No. 16-2492

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

FEDERAL TRADE COMMISSION, *et al.*,

Plaintiffs–Appellants,

v.

ADVOCATE HEALTH CARE NETWORK, *et al.*,

Defendants–Appellees.

On Appeal From The United States District Court
For The Northern District Of Illinois (No. 1:15-cv-11473)

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF APPELLEES AND AFFIRMANCE

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 16-2492

Short Caption: Federal Trade Commission, et al. v. Advocate Health Care Network, et al.

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American Hospital Association

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Gibson, Dunn & Crutcher LLP

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

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Attorney's Printed Name: Joshua H. Soven

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTRODUCTION AND INTERESTS OF *AMICUS CURIAE* 1

ARGUMENT 4

I. The Government's Proposed "Test" Ignores Core Legal and Economic Principles 4

II. The District Court Properly Considered Relevant Facts Concerning the Changing Healthcare Markets 7

CONCLUSION 14

TABLE OF AUTHORITIES

Page(s)

CASES

Brown Shoe Co. v. United States,
370 U.S. 294 (1962) 5, 6

California v. Sutter Health Sys.,
84 F. Supp. 2d 1057 (N.D. Cal. 2000) 15

Food Lion, LLC v. Dean Foods Co.,
739 F.3d 262 (6th Cir. 2014) 5

FTC v. Freeman Hosp.,
69 F.3d 260 (8th Cir. 1995) 6, 8, 9

FTC v. Tenet Health Care Corp.,
186 F.3d 1045 (8th Cir. 1999) 6, 8, 9, 10, 13

Tampa Elec. Co. v. Nashville Coal Co.,
365 U.S. 320 (1961) 4

United States v. Phila. Nat'l Bank,
374 U.S. 321 (1963) 4

United States v. Rockford Mem'l Corp.,
717 F. Supp. 1251 (N.D. Ill. 1989) 8, 15

United States v. Rockford Mem'l Corp.,
898 F.2d 1278 (7th Cir. 1990) 9

STATUTE

Clayton Act § 7, 15 U.S.C. § 18 1

TABLE OF AUTHORITIES
(continued)

Page(s)

OTHER AUTHORITIES

2 Earl W. Kinter et al., *Federal Antitrust Law* § 10.15 (2013) 5

2A Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* § 554 (2016)..... 6

Am. Hosp. Ass'n, *Trendwatch Chartbook 2015* 3, 11

Edward Levine et al., *The Impact of Coverage Shifts on Hospital Utilization* (2013)..... 3

Medicare Payment Advisory Comm'n, *A Data Book: Health Care Spending and the Medicare Program* (2016)..... 13

Outpatient Construction Targeting Population Health Has Doubled, Hosps. & Health Networks (Mar. 17, 2016) 12, 13

PWC Health Research Inst., *Medical Cost Trend: Behind the Numbers 2016* (2015) 3, 11, 12

Rebecca Vesely, *The Great Migration*, Hosps. & Health Networks (Mar. 11, 2014)..... 12

Robert York et al., *Where Have All the Inpatients Gone? A Regional Study with National Implications*, Health Affairs Blog (Jan. 6, 2014) 12

U.S. Dep't of Justice & FTC, Horizontal Merger Guidelines (2010)
§ 1 5
§ 4.1.3 6
§ 5.1 9

INTRODUCTION AND INTERESTS OF *AMICUS CURIAE*[1]

The American Hospital Association ("AHA") is a national organization that represents nearly 5,000 hospitals, healthcare systems, networks, and other providers of care, as well as 43,000 individual members. As the AHA and its members are well aware, the healthcare market is continually evolving and changing. The passage of the Patient Protection and Affordable Care Act ("ACA") has accelerated the structural changes in the hospital sector that are producing an unprecedented realignment in the provision of medical care. That includes greater use of outpatient facilities, a development that has significantly changed the dynamics of competition among hospitals, for both inpatient and outpatient procedures. Within the rapidly changing healthcare sector, hospital mergers can offer significant pro-competitive benefits by allowing hospitals to increase access, provide cost savings, and deliver more integrated and innovative care to communities. As a result, the AHA and its members have a strong interest in ensuring that the standards used to evaluate such mergers under Section 7 of the Clayton Act, 15 U.S.C. § 18, comport with market realities.

Given the complexities and the changing nature of the healthcare industry, the AHA respectfully submits that this Court should decline the Government's invi-

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[1] All parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part, no party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person other than *amicus curiae*, its members, and its counsel contributed money that was intended to fund preparing or submitting this brief.

tation to adopt a formulaic and narrow version of the "hypothetical monopolist test" as the governing standard for defining relevant geographic markets. The Government's proposal would sharply limit the types of relevant evidence that district courts may consider in defining geographic markets, requiring them to ignore commercial realities. Such a result would be inconsistent with decades of antitrust jurisprudence requiring courts to examine all relevant market factors.

The Government's position is that a district court errs as a matter of law if it examines the full range of evidentiary facts that may affect the geographical scope of a market. Indeed, the Government asserts, without citation, that the district court was required to accept its version of the hypothetical monopolist test notwithstanding that the Government's application of the test excludes close competing hospitals, including hospitals with a significant outpatient presence within the Government's putative geographic market. As the evidence in this case demonstrated, patients develop relationships with these hospitals through their locally operated outpatient facilities, which in turn drive demand for the hospitals' inpatient services.

The Government's proposed standard not only conflicts with controlling law, but also makes no sense because it ignores how healthcare markets work. The shift to outpatient care has fundamentally changed the nature of geographic market analysis for inpatient hospital services, particularly in large urban areas like Chicago. As the district court correctly ruled, these outpatient facilities serve as the "front doors" to their affiliated hospitals, expanding the size of the geographic re-

gions from which hospitals draw patients for their inpatient services. Op. 11 (internal quotation marks omitted).

The statistics reflecting the growth of outpatient services are telling:

- "[H]ospitals have faced declining growth in inpatient utilization since 2005, driven largely by the ongoing shift of many procedures to the outpatient setting." Edward Levine et al., *The Impact of Coverage Shifts on Hospital Utilization* 1 (2013), *available at* http://healthcare.mckinsey.com/sites/default/files/793546_Coverage_Shifts_on_Hospital_Utilization.pdf.
- More than 60 percent of surgeries performed today occur in outpatient facilities. *See* Am. Hosp. Ass'n, *Trendwatch Chartbook 2015*, at 34, *available at* http://www.aha.org/research/reports/tw/chartbook/2015/15chartbook.pdf.
- Since 2003, "the number of outpatient visits has increased 12% while inpatient care has decreased by nearly 20%." PWC Health Research Inst., *Medical Cost Trend: Behind the Numbers 2016*, at 8 (2015), *available at* https://commissiononcare.sites.usa.gov/files/2016/01/20151116-05-Medical_Cost_Trend-Behind_the_Numbers_2016_PWC.pdf.

There is no dispute that the "destination" and other Chicago-area hospitals, which the Government excluded from its putative geographic market here, are part of these trends. They have expanded their physical presence in the northern suburbs of Chicago through outpatient facilities, which in turn has driven demand for

the hospitals' inpatient services among residents of the northern suburbs. The Government not only fails to credit these facts in defining its narrow geographic market, but also urges this Court to adopt a standard that requires district courts to do the same.

The Government's proposed test similarly ignores how hospitals actually negotiate prices. Hospitals often negotiate system-wide prices for all services—including inpatient, outpatient, and physician services—simultaneously. As a result, the final prices for many hospitals are the product of trade-offs about facilities over a wide geographic area, including, in this case, hospitals outside of the Government's putative geographic market.

The Government cites no authorities for using a geographic market definition that ignores such market realities, and this Court should reject the Government's invitation to become the first Court to adopt such a standard.

ARGUMENT

I. The Government's Proposed "Test" Ignores Core Legal and Economic Principles.

The principles for defining a geographic market are well established. A geographic market is the "area of effective competition … in which the seller operates, and to which the purchaser can practicably turn for supplies." *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961); *see also United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963). As the district court correctly recognized, "[t]here is no formula for determining the geographic market" under this definition. Op. 6. "Congress neither adopted nor rejected specifically any particular tests for measur-

ing the relevant markets, either as defined in terms of product or in terms of geographic locus of competition, within which the anti-competitive effects of a merger were to be judged." *Brown Shoe Co. v. United States*, 370 U.S. 294, 320-21 (1962). It instead "prescribed a pragmatic, factual approach to the definition of the relevant market and not a formal, legalistic one." *Id.* at 336.

The Government urges this Court to ignore the Supreme Court's standards in favor of its own formulaic and narrow version of the "hypothetical monopolist test," which the Government used here to exclude from its proposed market definition many significant competitors from the outset. The Government asserts, without citation, that "[w]here an antitrust plaintiff relies on the hypothetical monopolist test to establish the relevant market, and no alternative test is suggested, the district court is obliged to consider whether the test is satisfied." FTC Br. 23. This argument is inconsistent with decades of case law and the Government's own guidelines for using the hypothetical monopolist test, which require careful consideration of how healthcare markets actually work.

The hypothetical monopolist test is not a litmus test for delineating the scope of a geographic market. Instead, it simply provides "'a useful framework for organizing the factors the courts have applied in geographic market definition.'" *Food Lion, LLC v. Dean Foods Co.*, 739 F.3d 262, 282 (6th Cir. 2014) (quoting 2 Earl W. Kinter et al., *Federal Antitrust Law* § 10.15 (2013)), *cert. denied*, 135 S. Ct. 676 (2014). Contrary to the Government's suggestion otherwise, the test does not prescribe the use of a particular methodology or econometric model. *See* U.S. Dep't of Justice &

FTC, Horizontal Merger Guidelines § 1 (2010), *available at* http://www.justice.gov/atr/public/guidelines/hmg-2010.html#4cd ("merger analysis does not consist of uniform application of a single methodology"); 2A Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* § 554 (2016) (listing a number of relevant "factors" under the hypothetical monopolist test).

Nor could it do so. "The geographic market selected must … both 'correspond to the commercial realities' of the industry and be economically significant." *Brown Shoe*, 370 U.S. at 336-37 (citation and footnote omitted). As a result, a "broad range of evidence … may be of value in determining a geographic market," and courts have accordingly "hesitate[d] to require particular evidence, especially in litigation involving complex industries such as health care." *FTC v. Freeman Hosp.*, 69 F.3d 260, 271 (8th Cir. 1995); *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999) ("Determination of the relevant geographic market is highly fact sensitive."). Indeed, the Government's Horizontal Merger Guidelines state that the Department of Justice and the Federal Trade Commission must "take into account any reasonably available and reliable evidence" in "[i]mplementing the Hypothetical Monopolist Test." Horizontal Merger Guidelines § 4.1.3.

That is the methodology the district court used here when it evaluated the evidence in the record and made its findings of fact concerning the relevant geographic market. Seeking to avoid clear-error review, the Government attempts to recast the district court's analysis in terms of legal error, asserting that the district

court improperly failed to follow the hypothetical monopolist test as a matter of law. FTC Br. 23. But the district court did apply the proper analysis, which included analyzing the facts used to apply the hypothetical monopolist test. As explained below, the district court considered all the relevant evidence about where Chicago-area hospitals compete and which hospitals are likely to constrain the parties' prices, made well-supported findings of fact, and based on these findings reasonably rejected the Government's overly narrow geographic market definition. This Court should affirm.

II. The District Court Properly Considered Relevant Facts Concerning the Changing Healthcare Markets.

While the Government styles its argument as a request for this Court to endorse the hypothetical monopolist test, in reality it is asking this Court to define and limit the types of evidence that a district court may consider in defining markets and how the district court should weigh such evidence. The Government's position is that the district court should have accepted its narrow geographic market definition based on: (1) the general proposition that patients prefer to use "local" hospitals that are "near" or "close" to where they live; (2) the views of some, but not all, of the testifying insurance companies; and (3) an incomplete diversion analysis that *a priori* excludes competing facilities from the analysis.

First, the Government's rhetorical position that patients prefer to use hospitals near or close to where they live misses the point. *See* FTC Br. 43. The issue is not whether some patients have a general preference for "local" hospitals, but which hospitals are close *enough* to provide viable alternatives to the merging hospitals

and prevent the exercise of market power. *See Freeman Hosp.*, 69 F.3d at 265 n.9 ("If patients utilize hospitals outside the area, those hospitals can act as a check on the exercise of market power by the hospitals within the service area."). This is particularly true in highly mobile metropolitan areas, where "local" hospitals may be located near where patients both live and work. As a result, the district court did not err (much less clearly err) by considering whether the "downtown 'destination' hospitals and local hospitals that overlap with either Advocate or NorthShore (rather than with both) must be included in the market." FTC Br. 24. Nor did it err in considering the role that outpatient centers in the Government's putative geographic market play in driving demand by patients for inpatient services provided by ostensibly "out-of-market" hospitals, thereby extending the geographic region over which those hospitals exercise price-constraining effects for inpatient services. In fact, these are the types of facts that courts typically analyze when applying the hypothetical monopolist test. *See*, *e.g.*, *Tenet Health Care*, 186 F.3d at 1053-54 (rejecting "as absurd" the Government's "contrived market area that stops just short of including a regional hospital … that is closer to many patients than the [in-market] hospitals"); *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1277-78 (N.D. Ill. 1989) (expanding geographic market to include "four other hospitals" because "patient origin and destination data" indicated that hospitals outside of this area "would impose some discipline on the defendants' exercise of market power," even though "third party payers would resist forcing their subscribers to travel in light of" "a small but significant non-transitory price increase at the defendants' hospi-

tals"), *aff'd*, 898 F.2d 1278, 1285 (7th Cir. 1990) (noting district judge's "considerable expansion of the government's tiny proposed market"); *see also* Horizontal Merger Guidelines § 5.1 ("All firms that currently earn revenues in the relevant market are considered market participants.").

Second, the Government asks the Court to give significant credit to the testimony of only a few insurer witnesses, even while other insurer representatives provided contrary testimony and expressed support for the merger's benefits for consumers. FTC Br. 47-48. The district court, however, did not err in "requir[ing] more than that evidence in order to accept the FTC's proffered geographic market." *Freeman Hosp.*, 69 F.3d at 270 n.14. Although courts have "recognized the importance of exploring th[e] perceptions" of market participants, the case law "clearly demonstrates that the views of market participants are not always sufficient to establish a relevant market, especially when their testimony fails to specifically address the practicable choices available to consumers." *Id.* at 270; *Tenet Health Care*, 186 F.3d at 1054 ("question[ing] the district court's reliance on the testimony of managed care payers, in the face of contrary evidence, that these for-profit entities would unhesitatingly accept a price increase rather than steer their subscribers to hospitals [outside the suggested market]").

Finally, and critically, the Government asks this Court to place dispositive weight on its econometric model, notwithstanding its omission of key competitor hospitals and failure to directly consider or economically model the role played by outpatient facilities in driving demand for inpatient services provided by hospitals

outside of the Government's hypothesized geographic market. The case law does not permit such a formulaic and restrictive approach that is divorced from marketplace realities.

As the district court noted, the Government's incomplete diversion analysis ignores market realties, including the "tremendous growth [in outpatient services] over the last five years," which has opened the door to hospitals providing inpatient services to patients who reside in a geographically larger area. Op. 11 (internal quotation marks omitted) (alteration in original).[2] The Government argues incorrectly that "[t]he factors cited by the district court relating to outpatient services have no bearing on the proper determination of the geographic market for inpatient services." FTC Br. 24; *see also id.* at 39 (suggesting that the court relied on "an assessment of competitive conditions for outpatient services" to analyze the geographic market for inpatient hospital services). To the contrary, the district court correctly found that the growth of outpatient services has substantially widened the geographic reach of hospitals and hospital systems, and thus the number of hospitals likely to have a price-constraining effect on the parties for inpatient services. Op. 11-12. As the Eighth Circuit has explained, "the advent of shorter hospital stays and more outpatient procedures has made travel less onerous," "broaden[ing] geographic markets" even for inpatient services. *See Tenet Health Care*, 186 F.3d at

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[2] Outpatient facilities include ambulatory surgery centers, freestanding emergency departments, urgent care centers, imaging centers, cancer centers, and medical office buildings, which treat millions of patients every day.

1055. "[H]ospitals 'extend their geographic breadth' by opening outpatient centers and doctor's offices because the doctor 'plays a significant role [in determining] where [a] patient goes to seek [inpatient] care.'" Op. 12 (quoting Joint Hr'g Ex. 19, Maxwell Dep. at 94:1-24) (alterations in original); *see also id.* 11-12 (collecting evidence); Defs.' Proposed Findings of Fact ("DPFOF") ¶ 66, No. 1:15-cv-11473 (N.D. Ill. May 27, 2016), ECF No. 467 (describing outpatient facilities as the "'front doors' to a hospital").

The facts demonstrating this market transformation are compelling. "Despite population growth and demographic shifts," including increasing numbers of patients qualifying for Medicare and Medicaid, "hospitals have faced declining growth in inpatient utilization since 2005, driven largely by the ongoing shift of many procedures to the outpatient setting." Levine, *supra*, at 1; *see also*, *e.g.*, DPFOF ¶ 64 (describing inpatient services as "a very rare or never event" (internal quotation marks omitted)). For example, more than 60 percent of surgeries performed today—including, for example, "a host of laparoscopic surgeries," DPFOF ¶ 62—occur in outpatient facilities. *See Trendwatch Chartbook 2015*, *supra*, at 34; *see also* DPFOF ¶ 62 (the list of previous inpatient procedures that "can now be performed on an outpatient basis" is "'growing greatly every day'" (quoting Hr'g Tr. 767:19-768:11)).

As a result of these changes, since 2003, "the number of outpatient visits has increased 12% while inpatient care has decreased by nearly 20%." *Medical Cost Trend: Behind the Numbers 2016*, *supra*, at 8. At least one study has "[c]onfirm[ed]"

this trend in the Chicago regional area, finding that "inpatient utilization in the [seven] studied counties declined by approximately 47,000 discharges—dropping from approximately 1,017,000 discharges in 2010 to 970,000 discharges in 2012." Robert York et al., *Where Have All the Inpatients Gone? A Regional Study with National Implications*, Health Affairs Blog (Jan. 6, 2014), http://healthaffairs.org/blog/2014/01/06/where-have-all-the-inpatients-gone-a-regional-study-with-national-implications/.

The ACA has amplified this trend by "driving … hospitals and health systems [to] adopt population health management and better manage care across the [care] continuum." *Outpatient Construction Targeting Population Health Has Doubled*, Hosps. & Health Networks (Mar. 17, 2016), http://www.hhnmag.com/articles/6969-outpatient-construction-targeting-pop-health-on-the-rise. It has also made consumers more cost-conscious—and therefore willing to go beyond their neighborhoods to shop for services based on quality and price—by, among other methods, providing incentives for employers to adopt health insurance plans that provide for "greater employee cost-sharing." *Medical Cost Trend: Behind the Numbers 2016*, *supra*, at 11-13. These changes motivate employees to choose lower-cost providers.

For hospitals and hospital systems, developing a network of outpatient and ambulatory care facilities and alternatives is an essential part of building the infrastructure necessary to support population health and better manage care in this changing environment. *See*, *e.g.*, Rebecca Vesely, *The Great Migration*, Hosps. & Health Networks (Mar. 11, 2014), http://www.hhnmag.com/articles/5005-the-great-

migration. Thus, in the last year alone, "outpatient construction projects to address population health doubled across most categories." *See Outpatient Construction Targeting Population Health Has Doubled*, *supra.* Hospitals and hospital systems have also increased their employment of physicians to support these managed care initiatives with the percentage of physicians and surgeons directly employed by hospitals increasing by 25.5 percent between 2010 and 2014. Medicare Payment Advisory Comm'n, *A Data Book: Health Care Spending and the Medicare Program* 57 (2016), *available at* http://www.medpac.gov/documents/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.

By allowing patients to develop relationships with more distant hospitals through their locally operated outpatient facilities, this expansion of outpatient facilities has increased the size of the geographic regions from which hospitals draw patients for their inpatient services. Only by side-stepping these highly relevant facts was the Government able to use its application of the hypothetical monopolist test to reverse engineer its narrow geographic market. By not fully evaluating how hospitals compete for inpatient admissions, the Government's formulaic application of the hypothetical monopolist test reflects the "days of old-fashioned and local, if expensive and inefficient, healthcare." *Tenet Health Care*, 186 F.3d at 1055. As demonstrated above, however, "recent trends in healthcare management have made the old healthcare model obsolete." *Ibid*. As a result, the district court did not err by taking these commercial realities into account and ruling that the Government failed to prove that hospitals outside of the Government's putative geographic mar-

ket could not constrain a post-merger attempt by the parties to raise inpatient prices.

The Government's one-dimensional version of the hypothetical monopolist test also ignores how payers and hospitals negotiate prices in the Chicago region and throughout the country. The Government's test implicitly embodies an "a la carte" world in which hospital prices are negotiated on a hospital-by-hospital basis. But that is not how hospitals and insurers negotiate prices in the real world. Today the norm is for payers and hospitals to negotiate a single contract with a hospital system for both inpatient and outpatient services, often across a wide range of geographic areas. *See* DPFOF ¶ 68 ("Payers negotiate inpatient and outpatient services as one in a single contract, focusing on the total spend due to price trade-offs between inpatient and outpatient services, which demonstrates that outpatient services can significantly impact inpatient pricing." (internal quotation marks omitted)); *id.* ¶ 74 ("Rates for multi-hospital systems are negotiated system-wide, rather than by individual hospital, and do not vary based on the location of the hospital or the patient using it."). The Government's model, however, fails to account for how these multi-dimensional negotiations affect final prices. It therefore cannot provide dispositive evidence of the geographic market.

CONCLUSION

Given the rapidly changing nature of markets for healthcare and health insurance, this Court should decline the Government's invitation to endorse a narrow application of the hypothetical monopolist test that limits the types of evidence that

courts may consider in defining geographic markets and ignores fundamental changes in the industry. Here, as in *Rockford Memorial*, the district court did not err in "thoroughly examin[ing] the testimony and exhibits submitted by expert witnesses, the testimony of lay witnesses, the physical geography of the area, including the location of the respective hospitals," while "also appl[ying] a simple, commonsense, approach to the question of what the geographic market should be." 717 F. Supp. at 1278; *see also California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1069-81 (N.D. Cal.) (considering a wide variety of factors and evidence as part of conducting the "small but significant non-transitory price increase" analysis, and rejecting the proposed market), *aff'd*, 217 F.3d 846 (9th Cir. 2000). Because this is what the law requires, this Court should affirm.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that the foregoing brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(d) because it contains 3,561 words, as determined by the word-count function of Microsoft Word 2010, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

I further certify that this brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5), the type style requirements of Federal Rule of Appellate Procedure 32(a)(6), and Circuit Rule 32(b) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 12-point New Century Schoolbook font.

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CERTIFICATE OF SERVICE

I hereby certify that on August 8, 2016, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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