No. 21-2603

In the United States Court of Appeals for the Third Circuit

FEDERAL TRADE COMMISSION, PLAINTIFF-APPELLEE

v.

HACKENSACK MERIDIAN HEALTH, INC. AND
ENGLEWOOD HEALTHCARE FOUNDATION, DEFENDANTS-APPELLANTS

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

BRIEF OF AMICI CURIAE PROFESSORS OF LAW AND ECONOMICS, ECONOMISTS, AND HEALTH POLICY RESEARCHERS IN SUPPORT OF APPELLEE URGING AFFIRMANCE

Douglas F. Johnson, Esquire
NJ Bar ID: 035371982
EARP COHN P.C.
20 Brace Road, Suite 400
Cherry Hill, NJ 08034
(856) 354-7700 (telephone)
(856) 354-0766 (facsimile)
dfjohnson@earpcohn.com

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IDENTITIES AND INTERESTS OF AMICI CURIAE

The *amici* are professors of law and economics, economists, and health policy researchers. *Amici* have testified before Congress as well as state legislatures regarding the harms of consolidation within healthcare markets in the United States. They have also conducted extensive research and have published widely on topics of healthcare consolidation, the role of states and the federal antitrust enforcement agencies in addressing that consolidation, and antitrust law in health care. Their interest in this case is to illustrate the harms of consolidation of healthcare markets. In this case, they have examined the district court's August 4, 2021 opinion and based on their expertise, the evidence before the court, and other publicly available information discussed herein, *Amici* have concluded that the court properly preliminarily enjoined the proposed merger of Hackensack Meridian Health and Englewood Healthcare Foundation. The following *Amici* submit this brief to aid the Court's consideration of this important issue:

Thomas L. Greaney, J.D., is a visiting professor at the University of California Hastings College of the Law and the Chester A. Myers Professor Emeritus at Saint Louis University School of Law.

Alexandra D. Montague, J.D., is a Health Policy Researcher at The Source for Healthcare Price and Competition at the University of California Hastings College of the Law.

Jaime S. King, J.D., Ph.D., is the John and Marylyn Mayo Chair in Health Law and Professor of Law at the University of Auckland, Faculty of Law, Senior Affiliate Scholar to the UCSF/UC Hastings, Consortium on Science, Law and Health Policy, and the Executive Editor of The Source on Health Care Price and Competition.

Richard M. Scheffler, Ph.D., is a Distinguished Professor of Health Economics and Public Policy and Director of The Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare at the University of California, Berkeley.

Katherine M. Gudiksen, M.S., Ph.D., is a Senior Health Policy Researcher for The Source on Healthcare Price and Competition.

Brent D. Fulton, Ph.D., MBA, is an Associate Adjunct Professor of Health Economics and Policy, School of Public Health and Associate Director of The Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare at the University of California, Berkeley.

Daniel R. Arnold, Ph.D., is an Assistant Research Economist in the School of Public Health and Research Director of The Nicholas C. Petris Center on Healthcare Markets and Consumer Welfare at the University of California, Berkeley.

Amici professors**,** lawyers, economists, and scholars file this brief pursuant to Rule 29(a) of the Federal Rules of Appellate Procedure with the consent of all parties to this appeal.

Counsel for the Appellee did not author the brief in whole or in part. Appellee's counsel did not contribute financial support intended to fund the preparation or submission of this brief. No individual(s) or organization(s) contributed financial support intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case is yet another in a long series of attempted hospital mergers that are remarkable for their boldness. One is hard-pressed to find another industry in which firms repeatedly propose mergers to near monopoly and do so in the face of legal precedent. The willingness to propose such mergers reflects an apparent belief that there is no merger not worth trying. The cause is not the lack of enforcement or clarity of legal precedent but rather a disproportionate risk/reward structure. The potential long-term reward of supercompetitive profits in health care assured by entry barriers and regulatory protections greatly outweigh the costs of undertaking mergers. In recent years, five hospital mergers have been successfully challenged in federal court by the Federal Trade Commission with only one resulting in a judgement for the merging entities.[1] A number of other highly concentrative

[1] The five cases include*: FTC. v. OSF Healthcare Sys*., 852 F.Supp. 2d 1069 (N.D. Ill. 2012); *ProMedica Health System, Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014); *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys*., Ltd., 778 F.3d 775, 784 (9th Cir. 2015); F.T.C. v. Advocate Health Care Network, 841 F.3d 460, 474 (7th Cir. 2016*); FTC v. Penn State Hershey Medical Ctr*., 838 F.3d 327, 344

mergers were abandoned after receiving inquiries from antitrust enforcers. *See, e.g.,* Order Dismissing Complaint, In the Matter of Reading Health System and Surgical Inst. of Reading, FTC Docket No. 9353 (Dec. 7, 2011). Notably most of these cases have involved mergers to monopoly or near monopoly levels as commonly defined by antitrust law standards.[2]

The likely adverse effects of hospital mergers of this kind are well-documented in the record of this case and the extensive economic literature concerning hospital market concentration. The unmistakable lessons of the evidence adduced at trial, confirmed by extensive academic studies, are: (1) people strongly prefer to receive acute care hospital services close to home and accordingly antitrust markets are highly localized; (2) competition among hospitals occurs in two stages, with the first stage—bargaining between hospitals and payers for inclusion in payer networks—being the pivotal juncture that determines prices; (3) increases in bargaining leverage from elimination of close competitors allows hospitals to demand higher payments from insurers, which ultimately results in higher insurance premiums and co-pays for employers and individuals; and (4) promised efficiencies

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(3d Cir. 2016). The one loss: Order, *FTC et al. v. Thomas Jefferson University et al.*, No. 2:20-cv-01113 (E.D. Pa. 2020).

[2] For example, in *ProMedica* post-merger market shares of 50% for primary and secondary services and 80.5% for obstetrical services. Likewise in *Hershey* 78% of general acute care hospital services and in *Advocate* 60% of acute care hospital services. In *St. Luke's*, the hospital acquisition led to combining 80% of primary care physician providers.

from hospital mergers are often overstated, and the elimination of competition reduces quality of care and innovation. *See generally* DAVID DRANOVE & LAWTON ROBERT BURNS, BIG MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTH CARE IN AMERICA (2021).

The district court's assessment of the pertinent facts and likely consequences of the merger identify precisely the circumstances the Clayton Act was designed to address: Hackensack Meridian Health's two hospitals and Englewood are close competitors in Bergen County and eliminating their rivalry will likely lead to higher prices and reduced incentives for providing quality care and innovation. The hospitals' primary defense—that the district court incorrectly identified Bergen County as the relevant antitrust market—misapprehends the standard for defining geographic markets and ignores unique aspects of payer/hospital bargaining. Furthermore, claimed justifications must clear the high bar of constituting "extraordinary great cognizable efficiencies" where, as here, a strong *prima facie* case has been presented. Finally, the amicus brief of the New Jersey Hospital Association does not adequately portray the relationship between state merger review under charitable trust law and antitrust law.

ARGUMENT

I. THE POTENTIAL HARMS FROM HOSPITAL CONSOLIDATION ARE WELL DOCUMENTED.

While it is well known that America spends more on health care than other developed nations without commensurate increases in quality, access, or outcomes, the significant role that provider consolidation and market power play in health care spending is less well-known. Many experts agree that health care markets are not functioning well. For example, Professor Martin Gaynor testified before the U.S. Senate Judiciary Committee that "[p]rices are high and rising . . . they vary in seemingly incoherent ways, there are egregious pricing practices . . . there are serious concerns about the quality of care, and the system is sluggish and unresponsive, lacking the innovation and dynamism that characterize much of the rest of our economy." *Hearings before the Sen. Com. on the Judiciary, Subcom. on Competition Policy, Antitrust, and Consumer Rights on Antitrust Applied: Hospital Consolidation Concerns and Solutions*, 117th Congress, 1st Sess. (2021) (statement of Professor Martin Gaynor, Carnegie Mellon University).

An extensive—and largely undisputed—literature demonstrates that anticompetitive consolidation enables merging hospitals to gain market power which leads to immediate price effects. As summarized by a recently published report by Medicare Payment Advisory Commission (MedPAC), the "preponderance of the research suggests that hospital consolidation leads to higher prices." MEDPAC,

MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 470 (2020). Nearly all studies have found that prices increased following a hospital merger, with a comprehensive meta-study concluding that most studies found the magnitude of prices increases to be quite significant, with most exceeding 20%. Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update,* THE SYNTHESIS PROJECT: ROBERT WOOD JOHNSON FOUND. 2 (2012). Another important study found that following a merger, three-quarters of the hospitals studied increased prices by more than the median price increase and no merging hospital had price increases below the median price increase. Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFF. 175 (2004).

An extensive body of research has also shown that quality of care suffers where there is less competition. While one study funded by the American Hospital Association (AHA) that examined all consummated mergers between 2009 and 2014 found "small improvements in quality for some quality measures" following the merger, the majority of studies have not found similar results. Monica Noether & Sean May, *Hospital Merger Benefits, a Review and Extension*, AM. HOSP. ASS'N. (2018). For instance, a study published in 2020 found that acquired hospitals' outcome measures did not improve post-merger. Nancy Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382 NEJM 51(2020). That study also found that patient experience measures worsened after a merger. *Id.*

Provider merger enforcement cases have also uniformly found that alleged efficiencies do not outweigh competitive harms. *See, e.g., FTC v. Penn State Hershey Medical Center*, 838 F.3d 327, 349-51 (3d Cir. 2016); *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd.*, 778 F.3d 775, 789 (9th Cir. 2015); *FTC v. OSF Healthcare System*, 852 F. Supp. 2d 1069, 1089. (N.D. Ill. 2012). Indeed, no court has upheld a presumptively unlawful hospital merger based on the improvements in quality it would, or did, generate. JOHN J. MILES, HEALTHCARE AND ANTITRUST LAW, REBUTTING THE PRIMA FACIE CASE—EFFICIENCIES § 12:18 (2021).

Courts have long recognized that the central intent of the Clayton Act is "that tendencies towards concentration . . . are to be curbed in their incipiency" in order to prevent the exercise of market power by firms that might attain a dominant position through acquisitions. *Brown Shoe v. United States*, 370 U.S. 294, 346 (1962). The experience of the health care sector reflects the legitimacy of that concern, as markets around the nation have experienced the harmful consequences of neglecting rampant hospital acquisitions by large systems. According to one study, 90% of Metropolitan Statistical Areas (MSAs) are highly concentrated for hospitals. Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFF. 1530, 1533 (2017). As health systems grow across markets, recent research shows that they are able to

leverage their market power accumulated in one market to other markets in which they have hospitals, enabling them to raise prices beyond the local markets in which each of their hospitals compete. These large systems are able to raise prices across the board by various techniques, such as "all-or-nothing contracting"— which enables the health system to leverage the market power of its "must have" facilities to extend those monopoly rates to all of its facilities, including those in more competitive markets. After-the-fact remedies to health system market power are of course available. For example, the Attorney General of California has challenged such contracting practices by a dominant hospital system. *See* Complaint, People of California ex rel Xaviar Becerra v. Sutter Health, CGC 18-565398 (Cal. Super. Ct. 2019). States have also begun to adopt legislation targeting anticompetitive contracting practices by dominant health systems. *See* Katherine Gudiksen et al., *Preventing Anticompetitive Contracting Practices in Healthcare Markets*, THE SOURCE ON HEALTHCARE PRICE AND COMPETITION (2020). However, neither after-the-fact litigation nor legislation is an ideal solution to market power. The better course is found in the Clayton Act's mandate to arrest concentration in its incipiency.

II. THE DISTRICT COURT UNDERTOOK THE APPROPRIATE GEOGRAPHIC MARKET ANALYSIS.

The task of delineating hospital geographic markets has proven to be the hobgoblin of antitrust merger litigation. For many years, enforcers and courts applied the Elzinga Hogarty (EH) test which relied on patient flow data as the

primary tool for market definition. However as theoretical economic studies and retrospective evaluations of consummated hospital mergers eventually revealed, EH was highly inaccurate because it assumed the willingness of a few patients to travel for hospital care implied that a larger number would also do so if prices increased. Cory Capps et al., *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers* (NBER, Working Paper No. 8216, 2001). Courts have uniformly abandoned the EH test, and now apply more holistic approach, using sophisticated econometric tests, together with documentary evidence and buyer testimony to answer the widely accepted hypothetical monopolist test that frames market definition. However, because market definition is a highly complex undertaking especially in health care, it will always be a convenient target for litigation. But in this case the factual predicate for geographic market definition is not controversial. The district court's analysis was entirely consistent with the methods and evidence relied upon in prior hospital merger cases.

In concluding that the relevant geographic market consisted of Bergen County, the district court relied upon multiple indicia used to define markets used in the numerous hospital merger cases cited above. It examined evidence from the merging parties' ordinary course documents, testimony and contracting practices of insurers, hospital usage patterns by Bergen County residents, and the empirical studies and opinions set out by the FTC's economic expert. Of particular note was

a key factual finding that the hospitals apparently do not dispute: that health insurers could not sell their plans to Bergen County residents and employers without any Bergen County hospitals included in their provider networks. The unmistakable result, confirmed by New Jersey's largest insurer, Horizon Blue Cross & Blue Shield of New Jersey, is that payers would have to accept any hospital rate increases demanded by Hackensack. These findings are fully supported by testimony and documentary evidence demonstrating the importance of Bergen County hospitals to local residents and the insurers and employers that contract with them.

Faced with the oncoming rush of multiple indicators confirming the validity of the geographic market identified by the district court, the Appellants offer up a novel Hail Mary defense. *Cf. ProMedica Health System Inc. v. FTC*, 749 F.3d 559, 572 (2014). Their claim is that defining geographic markets based in part on patient preferences requires proof of price discrimination, i.e. that patients inside the market pay more for commercial insurance than those outside the alleged market. This argument is flawed in several respects. First, it is based on a misreading and misunderstanding of the government's Horizontal Merger Guidelines. Not only is it clear that those advisory guidelines are not binding, and do not rigidly impose a single methodology, the language in the Guidelines is permissive and is not intended to cabin the flexibility or breadth of analysis. *See FTC v. Penn. State Hershey Medical Ctr.*, 838 F.3d 327, 338 n.2 (2016); U.S. Dep't of Justice & FTC, *Horizontal*

Merger Guidelines, §§ 1, 4.2 (2010). Moreover, application of a price discrimination requirement to hospital/payer bargaining does not accommodate the fact that competition occurs in two stages. Because prices are the product of negotiations in the first stage, when insurers and hospitals are bargaining over inclusion in the payers' networks, while the service is delivered in the second stage when the patient travels to the hospital, the essence of the transaction seems to fall somewhere between those that are based on where the customer receives services and where the supplier is located.[3] *See* Cory Capps et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L. J. 441, 490 (2019). That is, under the two-stage process that determines price in payer-hospital contracting, a kind of price discrimination *does* occur, as insurers individually negotiate contracts on behalf of patients (i.e., their customers) with hospitals, and hospitals can and do charge different prices to different insurers. In any event, it is evident from the district court's analysis that the evidence also satisfied a hospital-based approach. That is, insurers' testimony and other evidence demonstrated that commercially viable plans needed to include Bergen County hospitals and that they would have to

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[3] Cory Capps notes that "the economic transaction aligns more closely, though perhaps not perfectly, with the language [of the Guidelines] describing geographic markets based on the location of customers" which do not require a showing of price discrimination. However, Capps goes on to note that the distinction is "only relevant to the structural exercise of calculating market shares and drawing inferences from concentration statistics."

pay more than a "small but significant and non-transitory increase" in price to a hypothetical monopolist of all hospitals in the county. That evidence fully satisfied the federal Horizontal Merger Guidelines hypothetical monopolist test for defining a geographic market. U.S. Dep't of Justice & FTC, *Horizontal Merger Guidelines*, § 4.2 (2010).

III. THE DISTRICT COURT PROPERLY PLACED A HIGH BURDEN ON CLAIMS OF PROCOMPETITIVE EFFECTS.

Appellants contend that evidence of procompetitive effects should have been sufficient to rebut the Appellee's *prima facie* case. However, extensive precedent as well as the Horizontal Merger Guidelines make it clear that the court utilized the appropriate standard. Indeed, contrary to the Appellants' contention, requiring "extraordinary efficiencies" to justify highly concentrative mergers is supported by ample precedent. Multiple cases have required proof of "extraordinary efficiencies" when the court finds that the merger would result in high post-merger concentration as the district court did in this case. *See FTC v. H.J. Heinz Co*., 246 F.3d 708, 720 (D.C. Cir. 2001); *FTC v. Advocate Health Care*, 2017 WL 1022015 at *12 (N.D. Ill. 2017); *United States v. Aetna Inc*., 240 F. Supp. 3d 1, 94 (D.D.C. 2017); *FTC v. Sysco Corp*., 113 F. Supp. 3d 1, 81–82 (D.D.C. 2015). Additionally, the well-respected antitrust treatise by Phillip Areeda and Herbert Hovenkamp also asserts that "extraordinary" efficiencies should be required where the "HHI is well above 1800 and the HHI increase is well above 100." *FTC v. H.J. Heinz Co*., 246 F.3d

708, 720 (D.C. Cir. 2001) (citing PHILLIP AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 971f). Here, the district court found the post-merger HHI to be 2,835 and a change in HHI 841, well above those thresholds. Dist. Ct. Op. 44–45. There is no question that precedent places a high burden on defendants. In the healthcare context, courts evaluating health care mergers have uniformly found that alleged efficiencies do not outweigh competitive harms. *See, e.g., FTC v. Penn State Hershey Medical Center*, 838 F.3d 327, 349-51 (3d Cir. 2016); *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd.*, 778 F.3d 775, 789 (9th Cir. 2015); *FTC v. OSF Healthcare System*, 852 F. Supp. 2d 1069, 1089 (N.D. Ill. 2012). In fact, it appears no court has ever held that claimed efficiencies alone outweigh a presumptively anticompetitive merger. Herbert J. Hovenkamp, *Appraising Merger Efficiencies*, 24 GEO. MASON L. REV. 703, 714 (2017).

There are sound reasons for placing a high burden on justifications. First, evaluating the extent and efficacy of future adjustments to delivering health care and changing administrative processes is inherently uncertain. Moreover, as Professor Hovenkamp has argued, because the market share and concentration thresholds applied in the case law and merger guidelines are highly tolerant of horizontal mergers, and probably understate the risks of consolidation, a very high bar for such claims is entirely warranted. *Id.* That is, an implicit recognition of efficiency

benefits is already hard-wired into merger law and thus it is appropriate to insist on convincing evidence of benefits in order to excuse highly concentrative mergers. Lastly, a high burden on justifications is warranted given the extreme practical difficulties of unwinding a consummated merger, often referred to as "unscrambling the egg." Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564, 1565 (2017). Given this difficulty mergers should be manifestly justified in order to move forward.

IV. THE DISTRICT COURT ALSO PROPERLY EVALUATED POTENTIAL ANTICOMPETITIVE EFFECTS ON QUALITY AND INNOVATION.

Measuring or assessing post-merger changes in the quality of care against the merger's likely anticompetitive effects can be a complex endeavor. Potential improvements in quality are often difficult to measure and there is little guidance from precedent. For that reason it is not surprising that "[no] appellate decisions have actually held that a § 7 defendant has rebutted a prima facie case with an efficiencies defense." *Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System Ltd.*, 778 F.3d 775, 789 (9th Cir. 2015); JOHN J. MILES, HEALTHCARE AND ANTITRUST LAW, REBUTTING THE PRIMA FACIE CASE—EFFICIENCIES § 12:18 (2021). In fact, the preponderance of economic evidence tends to show that "hospital consolidation more likely decreases quality than increases it." William Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, THE SYNTHESIS PROJECT: ROBERT WOOD JOHNSON FOUND. 1, 11

(2006). However, the record in this case contains probative evidence that the merger would actually *reduce* quality and innovation. In practice, the hospitals monitored each other's quality ratings and clinical improvements in an attempt to maintain an edge against one another. Dist. Ct. Op. at 53. The court correctly held that eliminating rivalry between the hospitals "would remove incentive for both entities to continue to improve quality metrics and offer innovative medical technology." *Id*. The court's consideration of this direct evidence of diminished competition on quality was properly weighed as a facet of the anticompetitive effects of the merger.

V. THE REVIEW PROCESS AND RECOMMENDATIONS OF NEW JERSEY'S DEPARTMENT OF HEALTH AND ATTORNEY GENERAL SHOULD NOT BE AFFORDED SIGNIFICANT WEIGHT.

The amicus brief filed by the New Jersey Hospital Association argues that the merger review processes by the New Jersey Department of Health and Attorney General should be afforded deference by the court and the FTC. We disagree. Similar state merger review processes, like the one set out in New Jersey's Community Health Care Assets Protection Act (CHAPA), are found in many state nonprofit corporation and charitable trust laws. *See Market Consolidation*, THE SOURCE ON HEALTHCARE PRICE AND COMPETITION, https://sourceonhealthcare.org/market-consolidation/. The primary goal of these laws is to assure that these entities fulfill their charitable mission. The New Jersey statute illustrates that its purpose is to ensure that "appropriate steps have been taken

to safeguard the value of the charitable assets of the hospital and to ensure that any proceeds from the proposed acquisition are irrevocably dedicated for appropriate charitable health care purposes." *See* N.J.S.A. 26:2H-7.11(b). The CHAPA process also does not purport to conduct an in-depth competitive analysis. Indeed, the mandate of the inquiry makes it clear that a broad array of factors are considered. *See id*. Plainly, CHAPA and the Clayton Act are not analyzing the same thing. The FTC and the court clearly did not need to provide due deference to a decision reached under charitable trust law when engaging in the fact-intensive inquiry required under antitrust merger law.

CONCLUSION

For the foregoing reasons, this Court should affirm the preliminary injunction.

November 5, 2021

Counsel for Amici Curiae:

Thomas L. Greaney, J.D., Alexandra D. Montague, J.D., Jaime S. King, J.D., Ph.D., Richard M. Scheffler, Ph.D., Katherine M. Gudiksen, M.S., Ph.D., Brent D. Fulton, Ph.D., MBA, and Daniel R. Arnold, Ph.D.

Respectfully submitted,

/s/ Douglas F. Johnson

Douglas F. Johnson, Esquire
NJ Bar ID: 035371982
EARP COHN P.C.
20 Brace Road, Suite 400
Cherry Hill, NJ 08034
(856) 354-7700 (Telephone
(856) 354-0766 (Facsimile)
dfjohnson@earpcohn.com

CERTIFICATE OF BAR MEMBERSHIP

Pursuant to Third Circuit Local Appellate Rule 46.1, I, Douglas F. Johnson, certify that I am a member in good standing of the bar of the United States Court of Appeals for the Third Circuit.

Dated: November 5, 2021

By: */s/ Douglas F. Johnson*
Douglas F. Johnson, Esquire
NJ Bar ID: 035371982
EARP COHN P.C.

Counsel for Amici Curiae

CERTIFICATE OF COMPLIANCE

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

1. This brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29 (a)(5) and 32(a)(7)(B) because it contains 3,882 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

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

3. Pursuant to Third Circuit Local Appellate Rule 31.1(c), I certify that the text of the brief filed electronically with the Court via CM/ECF is identical to the text of the paper copies.

4. I further certify that the electronic version of the brief has been scanned for viruses by Sophos Anti-Virus software, and no viruses were detected.

Dated: November 5, 2021

By: *<u>/s/ Douglas F. Johnson</u>*
Douglas F. Johnson, Esquire
NJ Bar ID: 035371982
EARP COHN P.C.

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

Pursuant to Federal Rule of Appellate Procedure 25(d) and Local Rule 27.2, I hereby certify that on November 5, 2021, I electronically filed the foregoing Brief with the Clerk for the United States Court of Appeals for the Third Circuit using the appellate CM/ECF system. Service on counsel for all parties has been accomplished via CM/ECF and counsel to all parties are registered to use CM/ECF and receive service by a Notice of Docket Activity.

Dated: November 5, 2021

By: */s/ Douglas F. Johnson*
Douglas F. Johnson, Esquire
NJ Bar ID: 035371982
EARP COHN P.C.

Counsel for Amici Curiae