ASSESSING THE DIGITIZATION OF HEALTHCARE: HOW SHARING PATIENT DATA AFFECTS COMPETITION AND INNOVATION

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TABLE OF CONTENTS

I. Introduction

The healthcare industry knows more about its patients than ever before. Advances in information technology have significantly reduced the cost and time of collecting, processing, and storing information about patients' treatment and care. Often, however, providers do not keep patient data to themselves. An important aspect of the "digitalization" of healthcare is the increased potential for data portability and interoperability between firms. The industry has taken advantage of these developments, striving towards more integrated health plans that connect a patient and their data to their pharmacies, physicians, hospitals, insurers, and claims processors, and facilitate data exchanges between providers, payers, and intermediaries.

Sharing patient data has the potential to enhance innovation and efficiency in the healthcare system in numerous ways. When providers pass patient data amongst each other, they glean a more complete picture of a patient's medical history and profile. Armed with artificial intelligence, machine learning, and other new technologies, they have the potential to substantially improve the speed and quality of care provided. Moreover, sharing patient data with payors (i.e., insurers) can lead to cost reductions in the price consumers pay for their healthcare.[1] Consumers, with easier and more fulsome access to their own data, can further enjoy the benefits of greater control over and knowledge of their health information.[2] When paired with lower costs and a higher quality of care, such benefits can increase consumer demand for healthcare.

At first blush, the ability to share patient data between healthcare entities seems hugely beneficial. As in many areas of the economy, data analytics promises significant efficiencies, by

[1] See, e.g., Julia Kapchinsky, The Duality of Provider and Payer in the Current Healthcare Landscape and Related Antitrust Implications, 55 San Diego L. Rev. 617 (2018).
[2] Nicolas Terry, 'Prime Health' and the Regulation of Hybrid Healthcare, 8 NYU Journal of Intellectual Property & Entertainment Law 1 (2019).

replacing manual processing systems, offering new insights on trends, allowing for personalization, and enabling product and service improvements. Advances in medical treatment that occur today are also driven by data collection, predictions, and algorithmic judgments. [3] All of these can be thought of as "innovations" – creations of new or improved products that result from technologies, processes, or ideas.[4] Many argue that the United States has a particularly expensive and low-quality healthcare system because it does not have *enough* integration of information – evidenced by low levels of communication between providers, duplicative medical testing, and substantial administrative inefficiencies.[5] For a nation in which healthcare industry is bemoaned as costly and opaque, data sharing seems like a revolution we should embrace with open arms.

Despite these benefits, sharing patient data may clash with antitrust's goals of free and fair competition. The federal antitrust laws in the United States have long regulated the ways in which information sharing between companies can soften vigorous competition. Different forms of data integration have different competitive implications. For instance, certain information exchanges between rival firms violate Section 1 of the Sherman Act, which prohibits agreements that unreasonably restrain trade. Along with Section 1, policy statements from the Department of Justice have historically governed the exchange of information between healthcare entities. The policies they promulgated set out guidelines and exceptions to the antitrust laws, allowing certain lawful transfers of information to occur with lower scrutiny. In February 2023, the DOJ changed course, withdrawing the 1993, 1996, and 2011 policy statements. The DOJ expressed its intent to scrutinize healthcare information exchanges more closely, noting that the data is shared and used

[3] James Stramm, Responding to the Digital Health Revolution, 28 RICH. J.L. & TECH. 86 (2021).
[4] *Innovation*, DICTIONARY.COM, available at https://www.dictionary.com/browse/innovation (last accessed Apr. 21, 2023).
[5] Devon S. Connor-Green, *Blockchain in Healthcare Data*, 21 INTELL. PROP. & TECH. L. J. 93 (2017).

in ways that would be "unrecognizable" decades ago.[6] The twin forces of datafication and integration have significantly altered the healthcare industry, Principal Deputy Assistant AAG Doha Mekki argued, and antitrust law must catch up.[7]

Firms can also share patient data by acquiring or merging with another firm that either holds or receives this data. These transactions are typically either "horizontal" or "vertical" in form: the former referring to those between competitors of substitute goods, and the latter between two companies within the same supply chain. Each raises different concerns from a data-sharing perspective. Horizontal transactions involve assessing whether the combined patient data set affects the merged entity's ability to exercise market power, through unilaterally increasing prices, limiting quantity, and decreasing quality or innovation. It may also facilitate coordination between parties in the market, leading to similar concerns as those expressed in the Section 1 context of information exchanges. On the other hand, vertical transactions can enable providers to share patient data with payors, insurers, pharmacy benefit managers, and other entities which did not previously have direct access to information from patients. This integration can create potential for harms including foreclosure and misuse of competitively sensitive information. At the same time, patient data may introduce significant efficiencies, allowing for reduced costs, earlier and more effective patient interventions, and other innovations in the delivery of healthcare.

In this paper, I analyze the ways in which healthcare entities' exchange of patient data can affect competition and innovation. Some argue that creating a more integrated healthcare industry that allows for patient data to be shared across firms enables more comprehensive, less

[6] Doha Mekki, Principal Deputy Assistant Att'y General, Department of Justice Antitrust Division, Remarks at GCR Live: Law Leaders Global (February 2, 2023) ("The safety zones were written at a time when information was shared in manila envelopes and through fax machines. Today, data is shared, analyzed, and used in ways that would be unrecognizable decades ago.")
[7] Mekki, Remarks at GCR Live.

expensive, and higher quality medical care. Others argue the exact opposite: incentives to compete in the healthcare industry decrease with increasing data integration, contributing to the high prices and low quality of care many Americans experience. In analyzing how firms may share patient data, in practice and in theory, through information exchanges and mergers, I find that patient data can be both a tool for anticompetitive conduct and for beneficial innovations. To address this nuance, the antitrust agencies should embrace a more flexible, effects-based approach to identifying information exchanges under Section 1, with a particular eye towards future competition from platforms. They should also expand enforcement of consumer protection and data privacy laws, as well as Section 5 of the FTC Act, to target anticompetitive data sharing in the merger context, and explore novel theories of harm that more adequately capture the risks posed by data-driven transactions.

Healthcare companies share many different types of data, for many different purposes. Given that each kind of data can raise unique questions, this paper will focus specifically on patient data. I define patient data as any information collected from a patient by a healthcare provider in the course of treatment, including through their diagnosis, test results, medications, and treatment plans.[8] I also limit my inquiry to how firms use patient data to affect consumer experiences, through quality of care and cost, as opposed to for scientific research and development activity. Other important discussions have explored how sharing research and

[8] Brian Foy, Healthcare Data Sharing is Essential to the Future of Medicine, FORBES TECH COUNCIL (Jul. 21, 2022, 7:30 AM), https://www.forbes.com/sites/forbestechcouncil/2022/07/21/healthcare-data-sharing-is-essential-to-the-future-of-medicine/?sh=66f413f66777.

development data can influence innovation and competition,[9] how sharing patient data can impact privacy,[10] whether patients should be compensated for their data,[11] and more.

In Part II, I provide an overview of the current landscape of the healthcare industry in the United States, as well as the antitrust laws and policies regulating it. In Part III, I analyze how information-sharing conduct by firms would be analyzed under U.S. antitrust laws and healthcare policies. Part IV reviews how patient data sharing is considered in horizontal and vertical mergers. Part V concludes.

II. Background: Antitrust in the Healthcare Industry

a. Healthcare in the United States

The Affordable Care Act ("ACA") revolutionized the healthcare industry. Passed in 2010, and fully operational by around 2018, the ACA radically changed the process through which providers deliver health services and consumers pay for their care.[12] The model in existence prior to the ACA was called "fee-for-service". Under the fee-for-service model, doctors treated patients for the particular medical issue causing the visit, and billed their payer accordingly.[13] In contrast, the ACA's holistic approach requires doctors to assess and treat all prior preexisting conditions, and bill to this effect.[14] Due to its emphasis on developing a continuum of patient care, the new model is often referred to as "managed care". Under the

[9] Joanna Shepherd, *Consolidation and Innovation in the Pharmaceutical Industry: The Role of Mergers and Acquisitions in the Current Innovation Ecosystem*, 21 J. HEALTH CARE L. & POL'Y 1 (2018).
[10] *See, e.g.,* James Stramm, *Responding to the Digital Health Revolution*, 28 RICH. J.L. & TECH. 86 (2021).
[11] *See, e,g,,* Jennifer Hinkel, *Needed: A New Framework to Make Sure Health Companies Play Fair with Patient Data*, STAT NEWS (Feb. 24, 2013), https://www.statnews.com/2023/02/24/new-framework-health-companies-play-fair-patient-data/.
[12] Kapchinsky, *The Duality of Provider and Payer*.
[13] *Id.*
[14] Jessica Heeringa et al., *Horizontal and Vertical Integration of Health Care Providers: A Framework for Understanding Various Provider Organizational Structures*, INT. J. INTEGR. CARE 20(1) (Jan. 20, 2020).

ACA, healthcare businesses are encouraged to share more information and cooperate with other entities in their market space and their vertical. For example, through the ACA's Medicare Shared Savings Program, firms are encouraged to form Accountable Care Organizations. "ACOs" consist of groups of providers and suppliers that work together to manage and coordinate care for Medicare fee-for-service beneficiaries.[15] They are accountable for a patient population through integrated health care delivery systems, receiving claims data for all aligned beneficiaries.[16] Unless the patient opts out of data sharing, ACOs can perform extensive data analysis on the services the patient received.[17]

Changes in the way in which providers are paid under the ACA, including through bundled discounts and Accountable Care Organizations, created strong financial incentives for firms to consolidate. Vertical integration has become particularly favorable, including through joint ventures, medical foundation models, management agreements with physicians, and other collaboration agreements.[18] Most of the major insurance companies now own pharmacy benefit managers, providers, health data analytics companies, and acute care clinics.[19] CVS Health, for example, owns CVS Pharmacy, MinuteClinic, and a pharmacy benefit manager called Caremark. In this environment, integration functions as a cost-containment strategy, a method through which firms can increase patient-consumer engagement, and a marketing technique to encourage dependence on a particular provider.[20] This level of integration is unprecedented in our healthcare system.

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[15] U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, STATEMENT OF Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (2011), available at https://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf.
[16] FEDERAL TRADE COMMISSION, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.10.28OverviewHealthcare.pdf.
[17] Kapchinsky, *The Duality of Provider and Payer*.
[18] *Id*.
[19] Herringa et al., *Horizontal and Vertical Integration of Health Care Providers*.
[20] Kapchinsky, *The Duality of Provider and Payer*.

A number of other federal and state laws facilitate information sharing between healthcare entities. The Heath Insurance Portability and Accountability Act ("HIPAA"), enacted in 1996, contains two important features regarding data sharing. HIPAA applies to holders of "protected health information" – health information linked to a patient's identity – when those holders are "covered entities" (e.g., physicians, hospitals, health plans, and firms that process digital health information for billing).[21] HIPAA allows for the transmission of the protected health information between covered entities of a patient to which both entities are providing care. In this circumstance, the consent of the patient is not required.[22] The second data-sharing provision in HIPAA allows patients to transmit their protected health information themselves. Individuals can view, download, and send their information to anyone they wish, including competing health providers.[23] The Health Information Technology for Economic and Clinical Health Act, passed in 2009, also provides financial incentives for physicians and hospitals to digitize clinical data.[24]

b. Antitrust Laws and Policies for Healthcare

The Sherman and Clayton Acts govern competition in the healthcare industry at the federal level.[25] Section 1 of the Sherman Act prohibits unreasonable horizontal and vertical agreements in restraint of trade, and Section 2 prohibits the willful acquisition, attempted acquisition, or maintenance of monopoly power through unlawful means.[26] The Clayton Act, in relevant part, prohibits mergers, acquisitions, joint ventures, and stock purchase agreements that

[21] Lucia Savage, Martin Gaynor, & Julia Adler-Milstein, *Digital Health Data and Information Sharing: A New Frontier for Health Care Competition*, 82 ANTITRUST L.J. 593 (2019).
[22] The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.
[23] Savage et al., *Digital Health Data*.
[24] *Id*.
[25] State Attorneys-General also enforce state antitrust laws, many of which resemble the federal antitrust laws.
[26] 15 U.S.C. §§1, 2 ("Sherman Act").

substantially lessen competition.[27] The FTC also possesses a broad mandate to prosecute "methods of unfair competition", under Section 5 of the FTC Act.[28]

For many years, policy statements promulgated by the DOJ supplemented the aforementioned laws in the healthcare antitrust space. On February 2, 2023, the Department of Justice announced the withdrawal of three antitrust policy statements regarding information sharing in the healthcare industry. The first statement, issued in 1993, established "safety zones" in which healthcare firms could operate without fear of condemnation from the antitrust authorities. Safety zones were identified in the following arrangements: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures.[29] For example, the agency established a safety zone for mergers where one of the merging hospitals is small; for provision of non-price information by physicians to purchasers of healthcare services; for hospital participation in written surveys of prices for hospital services or wages, and for physician network joint ventures. In particular, the safety zones were noted to cover data shared through third-party intermediaries that was anonymized and at least three months old.[30]

[27] 15 U.S.C. §18 ("Clayton Act").
[28] 25 U.S.C. §45 ("The FTC Act").
[29] U.S. DEPARTMENT OF JUSTICE, ANTITRUST ENFORCEMENT POLICY STATEMENTS ISSUED FOR HEALTH CARE INDUSTRY (Sept. 15, 1993), available at https://www.justice.gov/archive/atr/public/press_releases/1993/211661.htm (hereinafter "1993 Policy Statement").
[30] 1993 Policy Statement.

The 1996 Statement expanded the 1993 safety zones, focusing particularly on physician network joint ventures and multi-provider networks.[31] It also provided the following with respect to underlying medical data:

> Providers' collective provision of underlying medical data that may improve purchasers' resolution of issues relating to the mode, quality, or efficiency of treatment *is unlikely to raise any significant antitrust concern* and will not be challenged by the Agencies, absent extraordinary circumstances. The Agencies also will not challenge, absent extraordinary circumstances, providers' development of suggested practice parameters—standards for patient management developed to assist providers in clinical decision making—that also may provide useful information to patients, providers, and purchasers. Because providers' collective provision of such information poses little risk of restraining competition and may help in the development of protocols that increase quality and efficiency, the Agencies will not challenge such activity, absent extraordinary circumstances. [emphasis added].

Put simply, the Statement asserts that collecting and sharing clinical information for the purpose of improving treatment is unlikely to be challenged by the agencies as anticompetitive.

Finally, in 2011, the agencies released another Policy Statement to harmonize the guidelines with the Affordable Care Act. The 2011 Statement applies to Accountable Care Organizations (ACOs). It describes when the agencies will apply rule of reason treatment to their agreements, including those regarding joint pricing, and establishes safety zones for certain arrangements.[32]

In all three healthcare policy statements, the government expressed its purpose as one of increasing innovation along multiple lines, allowing for the realization of efficiencies, and removing any chilling effect antitrust scrutiny may have on procompetitive arrangements

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[31] U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (August 1996), available at https://www.justice.gov/atr/page/file/1197731/download.
("The safety zones for physician network joint ventures remain unchanged, but the revised statement identifies additional types of financial risk-sharing arrangements that can qualify a network for the safety zones….The revised statement on multiprovider networks emphasizes that it is intended to articulate general principles relating to a wide range of health care provider networks")

[32] U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, STATEMENT OF Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (2011), available at https://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf. (hereinafter, "2011 Policy Statement").

between healthcare entities. The 1993 Statement emphasized how the sharing of non-price information between physicians and health care purchasers can improve the quality of care. Likewise, in 1996, the government recognized that mergers and information-sharing arrangements often lead to the provision of higher-quality healthcare services. In the 2011 Statement, the DOJ stated their intent to "maximize and foster opportunities for ACO innovation and better health for patients".[33] From these explanations, we gather that the government believed the importance of facilitating the pursuit of higher quality products and services for patients justified giving the healthcare industry a more relaxed level of antitrust scrutiny in many areas. As the next section describes, the revocation of the guidelines suggests that the government believes that the categories of conduct to which it granted safe harbor are no longer obviously procompetitive.

III. Information Exchanges

Following the recission of the policy statements, it is not clear how the antitrust agencies will view the legality of patient-data exchanges between healthcare entities. Previously, sharing patient data likely fell into the safety zone of "provision of non-price information by physicians to purchasers of healthcare services."[34] Moreover, under the 2011 Policy Statement, ACOs received rule of reason treatment for their joint pricing activities. After the policy statements' revocation, such agreements could be treated as per se agreements under Section 1. Industry experts posit that sharing health data among providers, technology companies, and other parties is "rampant".[35] The revocation of the safe harbors may cause some firms to reconsider their

[33] 2011 Policy Statement.
[34] The recission also removed the safety zone for sharing data through third-party intermediaries that was anonymized and at least three months old.
[35] *See* Hinkel, *Needed: A New Framework*. ("[S]haring health data is rampant among health care providers, the financial and IT companies that support them, and the tech companies that are increasingly blurring the line between health, consumer, and

current data-sharing arrangements, as the agencies could begin to challenge such exchanges. This section reviews precedent on information sharing and notes how it may be applied to the exchange of patient data, particularly in the context of new platform-healthcare partnerships.

a. Information Exchanges under Section 1

Antitrust law classifies sharing data between firms as an "information exchange". Information exchanges are a type of collaboration among competitors that can raise antitrust issues under Section 1 of the Sherman Act. The methods through which firms can share information varies. In addition to direct communications, like emails and meetings, information can be passed through third parties and via surveys, software or algorithms used to calculate prices, industry reports, and the like.

The law classifies information exchanges in two ways. First, such practices may constitute supporting evidence, or "plus factors", from which one can infer an anticompetitive agreement. Plus factors reduce the likelihood that defendants were acting independently. Second, information exchanges may be contracts, combinations, or conspiracies that unreasonably restrain trade.[36] In other words, information exchanges may violate Section 1, in and of themselves.

i. Anticompetitive Effects

In *United States v. Gypsum*, the Supreme Court set out the current standard for treatment of information exchanges. The Court held that information exchanges are not a per se violation of Section 1, and instead should be analyzed under the rule of reason. It pointed to two factors

advertising data. In many cases, such data sharing is not only enabled by existing regulations, including HIPAA, but is facilitated, helping businesses share data to adjudicate insurance claims and make payments, for example.")

[36] Phillip E. Areeda et al., ANTITRUST ANALYSIS: PROBLEMS, TEXT, AND CASES (8th ed. 2021).

guiding the rule of reason inquiry: the structure of the industry involved, and the nature of the information exchanged. In applying the first factor, courts examine whether the industry is highly concentrated, and thus "susceptible to the exercise of market power through tacit coordination."[37] Coordination is also more likely in markets with fungible products subject to inelastic demand.[38] Product homogeneity makes it easier for firms to reach a consensus, and inelastic demand makes it more difficult for consumers to abstain from purchasing the product.[39]

Although oligopolistic markets are more likely to enable coordination, information exchanges can also occur in less concentrated markets. Indeed, in Deputy Assistant AAG Mekki's speech on the repeal of the policy statements, she explicitly warned against relying on an "overly formalistic approach" to analyzing market structure in information sharing agreements. Mekki emphasized that information exchanges can be "persistent and harmful" in markets with many competitors.[40] DOJ brought this principle to bear in its prosecution of an information exchange in the poultry processing industry in 2022. In *United States v. Cargill Meat Solutions Corp*., DOJ alleged that at least 15 poultry processors participated in a scheme to exchange competitively-sensitive wage and benefit information.[41] DOJ pointed to information exchanged through meetings, communications, and surveys designed by a third-party consulting firm as evidence of that the arrangement was anticompetitive, despite the unconcentrated market structure.[42] A flexible "market structure" guidepost may come in handy if the agencies target information exchanges in healthcare markets, as some segments continue to be relatively unconcentrated.

[37] *Todd v. Exxon Corp*., 275 F. 3d 191, 198 (2d Cir. 2001) (citing *Battipaglia*, 745 F.2d at 174-75).
[38] *Todd v. Exxon Corp*., at 208.
[39] *Id*.
[40] Mekki, Remarks at GCR Live.
[41] Complaint, United States v. Cargill Meat Solutions Corp., Dkt. No. 1:22-cv-01821, ECF No. 1 (D. Md. July 25, 2022).
[42]

When assessing the second factor in the rule of reason inquiry – the nature of the information exchanged – courts consider broadly whether it is similar to the information in *American Column & Lumber Co. v. United States* or *Maple Flooring Manufacturers Ass'n v. United States*.[43] The first aspect assessed is the time frame of the data. Current or forward-looking data are more likely to be considered anticompetitive, given their potential to be used in pricing.[44] Historical data is less helpful in this regard. Courts then consider the specificity of the information exchanged. Aggregated data is preferred over disaggregated, and data that identifies particular parties, transactions, and prices are more troublesome than industry averages. Lastly, courts also consider whether the data is publicly available.[45] When data is disseminated to the public, it is no longer competitively sensitive, thereby ridding it of its anticompetitive potential.

These factors prove to be largely unhelpful in discerning whether sharing patient data is anticompetitive. The first factor – the time frame of the data – suggests that current or forward-looking data is more concerning than historical data. Most patient data is historical in nature: medical histories, or records about patient health, feature information about prior courses of treatment, major operations or procedures, and historical test results. But such records can be used by physicians in determining future courses of treatment and insurer-payors in determining healthcare eligibility.[46] To the extent physicians and payor compete along these lines, historical data can provide competitively sensitive insights. In addition, historical data can also be used to

[43] FRANCIS AND CHRISTOPHER J. SPRIGMAN, ANTIRUST: PRINCIPLES, CASES, AND MATERIALS, 250-57.
[44] *Id*.
[45] *Todd v. Exxon*, at 212 ("Public dissemination is a primary way for data exchange to realize its procompetitive potential") (Sotomayor, J.).
[46] *Finding and Using Statistics: Medical Records*, National Library of Medicine (last reviewed Feb. 6, 2019), https://www.nlm.nih.gov/nichsr/stats_tutorial/section3/mod2_medical.html#:~:text=Medical%20records%20are%20used%20to,characteristics%2C%20and%20quality%20of%20care.

create forward-looking pricing models, which is more obviously anticompetitive under existing case law.[47]

Likewise, current or forward-looking patient data can provide insights on rivals' competitive strategies. Though data about ongoing diagnoses, underlying conditions, and current medications is not pricing data, per se, it is a significant factor in a payors' calculations of cost – which contributes to price-setting. Pricing in healthcare is personalized to a particular patient's treatment and care. Access to the data underlying competitors' pricing decisions could allow firms to forecast competitors' pricing strategies more accurately, and adjust their own accordingly.[48] Furthermore, if firms compete along innovation lines, sharing the data driving these innovations can soften competition without necessarily impacting pricing.[49] This could include the development of new methods of treatment, new surgical procedures, and other processes which increase the quality of care and reduce prices.[50]

Likewise, patient data that is anonymized and aggregated may facilitate collusive practices just as easily as identifiable and disaggregated information. "Anonymizing" health data implies the removal of identifiers like name, address, date of birth, and Social Security numbers. The information that remains on medical history, current courses of treatment, and the like can still provide valuable insights to healthcare companies. Anonymized and aggregated health data can enhance healthcare marketing precision, for example, by revealing trends in diagnosis and treatment.

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[47] Steve Medlock et al., *V&E on DOJ info sharing guidelines*, VINSON & ELKINS (Feb. 23. 2023), https://www.velaw.com/insights/from-manila-envelopes-to-algorithms-the-department-of-justice-revisits-antitrust-information-sharing-guidance/.
[48] Mekki, Remarks at GRC Live.
[49] *Id.*
[50] The edits to the claims data referenced in the *United Health/Change* complaint present a nice example of how sharing underlying patient data can soften competition between rival health insurers. Section III discusses the *United Health/Change* transaction in greater detail.

What's more, data that is anonymized may not always remain anonymized. Advanced technologies that enable reverse engineering now make it possible to connect anonymized information back to patient identities.[51] Use of de-anonymized data, such as in making personalized pricing decisions or marketing to particular consumers, could violate both HIPAA and the Sherman Act.

Whether data is shared publicly or not is also a poor indicator of competitive harm. HIPAA prevents healthcare entities from sharing identifiable patient data without the patient's consent. But data that is *not* identifiable is no longer captured under HIPAA. Companies are free to use de-identified patient data as they wish, including by sharing it externally. [52] As noted above, de-identified data remains valuable for analyzing healthcare trends and deriving competitive insights.

Given the risks that historical, forward-looking, anonymized and de-anonymized patient data may create, looking at the effects of data sharing on competition is more useful in discerning its anticompetitive potential. Data sharing for the purpose of comparing cost, quality, or specific outcomes across providers and payors is more likely to be anticompetitive, by enabling collusion or otherwise softening direct competition. Such harms can arise not only by exchanging pricing and cost data, but also by sharing patient health information. Future analysis of information exchanges in the healthcare sector should embrace a more holistic analysis of how shared data is actually used to compete.

[51] See the DOJ's discussion of this possibility in the *UnitedHealth/Change* merger.
[52] Statement of Commissioner Alvaro M. Bedoya Joined by Commissioner Rebecca Kelly Slaughter Regarding Amazon.com, Inc.'s Acquisition of 1Life Healthcare, Inc., FEDERAL TRADE COMMISSION (Feb. 27, 2023) ("When you hear a company tell you that they will abide by HIPAA, it does not mean that they cannot use your data for other purposes. Rather, it means they must simply remove from that data certain markers that would tie that data back to you").

ii. Procompetitive Justifications

When Section 1 agreements are analyzed using the rule of reason, defendants have the opportunity to offer procompetitive justifications for their conduct. In the healthcare space, these justifications could include that the agreement increases innovation, lowers costs, and increases quality of care. Increasing innovation may involve the ability to innovate at a faster rate by sharing data. Though antitrust law generally recognizes procompetitive justifications on innovation lines, whether data-sharing efficiencies are present in a particular healthcare market is fact-specific.[53] As noted above, many industry experts and policymakers show substantial support for the idea that creating a more connected healthcare system will lead to more accurate, more efficient care.[54] The Affordable Care Act itself created ACOs on the basis that information sharing between competitors creates a lower cost, higher quality patient treatment model. These arguments appear compelling, but the weight they hold will depend on the particular purpose and effect of data sharing in the market in which they are alleged.

Many states and private parties also take the position that increasing integration of patient data is key to lowering healthcare costs and increasing quality of care. Today, eighteen states have passed legislation authorizing the creation of centralized claims databases that aggregate claims and corresponding administrative data.[55] Public and private insurers may, but are not required, to report claims data to the claims databases.[56] Consumers can use the databases to

[53] For example, in the classic case *United States v. American Can*, the Supreme Court held the defendant-manufacturer's purchase of multiple rival manufacturers did not violate Section 1, because the acquisitions allowed it to invest in innovative quality-control measures and undertake substantial research-and-development efforts aimed at improving existing technology. *United States American Can Co.*, 280 U.S. 412 (1930). *See also* John M. Newman, *Procompetitive Justifications in Antitrust Law*, 94 Indiana Law Journal 501 (2019).
[54] *See, e.g.,* Savage et al., *Digital Health Data*.
[55] In addition, more than 30 States maintain, are developing, or have a strong interest in developing an APCD. *All-Payer Claims Databases*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, https://www.ahrq.gov/data/apcd/index.html#:~:text=To%20date%2C%2018%20States%20have,interest%20in%20developing%20an%20APCD (February 2018).
[56] *Frequently Asked Questions*, ALL-PAYER CLAIMS DATABASE COUNCIL, https://www.apcdcouncil.org/frequently-asked-questions (2023).

compare price and performance of providers within their state.[57] In California, the state legislature recently passed an even more robust data exchange framework. The framework is described as a statewide agreement between hospitals, physician organizations and medical groups, skilled nursing facilities, health plans and disability insurers, clinical laboratories, and acute psychiatric hospitals to share patient information. Paired with policies governing how the data will be securely exchanged, the framework aims to ensure that providers can access the information they need to treat patients quickly and safely, and public healthcare actors can better assess the needs of various communities.[58]

Though it seems unlikely that state-sponsored claims databases and data-exchanges will be challenged as anticompetitive information exchanges, given their public nature, their existence underscores that there is widespread support for data-sharing arrangements at the state level. As a result, the federal government should take care to preserve beneficial exchanges that are truly public in nature.

b. Data-Sharing Agreements with Digital Platforms

Access to patient data can enable entry and expansion into the provision of healthcare services. Prominent digital platforms, including Google and Amazon, have recently begun to use agreements to share patient data to do just that. Google began its foray into healthcare with a digital health database in 2008 that allowed patients to upload and store their medical files.[59] When the product enjoyed little success, Google pivoted to other software pursuits, including

[57] *Id.*
[58] *Data Exchange Framework*, Center for Data Insights and Innovation, https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/ (2023).
[59] Google offers products like Nest Home smart home devices, which track your sleep; Fitbit wearables, for fitness tracking; and Care Studio HER search tools. Google established "Google Health" in 2018, but unwound the division in 2021, though it says its projects will continue. See Rob Copeland, Google's 'Project Nightingale' Gathers Personal Health Data on Millions of Americans, Wall Street Journal, https://www.wsj.com/articles/google-s-secret-project-nightingale-gathers-personal-health-data-on-millions-of-americans-11573496790 (Nov. 11, 2019).

developing programs that can help detect disease, enable providers to search a repository of patient data, and much more. = Google contracts with large hospital systems and providers to view or analyze tens of millions of patient health records in at least three-quarters of U.S. states.[60]

To illustrate, Google partnered with Ascension in 2018 to gain access to its broad network of patient data.[61] Ascension is a chain of 2,600 hospitals, doctors' offices, and other providers based in St. Louis. As such, Ascension gathered data on patients' names, dates of birth, lab results, diagnoses, hospitalization records, and more. From a privacy perspective, Google claims that HIPAA legalizes this data-sharing – despite the fact that neither the patients nor doctors were notified of the agreement. HIPAA allows providers to share data with business partners without patient disclosure if the information that is used "only [helps] the covered entity carry out its health functions."[62] Google claims it intends to use the data to design new software that allows patients to suggest changes to their care, using machine learning and artificial intelligence. One of the products in development would resemble a search tool containing patient information for use by doctors and other providers.[63] But documents from Ascension show that the hospital system intends to gather data for the purpose of "identify[ing] additional tests that could be necessary or other ways in which the system could generate more revenue from patients".[64]

Google holds similar agreements with Intermountain and Mayo Clinic. The agreement with Intermountain, a Utah-based hospital network, allows Google to access its repository of

[60] Rob Copeland, *Inside Google's Quest for Millions of Medical Records*, Wall Street Journal (Jan. 11, 2020), https://www.wsj.com/articles/paging-dr-google-how-the-tech-giant-is-laying-claim-to-health-data-11578719700.
[61] Copeland, *Google's 'Project Nightingale'*.
[62] *Id.*
[63] Copeland, *Inside Google's Quest*.
[64] *Id.*

patient data.[65] Google's 10-year agreement with Mayo Clinic covers the storage of the hospital system's genetic, medical, and financial records in Google Cloud. Both Intermountain and Mayo claim the data are anonymized prior to being re-used for software design.[66]

Pushback against Google's agreements have largely come from privacy and consumer protection advocates who are concerned with Google's ability to safeguard patient data.[67] Federal lawsuits have challenged Google's claims that the information will remain anonymous, claiming that Google could re-identify individuals by cross-referencing its data from other business units.[68] Google denies these claims, and assures that the hospital systems retain control over who accesses the data.[69] Google further argues its agreements help expand access to care and make the field more equitable, emphasizing that the future of healthcare is consumer-driven.[70] Moreover, the large data troves Google amasses feed into algorithms it is developing to detect diseases, offering the potential to improve health outcomes.

It is worth asking whether data-sharing agreements between platforms like Google and healthcare providers may someday be challenged as anticompetitive information exchanges. The first hurdle would be showing that Google and the health care providers actually compete. At the moment, this does not appear to be the case: Google's products are not yet widely-used by consumers, and some products appear to function more like complements to traditional health care. The search tool, for example, is intended to be used by providers themselves. But some

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[65] Copeland, *Inside Google's Quest*.
[66] Not all of Google's attempts to form agreements have succeeded, however: in 2019, it lost an opportunity to store data for health-data company Cerner to Amazon, allegedly due in part to the fact that Amazon had more a trustworthy data security system. *See* Copeland, Google's 'Project Nightingale'.
67 Heather Landi, Google defends use of patient data on Capitol Hill among scrutiny of Ascension deal, Fierce Healthcare, https://www.fiercehealthcare.com/tech/senators-pressing-ascension-google-data-deal-as-tech-giant-defends-its-use-patient-records (Mar. 4, 2020).
[68] *Everything You Need to Know About Google Class Action Settlement for Illinois Residents*, NBC Chicago, nbcchicago.com/news/local/everything-to-know-about-google-class-action-settlement-for-illinois-residents/2955833/ (Oct. 1, 2022).
[69] Copeland, *Inside Google's Quest*.
[70] Mary Kekatos, *Here's what you need to know as Google expands into health care AI*, ABC News, https://abcnews.go.com/Health/google-expands-health-care-ai/story?id=97875499 (Mar. 15, 2023).

healthcare firms have already noted their wariness at sharing their data with Google out of fear that they will become a future competitor.[71] Google's products could someday begin to supplant traditional health care service models – especially its AI diagnostics tools, which promise to be able to provide personalized diagnoses and treatment plans.[72]

Still, Google-generated health care does not necessarily mean consumers will face higher prices, lower quality of care, or other welfare losses. The most obvious potential harms from Google's data-sharing agreements are to patients' privacy and data security. But privacy and security, while important, are not traditionally the kinds of harms that antitrust law condemns. Moreover, Google has not spoken to whether the search engine will charge users for their services, so it is not clear how access to the data would affect pricing. And as noted above, Google hopes to increase the accuracy and availability of healthcare to patients. Even if Google did compete with traditional healthcare providers, then, it is far from obvious that its data-sharing agreements would be anticompetitive.

The mere fact of market entry is also presumably beneficial from an antitrust perspective. Indeed, some commentators have argued that a platform business model would reinvigorate the healthcare landscape, through their prevention-first strategies, workflow automation, and patient-centric services.[73] Platforms can offer a more sustainable model of information sharing, which can simultaneously spur innovation by harnessing more advanced data analytics. Indeed, existing healthcare companies increasingly look more like platforms themselves. Anthem, for example, a top national insurer, recently announced an integration with Epic's Electronic Health Records

[71] Copeland, *Inside Google's Quest*.
[72] Kekatos, *Here's what you need to know*.
[73] Lital Marom, *Healthcare Revolution in the Platform Economy,* Forbes (Mar. 1, 2021), https://www.forbes.com/sites/forbescoachescouncil/2021/03/01/healthcare-revolution-in-the-platform-economy/?sh=7e877bae41b4.

Payer Platform.[74] The platform allows for the exchange of clinical and hospital data. In addition, Anthem stated it would integrate claims data and health information received from public health information exchanges. By integrating the payer platform into its operation system, Anthem believes it can leverage data to improve quality of care and patient outcomes.[75] As a result, is far from clear that platforms sharing patient data will be a problem meriting antitrust concern.

IV. Data Sharing through Mergers and Acquisitions

Firms can also share patient data through mergers and acquisitions. The rescinded policy statements had less to say about how the agencies should analyze mergers in the healthcare space, besides creating "safety zones" for mergers between hospitals of a certain size and joint ventures between physician networks and services.[76] But the Federal Trade Commission, which reviews healthcare provider mergers, recently indicated its intention to look more closely at mergers in the healthcare industry. The Bureau of Economics in the Commission ("BE") announced in January 2021 that it ordered six health insurance companies to provide information for the agency's study of consolidation in physician groups and healthcare facilities, from 2015-2020. The health insurance companies are large players, including Aetna, Anthem, Cigna, and United Healthcare.[77] Within these orders, the FTC seeks patient-level commercial claims data for inpatient, outpatient, and physician services in 15 U.S. states, which it claims will help it to assess the impact of physician consolidation during the specified five-year period. It will also use the data to assess healthcare facility consolidation.[78]

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[74] Hannah Nelson, *Anthem Integrates Epic Payor Platform for Care Coordination, Interoperability*, TECHTARGET (May 24, 2021).
[75] *Id*.
[76] See 1996 Policy Statement ("Except in extraordinary circumstances, the Commission will not challenge mergers of general hospitals where one hospital has fewer than 100 beds, fewer than 40 patients a day, and is more than five years old.").
[77] Michael Vita, *Physician Group Healthcare Facility Merger Study*, Federal Trade Commission, https://www.ftc.gov/enforcement/competition-matters/2021/04/physician-group-healthcare-facility-merger-study (April 14, 2021). Orders were also issued to Florida Blue and Health Care Service Corporation.
[78] *Id.*

In its explanation for the study, the FTC notes that U.S. physician markets have undergone a dramatic restructuring in recent years. While many physician practices used to be owned by a singular physician or be comprised of small, single-specialty groups, today many have consolidated into large, multiple-specialty groups or are owned by broader hospital systems. Operators that have healthcare facilities, such as imaging laboratories or outpatient surgical centers, have also experienced significant consolidation. These restructurings are under-studied, which is troubling for an area that occupies a high percentage of the FTC's enforcement budget.[79] The FTC study states two specific objectives with respect to horizontal mergers: first, to examine "how horizontal mergers…have affected provider prices, and whether price effects have been more pronounced for mergers involving certain medical specialties", and second, to examine "how [they] affect non-price outcomes, including better or worse healthcare outcomes for patients of merged providers."[80] The study will also assess the vertical concerns in acquisitions of physician practices by hospitals. However, the FTC notes that such mergers could very well result in efficiencies, like enhanced coordination of care that results in improved healthcare outcomes, that may outweigh potential competitive harms.[81]

The design of this study suggests that the FTC views patient data as containing important information about whether our healthcare markets function competitively. The study also indicates a willingness to revisit prior treatment of mergers between physicians, hospitals, and healthcare facilities, likely with an eye towards whether such transactions have contributed to the increased costs observed within the industry. Against this backdrop, this section reviews how the agencies analyze both horizontal and vertical mergers enabling the exchange of patient data.

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[79] *Id.*
[80] Vita, *Physician Group Healthcare Facility Merger Study*.
[81] Vita, *Physician Group Healthcare Facility Merger Study*.

Mergers are primarily reviewed under Section 7 of the Clayton Act and Section 5 of the FTC Act. In analyzing transactions under these statutes, the antitrust agencies rely on the analytical framework and standards found in the Horizontal Merger Guidelines ("HMGs") and Vertical Merger Guidelines ("VMGS"). The agencies are currently revising the guidelines in an effort to "modernize" antitrust law in merger enforcement. [82] This includes accounting for the unique characteristics of digital markets, including data aggregation. The revised guidelines are set to be released in the upcoming months.[83]

Agencies analyze anticompetitive harm by assessing the unilateral or coordinated effects of a merger. Unilateral effects result in the loss of head-to-head competition between merging parties, thus changing the incentives of the new firm to compete vigorously. These include, for example, the ability to increase prices, reduce incentives to innovate, and decrease product quality.[84] Mergers in concentrated markets may also raise concerns regarding coordinated effects, which arise from improving the ability and incentive of the remaining firms to engage in coordination. Actual or tacit collusion between two competitors could include the sharing of information relating to the competitors' product offerings, customers, and pricing models.[85]

If the government succeeds in showing the requisite anticompetitive effect in a defined market, the burden shifts to the merging parties to show that the transaction produces merger-specific efficiencies. Horizontal merger analysis assesses how competition is affected by the

[82] "Federal Trade Commission Withdraws Vertical Merger Guidelines and Commentary," *Federal Trade Commission* (September 15, 2021).
[83] "Justice Department Issues Statement on the Vertical Merger Guidelines," *Department of Justice, Office of Public Affairs* (September 15, 2021). The DOJ stated the review would involve considerations such as whether the VMGs unduly emphasize the quantification of price effects; whether the VMGs should more fully explain the range of circumstances that can lead to a concern that a merger may have anticompetitive effects; and whether the VMGs appropriately account for the traditional burden shifting framework applied by U.S. courts in their review of mergers.
[84] *See* Horizontal Merger Guidelines.
[85] *CCC Holdings/ Mitchell International*, Federal Trade Commission, https://www.ftc.gov/legal-library/browse/cases-proceedings/081-0155-ccc-holdingsmitchell-international (March 9, 2009).

elimination of a competitor, primarily through the lens of market power. [86] When analyzing vertical mergers, the VMGs focus on whether the acquisition of an upstream or downstream firm will raise rivals' costs (e.g., by foreclosing or otherwise discriminating against their rivals' access to goods or services they need to compete) or facilitate collusion.

Though vertical mergers typically face less scrutiny than horizontal mergers, the agencies have been increasingly active in challenging transactions between different entities within the healthcare supply chain. The agencies' recent vertical merger challenges highlight misuse of competitively sensitive information and input foreclosure.[87] The Department of Justice also recently argued in its challenge to the merger between UnitedHealth and Change Technologies that data sharing would effectively soften competition in the health insurance industry. Many vertical healthcare mergers involve granting access to patient data, and such access will likely be an increasingly significant factor motivating vertical transactions.

a. Physician Practices and Drug Providers

In evaluating mergers between healthcare entities, the FTC and DOJ do not typically undergo an in-depth review of how enabling patient data-sharing will affect competition. For example, in challenging a recent merger between physician practice groups Sanford Health and Mid Dakota Clinic, the FTC focused on the potential for the merger to increase prices in the provision of adult primary care physician services, pediatric services, obstetrics and gynecology services, and general surgery physician services in Bismarck and Mandan, North Dakota. [88] The

[86] DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION, HORIZONTAL MERGER GUIDELINES (Aug. 19, 2010), available at https://www.ftc.gov/system/files/documents/public_statements/1599783/statement_of_chair_lina_m_khan_regarding_the_request_for_information_on_merger_enforcement_final.pdf (hereinafter, "Horizontal Merger Guidelines").
[87] *See, e.g.*, Complaint, *FTC v. Lockheed Martin Corp.*, No. 1:22-cv-00174-RDM (D.D.C. Jan. 27, 2022), ECF No. 31-1.
[88] Federal Trade Commission v. Sanford Health, Sanford Bismarck and Mid Dakota Clinic, P.C., FTC File No. 1710019, 1:17-cv-00133-DLH-ARS (complaints filed June 21, 2017 and June 22, 2017). The complaint alleged that the transaction would bolster the parties' ability to negotiate better reimbursement rates with commercial payers, who would then pass on their higher rates to customers in the form of increased premiums and, potentially, higher out-of-pocket expenses like co-pays and deductibles.

only reference to patient data came from the parties themselves, who identified cost savings from the merger related to electronic medical records and information technology.[89] But the court found these to be small and unverified, and temporarily enjoined the merger.[90]

In contrast, the agency recognized the potential for significant efficiencies related to data sharing in CVS Health's acquisition of Aetna in 2017.[91] The transaction had both horizontal and vertical components. CVS and Aetna were the second and fourth largest biggest prescription drug providers in the United States, respectively, and had particularly significant overlaps in sixteen Medicare Part D regions. CVS also owned Caremark, a major pharmacy benefit manager. Aetna was the third-largest health insurance company in the country. The government alleged that the transaction would lead to anticompetitive effects in the market for prescription drug provision, including increased prices, inferior customer service, and decreased innovation in the Medicare Part D regions. After investigation, the government mandated the divestiture of Aetna's Medicare Part D individual prescription drug plan business to a health insurer called WellCare Health Plans.[92]

Though public documents give little mention of the pro-competitive efficiencies involved in the transaction, efficiencies received considerable attention in public commentary. The Assistant Attorney General of the DOJ at the time, Makan Delrahim, noted that the transaction created an integrated pharmacy and health benefits company that had the potential to improve the quality and lower the costs of the healthcare services for American consumers.[93] Likewise, in

[89] *Id.*
[90] Memorandum of Decision, Findings of Fact, Conclusions of Law, and Order, *F.T.C. and State of North Dakota v. Sanford Health et. al*, Case 1:17-cv-00133-ARS (D.N.D. 2017). The parties subsequently abandoned the transaction.
[91] *Justice Department Requires CVS and Aetna to Divest Aetna's Medicare Individual Part D Prescription Drug Plan Business to Proceed with Merger*, DEPARTMENT OF JUSTICE OFFICE OF PUBLIC AFFAIRS, https://www.justice.gov/opa/pr/justice-department-requires-cvs-and-aetna-divest-aetna-s-medicare-individual-part-d (Oct. 10, 2018).
[92] *Id*.
[93] *Justice Department Requires CVS and Aetna to Divest*.

his testimony before the United States House of Representatives, the General Counsel of CVS Health explained:

> "We need health insurance models that eliminate cost barriers to better care and medical outcomes, resulting in lower costs. The CVS-Health-Aetna combination will allow us to create this type of new model, *one that better integrates data* to ensure that consumers and providers have all the information they need to make the best care decisions" (emphasis added).

Integrating pharmacies, pharmacy benefit managers, and CVS's MinuteClinic Services would break down existing data silos between pharmacy and medical care. This would allow for earlier interventions, which reduce cost and lead to improved patient outcomes.[94]

Whether or not the efficiencies noted in *CVS Health-Aetna* have played out is subject to debate. Prices for prescription drugs have continued to rise, and markets involving pharmacy benefit managers like CVS' Caremark are increasingly subject to antitrust scrutiny. [95] Indeed, in 2022, the Federal Trade Commission announced a Section 6(b) inquiry into how vertical integration has affected the access and affordability of prescription drugs.[96] Even if data sharing itself is beneficial, then, other potential harms to competition arising from allowing vertical healthcare transactions may justify stronger enforcement.

Though the effects of patient data-sharing do not currently play a major role in merger review, the FTC recently indicated that it is paying close attention to patient data in the context of consumer protection and data privacy law. In February 2023, Amazon acquired One Medical,

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[94] Thomas M. Moriarty, Testimony to the United States House of Representatives Committee on the Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law: "Competition in the Pharmaceutical Supply Chain: the Proposed Merger of CVS Health and Aetna" (Feb. 27, 2018), available at https://docs.house.gov/meetings/JU/JU05/20180227/106898/HHRG-115-JU05-Wstate-MoriartyT-20180227.pdf.

[95] The FTC has authority to conduct studies without a particular law enforcement purpose under Section 6(b) of the FTC Act. *FTC Launches Inquiry Into Prescription Drug Middlemen Industry*, FEDERAL TRADE COMMISSION, https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry (Jun. 7, 2022).

[96] *FTC Launches Inquiry Into Prescription Drug Middlemen Industry*. Pharmacy benefit managers are the middlemen of the prescription drug industry, connecting drug manufacturers and insurers to help negotiate rebates and fees, create drug formularies, and reimburse pharmacies for patients' prescriptions. As a result, they hold significant sway over the drugs patients choose to take and their price.

a national membership-based primary care practice. The transaction gave Amazon access to more than 220 physician offices, a subscription telehealth service, and an electronic health record and contracts with 9,000 employers.[97] The FTC investigated the transaction, but ultimately declined to challenge its consummation.[98] However, in two statements following the finalization of the merger, the Commission emphasized the risks inherent in allowing the parties to share sensitive health data. Both Amazon and One Medical made representations to their consumers about their future use of the data they would share with the other, including that they would not share consumers' personal health information for advertising and marketing purposes without their permission.[99] In a joint statement, Chair Khan and Commissioners Slaughter, Wilson, and Bedoya warned that failing to live up to these promises could constitute a violation of Section 5 of the FTC Act. They emphasized the importance of transparency regarding how protected health information would be used, calling upon Amazon and One Medical to make clear "not only how they will use protected health information…but also how the integrated entity will use any One Medical patient data for purposes beyond the provision of health care." Commissioner Bedoya also wrote separately to highlight the need for Congress to consider new privacy laws to address the reality of how firms can use health data today.[100]

The Commissioners' statements reveal that the risk posed by mergers enabling information sharing between healthcare entities is not going unnoticed. At the moment, the Commission seems wary of using the merger laws to address potential consumer harm from improper sharing of personal health data. But the FTC has a dual consumer protection and

[97] Rebecca Pifer, *Why Regulators Didn't Challenge Amazon-One Medical Deal, Despite Data Concerns*, Healthcare Dive (March 1, 2023), https://www.healthcaredive.com/news/why-regulators-didnt-challenge-amazon-one-medical-deal-data/643316/.
[98] Rebecca Pifer, *Why Regulators Didn't Challenge Amazon-One Medical Deal, Despite Data Concerns*.
[99] Joint Statement of Chair Khan, Commissioner Slaughter, Commissioner Wilson, and Commissioner Bedoya Regarding Amazon.com, Inc.'s Acquisition of 1Life Healthcare, Inc., FEDERAL TRADE COMMISSION (Feb. 27, 2023)
[100] Statement of Commissioner Alvaro M. Bedoya Joined by Commissioner Rebecca Kelly Slaughter Regarding Amazon.com, Inc.'s Acquisition of 1Life Healthcare, Inc.,

competition mandate, and is thus well-positioned to prosecute misuses of data that constitute unfair methods of competition under Section 5 of the FTC Act. The revised Merger Guidelines may also expand the ability of the agency to target vertical transactions that allow firms to aggregate large amounts of data.[101]

b. Health Insurers and Health Technology Firms

The DOJ tested a novel theory of harm relating to data-misuse in the recent vertical merger of United Health and Change Technologies. United Health Group is one of the top national healthcare insurers, and Change is an operator of insurance claims adjudication technology.[102] The primary theory of harm the DOJ put forth was that post-acquisition, United's access to Change's claims data from rival health insurers would harm competition by allowing United to anticipate and copy rivals' innovations in claims edits. It also alleged that United would lack the incentive to pursue innovation itself, resulting in less affordable or lower quality insurance plans. Lastly, the DOJ argued that harm would furthermore manifest in United's ability to anticipate its rivals' bids on competitive national accounts.[103] The D.C. District Court ultimately dismissed the DOJ's case, arguing that there was insufficient evidence to show United would be incentivized to misuse the data of its rivals or that innovation would be reduced in such a way as to substantially lessen competition in the relevant markets.[104] Still, the theory that certain types of data sharing can soften competition is worth exploring, as the government may deploy it with more success in future cases – particularly in the healthcare sector.

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[101] *Federal Trade Commission and Justice Department Seek to Strengthen Enforcement Against Illegal Mergers*, FEDERAL TRADE COMMISSION (Jan. 18, 2022).
[102] Complaint, *United States et al. v. UnitedHealth Group Incorporated and Change Healthcare, Inc.*, (D.D.C. Feb. 24, 2022).
[103] Complaint, *United States et al. v. UnitedHealth Group Incorporated and Change Healthcare, Inc.*
[104] Opinion, *United States et al. v. UnitedHealth Group Incorporated and Change Healthcare, Inc.*, Case 1:22-cv-00481-CJN (D.D.C. Sept. 21, 2022).

To understand why the government alleged that United's access to Change's data would be harmful, a bit of background on the current health insurance landscape is necessary. United Health Group operates numerous healthcare business lines, including the largest health insurance company in the United States, a pharmacy benefit manager (PBM), and a healthcare technology business that facilitates the analysis of health insurance claims.[105] Change Healthcare operates insurance claims adjudication technology.[106] This technology, called ClaimsXten, enables healthcare insurers to apply custom edits to their plan's cost structures. In the insurance market, cost is a significant driver in the choice between insurance plans for national accounts and large group employers. By implementing creative edits which combat unnecessary costs, Change's editing solution thus allowed it to differentiate itself.[107] Change had 90% of the market in claims editing technology, and nearly all of United's rival health insurers relied on Change's services. United, however, relied upon its own, vertically integrated version of the claims editing technology, called OptumInsight.

The health insurance market also relies upon electronic data interchange (EDI) clearinghouses to transmit claims data between healthcare providers and insurers.[108] Clearinghouses reduce the time it takes health insurers to receive claims and send electronic remittance advice, leading to faster reimbursement for providers. Roughly 50% of all claims data flows through an EDI clearinghouse owned by Change each year. United operated its own, internal EDI clearinghouse, and strictly limited disclosure of the data processed through OptumInsight and its clearinghouse.[109] Change also had absolute data rights to use more than 60% of this claims data for its own healthcare analytics and could access the proprietary plan and

[105] Complaint, *UnitedHealth Group Incorporated and Change Healthcare*, at 4.
[106] *Id.*
[107] *Id.*
[108] *Id*.
[109] *Id,* at 6-7.

payment rules for most health insurance companies it served. [110] Accordingly, neither United nor Change were "neutral" clearinghouse operators. The claims data gathered from their platforms fueled the maintenance and growth of their complementary technologies.

The government claiming that access to Change's data softened competition between United and its rival health insurers, by allowing United to access other insurers' claims edits through the data transferred in Change's EDI clearinghouse. Regardless of whether it acquired ClaimsXten, United would be able to reverse-engineer the claims edits to reveal its competitors' innovations in plan design, benefits, reimbursements, coverage terms, and more.[111] This data could also come from third parties that interact with Change, like healthcare providers or channel partners. As a result, the government argued that neither a firewall nor a divestiture of ClaimsXten would allay anticompetitive concerns.

In the D.C. District Court's dismissal of the case, it argued that there was insufficient evidence to show United would be incentivized to misuse the data of its rivals or that innovation would be reduced so as to substantially lessen competition in the relevant markets.[112] If the government's innovation sharing theory were true, it said, this would require United to "uproot its entire business strategy and corporate culture, intentionally violate or repeal longstanding firewall policies; flout existing contractual commitments; and sacrifice significant financial and reputational interests."[113] It is worth noting that the Court declined to point to any hard evidence that these incentives outweighed those to misuse the newly acquired data.

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[110] *Id,* at 4-5.
[111] *Id,* at 8.
[112] Opinion, *United States et al. v. UnitedHealth Group Incorporated and Change Healthcare, Inc.* ("[T]he central problem with this vertical claim is that it rests on speculation rather than real-world evidence that events are likely to unfold as the Government predicts.")
[113] *Id*.

We learn three important lessons from the Court's rejection of the innovation sharing theory. First, competitively sensitive data shared via vertical mergers may only be problematic if the parties did not previously have access to the data. With pre-existing access, any potential harm from misuse of that data down the line would not be merger-specific. In *UnitedHealth*, The Court found that Optum could already access much of the information underlying the data that passes through Change's EDI clearinghouse, undercutting the basis for its theory that the merger would present a new opportunity to wield this information to its competitive advantage. [114] To strengthen its claim, the government should have sought to identify and quantify the new data Optum would receive through combination with ClaimsXten.[115] Second, the government must weigh the competing incentives companies hold regarding the data being shared. United faced contractual and structural obligations to protect external customers' data, the court pointed out, and the government did not present sufficient evidence to support the contention that United's incentives to collect its rivals' information through this data outweighed its privacy interests. In other words, the Court wanted evidence that United executives were seeking Change's data and data rights *for the purpose* of providing United with its rivals' competitive information. [116]

Lastly, the opinion implicitly validates innovation sharing through data as a practically and economically sound theory of harm. While the judge argued that the theory's application to the UnitedHealth merger was unsubstantiated, they accepted the premise that providing a new source of access to the data of rivals can impair innovation under the right set of incentives.[117]

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[114] *Id*.
[115] *Id.*
[116] *Id*. Court wanted evidence that the merger would instill in United a new ability and incentive to exploit the new and existing information on its rivals. Note that even so, agreed that Optum would acquire some incremental data and corresponding secondary-use rights, so the Court assumed that the government established the first step of its data misuse theory.
[117] E.g., the Court accepted the first step of the theory (see above).

This leaves the door open to consider in what other circumstances it should be deployed, when stronger evidence is available.

V. Conclusion

Inevitably, healthcare companies will continue to find new ways to use data to innovate and compete. Though many of the means in which data-sharing is and can be deployed are beneficial for patients and consumers, we should be wary of instances in which it may soften competition and increase coordination within the industry. As in many areas of our society, the development of healthcare technology has rapidly outpaced developments in the law governing it. There are many open and evolving questions regarding what firms can do with the data being shared, such as if and when re-identification of patients' identity and personal details is possible and whether digital platforms like Google and Amazon will begin to compete with traditional healthcare providers. This uncertainty, along with the wide variation in how data can be used, makes it difficult to deduce general rules regarding the appropriateness of data-sharing from an antitrust perspective. The competitive effects of sharing patient data are very often differ based on the circumstances and markets in which it occurs. Future studies and enforcement actions should focus on whether the purpose and effect of data-sharing is to forestall important innovations, facilitate collusive activity between rivals, allow for consumer exploitation, and otherwise impair the pursuit of competitive markets.