IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

FEDERAL TRADE COMMISSION, Plaintiff, v. HACKENSACK MERIDIAN HEALTH, INC. and ENGLEWOOD HEALTHCARE FOUNDATION, Defendants.	Civil Action No. 2:20-cv-18140-JMV-JBC

DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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GLOSSARY OF ABBREVIATED TERMS

Abbreviations used in Defendants' Proposed Findings of Fact and Conclusions of Law have the following meanings:

1. *Exhibits and Transcripts*

PX	Plaintiff's Exhibit
DX	Defendants' Exhibit
JX	Joint Plaintiff's and Defendants' Exhibit
PPX	Plaintiff's Demonstrative Exhibit
DDX	Defendants' Demonstrative Exhibit
Hr'g Tr.	Hearing Transcript
Dep. Tr.	Deposition Transcript

2. *Names and Terms*

AMC	Academic Medical Center
Aetna	Aetna Inc.
Amerigroup	Amerigroup New Jersey, Inc.
AmeriHealth	AmeriHealth New Jersey
Atlantic	Atlantic Health System
BD	Becton Dickinson
Chartis	The Chartis Group
Cigna	Cigna Corp.
CMS	Centers for Medicare and Medicaid Services
Defendants	HMH and Englewood, collectively
Definitive Agreement	Affiliation Agreement executed by HMH and Englewood, dated Sept. 23, 2019
Doyle	Doyle Alliance Group
DRG	Diagnosis Related Grouping
Englewood or EH	Englewood Health
FTC	Federal Trade Commission
GAC	General acute care
Garmon Study	Garmon, C. "The accuracy of hospital merger screening methods." RAND Journal of Economics, vol. 48, 2017.
HHI	Herfindahl-Hirschman Index
HMH	Hackensack Meridian *Health*, Inc.

HMS	Hospital Merger Simulation Model
HMT	Hypothetical Monopolist Test
Holy Name or HNMC	Holy Name Medical Center
Horizon	Horizon Blue Cross Blue Shield of New Jersey
HSS	Hospital for Special Surgery
Hudson Regional or HRHS	Hudson Regional Health System
HUMC	Hackensack University Medical Center
JCMC	Jersey City Medical Center (RWJBarnabas)
MSK	Memorial Sloan Kettering
Merger	Proposed merger between HMH and Englewood
Guidelines	Department of Justice and Federal Trade Commission's Horizontal Merger Guidelines (2010)
Mountainside or MMC	Hackensack Meridian Health Mountainside Medical Center
Mt. Sinai	Mount Sinai Health System
NBI	Newark Beth Israel Hospital (RWJBarnabas)
NY-Presbyterian	NewYork-Presbyterian Healthcare System
NYU-Langone	NYU Langone Health
Palisades or PMC	HMH Palisades Medical Center
Pascack Valley or PVMC	Hackensack Meridian Health Pascack Valley Medical Center
PSA	Primary Service Area
RWJB	RWJBarnabas Health
SBMC	St. Barnabas Medical Center (RWJBarnabas)
St. Joseph's	St. Joseph's Health System
SSNIP	Small but significant non-transitory increase in price
St. Mary's	Prime St. Mary's General Hospital
UH	Robert Wood Johnson University Hospital (RWJBarnabas)
United	UnitedHealthcare
WTP	Willingness-to-pay Model

3. ***Hearing Witnesses***

Lisa Ahern	Defendants' Expert
Sue Anderson	Principal, Chartis
Dr. Stephen Brunnquell	President, Englewood Health Physician Network
Dr. Leemore S. Dafny	Plaintiff's Expert
Robert Garrett	President & Chief Executive Officer, HMH
Warren Geller	President & Chief Executive Officer, Englewood
Dr. Gautam Gowrisankaran	Defendants' Expert
Lynda Grajeda	Director of Contracting for Medicaid and Medicare, Amerigroup
Allen Karp	Executive Vice Presidents of Healthcare Management and Transformation, Horizon
Ken Kobylowski	Senior Vice President for Provider Contracting and Network Operations, AmeriHealth
Kevin Lenahan	Senior Vice President, Chief Administrative Officer, Chief Financial Officer, Atlantic
Michael Maron	President and Chief Executive Officer, Holy Name
Dr. Gregg Meyer	Defendants' Expert
Michele Nielsen	Vice President of Network Contracting and New Jersey Market Lead, United
Kevin (Casey) Nolan	Defendants' Expert
Dr. Patrick Romano	Plaintiff's Expert
Mark Sparta	President and Chief Hospital Executive, HUMC
Kristen Strobel	Senior Director of Global Benefits, Becton, Dickinson and Company
Ryan Tola	President, New Jersey Division, Doyle Alliance Group
Dr. Lawrence Wu	Defendants' Expert
Walter Wengel	Senior Director, Aetna
Patrick Young	President of Population Health, HMH

4. ***Deponents and Declarants***

James (Jim) Blazar	Executive Vice President & Chief Strategy Officer, HMH
Ellen Busteed	Acting Director of Personnel, County of Bergen
John Caby	Senior Vice President, Tri-State Network Management, Cigna
Edward Condit	President & Chief Executive Officer, St. Mary's General Hospital (Prime)
John Grywalski	Chief Financial Officer, Hudson Regional Hospital
Kathy Kaminsky	Senior vice president, Patient Care Services & Chief Nursing Officer, Englewood
James Kirkos	Chief Executive Officer, Meadowlands Chamber of Commerce
Arthur Klein	President, Mount Sinai Health System
Patrick Knaus	EVP of System Strategy, RWJBarnabas Health
Jeffrey Le Benger	Chief Executive Officer, Summit CityMD (formerly Summit Medical Group)
Audrey Meyers	President & Chief Executive Officer, Valley Health System
Anthony Orlando	Senior Vice President & Chief Financial Officer, Englewood
Vijayant Singh	Chief Hospital Executive, Bayonne Medical Center (CarePoint Health)
Kevin Slavin	President & Chief Executive Officer, St. Joseph's Health
Mark Stauder	Chief Operating Officer, HMH
Deborah Visconi	President & Chief Executive Officer, Bergen New Bridge

FINDINGS OF FACT

I. Defendants' Procompetitive Plans to Optimize Healthcare Service Delivery in Northern New Jersey.

A. The Party Hospitals.

1. HMH is a comprehensive health system with three AMCs, nine community hospitals, four specialty hospitals, 500 care sites, 7,300 affiliated physicians, 1,000 employed physicians, a medical school, and a major research institution.[1]

2. HMH organizes its operations across three regional service areas in New Jersey: Northern Region, Central Region, and Southern Region.[2] HMH's Northern Region includes HUMC, HMH's flagship AMC, and three community hospitals (PVMC, PMC, and MMC).[3] HUMC is the only HMH hospital that performs complex tertiary and quaternary care.[4]

3. Englewood is a community teaching hospital that provides primary, secondary, and non-complex tertiary services.[5] It has physician offices in over 100 sites in Bergen, Hudson, Passaic, Morris, and Essex Counties (among others) in New Jersey, and Rockland County in New York.[6] Englewood currently operates hospital

[1] Hr'g Tr. 734:2-735:2, May 13 (R. Garrett, HMH).
[2] Hr'g Tr. 772:18-773:11, May 13 (R. Garrett, HMH).
[3] Hr'g Tr. 772:23-773:4, May 13 (R. Garrett, HMH).
[4] Hr'g Tr. 735:3-10, May 13 (R. Garrett, HMH).
[5] Hr'g Tr. 845:3-19, May 14 (W. Geller, Englewood).
[6] Hr'g Tr. 850:2-6, 852:11-14. May 14 (W. Geller, Englewood); Hr'g Tr. 1310:25-1311:24, May 18 (S. Brunnquell, Englewood); [redacted]

outpatient departments ("HOPDs") in Bergen, Essex, Morris, and Passaic Counties and plans to open a 75,000 square-foot HOPD in Hudson County in the next year.[7]

B. Englewood's Search for a Merger Partner.

4. As of 2018, Englewood's needs were growing more rapidly than its resources.[8] As Englewood's President and CEO Warren Geller explained, Englewood was [redacted].[9] Englewood also needed resources to [redacted][10]

5. Accordingly, in 2018, the Executive Committee of Englewood's Board of Trustees hired Chartis to evaluate Englewood's strategic plan and future needs.[11]

6. Chartis performed a comprehensive analysis of Englewood's strategic plan, finances, and projections, and did an independent market assessment.[12] Englewood's "lower liquidity reserves" made it more challenging to serve its capital needs through self-funding and to compete in a "crowded region with high-quality competitors."[13]

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[7] Hr'g Tr. 851:8-852:7, May 14 (W. Geller, Englewood).

[8] [redacted]; Hr'g Tr. 389:4-7, May 11 (S. Anderson, Chartis); DX4121; [redacted].

[9] [redacted]; [redacted]; [redacted]; DX4121.

[10] [redacted]

[11] Hr'g Tr. 870:25-871:11, May 14 (W. Geller, Englewood); Hr'g Tr. 386:5-10, 386:23-387:3, May 12 (S. Anderson, Chartis).

[12] Hr'g Tr. 873:1-15, May 14 (W. Geller, Englewood); Hr'g Tr. 389:4-7, May 11 (S. Anderson, Chartis); [redacted].

[13] [redacted]; Hr'g Tr. 501:3-502:6, May 12 (S. Anderson, Chartis).

Chartis recommended that Englewood seek a merger partner, and its Board agreed.[14]

7. Chartis then assisted Englewood in finding a partner, with five systems expressing interest: [redacted].[15]

8. [redacted] HMH made it to the final stages of the bidding process.[16] [redacted] submitted an offer.[17] [redacted] provided an offer, but Englewood's Board eliminated [redacted] —all of which were significant to the Englewood Board.[18]

9. Englewood developed specific "deal asks" outlining the criteria it wanted in a merger partner, which Chartis presented to [redacted] HMH.[19] Englewood asked [redacted].[20] In making that request, Englewood's Board was [redacted][21]

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[14] [redacted]; Hr'g Tr. 399:13-18, May 11 (S. Anderson, Chartis); [redacted]; [redacted]

[15] Hr'g Tr. 399:19-400:12, 511:16-21, May 11-12 (S. Anderson, Chartis); [redacted]

[16] [redacted]; [redacted]; [redacted].

[17] [redacted]; [redacted]

[18] [redacted]

[19] DX0103; [redacted]; [redacted]

[20] [redacted]; DX0103.

[21] [redacted].

10. In its review of [redacted] finalists' offers, the Englewood Board found that [redacted] and offered [redacted] to Englewood.[22] [redacted] capital commitment had material qualifications: [redacted], and conditioned on Englewood [redacted].[23]

11. [redacted], HMH's offer did not have similar caveats and limitations. Its capital commitment of over $400 million was "front loaded" (60% would be provided in the first four years), had no financial or operating conditions, and would not be reduced based on money raised by Englewood Health Foundation.[24] HMH told Englewood about HUMC's "significant capacity challenges" and its plan to decant specific types of patients to Englewood from HMH hospitals in the Northern Region, thereby developing Englewood as a "robust tertiary hub," [redacted][25] Indeed, the Englewood

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[22] [redacted]; [redacted]; *see* [redacted]

[23] [redacted].

[24] [redacted].

[25] [redacted]; [redacted]; DX3768-007-008.

Board [redacted][26]

12. The Englewood Board [redacted][27] It would be [redacted] would ever offer the commitments Englewood's Board required for an acceptable deal.[28] The Board [redacted] to move forward to negotiate a merger agreement with HMH.[29]

C. HUMC's Overcapacity Challenges.

13. As the busiest hospital in the state, HUMC has experienced significant ongoing inpatient bed capacity constraints that have impaired its ability to expand the highly complex services it offers today.[30] HUMC has implemented several measures to alleviate its overcapacity issues, but its occupancy levels remain well above the industry's maximum recommended occupancy rates.[31]

14. The industry recommended maximum for overall hospital occupancy is 85%, as recognized by a study commissioned by the State of New Jersey that analyzed hospital conditions across the state and found that 83% is "full occupancy."[32] HUMC

[26] [redacted].
[27] [redacted].
[28] [redacted]
[29] [redacted].
[30] DX5003-1 ¶¶ 55-91; DX3601-006; Hr'g Tr. 1185:20-1186:7, 1192:9-1194:5, May 17 (Mr. Nolan); Hr'g Tr. 1142:20-25, May 17 (M. Sparta, HMH).
[31] DX5003-1 ¶¶ 92-114; DX3601-007-009; Hr'g Tr. 1149:21-1150:22, May 17 (M. Sparta, HMH); Hr'g Tr. 1196:2-24, May 17 (Mr. Nolan).
[32] New Jersey Commission on Rationalizing Health Care Resources, Final Report,

has consistently operated above that maximum.[33] Hospitals seek to operate at or below the industry recommended maximum 85% overall occupancy to provide a safety margin of available beds to accommodate patients who need them.[34]

15. The size of the safety margin varies by bed type.[35] The maximum recommended occupancy for a hospital's primary bed type ("med/surg" beds) is 85%, although maximum occupancy levels are set lower for specialized bed types or units: obstetrics and pediatrics beds (75%); intensive care units ("ICU"), critical care units ("CCU"), and neonatal intensive care ("NICU") units (70%).[36] Hospital planners set a target maximum of 80% for operating room ("OR") utilization.[37]

16. HUMC's occupancy rates are consistently beyond these levels.[38] HUMC experienced an average 90% occupancy in 2018 and 2019 for its med/surg beds.[39] When factoring in "temporary surge," meaning the housing of patients in temporary

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49 (Jan. 24, 2008) https://www.nj.gov/health/rhc/documents/entire_finalreport.pdf; Hr'g Tr. 1186:8-188:3, May 17 (Mr. Nolan); Hr'g Tr. 1462:7-1463:17, May 18 (Dr. Romano); [redacted]

[33] DX5003-1 ¶¶ 68-69; DX3601-006; Hr'g Tr. 752:15-753:24, May 13 (R. Garrett, HMH); Hr'g Tr. 1142:20-25, May 17 (M. Sparta, HMH); Hr'g Tr. 1192:9-1194:5, May 17 (Mr. Nolan).

[34] DX5003-1 ¶¶ 39-45; Hr'g Tr. 1144:23-1145:5, May 17 (M. Sparta, HMH); Hr'g Tr. 1189:16-1190:5, May 17 (Mr. Nolan).

[35] DX5003-1 ¶¶ 53-54, 57; Hr'g Tr. 1189:16-1190:19, May 17 (Mr. Nolan).

[36] DX5003-1 ¶ 57; Hr'g Tr. 1189:16-1190:19, May 17 (Mr. Nolan).

[37] DX5003-1 ¶¶ 85-87; Hr'g Tr. 1195:5-1196:1, May 17 (Mr. Nolan).

[38] DX5003-1 ¶¶ 68-69; Hr'g Tr. 752:15-753:24, May 13 (R. Garrett, HMH); Hr'g Tr. 1144:11-22, May 17 (M. Sparta, HMH); Hr'g Tr. 1192:9-1194:5, May 17 (Mr. Nolan).

[39] DX5003-1 ¶ 64, 69; DX3601-006; Hr'g Tr. 1192:9-1194:5, May 17 (Mr. Nolan).

areas, HUMC's med/surg occupancy rates reached 95% in 2018 and 94% in 2019.[40] In 2018 and 2019, HUMC's CCU/ICUs were at 92% occupancy rates, far above the industry recommended maximum of 70%.[41] Measured against availability for the most desirable operating hours for physicians, HUMC's OR utilization was 126% and 125% for 2018 and 2019, far in excess of the industry maximums.[42]

17. Dr. Patrick Romano, the FTC's purported expert on capacity, acknowledges that HUMC faces "real-world capacity problems," agrees that HMH witnesses are "truthful and honest" about these problems, and "[is] not claiming that anything here is fraudulent"—a stark contrast to Plaintiff's assertion in its pre-trial briefing that HUMC's capacity challenges were made up for litigation.[43] In fact, he agreed that HUMC's occupancy levels for such beds and its OR utilization are higher than industry maximums and those at comparable AMCs.[44]

18. Since 2012, HUMC has been working to modernize its facility through a $714 million project ("Second Street Tower") that, when completed in 2023, will convert its current semi-private beds in its existing facilities to private beds, add a net of 22 ICU beds, and replace outdated ORs with larger facilities and a net of 6 additional

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[40] DX5003-1 ¶ 69; Hr'g Tr. 1193:13-1194:5, May 17 (Mr. Nolan).
[41] DX5003-1 ¶ 80; Hr'g Tr. 1194:18-1195:4, May 17 (Mr. Nolan); Hr'g Tr. 1145:6-24, May 17 (M. Sparta, HMH).
[42] DX5003-1 ¶¶ 85-87; DX3601-006; Hr'g Tr. 1195:5-1196:1, May 17 (Mr. Nolan); Hr'g Tr. 1145:25-1148:6, May 17 (M. Sparta, HMH).
[43] Hr'g Tr. 1461:6-15; 1464:25-1465:11, May 18 (Dr. Romano).
[44] Hr'g Tr. 1461:16-1462:6, May 18 (Dr. Romano).

ORs.[45] Even with these additions, industry maximums will be exceeded.[46]

D. The Merger Agreement and the Service Optimization Plans.

19. As expressly stated in the Definitive Agreement, executed on September 23, 2019, HMH's rationale for the transaction is to optimize the provision of care between HMH and Englewood and thereby reduce HUMC's overcapacity.[47] In it, HMH made numerous clinical, operational and financial commitments to Englewood.[48] These include a $439.5 million investment over eight years to expand Englewood's clinical operations and update its facilities to "support EHMC's role as a tertiary care and academic hub in the HMH Northern Region."[49]

20. The "Clinical Initiatives" specified in Paragraphs 1-19 of Exhibit C to the Definitive Agreement are readily enforceable by an independent third party, the Englewood Trust ("Trust"), a special purpose nonprofit corporation.[50] The Trust is empowered with "the right to *oversee and enforce* the post-Closing covenants" in

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[45] DX5003-1 ¶¶ 76-77, 109-111; Hr'g Tr. 1150:23-1152:5, May 17 (M. Sparta, HMH); Hr'g Tr. 1197:13-1198:8, May 17 (Mr. Nolan).
[46] DX5003-1 ¶ 89; Hr'g Tr. 1150:23-1152:5, May 17 (M. Sparta, HMH); Hr'g Tr. 1197:13-1198:8, May 17 (Mr. Nolan).
[47] DX3800-077; Hr'g Tr. 742:17-743:24, May 13 (R. Garrett, HMH); [redacted]; Hr'g Tr. 1185:22-1186:7, May 17 (Mr. Nolan). *See also supra* Section I.C.
[48] DX3800-015-017, -073-078; Hr'g Tr. 745:17-747:2, May 13 (R. Garrett, HMH); [redacted].
[49] DX3800-014, -016-017, -073-078; Hr'g Tr. 745:17-747:2, May 13 (R. Garrett, HMH); [redacted].
[50] DX3800-049-055; [redacted].

these paragraphs, and is provided all necessary funding for it to do so through binding arbitration.[51] The "Operational Commitments" specified in Paragraphs 20-27 of Exhibit C are subject to oversight of the Post-Closing EHMC Board.[52]

21. As required by the Definitive Agreement, Defendants, led by an Executive Steering Committee ("SteerCo"), immediately began developing an integration roadmap and a plan for the first day of operations post-closing, with robust integration planning activities by its 19 integration work teams comprised of more than 200 team members who have held over 300 meetings to date.[53]

22. The work teams reported their initial findings to the SteerCo at the end of 2020, and Defendants utilized the gathered data and information to further develop their service optimization plans, including documents that summarize their plans to grow the complex tertiary and quaternary services offered at HUMC by decanting non-complex tertiary cases to Englewood as a tertiary hub (the "Framework").[54] These growth plans further HMH's "New Jersey First" strategy.[55]

23. Defendants' plans call for HMH to decant a minimum of 1,061 non-complex

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[51] DX3800-049 (emphasis added).
[52] DX3800-014.
[53] DX3800-014; Hr'g Tr. 755:9-756:11, 758:21-759:15, May 13 (R. Garrett, HMH); Hr'g Tr. 889:7-890:8, May 14 (W. Geller, Englewood); Hr'g Tr. 1152:18-1153:8, May 17 (M. Sparta, HMH).
[54] DX3602-001-004; PX1221-001; DX3601-001; Hr'g Tr. 756:14-757:7, 758:19-759:15, 760:21-761:6, 762:3-763:9 May 13 (R. Garrett, HMH).
[55] Hr'g Tr. 737:18-738:6, 767:24-768:12, May 13 (R. Garrett, HMH).

tertiary cases to Englewood beginning on Day 1 post-merger, with over two-thirds of these cases (711) being redirected to Englewood instead of HUMC from HMH's three community hospitals in the region.[56] These are patients and cases that Englewood can treat immediately because of Englewood's clinical capabilities and ample available capacity, with no need for any significant investments.[57] Englewood's case mix index and DRGs show that Englewood falls precisely between HUMC and HMH's community hospitals.[58]

24. The plans will generate approximately 16,000-19,000 additional annual patient days from redirecting patients from HUMC to Englewood.[59] Even with this increased volume, Englewood's capacity would still be at a manageable 72%.[60]

25. As discussed in Section V.B, the Merger is HMH's only financially feasible and practical option for optimizing care and relieving overcapacity at HUMC.[61]

II. The FTC Has Not Established a Prima Facie Case Entitling it to a Presumption of Illegality.

[56] DX3601-011; Hr'g Tr. 763:12-764:11, May 13 (R. Garrett, HMH).
[57] DX3601-011; Hr'g Tr. 763:12-765:11, May 13 (R. Garrett, HMH); Hr'g Tr. 1200:23-1201:16, May 17 (Mr. Nolan).
[58] DX5003-1 ¶¶ 115-118; Hr'g Tr. 1200:23-1201:16, May 17 (Mr. Nolan); [redacted]
[59] DX5003-1 ¶¶ 124-125; Hr'g Tr. 1201:17-1202:7, May 17 (Mr. Nolan); DX3601-010-016.
[60] DX5003-1 ¶ 136; Hr'g Tr. 1201:17-1202:7, May 17 (Mr. Nolan).
[61] Hr'g Tr. 768:13-769:19, May 13 (R. Garrett, HMH); Hr'g Tr. 1148:9-23, May 17 (M. Sparta, HMH); Hr'g Tr. 1198:9-1202:7 (Mr. Nolan); *see also supra* Sec. I.C.

A. None of the Three "Principal Reasons" Cited by the FTC's Expert Supports Bergen County as a Relevant Geographic Market.

26. The FTC and its expert, Dr. Leemore Dafny, have proposed a relevant geographic market limited to commercially insured patients residing in Bergen County.[62] Dr. Dafny acknowledges that this is a *patient*-based, not a *hospital*-based approach to defining a relevant geographic market.[63]

27. Dr. Dafny relies on three "principal reasons" for defining her patient-based Bergen County geographic market: (1) Englewood and HUMC are both located in Bergen County; (2) 77% of Bergen County patients receiving inpatient GAC services provided by both HUMC and Englewood receive care at a Bergen County hospital; and (3) Bergen County is "economically significant" to commercial insurers because it has a sizeable and attractive customer base for the insurers' products.[64]

28. Dr. Dafny is not aware of other cases relying on these same reasons for defining a relevant geographic market in prior FTC hospital merger cases, and they do not support the FTC's proposed Bergen County market here.[65]

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[62] Hr'g Tr. 592:25-593:3, 596:18-24, May 12 (Dr. Dafny) (proposed market consists of "commercially insured residents and patients of Bergen County").

[63] Hr'g Tr. 557:13-17, May 12 (Dr. Dafny) (testifying that her market "is not" "defined around the hospitals in Bergen County" but is "defined on the location of [] the commercially insured patients in Bergen County"); [redacted]

[64] Hr'g Tr. 557:19-558:13, May 12 (Dr. Dafny); [redacted] *see* PDX004-021.

[65] *See* [redacted]

29. First, while Dr. Dafny observes that both Englewood and HUMC are located in Bergen County, she does not offer an opinion that either hospital is each other's closest rival, and does not show that county lines are meaningful to patients.[66]

30. Second, while Dr. Dafny opines that Bergen County is "likely to capture a significant amount of the potential harm from the transaction," she admits that "significant" is a subjective term and she does not know how much of the alleged harm would take place in Bergen County versus outside the county, or even whether most of the alleged harm would take place within Bergen County.[67]

31. Third, while Dr. Dafny opines that Bergen County is an "economically significant" area for insurers, she admits that others, including counties surrounding Bergen County, are also significant to them.[68] As Dr. Dafny admits, subareas or "ordinary course markets" "are not necessarily antitrust relevant markets."[69]

B. The Proposed Market Does Not Comport with Either the Principles Outlined in the *Guidelines* or Commercial Realties.

1. The FTC Has Improperly Relied on Political Boundaries, Not Antitrust Analysis, to Define Its Proposed Market.

32. Bergen County is a political boundary that does not correspond to how

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[66] Hr'g Tr. 621:6-20, [redacted] May 13 (Dr. Dafny); *see also* Hr'g Tr. 592:25-598:11, May 12 (Dr. Dafny).
[67] [redacted] ¶ 138; Hr'g Tr. 622:2-15, 623:17-21, May 13 (Dr. Dafny).
[68] [redacted] ¶ 138; Hr'g Tr. 624:9-21, 625:10-626:6, [redacted] May 13 (Dr. Dafny); Hr'g Tr. 1508:10-19, May 18 (Dr. Dafny).
[69] Hr'g Tr. 554:13-16, 592:1-24, 624:16-21, May 12-13 (Dr. Dafny).

insurers construct hospital networks or how patients select hospitals.[70]

33. When insurers build networks of hospitals for health plans, they must comply with New Jersey's geographic access requirements, requiring that an insurer include at least one hospital within 20 miles and 30 minutes of 90% of their members.[71] Significantly, to comply with these regulatory standards, insurers will look for hospitals without regard to county lines.[72]

34. Likewise, while patients seeking inpatient services generally prefer to receive care at "nearby" hospitals, that preference does not limit their selection of hospitals to those inside county lines.[73] In fact, a non-Bergen County hospital is the first or second closest hospital for 39% of Bergen County residents, and more than half of Englewood and HUMC's commercial revenue comes from outside Bergen County.[74]

35. The FTC's arbitrary political boundary produces anomalous results: for example, a patient residing just outside Bergen County who visits a nearby hospital in Bergen County is excluded from the market, even if that patient has the same

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[70] Hr'g Tr. 937:19-938:12, May 14 (Dr. Wu); Hr'g Tr. 598:12-599:6, May 12 (Dr. Dafny).

[71] [redacted] PX7051, [redacted] 68:7-15, 71:17-20; DX1220-027.

[72] [redacted]

[73] Hr'g Tr. 947:10-23, May 14 (Dr. Wu); Hr'g Tr. [redacted]; [redacted].

[74] DX5001 ¶ 78; Hr'g Tr. 941:2-942:3, May 14 (Dr. Wu) (over 50% of HUMC's and Englewood's revenue is from non-Bergen County residents); Hr'g Tr. 851:3-7, May 14 (W. Geller, Englewood); Hr'g Tr. 783:4-14, May 12 (R. Garrett, HMH).

employer and health plan as a patient in Bergen County,[75] or even if that patient is as close or closer to a Bergen County hospital than patients in Bergen County.[76]

2. Neither the FTC Nor Its Economist Has Justified the Proposed Market By Showing That Geographic Price Discrimination Is Feasible.

36. Dr. Dafny purports to rely on the FTC / DOJ *Horizontal Merger Guidelines* in defining her proposed geographic market based on the location of customers, but she has not proffered any evidence of price discrimination based on the location of enrollees in Bergen County (as prescribed by the *Guidelines*), nor did she proffer an opinion in either of her expert reports that such discrimination based on enrollee location is even feasible.[77]

37. Geographic price discrimination is when a seller charges its customers different prices depending on where the customer lives.[78]

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[75] Hr'g Tr. 597:13-598:11, May 12 (Dr. Dafny); [redacted].

[76] Hr'g Tr. 937:2-16, 950:6-23, May 14 (Dr. Wu); *see also* [redacted]; Hr'g Tr. 1539:20-1540:14, May 18 (Dr. Dafny) (admitting that a patient residing in Bergen County who travels 30 minutes to HUMC is included in the FTC's market, but a patient residing outside Bergen County who travels 20 minutes to HUMC is not included).

[77] *Guidelines* §§ 4, 4.2; [redacted]; Hr'g Tr. 599:13-600:5, 604:15-23, May 12 (Dr. Dafny); Hr'g Tr. 1503:19-22, May 18 (Dr. Dafny); *see also* [redacted]; Hr'g Tr. 938:15-939:12, May 14 (Dr. Wu).

[78] Hr'g Tr. 939:24-941:1, May 14 (Dr. Wu).

38. As Dr. Wu observed, there is no evidence that the prices New Jersey hospitals charge insurers are different depending on where the insurer's enrollees live (*e.g.*, a particular county).[79] Likewise, no commercial insurer testified that a hospital does or could charge different prices based on where the insurer's enrollees reside.[80]

39. There are several reasons why geographic price discrimination is not even feasible, given the commercial reality of how commercial insurance agreements are negotiated and how insurance plans are sold. First, changes to HMH's negotiated rates with commercial insurers are uniform across all of its facilities, and the hospitals encompassed within those negotiations (including HUMC and Pascack Valley) serve multiple counties.[81] At both HMH and Englewood, reimbursement rates for hospital services do not depend on where an insurer's enrollee resides.[82]

40. Second, HMH does not factor the geographic distribution of an insurer's members into its negotiations.[83] HMH does not have the data to attempt to tailor its

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[79] Hr'g Tr. 940:12-18, May 14 (Dr. Wu); DX5001 ¶ 99 & n. 222 (finding that Defendants "do not and cannot price discriminate across patients based on place of residence" and that there is no geographic price discrimination in Defendants' commercial insurance contracts); *see also* [redacted]; Hr'g Tr. 1009:25-1010:7, May 14 (K. Strobel, BD); Hr'g Tr. 1027:10-1028:6, May 14 (P. Young, HMH).

[80] *See* [redacted]; Hr'g Tr. 1105:20-1106:6, May 17 (A. Karp, Horizon).

[81] Hr'g Tr. 1026:9-16, May 14 (P. Young, HMH); Hr'g Tr. 772:23-773:4, May 13 (R. Garrett, HMH).

[82] Hr'g Tr. 866:5-22, May 14 (W. Geller, Englewood); Hr'g Tr. 1026:23-1028:3, May 14 (P. Young, HMH); DX5001 ¶ 99 & n. 222.

[83] *Compare* Hr'g Tr. 602:15-23, 603:7-9, May 12 (Dr. Dafny), *with* Hr'g Tr.

rates based on the location of individual insurers' prospective enrollees.[84]

41. Finally, as Dr. Dafny acknowledges, the employers and other plan sponsors of Bergen County enrollees are not necessarily located in Bergen County. Those employers/plan sponsors offer the same insurance plans, with the same terms, to their employees/enrollees whether they reside in Bergen County or not.[85]

3. A Market Limited to Bergen County Enrollees Ignores the Reality of How Hospitals and Insurers Negotiate in Stage 1.

42. Although commercial insurers sometimes consider Bergen County alongside other counties when forming networks, Bergen County is not unique in its economic significance to commercial insurers.[86] Testimony and documentary evidence demonstrate that payors and employers do not view Bergen County as a distinct area when forming their commercial networks.[87]

43. Commercial insurers in Northern New Jersey seek to construct broad, statewide networks that are attractive to customers across all of New Jersey.[88]

1027:10-1028:6, May 14 (P. Young, HMH).

[84] Hr'g Tr. 1027:20-1028:3, May 14 (P. Young, HMH).

[85] Hr'g Tr. 594:2-9, 595:23-597:7, 597:13-598:11, May 12 (Dr. Dafny).

[86] [redacted] PX7046, E. Busteed (County of Bergen) Dep. Tr. 59:12-19, 62:7-15; PX7044, J. Kirkos (Meadowlands) Dep Tr. 149:22-151:22.

[87] [redacted].

[88] [redacted] Hr'g Tr. 1104:4-

44. Insurers generally do not consider only a single county like Bergen County when forming networks of hospitals at Stage 1. [redacted] and AmeriHealth, for example, examine hospital networks across two regions, Northern New Jersey and Southern New Jersey.[89] When examining hospital prices, [redacted] assesses hospitals over a "relevant service area" of Bergen, Essex, Hudson, Morris, and Passaic Counties.[90] Likewise, when assessing the profitability or attractiveness of its plans, [redacted] does not look at a specific county, but rather "look[s] at things more globally across the market" and "across all of New Jersey."[91]

45. Contrary to the FTC's proposed market, commercial insurers do not offer health plan networks of hospitals designed to cover inpatient GAC hospital services only to patients residing in Bergen County. [redacted] Horizon, [redacted] all testified that there are no commercial products offered solely in Bergen County, and they do not have plans to offer any commercial products limited to Bergen County.[92]

46. Likewise, HMH and Englewood do not negotiate with insurers to sell

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25, May 17, (A. Karp, Horizon); [redacted]

[89] Hr'g Tr. 703:5-8, May 13 (K. Kobylowski, AmeriHealth); [redacted] *see* [redacted]; [redacted]

[90] DX1106; [redacted]

[91] [redacted]

[92] [redacted] Hr'g Tr. 1105:1-19, May 17 (A. Karp, Horizon); *see* Hr'g Tr. 626:16-23, May 13 (Dr. Dafny).

inpatient services to residents of a single county, and insurers do not ask them to do so.[93] Insurers have never asked HMH to participate in a plan limited to hospitals in only one county or that covered only patients residing in a single county.[94]

47. Like payors, employers believe it is important to have a broad range of hospital options.[95] Many employers in New Jersey have employees residing in more than one county, and these employers want to meet the healthcare needs of their employees in all counties in which they reside.[96] They also have employees residing in Northern New Jersey who utilize hospitals both inside and outside of Bergen County.[97] A commercial product that included only hospitals located in Bergen County would not be palatable to employers or their employees.[98] Accordingly,

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[93] Hr'g Tr. 1025:7-9, May 14 (P. Young, HMH); Hr'g Tr. 866:1-4, May 14 (W. Geller, Englewood).

[94] Hr'g Tr. 1029:17-1031:6, May 14 (P. Young, HMH).

[95] Hr'g Tr. 375:2-4, May 11 (W. Wengel, Aetna); PX7046, E. Busteed (County of Bergen) Dep. Tr. 59:12-19, 62:7-15; PX7044, J. Kirkos (Meadowlands) Dep. Tr. 149:22-151:22.

[96] [redacted] Hr'g Tr. 1105:11-19, May 17 (A. Karp, Horizon) (testifying that Horizon does not offer plans limited to a single county because "the employers [] have employees in multiple counties, so even a small business or a midsized business have employees, particularly in the very dense northern part of the state could have employees in Essex County and Passaic County as well as Bergen County").

[97] Hr'g Tr. 1007:13-1008:22, May 14 (K. Strobel, BD); [redacted]

[98] [redacted] *see* PX7046, E. Busteed (County of Bergen) Dep. Tr. 58:7-16;Hr'g Tr. 1031:1-14, May 14 (P. Young, HMH).

neither employers nor individual employees and enrollees have expressed an interest in a network limited to hospitals in Bergen County.[99]

4. The FTC Has Not Demonstrated that its Market Satisfies the Hypothetical Monopolist Test.

48. Once a candidate geographic market is proposed, the HMT is employed to test whether the market is sufficiently broad to constitute a relevant antitrust market. For geographic markets based on the location of customers, such as the patient-based market proposed by the FTC, the HMT asks whether a hypothetical monopolist could profitably charge a small but significant non-transitory increase in price for customers inside the market while holding constant the price for those outside it.[100]

49. Although the FTC's proposed geographic market is based on the location of commercially insured *patients* residing in Bergen County and "includes all hospitals—inside and outside of Bergen County—that Bergen County residents visit for care,"[101] Dr. Dafny tested her candidate market by using a *hospital*-based approach.[102] In particular, she asked whether a hypothetical monopolist of the six hospitals in Bergen County could raise prices to patients *everywhere*; she did not test whether a hypothetical monopolist of all hospitals—inside and outside Bergen

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99 [redacted]

100 *Guidelines* § 4.2.2; Hr'g Tr. 552:21-553:15, May 12 (Dr. Dafny); DX5001 ¶ 63.

101 [redacted]

102 [redacted] Hr'g Tr. 563:11-564:2, May 12 (Dr. Dafny); [redacted]

County—that serve Bergen County residents could raise prices *only to them*.[103]

50. This mismatch between the FTC's candidate market and Dr. Dafny's HMT shows up in two ways. First, Dr. Dafny examined the testimony of commercial insurers, who were asked whether they would continue to market plans in Bergen County that excluded *all Bergen County hospitals*.[104] Dr. Dafny concedes that "the insurers had some trouble understanding the question" that was asked of them.[105] Nonetheless, at least one commercial insurer, Horizon, testified that such a "hypothetical system" will not gain sufficient leverage to profitably impose a SSNIP in the first instance "because [it has] other alternatives in the region."[106]

51. Second, Dr. Dafny performed a "confirmatory" HMT by examining changes in WTP for patients located in *either* Bergen County or the four-county area in northern New Jersey, *not* in her alleged market.[107] Again, however, her HMT was defined in terms of the WTP for *only* the six Bergen County hospitals, not all hospitals serving Bergen County residents, which she purportedly included in her proposed relevant geographic market.[108] Dr. Dafny never performed an HMT on all hospitals serving Bergen County residents (*i.e.*, the purported hospital participants

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[103] Hr'g Tr. 943:8-944:16, May 14 (Dr. Wu).

[104] [redacted]

[105] [redacted]

[106] Hr'g Tr. 1106:13-25, May 17 (A. Karp, Horizon).

[107] Hr'g Tr. 1509:21-1510:20, May 18 (Dr. Dafny).

[108] [redacted] Hr'g Tr. 943:8-944:16, May 14 (Dr. Wu).

in her proposed market) because her "model would explode."[109]

52. Dr. Dafny's assumption that, if a "subset" of hospitals could impose a SSNIP, then a hypothetical monopolist that owned *all* hospitals serving Bergen County residents could also impose a SSNIP is unfounded and contrary to commercial realities.[110] For a hypothetical monopolist comprised of *all* hospitals serving Bergen County residents to be able to profitably impose a SSNIP just on them, it would need to be able to price discriminate geographically—*i.e.*, charge patients in Bergen County higher prices than patients residing outside of Bergen County (whom the hypothetical monopolist also serves)—so as to retain those non-Bergen County patients and not lose them to other competing hospitals.[111]

C. The FTC's Structural Case Also Ignores Commercial Realities of Intense Hospital Competition in Northern New Jersey.

53. The FTC's alleged geographic market of Bergen County residents runs counter to the commercial realities of northern New Jersey, where numerous hospitals compete against HUMC and Englewood at Stage 1 for inclusion in payors' broad networks that cover residents both inside and outside Bergen County.

1. Englewood and HUMC Attract Patients from a Broad Area, Which Informs Stage 1 Negotiations with Insurers.

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[109] [redacted]. *See also* Hr'g Tr. 563:17-564:7, May 12 (Dr. Dafny); [redacted]

[110] Hr'g Tr. 943:24-944:25, May 14 (Dr. Wu).

[111] *Guidelines* § 4.2.2; Hr'g Tr. 943:24-944:16, May 14 (Dr. Wu).

54. When building networks of hospitals, insurers are interested in both where the hospitals are located and the service areas they cover.[112]

55. Over a third of Englewood's PSA zip codes are located outside of Bergen County, and over a third of Englewood's PSA discharges are from outside Bergen County.[113] Likewise, nearly 50% of HUMC's PSA zip codes are located outside of Bergen County.[114] Of the ten zip codes from which HUMC draws the most patients, four are not within Bergen County.[115]

56. Defendants' ordinary course documents demonstrate that Englewood and HUMC do not consider their service areas as limited to Bergen County. HUMC defines its primary service area to include four counties in Northern New Jersey, Bergen, Passaic, Essex, and Hudson Counties.[116] It attracts patients from all four counties, as well as from parts of Morris County and other counties in New Jersey.[117]

57. Likewise, Englewood draws most of its patients from Bergen, Passaic, Essex,

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[112] [redacted] ("So if [a payor is] trying to have a discussion with the hospital[,] thinking about the counties where that hospital draws patients is a useful basis for discussion."); Hr'g Tr. 946:4-947:9, 974:25-975:16, May 14 (Dr. Wu); Hr'g Tr. 1552:14-19, May 18 (Dr. Dafny); [redacted]; [redacted] PX1036.

[113] DX5001 Ex. 8 (relying on New Jersey Inpatient Discharge Data).

[114] DX5001 ¶ 97; Hr'g Tr. 783:4-14, May 13 (R. Garrett, HMH); [redacted]

[115] Hr'g Tr. 783:17-784:4, May 13 (R. Garrett, HMH).

[116] Hr'g Tr. 772:7-773:4, May 13 (R. Garrett, HMH); [redacted] DX3204-002; DX3205-024; DX3206-003–004.

[117] Hr'g Tr. 783:4-14, May 13 (R. Garrett, HMH); DX3206-003–004.

and Hudson Counties in New Jersey and from Rockland County in New York.[118] Approximately 45% Englewood's inpatient discharges come from Hudson, Essex, Passaic, and Rockland Counties.[119] In the last several years, Englewood has seen its largest overall growth in Hudson, Essex, and Passaic Counties; for example, there has been double-digit growth several years in a row in Hudson County, and Englewood performs 150 heart surgeries a year on patients from Essex County.[120]

58. HUMC faces "intense" competition from health systems located outside Bergen County.[121] This includes RWJB throughout the Northern Region, as well as important competitors like St. Joseph's, CarePoint, and University Hospital in Newark.[122] HUMC's primary competitors for inpatient services are other AMCs in New Jersey and New York, including Atlantic's Morristown, RWJB's SBMC and JCMC, NY-Presbyterian, Mt. Sinai, HSS, NYU Langone, MSK, and Montefiore.[123]

59. Both Englewood and HUMC view Hudson County as a key area from which they attract patients for inpatient care.[124] The patients they treat from Hudson County

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[118] Hr'g Tr. 850:2-851:7, May 14 (W. Geller, Englewood); [redacted].
[119] Hr'g Tr. 849:19-850:6, May 14 (W. Geller, Englewood).
[120] Hr'g Tr. 850:7-25, May 14 (W. Geller, Englewood).
[121] Hr'g Tr. 774:23-775:4, May 13 (R. Garrett, HMH).
[122] Hr'g Tr. 774:23-777-15, May 13 (R. Garrett, HMH); DX3205-006, 012–014; DX3209-009–010, 016; DX3213-019–022.
[123] Hr'g Tr. 781:12-782:1, May 13 (R. Garrett, HMH); [redacted].
[124] DX3211-002; DX3787; Hr'g Tr. 851:8-852:7, May 14 (W. Geller, Englewood); DX3204-002; DX3205-009–014; DX3206-003–004; DX3212-004.

are increasing and the patients they treat from Bergen County are decreasing.[125]

60. Both also view New York hospitals as significant competitors who actively attract Bergen County residents for both routine and complex inpatient care.[126]

2. Other Bergen County Hospitals Draw From a Broad Area.

61. Other hospitals located in Bergen County also attract patients from and are local options for patients residing outside Bergen County.[127] Dr. Dafny admits that she offered no opinion as to whether, if HMH and Englewood were not available, a commercial insurer could build a marketable plan around Valley and Holy Name.[128]

62. Valley competes for patients inside and outside Bergen County. Valley's primary and secondary service area includes towns [redacted] and its competitors include [redacted][129] Valley expects its hospital's new location, further east and closer to both Englewood and HUMC, will enhance its "market share and geographic reach" and expand its "dominant and stable" market share beyond Bergen County."[130]

63. Holy Name CEO Mike Maron testified that it competes for patients beyond

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[125] Hr'g Tr. 784:18-23, May 13 (R. Garrett, HMH); Hr'g Tr. 850:7-13, May 14 (W. Geller, Englewood).

[126] DX3204; Hr'g Tr. 778:19-24, May 13 (R. Garrett, HMH); [redacted]; DX3204-002; DX3209-010; DX3212-005; DX3213-020.

[127] *See, e.g.*, Hr'g Tr. 118:23-119:8, May 10 (M. Maron, HNMC).

[128] [redacted]

[129] [redacted].

[130] DX0928-009, -059.

Bergen County's borders.[131] Holy Name's service areas include parts of Hudson and Passaic Counties.[132] Mr. Maron testified that Holy Name has physician offices in Hudson County that have "driven some volume from Hudson County into [Holy Name's] Bergen County hospital."[133] In addition, Holy Name's secondary service area includes [redacted].[134] Mr. Maron testified that 15-20% of Holy Name patients "are from Hudson County and Passaic County… [a]nd elsewhere."[135]

64. [redacted] PSA extends into Passaic County.[136] [redacted] [redacted] [redacted] [redacted][137]

65. In addition, these hospitals have established physician practices in other counties in order to increase volume to their hospitals located in Bergen County.[138]

3. Hospitals Located Outside Bergen County Compete with Defendants and Draw Patients From a Broad Area.

66. Many Bergen County residents utilize hospitals outside it for services.[139] Although the FTC purports to include these hospitals as market participants when

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[131] Hr'g Tr. 118:11-13, 119:9-15, May 10 (M. Maron, HNMC); [redacted]; [redacted]; DX0821 (OBGYN Associates, with offices in Hudson and Passaic, joined Holy Name).
[132] Hr'g Tr. 118:11-13, [redacted], May 10 (M. Maron, HNMC); [redacted].
[133] Hr'g Tr. 119:9-15, May 10 (M. Maron, HNMC).
[134] [redacted].
[135] Hr'g Tr. 119:22-25, May 10 (M. Maron, HNMC).
[136] [redacted]
[137] [redacted].
[138] *See, e.g.*, Hr'g Tr. 119:9-15, May 10 (M. Maron, HNMC).
[139] Hr'g Tr. 1016:3-19, May 14 (K. Strobel, BD); Hr'g Tr. 120:1-5, May 10 (M. Maron, HNMC).

calculating market concentration, the FTC understates the significance of these hospitals in its share calculations and the pricing constraint each hospital places on HUMC and Englewood at Stage 1, by proposing a market based on patient location instead of hospital location.[140]

67. When measured by drive time, there are 24 competing (non-party) hospitals located within 30 minutes of Englewood—eight of them within a 25-minute drive.[141] In terms of drive distance, there are 26 competing non-party hospitals within 15 miles of Englewood, with nine of them within 10 miles.[142] These hospitals include RWJB's Clara Maass, St. Joseph's, St. Mary's, HRHS, and Atlantic's Chilton.[143]

68. Payors recognize that Bergen County residents have a number of alternative options outside Bergen County.[144] [redacted] testified that patients are willing to travel 20 miles for inpatient care, and recognized that there are many hospitals located outside Bergen County that are less than 20 miles from HUMC or Englewood.[145]

69. Several hospitals located outside of Bergen County view it as a key geography and aggressively compete for patients residing in Bergen County. For example,

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[140] [redacted]

[141] [redacted]

[142] [redacted]

[143] [redacted]

[144] Hr'g Tr. 248:4-13, May 11, 2021 (M. Nielsen, United); Hr'g Tr. 1108:1-1109:7, May 17, 2021 (A. Karp, Horizon); Hr'g Tr. 685:7-21, May 13 (K. Kobylowski, AmeriHealth); [redacted]

[145] [redacted]

HMH's largest competitor in its Northern Region, RWJB, a health system comprised of eleven hospitals spanning eight counties in New Jersey (including four in Hudson and Essex Counties), competes with HMH and Englewood for patients both inside and outside Bergen County.[146] RWJB considers Bergen County to be a "crucial geography" and part of a specific strategy for its northern region, as it "continue[s] to press" into counties in Northern New Jersey.[147] RWJB has established ambulatory and primary care physician practices in Bergen and Passaic counties to attract patients from those areas to its hospitals, and views HMH's expansion into Passaic County, [redacted], [redacted][148]

70. Atlantic already has a [redacted]

[redacted].[149]

Atlantic views Englewood's service area as part of [redacted] it advertises in Bergen County for inpatient care; and its internal documents describe

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[146] Hr'g Tr. 774:23-775:14, May 13 (R. Garrett, HMH); [redacted] PX7016, P. Knaus (RWJB) Dep. Tr. 30:20-32:18 (noting HMH is a "close competitor"), 172:12-174:8; [redacted]

[147] PX7016, P. Knaus (RWJB) Dep. Tr. 41:20-42:20, 51:10-18, 52:9-11, 741:20-72:20; DX0402-007; [redacted]..

[148] DX0401-006; PX7016, P. Knaus (RWJB) Dep. Tr. 41:13-43:20, 44:16-46:13, [redacted].

[149] [redacted]; [redacted].

HMH, Valley, and Holy Name as "key competitors."[150] Atlantic's expansion into northern New Jersey includes [redacted][151]

71. St. Joseph's, based in Passaic County, views its service area as including [redacted][152] Its two hospitals are both [redacted] from Bergen County.[153] St. Joseph's has [redacted] and views [redacted], including with advertising [redacted][154] Today, St. Joseph's competes [redacted].[155]

72. Hudson Regional is mere yards from Bergen County on the east bank of the Hackensack River in Secaucus and its service area encompasses Bergen, Hudson, and Passaic Counties.[156] It views HUMC, Englewood, and Holy Name as among its

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150 [redacted]; DX1805; DX1808.

151 [redacted]; DX1821-006; DX1808; DX4170.

151 [redacted]

152 [redacted].

153 [redacted].

154 [redacted]; DX4170; [redacted].

155 [redacted].

156 PX7035, J. Grywalski (HRHS) Dep. Tr. 49:1-4.

"primary competitors."[157] Hudson Regional recently became in-network with commercial health plans, making it a new option for commercial patients.[158]

73. [redacted] that competes with HUMC and Englewood—the only competitors outside Hudson County that it regularly tracks.[159] [redacted] recognizes that a "sizeable number" of Hudson County residents receive their care at HUMC and Englewood.[160] Its internal analyses show that HUMC and Englewood have the second and third largest commercial inpatient volume for Hudson County residents.[161] Like [redacted] recently became in-network with commercial health plans, which it believes will lead to treating more commercial patients.[162]

74. [redacted]located in Passaic County, likewise competes intensely with HMH for patients inside both Bergen and Passaic Counties.[163] [redacted] considers HUMC to be one of its strongest competitors, with a 20-30% market share in [redacted] PSA which is comprised of townships in Passaic and Bergen Counties.[164] [redacted]

[157] PX7035, J. Grywalski (HRHS) Dep. Tr. 116:5-117:3.
[158] DX1703; PX7035, J. Grywalski (HRHS) Dep. Tr. 25:16-27:13, 69:19-73:3.
[159] [redacted]
[160] [redacted]
[161] [redacted]
[162] [redacted]
[163] [redacted]
[164] [redacted]

actively seeks to attract patients in Bergen County, targeting its residents with local billboards, television, radio, and mail advertising.[165]

75. Testimony from payors, employers, and other providers confirm that increasing numbers of Bergen County residents travel to New York City for both routine and complex care.[166] Approximately 10% of Horizon's commercial members seek care in New York.[167] Similarly, approximately 20-25% of [redacted] commercial members in Bergen County seek care in New York.[168]

76. New York providers compete with HUMC and Englewood by targeting patients in northern New Jersey through advertising, partnering with New Jersey hospitals and physician groups, and by establishing ambulatory care centers and outpatient locations as "front doors" to attract New Jersey patients and refer them back to New York hospitals.[169] For example, [redacted] has a comprehensive [redacted]

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[165] [redacted]

[166] Hr'g Tr. 1008:15-22, May 14 (K. Strobel, BD); PX7046, E. Busteed (County of Bergen) Dep. Tr. 113:2-115:20; PX 7044, J. Kirkos (Meadowlands) Dep. Tr. 152:10-153:10; PX7016, P. Knaus (RWJB) Dep. Tr. 81:6-82:19, 102:7-103:14, 165:3-12; [redacted]); Hr'g Tr. 248:4-13, May 11 (M. Nielsen, United); [redacted]

[167] Hr'g Tr. 1098:7-15, May 17 (A. Karp, Horizon).

[168] [redacted]

[169] [redacted]; [redacted]; DX4170-002; DX4157 (NYU Langone Lincoln Tunnel Billboards); [redacted].

[redacted] that includes clinical affiliations with [redacted], as well as opening "front door" physician practices in New Jersey.[170] MSK recently built a $180 million-dollar outpatient facility in Bergen County that refers patients to their New York facilities for inpatient care.[171] [redacted] operates three physician offices in Bergen County, and its internal documents include Bergen and Hudson Counties in its service area.[172] [redacted] which is currently in discussions [redacted],[173] opened a large outpatient facility in Paramus to send patients "to HSS in Manhattan to do surgery."[174] [redacted] internal strategy documents state that it competes with [redacted] for patients.[175]

D. The FTC's Market Concentration Estimates Are Highly Sensitive to Small and Reasonable Changes to Its Market Definition.

77. Market shares and market concentration—calculated using the Herfindahl-Hirschman Index ("HHI")—must be measured against an appropriately defined relevant geographic market.[176]

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[170] [redacted]; DX1607; DX1609; DX1611-001, -002; [redacted].

[171] Hr'g Tr. 74:21-75:1 (M. Maron, HNMC); Hr'g Tr. 1313:6-25, May 18 (Dr. Brunnquell, Englewood); [redacted]

[172] [redacted]; PX4004-001; [redacted].

[173] [redacted].

[174] Hr'g Tr. 1313:6-25, May 18 (Dr. Brunnquell, Englewood); JX0035; Hr'g Tr. 127:21-128:14, May 10 (M. Maron, HNMC); [redacted]

[175] [redacted]

[176] Hr'g Tr. 949:4-950:5, May 14 (Dr. Wu).

78. The FTC identified to the Court two sets of post-merger HHI calculations;[177] however, only the first set corresponds to the *patient*-based geographic market proffered by the FTC and its economic expert. The second set (with a substantially higher HHI number) corresponds to a *hospital*-based geographic market that Dr. Dafny did not proffer, and actually rejected, in her reports or at the hearing.[178]

79. Moreover, market concentration statistics do not, on their own, signify that a transaction is anticompetitive and can lead to false positives.[179]

80. Where there are different plausible candidate markets that result in post-merger HHIs that lead to differing conclusions on the competitive effects of a merger, the *Guidelines* advise examining "direct" forms of evidence instead of relying on market concentration estimates.[180]

81. Several reasonable adjustments to the FTC's proposed Bergen County market demonstrate the fragility of Dr. Dafny's market concentration assessment. These alternative plausible markets capture important customers for insurers.[181]

82. The FTC's witnesses testified that Bergen County residents are willing to travel 20 minutes, or 10 to 20 miles, to receive inpatient care.[182] When calculating

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[177] *See* PDX001-002; PDX004-032, 035; PDX006-035.
[178] *See supra* Paragraphs 26, 51.
[179] *See* DX3817-023; [redacted]
[180] *Guidelines* § 4; Hr'g Tr. 953:14-24, May 14 (Dr. Wu).
[181] *See supra* Section II.C.
[182] Hr'g Tr. 53:7-15, May 10 (M. Maron, HNMC); [redacted] *see also* [redacted]

market concentrations for a market that includes Bergen County residents (already included in the FTC's market) and patients within a 20-minute drive of HUMC or Englewood, the post-merger HHI falls below the 2,500 structural presumption.[183]

83. When calculating market concentrations for a market that includes patients residing within a 20-minute drive of HUMC or Englewood, irrespective of whether those patients reside in or outside of Bergen County, the post-merger HHI falls even further below the 2,500 structural presumption. This alternative relevant geographic market is *even narrower* than the FTC's proposed Bergen County market, but it does not depend on arbitrary political borders.[184]

84. As noted above, insurers look at a hospital's service area when forming a network.[185] When calculating market concentrations for a market that includes patients residing in HUMC's and Englewood's combined primary service area, the post-merger HHI falls to 1,656, which is 156 points above the level in which the *Guidelines* consider to be not concentrated.[186]

III. HUMC and Englewood Are Not Close Substitutes for Insurers.

A. HUMC Is an AMC; Englewood Is a Community Hospital.

85. HUMC and Englewood are not close substitutes, but rather function more as

[183] Hr'g Tr. 950:24-951:17, May 14 (Dr. Wu).
[184] Hr'g Tr. 951:18-952:4, May 14 (Dr. Wu).
[185] *See supra*, Paragraph 54.
[186] Hr'g Tr. 952:5-18, May 14 (Dr. Wu).

complements to one another for payors when forming networks.[187]

86. The FTC's own expert, Dr. Dafny, is not offering an opinion that Englewood's closest competitor is HUMC, or that HUMC's closest competitor is Englewood.[188]

87. HUMC is an AMC that provides services encompassing the entire continuum of care, including complex tertiary and quaternary services.[189] By contrast, Englewood is a community hospital providing primary, secondary, and some non-complex tertiary services, but does not perform complex tertiary and quaternary services and lacks the expertise, regulatory approval, and facilities to add them.[190] Neither the insurers nor Dr. Dafny testified that Englewood was an AMC.[191]

88. Commercial insurers negotiate for the entire suite of services offered by a hospital, rather than a subset of services.[192] An analysis of each hospital's DRGs confirms that HUMC is similar to other AMCs in the area and Englewood is similar

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[187] *See, e.g.*, Hr'g Tr. 1109:23-110:17, May 17 (A. Karp, Horizon); Hr'g Tr. 702:11-14, May 13 (K. Kobylowski, AmeriHealth); [redacted]

[188] Hr'g Tr. 620:22-621:20, May 13 (Dr. Dafny).

[189] Hr'g Tr. 735:3-736:19, May 13 (R. Garrett, HMH); Hr'g Tr. 1140:21-1141:9, May 17 (M. Sparta, HMH); [redacted]

[190] Hr'g Tr. 845:13-846:3, May 14 (W. Geller, Englewood); [redacted]

[191] *See* [redacted] Hr'g Tr. 1109:12-15, May 17 (A. Karp, Horizon); [redacted] *see also* [redacted]

[192] *See, e.g.*, Hr'g Tr. 361:16-362:3, May 11 (W. Wengel, Aetna); Hr'g Tr. 1024:19-1026:8, May 14 (P. Young, HMH); [redacted]

to the far larger number of other community hospitals in the area.[193]

89. Payors recognize that HUMC is an AMC that provides high-end tertiary and quaternary services that Englewood does not provide.[194] [redacted] United, [redacted] and Horizon all testified that if HUMC were not in-network, patients needing such high-end services would seek care at other AMCs in New Jersey or New York, including RWJB's three AMCs (SBMC, NBI, and UH), Atlantic's Morristown, NY-Presbyterian, Mt. Sinai, NYU Langone, and Montefiore.[195] Payors view Englewood as a "solid" community hospital akin to Valley and Holy Name, but recognize that patients seeking high-end services could not seek care at Englewood and would turn instead to one of the AMCs outside Bergen County if HUMC was not available.[196]

90. Employers similarly recognize that their Bergen County employees have a number of high-quality hospital options both inside and outside Bergen County, based on their analysis of claims data, including Valley, Morristown, NY-Presbyterian, Mt. Sinai, and MSK, to meet the full range of services for patients.[197]

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[193] [redacted]

[194] [redacted] Hr'g Tr. 1107:22-1108:3, May 17 (A. Karp. Horizon).

[195] Hr'g Tr. 248:4-13, May 11 (M. Nielsen, United); [redacted] Hr'g Tr. 1108:1-1109:22, May 17 (A. Karp, Horizon).

[196] *See supra* note 195; [redacted]

[197] *See* Hr'g Tr. 1007:22-1009:17, 1010:21-1011:23, May 14 (K. Strobel, BD).

B. HMH and Englewood Do Not Compete in Stage 1 to Be Included in Insurers' Networks.

91. Payor testimony confirms that commercial insurers do not view HUMC and Englewood as close substitutes for one another for purposes of rate negotiations or the formation of tiered or narrow network products.[198]

92. Indeed, insurers have testified, and Dr. Dafny opines, that Englewood adds "little value" to commercial insurers' networks and that they do not view Englewood as a critical component to their networks.[199] AmeriHealth's SVP for Payor Contracting agreed that members do not purchase health plans based on whether Englewood is in-network, and having Englewood out of network "would not also impact the importance of having HUMC in network."[200]

93. In forming commercial networks, payors seek to provide access to enrollees for all services.[201] HUMC is valuable to commercial networks because of its wide scope of services, including services that patients can only obtain outside Bergen County if HUMC were unavailable.[202] Insurers could not form a network "that

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[198] Hr'g Tr. 1109:23-1110:17, May 17 (A. Karp, Horizon); [redacted] Hr'g Tr. 702:11-14, May 13 (K. Kobylowski, AmeriHealth).

[199] [redacted] *see* Hr'g Tr. 699:22-700:1, 702:7-14, May 13 (K. Kobylowski, AmeriHealth); [redacted] *see also* Hr'g Tr. 1010:16-1011:6, May 14 (K. Strobel, BD) (noting Englewood is not a highly utilized facility for BD employees).

[200] Hr'g Tr. 702:7-14, May 13 (K. Kobylowski, AmeriHealth).

[201] Hr'g Tr. 361:16-362:3, May 11 (W. Wengel, Aetna).

[202] *See supra* note 195; Hr'g Tr. 1109:23-1110:9, May 17 (A. Karp, Horizon); Hr'g

centered" around Englewood because, as a single-facility community hospital, it does not have the necessary geographic scope or service offerings.[203] In fact, Englewood provides only 73% of the services performed at HUMC, with the additional non-overlapping services comprising 17% of HUMC's total revenue.[204]

94. Like other AMCs, HUMC incurs higher costs in the provision of healthcare services due to its academic and research functions, and its specialized equipment, facilities, and staff to treat higher-acuity patients.[205] HUMC's prices reflect its significant cost differences with community hospitals—on a case-mix adjusted per discharge basis, HUMC's prices are 95% higher than that of Englewood's prices.[206]

95. Despite this price differential, there is no evidence that payors have attempted to steer patients from higher-priced HUMC to lower-priced Englewood, as they would be incentivized to do if Englewood, with its available capacity and proximity, were in fact viewed as being a close substitute for HUMC.[207]

96. In negotiations with insurers, HMH has never sought to exclude Englewood from an insurer's commercial network or place Englewood in a lower tier,[208] and

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Tr. 956:3-20, May 14 (Dr. Wu).

[203] Hr'g Tr. 1110:10-17, May 17 (A. Karp, Horizon).

[204] Hr'g Tr. 956:3-20, May 14 (Dr. Wu); [redacted]

[205] Hr'g Tr. 765:21-25, May 13 (B. Garrett, HMH); Hr'g Tr. 1140:21-1141:5, May 17 (M. Sparta, HMH); PX7018, M. Stauder (HMH) Dep. Tr. 21:3-24:4.

[206] Hr'g Tr. 954:18-955:18, May 14 (Dr. Wu); [redacted]

[207] Hr'g Tr. 955:19-25, May 14 (Dr. Wu); [redacted]

[208] Hr'g Tr. 1033:15-22, May 14 (P. Young, HMH); *see* [redacted]

payors do not attempt to leverage Englewood against HMH in negotiations.[209] Likewise, Englewood has never offered a discount in order to exclude HMH from an insurer's network.[210] In contrast, there is ample evidence that payors have sought to leverage HMH and RWJB against each other.[211]

97. The complementary nature of Englewood and HUMC is also illustrated by their joint inclusion or exclusion in insurers' plans. For example, Englewood and HUMC are both [redacted] because they offer complementary services and geographies.[212] [redacted].[213] Likewise, [redacted] considers HMH and Englewood as [redacted] for its narrow network products, and is interested in marketing a product that excludes both Englewood and HMH.[214]

C. Diversion Ratios and the FTC's Cited Materials Reflect Stage 2 Competition.

98. Defendants' economists agree that diversion ratios reflect the choices *patients*

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[209] Hr'g Tr. 1031:17-1032:14, May 14 (P. Young, HMH); PX7051, K. Kobylowski (AmeriHealth) Dep. Tr. 153:21-154:2.

[210] Hr'g Tr. 870:4-24, May 14 (W. Geller, Englewood); PX7047, A. Orlando (Englewood) Dep. Tr. 253:5-10.

[211] *See* [redacted]; *see also* DX0408-003, 007 (RWJB benchmarking its rates against HMH hospitals).

[212] *See, e.g.*, DX3717-001; [redacted]; PX7026, P. Young (HMH) Dep. Tr. 183:22-184:7.

[213] [redacted]

[214] [redacted]

make if their first choice hospital is unavailable.[215] As such, diversion ratios reflect patient preferences in Stage 2 competition, not Stage 1 competition, where bargaining leverage and price impact an insurer's network formation.[216]

99. Because prices do not impact patient preferences, diversion ratios do not always reflect payor preferences for hospital substitution in network formation.[217]

100. In an attempt to bolster her use of diversions as a measure of Stage 1 substitution, Dr. Dafny cites to payor redirection or termination analyses.[218] However, these highly informal analyses were undertaken to assess the rough financial impact of hospital terminations, not to evaluate Stage 1 substitution in network formation, and all were based on [redacted] and not real-world data of patient preferences.[219] By contrast, employers' analysis of patient preferences based on actual claims data demonstrates that Bergen County patients seek care at a large number of hospitals both inside and outside Bergen County.[220]

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[215] Hr'g Tr. 571:22-572:2, May 12 (Dr. Dafny); Hr'g Tr. 957:17-25, May 14 (Dr. Wu).

[216] Hr'g Tr. 957:17-959:2, Dr. Wu) (discussing DDX004-037).

[217] Hr'g Tr. 957:17-959:2, May 14 (Dr. Wu); [redacted]

[218] Hr'g Tr. 575:11-21, May 12 (Dr. Dafny) (discussing PDX004-040 and citing [redacted] and [redacted] Hr'g Tr. 1518:14-23, May 18 (Dr. Dafny).

[219] [redacted]

[220] *See* Hr'g Tr. 1007:22-1009:17, 1010:21-1011:23, May 14 (K. Strobel, BD).

101. Instead of demonstrating that HMH and Englewood compete for inclusion in payors' networks at Stage 1, the ordinary course materials cited by the FTC only suggest HMH and Englewood compete to some degree for patients at Stage 2.[221] As discussed above, at Stage 1, insurers do not consider HUMC and Englewood to be close competitors, and at Stage 2, both compete with many nearby hospitals.[222]

IV. The FTC Has Not Established that Anticompetitive Effects are Likely.

A. The Two Main Components of the FTC's "Rough Estimate" Price Increase are Both Unreliable.

102. Dr. Dafny attempted to quantify the price effect of the merger—without accounting for efficiencies, other procompetitive benefits and mitigating factors—by (1) measuring percentage changes in patients' WTP resulting from the merger, and (2) selecting a single coefficient from a single 2017 study (the "Garmon Study") to convert the change in WTP to a change in price.[223] Both components of her competitive effects analysis are unreliable bases for what Dr. Dafny admits is just a "rough estimate" predicting a $31 million annual price effect from the merger.[224]

1. Changes in Willingness to Pay Reflect Patient Preferences.

103. WTP is a numerical estimate of the value *patients* place on having a hospital in an insurer's network; like diversion statistics, these patient choices are not

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[221] *See, e.g.*, PDX006-016 (citing PX2358 (Englewood) and PX1102 (HMH)).
[222] *See supra* Sections III.B (Stage 1) and II.C (Stage 2).
[223] [redacted] Hr'g Tr. 575:22-577:8, May 12 (Dr. Dafny); Hr'g Tr. 960:4-961:7, May 14 (Dr. Wu).
[224] Hr'g Tr. 960:4-962:5, May 14 (Dr. Wu).

impacted by price differences between providers.[225]

104. Dr. Dafny nonetheless treats WTP as a "proxy" for the value of a hospital to a payor, but she has not quantified its strength as a proxy for New Jersey payors.[226]

2. The Conversion Factor Is a Cherry-Picked Coefficient from a Single Study of Mergers Outside New Jersey.

105. The conversion factor that Dr. Dafny relies upon for her "rough estimate," which consists of a single coefficient in Table 5 of the Garmon Study,[227] is not a reliable basis to predict a price increase for several reasons.[228]

106. First, the Garmon Study itself recognized that its estimated relationship between WTP and price was based on data that are "not an ideal proxy for each hospital's commercial price."[229]

107. Second, the conversion factor that Dr. Dafny relies on to predict a price effect comes from an analysis of a subset of the mergers included in the Garmon Study.[230] Dr. Dafny focuses only on those mergers that failed to result in any variable cost savings, yet Dr. Dafny does not offer an opinion in this case that there will be no variable cost savings associated with the proposed merger.[231]

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[225] Hr'g Tr. 548:11-20, May 12 (Dr. Dafny); [redacted]
[226] [redacted]
[227] Hr'g Tr. 961:3-7, May 14 (Dr. Wu); Hr'g Tr. 576:14-577:8, May 12 (Dr. Dafny).
[228] Hr'g Tr. 961:11-962:5, May 14 (Dr. Wu); Hr'g Tr. 576:14-577:8 May 12 (Dr. Dafny).
[229] Hr'g Tr. 961:11-962:5, May 14 (Dr. Wu).
[230] Hr'g Tr. 962:9-20, May 14 (Dr. Wu).
[231] Hr'g Tr. 962:9-20, May 14 (Dr. Wu); [redacted]

108. Third, the full sample of 28 mergers included in the Garmon Study shows that there is no statistically significant relationship between changes in WTP and price.[232]

109. Fourth, the Garmon Study sample of 28 hospital mergers did not include any hospital mergers in New Jersey.[233]

110. Finally, the Garmon Study found no price increases for the majority of mergers analyzed and thus provides no basis for the assumption that an increase in WTP would necessarily lead to an increase in prices paid by commercial payors.[234]

B. Analysis of New Jersey Data Shows No Predicted Price Increase.

111. Rather than using a single cherry-picked conversion from the Garmon Study, Defendants' expert, Dr. Wu, analyzed New Jersey claims data from the commercial insurers, which the Garmon Study characterizes as the "ideal data for hospital price measurement."[235] The data Dr. Wu evaluated captures what New Jersey payors paid to New Jersey hospitals for services provided to New Jersey patients.[236]

112. Using this data, Dr. Wu evaluated whether hospitals or health systems in New Jersey with high WTP can garner higher prices from payors.[237] Dr. Wu found there

[232] Hr'g Tr. 962:21-963:14, May 14 (Dr. Wu); [redacted]

[233] Hr'g Tr. 961:11-962:5, May 14 (Dr. Wu); [redacted] *see* DX3817-029.

[234] Hr'g Tr. 963:24-964:12, May 14 (Dr. Wu).

[235] DX3817-014; Hr'g Tr. 964:15-965:11, May 14 (Dr. Wu).

[236] Hr'g Tr. 964:15-965:11, May 14 (Dr. Wu).

[237] Hr'g Tr. 964:15-965:11, May 14 (Dr. Wu).

to be no statistically significant relationship between WTP and hospital prices in New Jersey.[238] Thus, one cannot reliably infer a price increase in this case from a change in patients' WTP. This is consistent with the Garmon Study, which found *no* statistically significant price increase for 19 of the 28 mergers it analyzed.[239]

C. Adding Englewood Will Not Increase HMH's Leverage in Stage 1 Negotiations with Insurers.

113. Prices and contract terms are a result of negotiations between commercial insurers and health systems in Stage 1, and are based in part on the relative bargaining leverage that each possesses.[240]

114. The four major insurers in New Jersey are important sources of revenue for HMH and Englewood and have significant leverage during negotiations.[241] By

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[238] Hr'g Tr. 964:15-965:11, May 14 (Dr. Wu).

[239] Hr'g Tr. 963:24-964:12, May 14 (Dr. Wu).

[240] *See* Hr'g Tr. 935:13-22, 936:10-23, May 14 (Dr. Wu); Hr'g Tr. 543:15-544:6, 545:10-546:11, May 12 (Dr. Dafny).

[241] [redacted]; Hr'g Tr. 1024:3-14, 1048:2-25, 1049:17-1050:10, 1063:9-1066:3 May, 14 (P. Young, HMH); PX7047, A. Orlando (Englewood) Dep. Tr. 205:8-18 ("[Payors] hold all of the cards. They hold all of the leverage. They know we need to participate in their networks in order to treat their members."); Hr'g Tr. 1130:11-15, May 17 (A. Karp, Horizon) (testifying that Horizon "hold[s] significant leverage"); *see also,* DX0732 (United unilaterally terminating shared savings program for HMH physicians with one week's notice); DX3005 (same); [redacted] DX3001-002 (HMH physician stating that Amerigroup's refusal to contract with HMH "is literally killing us").

contrast, HMH and Englewood lack significant bargaining leverage relative to the insurers in negotiations given the hospitals' need to remain in-network with each insurer to remain financially viable.[242]

115. For example, during its most recent negotiations with United, HMH estimated that it would stand to lose $194 million if HMH could not reach an agreement and was forced to go out-of-network. This reality compelled HMH to make concessions to United—the largest health insurer in the country with $22 billion in annual profits—and reach an agreement to remain in-network.[243] HMH also had to compromise with other insurers to avoid being terminated, such as in its 2020 negotiations with Aetna where HMH made concessions on both rates and contractual terms after Aetna threatened termination.[244]

116. Neither HMH nor Englewood has gone out-of-network with any major insurer, because this would result in a [redacted] on their finances and

[242] *See* Hr'g Tr. 1043:9-23, 1074:11-16, May 14, 17 (P. Young, HMH); PX7047, A. Orlando (Englewood) Dep. Tr. 225:6-7.

[243] [redacted] Hr'g Tr. 1041:1042:25, 1049:1-16, May 14 (P. Young, HMH); *see also* [redacted]

[244] *See*, *e.g.*, Hr'g Tr. 1062:1-1066:3, May, 17 (P. Young, HMH); [redacted]

"disruption to patients, disruption to physicians."[245] In contrast, for example, during its most recent HMH negotiations in 2020, [redacted] estimated that it would *save* [redacted] if HUMC went out of network.[246]

117. HMH's growth over the past few years has not changed these bargaining dynamics: while negotiating system-wide for all its hospitals, HMH's size has not enabled it to extract higher rates or more favorable terms from payors.[247]

118. As Dr. Dafny testified, "Englewood doesn't have much bargaining leverage."[248] Englewood is not a "must have" for payors, and payors have multiple alternatives to it.[249] It therefore typically receives relatively low reimbursement rate increases during negotiations.[250] Thus, the Merger will not meaningfully enhance Defendants' leverage in negotiations and substantially lessen competition.[251] Indeed,

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[245] Hr'g Tr. 1038:16-1040:4, May 14 (P. Young, HMH); [redacted]; *see* Hr'g Tr. 785:19-786:3, May 12 (R. Garrett, HMH).

[246] [redacted]

[247] Hr'g Tr. 1066:15-19, 1067:18-23, 1068:8-17, May 17 (P. Young, HMH).

[248] Hr'g Tr. 1522:9-10, May 18 (Dr. Dafny).

[249] *See supra* Sections II.C and III.B; [redacted]; Hr'g Tr. 699:22-702:14, May 13 (K. Kobylowski, AmeriHealth) (not having Englewood in-network would not impact the marketability of AmeriHealth's plans "at all").

[250] [redacted]; *see also* DX0717-001 (If any Englewood merger results in United "directly or indirectly . . . paying for Covered Services at rates greater than the Negotiated Rates with respect to dates of service on or prior to December 31, 2023, *Provider will pay United the aggregate amount of any difference*.") (emphasis added).

[251] *See* Hr'g Tr. 1068:18-1069:9, May 17 (P. Young, HMH).

representatives of both Horizon and [redacted] testified that the Merger will not significantly increase HMH's bargaining leverage post-merger.[252] HMH agrees, and never even discussed raising prices post-merger.[253]

119. This is consistent with support for the merger from the Horizon, the largest commercial insurer in New Jersey.[254] Horizon believes the Merger will lead to better coordination between Englewood and HMH, reduce outmigration to New York for quaternary services, and thereby result in lower costs for Horizon through lower fee-for-service rates for Bergen and non-Bergen County residents alike.[255]

120. [redacted] commercial insurers testified that this Merger is unlikely to lead to higher costs. Horizon testified that the Merger will not impact its total cost of care at Englewood.[256] [redacted] also testified that it does not believe that the Merger will result in increased inpatient prices at Englewood.[257]

121. Aetna and United compete directly against HMH and Englewood in the provision of outpatient and physician services, and against HMH in the sale of health insurance from its Braven Health joint venture with Horizon and RWJB—giving

[252] Hr'g Tr. 1103:16-24, May 17 (A. Karp, Horizon); [redacted]

[253] Hr'g Tr. 786:4-17, May 13 (R. Garret, HMH); Hr'g Tr. 1068:22-1069:9, May 17 (P. Young, HMH).

[254] Hr'g Tr. 1092:5-12, 1094:19-1096:19, May 17 (A. Karp, Horizon); DX1101.

[255] Hr'g Tr. 1097:7-1098:6, 1098:16-1100:15, 1102:10-1103:1, May 17 (A. Karp, Horizon).

[256] Hr'g Tr. 1103:2-15, May 17 (A. Karp, Horizon).

[257] [redacted]

each a competitive incentive to oppose the merger.[258] Nevertheless, [redacted] [259] AmeriHealth's opinions are not specific to this merger but are limited to consolidation generally; moreover, AmeriHealth believes that provider consolidation has *not* had an impact on rate schedules for providers.[260]

D. Repositioning and Other Mitigating Factors Will Also Offset Any Theoretical Price Increase.

122. The FTC's backward-looking "snapshot in time" competitive effects analysis, which is based on data only through 2019, fails to appropriately account for (1) the likelihood of competitors and payors taking action in response to the merger and (2) current and forthcoming repositioning by competitors in the region that mitigates any potential price increase of this Merger.[261]

123. Payors can and do react to possible price increases by redesigning their plans

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[258] Hr'g Tr. 1047:25-1048:25, 1050:2-8, 1070:20-1072:4, May 14 (P. Young, HMH); (in its first year, Braven's Medicare Advantage insurance plans have had "unprecedented success," attracting thousands of enrollees previously served by United and Aetna.); Hr'g Tr. 859:8-21, May 14 (W. Geller, Englewood); PX7027, M. Nielson (United) Dep. Tr. 135:5-7.

[259] [redacted]; Hr'g Tr. 787:10-788:9, May 13 (R. Garrett, HMH); Hr'g Tr. 1036:5-1038:11, May 14 (P. Young, HMH); [redacted]

[260] Hr'g Tr. 703:13-704:6, May 13 (K. Kobylowski, AmeriHealth).

[261] [redacted]

to steer patients to cheaper hospitals, making it risky for hospitals to attempt to raise prices. For example, insurers can steer patients through tiered networks or by encouraging physicians to refer to preferred providers.[262] This is an essential point that Dr. Dafny's economic model fails to consider.[263] The FTC offers no evidence rebutting the ability of insurers to reposition in response to price increases.[264]

124. [redacted] has considered a "redirection strategy to steer business away from HMH" that would include working with physicians to redirect care and incentivizing patients to choose other providers.[265] [redacted] has already used redirection in response to requests for higher rates from HMH, admitting that it simply "stopped sending them kidney transplants."[266] [redacted] has used Valley as a substitute for HMH in its [redacted],[267] which has already attracted 21,000 members since launching in 2019.[268]

125. [redacted] use of its affiliated [redacted] physicians provides another example of how payors and physician groups can drive repositioning, and specifically as a

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[262] [redacted] *see, e.g.*, [redacted]

[263] Hr'g Tr. 968:25-969:23, May 14 (Dr. Wu); DDX004-050.

[264] [redacted] 1522:21-1525:1, May 18 (Dr. Dafny) (pointing to lay opinions contained in "insurer documents" about "difficulty" of reacting to price increases, but not providing data).

[265] [redacted]

[266] [redacted]

[267] [redacted]

[268] [redacted]

"redirection opportunity away from Hackensack" due to its costs.[269]

126. Insurers already exclude HMH, providing a snapshot of what that redirection could look like. [redacted] sells a marketable plan to Bergen County residents without HMH facilities because it needed only [redacted].[270]

127. As discussed above, hospitals outside of Bergen County in both New York and New Jersey, use outpatient facilities as "front doors" to their inpatient services to reposition themselves as even stronger competitors.[271]

128. In addition, significant repositioning by *competitors* in the region is already occurring. Valley, which already holds a "dominant and stable" inpatient market share within its primary service area,[272] is constructing a replacement campus located in Paramus.[273] Valley's replacement campus is five miles closer to Englewood and HUMC and is closer to major nearby thoroughfares and population centers, positioning Valley to be even more competitive in the near term.[274]

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[269] [redacted] PX7016, P. Knaus (RWJB) Dep. Tr. 385:1-386:13; *see* [redacted]

[270] [redacted]; [redacted]

[271] *See supra* Section II.C.

[272] DX0928-009.

[273] Hr'g Tr. 776:11-777:5 (R. Garrett, HMH); DX0914-002 -003; DX0928-040; [redacted].

[274] [redacted]; DX0928-040 (New Valley has "[e]asy access to/from Route 17, Garden State Parkway, E. Ridgewood Avenue, [and] A&S Drive (Paramus Park Mall)."); Hr'g Tr. 776:11-777:2, May 12 (R. Garrett, HMH); [redacted].

129. Another competitor undertaking significant repositioning is [redacted] which recently entered into agreements with the major commercial payors to make the facility more attractive and competitive.[275] Its new strategic initiative includes significant physical and technological improvements, with additional improvements planned for the future, to transform the facility [redacted] to a [redacted] GAC hospital for New Jersey patients.[276]

V. Defendants Have Also Produced Substantial Rebuttal Evidence that the Merger Will Create Significant Procompetitive Benefits.

130. The Merger will produce significant procompetitive benefits for both insurers and patients, including: the transformation of Englewood into a fully integrated hub for tertiary care with enhanced capabilities; expansion of the complex tertiary and quaternary care HUMC provides; direct and substantial cost savings for payors from service optimization; and significant improvements in quality of care.

A. The Merger Will Transform Englewood into a Tertiary Hub and Expand the Services it Provides.

131. Robert Garrett, HMH's CEO, explained that HMH's merger rationale is to convert Englewood into "a leading provider of tertiary care in Northern New Jersey."[277] HMH's $439 million investment will be used for capital projects, service

[275] [redacted]

[276] [redacted]

[277] Hr'g Tr. 743:5-8, May 13 (R. Garrett, HMH).

line commitments, and other initiatives to improve Englewood's facilities and capabilities.[278] The larger volume of tertiary patients that the optimization plans will bring to Englewood will support expanded tertiary care programs there.[279]

132. The other 17 clinical initiatives specified in the Definitive Agreement include expanding Englewood's robotic surgery services; developing comprehensive thoracic surgery services; and constructing a new Level 3 High Risk NICU.[280]

133. Englewood's integration into the HMH system will make it more attractive to patients.[281] This integration will produce efficiencies in the delivery and coordination of care, the pooling of resources, and increased access to capital. All of these will improve the quality and value that Englewood provides to patients.[282]

B. The Merger Will Enable HUMC to Provide Expanded High-Acuity Services to New Jersey Residents.

134. The Merger will allow HUMC to expand its highest acuity—or complex tertiary and quaternary—services, increase its quality of such services, and reduce the outmigration of high-acuity patients to New York AMCs.[283]

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[278] Hr'g Tr. 745:24-747:2, May 13 (R. Garrett, HMH); Hr'g Tr. 1235:19-1237:22, May 17 (Dr. Gowrisankaran); [redacted]; [redacted]; [redacted].

[279] [redacted] Hr'g Tr. 847:5-19, [redacted], May 14 (W. Geller, Englewood); [redacted].

[280] [redacted]

[281] Hr'g Tr. 1254:7-1257:16, May 17 (Dr. Gowrisankaran); [redacted]

[282] Hr'g Tr. 1254:7-1257:16, May 17 (Dr. Gowrisankaran); [redacted]

[283] [redacted] Hr'g Tr. 1239:7-1242:9, May 17 (Dr. Gowrisankaran); Hr'g

135. HUMC's role as a leading AMC in New Jersey depends on its ongoing improvement and expansion of high-acuity care, including complex oncology, neuroscience, musculoskeletal, and transplant services.[284] But developing these highly complex specialties requires capacity to treat increasing numbers of cases.[285]

136. HUMC's current capacity constraints limit the number of high-acuity patients it can treat.[286] HUMC is limited in the number of transplant patients it can treat because it lacks the capacity to dedicate space for the specialized beds required for these procedures,[287] often resulting in scheduling challenges that delay high-acuity treatments and drive physicians to refer their patients for care at other AMCs in New Jersey and New York.[288] Likewise, these capacity constraints are preventing HUMC from treating cardiac and liver transplant patients.[289] The Merger will ease HUMC's capacity constraints by redirecting non-complex tertiary patients to Englewood.[290] Doing so will increase HUMC's capacity to accept patients that need "more

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Tr. 742:15-743:24, 767:7-768:12, May 13 (R. Garrett, HMH).

[284] Hr'g Tr. 735:3-20, May 13 (R. Garrett, HMH); Hr'g Tr. 1257:18-1259:8, May 17 (Dr. Gowrisankaran); [redacted] DX3601-003.

[285] Hr'g Tr. 743:25-744:18, 762:3-23, May 13 (R. Garrett, HMH); Hr'g Tr. 1257:18-1259:8, May 17 (Dr. Gowrisankaran); [redacted]

[286] Hr'g Tr. 762:3-23, May 13 (R. Garrett, HMH).

[287] [redacted]

[288] Hr'g Tr. 1239:7-19, May 17 (Dr. Gowrisankaran); [redacted]; Hr'g Tr. 1147:7-1148:6, May 17 (M. Sparta, HMH).

[289] Hr'g Tr. 762:5-23, May 13 (R. Garrett, HMH)

[290] Hr'g Tr. 742:17-743:24, May 13 (R. Garrett, HMH); Hr'g Tr. 1257:18-1259:8, May 17 (Dr. Gowrisankaran); [redacted]

sophisticated work" and newer "more complex" procedures.[291]

137. Alternatives to the Merger to address HUMC's overcapacity are neither reasonably feasible, financially sound, nor sufficiently timely. HUMC is constrained from expanding vertically or horizontally due to zoning regulations and lack of physical space on its dense campus.[292] Building a new hospital elsewhere requires enormous financial resources and many years, or even decades, to complete.[293]

138. Further, each of HMH's three community hospitals in its Northern Region—Palisades, PVMC, and MMC—are not licensed, designed, equipped or staffed to provide tertiary care, and have other constraints limiting their ability to do so.[294] When their patients need tertiary or higher care, those patients must be transferred to HUMC.[295] It would require at least 3-5 years and more than $400 million to build out these hospitals to accommodate the higher levels of care.[296]

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[291] Hr'g Tr. 1257:18-1259:8, May 17 (Dr. Gowrisankaran); [redacted].

[292] [redacted] DX3601-008; Hr'g Tr. 1148:18-23, May 17 (M. Sparta, HMH); Hr'g Tr. 1198:9-20, May 17 (Mr. Nolan); [redacted]

[293] [redacted] Hr'g Tr. 582:24-583:4, May 12 (Dr. Dafny); Hr'g Tr. 1200:16-21, May 17 (Mr. Nolan).

[294] [redacted] DX3601-009; Hr'g Tr. 768:13-769:14, May 13 (R. Garrett, HMH); Hr'g Tr. 1198:21-1199:23, May 17 (Mr. Nolan); [redacted]

[295] Hr'g Tr. 1142:2-19, May 17 (M. Sparta, HMH); Hr'g Tr. 1198:21-1199:23 (Mr. Nolan).

[296] [redacted] Hr'g Tr. 1198:21-1199:23, May 17 (Mr. Nolan); [redacted]

139. Dr. Romano offers no opinion as to whether any of his suggested capacity-reducing alternatives are financially feasible, and provides no analysis of how much capacity any such measures could provide at HUMC, even assuming, without any analysis, that any was financially feasible or achievable.[297]

140. By increasing its capacity to treat additional high-acuity patients and adding new complex care programs, HUMC will expand local access to complex tertiary and quaternary care for northern New Jersey residents, who will benefit from having HUMC as a more attractive option closer to home, particularly for quaternary care typically involving lengthy hospital stays.[298]

141. Dr. Dafny criticizes Dr. Gowrisankaran's procompetitive effects analysis on the grounds that it is not "merger specific" because he did not compare the procompetitive benefits of the Merger to a hypothetical merger between Englewood and a theoretical partner.[299] This criticism is based on a faulty conception of the "but-for world." As Dr. Gowrisankaran testified, the but-for world in a competitive effects analysis is a "counterfactual world where there is no merger . . . The world without the merger is the status quo. It's a world where Englewood is a stand-alone hospital."[300] Indeed, comparing the Merger to a hypothetical alternative would be of

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[297] Hr'g Tr. 1465:12-18, May 18 (Dr. Romano).
[298] Hr'g Tr. 765:12-766:21, May 13 (R. Garrett, HMH); Hr'g Tr. 1259:14-1260:18, May 17 (Dr. Gowrisankaran); [redacted]
[299] [redacted]
[300] Hr'g Tr. 1265:3-25, May 17 (Dr. Gowrisankaran).

little value because it would be wildly speculative and, as Dr. Dafny concedes, a net procompetitive merger cannot be deemed anticompetitive simply because another hypothetical merger partner can be identified.[301]

C. The Procompetitive Benefits of the Merger Will Result in Direct and Substantial Cost Savings to Insurers.

1. The Shift of Patients to Englewood Will Trigger At Least $20.6 Million in Direct Cost Savings for Payors.

142. Upon closing, HMH will immediately integrate Englewood into its regional transfer center, and tertiary care patients will be treated at Englewood.[302] Defendants have identified 1,061 non-complex tertiary patients annually that will be treated at Englewood starting on day-one following the Merger.[303]

143. Dr. Gowrisankaran further concluded that HMH's $439 million investment will result in additional increases in Englewood's patient volume by more than 1,000 commercial patients annually.[304] He reached this conclusion by studying the effect prior capital investments at nearby hospitals had on inpatient discharge volume.[305]

144. The addition of these patients to Englewood, including 1,300 commercially

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[301] [redacted]; *see also supra* Section I.B.

[302] Hr'g Tr. 762:3-763:9, May 13 (R. Garrett, HMH); [redacted]; DX3601-011, -014; Hr'g Tr. 1242:10-1245:16, May 17 (Dr. Gowrisankaran).

[303] Hr'g Tr. 763:12-764:11, May 13 (R. Garrett, HMH); DX3601-011; [redacted] Hr'g Tr. 1242:10-1245:16, May 17 (Dr. Gowrisankaran).

[304] [redacted] Hr'g Tr. 1246:6-1248:2, May 17 (Dr. Gowrisankaran).

[305] [redacted] Hr'g Tr. 1246:6-1248:2, May 17 (Dr. Gowrisankaran).

insured, will reduce the overall cost of care for payors because Englewood provides inpatient GAC services at lower prices on average than the hospitals that would otherwise treat these patients.[306] Dr. Gowrisankaran employed a patient choice model to determine which hospitals these additional commercial patients would have gone to in a world without the Merger.[307] He then extrapolated the price differential between Englewood and the other hospitals for the relevant services to calculate the savings that payors will experience as a result of the post-merger patient shifts.[308] Dr. Gowrisankaran concluded that payors will save at least $20.6 million per year from the additional patients Englewood will serve.[309]

145. Dr. Dafny opined that there will be price increases at Englewood following the Merger that will reduce the cost savings identified by Dr. Gowrisankaran.[310] Her assessment lacks any reliable foundation. HMH negotiates price changes on a system-wide basis—thus, Englewood will remain less expensive than the other HMH hospitals and the savings for redirection to Englewood from HMH hospitals will remain relatively constant in the future.[311] As Dr. Gowrisankaran testified, Dr.

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[306] Hr'g Tr. 1248:4-1252:6, May 17 (Dr. Gowrisankaran); [redacted]
[307] Hr'g Tr. 1265:3-1266:8, May 17 (Dr. Gowrisankaran).
[308] Hr'g Tr. 1248:4-1252:6, May 17 (Dr. Gowrisankaran); [redacted]
[309] Hr'g Tr. 1248:4-1252:6, May 17 (Dr. Gowrisankaran); [redacted]
[310] [redacted]
[311] Hr'g Tr. 1248:4-1252:6, May 17 (Dr. Gowrisankaran); [redacted]; Hr'g Tr. 1024:19-1027:9, May 14 (P. Young, HMH); [redacted]

Dafny admits that she is not offering "any substantiated opinions or any evidence" that "the price increase at Englewood post-merger would be different from any other HMH hospital."[312]

2. The Expansion of Quaternary Services at HUMC Will Reduce Outmigration to New York and Trigger At Least $1.5-2.2 Million in Direct Cost Savings for Payors.

146. By alleviating its capacity constraints and expanding its quaternary services, HUMC will be able to recapture at least 10%, and as much as 15%, of patients from Bergen, Essex, Hudson, and Passaic counties who currently travel to New York hospitals for quaternary care.[313] Because those services are less expensive at HUMC than at New York AMCs, their recapture will yield direct saving to payors.[314]

147. In 2019, 89% of the Bergen County residents that received quaternary care in New York lived closer to HUMC than the hospital they visited, and the same is true for 71% of the out-migrating quaternary patients from Bergen, Hudson, Essex, and Passaic Counties.[315] With expanded quaternary capacity, at least some physicians that would have referred quaternary patients to New York AMCs will be more likely to send their patients to HUMC.[316] These savings do not depend on large shifts in

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[312] Hr'g Tr. 1251:23-1252:6, May 17 (Dr. Gowrisankaran); [redacted]
[313] Hr'g Tr. 1258:3-1259:13, May 17 (Dr. Gowrisankaran); [redacted]
[314] Hr'g Tr. 1258:3-1259:13, May 17 (Dr. Gowrisankaran); [redacted]
[315] [redacted] PX7030, J. Le Benger (Summit) Dep. Tr. 61:3-62:8.
[316] Hr'g Tr. 1257:17-1261:24, May 17 (Dr. Gowrisankaran); [redacted]

patient care—Dr. Gowrisankaran's 10% and 15% recapture rates equate to 37 and 56 additional commercial patients, respectively.[317]

148. Using payor claims data to determine the pricing differentials between HUMC and the New York AMCs, Dr. Gowrisankaran concluded that the Merger will lead to at least $1.5 to $2.2 million in payor savings on complex tertiary and quaternary services for patients who will receive care at HUMC rather than at other hospitals.[318] This is consistent with Horizon's testimony that the Merger will create savings from HUMC's recapture of patients receiving quaternary care at New York AMCs.[319]

149. These savings are only a partial measure of the procompetitive benefits that will result from the expansion of HUMC's quaternary and complex tertiary capacity. For instance, additional capacity will incentivize HUMC to compete for additional patients by negotiating lower reimbursement rates.[320]

3. Together with the Other Quantifiable Benefits, the Merger-Specific Benefits Will Outweigh Any Predicted Harm.

150. As discussed in Section VI, Defendants' efficiencies expert, Ms. Lisa Ahern, calculated $38 million in annual cost-savings efficiencies resulting from the Merger. Based on peer-reviewed literature and payor bargaining economics, Dr. Gowrisankaran estimated that 50% of these cost-savings would be passed through

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317 [redacted]

318 Hr'g Tr. 1258:3-1259:13, May 17 (Dr. Gowrisankaran); [redacted]

319 Hr'g Tr. 1097:7-1099:8, May 17 (A. Karp, Horizon).

320 Hr'g Tr. 1239:7-19, May 17 (Dr. Gowrisankaran); [redacted]

to payors, meaning that payors will save $19 million per year.[321] Dr. Dafny does not dispute Dr. Gowrisankaran's 50% pass-through rate.[322]

151. As discussed in paras. 142-144 above, Dr. Gowrisankaran also calculated that payors will realize $20.6 million in annual cost savings from increased patient volume at Englewood, and between $1.5 and $2.2 million in annual cost savings from HUMC treating quaternary patients who seek that care at New York AMCs.[323]

152. In sum, the procompetitive, merger-specific benefits that Defendants quantified total between $41.1 and $41.8 million per year.[324] Thus, even before accounting for the additional procompetitive, merger-specific benefits that have *not* been quantified by either Ms. Ahern or Dr. Gowrisankaran (such as improvements in quality), the record demonstrates that quantified benefits exceed the FTC's claimed (but unproven) "rough estimate" of $31 million in predicted annual harm.[325] Under any scenario, therefore, there is no factual basis to conclude that the Merger will likely have a net anticompetitive effect.[326]

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[321] Hr'g Tr. 1262:23-1264:6, May 17 (Dr. Gowrisankaran); [redacted]

[322] Hr'g Tr. 1550:12-1551:6, May 18 (Dr. Dafny).

[323] Hr'g Tr. 1246:6-1249:3, 1258:3-1259:13, May 17 (Dr. Gowrisankaran); [redacted]

[324] Hr'g Tr. 1240:21-1241:16, May 17 (Dr. Gowrisankaran).

[325] Hr'g Tr. 1241:17-1242:9, May 17 (Dr. Gowrisankaran); Hr'g Tr. 578:6-10, May 12 (Dr. Dafny); [redacted]

[326] Hr'g Tr. 1240:21-1241:16, May 17 (Dr. Gowrisankaran); Hr'g Tr. 933:20-935:7, 970:16-24, May 14 (Dr. Wu).

D. The Merger Will Improve Quality at Englewood and HMH.

153. Englewood's quality of care has "hit a ceiling," and "address[ing] quality issues" is like "a classic game of whack-a-mole."[327]

154. Dr. Meyer, Defendants' healthcare quality expert, further testified that "HMH has a strong and long history of being a leader in quality," with an established and "robust approach to improving quality of care in its acquisitions," including evaluations, implementation, and accountability.[328] Dr. Meyer found that HMH has a track record of improving quality at its merger partners.[329]

155. Both Dr. Meyer and Dr. Romano testified that the clinical initiatives specified in the Definitive Agreement can improve the quality of care at Englewood;[330] Dr. Dafny also [redacted].[331]

156. Englewood's quality of care will also improve by gaining access to HMH's advanced data analytics. Dr. Meyer testified that Englewood's current data analyses rely on manual processes that are too narrow and labor-intensive to monitor and

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[327] Hr'g Tr. 1314:2-1315:5, May 18 (Dr. Brunnquell, Englewood); *see also* Hr'g Tr. 846:17-847:4, May 14 (W. Geller, Englewood); [redacted]

[328] Hr'g Tr. 1342:14-1343:6, 1355:2-20, May 18 (Dr. Meyer); *see also* [redacted] Hr'g Tr. 747:23-748:13, May 13 (R. Garrett, HMH); Hr'g Tr. 1101:19-1102:9, May 17 (A. Karp, Horizon).

[329] Hr'g Tr. 1355:2-1356:6, May 18 (Dr. Meyer); [redacted]

[330] [redacted] Hr'g Tr. 1343:7-1344:12, 1345:3-25, 1352:11-1353:16, May 18 (Dr. Meyer); *see also* [redacted]

[331] [redacted].

improve hospital-wide quality and come "at the expense of not being able to look at everything else that you should be paying attention to."[332] Extending HMH's state-of-the-art data analytics infrastructure to Englewood will improve Englewood's ability to quickly and effectively identify and react to any quality-of-care deficiencies.[333] Dr. Romano [redacted], and this is consistent with Horizon's view that the Merger will improve quality.[334]

157. The Merger also will improve HMH's quality of care in a number of ways. For example, the Merger will alleviate overcapacity problems in HUMC's emergency department,[335] a result that Dr. Romano characterized as "very closely related" to and "inextricable" from quality of care.[336] As Dr. Gowrisankaran explained, if HMH can "increase its quaternary care volumes as it would if the merger were to go forward, then this is going to increase the quality of care" by allowing HMH to attract top physicians and by the learning-by-doing effect.[337] HMH will also achieve quality benefits by adding Englewood's strengths to its system.[338]

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[332] Hr'g Tr. 1348:19-1349:6, May 18 (Dr. Meyer); *see also* Hr'g Tr. 1318:13-1319:6, May 18 (Dr. Brunnquell, Englewood); [redacted].

[333] Hr'g Tr. 1348:19-1350:8, May 18 (Dr. Meyer); [redacted]

[334] [redacted]; Hr'g. Tr. 1101:19-1102:9, May 17 (A. Karp, Horizon).

[335] Hr'g Tr. 1353:17-1354:16, May 18 (Dr. Meyer); [redacted]

[336] Hr'g Tr. 1425:23-1426:22, May 18 (Dr. Romano).

[337] Hr'g Tr. 1260:19-1261:24, May 17 (Dr. Gowrisankaran); *see also* [redacted] Hr'g Tr. 762:24-763:9, May 13 (R. Garrett, HMH).

[338] Hr'g Tr. 1344:18-1345:2, May 18 (Dr. Meyer); [redacted] Hr'g Tr.

158. The quality of care at both HMH and Englewood will also improve through the benefits of "systemness," which allows Defendants "to share capacity and move patients to the right care at the right place . . . in the right way," "to extend infrastructure across various parts of the system," "to share protocols to improve care across the system in a uniform and robust fashion," and "to participate in advanced value-based care arrangements" that incentivize and improve quality of care."[339] Dr. Romano admitted these [redacted].[340]

159. The Merger will also improve quality because Englewood will operate on HMH's "single instance" (version) of Epic, the electronic health records software system. Dr. Meyer opined that this Epic integration "is a major upgrade in terms of safety and quality and effectiveness in health care delivery."[341] Dr. Romano did not dispute the increased benefits to care that can result.[342]

160. Finally, once integrated, HMH and Englewood can pursue advanced value-based care arrangements with insurers that incentivize and improve quality of care.[343] Dr. Romano agreed that these arrangements can improve quality.[344]

1315:13-16, May 18 (Dr. Brunnquell, Englewood); Hr'g Tr. 747:3-22, May 13 (R. Garrett, HMH).

[339] Hr'g Tr. 1338:11-1339:14, May 18 (Dr. Meyer); *see also* [redacted] Hr'g Tr. 1468:12-21, May 18 (Dr. Romano); [redacted]

[340] [redacted].

[341] Hr'g Tr. 1346:12-1348:6, May 18 (Dr. Meyer); *see also* [redacted]

[342] Hr'g Tr. 1468:3-11, May 18 (Dr. Romano).

[343] Hr'g Tr. 1350:11-1352:10, May 18 (Dr. Meyer); [redacted]

[344] Hr'g Tr. 1468:12-21, May 18 (Dr. Romano).

VI. The Merger Will Also Create Substantial and Verifiable Merger-Specific Efficiencies.

161. Defendants' efficiencies expert analyzed under the framework of the *Guidelines* the cost savings that will be achieved from the Merger.[345] Ms. Ahern has spent her career advising health care providers on business and integration planning in functional and clinical areas, including following mergers, and she has significant experience analyzing proposed efficiencies in the manner prescribed by the *Guidelines*.[346] By contrast, the FTC's expert, Dr. Dafny, admitted that she has no expertise or experience in calculating such efficiencies.[347]

162. Ms. Ahern evaluated Defendants' ordinary course data; reviewed operating and integration plans with numerous executives; calculated efficiencies and one-time costs for each functional area; and confirmed her results with Defendants' functional leaders.[348] She reviewed HMH's proven track record of achieving savings from its past mergers, through its dedicated integration management office, and found HMH's real-world experience and plans corroborated her findings.[349]

163. In total, Ms. Ahern conservatively identified $38 million in annual recurring, verifiable, and merger-specific efficiencies net of recurring costs that will be

[345] Hr'g Tr. 1382:3-1383:20, May 18 (Ms. Ahern); [redacted]
[346] Hr'g Tr. 1380:2-1381:13, May 18 (Ms. Ahern); [redacted]
[347] Hr'g Tr. 1533:11-16, 1551:17-24, May 18 (Dr. Dafny).
[348] Hr'g Tr. 1388:21-1389:21, May 18 (Ms. Ahern); [redacted]
[349] Hr'g Tr. 1384:14-1385:18, May 18 (Ms. Ahern); [redacted]

achieved within four years post-Merger.[350] The FTC has not offered any expert testimony to rebut these cost savings and efficiencies resulting from the Merger. [351]

164. Specifically, Defendants will achieve these cost efficiencies through the consolidation of departments: corporate finance, supply chain, revenue cycle, purchased services, corporate risk, employee benefits, information technology, staffing, pharmacy services, laboratory services, and biomedical services.[352]

165. Ms. Ahern opines that the $38.0 million in quantified savings is a conservative estimate because there are additional merger-specific savings that Defendants will likely achieve as they integrate operations post-closing.[353]

166. These efficiencies are merger-specific because they depend on HMH's centralized organizational design and infrastructure, the specific purchasing functions and overlap in purchases between HMH and Englewood, and HMH's detailed plan for Englewood.[354] Moreover, there is no evidence of any other non-theoretical partner for Englewood, and "merely theoretical" alternatives need not be considered to satisfy the merger-specificity requirement.[355]

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[350] Hr'g Tr. 1385:21-1387:2, May 18 (Ms. Ahern); [redacted]

[351] Hr'g Tr. 1388:15-18, May 18 (Ms. Ahern); Hr'g Tr. 1533:11-16, May 18 (Dr. Dafny).

[352] [redacted]

[353] Hr'g Tr. 1388:9-14, 1395:20-1397:3, May 18 (Ms. Ahern); [redacted]

[354] Hr'g Tr. 1383:23-1384:11, 1390:2-23, 1392:17-1393:5, [redacted], May 18 (Ms. Ahern); [redacted]

[355] Hr'g Tr. 1383:23-1384:11, May 18 (Ms. Ahern); DX3815-033.

CONCLUSIONS OF LAW

I. The FTC Fails to Show A Likelihood of Success on the Merits.

A. The FTC Has the Burden of Persuasion at All Times.

1. When seeking the "extraordinary and drastic remedy" of a preliminary injunction prohibiting a merger (*FTC v. Exxon Corp.*, 636 F.2d 1336, 1343 (D.C. Cir. 1980)), the FTC bears the burden of persuasion to make "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 also FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 337 (3d Cir. 2016).

2. To establish a likelihood of success, the FTC must therefore show that "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 also*, 15 U.S.C. § 18.

3. To do so, the FTC first "must establish a prima facie case that the merger is anticompetitive" by "(1) propos[ing] the proper relevant market and (2) show[ing] that the effect of the merger in that market is likely to be anticompetitive." *Hershey*, 838 F.3d at 337-38. If, but only if, the FTC properly defines a relevant product and geographic market, and demonstrates undue concentration in that market, is it entitled to a presumption that the merger is anticompetitive. *Id*.

4. Defendants can rebut such a presumption by "producing evidence" showing that the FTC's "prima facie case inaccurately predicts the relevant transaction's probable effect on future competition." *United States v. Baker Hughes Inc.*, 908 F.2d

981, 982-83, 991 (D.C. Cir. 1990). Once Defendants produce such evidence, "the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *Id.* at 983; *accord Hershey*, 838 F.3d at 337.

B. The FTC Failed to Establish a Relevant Geographic Market.

5. The FTC failed to meet its burden to define a relevant geographic market for inpatient GAC services, and this failure is fatal. *See Hershey*, 838 F.3d at 338; *FTC v. Thomas Jefferson Univ.*, 2020 WL 7227250, at *27 (E.D. Pa. 2020).

6. A relevant geographic market is the "area in which a potential buyer may rationally look for the goods or services he seeks." *Hershey*, 838 F.3d at 338. "[A] market's geographic scope must 'correspond to the commercial realities of the industry' being considered." *Id.* at 338 (quoting *Brown Shoe*, 370 U.S. at 336-37). "Construction 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).

7. In the healthcare industry, the relevant market must be analyzed "through the lens of the insurers" because "the healthcare market is represented by a two-stage model of competition" wherein hospitals compete to be included in an insurance plan's network (Stage One), and only then compete to attract individual members of an insurer's plan (Stage Two). *Hershey*, 838 F.3d at 342.

8. Because the political boundary of Bergen County plays no meaningful role in either stage of hospital competition for GAC services sold to insurers, defining a geographic market based on that boundary does not "correspond to the commercial realities of the industry." *Id.* at 338 (quoting *Brown Shoe*, 370 U.S. at 336-37).

9. The FTC has typically defined relevant geographic markets in hospital mergers based on the location of suppliers (hospitals), not customers (insurers or patients). *See, e.g.*, *Hershey*, 838 F.3d at 338; *FTC v. Advocate Health Care Network*, 841 F.3d 460, 465-66 (7th Cir. 2016); *Jefferson*, 2020 WL 7227250, at *7-8. This is in keeping with its own *Guidelines* that "[i]n the absence of price discrimination based on customer location," the FTC "normally define[s] geographic markets based on the locations of suppliers." *Guidelines* § 4.2.

10. As a matter of law, only "[w]hen the hypothetical monopolist could discriminate based on customer location" may the FTC "define geographic markets based on the locations of targeted customers." *Id.* § 4.2.2; *see also FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 117-18 (D.D.C. 2016) (defining a market based on targeted customers requires finding that sellers can price discriminate); *In re Tronox*, 2018 WL 6630200, at *15-16 (F.T.C. 2018) (accepting a customer-based market because "Respondents' documents and testimony confirm that they charge different prices to customers depending on the region in which the customer is located.").

11. In this case, the FTC based its proposed geographic market on a targeted group of customers (*i.e.*, patients residing in Bergen County), not as it normally does on the location of the hospitals that supply GAC services. But it did so without producing the necessary expert opinions or evidence that hospital providers price discriminate based on the location of patients. *Id.*; *see also United States v. Eastman Kodak Co.*, 63 F.3d 95, 106-07 (2d Cir. 1995) ("it was incumbent upon the government to produce probative evidence of systemic price discrimination, which it failed to do"); *In re R.R. Donnelley & Sons Co.*, 120 F.T.C. 36, 158 (1995) (rejecting market based on customers rather than suppliers because the FTC did not show "the hypothetical monopolist [could] selectively and profitably increase prices").

12. Indeed, the HMT set forth in the *Guidelines* asks whether "a hypothetical monopolist could *profitably* impose a SSNIP," accounting for the commercial realities of the industry. *Hershey*, 838 F.3d at 342, 344 (emphasis altered).[356] If a hypothetical monopolist cannot price discriminate, then any price increase by it would also be imposed on its customers outside the proposed geographic market. Any competitive reaction from suppliers serving such customers that rendered the price increase unprofitable would mean the proposed market failed the HMT.

[356] That a proposed market satisfies the HMT does not itself satisfy the FTC's burden of proving a relevant geographic market. *Jefferson*, 2020 WL 7227250, at *13.

13. The FTC's expert, Dr. Dafny, did not perform an HMT using a proposed geographic market defined by patient location (as the FTC's proposed market is), but rather performed an HMT using a proposed market defined by hospital location (which is not the FTC's proposed market here). This too is fatal, because a "market is properly defined" using the HMT only when a hypothetical monopolist could impose a SSNIP "*in the proposed market*." *Hershey*, 838 F.3d at 338 (citing *Guidelines* § 4 (emphasis added)).

14. The FTC's customer-based geographic market also ignores the commercial reality that patients excluded from the proposed market may have the same employer and health plan as those inside Bergen County, or may be closer to a Bergen County hospital than that County's residents are. This market definition thus distinguishes between Bergen County residents and non-residents in a way that neither payors nor providers do.

15. The FTC's hospital-based "confirmatory test" is flawed in its conception and incomplete. First, unlike the "iterative process" described by Dr. Dafny herself, this HMT test started *and* ended with six hospitals and failed to consider closer alternative hospitals that compete with the six hospitals. Thus, it ignores the FTC's own *Guidelines*, which instruct that in conducting the HMT, close competitors must be included in any candidate geographic market, even if a monopolist excluding them could impose a SSNIP. *Guidelines* §§ 4.2.1, 4.1.1 Ex. 6. This is to ensure, as

the *Guidelines* require, that a SSNIP be profitable. *Hershey*, 838 F.3d at 338. Second, merely calculating whether the hypothetical monopolist of six hospitals could charge a SSNIP is not the end to a geographic market analysis. *Jefferson*, 2020 WL 7227250, at *13 (the "Court's geographic market determination is not merely a 'statistical exercise' looking for a hypothetical monopolist that can impose a SSNIP."). Substitute hospitals to which insurers "could practicably turn" for GAC services must be considered to ensure the geographic market reflects the "commercial realities" of the industry. *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 359 (1963); *Hershey*, 838 F.3d at 342; *Jefferson*, 2020 WL 7227250, at *14 (FTC acknowledging that a "geographic market which passes the HMT must correspond with commercial realities.").

16. The FTC's reference to the so-called "silent majority fallacy"—"the false assumption that patients who travel to a *distant* hospital to obtain care significantly constrain the prices that the *closer* hospital charges to patients who will not travel to other hospitals"—is a red herring. *Hershey*, 838 F.3d at 341 (emphasis added). That alleged fallacy is irrelevant both because the hospitals Bergen County residents visit as alternatives to Englewood and HUMC are not *distant* competitors and because the FTC has a patient-based rather than "supplier-based market definition" which makes *Hershey* "a totally different case." Hr'g Tr. 1542:9-11, May 18 (Dr. Dafny).

17. The FTC also ignores the commercial reality that, from the standpoint of insurers, HUMC and Englewood are complements, not substitutes. Although Dr. Dafny posits that diversion ratios, along with insurers' redirection and termination analyses, indicate HUMC and Englewood are substitutes, these "measures of patient substitution … do not translate neatly into options for insurers." *Advocate*, 841 F.3d at 475; *see also Jefferson*, 2020 WL 7227250, at *13. Dr. Dafny's analyses show only that HUMC and Englewood compete for some patients at Stage 2; not that HUMC and Englewood are substitutes for insurers during Stage 1 competition. *Hershey*, 838 F.3d at 342.

18. To measure market concentration, the FTC and the *Guidelines* use the HHI metric, which sums the squares of the relevant firms' market shares. Mergers that result in post-merger HHIs above 2,500 through an increase in HHI of over 200 are presumed to likely enhance market power. *Guidelines* § 5.3.

19. Before an HHI can be calculated, however, a relevant antitrust market must be defined. *See FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1222 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995). Here, the FTC's HHI analysis is not based on a properly defined geographic market. Moreover, even minor adjustments to the FTC's proposed market result in post-merger HHIs below the 2,500 threshold. The fact that small changes in the definition of the market generate large changes in the HHI

demonstrate that the FTC's market definition is unreliable. *See Guidelines* § 4. Thus, the FTC is not entitled to any presumption of enhanced market power.

C. The FTC Has Not Established Anticompetitive Effects Are Likely.

20. Setting aside the FTC's failure to make a prima facie case based on market-shares, which are not themselves "conclusive indicators of anticompetitive effects," "a further examination" of northern New Jersey's market realities, including "its structure, history and probable future," demonstrates that such effects are unlikely. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974) (quoting *Brown Shoe*, 370 U.S. at 322 n. 38).

21. The FTC's market share evidence "produce[s] an inaccurate account of the merger's probable effects on competition in the relevant market." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116 (D.D.C. 2004) (internal citations omitted). The FTC therefore bears "the burden of producing additional evidence of anticompetitive effect," which "merges with the ultimate burden of persuasion, which remains with the government at all times." *Baker Hughes*, 908 F.2d at 982-83, 991.

22. The FTC's central claim of anticompetitive harm is that the merged entity will be able to "unilaterally" charge higher prices to commercial insurers. However, insurers' current ability to resist price increases (or impose price decreases) on Defendants will not change post-merger, as there is no basis in the record to find that the acquisition of Englewood will materially increase HMH's existing bargaining

leverage with insurers.

23. The "rough estimate" of a price effect by the FTC's expert is unreliable, as it converts patient (as opposed to insurer) preferences to prices by selecting a single coefficient from a study of mergers outside New Jersey (the Garmon study) rather than by using available insurance claims data in northern New Jersey.

24. Market responses by competitors (*i.e.*, "repositioning"), such as building a new hospital, adding beds, or entering more fully into GAC services, will further constrain Defendants' ability to raise prices. *See Hershey*, 838 F.3d at 351-52.

D. Substantial Procompetitive Benefits Will Result from the Merger and Rebut the FTC's Claims that Anticompetitive Harm is Likely.

25. Defendants rebutted any FTC claim of anticompetitive effects by producing substantial evidence that the Merger will create significant procompetitive benefits in the form of direct cost-savings to insurers and enhanced quality of care for patients. Because "such evidence is relevant to the competitive effects analysis," it must be considered when determining if the FTC has carried its burden. *Arch Coal*, 329 F. Supp. 2d at 151; *see also*, *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999).

26. Defendants produced evidence demonstrating procompetitive benefits in the form of direct cost savings to insurers through their Framework, and through improved quality. Such evidence rebuts the FTC's and Dr. Dafny's "rough estimate" of a price effect and demonstrates that that this merger will be procompetitive.

E. Additional Cost Efficiencies Further Offset Plaintiff's Estimate of Potential Harm.

27. "[W]hether an acquisition would yield significant efficiencies in the relevant market is an important consideration in predicting whether the acquisition would substantially lessen competition." *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1222 (11th Cir. 1991). Anticompetitive effects can be offset by efficiencies that are "merger specific," *i.e.*, "cannot be achieved by either company alone"; "verifiable, not speculative"; and do not arise from "anticompetitive reductions in output or service." *Hershey*, 838 F.3d at 348-49 (internal quotation omitted).

28. The efficiencies identified by Defendants' expert, Lisa Ahern, meet these criteria. Efficiencies are procompetitive if they, for example, "lower[] prices or improv[e] the quality of [] services." *Id.* at 350. Here, the efficiencies would reduce costs and allow the combined HMH-Englewood to reduce payments by commercial insurers, improve quality of care, and strengthen Englewood (in the face of declining government reimbursement rates). *Id*.

29. There is no requirement that Defendants prove that these efficiencies, or any other procompetitive benefits of the Merger, could not alternatively be achieved by a different hypothetical transaction. Rather, efficiencies are merger-specific where "they 'cannot be achieved by either company alone' as otherwise those benefits could be achieved 'without the concomitant loss of a competitor.'" *See New York v. Deutsche Telekom AG, et al.*, 439 F. Supp. 3d 179, 210 (S.D.N.Y. 2020) (quoting

Hershey, 838 F 3d at 348). Moreover, any alternative merger would be "theoretical," "speculative," and not "reasonably practical, especially in the short term." *See id.* at 212-13; *Guidelines* § 10.

II. The Balance of Equities Weighs Against the Injunction.

30. Even if Plaintiff could show likelihood of success, the Court "must still weigh the equities in order to decide whether enjoining the merger would be in the public interest." *Hershey*, 838 F.3d at 352 (quoting *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 726 (D.C. Cir. 2001)). The equities analysis turns on "whether the harm that the Hospitals will suffer if the merger is delayed will . . . harm the public more than if the injunction is not issued." *Id*. Private and public equities may be considered. *Id*.

31. Issuing the injunction will derail the Merger and eliminate a unique opportunity to optimize care by relieving capacity constraints and expanding complex care at HUMC, and by transforming Englewood into a tertiary hub—and thereby denying the community of these significant healthcare benefits. Hr'g Tr. 791:22-792:11, May 14 (R. Garrett, HMH). Conversely, denying the injunction will permit these benefits of the Merger to translate into improved quality of care throughout northern New Jersey.

32. The private and public equities, therefore, strongly support denying the injunction. *See Hershey*, 838 F.3d at 353.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 2nd day of June, 2021, a true and correct copy of the foregoing was filed and served electronically by the Court's CM/ECF system upon all registered users in this action.

/s/ Paul H. Saint-Antoine
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