Replacement below $25,000 to private insurers—an agreement that is clearly an antitrust violation. Payer B is a private insurance entity that has existing contracts with both Hospital Systems A and X. Hospital System A merges with Payer B to create Payer-Provider AB. Hospital System A is now able to use claims data from Payer B to audit Hospital System X's compliance in their agreement.

The literature has shown that hospitals sharing information-technology (IT) infrastructure demonstrate increased pricing above competitive levels.[32] In this case, Hospital System A will have access to Hospital System X's direct billing practices to Payer B, without having to share an IT system. There is a danger that this could lead to similarly anticompetitive pricing, and guardrails would need to be put in place to prevent that occurrence.

It is also possible that even without a separate anticompetitive agreement with Hospital System X, Hospital System A's access to the billing practice of other hospital systems will have other potentially anticompetitive effects. For instance, Hospital System A will be able to see the highest-priced contracts currently negotiated by rivals with Payer B. If Hospital System A also contracts with other payers, then depending on its market power, it may use the pricing information to negotiate for higher prices than what it had been billing previously.

4. *Pro-Competitive Effects and Improved Outcomes*

Example 6: Elimination of double marginalization via reduction in billing-and-insurance related activity costs

Situation: Hospital System A merges with Payer B to form Payer-Provider AB. Prior to the merger, Hospital System A incurred costs in the generation of claims data as well as the communication of that data to Payer B. Similarly, Payer B would incur costs in receiving and interpreting that claims data as well as costs with the subsequent distribution of reimbursements to Hospital System A. Post-merger, Payer-Provider AB will be able to consolidate the departments responsible for preparing and processing claims data, thereby reducing fixed and variable costs that existed for the distinct firms pre-merger. As a result, Payer-Provider AB can lower the premiums offered to their patients as a means of competitive advantage and gaining market share. The end-result should be patients receiving

at-least the same quality of care with lower overall cost to themselves, increasing competition in the marketplace.

This example provides a key economic argument in favor of vertical integration between systems and payers. Billing-and-insurance related activity represents a significant proportion of domestic healthcare spending, with one study estimating costs as high as 25% of the total expenditure.[33] Single-payer and contract-simplification economic models have been shown to reduce that cost by 33-53% and 27-63%, respectively.[34] Vertical integration is an alternative policy and operational strategy to reduce administrative costs. In this scenario, the merged firm is passing along cost-savings to its customers, the patients. However, we have seen in previous examples other ways in which they can co-opt that cost-savings for the firm's own gain. In analyzing these transactions, the Agencies should consider the potential motivations of the individual firms. If the firms' goal is to increase their number of lives-served under the dual umbrella, then it would be advantageous for them to utilize their reduced overhead to offer competitive premiums while maintaining quality—increasing the value of the care they are providing. The Agencies could make stipulations pre-merger to ensure that endpoint is realized.

Example 7: Simplification of consumer choice and experience within a complex provider marketplace

Situation: John has Payer C as his insurance carrier. Colon cancer runs in his family, and he knows that he should undergo a standard screening colonoscopy starting at his current age to enable early detection. He does not have a primary care physician, and so he calls Payer C who then directs him to their website to find an in-network provider. He then discovers that his insurance will allow him to book an appointment directly with a gastroenterologist without requiring a referral from a primary care physician. After an initial consultation, he undergoes his screening colonoscopy without issue. Though he was able to get his specialty care expeditiously, he does not realize that he has untreated high blood pressure and the beginnings of chronic kidney disease as well. Because he otherwise feels fine, these problems will not be addressed for several years.

Matthew has the same health profile as John, but he has Payer-Provider AB as his insurance carrier. When he signed up for Payer-Provider AB, he was given a concise list of potential primary care physicians, their availabilities, and his appointment was scheduled. His new primary care physician not only coordinated his colonoscopy, but also diagnosed his high blood pressure and chronic kidney disease, prescribing medications to curtail their long-term effects.

Example 8: Decreased coordination costs and adoption of new technology to care for the multimorbid and complex patient

Situation: Jane has Payer C as her insurance carrier. She was recently diagnosed with Type II Diabetes Mellitus (T2DM). Because of this and its related comorbidities, her routine annual care will now require coordination between three provider specialties—primary care, ophthalmology, and podiatry. Her independent primary care physician must make referrals to the other two specialists in order for her to obtain appointments and be seen. Jane was initially referred to an out-of-network ophthalmologist for her standard screening. Fortunately, the mistake was caught when scheduling the appointment. Jane then had to contact Payer C to find a local in-network provider, and she was then able to return to her independent primary care provider to request a re-referral. Afterward, the independent primary care physician must then obtain records from the ophthalmologist and podiatrist to ensure that Jane has undergone the screening and will continue to follow-up at appropriate intervals. None of the physicians are able to use claims data to help automate or drive point of service clinical decision support to ensure guideline-driven pharmacotherapy and diagnostic testing.

Mary was also recently diagnosed with T2DM, but she has Payer-Provider AB as her insurance carrier. Because of the way her network is structured, Mary's primary care physician knows the appropriate providers to refer her to, receives the records from their offices automatically, and each member of her care team is prompted to steer Mary to guideline-driven diagnostic testing and closure of care gaps, all automatically identified from both the electronic health record and insurance claims data. Furthermore, at Mary's visit to her podiatrist for her diabetic foot exam and care, Mary's Payer-Provider AB prompts the administrative assistant to offer to schedule Mary for her annual mammogram, noting from claims data that she has not received one this year. Mary's annual diabetic eye exam is completed independent of a physician with the use of AI-driven technology and a technician-assisted exam.

For consumers, navigating the world of providers can be daunting. It is often difficult to know which physicians are in-network and to what degree items and services are covered. This difficulty has generated an entire third-party industry of websites designed to pair patients with physicians. The activation energy required to traverse the landscape can at times prevent patients from beginning the process at all, which can be detrimental to their health—as seen in the case of John and could be seen in the case of Jane had she not remained determined. Their counterparts, Matthew and Mary, had much different experiences. Because Payer-Provider AB is carrying the potential costs incurred by their *not* seeking care, the vertically integrated entity is heavily invested in preventing complications by removing frictions and promoting proactive treatment. While Payer C is also invested in this way, it has much less control over what exactly transpires because it is holding only the purse strings—Payer-Provider AB is able to act on its own to initiate the care journey.

This improvement in patient experience and well-being is procompetitive because the demystification and integration of the care delivery and reimbursement processes will likely be alluring to consumers, prompting both Payer and Provider marketplaces to further ease the burden.

Example 9: Improvement in overall patient care via the integration of claims data and clinical data

Situation: Hospital System A merges with Payer B to form Payer-Provider AB. Post-merger, the new firm can integrate clinical data and claims data to construct more accurate predictive models surrounding metrics like in-patient mortality, 30-day readmission rate, and future high utilizers. Identifying patients in this high risk and high-cost categories early allows Payer-Provider AB to funnel additional resources toward them in a proactive manner to reduce future complications and cost.

A key argument for vertical integration in healthcare is the ability to combine both clinical and claims data, with the vertical integration of payers and providers in the setting of risk-adjusted capitation managed-care programs providing a market incentive.[35] Clinical data is comprehensive in terms of medical narrative and the intent of providers (e.g. prescribed medications), whereas claims data is a more succinct representation of discrete diagnostic codes along with what actually occurs (e.g., filled prescriptions). The incorporation of claims data into clinical data has been shown to enhance predictive modeling across various settings ranging from inpatient/30-day post-discharge outcomes to the identification of those at risk of becoming high-cost, high-need patients.[36] These models are key in the allocation of scare resources. Hospital System A and Payer B post-merger will have the ability and incentive to more efficiently care for their lives served, and the value that is added will lead to higher quality care.

Conclusion

Transactions between payers and providers, whether via contracting or merger, are likely to increase in frequency, given the current CMS push to transition the delivery system towards value-based contracting, and in particular risk-adjusted capitation in the Medicare Advantage program and through the growth of state-based Medicaid managed care programs. While it is true that some of the benefits seen with vertical integration between payers and providers can be realized through close relationships and contracts short of mergers, these benefits may be more consistently realized with full integration.[37]

Vertical transactions are often more complex in scope and possible implications. Our proposed framework provides the Agencies with additional points of reference to use in evaluating payer-provider transactions under existing guidelines, as well as further context on the landscape for providers. Competition benefits consumers in both the payer and provider marketplaces, and many of the procompetitive benefits possible with payer-provider mergers can have a significant positive impact on overall consumer welfare and healthcare at-large. As Medicare and Medicaid program policy is driving vertical integration, it will be important to validate the competitive effects of payer-provider mergers.

The authors' views are their own and not necessarily those of their employers of affiliations. ■

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[20] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, et al., *Medicare Advantage in 2023: Enrollment Update and Key Trends.* KFF. (Aug. 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

[21] *Filtered Managed Care Enrollment Summary*, Data.Medicaid.gov (Oct. 16, 2024), https://data.medicaid.gov/dataset/52ed908b-0cb8-5dd2-846d-99d4af12b369/data?conditions%5b0%5d%5bresource%5d=t&conditions%5b0%5d%5bproperty%5d=year&conditions%5b0%5d%5bvalue%5d=2020&conditions%5b0%5d%5boperator%5d==.

[22] *See supra* note 2.

[23] *Justice Department Issues Statement on Vertical Merger Guidelines*, Office of Public Affairs U.S. Dep't of Justice (Sept. 15, 2021), https://www.justice.gov/opa/pr/justice-department-issues-statement-vertical-merger-guidelines.

[24] *See supra* note 3.

[25] In the Matter of Illumina, Inc., Dkt. No. 9401 (Mar. 31, 2023).

[26] Illumina, Inc. v. FTC, 88 F.4th 1036 (2023); *see also Statement Regarding Illumina's Decision to Divest Grail*, Federal Trade Commission (Dec. 18, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/12/statement-regarding-illuminas-decision-divest-grail.

[27] *Omni Healthcare Inc. v. Health First, Inc.,* No. 6:13-cv-1509-RBD-DAB, 2016 WL 4272164 (M.D. Fla. Aug. 13, 2016).

[28] Luke Gale, *Health First agrees to settle $346M antitrust lawsuit,* Healthcare Dive (Aug. 17, 2016), https://www.healthcaredive.com/news/health-first-agrees-to-settle-346m-antitrust-lawsuit/424608/.

[29] *See supra* note 2.

[30] *Merger Guidelines*, U.S. Department of Justice and the Federal Trade Commission (Aug. 19, 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[31] Of course, the ownership structure may involve a common parent owning both the payer and the provider, rather than a payer owning the provider (or vice-versa).

[32] Kui Du & Huseyin Tanriverdi, *Does IT Enable Collusion or Competition: Examining the Effects of IT on Service Pricing in Multi-market Multihospital Systems*, 47(4) Mgmt. Info. Sys. Quarterly (Dec. 24, 2022), https://doi.org/10.25300/MISQ/2022/16764.

[33] David U. Himmelstein, Miraya Jun et al., *A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far*, 33(9) Health Affairs (Sept. 2014), https://doi.org/10.1377/hlthaff.2013.1327.

[34] David Scheinker, Barak D. Richman, Arnold Milstein, Kevin A. Schulman, *Reducing administrative costs in US health care: Assessing single payer and its alternatives*, 56(4) Health Servs. Research. (Mar. 31, 2020), https://doi.org/10.1111/1475-6773.13649. 2021;56(4):615-625. doi:10.1111/1475-6773.13649.

[35] *See supra* note 18.

[36] Michael Pine & Donald E. Fry et al., *Adding Laboratory Data to Hospital Claims Data to Improve Risk Adjustment of Inpatient/30-Day Postdischarge Outcomes*, 32(2) Am. J. Of Med. Quality (Feb. 1, 2016), https://doi.org/10.1177/1062860616629205; Bradley G. Hammill & Lesley H. Curtis et al., *Incremental Value of Clinical Data Beyond Claims Data in Predicting 30-day Outcomes After Heart Failure Hospitalization*, 4(1) Cardiovascular Quality Outcomes (Dec. 7, 2010), https://doi.org/10.1161/CIRCOUTCOMES.110.954693; Itsuki Osawa, Goto Tadahiro, Yuji Yamamoto, Yusuke Tsugawa, *Machine learning-based prediction models for high-need-cost patients using nationwide clinical and claims data*, 3(148) NPJ Dig. Med. (Nov. 11, 2020), https://doi.org/10.1038/s41746-020-00354-8.

[37] *See supra* note 18.