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

APPEAL FROM THE U.S. DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY, NO. 2:20-CV-18140, HON. JOHN M. VAZQUEZ, PRESIDING

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS AND REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 29(a)(4)(A) and 26.1 and Third Circuit L.A.R. 26.1, *amici curiae* American Hospital Association and Association of American Medical Colleges make the following disclosure:

Amicus curiae American Hospital Association has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

Amicus curiae Association of American Medical Colleges has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

Amici curiae are not aware of any publicly held corporation not a party to this appeal that has a financial interest in the outcome of this proceeding.

Dated: SEPTEMBER 22, 2021

By: */s/ Steffen N. Johnson*
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IDENTITIES AND INTERESTS OF AMICI 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. AHA members are committed to improving the health of the communities that they serve and to helping ensure that care is available to and affordable for all Americans. The AHA provides extensive education for healthcare leaders and is a source of valuable information and data on healthcare issues and trends. It ensures that members' perspectives are heard and addressed in national health-policy development, legislative and regulatory debates, and judicial matters.

The Association of American Medical Colleges ("AAMC") is a national, not-for-profit association that represents and serves all 155 accredited U.S. medical schools, approximately 400 major teaching hospitals and health systems, and more than 70 academic societies. Through these institutions and organizations, the AAMC has more than 186,000 faculty members, 94,000 medical students, and 145,000 resident physicians. The AAMC leads and serves the academic medical community to improve the health of people everywhere. The AAMC is dedicated to transforming health through medical education, healthcare, medical research, and

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

community collaborations. In addition, the AAMC advocates on legislative and regulatory issues of importance to its members and their patients.

America's hospitals and medical schools are facing one of the most challenging times in their history. Facing a massive pandemic, hospital employees with skill and dedication have marshalled their resources to save hundreds of thousands of lives. To better serve their patients, the members of the AHA and AAMC continue to look for ways to lower their costs while maintaining access to care and ensuring quality. In this rapidly changing healthcare sector, hospital mergers can offer significant procompetitive benefits by allowing hospitals to increase access to patients, regardless of their ability to pay, as well as achieve cost savings and deliver more integrated and innovative care to communities.

Evaluating and pursuing hospital transactions requires a substantial commitment of both capital and human resources. As a result, the AHA and AAMC members have a strong interest in ensuring that the standards used to evaluate such mergers under the antitrust laws are predictable, rather than ad hoc or result-oriented, and comport with long-standing legal and economic principles and market realities. Defining the relevant geographic market is required for any antitrust merger case, and the market definition process is critical to hospitals' ability to predict how the FTC and the courts are likely to view a hospital transaction. Consequently, it is essential that the FTC use, and the courts apply, market definition tests that track the

law, well-settled economic principles, and the business realities of the healthcare sector. Moreover, notwithstanding the FTC's surprising statements to the contrary, Tr. 1577:7–18, it is important that FTC investigations and litigation positions not disregard the Department of Justice's and Federal Trade Commission's *Horizontal Merger Guidelines* when defining relevant markets.

INTRODUCTION

The FTC's approach to defining the relevant geographic market in this case conflicts with settled law and economic principles, as well as business reality. Indeed, the FTC is attempting to do something that it has never directly attempted in hospital merger litigation—define a relevant geographic market based on where "commercially insured patients" live—"in Bergen County." Op. 44.[2] Because the FTC's testifying expert defined a market of patients who live in Bergen County, settled antitrust law required the agency to show that the parties could "price discriminate" with respect to those patients—*i.e.*, charge one (presumably higher) price to insurers for their members who reside in Bergen County and different (presuma-

[2] In every other case that the FTC has litigated, it has defined the relevant geographic market based on the location of hospitals. *See, e.g., FTC v. Thomas Jefferson University*, No. 20-1113 (E.D. Pa. Oct. 12, 2020), Plaintiffs' Proposed Findings of Fact and Conclusions of Law (ECF 266), at ¶ 22 ("Because GAC Services are provided to a commercial insurer's members at the hospital, geographic markets for those services are properly defined by the locations of the hospitals.").

bly lower) prices to their members who reside outside Bergen County. It is undisputed that the FTC never even attempted to carry that burden. That failure alone warrants reversal.

Even if the FTC had tried to make this unprecedented showing, however, it would have failed. It is not feasible for hospitals to charge patients different prices based on where they live, and it would make no real-world sense to even try. As one leading treatise explains, "[t]he contracts that hospitals negotiate with third-party payors constrain them to charge each payor's patients the same set of prices, regardless of where the patients live or which company the patient works for." Thomas McCarthy & Scott Thomas, *Geographic Market Issues in Hospital Mergers*, *in* ABA ANTITRUST SECTION, HEALTH CARE MERGERS AND ACQUISITIONS HANDBOOK 50 (2003). And even if it were feasible for a hospital to charge different patients (or their insurers) different prices based on where the patients live, any hospital that attempted such "redlining" in its pricing would likely be rebuked, swiftly and severely, by government regulators. Put simply, the price discrimination on which the FTC's market definition rests is both practically and legally infeasible. Thus, the district court's acceptance of the FTC's relevant geographic market was legal error that compels reversal. *See FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 336–37 (3d Cir. 2016).

The FTC, of course, was (and is) well aware that it failed to carry its burden of proving a geographic market based on customer location. In the hope of avoiding this problem, the FTC's testifying economist purported to validate her patient-based geographic market by running market definition tests for two *different* relevant geographic markets. But this fallback effort was likewise deficient as a matter of law: it utilized and depended on the outputs of a model reported in an academic paper that analyzed hospital mergers that did not occur in New Jersey, much less in Bergen County. Tr. 961:11–20; Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods*, 48 RAND J. ECON. 1068, 1080 (2017). Hospitals operate in local markets with varying supply and demand conditions, and under settled Third Circuit precedent, geographic markets are "[d]etermined within the specific context of each case" and "must correspond to the commercial realities of the industry being considered." *Penn State Hershey Med. Ctr.*, 838 F.3d at 338 (internal quotation marks and citation omitted).

If the Court were to endorse the FTC's novel approach to market definition, its decision would open the floodgates to the FTC litigating (and threatening to litigate) hospital merger challenges based on artificially narrow markets that are unrelated to how hospitals actually negotiate prices with insurance companies. This in

turn would allow the FTC to challenge transactions that pose no threat to competition, while making it harder for hospitals to allocate capital to procompetitive transactions—a result squarely at odds with the purpose of the antitrust laws.

ARGUMENT

I. The FTC's novel approach to defining a geographic market based on the location of patients conflicts with settled law.

"Determination of the relevant product and geographic markets is a necessary predicate to deciding whether a merger contravenes the Clayton Act." *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618 (1974) (internal quotation marks and citation omitted). The tests and mechanisms used to define a market must "both 'correspond to the commercial realities' of the industry and be economically significant." *Brown Shoe Co. v. United States*, 370 U.S. 294, 336–37 (1962) (citation and footnote omitted). Here, the FTC's efforts to define a relevant geographic market fell far short of this standard.

As the district court found, the FTC's proposed geographic market is "commercially insured *patients in Bergen County*." Op. 35; Tr. at 557:15–17 (emphasis added). In other words, the FTC proposed to define the geographic market based on the location of *patients*, rather than the location of *hospitals*. The FTC's testifying economist, Dr. Leemore Dafny, made this clear at trial:

Q: Is your market defined around the hospitals in Bergen County?

> A: It is not. It's defined on the location of patients *so the patients, the commercially insured patients in Bergen County*. That's the definition that I use.

Tr. 557:13–17 (emphasis added).

It is settled law—and basic economics—that price discrimination is a prerequisite for defining a customer-based market. *See United States v. Bazaarvoice, Inc.*, 2014 U.S. Dist. LEXIS 3284, *102 (N.D. Cal. Jan. 8, 2014) ("Where, as here, a hypothetical monopolist could price discriminate, i.e., set different prices for different customers based on customer location, the geographic market is based on the location of the customers, not the suppliers."); *FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 117–18 (D.D.C. 2016) ("Defining a market around a targeted consumer . . . *requires* finding that sellers could 'profitably target a subset of customers for price increases . . . .'") (emphasis added) (citing *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 38 (D.D.C. 2015)). As the government's Merger Guidelines put it: "When the hypothetical monopolist could discriminate based on customer location, the Agencies may define geographic markets based on the locations of targeted customers." U.S. Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4.2.2 (2010) ("*Horizontal Merger Guidelines*").

Notwithstanding these clear legal authorities, however, Dr. Dafny did *not* test for whether the parties could price discriminate against patients who live in Bergen County. Nor is this surprising, as any such analysis would conflict with how the

hospital sector actually works. When a hospital negotiates prices with insurance companies, it is not feasible to charge an insurer different prices based on where the insurers' members live. As economists have known for decades:

> In the hospital industry, however, geographic price discrimination seems highly unlikely. The contracts that hospitals negotiate with third-party payors constrain them to charge each payor's patients the same set of prices, regardless of where the patients live or for which company they work. Moreover, third-party payors usually sell to a wide variety of employers. The location of each employer and the geographic dispersion of its covered employees are normally difficult to predict, so there is rarely a basis for devising a geographic price discrimination scheme.

McCarthy & Thomas, *Geographic Market Issues in Hospital Mergers*, HEALTH CARE MERGERS AND ACQUISITIONS HANDBOOK at 50.

If, contrary to settled law and economic reality, the Court endorses defining relevant geographic markets in hospital cases based on *patient* locations without proof that the parties can actually engage in price discrimination, the damage would be substantial. The FTC would gain the ability to define an artificially narrow relevant geographic market that does not track how hospital markets work.

The reason why is straightforward. Under the hypothetical monopolist test, the FTC must show that a hypothetical monopolist could profitably implement a small but significant and non-transitory increase in price ("SSNIP") in the proposed geographic market. Without the ability to price discriminate, given how hospitals negotiate contracts with insurance companies, the hypothetical monopolist would

have to increase price by a SSNIP to *all* of its customers, regardless of whether they live in the FTC's proposed geographic market. Accordingly, the FTC would need to show that customers who reside outside of the proposed geographic market would not switch away from the hypothetical monopolist to other hospitals (who do not serve the proposed geographic market) in sufficient numbers to render the SSNIP unprofitable. But, contrary to settled law and basic economics, affirming the decision below would let the FTC ignore, as it did before the district court, the potential ability of customers who reside outside of the proposed geographic market to defeat the hypothetical monopolist's price increase (and require rejecting the FTC's proposed narrow geographic market).

As the record confirms, this is not a speculative or innocuous concern. Approximately 50% of the patients that the parties serve live outside of Bergen County. Op. 5. Notwithstanding that the FTC failed to show that the parties could price discriminate against patients who live in Bergen County, the FTC's market definition process did *not* directly address the ability of this large group of patients who live outside Bergen County to contribute to defeating a SSNIP by a hypothetical monopolist that served Bergen County.

The bottom line is simple: If the district court's decision is upheld, to define a relevant geographic market, the FTC would need only to find a neighborhood (affluent or otherwise) where insurers are willing to say they must have the merging

parties' hospitals in network. The FTC would not need to show that it was actually feasible for the merging parties (or other hospitals) to raise prices to patients who live in that neighborhood. This would give the FTC the ability to define artificially narrow geographic markets that fail to track market realities, and to block transactions that pose no threat to competition.[3] This Court should reverse.

II. The district court's reliance on the hypothetical monopolist tests performed by the FTC's expert was legal error.

Aware that defining relevant geographic hospital markets based on patient location lacks any basis in how the hospital sector works, Dr. Dafny attempted to overcome this difficulty by running tests for two geographic markets that were different than the one she proposed. Specifically, she attempted to test whether two purported markets passed a hypothetical monopolist test: (1) the six hospitals located in Bergen County serving Bergen County residents, and (2) the six hospitals located in Bergen County serving residents of Bergen County and its three surrounding counties. Op. 36; Tr. 563:11–564:15, 1510:23–1512:7.

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[3] The federal courts and the FTC have repeatedly warned that price discrimination markets run the risk of creating artificially narrow markets. *See, e.g.*, *FTC v. Sysco Corp*., 113 F. Supp. 3d 1, 39 n. 20. (D.D.C. 2015) ("Absent limitations, price discrimination against a single customer might be used to justify blocking a merger. This is not a mere theoretical possibility."); *In re R.R. Donnelly & Sons*, 1995 FTC LEXIS 215, *47–48 (F.T.C. 1995) ("The Commission must be mindful of the analytical hazards of defining markets by reference to possible price discrimination . . . . The potential for this approach to swallow up the market definition principles established by the federal courts and the Commission is substantial.").

As an initial matter, the courts have warned the FTC against engaging in such searches for putative markets that can pass the hypothetical monopolist test in merger cases. *FTC v. Thomas Jefferson Univ.*, 505 F. Supp. 3d 522, 541 (E.D. Pa. 2020) ("[T]he Court's geographic market determination is not merely a 'statistical exercise' looking for a hypothetical monopolist that can impose a SSNIP."). But even putting this problem aside, Dr. Dafny's approach failed to comply with established legal requirements.

To attempt to implement her fallback hypothetical monopolist tests, Dr. Dafny used a "willingness-to-pay" analysis. Tr. 563:17–564:12. A willingness-to-pay analysis tries to estimate an insurer's willingness to pay for the hospitals in the subset if they are owned jointly, as compared to the insurer's willingness to pay if the hospitals negotiated independently. *Id.* But the willingness-to-pay analysis does not predict the *price* increases that would result from a proposed transaction. Thus, it cannot directly answer the question posed by the hypothetical monopolist test, which asks whether a hypothetical monopolist can impose a *price* increase.

To attempt to convert the willingness-to-pay finding into a predicted price increase, Dr. Dafny relied on a "conversion factor" in an academic paper that purported to convert willingness-to-pay into predicted price increases. *See* Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods*, 48 RAND J. ECON. 1068, 1080 (2017); Tr. 576:14–24. Notably, however, the conversion factor reported

in the paper is based on analysis of 28 hospital mergers, none of which occurred in New Jersey. Garmon at 1080.

The parties pointed out several limitations with the methodology reported in the Garmon paper. Opening Brief of Appellants 44–45.[4] But even assuming that the outputs of the study are valid, it was legal error for the district court to rely on Dr. Dafny's hypothetical monopolist tests when they depended on the conversion factor calculated from hospital data from other states. Geographic markets in hospital cases are local in nature with varying supply and demand conditions and the geographic market must be "[d]etermined within the specific context of each case." *Penn State Hershey Med. Ctr.*, 838 F.3d at 338 (internal citation omitted). *See also* Garmon at 1068 ("The negotiated prices [between hospitals and health insurance companies] are determined in large part *by local competitive conditions* and the ability of health insurance companies to substitute with competing hospitals in their managed care networks.") (emphasis added).

[4] As the parties point out, there is also no clear evidence that changes in an insurer's theoretical willingness to pay for a hospital results in the hospital gaining the ability to charge higher prices. Opening Brief of Appellants 43–44.

III. Endorsing the FTC's novel approach to defining the artificially narrow relevant geographic markets will harm patients.

The settled requirement that the FTC prove an economically sound relevant geographic market in hospital merger cases is essential to enabling hospitals to enter into procompetitive transactions that benefit consumers.

For decades, hospitals and health professionals have worked to improve patient outcomes and lower the costs of care by reducing fragmentation in the delivery of healthcare. By affiliating with hospital systems, community hospitals can lower costs effectively and improve clinical care while preserving access to care in underserved communities.

Consistent with the record here, economic research shows that community hospitals that partner with hospital systems are able to provide measurable benefits to patients in the form of lower healthcare costs, improved patient care, and better access to providers. *See* Monica Noether et al., *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis—An Update*, CHARLES RIVER ASSOCS. 1 (Sept. 9, 2019);[5] Margaret E. Guerin-Calvert & Jen A. Maki, *Hospital Rea-*

[5] https://media.crai.com/wp-content/uploads/2020/09/16164319/CRA-report-merger-benefits-2019-FINAL.pdf

lignment: Mergers Offer Significant Patient and Community Benefits, FTI CONSULTING 2 (2014).[6] Hospital mergers between 2009 and 2014 "were associated with a 2.5 percent reduction in operating expense per admission at the acquired hospitals." Noether et al. at 8. Extending the analysis through 2017, the same study found a 2.3% reduction in operating expenses per admission at acquired hospitals, with hospital systems reporting total expense savings of about 1.5% to 3.5% through consolidation of administrative and supply chain operations. Noether et al. at 3, 8. Other studies find statistically significant cost reductions at acquired hospitals averaging between 4% and 7%. *See* Matt Schmitt, *Do Hospital Mergers Reduce Costs?*, 52 J. HEALTH ECON. 74, 74 (2017).

Further, hospital transactions can generate substantial savings from improved IT systems and advanced data analytics. Consolidated hospital systems can better invest in IT infrastructure for both the clinical and financial data that they utilize to identify best practices for quality care that is more cost-effective and streamlined. Noether et al. at 3–4. These data systems have substantial but largely fixed costs, making them effectively inaccessible to independent hospitals. Noether et al. at 3. Hospital systems, by contrast, can spread the costs of such systems over a larger

[6] http://ignacioriesgo.es/wp-content/uploads/2014/06/hospital-realignment-mergers-offer-significant-patient-and-community-benefits.pdf

patient population, while using the larger patient database to perform more sophisticated analyses to identify patterns and ultimately improve care. *Id*.

Moreover, hospitals realize the cost benefits of mergers quickly, with hospitals largely reporting reduced operating expenses one year after the merger. Clark Knapp et al., *Hospital M&A: When Done Well, M&A Can Achieve Valuable Outcomes*, DELOITTE CTR. FOR HEALTH SOLUTIONS 5 (2017).[7] And these benefits last. One study found that cost savings remain evident four years after consummation of the merger, and another found lower cost growth rates and lower price growth rates at merging hospitals compared to non-merging hospitals over an extended period. Guerin-Calvert & Maki at 18.

These are just some of the benefits. In addition, community hospitals often cannot recruit clinical staff, upgrade technology, or offer specialty services. Noether et al. at 3. Nearly half of community hospitals report putting capital projects on hold. Guerin-Calvert & Maki at 11. As is the case here, the acquiring hospitals often provide capital infusions to community hospitals to address funding issues, as evidenced by the almost 80% of respondents in one survey who reported significant capital investments in the acquired hospital. Knapp et al. at 3. These capital infusions allow the acquired hospital to restart planned projects or undertake new investments in

[7] https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-hospital-mergers-and-acquisitions.pdf.

staff, technology, or facilities, not only preventing closure of the hospital or certain service lines but possibly improving quality of service and patient welfare. Guerin-Calvert & Maki at 16, 19.

Hospital transactions can also help improve resource allocation and address resource constraints, including in physical space, capital, and personnel. Guerin-Calvert & Maki at 15. With reduced patient volumes, community hospitals often have excess capacity, impairing their financial performance and access to capital. Monica Noether & Sean May, *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis*, CHARLES RIVER ASSOCS. 6 (Jan. 2017).[8] Academic medical centers, in contrast, often have capacity constraints because communities look to them not only for tertiary and quaternary services—including neurosurgery, severe burn treatment, cancer care, advanced neonatology, and transplantation—but also for less specialized services. *Id*.

Mergers and affiliations realign these resources to better meet community needs. Guerin-Calvert & Maki at 14. Integration of lower-cost community hospitals with high-throughput academic medical centers allows the system to optimize service mix to the most appropriate and cost-effective settings of care. Thomas Enders & Joanne Conroy, *Advancing the Academic Health System for the Future*, MANATT

[8] https://media.crai.com/sites/default/files/publications/Hospital-Merger-Full-Report-_FINAL-1.pdf.

HEALTH SOLUTIONS 26 (2014).[9] Patients who need less complex services can be treated at community hospitals, easing capacity constraints at the academic medical center, driving down costs, and often providing a more convenient location for the patients. *See id.* at 6, 26; Noether & May at 6. The academic medical center can then devote existing space for tertiary and quaternary services not available at community hospitals without new capital investments. Noether et al. at 5.

Finally, mergers and affiliations provide community hospitals with the scale needed to use sophisticated data analytics, identify best practices, and implement innovations such as telemedicine that improve access and patient outcomes. *Id*. at 3–5. For example, using CMS data for heart attack, heart failure, and pneumonia patients, researchers found statistically significant improvements in the 30-day readmission rates and mortality rates at acquired hospitals. *Id.* at 10. Other quality improvements following acquisitions include increased HCAHPS patient satisfaction scores, reduced readmissions, reduced appointment wait times, and reduced mortality. Knapp et al. at 8. And acquired hospitals improved their Leapfrog Hospital Safety Grade by a median of one grade category. Gay Casey et al., *Hospital*

[9] https://www.manatt.com/uploadedFiles/Content/2_Our_People/Enders,_Thomas/AdvancingtheAcademicHealthSystemfortheFuture_AAMC_Mar2014_Paper.PDF

Mergers and Acquisitions — Studying Successful Outcomes, BERKELEY RESEARCH GRP. 7 (2020).[10]

By enabling the FTC to stop hospital transactions that do not violate the anti-trust laws, the market definition approach endorsed by the district court threatens to put all of the foregoing benefits from hospital transactions at risk. This Court should intervene.

CONCLUSION

For the foregoing reasons, this Court should vacate the preliminary injunction and allow the parties to complete their transaction.

[10] https://www.thinkbrg.com/insights/publications/hospital-mergers-acquisitions-juniper/

Respectfully submitted,

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Dated: SEPTEMBER 22, 2021

CERTIFICATE OF BAR MEMBERSHIP

Pursuant to Third Circuit Local Appellate Rule 46.1, I, Steffen N. Johnson, certify that I am a member in good standing of the bar of the United States Court of Appeals for the Third Circuit. Jonathan Jacobson and Paul N. Harold are also members in good standing of the bar of the United States Court of Appeals for the Third Circuit.

Dated: SEPTEMBER 22, 2021

By: */s/ Steffen N. Johnson*
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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 Rule of Appellate Procedure 32(a)(7)(B) because it contains 3,894 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 Times New Roman 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.

4. I further certify that the electronic version of the brief has been scanned for viruses by Crowdstrike Falcon version 6.27.14105.0, and no viruses were detected.

Dated: SEPTEMBER 22, 2021

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CERTIFICATE OF SERVICE

Pursuant to Federal Rule of Appellate Procedure 25(d) and Local Rule 27.2, I hereby certify that on September 22, 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.

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