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

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INTRODUCTION AND SUMMARY

The FTC's Answering Brief confirms that there is no valid basis for affirming the preliminary injunction barring Englewood from merging with HMH. The competitive benefits of the merger are clear and undisputed: as the district court found and the FTC does not challenge on appeal, the merger will enable Englewood to upgrade its facilities and provide improved quality of care, to patients' benefit.

The FTC's claim that the merger should nonetheless be enjoined because of alleged anticompetitive effects flowing from increased market concentration fails at the very first step. As Appellants explained (Op. Br. 7) and the FTC does not dispute (FTC Br. 12, 24), proving a properly defined, relevant geographic market that is aligned with commercial realities is "a necessary predicate to deciding whether a merger contravenes the Clayton Act." *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 338 (3d Cir. 2016) ("*Hershey*"). When a proposed market does *not* align with commercial realities, the Clayton Act claim fails as a matter of law.

Here, the commercial reality is that Englewood competes with 24 other hospitals located within a 30-minute drive. In this highly competitive environment, no realistically defined market would show that aligning Englewood's community hospital with HMH's academic medical center at HUMC would create undue market concentration.

The FTC attempted to claim otherwise by manipulating the market definition to ignore half of the merging hospitals' patients and limit the market to insured patients residing in Bergen County. By adopting and relying on this market, the district court

erred as a matter of law. The economic literature, the courts, and the FTC's own Horizontal Merger Guidelines ("Guidelines") unanimously agree that a market based on the location of customers (patients) cannot be defined unless suppliers (hospitals) can price discriminate based on customer location. Op. Br. 26-32. The FTC's Brief does not cite *any* contrary authority, nor does it explain how a customer-based market would make any economic sense absent price discrimination. The FTC concedes, moreover, that this Court reviews *de novo* a lower court's use of flawed economic theories to define a market. FTC Br. 23. It further concedes that hospitals do not price discriminate based on patient location. FTC Br. 33. As a matter of law, therefore, the district court erred in adopting a geographic market limited to patients residing in Bergen County. The injunction must be reversed.

On appeal, the FTC essentially concedes that the patient-based market it proposed and the district court adopted is legally erroneous, but argues that the error is harmless because this Court can find a different, *hospital*-based geographic market on appeal—a market defined as just the six hospitals within Bergen County. FTC Br. 30-31. This is wholly improper. This Court is not a factfinder, and the district court did not assess or find a hospital-based market—because the FTC did not propose one. More than that, the FTC affirmatively *waived* a hospital-based market by having its expert expressly disavow such a market, both in discovery and at the evidentiary hearing. The record consequently does not contain any of the evidence or analysis necessary to find a new definition that would shrink the market from more than 50

hospitals to just six and that, in the process, would exclude some of Englewood's and HUMC's closest competitors.

Had the FTC proposed such a narrow hospital-based market below, another recent hospital merger case from this Circuit illustrates the scrutiny it would have faced. In *FTC v. Thomas Jefferson University*, the FTC proposed small hospital-based markets in a dense urban area that resulted in high concentration numbers. But discovery revealed those markets' failure to appropriately account for nearby competing hospitals, and the district court rejected them. 505 F. Supp. 3d 522, 534–35 (E.D. Pa. 2020). This Court then denied a stay pending appeal, 2020 WL 8455862 (3d Cir. Dec. 21, 2020), and the FTC abandoned the case, 2021 WL 2349954 (3d Cir. Mar. 4, 2021). The same result would have happened here, had the FTC given fair notice that it intended to try an even smaller hospital-based market. The FTC should not be allowed to evade the proper scrutiny of an antitrust market by proposing it for the first time on appeal.

Because the FTC failed to prove a relevant geographic market, it failed to prove its prima facie case. The district court was wrong to conclude otherwise. That is dispositive and the injunction must be lifted. As a result, this Court need not address the district court's legal errors in weighing the direct evidence of the merger's competitive benefits and harms. If it does, however, those errors likewise require reversal.

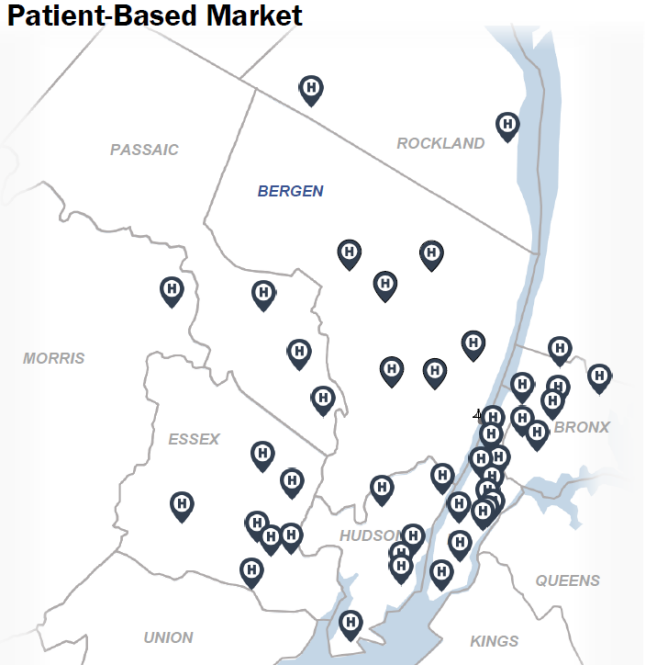
ARGUMENT

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

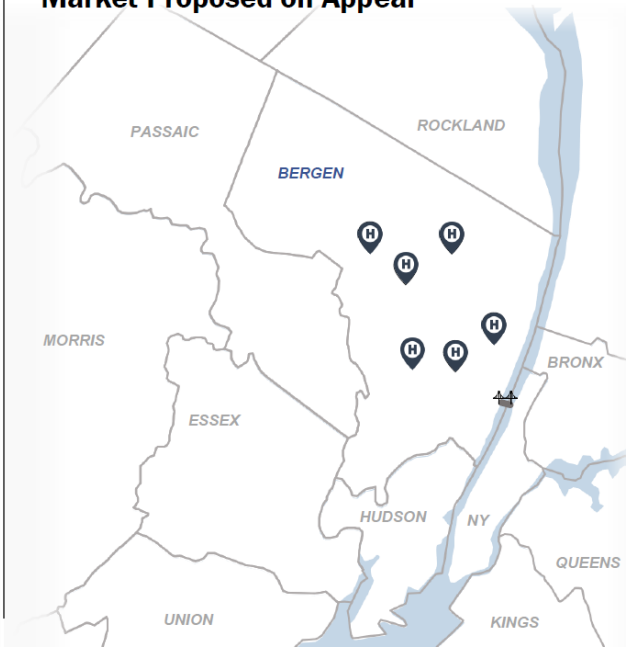
The FTC has made the extraordinary decision to try to defend the injunction issued below by largely abandoning the patient-based geographic market it proposed and the district court found, while asking this Court to engage in its own factfinding and adopt a different, hospital-based market that the FTC proposes for the first time on appeal. The FTC's litigation strategy is procedurally improper. Having waived a hospital-based market below, it cannot ask this Court to switch to that market on appeal—and the differences between the two markets are enormous.

As the FTC concedes, the patient-based market it proposed below "analyzed a broad set of more than 50 hospitals." FTC Br. 32. But the hospital-based market it is asking this Court to adopt on appeal dramatically shrinks the competitors considered to just ***six*** hospitals. FTC Br. 25, 37-38. When the FTC describes both markets simply as "Bergen County" (FTC Br. 8, 11, 19, 24, 25, 26, 28), it glosses over this radical change, as illustrated below:

Hospitals Included in FTC's Proposed Patient-Based Market



Hospitals Included in FTC's Hospital-Based Market Proposed on Appeal



Try as it might, the FTC cannot evade the indisputable fact that the market it proposed below, and that the district court found, was based upon ***patients, not hospitals,*** in Bergen County. As the court stated, the FTC's "candidate market is commercially insured patients in Bergen County." App-110. Responding to Appellants' criticism that the FTC "used customers, rather than suppliers, to define the area," the court agreed that the FTC used customers and defended that choice by ruling that "price discrimination is not required as a matter of law" to define a customer-based market. App-111–112. The court concluded: "Thus, in sum, the FTC demonstrates that commercially insured patients in Bergen County is a relevant geographic market." App-119.

In acting as if customer-based and supplier-based markets are equivalent, the FTC flouts its own Guidelines, which expressly distinguish between them. U.S. Dep't

of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* §§ 4.1.2, 4.2.2. The FTC also contradicts the economic literature, which explains that customer-based and supplier-based markets "can be quite different, depending on where one starts." App-341. In this case, the patient-based market the FTC proposed to the district court ignored half the patients served by Englewood and HUMC, while the hospital-based market it proposes on appeal ignores most of the hospitals competing with them. In sum, the FTC cannot escape scrutiny on appeal by pretending that it is not attempting to change market definitions, when it is.

A. The *patient*-based geographic market that the FTC proposed and the district court adopted was legally improper.

Although the FTC suggests that this Court "need not reach" the question whether its patient-based market was legally invalid (FTC Br. 32), Appellants will start with that market because it is the one the FTC proposed and the district court adopted.

1. It was legal error to limit the geographic market to the subset of patients located in Bergen County when the hospitals do not, and cannot feasibly, charge different prices for those patients.

As Appellants showed, it was legal error to use a market defined as patients residing in Bergen County to analyze the competitive effects of the proposed merger because case law, economic literature, and the Guidelines unanimously agree that a geographic market can be defined by customer location *only if* suppliers can price discriminate based on that location. Here, it is undisputed that hospitals do not (and cannot feasibly) price discriminate against patients in Bergen County. Op. Br. 25-31.

In response, the FTC does not claim that price discrimination against patients living in Bergen County either is occurring or could feasibly occur. It admitted at trial that such price discrimination is not occurring now. Op. Br. 15; App-1061. It likewise never claims that hospitals *could feasibly* charge higher prices to insurers just for those patients living in Bergen County, and Appellants showed they could not because of how insurers construct their plans. Op. Br. 14-15. *Amici curiae* agree that price discrimination would be "both practically and legally infeasible." Br. of *Amici Curiae* Am. Hosp. Assoc. & Assoc. of Am. Med. Colleges at 4, 7-9 (ECF 41).

The FTC and its economist *amici* attempt to defend the FTC's ***patient***-based market by arguing that price discrimination is possible between ***insurers***. FTC Br. 37; Br. of *Amici Curiae* Professors, Economists, and Scholars at 2-3, 6-8 (ECF 86). But this is an obvious non sequitur. If the geographic market were drawn based on insurers, it would be vastly larger than the market the FTC proposed because the insurers' plans all cover patients ***across the whole state of New Jersey***. App-275, 724–725, 739; ASA-70. The FTC never suggests that a merger between Englewood and HMH would produce undue concentration in a statewide market. And to shrink the relevant market to Bergen County, the FTC would have to show not just that insurers and hospitals are "aware" that Bergen County is a county important to insurers, *see* FTC Br. 37, but that they are able to negotiate and charge different prices for patients residing there. The record undisputedly showed, to the contrary, that the insurers have never offered or even attempted to develop separate health plans only for Bergen County residents, and

there is no evidence they ever discussed different prices for them. App-275, 513–514, 723, 737. The hospitals do not even know the geographic distribution of insurers' enrollees. Op. Br. 14-15; App-1009–1010. In short, the FTC cannot defend its ***patient***-based market by pointing to ***insurers***, when the insurers do not negotiate different prices for patients based on where they live. Op. Br. 14; *see* App-275–276.

The FTC is thus left to defend the district court's unprecedented ruling that "price discrimination is not required as a matter of law." App-112. But the ruling cannot be defended. Neither the FTC nor its *amici* cite any case other than the decision below holding, or even hinting, that a relevant geographic market can be defined by customer location without price discrimination. To the contrary, all the relevant authorities stand for the opposite.

For example, the Second Circuit plainly required price discrimination to define a customer-based market, holding that "***[i]f*** the company is capable of geographic price discrimination, ***then*** smaller geographic markets, defined by the regions in which the company is able to price discriminate, will be recognized." *United States v. Eastman Kodak Co.*, 63 F.3d 95, 106 (2d Cir. 1995) (citing 1992 *Horizontal Merger Guidelines* § 1.22). The FTC's response—that this means only that "where the government *relies on* a 'theory of price discrimination,'" it "should produce evidence of it" (FTC Br. 36)—ignores the plain language of the decision. The FTC's attempted distinction of *In re R.R. Donnelley & Sons Co.*, 120 F.T.C. 36 (1995), fares no better. That case rejected a customer-based market precisely because the FTC did not show that "the hypothetical monopolist

[could] selectively and profitably increase prices" to those customers. *In re R.R. Donnelley & Sons*, 120 F.T.C. at 158-60. That the market was supposedly "defined using highly specific criteria" is immaterial. FTC Br. 36. Whatever the specific criteria were, the FTC's failure to prove price discrimination doomed its customer-based market definition.

The FTC continues to falsely claim that the Ninth Circuit affirmed a patient-based market without evidence of price discrimination in *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys.*, 778 F.3d 775 (9th Cir. 2015). But as Appellants demonstrated, the FTC's own expert testimony and proposed findings of fact in that case show that the market was defined by the location of the suppliers—the primary care physicians (PCPs). Op. Br. 31-32. The FTC never addresses its own filings. It cites the district court opinion, but that opinion expressly adopts a supplier-based market, stating "the relevant market is the area ***where those PCPs practice***." *Saint Alphonsus*, No. 1:12-cv-00560, 2014 WL 407446, at *7 ¶ 58, *8 ¶¶ 72, 73 (D. Idaho Jan. 24, 2014) (emphasis added). The Ninth Circuit affirmed this supplier-based market, finding that the "district court correctly focused on the 'likely response of insurers to a hypothetical demand by ***all the PCPs*** in a particular market for a [SSNIP].'" *Saint Alphonsus*, 778 F.3d at 784.

The FTC also offers no substantive response to Appellants' showing that the FTC's own Guidelines repeatedly and unambiguously state that the FTC can use a customer-based market only "when price discrimination is feasible," § 3, "[i]f a

hypothetical monopolist could profitably target a subset of customers for price increases," § 4.1.4, or "[w]hen the hypothetical monopolist could discriminate based on customer location," § 4.2.2. *See* Op. Br. 29-30. The FTC argues that its Guidelines are not legally "binding" (FTC Br. 33), but it does not dispute that this Court and others have found them persuasive, *Hershey*, 838 F.3d at 338 n.2. The FTC also notes that the Guidelines often use discretionary language, but it does not argue that the language at issue here affords any discretion to use what the Guidelines call "price discrimination markets" without evidence of price discrimination. *Guidelines* § 4.1.4.

The FTC's position in recent cases also contradicts its arguments here. *See, e.g.*, *FTC v. RAG-Stiftung*, No. 1:19-cv-02337, Pl's Prop. Findings of Fact & Conclusions of Law (Dkt. 137), at 19-20 (D.D.C. Jan. 10, 2020) (proposing geographic markets based on the location of customers where "prices can differ based on customer location."); *In re Tronox, Ltd.*, FTC's Post-Trial Reply Findings of Fact & Conclusions of Law, Dkt. 9377, 2018 WL 4627643, at *297 (FTC Sept. 17, 2018) ("Complaint Counsel has alleged a price discrimination market based on the location of customers under Section 4.2.2 of the 2010 Horizontal Merger Guidelines….").

The FTC also offers no response, substantive or otherwise, to the economic literature Appellants cited holding that price discrimination is necessary to define a customer-based market. Appellants quoted three leading antitrust authorities—including the leading treatise—explaining that economic principles preclude customer-based geographic markets in the absence of price discrimination. Op. Br. 26-27. The

FTC never acknowledges these authorities.

Buttressing the literature, five prominent economics professors, including two primary drafters of the 1992 Horizontal Merger Guidelines, submitted an *amicus* brief explaining why, "as a matter of economics, simple logic and common sense, it is important to demonstrate that there is the potential for price discrimination when defining a relevant antitrust market around a select group of targeted customers." Br. of *Amici Curiae* Economists at 6 (ECF 39). "[O]nly when price discrimination is feasible can the hypothetical monopolist charge different prices to different customers, thus allowing the hypothetical monopolist to profitably target a price increase to some customers while charging low prices to customers who would forgo its product at the higher price." *Id.* at 12. The FTC makes no effort to rebut the Economists' analysis either.

The FTC's only economic argument does nothing to validate its proposed patient-based market. The FTC states that "the economics of hospital markets are more complex than traditional markets" and that "because of insurance, [patients] are largely indifferent to (or entirely unaware of) price." FTC Br. 34. That may be so, but it does not support the FTC. The FTC argues that "it is not clear how the concept of 'price discrimination' as to individual patients is relevant," *id.*, but it is the one defending a proposed market based on where individual patients live. The FTC's own arguments show that this is economically incoherent.

In sum, the undisputed reality is that to raise prices for insured patients living in

Bergen County, hospitals would also have to raise prices for their insured patients that live outside Bergen County. Therefore, a relevant geographic market cannot be limited to patients living in Bergen County because that does not accurately reflect—and materially understates—the commercial reality of competition. *See Hershey*, 838 F.3d at 338. In holding otherwise, the district court erred as a matter of law. Its injunction based on that erroneous market definition must therefore be lifted.

2. The FTC did not apply the Hypothetical Monopolist Test to its patient-based market, and the HMT cannot save an improperly defined market in any event.

For two reasons, the FTC's argument that it applied the Hypothetical Monopolist Test ("HMT") to its patient-based market cannot salvage that market.

First, *no* application of the HMT could validate a patient-based market limited to Bergen County residents absent the ability to price discriminate because, as the FTC conceded in another recent hospital merger case, even a "geographic market which passes the HMT must correspond with commercial realities." *Jefferson*, 505 F. Supp. 3d at 542-43. Here, the FTC's proposed market did not match the commercial reality that there is no patient-based price discrimination, so no application of the HMT could save it. Because hospitals would have to raise their prices to insurers across the board to raise prices only for Bergen County residents, utilizing data only for Bergen County residents in the HMT cannot accurately assess whether such price increases will be profitable.

Second, the FTC's HMT was never applied to its patient-based market, but only to a small fraction of the hospitals in that market. As the FTC's expert, Dr. Dafny

testified, "the hypothetical monopolist test in this case is . . . [whether] a hypothetical monopolist of . . . ***all the hospitals*** supplying the cluster of inpatient GAC services to residents of Bergen County profitably impose a SSNIP." App-783. This definition encompasses over 50 hospitals. FTC Br. 32. Yet Dafny tested only the six hospitals located in Bergen County. *Compare* Op. Br. 33-34 (demonstrating this limitation) *with* FTC Br. 37-39 (conceding it). She never tested whether the large number of hospitals located outside Bergen County could profitably raise their prices either just for Bergen County or across the board, as they would have to do to raise them for patients coming from Bergen County.

The FTC argues that, if the six hospitals in Bergen County could profitably raise their prices, then all the other hospitals could profitably raise their prices as well. FTC Br. 38. But that ignores the fact that the hospitals located outside Bergen County draw most of their patients from locations other than Bergen County. To determine whether the hospitals located ***outside*** Bergen County could ***profitably*** raise their prices across the board, Dafny would have had to examine how insurers and competing hospitals would react to such a price increase, which would affect the prices charged to patients across the region. Op. Br. 15-16, 26-28. But Dafny never performed that analysis, admitting that it would have made her model "explode." App-853–854.

This Court's *Hershey* decision does not support the FTC's argument that its patient-based market could be validated by applying the HMT to just the six hospitals located in Bergen County. *See* FTC Br. 38. As Dafny admitted, *Hershey* was a "totally

different case." App-1066. *Hershey* does not discuss, much less endorse, applying the HMT to a hospital-based market to attempt to validate a different, patient-based market. In addition, all the hospitals considered in *Hershey* were within the same four-county Harrisburg area. *Hershey*, 838 F.3d at 346. Here, in contrast, the FTC is seeking to extrapolate from Bergen County hospitals to dozens of hospitals in areas as different as New York City, on the assumption that competitive conditions in New York City are no different than they are in Bergen County. There is no basis in logic or in the record for that assumption.

B. The *hospital*-based market that the FTC raises for the first time on appeal was waived and is not supported by the record.

The FTC's lead argument on appeal is that this Court can affirm the injunction by becoming a factfinder and adopting a new geographic market that the district court did not find and the FTC did not propose—specifically, a supplier-based market comprised of the six GAC hospitals in Bergen County. This is altogether improper. The FTC waived a hospital-based market below, and it failed to prove one up in any event.

1. The FTC waived a hospital-based market by not proposing one in its expert report or asking the district court to find one.

The FTC admits that "[g]eographic market determinations are fact-intensive," FTC Br. 22—and the factfinder is the district court. This Court reviews the district court's factual findings supporting "the relevant geographic market [only] for clear

error." *Hershey*, 838 F.3d at 335.[1] Because the district court here did not find a geographic market comprised of the six hospitals in Bergen County, this Court cannot affirm the injunction based on that market. Any such order would "depend upon findings of fact which the district court did not make." *Dubern v. Girard Tr. Bank*, 454 F.2d 565, 571 (3d Cir. 1972).

Resisting this basic principle of appellate review, the FTC argues that this Court may affirm on any basis supported by the record. FTC Br. 30. But the cases it cites do not help the FTC for two reasons. First, they involved issues subject to *de novo* review, not issues committed to the district court for factfinding. *See T.D. Bank N.A. v. Hill*, 928 F.3d 259, 276 n.9 (3d Cir. 2019) (summary judgment); *Edinboro Coll. Park Apts. v. Edinboro Univ. Found.*, 850 F.3d 567, 580 (3d Cir. 2017) (motion to dismiss). Second, those cases did not involve issues that were waived below. The principle that this Court may affirm on alternative grounds "does not apply to cases in which the party has waived the issue in the district court." *Holk v. Snapple Beverage Corp.*, 575 F.3d 329, 335 (3d Cir. 2009). Here, the FTC repeatedly waived a hospital-based market in the district court.

First, in discovery, the FTC made it clear that it was proposing only a patient-based market and was not proposing a supplier-based market limited to hospitals in Bergen County. Thus, Dafny's rebuttal expert report emphasized that the proposed

[1] Legal errors and errors of economic theory are reviewed *de novo*. *See Hershey*, 838 F.3d at 335-37; FTC Br. 23.

geographic market "includes ***all hospitals—inside and outside of Bergen County***—that Bergen County residents visit for care." App-688. At Dafny's deposition, she reinforced that position, testifying: "I defined my geographic market based on customer location." App-710; *see also* App-267 (exhibit showing same).

Second, at the evidentiary hearing, Dafny repeated, unambiguously, that she was proposing only a patient-based market and ***not*** a hospital-based market. First, she testified:

> 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 Count. That's the definition that I use.

App-778 (emphasis added). Later, she repeated:

> Q: And your relevant geographic market is ***based around patients, not hospitals***. I think we established that earlier?
>
> A: ***Absolutely.***

App-858–859 (emphasis added).

Finally, after the hearing, the FTC did not ask the district court to find a hospital-based geographic market (ASA-94–107), and the district court did not find a hospital-based market. Rather, as shown above, the district court found a patient-based market. App-119. The court discussed hospital-based numbers only as a sensitivity check on the market concentration figures for the FTC's patient-based market. App-120, n.25 ("Dr. Dafny also calculated HHI using a hospital-based approach, as a 'sensitivity check'").

To preserve a hospital-based market for appeal, the FTC had to give Appellants fair notice of it and a chance to respond. *See Barna v. Bd. of Sch. Dirs. of Panther Valley Sch. Dist.*, 877 F.3d 137, 146 (3d Cir. 2017). The FTC also was required to "*unequivocally* put its position before the trial court at a point and in a manner that permits the court to consider its merits." *Shell Petroleum, Inc. v. United States*, 182 F.3d 212, 218 (3d Cir. 1999) (emphasis added). This was particularly so because defining and proving a relevant market is so fact intensive and this Court "cannot know on appeal what evidence the adverse party would have presented or brought out through cross-examination." *Id.* at 219. To "promote finality by encouraging parties to advance all relevant arguments and by binding counsel to their strategic choices," to "protect litigants from unfair surprise," and to "respect[] the work of the court of first instance," this Court should enforce the FTC's waiver. *Barna*, 877 F.3d at 146.

Neither case the FTC cites to defend its ability to raise a new market on appeal involved a waiver. In *FTC v. AbbVie Inc.*, unlike here, the FTC expressly "argued for [a market] definition in the alternative" in the district court, and the district court found that definition to be factually supported. 976 F.3d 327, 373 (3d Cir. 2020). In *Hershey*, unlike here, the geographic market the FTC argued for on appeal was the same market its expert proposed and the FTC argued for in the district court. *Hershey*, 838 F.3d at 345-46. Here, the FTC's expert did not propose and the FTC did not ask the district court to find a hospital-based market. That strategic choice waived the issue for appeal.

2. The record does not contain the evidence necessary for this Court to define and find a hospital-based market in any event.

In addition to waiving a hospital-based market claim, the FTC also failed to provide the evidence necessary to define and support such a market.

First, and dispositively, the FTC presented no expert testimony proposing or supporting a hospital-based market. Although the FTC argues that an expert is not always required to prove a geographic market, FTC Br. 31, it does not address the cases holding that "[c]onstruction of the relevant market . . . must be based on expert testimony." *Bailey v. Allgas, Inc.*, 284 F.3d 1237, 1246 (11th Cir. 2002); *see also* Op. Br. 35. But regardless, even if some simple markets could be constructed and proved without an expert, the complex market in this case would not fall within such an exception: Englewood and HUMC are located in one of the densest urban environments in the country. They are also engaged in a "two-stage model of competition" (*Hershey*, 838 F.3d at 342) that the FTC emphasizes is "more complex than traditional markets." FTC Br. 34. Hence, this case surely falls within the "great majority" where expert testimony is required to define and prove a relevant market. *See* P.E. Areeda & H. Hovenkamp, Antitrust Law: An Analysis of Antitrust Principles and Their Application ¶ 531 (4th & 5th eds. 2021).

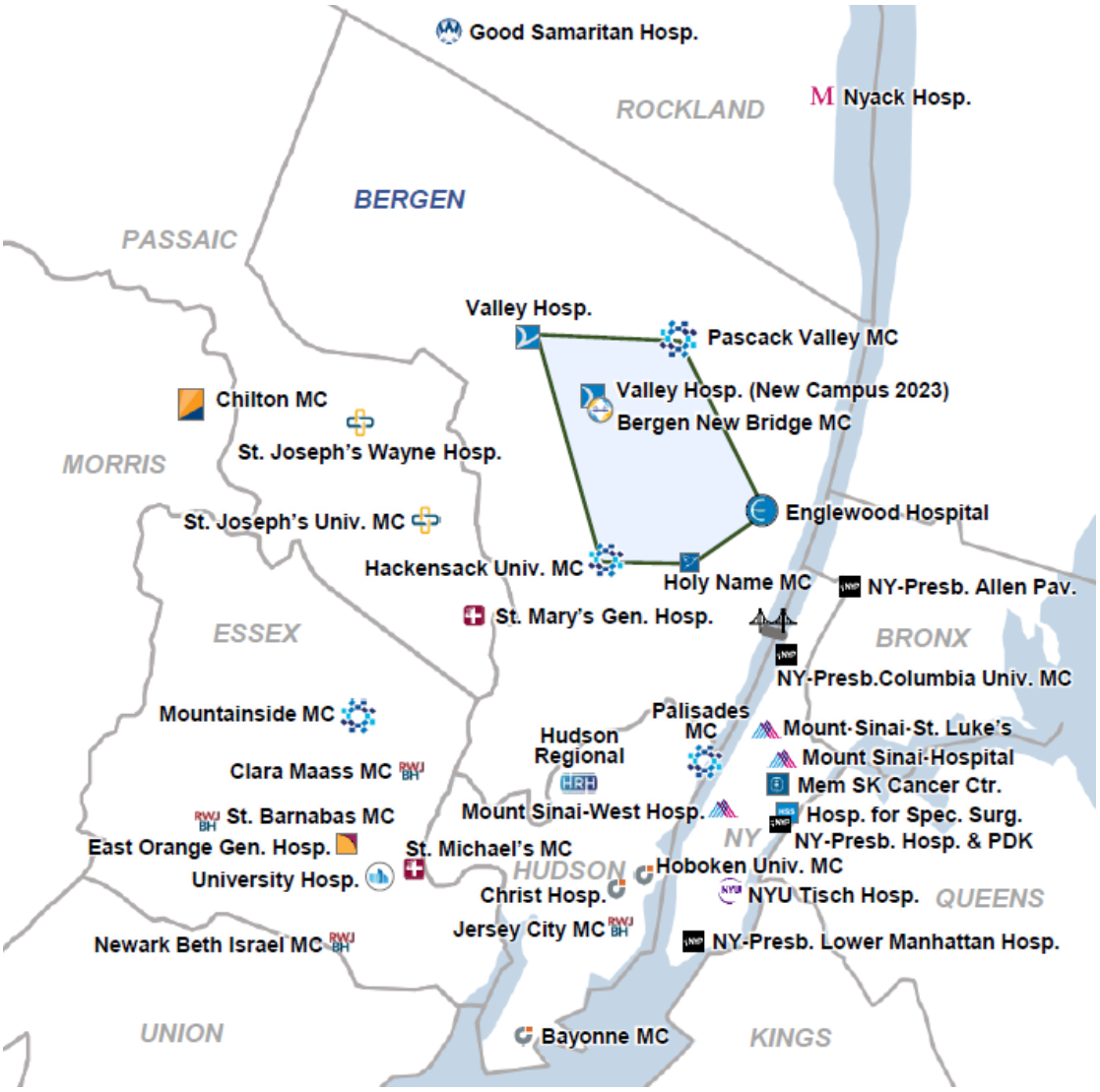
Second, whether through an expert or otherwise, the FTC never proved that limiting the market to the hospitals in Bergen County would capture the closest competitors to Englewood and HUMC and thus "correspond to the commercial

realities of the industry." *Hershey*, 838 F.3d at 338. The Guidelines state that a market cannot be drawn to include more distant competitors without also including a "closer substitute," even if a market of only the more distant competitors could charge a SSNIP. *Guidelines* § 4.1.1, Ex. 6; *Jefferson*, 505 F. Supp. 2d at 542-43; *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 37-38 (D.D.C. 2017). The compelling logic requiring closer competitors to be included is that, without them, the proposed market will not accurately reflect the commercial reality of competition. Ignoring its own Guidelines and the cases, the FTC argues that it need not provide evidence on closer competitors, but it cites no authority supporting that contention. FTC Br. 32.

Here, the FTC's expert admitted that she did not assess who Englewood's and HUMC's closest competitors are, App-831, and the FTC presented no other evidence to fill that void. This missing evidence was particularly important in this case, given how dense the competition is.[2] For example, there are 24 competing hospitals within a 30-minute drive of Englewood, and many other hospitals and health systems outside Bergen County compete against HUMC, Englewood, or both. *See* App-79–80, 83–84, 277–279, 497–498, 525–527, 620–625, 732–733; ASA-13, 71–72, 77. As the map below shows, many Bergen County residents live closer to competing hospitals just outside

[2] The group of Attorneys General supporting the FTC acknowledges that analyzing the competitive effects of a hospital merger depends on location-specific fact finding. Corrected Br. of the States as *Amici Curiae* § 1 (ECF 98). It is thus telling that the Attorney General of New Jersey did not join the *amicus* brief and, in fact, approved the merger as being in the public interest of New Jersey. *See* Appellants' Motion to Expedite Appeal at Ex. 4 (ECF 17).

Bergen County—such as St. Joseph's Medical Center, St. Mary's General Hospital, and Hudson Regional Hospital—than to Englewood or HUMC. App-84, 268–269, 620; ASA-5–6, 19–20, 26–28, 38, 45–48, 74–77.



In a market as densely competitive as this one, a careful analysis, an extensive evidentiary record, and factfinding by the district court are essential to define a market that accurately corresponds with commercial realities and guards against the high risk

of inaccurately finding market concentration where none exists. *Compare FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016) (Chicago) and *Jefferson*, 505 F. Supp. 3d at 541 (Philadelphia) *with FTC v. Sanford Health*, 926 F.3d 959, 963 (8th Cir. 2019) (Bismarck, North Dakota area) and *Hershey*, 838 F.3d at 345-46 (Harrisburg area). Here, that analysis, record, and factfinding were particularly crucial because the FTC's market concentration numbers only barely exceeded the HHI threshold and were highly sensitive to small changes in market boundaries. For example, Defendants' expert Dr. Wu found plausible geographic markets based on 20-minute travel times that resulted in concentration levels *below* the 2,500 HHI threshold necessary to generate a presumption of competitive harm under the Guidelines. Op. Br. 17; App-647–657, 958–960.

In arguing simplistically that the six hospitals in Bergen County constitute a relevant geographic market because insurers would not want to market a plan without at least one of them (FTC Br. 32), the FTC seeks to confuse the issue. The issue is not just whether *enough* hospitals are included to make the proposed market economically significant, but whether the *correct* hospitals are included to reflect the competitive realities—namely, the hospitals that are the merging parties' closest competitors and most significant constraints. As the district court in *Jefferson* recognized, "geographic market definition is not merely a 'statistical exercise' looking for a hypothetical monopolist that can impose a SSNIP;" rather, the proposed market must "reflect the

market's commercial realities." *Jefferson*, 505 F. Supp. 3d at 541.[3]

The commercial reality of numerous, nearby competing hospitals in this case is similar to the facts in *Jefferson*, the other recent hospital merger case litigated in this Circuit. There, the FTC's claim failed precisely because it tried to define unrealistic hospital-based markets in the urban Philadelphia area that did not account for close competitors. The district court rejected the market, this Court denied a stay pending appeal, and the FTC then abandoned the case. *See Jefferson*, 505 F. Supp. at 534–35, *stay pending appeal denied*, 2020 WL 8455862 (3d Cir. Dec. 21, 2020), *appeal dismissed*, 2021 WL 2349954 (3d Cir. Mar. 4, 2021). Here, because the FTC did not propose a hospital-based market below, the extensive record, expert analysis, and district court factfinding of a hospital-based market that were conducted in *Jefferson*—and that led to the conclusion that the FTC's proposed market was fundamentally flawed—do not exist here. The FTC should not be allowed to bypass district court scrutiny of its hospital-based market in this case by raising it for the first time on appeal.

[3] Asking only whether insurers would want at least one hospital in Bergen County also does not answer the question whether a monopolist owning the six hospitals located there could *profitably* impose a SSNIP absent the ability to price discriminate. Just as insurers cannot build networks without hospitals, hospitals cannot be profitable without being in insurer networks. There is leverage on both sides, and here the insurers did not testify that they would accept an anticompetitive SSNIP, only that they would accept "reasonable" price increases. App-110–111.

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

Because the FTC did not propose and prove a relevant geographic market and therefore failed to establish a prima facie case, its claim failed at step one of the Clayton Act analysis, and this Court need not address steps two or three. If the Court does reach those steps, however, it should still reverse the injunction because Appellants rebutted the FTC's historically weak prima facie case (step two), and the FTC did not provide reliable, direct evidence of anticompetitive price increases to offset the competitive benefits found by the district court (step three).

A. The FTC cannot defend the district court's requirement that procompetitive benefits must be "extraordinary" to be relevant in the merits analysis.

The district court applied an incorrect legal standard in ruling for the FTC: it held that procompetitive benefits must be "extraordinary" to be considered as part of the competitive effects analysis, instead of recognizing that *all* such benefits are relevant. Op. Br. 37, 40-41. Here, the district court found that the merger would in fact have procompetitive benefits, yet it failed to consider them because it did not find them to be extraordinary. This was legal error.

As Appellants showed (Op. Br. 38–39), and the FTC agrees (FTC Br. 57), a sliding scale governs the competitive-effects analysis—the weaker the prima facie case of anticompetitive harm, the less that is required to overcome it. Here, the FTC's prima facie case was historically weak. The HHI market-concentration numbers the FTC

claimed are the lowest of any recent hospital merger case and barely supported any presumption of competitive harm, even taken at face value. Op. Br. 38-39. The merger cases the FTC cites are inapposite and unconnected to the competitive realities of this transaction, and some of them also apply earlier versions of the Guidelines, which set lower HHI thresholds. FTC Br. 57-58, 58 n.14. Moreover, Appellants showed that even the FTC's weak HHI numbers were inaccurate because (1) the market definition producing them was improper, (2) minor adjustments in the definition *eliminated* any presumption of harm, and (3) direct testimony from insurers showed that Englewood would not give HMH any significant additional leverage. *See supra* Section I.B.2 and *infra* Section II.B. This evidence, by itself, was sufficient to rebut the FTC's prima facie case "by discrediting the data underlying the initial presumption in the government's favor." *United States v. Baker Hughes Inc.*, 908 F.2d 981, 991 (D.C. Cir. 1990); *see also Chi. Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008); *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1336, 1341 (7th Cir. 1981); *cf. DeMarines v. KLM Royal Dutch Airlines*, 580 F.2d 1193, 1200 (3d Cir. 1978) ("[t]he burden of producing evidence" requires "sufficient evidentiary material from which the jury *could reasonably infer* the existence of the fact to be proved").

In addition to discrediting the FTC's case, Appellants also produced evidence showing that the merger would have procompetitive benefits. Indeed, they not only *produced* evidence but *persuaded* the district court that the merger would in some ways produce "a procompetitive benefit to Bergen County." App-132. Most significantly, it

would enable Englewood "to upgrade its facilities and equipment" and allow it to offer "a broader array of services" to "more patients." App-132–133. In addition, it would enable "both hospitals (particularly Englewood) [to] likely see certain improvements in quality." App-140. The FTC wastes time discussing the competitive benefits the district court did *not* find. FTC Br. 59-60. But it neither disputes the benefits the district court *did* find nor claims clear error in those findings. It is therefore undisputed in this Court that the merger would strengthen Englewood's and HUMC's ability to compete for patients in the ways the district court found and thus require other hospitals to increase their quality as well, benefiting patients.

These procompetitive benefits of better facilities and increased quality cannot be ignored by claiming that they are "the same kinds of benefits [that] were asserted" in *Hershey*. FTC Br. 55. In *Hershey*, this Court analyzed as "efficiencies-based defenses" the defendants' argument that the merger would save the hospitals money by allowing Hershey to avoid constructing a new, previously planned bed tower. *Hershey*, 838 F.3d 347. That is very different from the procompetitive benefits the district court found, which are based on improvements in the quality of care that Englewood will achieve through HMH's new capital investments and patient volume. This new investment is the opposite of the alleged cost-saving claim in *Hershey*, and it will directly strengthen competition to patients' benefit. *Compare Guidelines* §§ 6-7 *with* § 10 (distinguishing between competitive effects or benefits and efficiencies).

The district court failed to weigh the procompetitive benefits it found at either

step two or step three of the analysis, because it confused the mandatory balancing necessary to assess the competitive effects of the transaction with a defense relying on efficiencies. To be perfectly clear, in demonstrating that there are both procompetitive benefits and efficiencies, Appellants are not raising an affirmative defense. They are not asking to be excused from a finding of liability because of extraordinary efficiencies. The FTC's attacks on such a defense are attacks on a straw man. FTC Br. 53-54. Appellants' argument is quite different: the FTC *did not prove its liability case* because the evidence showed that there would not likely be a substantial lessening of competition when both pro- and anti-competitive effects were duly considered as part of the analysis.

Here, it is undeniable that the district court erroneously applied the heightened standard for the efficiencies defense to Appellants' asserted procompetitive benefits. It held that, "addressing the competitive effects analysis, Defendants fail to establish ***extraordinary*** procompetitive effects to offset Plaintiff's prima facie case." App-131. If further held that, although "Englewood should be able to expand and upgrade its physical plant, equipment, and services," "these benefits do not amount to ***extraordinary efficiencies*** that offsets [sic] the likely anticompetitive effect." App-140. Of course, they are not extraordinary efficiencies; they are not efficiencies at all. They are competitive benefits that the district court weighed incorrectly. This legal error requires vacating the injunction.

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

Finally, the district court erred in concluding that the FTC provided reliable direct evidence of a likely anticompetitive price effect from the merger.

The primary evidence offered by the FTC was its expert's analysis of estimated changes in *patients'* willingness to pay ("WTP"), which she opined could be used to show that the hospitals could increase prices to *insurers* by $31 million due to increased market power. Her opinion was fundamentally unreliable, however, as the data showed no correlation between patients' WTP and insurers' prices ***in the New Jersey hospital market***. Op. Br. 43-45.

Two undisputed principles regarding the two-stage model of hospital competition must frame the Court's assessment of Dafny's WTP analysis. First, patient preferences are undeniably "relevant to the analysis, especially to the extent that their behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates." *Hershey*, 838 F.3d at 342. But second, there is a "fundamental difference" between patients (who "are largely insensitive to healthcare prices") and insurers (who are highly price sensitive), and the analysis must be conducted "through the lens of the insurers" since they are the ones who negotiate prices. *Id.*

Because patient preferences are relevant to, but fundamentally different from, insurers' negotiations with hospitals on prices, Dafny's WTP analysis required valid evidence showing *how* the two are correlated, *if at all*, ***in the market at issue***. This is

where the analysis had a complete gap. Simply put, no evidence showed that patient WTP is correlated with the prices insurers pay ***in New Jersey***. Op. Br. 44-45; *see also* Br. of *Amici Curiae* Am. Hosp. Assoc. & Assoc. of Am. Med. Colleges at 11-12 (ECF 41). Indeed, the "conversion factor" she used to translate patient WTP into prices did not include *any* hospital mergers in New Jersey and ignored the insurer claims data from New Jersey that were available. Op. Br. 44-45.

By contrast, Appellants' expert, Dr. Wu, analyzed the claims data from New Jersey and found that there was no statistically significant relationship between WTP and prices paid by insurers in New Jersey. Op. Br. 44; App-124–125. The FTC concedes that the district court did not reject the validity of Wu's analysis and did not find that Dafny rebutted this evidence. *See* FTC Br. 46. The FTC instead relies on the district court's acceptance of "the general proposition" that hospitals with a higher WTP can "command higher negotiated prices." FTC Br. 45 (quoting App-124). But there is no evidence in this case showing that this "general proposition" holds true here, and the lone article on which Dafny relied for her "conversion factor" did not find this "general proposition" to be true in all cases. *See* Op. Br. 44; App-235. Here, on this record, the evidence specific to New Jersey shows that, even if the transaction increased patients' WTP for HMH post-merger, that increase would not translate into higher prices paid by insurers. Op. Br. 44-45; App-676–677, 965, 978.

Nor is there any other reliable direct evidence to support the district court's prediction of a likely anticompetitive price effect from the merger. The district court

and the FTC cite contractual Acquisition Clauses that HMH had negotiated *long before* this proposed merger, which in certain circumstances allowed HMH to seek to apply its prices with certain insurers to an acquired hospital post-merger. App-125–127. These Clauses, however, are irrelevant to the competitive-effects analysis for two independent reasons: (1) they necessarily reflected HMH's *pre*-merger market power, not any claimed increase in market power from the merger with Englewood; and (2) HMH waived them in any event. Op. Br. 46-48. The FTC does not dispute either of these points.

That HMH may have had a contractual right to seek price changes after past acquisitions also is not direct evidence of a future anticompetitive price effect *from this merger*. App-126. The record showed that any past increases were due to the contractual Acquisition Clauses, making them irrelevant to the Englewood merger, where the Clauses have been waived. App-89–90, 126. Further, and more fundamentally, the Clayton Act does not bar price increases *per se*, it bars them only if they result from harm to competition caused by a merger. Prices may be increased for any number of reasons that have nothing to do with undue market power, including inflation, increases in quality due to investments in upgraded equipment, and a different market strategy. By simply positing likely price increases without valid evidence proving future anticompetitive market power resulting from *this* transaction, the FTC is missing the critical point. Moreover, if the FTC's logic that past price increases invariably show future anticompetitive price increases were accepted, it would produce the absurd conclusion that HMH could not acquire *any* hospital, *anywhere in the country*.

The controlling issue is whether this specific merger—the merger with Englewood's sole community hospital—would increase the pre-existing bargaining leverage of HMH to an anticompetitive level. The direct evidence from insurers' claims data showed that it would not. Indeed, no insurer testified that it needs Englewood to form a marketable network, and the insurers testified that the addition of Englewood would not significantly increase HMH's leverage. App-127 n.31; Op. Br. 45. There was thus no reliable direct evidence that the proposed merger would likely lead to any material increase in HMH bargaining power with the insurers.

CONCLUSION

For the reasons set forth above and in Appellants' Opening Brief, 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.

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Respectfully submitted,

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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 Ruleof Appellate Procedure 32(a)(7)(B) because it contains 7,452 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 November 12, 2021, I electronically filed the foregoing Reply 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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