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, Case No. 2:20-cv-18140 The Honorable John Michael Vazquez

OPENING BRIEF OF APPELLANTS

JEFFREY L. KESSLER
JEFFREY J. AMATO
JOHANNA RAE HUDGENS
Winston & Strawn LLP
200 Park Avenue
New York, NY 10163
(212) 294-6700

HEATHER P. LAMBERG
NEELY BETH AGIN
ANDREW E. TAUBER
Winston & Strawn LLP
1901 L Street, NW
Washington, D.C. 20036
(202) 282-5000

PAUL H. SAINT-ANTOINE
JOHN S. YI
Faegre Drinker Biddle & Reath LLP
One Logan Square, Ste. 2000
Philadelphia, PA 19103
(215) 988-2700

KENNETH M. VORRASI
JOHN L. ROACH, IV
JONATHAN H. TODT
ALISON M. AGNEW
Faegre Drinker Biddle & Reath LLP
1500 K Street, NW Suite 1100
Washington, D.C. 20005
(202) 842-8800

DAVID E. DAHLQUIST
KEVIN B. GOLDSTEIN
Winston & Strawn LLP
35 West Wacker Drive
Chicago, Illinois 60601
(312) 558-5600

Counsel for Appellant
Englewood Healthcare Foundation

DANIEL J. DELANEY
Faegre Drinker Biddle & Reath LLP
191 N. Wacker Drive, Suite 3700
Chicago, IL 60606
(312) 569-1000

AARON D. VAN OORT
Faegre Drinker Biddle & Reath LLP
2200 Wells Fargo Center
90 S. Seventh Street
Minneapolis, MN 55402
(612) 766-7000

Counsel for Appellant
Hackensack Meridian Health, Inc.

CORPORATE DISCLOSURE STATEMENT

Appellant Hackensack Meridian Health, Inc. has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

Appellant Englewood Healthcare Foundation has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

No publicly held corporation that is not a party to this appeal has a financial interest in the outcome of this proceeding.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES, RULES & REGULATIONS

OTHER AUTHORITIES

INTRODUCTION

This is an antitrust case brought under the Clayton Act in which the Federal Trade Commission ("FTC") is seeking to prevent a single community hospital in northern New Jersey ("Englewood") from joining a 16-hospital health system ("HMH"). In 2018, Englewood concluded that it needed to join a larger system to keep pace in New Jersey's highly competitive healthcare market. After a bidding process, it chose HMH, which agreed to provide more than $400 million in new capital investments that Englewood will use to improve its facilities and quality of care, to the great benefit of patients in northern New Jersey.

The district court, however, granted the FTC's motion to preliminarily enjoin the merger. The court concluded that the FTC had carried its burden of proving that the merger will be likely to substantially reduce competition in a relevant geographic market, but that decision rests on three fundamental errors.

First, and dispositively, the district court erred by allowing the FTC to define the relevant geographic market based on where patients live, rather than on where hospitals are located. Under this Court's precedent, a properly defined relevant market is an absolute prerequisite to a Clayton Act claim. Here, the FTC, through its expert Dr. Leemore Dafny, proposed a relevant market of commercially insured patients who live in Bergen County. The problem with this proposed market is that it is inconsistent with the undisputed fact that New Jersey hospitals do not charge targeted prices based on where patients live. Because of how insurers negotiate prices for hospital services,

hospitals charge the same prices for *all* patients covered by an insurer's plan, *regardless* of where the patients live. To raise prices for patients coming from Bergen County, a hospital would therefore have to raise prices for all its other patients covered by the insurer's plan, too—and risk losing money because of the many nearby hospitals competing for those patients.

In antitrust parlance, charging targeted prices based on customer location is known as price discrimination, and the presence of price discrimination is a prerequisite to defining a geographic market based on where customers are located. Absent price discrimination, a geographic market must be defined by where suppliers are located, so competition for all the suppliers' customers—and the net profit or loss incurred for all customers—is accounted for. The case law, the economic literature, and the FTC's own Horizontal Merger Guidelines ("Guidelines") unanimously agree on this point.

In this case, the FTC ignored these authorities to propose an antitrust market that does not exist—a market in which hospitals price discriminate based on patient location. This market is invalid as a matter of law, and because a properly defined market is a prerequisite to a Clayton Act claim, the FTC's case fails at the outset.

Second, even if the FTC had defined and proved a proper relevant market, it also failed to carry its ultimate burden of proving that the merger would be likely to "substantially lessen" competition. As the district court found, the merger will deliver procompetitive benefits to the people of New Jersey through improved facilities and patient care. Given those benefits, the FTC had the burden of producing direct evidence

of anticompetitive effects. To meet this burden, the FTC *claimed* that the merger will cause insurers to pay prices above a competitive level. But it provided no direct proof of that claim. All it provided was evidence of which hospitals *patients* prefer to visit, *independent* of price. As this Court has recognized, there is a fundamental difference between patient preferences (which are largely divorced from price because of insurance), and the prices insurers agree to pay for hospital services. The FTC argued that its economist could convert one into the other mathematically. But such a conversion can be performed only if patients' non-price preferences and insurers' agreed-upon prices are correlated. Here, the claims data from New Jersey insurers showed no statistical correlation between those two metrics. In short, the FTC provided no valid, direct evidence of a likely anticompetitive price increase to justify blocking the merger. For this reason, too, its case failed.

Third, even if the FTC had provided reliable, direct evidence of a likely anticompetitive price increase, the district court's decision must still be reversed because the court erroneously refused to weigh the merger's proven procompetitive effects of improved facilities and patient care unless they could be considered "extraordinary." That high legal standard, however, applies only to an asserted "efficiencies" defense. Procompetitive effects must always be considered in assessing whether the FTC has shown that a merger, on balance, will likely have a substantial anticompetitive effect. The district court erred in holding otherwise, and its legal error led it to improperly disregard the procompetitive effects it found.

For each of these reasons, the preliminary injunction must be vacated, and this valuable transaction be allowed to proceed.

JURISDICTIONAL STATEMENT

The district court had jurisdiction over the FTC's request for a preliminary injunction pursuant to 15 U.S.C. § 53(b) and 28 U.S.C. § 1331. The district court entered a final Order granting the preliminary injunction on August 4, 2021. ECF 367. The district court explained its reasoning in a separate Opinion with Findings of Fact & Conclusions of Law on August 4, 2021, ECF 366, which was filed under seal. The district court subsequently issued a redacted public version of that Opinion on August 19, 2021. ECF 368. Appellants timely filed a notice of appeal on August 25, 2021. App-1. This Court has jurisdiction under 28 U.S.C. § 1291 because the district court issued a final decision disposing of all claims in the case, and under 28 U.S.C. § 1292(a)(1) because the district court granted injunctive relief.

STATEMENT OF THE ISSUES

1. **Geographic market definition.** Did the district court act contrary to case law, basic economics, and the FTC's own Horizontal Merger Guidelines by allowing the FTC to define the relevant geographic market by patient location (instead of hospital location), when it is undisputed that hospitals do not engage in price discrimination based on where commercially insured patients live?

2. **Procompetitive benefits.** Did the district court err when it held that procompetitive effects must be "extraordinary" before they may be considered in

determining whether a merger would be anticompetitive, and therefore refused to weigh this merger's benefits of improved facilities and quality of care in the burden-shifting analysis?

3. **Direct evidence.** Did the district court err in holding that the FTC could establish a likely price increase above competitive levels by relying on estimates of patients' preferences for hospitals independent of price, when New Jersey claims data showed no correlation between such patient preferences and the prices insurers agreed to pay for hospital services?

RELATED CASES AND PROCEEDINGS

This case has not previously been before this Court. An administrative proceeding challenging the merger is pending before the Federal Trade Commission. *See* FTC Docket No. 9399.

STATEMENT OF THE CASE

This appeal challenges a preliminary injunction that the district court issued at the FTC's request to prevent a single community hospital from merging into an integrated health system.

A. The three-step, burden-shifting standard that governs cases brought under Section 7 of the Clayton Act.

The FTC's request for a preliminary injunction is based on Section 7 of the Clayton Act, 15 U.S.C. § 18, which bars mergers whose effect "may be to substantially lessen competition." A court may grant a preliminary injunction to enforce Section 7

only if the FTC makes "a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b); *see FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 337 (3d Cir. 2016) ("*Hershey*"). To make this showing, the FTC must demonstrate "there is a reasonable probability that the merger will substantially lessen competition." *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962); *see* App-106.

To assess whether a merger will substantially lessen competition, courts apply a three-step, sequential analysis.

Step 1: The FTC must first establish a prima facie case by proving the existence of a relevant market and showing that the proposed merger would likely have anticompetitive effects in that market.

"The relevant market is defined in terms of two components: the product market and the geographic market." *Hershey*, 838 F.3d at 338. A market is properly defined when the exercise of power *within* the market would not be constrained by competitive responses *outside* the market. To ensure that a market is not defined too narrowly, its "geographic scope must 'correspond to the commercial realities of the industry' being considered and 'be economically significant.'" *Id.* at 338 (quoting *Brown Shoe*, 370 U.S. at 336–37); *see also United States v. Sungard Data Sys.,* 172 F. Supp. 2d 172, 182 (D.D.C. 2001) (quoting *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 46 (D.D.C. 1998)) ("'[T]he determination of the relevant market in the end 'is a matter of business reality—how the market is perceived by those who strive for profit in it.'"). The market must also

pass "the hypothetical monopolist test," which asks whether "a hypothetical monopolist could impose a small but significant non-transitory increase in price ('SSNIP') in the proposed market." *Hershey*, 838 F.3d. at 338. If the hypothetical monopolist could not profitably impose a SSNIP, "the proposed market definition is too narrow." *Id.*

If the FTC does not prove the existence of a relevant market, the case ends. "'Determination of the relevant product and geographic markets is a necessary predicate to deciding whether a merger contravenes the Clayton Act.'" *Id.* (quoting *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618 (1974)).

If the FTC does prove the existence of a relevant market, it then must prove that the proposed merger would presumptively have anticompetitive effects in that market. In practice, courts use market concentration as a proxy to measure "the likely competitive, or anticompetitive, effects of a merger." *Hershey*, 838 F.3d at 346–47. Market concentration is commonly assessed using the Herfindahl-Hirschman Index ("HHI"), which is the sum of the squared market share of the participants in the relevant market.[1] "In determining whether the HHI demonstrates a high market concentration," courts "consider both the post-merger HHI number and the increase

[1] For example, if there are four firms in a market with shares of 30%, 30%, 20%, and 20%, the HHI is computed as 900 + 900 + 400 + 400 = 2,600. The HHI ranges from 10,000 for a pure monopoly to a number approaching zero as the shares of market participants approach zero. U.S. Dep't of Justice & FTC, *Horizontal Merger Guidelines* § 5.3 n.9 (2010).

in the HHI resulting from the merger." *Id.* at 346–47 (citing *Guidelines* § 5.3). "A post-merger market with a HHI above 2,500 is classified as 'highly concentrated,' and a merger that increases the HHI by more than 200 points is 'presumed to be likely to enhance market power.'" *Id.* (quoting *Guidelines* § 5.3).

Market scope and market power are usually inversely correlated: The broader the relevant market, the less likely it is to be concentrated enough to produce a presumption of market power. A narrow market is more likely to be highly concentrated—but it is also more likely to be affected by competition outside its boundaries and thus be improperly defined.

If the FTC proves *both* a properly defined relevant market *and* an increased degree of market concentration that entitles it to a presumption of anticompetitive effects, the analysis proceeds to the next step.

Step 2: The merging parties can rebut a presumption of anticompetitive harm by producing evidence showing that the FTC's "market-share statistics produce an inaccurate account of the merger's probable effects on competition in the relevant market." *United States v. H&R Block*, 833 F. Supp. 2d 36, 92 (D.D.C. 2011); *see also United States v. Baker Hughes*, 908 F.2d 981, 982–83 (D.C. Cir. 1990).

Step 3: If the merging parties produce evidence rebutting the presumption, the burden of production shifts back to the FTC, which must produce additional, direct evidence, beyond its prima facie case, of "anticompetitive effect." *Baker Hughes*, 908 F.2d at 983. The court then weighs all the evidence of procompetitive and

anticompetitive effects to determine if the FTC has shown a likelihood that the merger will substantially lessen competition. At all times, the FTC bears the ultimate burden of persuasion. *Hershey*, 838 F.3d at 337; App-107.

B. The party hospitals.

This case involves healthcare providers in northern New Jersey, one of the most densely populated metropolitan areas in the United States, where numerous hospitals and health systems compete vigorously to provide inpatient general acute care ("GAC") services.

Englewood Healthcare Foundation is a non-profit corporation that operates a single community hospital in Bergen County, New Jersey ("Englewood"). Englewood provides primary, secondary, and some non-complex tertiary services. It does not, however, provide more complex tertiary and quaternary services, and it lacks the expertise, regulatory approvals, and facilities to do so.[2] App-79, 385, 615, 680, 912–913.

Hackensack Meridian Health ("HMH") is a comprehensive health system with three academic medical centers, nine community hospitals, four specialty hospitals, a medical school, and a major research institution. App-889. HMH's flagship academic medical center, Hackensack University Medical Center ("HUMC"), and one community

[2] Hospital services are divided into four levels based on the complexity of care: primary, secondary, tertiary, and quaternary. App-79. Primary care is the least complex and quaternary care is the most complex. For example, delivery of a baby without complications is primary care, whereas organ transplants and high-end cancer treatments are quaternary care. *Id.*

hospital it co-owns, Pascack Valley Medical Center, are located in Bergen County. App-79; *see* App-889. HUMC is among the few hospitals in northern New Jersey that provides complex tertiary and quaternary services. App-80–81, 889–892.

Englewood and HUMC play different roles in commercial insurers' networks because HUMC provides higher-end services that few other facilities can provide, while Englewood does not. App-80–81, 104, 277–279, 489–490, 497–498, 521–525, 730–732, 733–734. Because of HUMC's ability to provide those higher-end services, it is distinctly valuable to commercial insurers. App-86, 104; *see* App-279–280, 734–735, 964. Its ability to provide those services, combined with the higher costs those services involve, App-281–282, 460–463, 899, have caused HUMC's prices to be significantly higher than Englewood's prices. App-88, 104, 658–661, 962–963.

C. The proposed merger and its benefits for patients.

In 2018, after years of subsisting as a community hospital, Englewood began to recognize that its needs were outpacing its resources. As its President and CEO Warren Geller testified, Englewood was nearing the limits of its debt covenants and was unable to take on any significant long-term debt to meet its large capital requirements. To evaluate its strategic plans and future needs, Englewood hired the Chartis Group. App-91, 203, 263–265, 390–393, 739–742, 748–749, 920–921.

Based on a comprehensive evaluation, Chartis concluded that "lower liquidity reserves" would make it challenging for Englewood to fulfill its capital needs through self-funding and to compete in a "crowded region with high-quality competitors." App-

394, 748–750. In response, Englewood's Board unanimously agreed that it should seek a merger partner to address these competitive weaknesses and improve its quality of care. App-92–93, 253–254, 390–393, 404, 743, 754–755, 756, 920–922.

Englewood solicited proposals, and five systems in New Jersey and New York expressed interest. After a screening process, HMH and one other New Jersey health system made it to the final stages of bidding. App-93–94, 263–265, 399, 404–405, 743–744, 747, 922–925. Englewood ultimately selected HMH as a merger partner because it offered a capital commitment that was front-loaded into the first four years of an eight-year period, did not have financial or operating conditions, and would not be reduced if Englewood's parent foundation also raised capital. In addition, HMH's offer included a firm volume commitment to transfer certain patients from HMH hospitals to Englewood and to develop Englewood into a "tertiary hub," which Englewood found "very exciting." App-96–97; *see* App-256–257, 400, 406, 751–753, 926–931. Englewood rejected the other offer because it included "unacceptable" financial qualifications and contained no plan to increase patient volume. App-97, 753, 927, 929–932.

Englewood and HMH signed a Definitive Agreement to effectuate a merger on September 23, 2019. App-97, 411. The Agreement articulates the rationale for the transaction, including optimizing services between Englewood and HMH, supporting Englewood as a tertiary hub within the broader HMH network, and reducing overcapacity problems at HUMC. *See* App-97–99, 893–899. In pursuit of these goals, HMH committed to a $439.5 million capital investment over eight years and made

numerous other clinical, operational, and financial commitments. App-97–98, 418–419, 893–899, 933–936.

D. The FTC's claims and the hospitals' defenses.

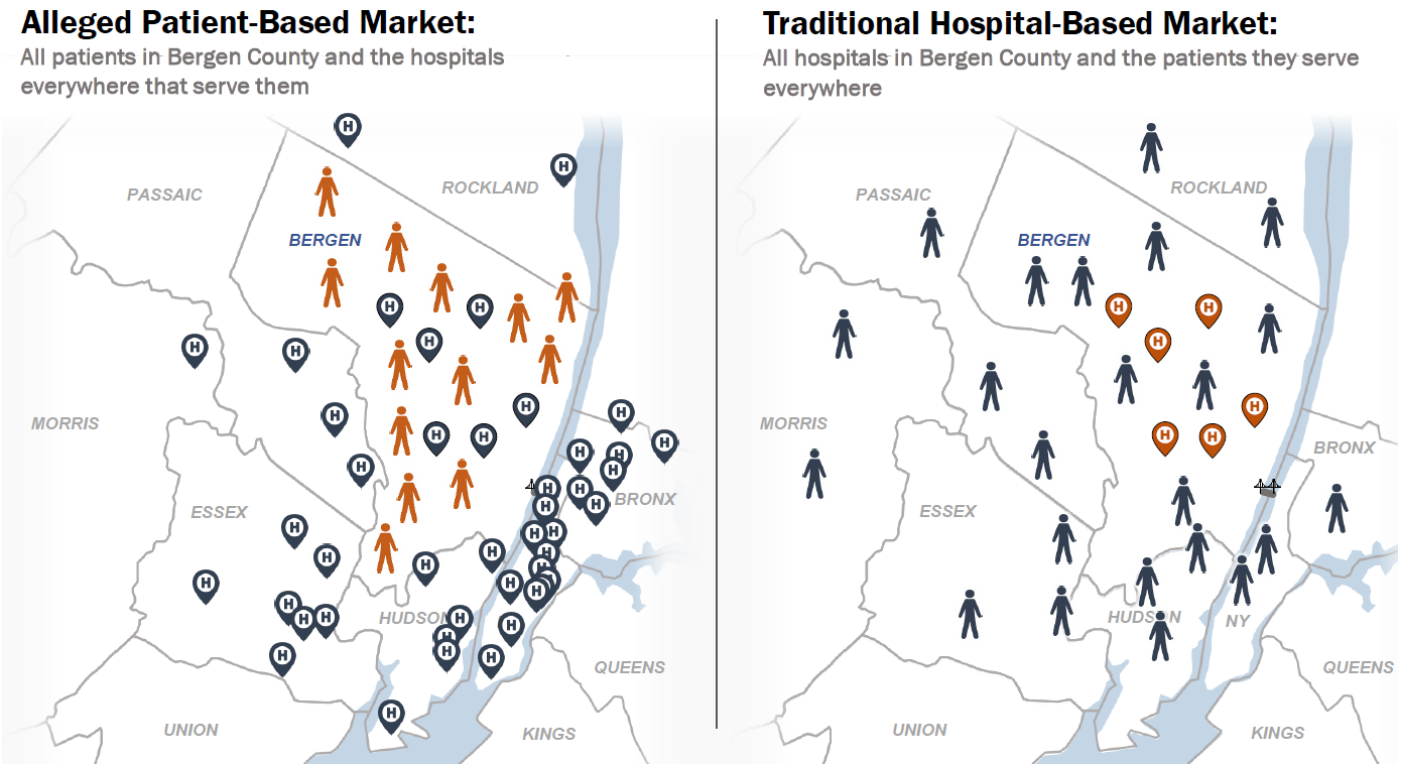
On December 3, 2020, after more than a year's delay, the FTC Commissioners authorized the FTC to file this action and also initiate an administrative proceeding challenging the merger as a claimed violation of Section 7 of the Clayton Act. App-104–105; *see* Compl. (ECF 14). Over the next several months, the parties completed discovery from competitor hospitals, insurers, employers in New Jersey, and expert witnesses. The district court conducted a seven-day evidentiary hearing in May 2021, with live testimony from fifteen fact witnesses and seven expert witnesses. App-77–78.

1. The FTC's prima facie case.

To establish a prima facie case of anticompetitive harm, the FTC relied on its expert witness, Dr. Leemore Dafny, who proposed a relevant market of inpatient GAC services (the product) provided to commercially insured patients living in Bergen County (the geographic scope).

As Dafny repeatedly emphasized, the geographic market she proposed was defined by patient location, not hospital location. App-778, 814, 817–818, 858–859. At her deposition, Dafny testified: "I defined my market based on customer location." App-720. She repeated that testimony at trial, saying her proposed market was "defined on the location of patients." App-778; *see also* App-267 ("Market defined based on location of patients"). The market thus covered only patients who reside in Bergen

County, but all hospitals those residents visit anywhere. As Dafny explained, "my definition includes all hospitals—inside and outside of Bergen County—that Bergen County residents visit for care." App-687–689; *see* App-994. Conversely, a hospital-based market would include only hospitals located in Bergen County, but all patients who visited them from anywhere. The difference between these two markets is illustrated by the following graphics:



By limiting the market to patients residing in Bergen County, Dafny excluded roughly half of both Englewood's and HUMC's patients and revenue. For Englewood, approximately half of its commercial revenue and 45% of its commercially insured patient discharges are attributable to patients who live outside Bergen County. App-80, 546, 914–916, 949–950, 1016–1017. For HUMC, *more than* half of its commercial

revenue and nearly 50% of its patient volume are attributable to patients who live outside Bergen County. App-80; *see* App-260–261, 440, 562, 569, 576–577, 626, 627, 902–903.

At trial, it was undisputed that Englewood and HUMC could not raise prices to an insurer for its covered patients living in Bergen County without raising prices for *all* that insurer's patients because of how insurers negotiate prices. As this Court recognized in *Hershey*, prices for hospital services are negotiated between hospitals and insurers. 838 F.3d at 342. The evidence at trial showed that insurers negotiate the same prices for all patients who will be covered by their plans, regardless of where the patients live. As the insurers uniformly testified, "the prices that [a] hospital charges to [the insurer], do[] not depend on where [the insurer's] members may live." App-275–276; *see* App-87–88, 725. Further, since the plans that insurers offer cover areas far larger than Bergen County, there is no reasonable prospect of pricing hospital services to target Bergen County residents alone. None of the four major commercial insurers offers, or intends to offer, a commercial health plan limited to patients who reside in Bergen County. App-87, 274–275, 476–478, 482, 513–514, 719, 722–724, 736, 737–738; *see* App-434, 435, 436, 443, 447, 450.

The testimony from Englewood and HMH mirrored that of the insurers: the prices Englewood and HMH charge insurers for GAC services do not depend on where the patients receiving those services live. App-629–630, 917–918, 1008–1010. An HMH executive testified, without contradiction, that "[w]here an individual resides has no

bearing whatsoever on [HMH's] prices," App-1009, and Englewood's CEO testified that the same is true for Englewood, App-918.

The only employer to testify at trial confirmed that it does not "pay different prices for the hospital services that [its] employees use based on which county in Northern New Jersey they may reside." App-1005–1006. The FTC's expert acknowledged that this is true of employers generally. App-815–819.

Given this undisputed evidence, the FTC's expert admitted that she was "not offering an opinion that today hospitals set a price that specifically varies based on the end patient's county of residence." App-1061; *see also* App-694. It is therefore undisputed that any hospital (wherever located) seeking to raise the prices of its GAC services provided to commercially insured patients residing in Bergen County would have to raise prices for all its patients covered by each insurer, including those who live outside Bergen County, and would have to face the competitive consequences for all those patients.

Contrary to this undisputed commercial reality, the FTC's expert limited her proposed geographic market to patients living in Bergen County.

Having proposed a patient-based market, however, the expert never tested it by evaluating whether a hypothetical monopolist controlling all hospitals anywhere in the country that served Bergen County residents could profitably charge a SSNIP to all its commercially insured patients. When asked why she did not perform this test on the market she proposed, Dafny said that her "model would explode." App. 853–854.

Instead, Dafny evaluated a *different* geographic market—a market defined by hospital location, not patient location. Specifically, she evaluated whether a hypothetical monopolist owning only hospitals located in Bergen County could profitably charge a SSNIP. *Guidelines* § 4.2.2; App-784–785, 850–852. Although Dafny thus assessed a hospital-based market, she did not actually propose any such hospital-based market. Indeed, she forthrightly conceded that she did not assess who Englewood's and HUMC's closest competitors are, even though the closest competitors must be included in a hospital-based market for it to correspond to the commercial realities of the actual market. App-831; *Guidelines* § 4.1.1 & Ex. 6. This was no small issue, given that 24 competing hospitals are located within a 30-minute drive of Englewood. App-269, 624.

At the final stage of the analysis, Dafny proceeded to calculate market shares and market concentration statistics in the patient-based market she had proposed but not tested. That market yielded a post-merger HHI of 2,835. App-595–596, 790–791. This barely exceeded the Guidelines' threshold for generating any presumption of anticompetitive market power.

2. The hospitals' production of evidence of procompetitive effects rebutting any presumption arising from the prima facie case.

At the second stage of the burden-shifting analysis, Appellants produced strong evidence that the FTC's prima facie case did not accurately indicate a likelihood of anticompetitive effects and that, even if it did, those effects were offset by procompetitive benefits such as improved quality of care.

First, Appellants showed that making small and reasonable adjustments to the FTC's proposed market would eliminate its fragile presumption of market power. *See Guidelines* § 4 (directing consideration of whether there are "alternative and reasonably plausible candidate markets," and whether "the resulting market shares lead to very different inferences regarding competitive effects"). Appellants' expert, Dr. Lawrence Wu, assessed at least three alternative markets that would result in post-merger HHIs below the 2,500 threshold: (1) a market compromised of Bergen County residents (already included in the FTC's market) *plus* patients within a 20-minute drive of HUMC or Englewood; (2) a market comprised *only* of patients residing within a 20-minute drive of HUMC or Englewood; and (3) a market comprised of patients residing in HUMC's and Englewood's combined primary service areas. App-647–657, 958–960. Under any of these alternatives, some of which are *smaller* than the market Dafny proposed, there would be no presumption of market power.

Second, although the district court did not credit all of Appellants' evidence, it nonetheless found that Appellants had proven procompetitive benefits. In particular, the court found that HMH's $439.5 million investment in Englewood will "provid[e] significant capital to Englewood for necessary improvements to its physical plant, including upgrades to the OR and the Heart Center of Excellence," as well as provide Englewood with a robot for Englewood's robotic urology services and physician resources. App-97–98, 132, 427–432. Expressly "recogniz[ing] that these improvements to Englewood could likely amount to a procompetitive benefit to Bergen

County, in that Englewood should be able to upgrade its facilities and equipment thereby offering a broader array of services for its patients," the court concluded that Appellants had "establish[ed] that improvements at Englewood will result in an adequate procompetitive benefit." App-132, 140. The court further found that "both hospitals (particularly Englewood) will likely see certain improvements in quality due to the merger." App-140. Finally, it found that the merger would have the additional, albeit "limited benefit of HUMC recapturing a small number of outmigration patients," *i.e.*, patients who would otherwise go to New York for complex treatment. *Id.*

3. The FTC's direct evidence.

Because Appellants identified flaws in the FTC's prima facie case and also produced evidence of procompetitive effects, the ultimate burden of proving likely anticompetitive price increases fell to the FTC.

To meet its burden, the FTC claimed to quantify a "rough estimate" of the merger's potential price effect. *See* App-597–601. To arrive at this "rough estimate," Dafny calculated how strongly patients prefer having a given hospital in their insurer's network, independent of the prices the hospitals charge insurers. She then applied a coefficient from an academic study of hospitals outside New Jersey to this metric, claiming that it could convert the patient preferences into an estimate of higher prices that insurers will supposedly agree to pay because of the merger. Appellants' expert, Wu, demonstrated that this calculation is unreliable, because the real-world claims data from New Jersey insurers showed no correlation between hospitals' prices and the non-

price preferences of patients on which Dafny relied. *See* App-245, 969–973; *cf.* App-865–868.

E. The district court's opinion.

On August 4, 2021, the district court granted the FTC's request for a preliminary injunction. ECF 366, 367, 368.

On the critical, disputed issue of the relevant geographic market, the district court allowed the FTC to define the market based on patient location, rather than hospital location, even though it was undisputed that hospitals do not price discriminate based on patient location. App-119. The court did so on the belief that price discrimination is not a prerequisite to defining a market based on customer location. App-112.

The district court then concluded that the FTC's patient-based geographic market had been validated by the HMT. App-111. The court acknowledged that the FTC had applied that test to a supplier-based market its expert did not propose rather than to the patient-based market she did propose, but it concluded the difference did not legally matter. App-117–118.

After concluding that the FTC had met its burden of establishing a prima facie case, App-130, the court found in the second stage of the analysis that Appellants had produced evidence of "an adequate procompetitive benefit," citing improved facilities at Englewood and improved quality of care at both Englewood and HMH. App-140. Nonetheless, the district court refused to weigh those benefits because it concluded

Appellants had "fail[ed] to establish" that they were "*extraordinary* procompetitive effects." App-131 (emphasis added). Because the court believed that "extraordinary" benefits were required, it concluded that Appellants had "fail[ed] to rebut the FTC's prima facie case." App-140.

The district court further stated that "[e]ven if" Appellants had "rebutted the FTC's prima facie case …, the Court would" nonetheless conclude that the FTC had met "its burden of persuasion." App-141. Here, the court accepted Dafny's "rough estimate" of increased prices for insurers based on patient preferences. App-121–125. To discount Wu's conclusion that the New Jersey data showed no statistically significant relationship between patients' hospital preferences and the prices insurers paid, the district court relied on clauses in HMH's commercial insurance contracts that were negotiated *before* the merger. App-125–127. The court reasoned, without basis and contrary to the FTC's own concessions about the irrelevance of *pre*-merger market power, that these contract provisions are direct evidence of how the merger will change market power. The district court also found it unimportant that the contract provisions had been waived. App-127; *see* App-904–906, 1011–1013. In so concluding, the court noted but did not address Appellants' argument that the waivers "are enforceable on equitable grounds." App-127.

Based on this analysis, the district court concluded that "the FTC establishe[d] a likelihood of success in demonstrating … that 'there is a reasonable probability that the challenged transaction will substantially impair competition.'" App-140–141.

SUMMARY OF ARGUMENT

Proposing and proving a relevant market "is a necessary predicate to deciding whether a merger contravenes the Clayton Act," *Hershey*, 838 F.3d at 338, and the FTC failed at that first step. Through its expert, the FTC proposed a customer-based geographic market of commercially insured patients who live in Bergen County, New Jersey. It is undisputed, however, that New Jersey hospitals do not price discriminate based on where patients live: Commercially insured residents of Bergen County are charged the same prices as commercially insured residents of Hudson, Passaic, Essex, and other counties. Hospital prices are negotiated with insurers, and insurers ask for—and get—the same price for *all* patients their plans cover, regardless of where the patients live. A hospital wanting to raise prices must therefore raise them for *all* covered patients, regardless of where they live, and risk losing money because of the many hospitals competing for those patients. The case law, the economic literature, and the FTC's own Guidelines unanimously agree that a price-discrimination market cannot be used where, as here, there is no price discrimination. By ignoring this authority, the district court applied an "erroneous economic theory to those facts that make up the relevant geographic market" and thus "committed legal error subject to plenary review." *Hershey*, 838 F.3d at 336. On the undisputed facts and controlling law, the FTC failed to establish a relevant geographic market. This failure "is dispositive" of the FTC's Clayton Act claim. *FTC v. Freeman Hosp.*, 69 F.3d 260, 272 (8th Cir. 1995). With no likely violation, there can be no injunction. This Court need not go further to reverse.

Even if the FTC had established a prima facie case by defining and proving a proper relevant market, the injunction would still have to be vacated because the FTC failed to carry its ultimate burden of proving that the merger would be likely to "substantially lessen" competition. As the district court found, the merger will strengthen Englewood's ability to compete for patients by allowing it to substantially improve its facilities and its quality of care, to patients' great benefit. App-140. Despite acknowledging this "adequate procompetitive benefit," however, the district court erroneously held that Appellants had not rebutted the FTC's prima facie case because it believed only "extraordinary" benefits could do that. App-131. That was error on two levels. *First*, it incorrectly created an overly high standard for rebutting a prima facie case. *Second*, it incorrectly applied the standard that governs asserted "efficiencies" defenses to its assessment of procompetitive benefits, when procompetitive benefits must *always* be considered in assessing whether the FTC has shown that a merger, on balance, will likely have a substantial anticompetitive effect.

Because Appellants concededly showed that the merger will strengthen Englewood's ability to compete, the FTC had the ultimate burden of producing direct evidence of anticompetitive effects and demonstrating that it was persuasive. To meet this burden, the FTC *claimed* that the merger will cause insurers to pay the merged entity prices above a competitive level. But it provided no direct proof of that claim. All it provided was evidence of which hospitals *patients* prefer to visit, *independent* of price. As this Court has recognized, there is a "fundamental difference" between patient

preferences and the prices insurers agree to pay for hospital services. *Hershey*, 838 F.3d at 342. The FTC argued that its economist could convert one into the other mathematically. But such a conversion can be performed only if patients' non-price preferences and the prices insurers agree to pay hospitals are shown to be statistically correlated. Here, the claims data from New Jersey insurers showed no such correlation. In short, the FTC provided no valid, direct evidence of a likely anticompetitive price increase to justify blocking the merger. For this reason as well, its case failed.

For each of these reasons, the preliminary injunction must be vacated, and this beneficial transaction be allowed to proceed.

STANDARD OF REVIEW

On appeal, 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 (quoting *Miller v. Mitchell*, 598 F.3d 139, 145 (3d Cir. 2010)); *see also McTernan v. City of York*, 577 F.3d 521, 526 (3d Cir. 2009). Factual findings are deemed to be clearly erroneous when they are "unsupported by substantial evidence, lack adequate evidentiary support in the record, are against the clear weight of the evidence or where the district court has misapprehended the weight of the evidence." *United States v. 6.45 Acres of Land*, 409 F.3d 139, 145 n.10 (3d Cir. 2005) (quoting *United States v. Roman*, 121 F.3d 136, 140 (3d Cir. 1997)).

While the issue of market definition in an antitrust case "is generally regarded as

a question of fact," "a trial court's determination of the market may be reversed where that tribunal has erred as a matter of law." *Hershey*, 838 F.3d at 335 (quoting *Am. Motor Inns, Inc. v. Holiday Inns, Inc.*, 521 F.2d 1230, 1252 (3d Cir. 1975)). Where the district court "applies an incomplete economic analysis or an erroneous economic theory to those facts that make up the relevant geographic market, it has committed legal error subject to plenary review." *Id.* at 336; *see also White & White, Inc. v. Am. Hosp. Supply Corp.*, 723 F.2d 495, 499 (6th Cir. 1983) ("[T]he preponderance of authority holds that the determination of a relevant market is composed of the articulation of a *legal* test which is then applied to the *factual* circumstances of each case.") (emphasis in original).

ARGUMENT

I. The FTC Failed to Establish a Prima Facie Case of Anticompetitive Harm Because It Failed to Prove a Relevant Geographic Market.

As this Court has held and the FTC conceded below, "[d]etermination of the relevant product and geographic markets is a necessary predicate to deciding whether a merger contravenes the Clayton Act." *Hershey*, 838 F.3d at 338 (quoting *Marine Bancorporation*, 418 U.S. at 618); *see* App-718. "Without a well-defined relevant market, an examination of the merger's competitive effect would be without context or meaning." *Hershey*, 838 F.3d at 338.

Here, the FTC failed to establish the "necessary predicate" to its claim because it proposed a geographic market defined by patient location despite the undisputed fact that hospitals do not price discriminate based on where commercially insured patients

live. The FTC's geographic market consequently excluded half of Englewood's and HUMC's patients and deprived its competitive analysis of "context or meaning." The district court erroneously agreed with the FTC's argument that price discrimination is not required to define a customer-based market, then it further erred by finding that the FTC had validated its customer-based market by applying the HMT to a different, supplier-based market—a market its expert neither proposed nor justified.

The FTC's failure to define a relevant geographic market "is dispositive." *Freeman Hosp.*, 69 F.3d at 272. Its case failed as a matter of law, and the order issuing an injunction must therefore be reversed.

A. The district court erred in allowing the FTC to use a patient-based geographic market when it was undisputed that hospitals do not price discriminate based on where patients live.

Neither the FTC nor the district court disputed the fact that hospitals do not price discriminate based on where commercially insured patients live. *See supra* at Stmt. of Case D.1. To the contrary, it is undisputed that Englewood and HUMC would have to raise prices to insurers for *all* their commercially insured patients to raise them for patients coming from Bergen County.

Unable to claim that price discrimination occurs, the FTC instead argued that patient-based markets can be proper even without price discrimination. The FTC's expert claimed, "There is no need for me to assess the price discrimination, as it wasn't central to defining my market." App-825–826. The district court agreed, "conclud[ing] that the lack of price discrimination here does not doom Bergen County as a relevant

geographic market." App-112.

In holding that price discrimination is not required to define a geographic market based on patient location, the district court relied on "an erroneous economic theory," the application of which was a "legal error subject to plenary review." *Hershey*, 838 F.3d at 336. Economic literature, case law, and even the FTC's own Horizontal Merger Guidelines unanimously agree that a market can be defined by customer location *only if* suppliers can price discriminate based on customer location. The reason is intuitive and obvious: Unless a supplier can price discriminate based on customer location, it must raise prices for all customers to raise prices for any of them, so the market must be defined to include all those customers to accurately assess whether a price increase will increase or decrease the supplier's net profits. Artificially limiting the market to only a subset of customers inaccurately ignores the real scope of competition. Here, for example, it is undisputed that patients outside Bergen County account for fully *half* of HUMC's commercial revenue and nearly *half* of Englewood's. *See supra* at Stmt. of Case D.1. The FTC's Bergen County patient-based market artificially excludes all these patients.

The economic literature unambiguously states that price discrimination is a prerequisite to defining a relevant customer-based geographic market: "If a hypothetical monopolist can 'profitably raise' price to a subset of its customers, these customers constitute a separate relevant market. If, on the other hand, profitable price discrimination against the subset of customers is not feasible, the subset does not define

a separate relevant market." App-286, J. Hausman et al., *Market Definition Under Price Discrimination*, 64 Antitrust L.J. 367, 369 (1995–96) (noting that when defining a relevant market around a subset of customers, the "crucial question concerns whether a hypothetical monopolist could profitably price discriminate"); P. Areeda & H. Hovenkamp, *An Analysis of Antitrust Principles and Their Application*, ¶ 534d (4th and 5th Eds., 2021) ("Successful price discrimination means that the disfavored geographic or product class is insulated from the favored class and, if the discrimination is of sufficient magnitude, should be counted as a separate relevant market.").

Indeed, in the economic literature, customer-based markets are *called* price-discrimination markets: "Geographic markets defined around customer locations are 'price discrimination markets' and are delineated only if sellers can charge different prices (net of transportation costs) at different destinations." App-320, G. Werden, *Why (Ever) Define Markets? An Answer to Professor Kaplow*, 78 Antitrust L.J. 729, 743 (2012).

Judicial decisions likewise uniformly hold that "[d]efining a market around a targeted consumer … *requires* finding that sellers could 'profitably target a subset of customers for price increases…'" *FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 117–18 (D.D.C. 2016) (emphasis added) (citing *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 38 (D.D.C. 2015)); *FTC v. Wilh. Wilhelmsen Holding ASA*, 341 F. Supp. 3d 27, 46–47 (D.D.C. 2018). This follows directly from the question at the core of the HMT, which is whether the monopolist "will be able to *profitably* impose a SSNIP." *Hershey*, 838 F.3d at 346; *see also United States v. Engelhard Corp.*, 126 F.3d 1302, 1306 (11th Cir. 1997) ("the question is

whether a hypothetical monopolist could *profitably* raise price").

Both the courts and the Federal Trade Commission (sitting as an adjudicatory body) have made price-discrimination a prerequisite for defining a customer-based market. *See United States v. Eastman Kodak Co.*, 63 F. 3d 95, 106–07 (2d Cir. 1995) (rejecting proposed customer-based market for failure "to produce probative evidence of systemic price discrimination"); *In re R.R. Donnelley & Sons Co.*, 120 F.T.C. 36, 158 (1995) (rejecting proposed customer-based market because the FTC did not show "the hypothetical monopolist [could] selectively and profitably increase prices"); *In re Tronox*, No. 3977, 2018 WL 6630200, at *15–16 (F.T.C. 2018) (accepting a customer-based market given evidence of suppliers charging customers different prices based on their locations).

In previous cases, the FTC itself argued that price discrimination is a prerequisite to defining a geographic market based on customer location. In one case, the FTC maintained that suppliers' ability to "profitably price discriminate by setting different prices to the targeted customers than to other customers" is the "*key condition* for defining a market around a particular type of customer." Pls' Prop. Findings of Fact & Conclusions of Law ¶ 12 (ECF 444), *FTC v. Staples, Inc.*, No. 1:15-cv-2115 (D.D.C. April 20, 2015) (emphasis added). In another case, the FTC and DOJ urged that, when "geographic price discrimination" is not feasible, "competition between suppliers effectively occurs at the points of production[,]" and the relevant geographic market is defined by supplier location. Br. of United States & FTC as Amici Curiae at 15 (ECF

36), *E.I. Du Pont De Nemours & Co. v. Kolon Indus., Inc.*, Nos. 10-1103, 10-1275 (4th Cir. May 4, 2010).

Moreover, the FTC's own Guidelines, which this Court recognizes as persuasive authority, *see Hershey*, 838 F.3d at 338 n.2, clearly tie customer-based market definitions to customer-based price discrimination. In a section titled "Targeted Customers and Price Discrimination," the Guidelines explain:

> When price discrimination is feasible, adverse competitive effects on targeted customers can arise, even if such effects will not arise for other customers. A price increase for targeted customers may be profitable even if a price increase for all customers would not be profitable because too many other customers would substitute away. *When discrimination is reasonably likely*, the Agencies may evaluate competitive effects separately by type of customer.

Guidelines § 3 (emphasis added). Because adverse competitive effects on targeted customers can arise only through price discrimination, the Guidelines state that "[t]he possibility of price discrimination influences market definition (see Section 4)." *Id.* § 3.

In Section 4, titled "Market Definition," the Guidelines directly link the propriety of defining a relevant market based on targeted customers to the supplier's ability to price discriminate to those customers. Addressing targeted-customer product markets, the Guidelines state:

> *If a hypothetical monopolist could profitably target a subset of customers for price increases*, the Agencies may identify relevant markets defined around those targeted customers, to whom a hypothetical monopolist would profitably and separately impose at least a SSNIP. *Markets to serve targeted customers are also known as price discrimination markets.* In practice, *the Agencies identify price discrimination markets* ***only*** *where they believe there is a realistic prospect of an adverse competitive effect on a group of targeted customers*.

Id. § 4.1.4 (emphasis added). The Guidelines repeat the same rule for targeted

geographic markets: "*When the hypothetical monopolist could discriminate based on customer location*, the Agencies may define geographic markets based on the locations of customers." *Id.* § 4.2.2 (emphasis added).

As commentators on the Guidelines have recognized, "[t]he presence of price discrimination (or not) *always* has been an analytical key to determining whether one should begin with supplier location or customer location; these are two very different approaches to market definition." App-341, K. Elzinga & V. Howell, *Geographic Market Definition in the Merger Guidelines: A Retrospective Analysis*, Review of Indus. Org. 453, 469 (2018) (emphasis added); *see also* P. Areeda & H. Hovenkamp, *An Analysis of Antitrust Principles and Their Application*, ¶ 534d (4th and 5th Eds., 2021) ("The 2010 Horizontal Merger Guidelines speak of price discrimination that is capable of permitting higher prices to 'targeted customers,' thus justifying a smaller market definition covering those customers.").

In this case, the FTC invoked the portions of the Guidelines that it found helpful, such as HHI-defined concentration levels, but ignored the portions showing that its customer-based market was improper. The district court, recognizing that the Guidelines are persuasive authority and attempting to distinguish them, argued that "Section 4.2 of the Guidelines does not use mandatory language" requiring price discrimination to define a customer-based market. App-112. This is wrong. Section 4.2 states that, "*[w]hen the hypothetical monopolist could discriminate based on customer location*, the Agencies may define geographic markets based on the locations of customers."

Guidelines § 4.2.2 (emphasis added). This language allows the FTC to use a customer-based market *only* "[w]hen the hypothetical monopolist could discriminate based on customer location." *Id.* (When price discrimination exists, the FTC still has discretion *not* to use a customer-based market definition, but it has no discretion to use one absent price discrimination.). That is clear not only from Section 4.2.2, but from all the other sections quoted above.

The district court also mistakenly believed that the FTC had "successfully used a patient-based market without evidence of price discrimination" in *Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health System*, No. 1:12-cv-00560, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff'd* 778 F.3d 775 (9th Cir. 2015). *See* App-112. In fact, the FTC used a supplier-based market in that case, not a patient-based market. The case involved the acquisition of a group of primary care physicians ("PCPs") in Nampa, Idaho. The FTC's expert made clear that the proposed market was based on the location of the PCPs, not the location of their patients. *See* Pls' Am. Proposed Findings of Fact ¶ 56 (ECF 454) (FTC's expert explaining that "a hypothetical monopolist controlling all Adult PCP services in Nampa" could profitably impose a SSNIP); Hr'g Tr. Day 8 at 1315–1316 (ECF 316) (FTC's expert testifying that operative question was whether "all the PCPs in Nampa [could] get away with a collective price increase?"); Demonstratives for the Testimony of Pls' Expert, Professor Dranove (October 2, 2013) at 21, https://www.ftc.gov/system/files/documents/cases/131002stlukedemodranove.pdf ("Hypothetical monopolist of all Adult PCPs in Nampa could profitably impose a

SSNIP"). Recognizing that the FTC's proposed relevant market was "the area where those PCPs practice," the court reviewed the evidence to determine whether "Nampa PCPs" could profitably impose a SSNIP on insurers. *St. Alphonsus*, 2014 WL 407446, at *8. Thus, contrary to what the court below believed, *Saint Alphonsus* involved a supplier-based market, not a patient-based market.

The use of a supplier-based market in *Saint Alphonsus* is consistent with how the FTC has defined the relevant market in previous hospital merger cases. *See, e.g.*, Compl. (ECF 1), *FTC v. ProMedica Health Sys., Inc.*, No. 11-00047 (N.D. Ohio Jan. 7, 2011); Compl. (ECF 1), *FTC v. OSF Healthcare Sys.*, No. 11-50344 (N.D. Ill. Nov. 18, 2011); Admin. Compl., *In re Cabell Huntington Hosp., Inc.*, No. 9366 (F.T.C. Nov. 6, 2015); *Hershey*, 838 F.3d at 338; *FTC v. Advocate Health Care Network*, 841 F.3d 460, 465–66 (7th Cir. 2016); *FTC v. Thomas Jefferson Univ.*, 505 F. Supp. 3d 522, 534–35 (E.D. Pa. 2020); Compl. (ECF 5), *FTC v. Methodist Le Bonheur Healthcare*, No. 20-02835 (W.D. Tenn. Nov. 16, 2020).

In short, the district court erred as a matter of law in allowing the FTC to define a geographic market based on patient location without proof that hospitals "could profitably target a subset of customers for price increases." *Staples*, 190 F. Supp. 3d at 118 (internal quotation marks omitted). In doing so, it applied "an erroneous economic theory" to the undisputed facts and thereby "committed legal error" that is "subject to plenary review." *Hershey*, 838 F.3d at 336. Because the FTC's proposed market was legally improper, its Clayton Act case failed as a matter of law, and the injunction must

be vacated.

B. The FTC did not verify its patient-based market with the hypothetical monopolist test and tested only a supplier-based market its expert did not propose.

Because the FTC's proposed geographic market was improperly defined, it could not be salvaged through any application of the HMT. But in fact, the FTC never applied the HMT to the patient-based market its expert proposed. Instead, it applied the HMT to a supplier-based market of the six hospitals located in Bergen County. The FTC's expert, however, neither proposed nor defended this supplier-based market. Thus, *no* relevant market was both proposed and properly tested.

It is undisputed, *first*, that the FTC never applied the HMT to the patient-based market its expert proposed. Dafny proposed a relevant market of *all* hospitals that serve patients from Bergen County, wherever those hospitals may be located, but *only* patients who reside in Bergen County. As she testified, "*any* hospital that serves a resident of Bergen County is included as a market participant." App-779 (emphasis added). When it came time to apply the HMT, however, Dafny never tested her patient-based market. For most of the hospitals in her proposed market, she performed no calculations at all. Instead, she tested only the six hospitals located in Bergen County. In addition, she tested all the patients those hospitals served from the surrounding four-county area. This was a supplier-based market, not a patient-based market. Indeed, Dafny conceded, and the lower court acknowledged, that she applied the HMT to a market "based on the location of facilities" rather than one based on the location of patients. App-702–

703; *see* App-111 ("WTP analysis examines the leverage that a hypothetical monopolist *of Bergen County hospitals* would have as to insurers") (emphasis added).

Dafny also cited testimony from insurers in support of her claim that a hypothetical monopolist could raise prices for patients from Bergen County. Once again, however, this testimony addressed a supplier-based market, not a patient-based market. The insurers were never asked whether a hypothetical monopolist owning all the hospitals anywhere in the country could profitably raise prices just for patients residing in Bergen County. Instead, they were asked whether they needed a hospital in Bergen County to offer insurance plans to Bergen County residents. App-110 ("The commercial insurers, including Horizon, testified that they cannot offer a marketable plan in Bergen County that does not include a Bergen County hospital."). Not only did this question fail to address the relevant issue of whether a hypothetical monopolist could profitably raise prices, but it also addressed the wrong market.

In sum, Dafny never tested the patient-based market she proposed. This left her proposed market unverified and the FTC's case unproven. To Appellants' knowledge, no case has ever approved one market based on applying the HMT to a different market, and this Court should not be the first.

Second, while Dafny tested a supplier-based geographic market, she neither proposed such a market as a potentially relevant market nor performed the analysis that would be required to do so. Indeed, she repeatedly and forthrightly agreed that she was *not* proposing a supplier-based market. App-778, 814, 858–859. She further agreed that

she had made no attempt to consider which of Englewood's and HUMC's competitors would need to be included in such a market to make it accurately reflect the commercial reality of competition. "[A] market's geographic scope must 'correspond to the commercial realities of the industry' being considered." *Hershey*, 838 F.3d at 338. Thus, validly defining a supplier-based market requires identifying the substitute hospitals to which insurers "could practicably turn" for GAC services. *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963); *Hershey* 838 F.3d at 342; *Guidelines* §§ 4.2.1, 4.11 Ex. 6.

Because of the complexity of this analysis, "[c]onstruction of the relevant market . . . must be based on expert testimony." *Premier Comp Sols. LLC v. UPMC*, 377 F. Supp. 3d 506, 526 (W.D. Pa 2019); *see also Colsa Corp. v. Martin Marietta Servs., Inc.*, 133 F.3d 853 (11th Cir. 1998) (finding that the construction of a relevant antitrust market cannot be based on lay opinion testimony); *Ky. Speedway, LLC v. Nat'l Assoc. of Stock Car Auto Racing, Inc.*, 588 F.3d 908, 919 (6th Cir. 2009) (finding that the use of lay testimony and marketing reports in lieu of expert testimony was insufficient to define relevant markets). Dafny, however, conceded that she did not perform this analysis for Englewood and HUMC. App-831. This was no minor issue, given that 24 competing hospitals are located within a 30-minute drive of Englewood. App-624; *see* App-269.

In short, the FTC did not prove the existence of any relevant geographic market. Because proving the existence of a relevant geographic is a "necessary predicate to deciding whether a merger contravenes the Clayton Act" (*Hershey*, 838 F.3d at 338), the FTC's case fails as a matter of law.

II. The FTC Failed to Carry its Ultimate Burden of Proving that the Merger is Likely to Substantially Lessen Competition.

Even if the FTC had met its burden of proving a relevant geographic market and had established a prima facie case (which it did not), the injunction would still have to be vacated because Appellants produced sufficient evidence to rebut the prima facie case, and the FTC then failed to carry its "ultimate burden of persuasion." *Hershey*, 838 F.3d at 337. In concluding otherwise, the district court committed two distinct errors. *First*, it did not properly weigh the merger's procompetitive benefits because it erroneously believed that only "extraordinary" benefits may be considered. App-131, 140. *Second*, the court erroneously concluded that the FTC could use measurements of *patients' non-price* preferences to establish that *insurers* would agree to pay *higher prices* to the hospitals after a merger, without establishing that the two metrics are correlated in New Jersey and even ignoring the evidence that they are not. Each of these errors is an independent ground on which to vacate the injunction.

A. The district court erroneously required a merger's procompetitive benefits to be "extraordinary" before they can be given weight.

In step two of the Clayton Act burden-shifting analysis, the merging parties must produce evidence rebutting the FTC's prima facie case. If they do so, in step three the FTC must produce direct evidence of anticompetitive harm and carry the ultimate burden of persuasion. Here, the district court erred at both stages by failing to properly weigh the procompetitive benefits it found the merger will deliver to New Jersey patients. App-131, 140.

As the district court found, allowing Englewood to join HMH will "produce a procompetitive benefit to Bergen County." App-132. Specifically, HMH's $439.5 million investment will enable Englewood "to upgrade its facilities and equipment," allowing it to offer "a broader array of services" to "more patients." App-132–133. In addition, "both hospitals (particularly Englewood) will likely see certain improvements in quality." App-140. Finally, the merger will have the additional, "limited benefit of HUMC recapturing a small number of outmigration patients," *i.e.*, patients who would otherwise go to New York for complex treatment. *Id.*

Despite finding that the merger will in fact deliver these benefits, the district court refused to weigh them at either step two or step three of the burden-shifting analysis because it believed they had to be "extraordinary" to be relevant. App-131, 140 (emphasis added). This was an error at both steps, and the error was particularly extreme at step two, where the burden on Appellants was low.

1. The procompetitive benefits the district court found were sufficient to rebut the FTC's historically weak prima facie case.

Although in step one the FTC "can establish a prima facie case through evidence on only one factor, market concentration," that does not end the inquiry. *Baker Hughes*, 908 F.2d at 985. A showing of market concentration can indicate that a merger will "*probably* lead to anticompetitive effects in that market." *Hershey*, 838 F.3d at 346 (emphasis added). But this is only a presumption, and the presumption can be rebutted in step two by a showing that the market-concentration statistics "inaccurately predict[]

the relevant transaction's probable effect on future competition." *Baker Hughes*, 908 F.2d at 992; *see also FTC v. Arch Coal*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004) (same); App-859–860, 957–958, 986. The defendant can do this either "by affirmatively showing why a given transaction is unlikely to substantially less competition, or by discrediting the data underlying the initial presumption in the government's favor." *Baker Hughes*, 908 F.2d at 991.

The burden of production on the defendant in step two cannot be "unduly onerous," because the burden of persuasion ultimately rests on the FTC. *Id.* "The more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Id.* Conversely, the weaker the prima facie case, the easier it is to rebut. Simply put, the defendant rebuts the prima facie case when it "produc[es] evidence to cast doubt on the accuracy of the [plaintiff's] evidence as predictive of future anticompetitive effects." *Chi. Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008).

Here, the FTC's prima facie case was extraordinarily weak. Even within its improperly defined market, the FTC could generate a post-merger increase in the HHI of only 841, resulting in a post-merger HHI of just 2,835. App-595–596, 790–791. This barely exceeded the minimum 2,500 threshold identified by the Guidelines for yielding any presumption of anticompetitive effects. Indeed, the HHI numbers in this case—an increase of 841 to an HHI of 2,835—are the lowest that the FTC has relied on in any

recent hospital-merger case involving GAC services.[3]

Given the FTC's weak showing, the evidence Appellants produced was easily sufficient to meet their burden of production and shift the ultimate burden of persuasion back to the FTC. Indeed, not only did Appellants *produce* evidence of procompetitive benefits, but the evidence *persuaded* the district court that the benefits will occur. The district court cited no authority that procompetitive benefits must be "extraordinary" to be considered at step two. Its holding at that step was erroneous as a matter of law.

[3] *See Hershey*, 838 F.3d at 347 (increase of 2,582 to a post-merger HHI of 5,984); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1079–80 (N.D. Ill. 2012) (increase of 1,767-2,052 to a post-merger HHI of 5,179-5,406); Admin. Compl. at 13–14, *In re Reading Health Sys.*, FTC Dkt. No. 9353 (F.T.C. Nov. 16, 2012) (increase of 2,050 to a post-merger HHI of 4,585); *ProMedica Health Sys. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014) (increase of 1,078 to a post-merger HHI of 4,391); Admin. Compl. at 8–9, *In re Cabell Huntington Hosp.*, No. 9366 (F.T.C. Nov. 6, 2015) (increase of 2,825 to a post-merger HHI of 5,824); *St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys.*, 778 F.3d 775, 786 (9th Cir. 2015) (increase of 1,607 to a post-merger HHI of 6,219 for primary care services); *FTC v. Advocate Health Care Network*, No. 15-cv-11473, 2017 WL 1022015, at *7 (N.D. Ill. Mar. 16, 2017) (increase of 1,782 to a post-merger HHI of 3,943); *FTC v. Sanford Health*, No. 1:17-cv-133, 2017 WL 10810016, at *12 (D.N.D. Dec. 15, 2017), *aff'd* 926 F.3d 959 (8th Cir. 2019) (increase of 1,152-4,602 to a post-merger HHI of 7,363-9,964 for physician services); Pls' Prop. Findings of Fact at 9–10 (ECF 266), *FTC v. Thomas Jefferson Univ.*, No.2:20-cv-1113 (E.D. Pa. Oct. 12, 2020) (increases of 887 and 1,359 to post-merger HHIs of 3,827 and 4,792); Compl at 2, 6, 8 (ECF 5), *FTC v. Methodist Le Bonheur Healthcare*, No. 20-02835 (W.D. Tenn. Nov. 16, 2020) (increase of more than 1,000 to a post-merger HHI of more than 4,500).

2. The procompetitive benefits should have been weighed in the final balance.

The district court's holding was also erroneous at step three, the final balancing step. The district court admittedly took the "extraordinary" standard from the context of judging an efficiencies defense. It believed, however, that the same standard applied to balancing a merger's pro- and anticompetitive effects. That confusion is reflected in the court's statement that "[w]hether" it "construes Defendants as invoking a formal efficiencies defense or as addressing the competitive effects analysis, Defendants fail to establish *extraordinary procompetitive effects*." App-131 (emphasis added).

As a matter of law, a court must consider all pro- and anti-competitive effects—ordinary or extraordinary—when determining whether the FTC has carried its burden of persuasion. Otherwise, the competitive-effects analysis will be fatally skewed in favor of finding an anticompetitive result. Thus, as the Eighth Circuit explained when reversing the grant of a preliminary injunction because the district court had erroneously applied a heightened standard to the competitive-effects analysis, "although [the defendant's] efficiencies defense may have been properly rejected…, the district court should nonetheless have considered evidence of enhanced efficiency in the context of the competitive effects of the merger." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999); *see also* 1 Antitrust Adviser § 4:26, *Assessing Merger Efficiencies* (5th ed.) (Dec. 2019) ("It is important … to differentiate between procompetitive efficiencies used as an affirmative defense (*i.e.*, to excuse an otherwise anticompetitive

merger) and those used as a negative defense (*i.e.*, to show that there is no anticompetitive impact from the merger in the first place)."); *compare Guidelines* §§ 6–7*, with id.* § 10.

In this case, the district court found that Appellants had shown that the merger would have procompetitive effects (*see supra* at Stmt. of Case D.2) but nonetheless failed to take them into account when evaluating whether the FTC had shown that the merger would, on balance, likely have an anticompetitive effect. That was legal error, born of the district court's misunderstanding of the applicable standard.

B. The FTC did not introduce any reliable evidence directly showing that the merger would lead to price increases above a competitive level.

The district court concluded in the alternative that the FTC carried its ultimate burden of persuasion even if Appellants did rebut the FTC's prima facie case. App-141. But that alternative holding rests on additional legal error because neither the evidence of customer preferences that the FTC relied on, nor the evidence of pre-merger contract provisions that the district court erroneously cited, provided any valid evidence to establish that the merger would lead to anticompetitive price increases.

1. The district court erred in relying on measures of patients' non-price preferences to find that insurers would agree to pay higher prices to the hospitals after a merger.

The primary evidence of competitive effects that the FTC pointed to was an analysis conducted by Dafny, the outcome of which was (in her words) a "rough estimate" that the hospitals could increase prices by $31 million after the merger. App-

598, 796–800, 863–864. This analysis, however, was legally invalid and fatally unreliable because it rested on estimates of how strongly *patients* preferred different hospitals *without any consideration of price*, not estimates of how much *insurers* would be willing to *pay to different combined hospitals*, and New Jersey claims data shows that there is no statistically significant correlation between those two metrics.

It is a settled principle in both the law and the economic literature addressing the healthcare market that hospital competition occurs in two stages. *Hershey*, 838 F.3d at 342. In the first stage, hospitals compete to be included in commercial insurers' networks, while in the second stage, hospitals compete to attract commercially insured patients. *Id.* The first stage is where prices are negotiated, and it is "highly price-sensitive." *Advocate*, 841 F.3d at 465. Indeed, Dafny conceded that insurers "are keenly concerned about the reimbursement rates they're going to have to pay." App-863. At the second stage of competition, in contrast, "[p]atients are largely *insensitive* to healthcare prices because they utilize insurance, which covers the majority of their healthcare costs." *Hershey*, 838 F.3d at 342 (emphasis added); *see* App-597–601, 616–619. Because of this divided market dynamic, it is an economic and legal error to assume "that there is no fundamental difference between analyzing the likely response" of patients versus the likely response of insurers to a hospital merger. *Hershey*, 838 F.3d at 342. "[P]atients, in large part, do not feel the impact of price increases. Insurers do." *Id.* Thus, although patients may be "relevant to the analysis," the price analysis must be performed "through the lens of the insurers." *Id.*

In this case, the FTC conflated patient preferences and the prices that insurers agree to pay in the same way that this Court found invalid in *Hershey*. The fundamental difference between the two metrics is clear from the *non*-price factors Dafny relied upon to measure the extent to which *patients* prefer to have certain hospitals in their insurer's network. Those factors included drive times, crossing county lines, hospital-specific effects, and patient characteristics (such as what procedure was needed). App-592, 593–594, 1080–1088. Based on these non-price factors, Dafny estimated how strongly patients preferred different hospitals (which she called "willingness to pay" or "WTP"), and where they would choose to go *independent of price* if their first-choice hospitals were not available (so-called diversion ratios). App-591, 665–666, 769–770, 864.

But patients are not the primary payors. Insurers are. And the prices *insurers* will agree to pay hospitals depend not just on patients' non-price preferences but on negotiating leverage. *Hershey*, 838 F.3d at 342; *see* App-109, 764–767, 943–944. As the Seventh Circuit explained in another hospital-merger case, "[i]f patients were the relevant buyers in this market, those [diversion] numbers would be more compelling." *Advocate*, 841 F.3d at 475. But these measures of patient preference "do not translate neatly into options for insurers." *Id.*; *see also* App-374, 376, K. Easterbrook et al., *Accounting for Complementarities in Hospital Mergers: Is a Substitute Needed for Current Approaches*, 82 Antitrust L.J. 497, 523, 525 (2019) (explaining that estimates of patient preference like WTP "do not yield a direct measure of hospital competition" and are of

limited utility because they can predict post-merger price increases "only when patients' preferences when seeking care align with insurers' preferences").

Dafny claimed that she could account for negotiating leverage and convert her estimates of patients' non-price preferences into estimates of how much more insurers would agree to pay simply by applying a "conversion factor" taken from an academic study of hospital-merger screening methods. *See* App-245, 598, 797–799. But the very study she cited revealed that there is no such "conversion factor" because there was no statistically significant correlation between a change in patient preferences and a change in price in the majority of the 28 studied mergers. App-235, 246; *see* App-867–868, 970–972. As the study's author concluded, to assess whether a correlation exists in any given market, "[t]he ideal data for hospital price measurement are comprehensive claims data," because they show the prices that insurers actually agree to pay. App-230; *see* App-667–668, 972. Those New Jersey claims data—the "ideal data for hospital price measurement"—were produced in this case because the FTC requested them during its investigation, but its expert chose not to rely on them.

Appellants' expert did what the FTC's expert did not do. Wu examined the New Jersey claims data and found that there is no statistically significant correlation between patient preferences and hospital prices in New Jersey. The absence of a relationship between a change in patients' WTP and hospital prices means that Dafny's calculation does not, and cannot, reliably show that a price increase will likely occur because of the merger. App-669, 673, 676–677, 968-974. The problem is not with applying the wrong

"conversation factor." The problem is that there *is no conversion factor* because patient preferences and hospital prices are not statistically correlated in New Jersey. In short, the FTC's purported direct evidence of likely anticompetitive price increases "reflects a misunderstanding of the 'commercial realities' of the healthcare market" and thus fails as a matter of law. *Hershey*, 838 F.3d at 342 (internal quotation marks omitted).

Although the FTC's failure to meet its burden is alone dispositive, Appellants also produced direct evidence showing that adding Englewood's single community hospital to HMH's larger system would not materially change the negotiating leverage it already had. The leverage of a commercial insurer is informed, in part, by the availability of alternative hospitals with which it can contract should negotiations fail and the insurer's ability to steer patients to alternative providers. App-86–87, 616–619.

Here, the district court found that HMH has significant, existing competitive leverage relative to other hospitals because its flagship academic medical center HUMC provides higher-end complex tertiary and quaternary services that few other facilities can provide. *See* App-104 ("no party disputed that HMH, as a large health system, and HUMC, as a large academic center, are more desirable to insurers than Englewood."); *see also* App-277–279, 489–490, 497–498, 521–525, 730–732, 733–734. Because of HUMC's ability to provide those rare higher-end services, it is distinctly valuable to commercial insurers. *See* App-86 ("Of critical importance is a network with a full scope of services…."); *see also* App-279–280, 734–735, 964.

Englewood, in contrast, does not have significant existing leverage because it

provides only the lower-acuity services that many other community hospitals provide. App-104 ("Englewood is not nearly as important to an insurer as HUMC," as "reflected in the large price differential for services between HUMC and Englewood."); *see* App-273, 280, 505–506. As the district court recognized and the insurers testified, Englewood is not a "must have" for insurers. *See* App-104, 539, 690, 727–728, 871, 1006–1007. Even the FTC's expert admitted that Englewood adds "little value" to commercial insurers' networks and "doesn't have much bargaining leverage." App-871, 1046. The addition of Englewood's single community hospital to the HMH system thus will not materially change its bargaining leverage. *See* App-271–272. Indeed, as one insurer testified, having Englewood in its network does not impact the marketability of its health insurance plans "at all." App-885–888.

In sum, the FTC's only evidence of alleged price increases is unreliable and inconsistent with the "commercial realities of the industry," *Hershey*, 838 F.3d at 338, and the reliable, direct evidence of bargaining leverage shows that the merger will not materially reduce competition. The FTC therefore did not make the showing that the Clayton Act required to enjoin the merger.

2. The district court erred in relying on *pre*-merger contract clauses as evidence of an increase in *post*-merger market power.

The district court, on its own, believed that additional evidence of *post*-merger market power could be found in contractual clauses that HMH negotiated *before* the merger, which would allow HMH to seek to apply the prices it had negotiated with

insurers to hospitals it later acquired. App-125–127. The FTC did not make this argument, for the obvious reason that contracts negotiated before a merger reflect the bargaining power an entity already has and are not evidence that the merger will enhance that power. Indeed, the FTC conceded that the contracts cited by the court reflected whatever bargaining power HMH "already has." FTC's Mot. for Preliminary Injunction at 29 n.71 (ECF 134).

The legally relevant question under the Clayton Act is "whether the merger will cause … a significant *increase* in the *Hospitals'* bargaining leverage" to a degree that will result in anticompetitive price increases. *Hershey*, 838 F.3d at 346 (first emphasis added). The cases are unanimous on this point. *See ProMedica*, 749 F.3d at 570 (explaining that the "ultimate inquiry in merger analysis" is "whether the merger is likely to *create or enhance* market power or facilitate its exercise") (emphasis added); *Baker Hughes*, 908 F.2d 991 (explaining that rebuttal evidence is focused on the transaction's "probable effect on *future* competition").

Here, the contractual clauses cited by the district court provided that, if HMH acquired a new facility, it could charge rates for that facility equal to those that HMH charged in a similarly situated HMH facility. App-904–905, 1011–1013; *see* App-387–388, 396, 408–410, 452. But those clauses were contained in agreements that HMH negotiated with insurers in 2009 and earlier, well before the proposed merger with Englewood was contemplated. App-904–905, 1011. They were therefore legally irrelevant to the Clayton Act inquiry.

Moreover, even if pre-merger contract clauses could somehow be relevant to that inquiry, they became utterly irrelevant here when HMH informed the relevant insurers that it was waiving them with respect to Englewood. App-603, 604, 605, 606, 905–909, 1011–1013. The district court doubted that these waivers would be binding on HMH absent consideration. App-127. But if the merger is allowed to proceed following HMH's representation to the court that the waivers are effective, they would, at a minimum, be enforceable by the insurers against HMH on equitable and judicial estoppel grounds. *See* Defs' Mem. Regarding Enforceability of Waiver Letters (May 24, 2021) (ECF 313, 316). Although the district court acknowledged Appellants' estoppel arguments and gave no reason to doubt them, App-127, it nevertheless still improperly relied on the pre-merger contracts as evidence of increased post-merger market power.

The court also criticized HMH for *not* making pre-merger "representations" to insurers about what it would do in future negotiations after merging with Englewood. App-127. Once again, this was error because, as the FTC itself admits, *pre*-merger agreements not to increase prices are irrelevant to the antitrust analysis. *H&R Block*, 833 F. Supp. 2d at 82; *cf. Hershey*, 838 F.3d at 344–45 (private agreements to cap prices between hospitals and insurers "have no place" in the analysis because courts must "predict" the parties' "negotiating position and rates" once the merger occurs).

Finally, the court again relied improperly on pre-merger market power when it concluded that, because HMH has "historically" negotiated higher annual percentage increases than Englewood has negotiated, "the reasonable inference" is that HMH will

be able to negotiate higher increases for *Englewood* if the merger occurs. App-127 (emphasis added). This is simply *ipse dixit*. To demonstrate a change in leverage would require an analysis of the bargaining environment. As above, that analysis shows that Englewood, because of its position as a community hospital providing low-acuity services, will not materially increase HMH's leverage. *See supra* at Section II.B.1. If HMH continues to negotiate the same percentage increases for Englewood as HMH has previously negotiated for its own historical facilities, that is nothing more than a reflection of its pre-merger bargaining leverage. It shows no *change* in the system's market power.

Once again, no evidence shows the likelihood of a substantial decrease in competition that is required to enjoin a merger under the Clayton Act.

* * *

In sum, even if the FTC had (contrary to fact) established a prima facie case, the injunction must be vacated because the district court committed reversible legal error at multiple stages of the competitive-effects analysis. It improperly ignored proven procompetitive benefits at each step, and erroneously found evidence of anticompetitive effects where there was none.

CONCLUSION

The injunction should be vacated, and Englewood should be allowed to combine with the HMH system to strengthen its ability to compete in the healthcare market and provide improved care to the citizens of New Jersey.

Dated: September 15, 2021

Respectfully submitted,

/s/Jeffery L. Kessler
Jeffrey L. Kessler
Jeffrey J. Amato
Johanna Rae Hudgens
WINSTON & STRAWN LLP
200 Park Avenue
New York, NY 10163
Telephone: 212-294-6700
Facsimile: 212-294-4700
jkessler@winston.com
jamato@winston.com
jhudgens@winston.com

Heather P. Lamberg
Neely Beth Agin
Andrew E. Tauber
WINSTON & STRAWN LLP
1901 L Street, NW
Washington DC 20036
Telephone: 202-282-5000
Facsimile: 202-282-5100
hlamberg@winston.com
nagin@winston.com
atauber@winston.com

David E. Dahlquist
Kevin B. Goldstein
WINSTON & STRAWN LLP
35 West Wacker Drive
Chicago, Illinois 60601
Telephone: 312-558-5600
Facsimile: 312-558-5700
ddahlquist@winston.com
kbgoldstein@winston.com

Counsel for Appellant
Englewood Healthcare Foundation

/s/ Paul H. Saint-Antoine
Paul H. Saint-Antoine
John S. Yi
FAEGRE DRINKER BIDDLE & REATH LLP
One Logan Square, Ste. 2000
Philadelphia, PA 19103
Telephone: 215-988-2700
Facsimile: 215-988-2757
paul.saint-antoine@faegredrinker.com
john.yi@faegredrinker.com

Kenneth M. Vorrasi
John L. Roach, IV
Jonathan H. Todt
Alison M. Agnew
FAEGRE DRINKER BIDDLE & REATH LLP
1500 K Street, NW, Suite 1100
Washington, D.C. 20005
Telephone: 202-842-8800
Facsimile: 202-842-8465
kenneth.vorrasi@faegredrinker.com
lee.roach@faegredrinker.com
jonathan.todt@faegredrinker.com
alison.agnew@faegredrinker.com

Daniel J. Delaney
FAEGRE DRINKER BIDDLE & REATH LLP
191 N. Wacker Drive, Suite 3700
Chicago, IL 60606
Telephone: 312-569-1000
Facsimile: 312-569-3000
daniel.delaney@faegredrinker.com

Aaron D. Van Oort
FAEGRE DRINKER BIDDLE & REATH LLP
2200 Wells Fargo Center
90 S. Seventh Street
Minneapolis, MN 55402
Telephone: 612-766-7000

Facsimile: 612-766-1600
aaron.vanoort@faegredrinker.com

Attorneys for Appellant
Hackensack Meridian Health, Inc.

CERTIFICATE OF BAR MEMBERSHIP

Pursuant to Third Circuit Local Appellate Rule 46.1, I, Paul H. Saint-Antoine, hereby certify that I am a member in good standing of the bar of the United States Court of Appeals for the Third Circuit. Jeffrey L. Kessler, Heather P. Lamberg, Andrew E. Tauber, John S. Yi, Kenneth M. Vorrasi, John L. Roach, IV, Jonathan H. Todt, Alison M. Agnew, Daniel J. Delaney, and Aaron D. Van Oort are also admitted to practice in the Third Circuit Court of Appeals and are members in good standing:

/s/ Paul H. Saint-Antoine
PAUL H. SAINT-ANTOINE

CERTIFICATE OF COMPLIANCE

In accordance with the Federal Rules of Appellate Procedure and this Court's Rules, I certify the following:

1. This brief complies with the type-volume limitation of Federal Ruleof Appellate Procedure 32(a)(7)(B) because it contains 12,604 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Garamond 14-point font.

3. Pursuant to Third Circuit Local Appellate Rule 31.1(c), I certify that the text of the brief filed electronically with the Court via CM/ECF is identical to the text of the paper copies. I further certify that the electronic version of the brief has been scanned for viruses by Virus Total, and no viruses were detected.

/s/ Paul H. Saint-Antoine
PAUL H. SAINT-ANTOINE

CERTIFICATE OF SERVICE

Pursuant to Federal Rule of Appellate Procedure 25(d) and Local Rule 27.2, I hereby certify that on September 15, 2021, I electronically filed the foregoing Brief with the Clerk for the United States Court of Appeals for the Third Circuit using the appellate CM/ECF system. Service on counsel for all parties has been accomplished via CM/ECF.

/s/ Paul H. Saint-Antoine
PAUL H. SAINT-ANTOINE