The New Health Care Merger Wave: Does the “Vertical, Good” Maxim Apply?

Thomas L. Greaney

“Four legs good, two legs bad” (Snowball, Animal Farm)1

“Vertical good, horizontal bad” (Jonathan Baker, adapting Snowball’s maxim to characterize Chicago School antitrust principles)2

I. Background: Vertical Integration in Health Care

American antitrust enforcement agencies (the Federal Trade Commission, Department of Justice and State Attorneys General) have long devoted an extraordinary proportion of their resources to the health care sector. For example, challenges to hospital mergers, physician cartels, and “reverse payments” by pharmaceutical companies, insurance company mergers, and anticompetitive practices have been featured prominently in government litigation, advisories, and policy statements.3 Indeed, it is fair to say that since the early 1980s health care has been and continues to be a top priority of antitrust enforcers under both Republican and Democratic administrations.

In recent years, the Agencies have won a series of important cases challenging horizontal mergers in the hospital,4 physician,5 and insurance6 sectors that have clarified the law and sent a clear message that combinations of competitors in concentrated local markets will face close scrutiny. Reversing a series of losses in litigated hospital merger cases, these decisions established what are likely to be enduring precedents. Among other things, they clarified that provider and insurer markets are highly localized; rejected arguments that market power will be checked by the countervailing power of large or sophisticated buyers; and declined to accept arguments that uncertainties arising from rapidly-changing market conditions undermine inferences of market power or that consolidation is essential to achieve beneficial integrative efficiencies.7

Not surprisingly — given these precedents and seismic shifts in government and commercial payment practices — action has shifted to vertical mergers. The combined effect of the Affordable Care Act (ACA), the Medicare Access & CHIP Reauthorization Act (MACRA) and other policy changes has created a strong gravitational pull toward integration.8 For example, the ACA created new incentives for hospitals and physicians to develop innovative organizational structures that can respond to new financing mechanisms such as bundled payments and global reim-

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bureaus. The “new new things” spreading rapidly around the country such as accountable care organizations (ACOs) and patient centered medical homes (PCMH), along with a revival of various forms of joint ventures and alliances, are responses to the legislative impetus to deliver care in a seamless and coordinated manner. MACRA has served to accelerate the move to physician employment by hospitals by providing strong financial incentives under Medicare reimbursement for physicians to join APMs — entities delivering integrated care using risk models. Moreover, the complexity and cost of creating such integrating organizations have driven physicians to accept employment opportunities by corporations, principally hospitals.9

Following suit, some insurers have begun to look to integrate vertically, merging with pharmacies and pharmacy benefit managers and acquiring hospitals,10 surgicenters,11 and physician groups.12 Several of the mergers under review as this article is being written combine formidable competitors in their respective sectors. Cigna, one of the largest health insurers in the country has proposed to acquire Express Scripts, the nation’s largest pharmacy benefit manager. CVS, the largest U.S. drugstore chain and one the second

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largest pharmacy benefit manager, has announced an agreement to acquire Aetna, the third biggest health insurer. The largest health insurer, UnitedHealth, which operates the third largest PBM and owns 250 urgent care centers and 200 surgical centers, is set to acquire DaVita Medical group which operates over 300 clinics and urgent care centers and employs over 2000 health care providers.13

The confluence of rapid change in regulation, payment, and delivery modalities has prompted debate about the appropriate course for antitrust enforcement in the health care sector. Some have counseled a “watchful waiting” approach that would allow innovation and experimentation to proceed free of strict antitrust scrutiny of structures and conduct.14 Indeed, a stronger version of this account argues that the need for significant, system-wide integration should be understood to override traditional antitrust concerns.15 While some critiques urge more direct regulatory controls over dominant players,16 consolidation is nevertheless often regarded as a prerequisite for innovation. Further, antitrust enforcers and courts have long relegated vertical mergers and exclusion issues to a very secondary role and legal doctrine is underdeveloped. Consequently, antitrust law may offer no buffer against the new health care merger wave.

This essay questions the wisdom of adherence to an indulgent approach to vertical integration in health care. It first critiques the bases for antitrust law’s traditional tolerance of vertical integration and describes contemporary economic learning that supports more robust antitrust enforcement. It goes on to dispute arguments urging extra caution in dealing with the health care sector and concludes with several justifications for close scrutiny of vertical health sector mergers.

II. The Law’s Inattention to Vertical Mergers

A. The Legal Vacuum.

Antitrust enforcers have shown little interest in opposing vertical mergers and consequently the case law on vertical mergers is dated and sparse. In its challenge the AT&T/Time Warner merger,17 the Department of Justice unsuccessfully litigated its first vertical merger case in forty years;18 its badly out-of-date Non-Horizontal Merger Guidelines were first issued in 1992;19 and the most recent Supreme Court decision dates back to 1972.20 Likewise the record on vertical mergers in health care is barren. In its first litigated case21 involving a physician merger, Saint Alphonsus Medical Center-Nampa & FTC v. St. Luke’s Health System,22 the FTC prevailed in a challenge to acquisition of a physician group by a hospital system that would have increased the hospital’s existing share of the primary care physician market to approximately 80 percent. Although the factual findings in the case tended to support a finding of vertical foreclosure, the FTC and the district court and Ninth Circuit focused on the merger’s horizontal effects and did not address the vertical theory advanced by a rival hospital.23 As discussed below, the government’s disinclination to challenge vertical mergers is rooted in a laissez-faire ideology that is premised on dubious economic principles.

B. Questioning the “Vertical, Good” Assumption

As a general matter, Chicago School analysis finds strong efficiency benefits in vertical arrangements and urges presumptions that favor such linkages. In the case of vertical mergers, it stresses potential efficiencies flowing from improved coordination in pricing, production, and design that can reduce costs and improve
product quality. Early Chicago critiques questioned whether competitive harm could ever arise from vertical mergers, arguing that they merely realigns purchase patterns among competing firms and that they cannot enhance monopoly power because there is only a “single monopoly profit” that can be earned, whether or not the monopolist is vertically integrated. These assumptions, which have been called into question by contemporary economic analyses, led to the mistaken assumption, reflected in enforcement policy and court decisions, that vertical mergers are invariably efficient and procompetitive.

To be sure, as a general matter vertical integration in health care delivery provides much-needed changes in economic incentives. For example, efficiencies arising out of hospital/physician integration have theoretical appeal given the woefully inefficient arrangements that preceded it. Vertically integrated care delivery holds the promise of improved efficiency through reductions in unnecessary and duplicative care while lowering transaction and administrative costs arising from the use of hierarchical commands rather than contractual arrangements to assure efficient coordination. Likewise integration of payment and delivery may redirect incentives away from rewarding volume instead of value. However, the potential for consumer benefits, even if significant, should not be the basis for turning a blind eye to instances of creation, entrenchment, or abuse of market power.

Economic analyses have become more skeptical of vertical consolidation. Post-Chicago school scholarship has challenged the conventional wisdom that “virtually all exclusion claims are chimerical” and has advanced the claim that under commonly occurring conditions exclusionary strategies can profit firms and harm competition. This account demonstrates that preconditions underlying Chicago’s critique “rarely hold, and the broad claim that there is a single monopoly profit can obscure how a particular merger may raise real competitive concerns.” While vertical mergers do not increase concentration they may enable conduct that limits rivalry at the horizontal level. By combining inputs with distribution, for example, a vertical merger can enhance incentives for the merged firm to exclude its downstream or upstream rivals, either by raising their costs or cutting off their access to critical resources. Professor Steven Salop’s extensive body of work provides a sound economic model of foreclosure risks and maps the potential legal framework for applying the so-called “raising rivals’ cost” principles to vertical mergers. Besides exclusionary effects, Post-Chicago analyses have identified other potential harms from vertical mergers including reducing potential competition, increasing coordinated effects, enabling evasion of regulation and facilitating harmful price discrimination.

C. Examples of Potential Harms Arising From Vertical Mergers in Health Care Markets

The new merger wave would reorganize markets in a variety of ways. While it is certainly true that “disruptive” change may spur innovation and invigorate competition, it is important to recognize that some forms of disruption can also enhance or create market power. I sketch below the means by which recent vertical mergers might harm consumers.

**Hospital Acquisitions of Physician Practices.** A core concern with hospital acquisition of physician practices is that they may foreclose rival hospitals and potential entrants into the hospital services market from obtaining a sufficient base of patients because they are deprived of access to physicians to admit, treat, or refer to their facilities. Economic harm may flow from either (1) eliminating competition from non-consolidated rival hospitals in hospital service lines so as to increase the market power of the vertically-integrated hospital or (2) impairing the non-vertically consolidated hospitals’ ability to compete resulting from reduction of their outputs, higher average costs, and higher prices. Where such strategies enhance the bargaining power of the vertically-integrated hospital vis a vis payers, cognizable consumer harms may arise.

**Linkages of Pharmacies, Health Insurers, and PBMs.** The proposed merger which of CVS, which has significant market power in retail pharmacy and PBM services, with Aetna, a leading health insurer illustrates the risk of foreclosure or raising costs to rival insurers. Letters to the Justice Department by the California Department of Insurance, the American Medical Association, and the American Antitrust Institute opposing the merger explain risks. First, the merged firm could impose a variety of conditions that would disadvantage rival insurers needing PBM services thereby impairing competition in downstream health insurance markets. For example, CVS could develop formularies for rivals that do not include important drugs that are in demand by their subscribers or offer pharmacy networks that do not provide important pharmaceutical distribution options to rival subscribers. Another plausible anticompetitive strategy would be to foreclose or raise costs to rival pharmacies needing access to customers insured by Aetna. This could be accomplished by cutting off independent pharmacies’ access to Aetna customers altogether or raising their costs by exercising the bargaining leverage of the CVS PBM in contracting for pharmacy services.
**PBM/Health Insurance Oligopoly.** Vertical mergers may also impair competition when they enhance the ability and incentives to engage in horizontal coordination. As an example, the mergers currently under review — Express Scripts’ announced plans to merge with Cigna and CVS’s acquisition of Aetna — along with UnitedHealthcare’s operation of a PBM would establish an oligopolistic market in health and pharmacy management with three of the nation’s largest health insurers owning the three largest pharmacy benefit management entities.\(^38\) Controlling by some estimates over 70% of the PBM market, and with only a very small portion of the market served by entities not integrated with a health insurer, the “Big Three” vertically integrated firms would have common incentives to weaken the competitive conditions of rival health insurers.\(^39\) For example, as one analysis put it, they could “act on shared incentive to withhold or weaken PBM bids to health plan rivals” that would “raise rivals’ costs or lead to a diversion to sub-scale PBMs with higher costs and lower quality.”\(^40\) Given cost advantages arising to their leverage in negotiating with pharmaceutical companies, the Big Three would face little threat from rival PBMs and have strong incentives and capacity to coordinate their strategies to disadvantage rival health insurers.

Applying raising rivals’ cost principles to these cases undoubtedly entails a heavily fact-intensive inquiry. Fact finders need to assess not only whether exclusion is likely to occur but also whether such exclusion will harm competition, and if so, whether merger-specific efficiencies are sufficient to prevent or mitigate the exercise of market power. While legal precedent and agency guidance establishing workable principles and presumptions are lacking, some baseline factors can be identified that should trigger concern about vertical mergers. For example, economists identify market structure conditions including market dominance, barriers to entry, scale economies and network effects as important indicia of potential competitive harm.\(^41\) Qualitative factors such as economic incentives to use vertical mergers to forestall entry or raise rivals’ costs and regulatory conditions that encourage vertical consolidation are also relevant.\(^42\) The next section describes aspects of health care markets that may make them vulnerable to adverse effects of vertical mergers.

### III. Why Vertical Mergers in Health Care May Harm Competition

Antitrust law has long recognized that market conditions in the health care sector, while assuredly less than optimal, are nonetheless subject to the same kinds of abuses from anticompetitive mergers and conduct as other sectors of the economy. The following offers several reasons why the vertical merger wave in health care should be subject to close scrutiny by antitrust enforcers and courts.

#### A. Market Conditions and Performance

Provider, payer, and health pharmaceutical management markets exhibit key pre-conditions for harm from vertical mergers: they are highly concentrated, exhibit durable barriers to entry, and have historically performed poorly. The following chart illustrates the degree of concentration in the several sectors which are involved in the new merger wave.

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<th>Commercial insurance:</th>
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<td>• 69% of insurance markets highly concentrated.(^43)</td>
<td>• In half of all markets, 2 largest insurers have &gt;70% of the market.(^44)</td>
<td>• The share of the largest four insurers increased from 74 to 83% from 2006 to 2014.(^45)</td>
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<td>Pharmacy Benefit Management</td>
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<td>• Three largest PBMs control approximately 70% of the national market.(^46)</td>
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<td>Physician services</td>
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<td>• 65% of MSAs have highly concentrated specialty markets; 39% have concentrated primary care markets.(^47)</td>
<td>• Hospital employment of primary care physicians grew from 28% to 44% between 2006 and 2016.(^48)</td>
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<td>Retail Pharmacies</td>
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<td>• The two largest chains control 50-75% of the drug stores in the nation’s 14 largest markets.(^49)</td>
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<td>Hospitals</td>
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<td>• 90% of inpatient acute care hospital markets are highly concentrated.(^50)</td>
<td>• Many large metropolitan markets, e.g. Boston, Pittsburg, San Francisco are dominated by one or two hospitals.(^51)</td>
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In each sector there is evidence that entry barriers are high, as market shares have grown or stabilized at high levels of concentration and entry has been limited or non-existent.\(^52\) In addition, numerous studies demonstrate that concentration in health care is associated with high prices,\(^53\) and in some cases reduced quality.\(^54\) Moreover, a variety of health market characteristics including inelasticity of demand, imperfect information and imperfect agency relationships make health care markets vulnerable to the exercise of...
market power. Such conditions exacerbate the risks of competitive harm resulting from stacking of one dominant firm on another.

B. The Yet-Unproven Record of Vertical Integration
Although it is sometimes assumed that cost savings and quality improvements inevitably flow from hierarchical structures, economic evidence is lacking. Analysis of health system organizations suggests that economic integration has historically failed to generate clinical integration that results in either cost savings or improved efficiency. For example, studies find no evidence that hospital systems lower costs or that integrated delivery systems perform better than independent practices. This should come as no surprise as economic theory recognizes that upward pricing pressure results from vertical mergers. Further, as Martin Gaynor has reminded, “consolidation is not coordination.” Not unlike horizontal mergers, vertical mergers are subject to problems associated with culture clashes, inadequate pre-merger information, and challenges inherent in management integration.

The lesson from hospital-physician consolidation provides a cautionary example of the risks of under-enforcement of vertical mergers. A number of studies suggest that hospital-physician integration, which has grown rapidly in recent years, has raised physician costs, hospital prices, and per capita medical spending. Moreover, a study of hospital ownership of physician practices in California demonstrates, the impact of higher hospital concentration on premiums becomes larger as vertical concentration increases. Finally, while merger proponents usually claim that efficiencies—cost savings and quality improvements—may offset the harms of increased market power, the experience with physician-hospital consolidation is to the contrary. As a Leemore Dafny and Thomas Lee have concluded, “The harsh reality is that it is difficult to find well-documented examples of health care mergers that have generated better outcomes or lower costs.”

C. Many Health Care Regulations Artificially Encourage Mergers and Inhibit Competition
Another reason why vertical mergers in health care merit close scrutiny is the regulatory context in which firms operate. As is widely recognized, a host of regulations limit competition in health care. Many of these regulation make it difficult for rivals to enter markets, thereby increasing the likelihood of and rewards for consolidation. For example, certificate of need laws and payment regulations create significant barriers to competition in hospital markets; scope of practice and licensure laws inhibit rivalry in care delivery. Incentives and ability to engage in foreclosure strategies are greatest where the entry or expansion by rivals is curtailed.

In addition, other health care regulations give providers strong financial incentives to consolidate that are unrelated to improving system efficiency.

Antitrust law sometimes finds itself playing catch-up to economic learning. Adherence to the outmoded theories underlying enforcers’ disinclination to challenge vertical mergers can impose significant costs on consumers and entrench dominant firm for years. With most health care sectors already highly concentrated and competition anemic at best, vertical consolidation should be closely monitored. And let’s remember, in the end, the four-leg/two leg distinction evaporated in Animal Farm.

For example, some Medicare payment rules (which are often followed by commercial insurers), strongly encourage physician employment. For example under “facility-based billing,” hospital-owned practices charge more for outpatient visits and facility fees than independent physician practices, thus creating a strong financial incentive for physician employment by hospitals. Likewise Medicare’s 340B program which provides discount outpatient drug pricing for qualifying entities, has led hospitals to increase their employment of physicians in certain specialties. Further, certain payment and fraud and abuse regulations make employment by hospitals more attractive than independent practice or joint ventures. For example, Medicare reimbursement for employed physicians practicing in hospital outpatient departments is often much higher than it is for physicians performing the same services in their own offices as independent practitioners. Further, the Stark Law and Anti-Kickback statute allow far greater leeway for physicians to refer to the hospitals that employ them than are recognized for joint ventures or other arrangements.
D. Market Dominance Gives Rise to Anticompetitive Conduct

Experience demonstrates that the conditions described above offer opportunities and incentives to engage in anticompetitive conduct. The history of antitrust law in the health care sector is littered with examples of hospitals, physician organizations, and insurers that have taken advantage of their dominant market positions, barriers to entry, and the absence of effective regulatory oversight to disadvantage rivals and impair competition. For example, in just the last several years antitrust cases have been brought against: a dominant insurer that lessened competition by requiring hospitals to agree to most favored nations clauses; a hospital with market power insisting that payors refrain from using tiering arrangements discouraged competitive contracting; a large hospital system restraining competition by “all or nothing” contracting for its hospitals, restricting sharing of cost information and other practices; and patented drug manufacturers conspiring with generic firms to delay competitive entry.74

At the same time, antitrust doctrine is tolerant of extant market power and rarely sanctions dominant firms, especially in cases involving unilateral refusals to deal with rivals.75 It only condemns monopolists that inappropriately obtain or maintain market power, and even in those cases plaintiffs may settle for conduct commitments rather than divestiture of assets. Moreover, cases alleging anticompetitive exclusion have faced high doctrinal hurdles.76 Given the law’s tolerance of extant market power and the propensity of dominant firms to entrench or extend their reach, merger law’s prophylactic remedies are especially important. As Professor Herbert Hovenkamp has argued, it is appropriate to apply the more demanding standard in merger cases” where a merger is likely to lead to conduct that is both anticompetitive but also is difficult or impossible for antitrust law to reach once the merger has occurred.”77

E. Uncertainty is a Two-Way Street

Because merger law is almost universally applied prospectively, cases necessarily apply predictions of future conduct and effects. Although considerable uncertainty attends such inquiries, antitrust precedent has made clear that the job of courts is to arrest “a rising tide of concentration” and to do so in its “incipiency.” This standard appropriately lowers the bar and should be applied to mergers where there is an appreciable danger of unilateral conduct, such as anticompetitive exclusion resulting from vertical mergers.78

At the same time, justifications for mergers merit close examination and courts in recent cases have been reluctant to accept efficiency justifications in horizontal merger cases.79 Even where beneficial change is likely to eventually result from vertical linkages, several subsidiary questions must be addressed before enforcers should consider adopting a go-slow approach. First, how long will it take for promised benefits to be achieved? Horizontal merger analysis provides an important caution regarding applying the “ease of entry” defense. It excuses competition-stifling consolidations only when parties can demonstrate that entry will be “timely.”80 The logic of this requirement applies to evaluating justifications advanced for postponing antitrust interventions to prevent vertical foreclosure: consumers should not be forced to endure monopolistic pricing if promised, offsetting integrative benefits will not be forthcoming in the near future. Second, what assurances exist that the cost-savings will be passed along to consumers? In cases involving significant foreclosure, dominant hospitals acquiring physician practices and insurers enhancing their bargaining leverage likely lack incentives to reduce price or to aggressively innovate.

IV. Conclusion

Antitrust law sometimes finds itself playing catch-up to economic learning. Adherence to the outmoded theories underlying enforcers’ disinclination to challenge vertical mergers can impose significant costs on consumers and entrench dominant firm for years. With most health care sectors already highly concentrated and competition anemic at best, vertical consolidation should be closely monitored. And let’s remember, in the end, the four-leg/two leg distinction evaporated in Animal Farm.81

References

4. FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327 (3d Cir. 2016); ProMedica Health Sys., Inc. v. FTC, 749 F.3d 559, 571 (6th Cir. 2014).


21. The FTC’s first challenge to a physician merger, commenced in 2012, involved the acquisitions by the largest hospital system in the Reno, Nevada area of two cardiology groups — making the system the employer of 88% of the active cardiologists in the market. The FTC entered into a consent order that did not enjoin the merger but rather required the system to release physicians from covenants not to compete. In the Matter of Renown Health, FTC Dkt. No. Docket No. C-4566 (December 4, 2012), available at <www.ftc.gov/enforcement/cases-proceedings/110101/renown-health-matter> (last visited November 1, 2018).


24. See, supra note 2 (comparing the broad brush antitrust maxim, “vertical good, horizontal bad” to Snowball’s “four legs good, two legs bad” in George Orwell’s Animal Farm).

25. Herbert Hovenkamp described Robert Bork’s “beguilingly simple” account of the competitive effects of vertical mergers as follows:

First, if vertical integration increased efficiencies, then a vertically integrated firm would have cost advantages over unintegrated rivals. In that case vertical integration would deter unintegrated entry, but it is not antitrust’s purpose to condemn cost savings. Second, if vertical integration did not create any efficiencies, then it would not impede entry by anyone. Firms that wished to enter at one stage alone could contract with firms at the other stage and be just as efficient as the vertically integrated firm. Third, if vertical integration resulted in higher costs, then vertically integrated firms would decline in favor of unintegrated firms. Fourth, in competitively structured markets vertical integration would lead to self-dealing, but that would do no more than force realignment in purchasing and sale patterns. Bork’s observations were built on an extraordinarily narrow conception of entry barriers. He barely mentioned patents or other intellectual property rights. There was no conception that sunk costs plus risk could facilitate entry deterrence. H. Hovenkamp, “Robert Bork and Vertical Integration: Leverage, Foreclosure, and Efficiency,” Antitrust Law Journal 79, no. 3 (2014): 963–1001.


29. Professor Salop’s recent work systematically refutes the bases upon which Chicago School’s permissive approach to vertical mergers is based. S. C. Salop, “Invigilating Vertical Merger Enforcement,” Yale Law Journal 127, no. 7 (2018): 1962–1964. Other scholars have also criticized the law’s neglect of

30. S. C. Salop and D. P. Culley, “Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners,” December 8, 2014, available at <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=2404&context=facpub> (“Vertical mergers seldom involve items that have monopolies protected by prohibitive entry barriers. If there is no monopoly, then there is no single monopoly profit.”)


32. For example, vertical mergers may facilitate coordination in the hospital market by weakening the disruptive behavior of a nonintegrated hospital, a strategy that could be implemented with targeted input foreclosure or threats of foreclosure. See, Salop and Culley supra note 30 at 25-26.


36. Id.

37. Id.

38. See Madara Letter supra note 35; Greaney Statement supra note 35.


41. Id. See also, Greaney and Ross, supra note 23.


46. Id.


48. Fulton, supra note 47.

49. See also, Dafny, Health Care Consolidation, supra note 45.

50. See generally id. at 7-9; See also M. Gaynor and R. J. Town, “The Impact of Hospital Consolidation,” (2012) The Synthesis Project, Policy Brief No. 9, Robert Wood Johnson Foundation (hospitals); see also note 56 infra (physicians).

51. See Gaynor, supra note 44 at 10-11.


55. See Salop, Invigorating Vertical Merger Enforcement, supra note 29 at 1973 (“these are the inherent upward pricing pressure occurs for vertical mergers” as for horizontal mergers).


58. See Gaynor, supra note 59.


61. R.A. Berenson, “A Physician’s Perspective on Vertical Integration,” Health Affairs 36, no. 9 (2017): 1585-1590 at 1586 (lit-
erature reviews find integration has not improved quality and could even reduce it because of reduced competition).


66. See Greaney and Richman, supra note 3.


70. See 42 C.F.R. 411.357 (Stark Law exception allowing physician with bona fide employment relationship to make referrals to employer-hospital subject to certain conditions).


78. See Id. (discussing the application of the incipiency test in the case of vertical mergers).


81. Animal Farm, supra note 1. (“The creatures outside looked from pig to man, and from man to pig, and from pig to man again; but already it was impossible to say which was which.”)