No. 21-2603

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

FEDERAL TRADE COMMISSION,
Plaintiff-Appellee,

v.

HACKENSACK MERIDIAN HEALTH, INC. AND ENGLEWOOD HEALTHCARE FOUNDATION,
Defendants-Appellants,

On Appeal from the United States District Court
for the District of New Jersey
No. 2:20-cv-18140
Hon. John Michael Vazquez

ANSWERING BRIEF OF THE FEDERAL TRADE COMMISSION [PUBLIC REDACTED VERSION]

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QUESTION PRESENTED

This antitrust case involves the acquisition by the largest health system in New Jersey of a key local competitor to its flagship hospital in Bergen County. The hospitals compete both for inclusion in health insurance networks and for patients, constraining prices and spurring quality improvements that benefit local residents. The merger would eliminate that competition, creating a single entity controlling a large share (47 to 65 percent) of the market for inpatient services sold to commercial insurers in Bergen County. That level of control raises a presumption that the merger is unlawful.

The district court granted a preliminary injunction blocking the merger while the Federal Trade Commission conducts an administrative adjudication assessing its legality. The questions presented are:

1. Whether the district court properly defined the geographic market;

2. Whether the court properly found that direct evidence showed a likely harm to competition; and

3. Whether the court properly found that the merger's supposed efficiencies did not overcome its likely anticompetitive effects.

STATUTES AND REGULATIONS

Section 7 of the Clayton Act bars mergers whose effect "may be substantially to lessen competition." 15 U.S.C. § 18.

Section 13(b) of the FTC Act empowers the Commission to seek a preliminary injunction blocking a merger it believes violates the Clayton Act, pending a full administrative proceeding on the merits. 15 U.S.C. § 53(b). The district court may grant the injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of success, such action would be in the public interest." *Id.*

STATEMENT OF THE CASE

A. The Proposed Merger

Hackensack Meridian Health, the largest hospital system in New Jersey, owns two hospitals in Bergen County: Hackensack University Medical Center (HUMC), the county's largest, and Pascack Valley, a smaller facility. This case concerns Hackensack's acquisition of Englewood, a high quality Bergen County hospital just five miles from HUMC. The parties' hospitals provide highly similar services; more than 97% of their commercial admissions are for services offered by both.[1] A777; SA296-97. They compete head-to-head both for patients and for

[1] "Op." refers to the decision below (Dkt. 366; public version, Dkt. 368); "A," to the hospitals' Appendix; "SA," to the FTC's Supplemental Appendix; "DX," to the hospitals' hearing exhibits.

inclusion in the healthcare networks of insurers. Common ownership would eliminate that direct competition, reducing their incentive to improve quality and giving the combined hospitals the ability to demand higher prices from insurers in rate negotiations. Indeed, Hackensack has acquired multiple providers in recent years, [redacted]. Op. 13-14, 51; SA151-55, 174, 204-06. It likely would do so at Englewood, whose prices are far lower than HUMC's.

B. The Economics of Hospital Markets

1. Understanding this case requires understanding the competitive dynamics of hospital markets. Unlike the typical buyer-seller market, the market for hospital services has four participants: *hospitals*, which provide healthcare services; *health insurers*, which negotiate the prices of hospital services, market health plans to employers and employees, and pay the bulk of the bills; *employers*, who select among competing plans to offer employees; and *policyholders*, the employees who choose which insurance plan to buy, use hospital services, and decide which hospital to use.[2]

The relationship between these four participants is complex. Insurers compete with one another to sell policies and therefore must offer plans attractive to employers and employees. Whether a policy is attractive depends both on price

[2] Policyholders are consumers, members, and patients. Insurers are payors.

and on the desirability of the service providers, including hospitals, in the insurance "network" – the providers that have agreed to provide treatment at negotiated prices, which are usually much lower than those of out-of-network providers. A policy that requires the purchaser to use inconvenient hospitals will be unattractive. Insurers thus strive to assemble a desirable network at the lowest cost. SA138-39, 245, 247-48. Because insurers, not policyholders, negotiate prices, they are the hospitals' direct customers. A763, 616; SA293-94.

Competition between hospitals takes place in two distinct but interrelated stages. In stage one, hospitals compete to be in an insurer's network (largely on price); in stage two, hospitals compete to attract individual members of an insurer's plan (largely on non-price factors). Op. 34; *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 342 (3d Cir. 2016); *see, e.g.*, Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 Antitrust L.J. 671, 684-85 (2000).

Inclusion in the insurer network provides a hospital with a ready source of patients. Insured patients rarely choose out-of-network providers because plans typically do not cover out-of-network care at all or require patients to bear much more of the cost. Thus, an out-of-network hospital likely will lose access to that insurer's members. Op. 12.

Once price has been established, hospitals compete for business almost entirely on the basis of quality and convenience. Op. 34; SA07; A765-66, 771-72.

Insured patients typically face no significant price difference between in-network hospitals and choose based on other factors instead. One especially important factor is location; patients typically demand access to local care. A hospital's proximity to policyholders therefore is a core consideration for insurers when assembling their provider network. Op. 11; SA02-03, 137, 29, 177-78.

2. Each health insurer negotiates prices for services with each hospital (or system). *See* Op. 12. Like any bargaining process, both sides have some leverage, and the agreement reached depends on the relative strength of their leverage.

The insurer's leverage depends on the number of patients it can potentially provide to the hospital. The hospital's leverage depends on how important it is to the insurer's network, which reflects both patient preferences for the hospital and the availability of desirable substitute hospitals. If the insurer can exclude the hospital from its network and include a close substitute instead, it can resist a demand for higher prices. If, however, the insurer needs to include the hospital to offer an attractive network, it will have little choice but to pay higher rates the hospital demands, giving the hospital substantial leverage. Otherwise, its policy will not be attractive to buyers. SA125-26, 71, 213, 286-87; A766-69; *see ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 562 (6th Cir. 2014); *St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health System*, 778 F.3d 775, 784-85 (9th Cir. 2015) ("*St. Luke's*").

Greater hospital competition leads to lower prices. The more hospitals that compete for inclusion in insurance networks, the stronger the insurer's ability to resist price increases. SA124-25; A767-68; *see ProMedica*, 749 F.3d at 562. The benefits flow directly to consumers via lower premiums, co-payments, and deductibles. Competition also spurs improvements in quality-of-care. SA04-06, 28.

When competing hospitals merge, the new entity has greater leverage because there are fewer substitutes for insurers. SA283-88. The increased leverage leads to higher reimbursement rates, higher insurance premiums, and reduced incentives to compete on quality-of-care. SA147-48, 220; A771. An insurer facing a hospital with increased leverage will agree to pay more because doing so is preferable to marketing a network that lacks the hospital. Courts frequently recognize these dynamics. *See, e.g.*, *Hershey*, 838 F.3d at 342-43; *ProMedica*, 749 F.3d at 562; *FTC v. Advocate Health Care Network*, 841 F.3d 460, 470-71 (7th Cir. 2016).

3. The record below showed that this bargaining model depicts the commercial reality for Bergen County hospitals and insurers. Five main commercial insurers offer plans covering Bergen County: Horizon, United, Aetna, Cigna, and AmeriHealth. Testimony from multiple insurers confirmed that the outcome of price negotiations turns on their relative bargaining leverage with hospitals. As one insurer testified, if there are "a limited number of providers" to

choose from, "the less leverage you have in the negotiation to drive better rates." SA231-32; *see also* SA21-22. In particular, if an insurer has "another option within a reasonable geographic distance to the membership," the hospital's "leverage comes down." SA125; *see also* SA22-23. Others testified similarly. SA213, 220-21, 224-25, 249-55.

Bergen County hospital executives confirmed that prices turn on leverage. [redacted] a hospital with greater leverage has "a greater ability to achieve [its] goal," which is to "extract as much . . . revenue" as possible "from the insurer." SA242, 238-39; *see also* SA119. Appellants agreed: the executive responsible for insurer contracting testified that Hackensack's only negotiating goal is increasing revenue, and it brings to the table all the leverage it has to maximize its prices. SA36-37; 74-75. Englewood executives likewise recognize this relationship between hospital leverage and prices. *See* SA59.

C. The Preliminary Injunction

In 2019, Englewood agreed to be acquired by Hackensack. Op. 22. Believing that the merger would be anticompetitive, the Commission voted unanimously to challenge the deal in an administrative proceeding. The Commission also sought a preliminary injunction to stop the merger pending resolution of the administrative case. Op. 29-30.

After discovery and a seven-day evidentiary hearing, including 22 witnesses and over 500 exhibits, the district court held that the proposed merger likely violated the Clayton Act and preliminarily enjoined it.

1. The Relevant Markets

The court began with a "fact-specific analysis" of the relevant product and geographic markets. Op. 32. It found that the product market is the cluster of general acute care inpatient services offered by both parties and sold to commercial insurers ("inpatient services"). Op. 32-33. That determination is uncontested here.

The relevant geographic market, the court determined, is Bergen County. The court accepted the economic hospital/insurer bargaining model described above. Op. 10-14, 33-35. It determined that the geographic market is where insurers, the buyers of hospital services, could practicably turn for alternatives as they assemble their provider networks. Op 33-34. The insurer's view of practicable substitutes is in turn driven by patient preferences for local hospitals. Op. 34-35. Assessing the evidence, the court determined that Bergen County residents demand access to Bergen County hospitals, and that an insurer could not market a viable policy without an in-county hospital. Op. 34-36.

a. The court confirmed that Bergen County was a proper geographic market by applying the hypothetical monopolist test, a standard economic tool of market definition. That test assesses whether buyers would rather accept an increase in

price than seek a good or service outside of a proposed geographic market. It considers whether one entity that owns all sellers in the proposed market could impose a "small but significant, non-transitory increase in price" – a "SSNIP" (pronounced "snip") – of at least five percent at any facility without driving away enough consumers to make the increase unprofitable. Op. 33-34; A773-74. If the monopolist could successfully demand the price increase, then that area is a relevant geographic market. Op. 33-34; A774.

The court determined that a hypothetical monopolist owning all Bergen County hospitals could profitably impose a SSNIP. Op. 35. The court found that insurers would accede to a SSNIP "to continue competing in the county," rather than offer a plan without a Bergen County hospital in-network. Op. 34-36. At bottom, the court determined as a factual matter that insurers "could not market a plan to Bergen County residents if the plan did not include a Bergen County hospital." Op. 12, 35-36.

In particular, the court found, Bergen County residents strongly prefer to stay within the county for inpatient hospital care – more than 75% of them use in-county hospitals. Op. 40 (noting the hospitals' expert did not dispute that statistic); SA300-01 ("strong preference" for in-county care). Insurers recognized this reality, routinely incorporating patients' preference to stay close to home in their market analyses. *See* SA137, 144-45, 160-65. Ordinary course assessments estimated that

many Englewood patients would go to Hackensack's Bergen County hospitals if Englewood went out-of-network, and vice versa. *See, e.g.*, SA143-44, 203 ([redacted] of [redacted] Englewood members would go to HUMC); SA160-61, 208 ([redacted] of [redacted] HUMC members would go to Englewood), SA207 (Pascack Valley); *see also* SA258 (Horizon).

In addition, the court determined that Bergen County is an especially important area for insurers because of its large volume of commercially insured patients and its affluence. Op. 12, 38. It found that "insurers treat Bergen County as a significant target within the larger New Jersey market," specifically looking at Bergen County as they build networks to ensure their plans are attractive to Bergen County policyholders. Op. 38. For example, [redacted] "drills [coverage] down to the county level" and considers Bergen County a "submarket" of the larger New Jersey area. SA127, 143. AmeriHealth likewise tracks membership and sales in Bergen County and has tried to grow its membership there. SA17. Horizon, too, acknowledged the county's importance. SA39. Other insurers agreed. SA158-59 ([redacted]); A484 ([redacted]).

Testimony by all five major insurers confirmed that they "cannot offer a marketable plan in Bergen County that does not include a Bergen County hospital." Op. 35, 12, 38, 43; SA131-32, 134 ([redacted]), SA11-12, 218 (Aetna), SA21, 25 (AmeriHealth), SA40-41 (Horizon), SA367-68 ([redacted]). As an Aetna

executive put it, an insurer without an in-network Bergen County hospital trying to sell policies to residents there will "lose those cases nine times out of ten" to a competitor whose network includes a local facility. SA11-12. To continue competing in the county, insurers would be forced to accept a price increase from a hypothetical monopolist.

b. Expert testimony reinforced the insurer testimony. The Commission's expert, Dr. Dafny, demonstrated that the county is economically significant to insurers and that they want to market a plan that is attractive to Bergen County residents. A780-81; SA303-08. The qualitative evidence showed that the hypothetical monopolist test was satisfied: insurers would accede to a price increase rather than stop marketing plans there. A783-84, 883-84; SA303-08.

Dr. Dafny also quantified the "negotiating leverage that a hypothetical monopolist of Bergen County hospitals would have as to insurers" using a "willingness to pay" (WTP) analysis. Op. 36. WTP measures the value of specific hospitals to an insurer's network and the change in bargaining leverage from a merger. A784-85, 1034-35. Dr. Dafny showed that a single owner of all Bergen County hospitals would have far more leverage than separate owners negotiating independently, and that this added leverage would translate to a sizeable price increase. Op. 36; SA308-10; A784-85, 1035-36. The court credited that analysis, which confirmed that a Bergen County market satisfies the hypothetical

monopolist test – whether considering "all hospitals in Bergen County" or "all hospitals that serve Bergen County patients." Op. 36, 42.

2. Clayton Act Analysis

The court applied the three-part framework used in Clayton Act cases. Op. 31-32. The FTC first must show a *prima facie* case that the merger is likely to be anticompetitive. Op. 31. That showing raises a presumption of illegality. Op. 32. The hospitals then may rebut the presumption by showing "'either that the combination would not have anticompetitive effects or that the extraordinary effects of the merger will be offset by extraordinary efficiencies resulting from the merger.'" *Id.* (quoting *Hershey*, 838 F.3d at 337). If they make that showing, then the burden of production shifts back to the FTC, which always bears the ultimate burden of persuasion. *Id.*

a. Presumption of illegality

The district court found that the FTC showed a *prima facie* case. It measured market concentration using the Herfindahl-Hirschman Index (HHI), a common economic tool used to determine whether a merger is likely to enhance market power. Op. 44; *Hershey*, 838 F.3d at 346-47. The HHI is calculated by summing the squares of the market shares for all market participants. *Hershey*, 838 F.3d at 347. "A post-merger market with a HHI above 2,500" is "highly concentrated, and a merger that increases the HHI by more than 200 points is presumed likely to

enhance market power." *Id.* (cleaned up). High market concentration based on HHI alone can establish a *prima facie* case. *Id.*

The court recognized two ways of calculating HHI for the Bergen County market, both of which raised a presumption of unlawfulness. Under a "hospital-based" approach, only hospitals physically located in the county are considered. *See* Op. 45 n.25; A788-89, 791. That includes Hackensack's HUMC and Pascack Valley, with a 51% share of inpatient discharges; Valley, with 24%; Englewood, 15%; and Holy Name, 10%. SA314. A combined Hackensack-Englewood would command over 65% of the market. *Id.*; A788-89. This approach produces a post-merger HHI of 5,002, an increase of 1,510, far exceeding the presumption threshold. *See* Op. 45 n.25; SA313-14.

A "more conservative" "patient-based" approach considers both the hospitals in Bergen County and hospitals outside the county that are used by county residents. Op. 44-45; A787-88. That approach added more than 50 hospitals to the calculus, yielding a market share for Hackensack of 35% and for Englewood of 12%. SA342-43. Their combined 47% share dwarfed the next two closest competitors, Valley, with 21%, and Holy Name, with 9%. A788; SA312-13. This method produced a post-merger HHI of 2,835, an increase of 841, also raising a

presumption of illegality. Op. 44-45; SA313. Under either approach, the HHI figures alone established a *prima facie* case.[3] Op. 45 & n.25.

b. Anticompetitive effects

Apart from HHIs, the court found separately that "direct evidence supports the conclusion that the merger will substantially lessen competition in Bergen County," in several ways. Op. 46.

Elimination of close competition. Ordinary course documents and internal emails showed that Hackensack and Englewood are close competitors. Each hospital routinely described the other one as a competitor. Op. 18-19, 47. In particular, internal Englewood emails recognized Hackensack as "a fierce but respected competitor," SA65, expressed concern that sharing information would "[redacted]," SA196, and questioned whether Hackensack's motivation for the merger may be because Englewood has been "[redacted]" SA198; Op. 47. Hackensack's CEO also acknowledged that Englewood is a competitor. Op. 47; SA68. The court rejected the parties' "mantra" that they are "complements rather than competitors." Op. 18-19. The merger would eliminate their competition. Op. 47-49, 53.

[3] These shares were consistent with the hospitals' views of their shares. SA13-15 (49.5% combined share in Englewood PSA); SA193; SA185 ([redacted]); SA117 (46.1% combined); *see* Op. 46.

Insurers also "viewed the two as competitors." Op. 41. As noted, insurers estimated that many Englewood patients would go to Hackensack's Bergen County hospitals if Englewood went out-of-network, and vice versa. *See supra*, 9-10. Diversion models by the FTC's expert yielded similar results. Op. 47-48; A794-95. HUMC in particular "places a strong competitive constraint on Englewood" – one the merger would remove. Op. 48; A795.

The court found that such patient preferences inform "insurers' decisions when creating networks and negotiating rates." Op. 48, 43. As it explained, "if an insurer knows that individuals frequently choose Hospital A over Hospital B, that insurer would want Hospital A in its network because that hospital makes the network more desirable." Op. 43. Insurers considered Hackensack and Englewood competing alternatives for networks; their merger would eliminate a key alternative and diminish insurer leverage relative to Hackensack. It also would give Hackensack a huge percentage of insurers' Bergen County business. Op. 46; SA201 ([redacted] of [redacted] inpatient business); SA166 ([redacted] of [redacted]). Accordingly, many insurers believed the merger would have anticompetitive effects, which the court found persuasive. Op. 46-47.

Higher prices. The reduction in competition would likely lead to higher prices. Op. 48-52. Using a conversion factor from a peer reviewed study of consummated hospital mergers, Dr. Dafny translated Hackensack's projected gain

in leverage from the merger into higher prices, estimating a price increase of $31 million per year. The court credited that estimate, finding her methodology sound and supported by "substantial literature." Op. 48-49; A798, 864.

Hackensack's conduct after prior acquisitions confirmed the likelihood of higher prices. After each acquisition, the court found, Hackensack "[redacted]." Op. 14, 51; SA174. More broadly, the court found that adding Englewood "will further increase Hackensack's leverage with insurers." Op. 52 n.31. Hackensack "has historically been able to negotiate higher rate increases than Englewood," so likely "will be able to do so after the merger (with the benefit of having added Englewood to its portfolio)." Op. 52.

Non-price harms. The court found likely harm to non-price measures of competition. The record showed that the parties had closely monitored each other's service offerings to gain a competitive edge, purchasing advanced technology "to keep up with" or outpace the other and pursuing higher quality ratings. Op. 53. "If Englewood and HUMC were no longer competitors," the court concluded, neither would have the same "incentive . . . to continue to improve quality metrics and offer innovative medical technology." *Id.* Indeed, when Englewood was considering merger partners, one "pro" favoring Hackensack over an out-of-market

suitor was "[redacted]" SA216 – *i.e.*, "future competition between HUMC and Englewood." Op. 53.

c. Rebuttal

The court rejected the hospitals' claims that the merger's benefits (or "efficiencies") overcame its anticompetitive effects. To begin with, many alleged benefits were unsupported or overblown. The court rejected as unreliable a document central to the hospitals' defense – the parties' "Optimization Plan," created after they agreed to merge, which "reads like an advocacy piece created for the current litigation." Op. 59-61.

The court found that the evidence largely did not support the hospitals' promised benefits – upgrades and increased capacity at Englewood, relieved capacity and service expansion at HUMC, service optimization, and quality improvements. *See* Op. 57-65. It found that "many of the 'hard commitments'" to expand services at Englewood in fact were merely "to explore" issues, or not enforceable. Op. 57. And the court doubted the need for the merger to relieve capacity constraints. The claim rested on testimony the court found unpersuasive, Op. 58, and *no* "ordinary course documents discuss[ed] HUMC's capacity challenges before Englewood sought a merger," Op. 26.

Even benefits the court recognized might occur – such as upgrades to Englewood's physical plant – were "not as comprehensive or firm as represented

. . . during the hearing." Op. 57. Quality improvements, too, were unlikely to be significant. Op. 65. In any event, the benefits would not be substantial enough to offset the merger's likely harms. *Id.*

The court concluded that the hospitals had failed to rebut the FTC's *prima facie* case and that the FTC was likely to succeed in showing the merger unlawful. Op. 65-66. It alternatively held that the FTC met its ultimate burden of persuasion. Op. 66 n.40. Weighing the equities, the court found they favored the injunction. Otherwise, if the Commission found the merger unlawful, it would "be difficult to unscramble the proverbial egg" after consummation. Op. 66.

SUMMARY OF ARGUMENT

The Commission will determine in an administrative proceeding whether the effect of Hackensack's proposed acquisition of Englewood "*may be* substantially to *lessen competition*." 15 U.S.C. § 18 (emphasis added). The only question here is whether the FTC has shown that it will likely succeed in making that ultimate showing, which itself requires only a likelihood that the merger will be anticompetitive. As the district court found after assessing a substantial factual record, the answer is clearly yes.

Hackensack and Englewood, with neighboring, high-quality hospitals providing highly similar inpatient services, currently compete for inclusion in health insurer networks that cover Bergen County. That head-to-head competition

motivates quality-of-care improvements and innovation that benefit patients. It also acts as a restraint on prices, which are set through rate negotiations with insurers. The insurers' bargaining leverage in that process depends on their having adequate fallback options to assemble a marketable healthcare network if a deal cannot be reached. By eliminating a key alternative hospital, the acquisition will substantially reduce that leverage, likely leading to higher prices and lower incentives to improve quality. The effect will be especially pronounced at Englewood, which currently has much lower prices that Hackensack almost surely will increase.

The district court's factual findings were correct, and the hospitals barely challenge them. The court's determinations of the market and the merger's likely anticompetitive effects flow directly from the facts and are plainly proper under, if not outright compelled by, this Court's opinion in *FTC v. Penn State Hershey*, 838 F.3d 327 (3d Cir. 2016).

1. The district court properly found Bergen County to be a relevant geographic market for antitrust purposes. It applied the hypothetical monopolist test, which showed that insurers would rather accept a price increase than try to market a plan that did not give members access to a Bergen County hospital. The evidence showed that the vast majority of Bergen County residents – 77% – seek inpatient hospital care within the county. Insurers must cater to those strong preferences because Bergen County – the most populous county in New Jersey,

with a huge number of commercially insured patients – is essential to the insurers' businesses. Every major insurer in the area testified that a plan without a Bergen County hospital would not be viable; insurers plainly would pay higher prices rather than abandon Bergen County business.

Bergen County is a proper market whether the Court considers all hospitals used by county residents (a "patient-based" approach, including hospitals outside the county), or all hospitals physically located in-county (a "hospital-based" approach). Both approaches pass the hypothetical monopolist test and are fully supported by the evidence. Likewise, both yield market shares and concentration levels that raise a presumption that the merger is anticompetitive. Unanimous insurer testimony showed, and the court found, that insurers would sooner pay more than try to market a policy that does not include a Bergen County hospital – the very evidence this Court relied on in *Hershey* to define the market. The hospitals do not challenge the district court's factual finding on that score, which is enough in itself to sustain the judgment.

Insofar as the district court employed a patient-based approach to the market, the law does not require the Commission to have shown that Bergen County patients can be charged more than those living elsewhere. That "price discrimination" principle may make sense in other contexts, but it does not

sensibly apply here, where insurers negotiate prices and pay the bills, but patients select the hospital and receive the services.

2. Market concentration statistics raised a presumption of anticompetitiveness that would have sufficed by itself to shift the burden to the hospitals. But the court went further and found as fact that direct evidence – documents, testimony, and expert analysis – proved that the merger would likely have anticompetitive effects such as significant price increases and diminution of incentives to improve quality. Indeed, Englewood's own documents showed that it wished to merge with Hackensack – which it dubbed a "fierce but respected competitor" – at least in part to avert future local competition. The direct evidence independently satisfied the FTC's burden to demonstrate it likely would succeed in showing a Clayton Act violation. Further, the court properly credited as methodologically sound and supported by the evidence the FTC's economic model showing that the bargaining leverage Hackensack would gain from the merger would lead to price increases of $31 million per year. Substantial economic literature corroborated this connection between leverage and prices, and the court found the FTC's expert credible. Other evidence – largely ignored by the hospitals – separately showed sufficient anticompetitive effects to make the merger unlawful, including elimination of the hospitals' direct competition and reduced incentives to innovate and improve quality-of-care.

3. The district court properly rejected the hospitals' claim that the merger's anticompetitive effects were overcome by its alleged efficiencies (which the hospitals euphemistically term "procompetitive benefits"). To the extent the Clayton Act even allows such a defense, *Hershey* requires that efficiencies be "extraordinary," which the district court found they were not. Even if the standard were less demanding, however, the court's findings show that the hospitals could not meet it. The court rejected their principal "proof" of improvements in service as an unreliable, made-for-litigation, advocacy document without credibility. It likewise rejected testimony of the hospitals' experts as non-credible and unsupported by underlying evidence. The court properly concluded that the likely harm from the deal outweighed the hospitals' speculative plans and promises.

STANDARD OF REVIEW

This Court reviews a district court's "findings of fact for clear error, its conclusions of law *de novo*, and the ultimate decision to grant the preliminary injunction for abuse of discretion." *Hershey*, 838 F.3d at 335 (cleaned up). A fact finding is clearly erroneous only if it is "completely devoid of a credible evidentiary basis." *FTC v. Lane Labs-USA, Inc.*, 624 F.3d 575, 582 (3d Cir. 2010).

Geographic market determinations are fact-intensive and typically reversed only for clear error, especially if they turn "on the 'special characteristics' of the healthcare market." *Hershey*, 838 F.3d at 335; *see also Brown Shoe Co. v. United*

States, 370 U.S. 294, 336 (1962) (noting "pragmatic, factual approach" to market definition). Application of a wrong legal standard, which can include "an erroneous economic theory," is subject to plenary review. *Hershey*, 838 F.3d at 336.

The decision below may be affirmed on any ground supported by the record. *TD Bank N.A. v. Hill*, 928 F.3d 259, 270 (3d Cir. 2019).

ARGUMENT

Section 7 of the Clayton Act prohibits mergers that "may" substantially lessen competition "in any line of commerce" and "in any section of the country." 15 U.S.C. § 18. Congress used the word "may" deliberately to "indicate that its concern was with probabilities, not certainties," making liability "relatively expansive." *Hershey*, 838 F.3d at 337 (cleaned up). Doubts must be resolved against the transaction. *Id.*

The FTC enforces Section 7 and can sue in district court to preserve the *status quo* pending an administrative hearing on the merits. 15 U.S.C. § 53(b). In seeking a preliminary injunction, the FTC "is not required to *establish* that the proposed merger would in fact violate Section 7." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001); *Hershey*, 838 F.3d at 337. It must show only some likelihood that the merger will be found unlawful in the FTC proceeding, which it can do by raising "questions going to the merits so serious" and "substantial" that

they are "fair ground" for "determination by the FTC in the first instance."[4] *Heinz*, 246 F.3d at 714-15, 727 (court need not decide which party "will carry the day"); *FTC v. Warner Comms. Inc.*, 742 F.2d 1156, 1162 (9th Cir. 1984); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1218 (11th Cir. 1991). If that is shown, the court will grant an injunction after weighing the equities if it is in the public interest. *Hershey*, 838 F.3d at 337, 353 (emphasizing "limited scope" of inquiry).

I. BERGEN COUNTY IS A PROPER GEOGRAPHIC MARKET.

A relevant geographic market "is that area in which a potential buyer may rationally look" for the services it seeks. *Hershey*, 838 F.3d at 338 (cleaned up). In the merger context, it is any area "where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 357 (1963). It must "correspond to the commercial realities of the industry" and "be economically significant." *Brown Shoe*, 370 U.S. at 336-37; *Hershey*, 838 F.3d at 338.

As shown below, the district court properly determined that Bergen County was a relevant geographic market. Much of the hospitals' brief is devoted to an attack on that holding, mostly on the ground that the court improperly defined a "patient-based" market instead of a "hospital-based" one. There was no error, as

[4] The hospitals ignore this important distinction, wrongly suggesting the FTC must meet the underlying Clayton Act standard here. *See, e.g.*, Br. 25, 46, 49.

we explain, but more fundamentally the claim is misdirected for two independent reasons. First, the distinction between the two approaches in this case pertains only to how market shares are calculated; under either approach, the Bergen County market passes the hypothetical monopolist test, and the merger is presumptively illegal. Second, wholly apart from the market share analysis, the court found (as discussed in Argument II) direct evidence that the merger would have anticompetitive effects in Bergen County.

A. The Court Properly Determined That Bergen County Is A Relevant Geographic Market.

To define the geographic market, the district court applied the hypothetical monopolist (or SSNIP) test, an approach supported by both sides. Op. 33. Drawing on both fact and expert testimony, the court concluded that Bergen County was a relevant antitrust market because a hypothetical owner of all hospitals there could profitably demand a substantial price increase from insurers. Op. 35-36. Bergen County is especially important to insurers because of its large population of commercially insured residents, who demand local care, so no rational insurer would try to sell a policy that offered access only to out-of-county hospitals. *See* Op. 38. Insurers would rather pay higher reimbursement rates than lose Bergen County customers to competitors who offer local hospitals. Op. 35-36.

Those factual findings rested on conclusive record evidence. Executives of the five major insurers in the area testified that commercially viable plans must

include local Bergen County hospitals. Op. 12. [redacted] explained that Bergen County is [redacted] "most populous county" with about [redacted] members, and those members require access to local care. SA126, 131. Any plan marketable to them must include Bergen County hospitals. SA131, 134, 128 (HUMC and Englewood were both "critical participants to an attractive Bergen County network"). Aetna likewise confirmed that Bergen County members would not buy a plan without Bergen County hospitals; an insurer that does not offer in-county hospitals would lose business to a competitor that does "nine times out of ten." SA11-12, 158-59. Tellingly, neither Aetna nor [redacted] has ever tried to market a network without them. SA11-12, 130-31. (Nor is there evidence that any other local insurer has tried.)

All other insurers agreed. *See* SA25, 79 (AmeriHealth); SA367-69 ([redacted]). Even Hackensack's joint venture partner Horizon conceded that it could not sell a plan to county residents and employers that did not include any Bergen County hospital. Op. 15 n.11; SA40-41, 228. A local broker and local employer concurred too. SA26-27, 32-33. Horizon testified that it would accept a rate increase from all hospitals serving its Bergen County members and employers rather than stop selling plans there, SA41; [redacted] "would likely be forced" to do the same, SA233-34. In short, the commercial realities show that Bergen County "is that area in which a potential buyer may rationally look." *Hershey*, 838 F.3d at 338.

Ordinary course documents backed up this testimony. [redacted] determined that [redacted] of its Bergen County members seek inpatient care in-county, and estimated that [redacted] of members using Englewood for elective services would turn to other Bergen County hospitals if it went out-of-network. SA136-37, 143-44, 201-03. [redacted] determined that if Englewood, HUMC, or Pascack Valley went out-of-network, its insureds would go to alternative in-county hospitals. SA160-65, 200, 207-08. [redacted] reached the same conclusion for HUMC and Pascack Valley. SA211.

Expert economic testimony ratified this evidence. The Commission's expert, Dr. Dafny, testified that Bergen County residents have a strong preference for local hospital care, with "the vast majority" – "more than three-quarters" – of residents relying on inpatient services provided in-county. A778-80. She further concluded that, with 600,000 insureds, Bergen County is economically significant to insurers; they "want to offer health plans that [are] attractive to residents of Bergen County." A781-82; *see also* SA39-40. Dr. Dafny explained that these marketplace realities mean that insurers would rather accept a substantial price increase than try to sell a plan without a Bergen County hospital. A783-84. As insurers themselves had testified, they "wouldn't choose to just give up on Bergen County," but "would accept the SSNIP." *Id.*; *see also* A1031-32; SA233-34, 372-73. Bergen County thus was "a relevant geographic market." SA297-310.

Dr. Dafny's quantitative "willingness to pay" analysis confirmed this conclusion. Her analysis showed that a single owner of all Bergen County hospitals would gain substantial bargaining leverage over insurers with members in Bergen County. Using data for Bergen County patients, WTP would be 65% greater for a monopolist than if the hospitals negotiated independently, which translates to a price increase of 37% – far more than a SSNIP. Op. 36; A784-85, 1035; SA308-09. An additional analysis took into account the same set of Bergen County hospitals, but used data for all patients in a broader four-county area; that assessment also found a large WTP increase (49%), and also yielded a price increase exceeding a SSNIP (28%). Op. 36; A1035-36; SA309-10.

On that record, the court was correct to conclude that the FTC's "proposed geographic market of Bergen County" satisfies the hypothetical monopolist test. Op. 35-36. The court found as fact that "[a]ll insurers who testified indicated that they could not market a plan to Bergen County residents if the plan did not include a Bergen County hospital." Op. 12, 35. Given Bergen County's size and importance, insurers would not simply abandon doing business there but "would be forced to accept a SSNIP" to "continue competing in the county." Op. 35-36.

Hershey dictates that the district court's market determination was correct. There, this Court applied the same test "through the lens of the insurers," relying on the same kind of insurer testimony to conclude that a market is properly defined

if insurers could not sell a plan without a hospital from the proposed market. 838 F.3d at 342, 345. The Ninth and Seventh Circuits have reached the same conclusion. *See St. Luke's*, 778 F.3d at 784-85; *Advocate*, 841 F.3d at 474.

B. The Hospitals Have Shown No Error In The Court's Analysis.

The hospitals challenge none of the court's core factual findings, which were central to its geographic market determination. Op. 35-36, 38. They do not dispute that Bergen County is an important area of competition for local insurers (as well as for Hackensack and Englewood). *See* Op. 38, 46. And they agree that the hypothetical monopolist test is a proper method of market definition. Op. 33; Br. 6-7, 33-34.

Their complaint about the geographic market comes down to a claim that the court should have used a "hospital-based" approach to "define the relevant geographic market" rather than a "patient-based" one. Br. 1, 24. But the distinction makes no ultimate difference, because on this record the two approaches do not produce meaningfully different results for Clayton Act purposes. Rather, they boil down to alternative ways of calculating shares of a Bergen County market.[5] The record supports both approaches, both show that a Bergen County market passes the hypothetical monopolist test, and either demonstrates a presumptively unlawful

[5] *See* Capps, *Continuing Saga*, cited *infra* at 34 (SA115) (noting the distinction "is only relevant to the structural exercise of calculating market shares and drawing inferences from concentration statistics").

merger. *See* Op. 42, 44-45. Indeed, the hospital-based approach demanded by the hospitals shows even *higher* combined market share (65% vs. 47%), HHIs (5,002 vs. 2,835), and increases in concentration (1,510 vs. 841). A857-59; SA312-15. In any event, the hospitals are wrong that a patient-based approach is invalid. They identify no error, much less reversible error.

1. The record supports a hospital-based approach.

The Court "may affirm on any basis supported by the record." *TD Bank*, 928 F.3d at 270; *see also Edinboro Coll. Park Apts. v. Edinboro Univ. Found.*, 850 F.3d 567, 580 (3d Cir. 2017). As discussed above, the record showed – and the court recognized – that a market of all Bergen County hospitals passed the hypothetical monopolist test. Op. 12, 35-43; *supra*, 25-28. Marketplace realities likewise support it. Op. 35-36. The market therefore satisfies *Hershey*'s requirements for a geographic market. 838 F.3d at 345-46.

The hospitals primarily contend that a hospital-based market cannot be the basis for an injunction because the Commission's expert did not "propose" it. Br. 33-34. In fact, Dr. Dafny presented evidence that supports both market formulations. *See* SA297-315; A783-86, 883-84, 1034-36. She showed that a hypothetical monopolist of all Bergen County hospitals could profitably impose a SSNIP, not only on insurers marketing plans in Bergen County, but also in a broad area covering Bergen, Essex, Hudson, and Passaic counties. A1035-36; SA309-10

(showing 49% WTP increase and 28% price increase); Op. 36. She also calculated HHIs using hospital-based shares and found that the presumption of illegality was stronger using that approach. A857-59; SA313-14; Op. 45 n.25.

More importantly, there is no requirement that a relevant antitrust market originate with, or be formally proposed by, a party's expert. This Court has upheld an antitrust market where the FTC's expert "did not 'endorse' the market" that was "ultimately defined," but "his testimony supported [that] market definition." *FTC v. AbbVie Inc.*, 976 F.3d 327, 373 (3d Cir. 2020) (affirming market defined "in terms no expert had endorsed"). As the Supreme Court has recognized, antitrust cases turn on "market facts," and while expert testimony is "useful as a guide to interpreting" those facts, it "is not a substitute for them."[6] *Brooke Group v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993); *Brown Shoe*, 370 U.S. at 325 (market turns on "practical indicia"). Indeed, *Hershey* demonstrates that a relevant market need not be based on experts at all: there the Court relied exclusively on fact evidence – insurer testimony – to determine the geographic market. 838 F.3d at 345-46.

[6] There is no one-size-fits-all rule for whether market definition calls for experts. *See, e.g.*, *Kentucky Speedway v. Nat'l Assoc. of Stock Car Auto Racing*, 588 F.3d 908, 919 (6th Cir. 2009) (making case-specific determination); *McWane, Inc. v. FTC*, 783 F.3d 814, 829-30 (11th Cir. 2015) (only "in some circumstances").

The hospitals' comeback is that Dr. Dafny did not sufficiently analyze the degrees of competition between specific hospitals to support a hospital-based market. Br. 34-35. No such evaluation was required on a record that overwhelmingly showed that no insurer would attempt to market a network excluding all Bergen County hospitals and that insurers did not view hospitals outside the county as viable alternatives to in-county hospitals. *See supra*, 25-28.

2. A patient-based approach is valid.

Because the Court can affirm for the reasons discussed above, it need not reach the hospitals' criticism of "patient-based" market definition. But the Commission also showed that a patient-based approach is valid, and the hospitals' complaints about that approach are meritless. Their grievance is that a patient-based analysis results in an unduly *narrow* market that exaggerates the merger's harm by inflating shares and, accordingly, the HHI-based presumption. *E.g.*, Br. 26 (claiming market "inaccurately ignores the real scope of competition."). As the court correctly found, however, the patient-based method, which analyzed a broad set of more than 50 hospitals (including in New York City and elsewhere), was "the more conservative of the two approaches." Op. 45 n.25. Under a hospital-based approach, the parties' market shares are larger and the HHI-based presumption is even stronger. *See* SA312-14.

a. Price discrimination was not required.

Even if the hospitals' position made logical sense, it is wrong on the law and oversimplifies the commercial realities in healthcare markets. Their claim largely comes down to the proposition that a patient-based approach may be used only with proof of "price discrimination," which they say means that patients inside the market can be charged higher prices than those outside. Br. 25-32. Because the FTC did not present such evidence, the argument goes, the court's market was unlawful. The claim fails on multiple grounds.

To begin with, the argument rests entirely on a section of the antitrust agencies' Horizontal Merger Guidelines; the hospitals cite no statutes or judicial precedent establishing their proposition. But this is insufficient to prove that the court erred as a matter of law in defining the market. Contrary to the hospitals' view (Br. 31), the Guidelines do not remove the FTC's "discretion to use" a customer-based market without also showing price discrimination. *See* U.S. Dep't of Justice & FTC, *Horizontal Merger Guidelines*, §§ 1, 4.2 (2010) (SA84-85, 96-98). Indeed, such a straightjacketed reading is inconsistent with the Guidelines' very nature as a flexible policy tool for assessing a broad range of situations. *See* SA84-85; *Chi. Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 434 n.13-14 (5th Cir. 2008) (Guidelines are not binding on the courts or the Commission, and instruct flexibility). That is why the Guidelines use words like "normally" and "may,"

SA96-98 (§ 4.2); explicitly caution that merger analysis "does not consist of uniform application of a single methodology," SA84-85 (§ 1); and explain that they neither describe how the FTC litigates cases nor exhaust possible analytic approaches, SA84-85 (§ 1 & n.2). In *Advocate*, the Seventh Circuit rejected a similar attempt to convert "normally" language from the Guidelines into a hard-and-fast requirement, noting that in a healthcare case, the argument "overlooks insurers' role in the marketplace." 841 F.3d at 476 n.5.

Flexibility is warranted here because the economics of hospital markets are more complex than traditional markets involving direct buyers and sellers. As explained, insurance companies pay for hospital services (and negotiate prices), but do not use those services. Op. 34. Consumers who purchase health plans use the services, and because of insurance, they are largely indifferent to (or entirely unaware of) price. *Id.* (describing "healthcare industry" as "unique" in this way); *see Hershey*, 838 F.3d at 342. In that situation, it is not clear how the concept of "price discrimination" as to individual patients is relevant.[7] *See* Cory Capps et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 Antitrust L. J. 441, 488-90 (2019) (SA113-15) (noting problems applying concept to hospital markets).

[7] As if to illustrate the point, the hospitals themselves confuse whether their theory requires *patients* or *insurers* to be charged different prices. *Compare* Br. 1, 24-25 (prices to patients) *with* Br. 14 ("prices to an insurer").

By contrast, because insurers must offer policies attractive to patients, an approach focused on patients makes considerable sense and allows market share calculations to reflect the competitive significance of all hospitals patients use. It thus is hardly surprising that the Ninth Circuit affirmed a patient-based market without citing to evidence of price discrimination in *St. Luke's*, 778 F.3d at 784-85, on which the district court relied. Op. 37. There, the geographic market was Nampa, Idaho – defined with respect to patients living in Nampa who sought primary care in Nampa. *See Saint Alphonsus Med. Ctr. - Nampa, Inc. v. Saint Luke's Health Sys.*, No. 1:12-CV-00560-BLW, 2014 U.S. Dist. LEXIS 182869, at *22 (D. Idaho Jan. 24, 2014) (¶¶ 50-73). Contrary to the hospitals' claim, the market there was not defined purely by supplier location; it was restricted to patients living in Nampa. *Id.* Like here, the evidence showed that Nampa residents "strongly preferred" access to primary care in Nampa, insurers "need to include Nampa [doctors] in their networks to offer a competitive product," and a monopolist thus could successfully demand a SSNIP.[8] *St. Luke's*, 778 F.3d at 785 (cleaned up).

[8] The FTC has used patient-based shares in other cases. *See* Compl., *In re Phoebe Putney Health System Inc.*, No. 9348, at 12-13 (F.T.C. Apr. 19, 2011) ("for commercial patients residing in the six county area"); Compl., *In re Cabell Huntington Hospital Inc.*, No. 9366, at 8-9 (F.T.C. Nov. 5, 2015) (based on residents in a four-county area).

The hospitals, by contrast, cite no judicial decision requiring price discrimination in defining a hospital market. Their cases, Br. 27-28, exclusively involved traditional supplier-customer markets. As this Court recently recognized, though, economic principles that apply in these types of markets do not necessarily work in healthcare markets. *See, e.g.*, *Hershey*, 838 F.3d at 340-41 (rejecting the Elzinga-Hogarty customer flow approach to hospital markets).[9] In any event, the cited cases do not bear the weight the hospitals place on them. *Kodak* held at most that where the government *relies on* a "theory of price discrimination" to support its market, it should produce evidence of it. *United States v. Eastman Kodak Co*., 63 F.3d 95, 105-07 (2d Cir. 1995). Others involve markets defined using highly specific criteria, hardly similar to the Bergen County market here. In *R.R. Donnelley & Sons Co.*, for example, the proposed market was a subset of customers with printing jobs meeting five detailed parameters. 120 F.T.C. 36, 47 (1995).

Even if price discrimination was required, it need only be feasible, not actual. *See FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 117 (D.D.C. 2016); *see also FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1046 (D.C. Cir. 2008) (Tatel, J.,

[9] This may explain why the hospitals' own lawyers urged a patient-based approach – with no reference to price discrimination – in another case, stating it "more reliably measure[s] the value that hospitals offer to insurers and their members, consistent with the two-stage model of hospital competition." *FTC v. Thomas Jefferson Univ.*, Case No. 2:20-cv-01113 (E.D. Pa. Oct. 14, 2020), *Defendants' Proposed Findings of Fact and Conclusions of Law* (Dkt. 270), ¶ 38.

concurring). The record shows sufficient feasibility here when insurers are viewed as the customers. Where sellers individually negotiate with customers "and possess substantial information about them," price discrimination is feasible. *See FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 45-46 (D.D.C. 2015). It is undisputed that insurers negotiate individual contracts with hospitals, who are generally aware of the importance of Bergen County to insurers. *See* Op. 12-14; *see, e.g.*, SA51 (Hackensack aware of Horizon's huge number of Bergen County members); SA195 ([redacted] presentation to [redacted] noting importance of Bergen County); SA187-88 ([redacted] recognizing county's importance to [redacted]); SA189-90 ([redacted] noting [redacted] is "[redacted]"). It likewise is undisputed that hospitals can raise prices to one insurer without raising prices to all. *See, e.g.*, Op. 12-14; A822-25, 1025-28, 1077-78; SA261, 264. If price discrimination is relevant, it need not take the form claimed by the hospitals that patients inside the market can be charged higher prices than those outside. Br. 25-32; *see Whole Foods*, 548 F.3d at 1046.

b. The hypothetical monopolist test was satisfied.

The hospitals are also wrong that Dr. Dafny did not apply the hypothetical monopolist test to a patient-based market. She demonstrated that Bergen County is economically significant to insurers and, as a result, they would pay a SSNIP to a hypothetical monopolist of all hospitals serving Bergen County residents rather

than not market plans in Bergen County. A781-84. And the quantitative test she conducted for the set of all county hospitals dictated that a single entity controlling the *broader* set of all hospitals used by Bergen County patients likewise could raise price at county hospitals. A785-86 (if the smaller group could "impose a SSNIP, surely all the hospitals that are serving Bergen County could do so"); Op. 42-43. The court credited her explanation, which it noted the hospitals did not "meaningfully challenge," as persuasive in light of the insurer testimony, and found that "insurers would have even less choice in declining a SSNIP" in the latter scenario. Op. 42-43.

Hershey established that courts may properly extrapolate the results of a SSNIP test of a smaller set of hospitals to a larger set. *See* 838 F.3d at 345-46. There, the evidence showed insurers "would accept a price increase rather than excluding" even just the merged hospitals from their networks, so clearly a monopolist of *all* hospitals in the area could similarly raise price. *See id. Hershey* thus "approved one market based on applying the [SSNIP test] to a different market," disproving the hospitals' claim that no court has done so (Br. 34).

The hospitals argue that a geographic market must include *all* a seller's customers in order "to accurately assess" whether a SSNIP would be profitable, since the hospitals draw significant revenue from patients from outside Bergen County. Br. 26. But that argument resuscitates the patient-flow approach to

hospital market definition rejected by this Court in *Hershey*; experience showed it "resulted in overbroad" hospital markets. *Hershey*, 838 F.3d at 340-41. The Court held that focusing too much on customers outside the proposed market in a hospital case "is not consistent with the hypothetical monopolist test" because those customers do not necessarily constrain prices. *Id.* (explaining the "silent majority fallacy"); *see also Advocate*, 841 F.3d at 470-71. The key question is whether insurers faced with a price increase would turn to hospitals outside the market as substitutes for a hospital within it, and the evidence here conclusively showed they would not. *See supra*, 25-28.

The hospitals contend that without price discrimination, patients outside of Bergen County would also be charged any higher price and their response might make a SSNIP unprofitable. Br. 26-27. But patients using in-network hospitals are not price-sensitive; a SSNIP will not change their choices. Insurers, for their part, refuted this concern as a factual matter. They unequivocally testified that a plan without a Bergen County hospital would not be viable; insurers would accept a SSNIP rather than "give up on Bergen County" altogether, given its importance. A783-84; Op. 12; *see also* Op. 38. Insurers did *not* testify, as the hospitals' theory would indicate, that whether they accept the higher price would depend on how out-of-county members would respond, or whether they could limit the price increase to their Bergen County members.

Dr. Dafny's four-county WTP analysis also refutes this theory. A1035-36; SA309-11. As discussed, she applied the SSNIP test with respect to a health plan broadly offered across Bergen, Essex, Hudson, and Passaic counties. Even as to that larger area, a monopolist of all Bergen County hospitals *still* would be able to increase prices by 28%, showing that any out-of-county response would not prevent a successful SSNIP. SA310; *see also* Op. 36.

II. THE COURT PROPERLY FOUND THAT DIRECT EVIDENCE ALSO SHOWED THE MERGER WOULD LIKELY HARM COMPETITION

The district court found that the merger would result in a highly concentrated market with a large increase in concentration, raising a presumption of illegality. Op. 44-45. The court could have stopped there, since "high market concentration based on HHI numbers" alone can establish likely anticompetitive effects. *Hershey*, 838 F.3d at 347; *see also Heinz*, 246 F.3d at 716; *St. Luke's*, 778 F.3d at 788. But it also separately found that a substantial body of evidence directly showed the merger was likely to harm competition, including by raising prices and reducing incentives to innovate and improve quality. Op. 46-54. This finding satisfied the Commission's burden to show likely anticompetitive effects under any plausible Bergen County market, including alternatives proposed by the hospitals: in all cases, the "direct evidence supports the conclusion that the merger will substantially lessen competition in Bergen County." Op. 46.

The hospitals attack the court's determination that the FTC's expert presented a methodologically sound and factually supported model of post-merger price increases. Br. 41-42; Op. 48-49. Their claims of legal error are wrong, but would be insufficient to reverse in any event in light of ample additional evidence of anticompetitive effects that the hospitals do not even address, let alone challenge. Wholly apart from the Commission's pricing model, that evidence showed a reduction in competition, a likelihood of price increases, and a diminution of quality and innovation. Op. 46, 50.

A. The Court Correctly Found That The Merger Would Increase The Hospitals' Bargaining Leverage, Leading To Higher Prices.

Dr. Dafny estimated that the merger would raise prices by about $31 million per year. Op. 48-49; A797-99. She determined that figure by using a model of patients' hospital choices to estimate the increase in hospital leverage from the deal, and then applying a conversion factor from a peer reviewed study to translate that leverage gain into higher prices. A797. The court found her methodology reliable and supported by the evidence, and credited her testimony. Op. 48-49.

1. The hospitals contend that Dr. Dafny's pricing model "was legally invalid and fatally unreliable" because her estimate of hospital leverage was based on *patient* preferences for different hospitals. This approach, they claim, constitutes

"economic and legal error" because patient preference does not necessarily translate to insurers' preference. Br. 42.

The argument has no merit. To begin, it overlooks the court's repeated factual finding that "patients' preferences inform insurers' decisions when creating networks and negotiating rates." Op. 48; 34, 43, 49 ("patient preferences impact and inform stage 1 negotiations"). Insurers will pay more to ensure that their networks are attractive to members (patients). The court's determination of the key role patient preference plays was supported by evidence showing that insurers evaluate and rely on patient preferences in forming their networks. Indeed, as discussed, two insurers conducted their own "patient choice" evaluations in preparing for rate negotiations with hospitals, projecting which hospitals patients would turn to if one went out-of-network. SA141-45, 202-03; SA160-65, 199-200, 207, 208. These analyses corroborated the Commission's expert analysis, which the court found persuasive. *See* Op. 48-49; A1042-43 ("ultimately the patient preferences inform" insurers' preferences); SA317 ("closely competing hospitals from the patients' perspective constrain" hospital leverage). All these facts refute the hospitals' claim that patient preferences are not aligned with those of insurers. Br. 43-44. The court properly rejected the same criticism below, concluding that the "fact that elements of patient choice play a part of the WTP analysis is not fatal," given how patient preferences affect insurer decisions. Op. 43. The Sixth

Circuit rejected a similar claim in *ProMedica*, underscoring that insurers "assemble networks based primarily upon patients' preferences, not their own." 749 F.3d at 572.

The hospitals argue that "the prices *insurers* will agree to pay hospitals depend not just on patients' non-price preferences but on negotiating leverage," Br. 43, as if the two were unrelated. As discussed, insurers strive to provide members with access to desirable hospitals. The record thus unsurprisingly showed that a hospital's leverage depends on patient preferences – *i.e.,* that patients' "behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates." *Hershey*, 838 F.3d at 342. This Court recognized that patients are "*especially*" relevant when that dynamic exists. *Id.* (emphasis added). Relying on patient choice factors to project the merger's price impact thus was consistent with *Hershey*, not (as the hospitals claim) contrary to it.

It also was consistent with *Advocate*. There, the appeals court found the district court "erred in *assuming*" that insurers' preferences will mirror patients' preferences, without facts showing a sufficient connection. *Advocate*, 841 F.3d at 475 (emphasis added). The lower court there had failed to consider that insurers "may not offer even a broadly appealing plan if it lacks services in a particular region," and thus wrongly failed to view the market from insurers' perspectives. *Id.*

Here, as discussed, the evidence showed that patient preferences drove insurers' views, making it appropriate to rely on them to model the merger's effects.

Furthermore, the hospitals' view is inconsistent with economic literature, which recognizes that a hospital's negotiating leverage "is derived from the value enrollees place on that hospital." SA352; Robert Town and Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. Health Econ. 734 (2001); Cory Capps et al., *Competition and Market Power in Option Demand Markets*, 34 RAND J. Econ. 737, 743 (2003). This leverage (and the change to it that occurs when hospitals merge) is precisely what WTP measures. The WTP metric is derived from the two-stage model (discussed above) and is well accepted in the economic literature.[10] Courts and the Commission have relied on WTP as a proxy for hospital (and by extension, insurer) leverage in healthcare provider merger cases.[11] Indeed, the hospitals' own expert admitted that patient choice models like Dr. Dafny's can "measure substitution from the perspective of insurers" if insurers

[10] *See, e.g.,* Capps (2003), Town & Vistnes (2001), cited above; *see also* SA290 n.268-70 (citing literature validating WTP methodology).

[11] *See, e.g.*, *In re ProMedica Health Sys., Inc.,* No. 9346, at 49–50 (F.T.C. Mar. 28, 2012) (finding WTP appropriate measure of bargaining leverage), *aff'd*, 749 F.3d 559 (6th Cir. 2014); *FTC v. Sanford Health*, No. 1:17-cv-133, 2017 U.S. Dist. LEXIS 215937, at *42 (D.N.D. Dec. 15, 2017); *FTC v. OSF Healthcare Sys.,* 852 F. Supp. 2d 1069, 1086 (N.D. Ill. 2012).

factor in patient choices when forming networks. SA346-47, 352. That is precisely what the evidence showed and the court found. Op. 34-35, 43, 48-49.

2. The hospitals' criticism of Dr. Dafny's methodology, Br. 41-45, is misplaced for other reasons, too. For one thing, no quantification of price impact was needed at all; the Clayton Act does not require that a specific dollar value be placed on the predicted lessening of competition. *See United States v. AT&T, Inc.*, 916 F.3d 1029, 1045 (D.C. Cir. 2019) ("[T]he court does not hold that quantitative evidence of price increase is required in order to prevail on a Section 7 challenge."); *see also, e.g.*, *St. Luke's*, 778 F.3d at 788 (Section 7 requires only "that the merger create an appreciable danger" of anticompetitive effects like higher prices).

For another, the court's acceptance of the $31 million estimate turned on its determination that Dr. Dafny's testimony on this point was credible. It found that "substantial literature supported the general proposition that" hospitals "with higher willingness to pay command higher negotiated prices in the marketplace." Op. 48-49; A798, 864. The court likewise found her methodology sound, rejecting the hospitals' critiques and expressly finding her testimony on this issue "persuasive." Op. 49. Such factual findings based on credibility determinations are due "even greater deference" than other factfinding and "can virtually never be

clear error." *Anderson v. Bessemer City*, 470 U.S. 564, 575-76 (1985). The hospitals do not question those determinations; they simply ignore them.

The hospitals claim that there is no general relationship between WTP and price in New Jersey, but that was a disputed factual issue on which the experts offered different opinions. *See* SA355-62; A665-66. Dr. Dafny corrected flaws in the hospitals' expert's analysis of New Jersey claims data and showed not only a correlation, but that the data showed a price impact *greater* than her model predicted. SA362 (showing price increase of 7.7 to 14.2%); *see also* A799-800; SA355-62. Again, the hospitals ignore that evidence. The court ultimately did not resolve this dispute because it found that whatever the New Jersey data showed as a general matter, the direct evidence showed that *this* merger would likely lead to higher prices. Op. 49-50.

The hospitals next argue that adding Englewood "would not materially change the negotiating leverage [Hackensack] already had," because HUMC is more desirable than Englewood. Br. 45. By that logic, Hackensack would be free to acquire all the hospitals in Bergen County because HUMC is more desirable than any of them. But the evidence showed, and the district court determined as fact, that the merger *would* increase Hackensack's leverage. Op. 52 & n.31 ("adding Englewood . . . will further increase [Hackensack's] leverage with

insurers"); *see also, e.g.*, SA146-47 ( ); SA224-25 ( ). The hospitals have shown no clear error in that determination.

3. Apart from the pricing model, the court found that Hackensack's past practices also showed that prices likely would go up after the merger. That Hackensack powerfully indicated that it would raise Englewood's rates too. Op. 51. And there was considerable room for increase given that those rates are substantially lower than HUMC's, Op. 13, and that Hackensack "has historically been able to negotiate higher rate increases than Englewood." Op. 52. In light of testimony by its own executive that Hackensack fully deploys "all the leverage that it has" to maximize its prices and revenue in insurer negotiations, the court's determination that Hackensack would likely raise prices in the future was sound. SA37, 75.

The hospitals try to avoid the implications of on the ground that they stemmed from "acquisition clauses" in previously negotiated contracts . They assert that thus reflected leverage Hackensack *already* had and therefore do not show that this merger "will enhance that power."[12] Br. 47. But the court could

[12] They argue in the same breath that the Court *should* consider letters Hackensack sent insurers purporting to waive those clauses. Br. 48. The court properly gave those letters "little weight"; it found they were "a prime example of

properly rely on past effects to predict future ones. *See, e.g.*, *United States v. Gen'l Dynamics Corp.*, 415 U.S. 486, 501 (1974) (parties' "past performances" can "imply an ability to continue to dominate with at least equal vigor"). Indeed, the Ninth Circuit relied on "past actions," including price increases after a prior acquisition, to conclude St. Luke's likely would raise rates after a merger. *St. Luke's*, 778 F.3d at 787-88. In any event, the district court found, even without reference to past acquisitions, that adding Englewood to the Hackensack portfolio *would* increase its bargaining leverage. Op. 52 & n.31.

The evidence showed that prices almost surely would rise at Englewood, an effect the hospitals ignore but which is enough by itself to make the merger anticompetitive. Englewood prices are currently significantly lower than HUMC's; one way or another, Hackensack would increase those prices post-merger – either in the near term under the acquisition clauses, or in the next round of price negotiations. *See* Op. 52 (crediting testimony that price increases post-merger were "inevitable"); Op. 13 (HUMC's prices [redacted] than Englewood's); SA147-48, 156-57; A658-59. Indeed, Dr. Dafny showed that Hackensack could increase prices at Englewood alone more than 35%. A798-99; SA330-32; Op. 48 n.26.

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alleged business records that were created to bolster Defendants' litigation position," ran against Hackensack's "own financial interest," and in any event did not affect future negotiations. Op. 51-52.

B. Other Powerful Evidence Showed Anticompetitive Effects.

Beyond these price effects, the evidence showed, and the court found, other likely anticompetitive effects. Once again, the hospitals ignore these findings.

1. When two direct competitors merge, competition between them is necessarily eliminated. If substantial, that loss of competition may by itself constitute an anticompetitive effect under Clayton Act. In *Heinz*, for example, the D.C. Circuit held that "the indisputable fact that the merger will eliminate competition between the two merging parties" was powerful evidence of anticompetitive effects. *Heinz*, 246 F.3d at 717-19. Estimating the price harm from a merger is one way to show substantial competition loss, but is by no means the only way, nor is it required. *See, e.g.*, *AT&T*, 916 F.3d at 1045 ("quantitative evidence of price increase" is not required); *see also St. Luke's*, 778 F.3d at 788 (relying on internal emails and other fact evidence to conclude prices likely would increase); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1086 (N.D. Ill. 2012) ("a merger simulation to determine" price effect was not required).

The district court found that Hackensack and Englewood engage in direct, robust competition that constrains prices and boosts quality. The merger would eliminate that substantial competition and its benefits. *See* Op. 18-19, 47. The court emphasized that insurers viewed HUMC and Englewood as competitors and alternatives for network inclusion. Op. 41; SA38, 140-44, 176. Hackensack was a

particularly strong alternative to Englewood, with both insurer ordinary course documents and expert analyses predicting that a large percentage of Englewood patients – more than 40% – would go to Hackensack hospitals if Englewood were unavailable. Op. 48; A794; SA143-44, 160-61, 203, 207-08, 321; *see also* SA258. The court credited Dr. Dafny's testimony that HUMC "places a strong competitive constraint on Englewood," affecting "pricing and quality." Op. 48; SA320-21. Together with other evidence corroborating this dynamic, the elimination of this competition was an anticompetitive effect.

The parties' own statements confirmed their close competition, which the court found persuasive. Op. 18-19, 47. Englewood described Hackensack as "a fierce but respected competitor" (SA65) and voiced concern that sharing information as they explored a merger would "[redacted]" (SA196) because "[redacted]" (SA364). Executives further posited that Hackensack's motivation for the merger may stem from Englewood being "[redacted]" SA198. Below, as noted, the parties "downplayed the fact that they are competitors" and contended they were "complements rather than competitors," but the district court found the claim not credible because their own documents "demonstrate otherwise." Op. 18-19, 41, 47, 53-54, 58. The Sixth Circuit relied on similar evidence of direct competition between merging hospitals

to find anticompetitive effects in *ProMedica*.[13] 749 F.3d at 571 (noting ProMedica viewed St. Luke's as a "strong competitor").

2. The court also determined that the merger would "likely eliminate competition on a non-price level," too, by removing an incentive for the hospitals to improve quality and innovate. Op. 53-54; *see* SA57, 58, 66. The court cited recent examples of the two hospitals monitoring each other's offerings, thereby spurring efforts to launch new technology and "improve quality metrics." Op. 53. Perhaps most damningly, the court found that reducing the likelihood of "[redacted]" between them was part of Englewood's desire for a merger with Hackensack, as expressed by a consultant that advised Englewood on selecting a merger partner. Op. 21, 53-54. Englewood appeared concerned that choosing the other candidate would lead to more "direct competition" with Hackensack, which the court noted would result in "more and/or improved services for patients." Op. 53-54; *see also* SA216. That sort of future competition is exactly what the Clayton Act seeks to preserve. *Brown Shoe*, 370 U.S. at 311-23; *FTC v. Procter & Gamble Co*., 386 U.S. 568, 577 (1967). The court properly determined that eliminating

[13] *ProMedica* held the FTC *established* in a full merits trial that the merger likely was anticompetitive. Here the court needed only to find a *likelihood* that the FTC would make that ultimate showing. *See Hershey*, 838 F.3d at 337; *Univ. Health*, 938 F.2d at 1218; *Whole Foods*, 548 F.3d at 1042, 1046-49 (Tatel, J., concurring).

competition on these quality and service dimensions—*i.e.,* cutting off [redacted] — was an independent anticompetitive effect. Op. 53-54.

III. THE DISTRICT COURT PROPERLY HELD THAT THE HOSPITALS FAILED TO REBUT THE FTC'S STRONG SHOWING OF LIKELY HARM

The district court's findings raised a presumption that the merger would be anticompetitive, shifting to the hospitals the burden to present evidence that the *prima facie* case gives "an inaccurate account of the merger's probable effects on competition." Op. 55 (cleaned up); *Hershey*, 838 F.3d at 349. The court held that the hospitals did not meet that burden. The hospitals now claim that the decision was legal error because the court improperly required them to show "extraordinary" benefits rather than some lower level of proof and because the court improperly weighed the alleged benefits.

Those arguments fail. The hospitals' rebuttal claims amounted only to standard assertions of efficiency. This Court has expressed doubt that efficiencies can justify an anticompetitive merger, but has established that at a minimum such claims require an extraordinary showing, which the hospitals did not make. Beyond that, the district court properly determined as fact that the claimed benefits were unlikely to transpire and that their main supporting evidence was not credible.

A. The Hospitals Assert Standard Efficiencies Claims That Must Meet An Exacting Standard – If An Efficiency Defense Exists At All.

The hospitals claimed four main benefits from the merger: upgrades at Englewood, expansion of services at HUMC, cost-savings from service optimization, and quality improvements. Op. 55-65. Those claims do not show that the market concentration statistics, insurer testimony, expert analysis, and other evidence of anticompetitive effects "portray[] inaccurately the merger's probable effects on competition." *Hershey*, 838 F.3d at 349. They are claims that the merger will have benefits that offset its anticompetitive effects, such as quality improvements or cost savings – in other words, benefits that are treated by courts as standard efficiency defenses. *See, e.g.*, *Hershey*, 838 F.3d at 350 (assessing as efficiencies relief of capacity constraints and capital savings that would lower price or improve quality); *St. Luke's*, 778 F.3d at 791-92 (treating "better service to patients" as efficiency); *FTC v. Sanford Health*, 926 F.3d 959, 965-66 (8th Cir. 2019) (rejecting claimed "quality efficiencies").

The Supreme Court has never recognized an efficiencies defense under the Clayton Act. To the contrary, it has cautioned that under the Act "[p]ossible economies cannot be used as a defense to illegality." *P&G*, 386 U.S. at 580; *see also Brown Shoe*, 370 U.S. at 344 ("higher costs and prices might result" from "fragmented" markets, but Congress chose a policy of "decentralization"); *accord*

Philadelphia Nat'l Bank, 374 U.S. at 371. In keeping with that guidance, this Court thus has "never formally adopted" the defense and is "skeptical" that it "even exists." *Hershey*, 838 F.3d at 347-48. The Ninth Circuit has expressed similar views. *St. Luke's*, 778 F.3d at 790.

Nonetheless, this Court has recognized that if an efficiencies defense is available, it is subject to a "rigorous standard": any efficiencies must be "extraordinary," *i.e.,* significant enough to "offset the anticompetitive concerns in highly concentrated markets"; merger specific; verifiable; and ultimately passed on to consumers. *Hershey*, 838 F.3d at 347-51; *see also St. Luke's*, 778 F.3d at 790; *Heinz*, 246 F.3d at 720-23. They also "must not arise from any anticompetitive reduction in output or service." *Hershey*, 939 F.3d at 349. The defendant bears the burden to "clearly show" that any efficiency meets all these requirements. *Id.* at 348-49. No "reported appellate decisions have actually held that a § 7 defendant has rebutted a *prima facie* case with an efficiencies defense." *St. Luke's*, 778 F.3d at 789; *Heinz*, 246 F.3d at 720-24.

The district court did not resolve whether the hospitals asserted "efficiency" claims because, as discussed below, it found that they failed to overcome the anticompetitive effects under either the efficiencies standard or the novel standard proposed by the hospitals. Op. 55-56. Whether the claims are properly characterized as efficiencies is a question of law, and this Court can (and should)

hold that the hospitals' defense asserted typical efficiencies subject to *Hershey*'s stringent standard. Either way, the district court properly required the hospitals to show "extraordinary" benefits, which they did not do.

Hershey requires that the hospitals' claimed benefits meet the high bar for efficiencies. There, the same kinds of benefits were asserted, including capacity improvements and capital savings that would increase quality. 838 F.3d at 349-351. The Court found that while these claims had some truth, they did not meet the high standard required: they were not sufficiently verifiable or merger-specific, and it was "not clear" whether or how they "would ultimately be passed on to consumers." *Id.* at 351. The hospitals thus failed to rebut the *prima facie* case "irrespective of whatever benefits the merger may bestow." *Id.* at 351-52; *see also id.* at 350.

The hospitals' claims are not meaningfully different, and they meet the same fate under *Hershey*. They are not merger specific (since they can be achieved in other ways) or verifiable (since they are based mostly on made-for-litigation projections), and they will not be passed on to consumers. While the court did not frame its discussion as addressing the requirements for an efficiency defense, its assessment of the hospitals' evidence demonstrates they plainly are not met.

For example, the court "doubt[ed] that any costs savings [Hackensack] realizes will be passed through to payors," Op. 64, and noted that the hospitals'

expert "failed to conduct any analysis" as to what portion of those supposed savings "would be passed on to commercial insurers," Op. 29. It also questioned whether any savings were verifiable, since the expert took no notes and gave no explanation for how she was able to "synthesize over 100 interviews" with the parties' employees "from memory alone." Op. 64 n.38. As relevant to merger specificity, the court likewise found that Hackensack could transfer patients to its existing hospitals, or others, to alleviate capacity constraints, Op. 61-62, and that the merger likely was not required to improve quality, as Englewood's preexisting high performance showed, Op. 65. Ample other evidence supported these findings and showed Hackensack's claims did not meet *Hershey*'s "rigorous" requirements. *See, e.g.,* A803-10; SA54-56, 169-71, 181-82, 186; *FTC's Proposed Findings of Fact and Conclusions of Law*, Dkt. 320 at ¶¶ 154-75 (citing evidence).

B. The District Court Correctly Found That Any Meager Benefit Of The Merger Did Not Outweigh The Anticompetitive Effects.

Even if the claimed benefits are treated not as standard efficiencies but as some novel, separate category of "procompetitive benefits" (as the hospitals wrongly urged below), the district court made clear that they are insufficient under any standard to overcome the anticompetitive effects of the merger.

1. The hospitals first contend that because the Commission's showing of anticompetitive effects was "weak," their burden to countermand it was

correspondingly light. Br. 38-40. Courts have applied a sliding scale approach to the showing required to rebut a *prima facie* case of anticompetitiveness. This Court found that a *prima facie* case based on especially high HHI numbers required "extraordinarily great cognizable efficiencies" to rebut it. *Hershey*, 838 F.3d at 350. The Sixth Circuit likewise held that when additional evidence "buttresses" an HHI-based presumption, it makes the task on rebuttal "more difficult still." *ProMedica*, 749 F.3d at 571 (affirming finding that hospitals failed to rebut presumption); *see also Sanford*, 926 F.3d at 963 (strong evidence of anticompetitive effects requires strong rebuttal); *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 991 (D.C. Cir. 1991); *Chicago Bridge*, 534 F.3d at 426

The sliding scale principle is of no help to the hospitals, however, because the Commission's *prima facie* case was strong by any measure. Market concentration statistics were only one element, as discussed next. But those statistics showed that the merger would result in a "highly concentrated" market with an increase in HHI of at least four times the presumption threshold. *See supra*, 12-14. These numbers alone demonstrated a "strong *prima facie* case." *See University Health*, 938 F.2d at 1220 (market share of 43% and HHI increase of 630). Indeed, mergers have been held unlawful based on comparable or smaller market share and HHI figures. *See, e.g.*, *id.*; *Heinz*, 246 F.3d at 716 (combined share 33%, change in HHI 510); *United States v. Anthem*, 236 F. Supp. 3d 171,

208-09 (D.D.C. 2017), *aff'd*, 855 F.3d 345, 351 (D.C. Cir. 2017) (combined share 47-54%, change in HHI 537).[14] That some mergers result in even more concentrated markets, Br. 38, does not logically suggest that the *prima facie* showing here was weak.

Beyond those statistics, the Commission also showed, and the court found, significant direct evidence of anticompetitive effects, which bolstered the HHI-based *prima facie* case to make it even stronger. Op. 46-54; *supra*, 40-52. That evidence increased the hospitals' rebuttal burden, since the "stronger the Government's *prima facie* case, the more evidence that Defendants must present to successfully rebut the presumption." Op. 55. Yet the hospitals largely ignore the direct evidence. Given the powerful likelihood of anticompetitive effects the Commission showed, the court was justified in requiring a commensurate showing on rebuttal. *See, e.g.*, *Chicago Bridge*, 534 F.3d at 426 ("somewhat ineffectual" rebuttal evidence "did not rebut the Government's stalwart *prima facie* case"); *Sanford*, 926 F.3d at 963-966.

2. In any event, the hospitals did not rebut the *prima facie* showing under any standard because the court found the touted benefits were unlikely to occur or

[14] *See also, e.g.*, *United States v. H&R Block*, 833 F. Supp. 2d 36, 72 (D.D.C. 2011) (combined share 28.4%, change in HHI 400); *FTC v. CCC Holdings*, 605 F. Supp. 2d 26, 46 (D.D.C. 2009) (change in HHI 545).

would have only modest effects. It found the evidence on which the claims were based unreliable, and discredited testimony by several key defense witnesses.

In particular, the court found not credible the document central to the hospitals' rebuttal case, the "Optimization Plan" prepared by the parties after they agreed to merge. Op. 25, 59-61; DX3601. The hospitals relied heavily on the Plan below, featuring it prominently during the hearing and citing it repeatedly in briefing. *See, e.g., Defendants' Proposed Findings of Fact and Conclusions of Law*, Dkt. 324 (citing Plan 14 times). Their capacity expert cited the Plan 74 times in his report – including 40 where it was the sole support for an opinion. SA42-43. But as the court noted, the document was created during the litigation and mirrored text in an advocacy paper submitted to the FTC during its investigation. Op. 25, 59-61 & n.34. It lacked concrete details about how the claimed efficiencies would be achieved and was not supported by ordinary course documents. Op. 26-28, 59-60. The court found that the Plan "reads like an advocacy piece created for the current litigation" and "a sales pitch to justify the merger after the fact," ultimately giving it "little weight." Op. 59-60. It is not for this Court to second-guess those assessments. *See Anderson*, 470 U.S. at 574-75.

Further, the court found that the hospitals had exaggerated Hackensack's "hard commitments" to improve clinical offerings and increase patient volume at Englewood. Op. 57. In truth, those commitments were "not as comprehensive or

firm as represented . . . during the hearing," even if *some* upgrades to Englewood's facilities and equipment were likely. *Id.*; *see also* Op. 23-24. The court likewise expressed "doubts" that HUMC had serious capacity issues, finding it telling that Hackensack had failed to identify *any* pre-merger ordinary course documents showing as much, Op. 26, 58; highlighting inconsistencies in relevant testimony by Hackensack's CEO, Op. 58-59; and noting that Hackensack had similarly claimed capacity needs for a prior acquisition that proved exaggerated, Op. 62 n.35. It also noted others were not aware of capacity issues at HUMC. Op. 26. Conflicting evidence and inadequate explanation by Hackensack witnesses also drew into serious question whether the need to expand HUMC's more complex services was "as acute as Defendants make [it] out to be." Op. 61. As for cost savings, the court found that Hackensack provided no evidence that any such savings from two prior hospital acquisitions had been passed through to insurers; "with history as a guide," the court doubted any would be here. Op. 64.

The hospitals thus vastly overstate the matter in claiming that they "*persuaded* the district court that the benefits will occur." Br. 39; *see also* Br. 37, 41. Ultimately, the court concluded that the merger would at most yield limited benefits – improvements at Englewood and HUMC recapturing a small number of patients who seek complex care in New York – which were plainly insufficient to

"offset[] the likely anticompetitive effect of the merger." Op. 65. The hospitals thus "fail[ed] to rebut the FTC's *prima facie* case." *Id.*

The hospitals are also wrong that the court erred because it did not weigh the proffered benefits "in the final balance," or at "step three" of the framework. Br. 40. They do not contend that the court failed to consider important evidence, or that it wrongly interpreted the evidence; the claim is only that court considered it at the wrong step in the process. The argument has little force here because the court expressly held that, assessing the same evidence, it would find the Commission met its ultimate burden of persuasion. Op. 66 n.40.

But a rigid approach to the three-part framework is unwarranted, especially in a 13(b) preliminary injunction proceeding. As the Eleventh Circuit has recognized, as a practical matter Clayton Act litigation is not strictly sequential; the government "usually introduces all of its evidence at one time, and the defendant responds in kind." *University Health*, 938 F.2d at 1219 n.25. That is especially so in preliminary injunction proceedings, where "time is of the essence." *Id.* The Fifth Circuit noted the same practical realities in *Chicago Bridge*, emphasizing that courts and the Commission have discretion to decide that proffered rebuttal evidence is inadequate "without having to formally switch the burden of production back to the Government" for weighing at a third step. 534 F.3d at 424; *see also Sanford*, 926 F.3d at 963-966 (no error in requiring rebuttal evidence to

"clearly show" no likely anticompetitive effects). *Chicago Bridge* addressed a full-fledged administrative merits trial; its flexible approach is even more apt in a preliminary injunction action, where the question is only whether the Commission is *likely* to succeed in the administrative proceeding. *See University Health*, 938 F.2d at 1218-19 & n.25.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to the Federal Rules of Appellate Procedure and this Court's Rules, I certify the following:

1. The foregoing brief complies with the volume limitations of Fed. R. App. P. 27(d)(2)(A) because it contains **13,952** words, as created by Microsoft Word, excluding the items that may be excluded under Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

3. This brief complies with Local Rule 31.1(c). Windows Defender was run on the electronic brief and no viruses were detected.

4. The attorneys listed on this brief are federal government attorneys and thus exempt from Third Circuit admission requirements.

October 29, 2021

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CERTIFICATE OF SERVICE

I certify that on October 29, 2021, I filed the foregoing with the Court's appellate CM/ECF system. Both defendants-appellants are Filing Users with the court's electronic docketing system (CM/ECF) and therefore all parties, through below counsel of record, will be served by the CM/ECF system, per L.R. 113.4.

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