UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NORTH CAROLINA

FEDERAL TRADE COMMISSION, *Plaintiff*, v. NOVANT HEALTH, INC. and COMMUNITY HEALTH SYSTEMS, INC., *Defendants*.	Case No. 5:24-cv-00028-KDB-SCR **REDACTED VERSION OF DOCUMENT FILED UNDER SEAL (ECF NO. 214)**

DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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INTRODUCTION

The evidence overwhelmingly demonstrates that this transaction will improve the overall quality of care, inject much-needed capital investments, address severe staffing shortages, and expand in-demand service offerings at Lake Norman, while saving Davis from going completely dark. The evidence also overwhelmingly supports that this hard, but essential, work will lower the total cost of care and enhance competition (including with Atrium, the dominant healthcare system in the Charlotte area). Novant respectfully asks that it be given the opportunity to get to work immediately, preventing a further slide toward the precipice for both hospitals.

To obtain a preliminary injunction under Section 13(b), the FTC bears the burden of showing a "substantial likelihood" of success on the merits, *FTC v. Atl. Richfield Co.*, 549 F.2d 289, 291 (4th Cir. 1977), including that the transaction is likely to "substantially . . . lessen competition," 15 U.S.C. § 18 (Section 7 of the Clayton Act). If the FTC demonstrates a "substantial likelihood" of success, the Court then considers "the equities" of an injunction. *Atl. Richfield*, 549 F.2d at 292. There, the FTC must "demonstrate that the harm to the parties and the public that would flow from an injunction is outweighed by the harm to competition that would occur in the period between the injunction's denial and a final judgment on the merits." *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1227 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995).

The FTC has not met its burden. Rather, the evidence shows that the transaction is likely to *enhance* competition. As a standalone (mostly empty) hospital, Lake Norman has little chance of competing meaningfully against Atrium (or anyone else) in the future. A revitalized Lake Norman will spur other hospitals to compete more vigorously for patients, will give insurers a more credible alternative to secure rate discounts from Atrium, will give patients a higher-quality option close to home, and will bring Lake Norman's patients into Novant's existing contractual arrangements designed (and proven) to lower the total cost of care. *Infra* ¶¶ 117-127.

In the face of compelling evidence that the transaction will enhance competition, the FTC falls back on expert models and simulations to try to support a presumption that the transaction is anticompetitive. But the FTC's purported "markets"—and its market share and associated statistics derived therefrom—defy the commercial realities. *Infra* ¶¶ 105-115. After correcting even some of the obvious flaws in the FTC's analysis, the FTC's statistics fall below the thresholds in its own Merger Guidelines. *Infra* ¶ 116.

The equities also strongly support permitting Novant's investment and improvement in these hospitals immediately, even if the possibility of later divesture remains until the legal proceedings have run their course. *Infra* ¶¶ 130-132.

The central question for the Court is "what may happen if the merger occurs [compared] with what may happen if the merger does not occur." *FTC v. Nat'l Tea Co*., 603 F.2d 694, 700 (8th Cir. 1979). Here, the futures could not be more divergent. No other bidders wait in the wings to acquire Davis or Lake Norman. No joint ventures or partnerships are in the works. No capital infusions are coming from debt-laden CHS. If these hospitals are prohibited from joining Novant's high-quality, integrated system, Lake Norman's already precarious position will worsen, and Davis will close immediately. This transaction is the best, last, and only hope to revitalize Davis and Lake Norman—and doing so will resoundingly benefit the community.

DEFENDANTS' PROPOSED FINDINGS OF FACT

I. BACKGROUND

A. The Merging Parties: Novant Health and Community Health Systems

1. **Novant Health, Inc** is a not-for-profit North Carolina-based health system. Novant organizes its health system into regions, including one called the Greater Charlotte Market. Tr. 514:22-515:5 (Riley). Novant operates six hospitals in the Charlotte area, including Presbyterian Medical Center ("Novant Presbyterian") and Huntersville Medical Center ("Novant

Huntersville"). Tr. 834:1-10 (Ehtisham). These hospitals are located in Mecklenburg County. Novant does not own or operate a hospital in Iredell County. Novant employs a network of 3,200 physicians and other providers. Tr. 1480:4-14 (Oliver). Novant also operates the Novant Health Clinically Integrated Network, a network of independent and Novant-employed physicians that deliver high-quality, lower-cost services through value-based arrangements. *Id*.

2. Atrium and CaroMont are Novant's primary competitors in the Charlotte area. Tr. 1240:4-19 (Armato); Tr. 836:17-837:23 (Ehtisham); Tr. 507:4-18 (Riley). Novant does not consider Lake Norman to be a meaningful competitor. Tr. 510:8-24 (Riley); Tr. 1492:24-1495:9 (Oliver); Tr. 1243:7-15 (Armato); Tr. 836:17-837:23 (Ehtisham).

3. Novant is widely recognized as a high-quality healthcare system, Tr. 1547:18-1548:4 (Wyatt); Tr. 1245:6-13 (Armato); DX 008 (Iredell County Board); DX 011 (Dr. Korrapati), as established by numerous metrics. All of Novant's Charlotte-area hospitals, for example, have an "A" Leapfrog grade, and 4- or 5-star ratings from Vizient. Tr. 851:5-853:6 (Ehtisham); Tr. 509:22-510:7 (Riley); Tr. 1248:25-1249:16 (Armato); Tr. 1491:4-19, 1494:14-1495:5 (Oliver).

4. In particular, Novant significantly outperforms Lake Norman in numerous quality and safety measures, including Leapfrog grades and CMS-maintained measures of patient mortality, healthcare associated infections, and readmission rates. Tr. 1355:7-1359:7 (Jha); Tr. 852:19-853:6 (Ehtisham); Tr. 657:22-659:8 (Benet); DX 030; DX 035; DX 036.

5. Novant also has a track record of improving quality at its new and newly acquired hospitals. After Novant acquired Rowan Medical Center, for example, Novant improved quality within two years. Tr. 1245:18-1246:8, 1318:5-16 (Armato). Today, Rowan receives an "A" Leapfrog grade. *Id*. In 2018, Novant opened Mint Hill Medical Center, which, since it started

being graded by Leapfrog, has maintained an "A" grade, and is ranked second out of 336 hospitals in its Vizient cohort. DX668 at 027; *see also* Tr. 1513:10-22 (Oliver) (describing quality improvements at New Hanover after Novant's acquisition).

6. **Community Health Systems, Inc**. is an out-of-state, for-profit health system with 71 hospitals across 15 states. PX 5042 at 003 (CHS). CHS owns only two hospitals in North Carolina: Lake Norman Regional Medical Center and Davis Regional Psychiatric Hospital (previously, until 2022, called Davis Regional Medical Center).

7. **Lake Norman** is a general acute care hospital in Mooresville in Iredell County licensed for 123 beds. Tr. 769:5-7 (Music). Its average daily census has been declining for 20 years; it currently stands at 38 patients a day, meaning its average occupancy rate is 31%. Tr. 1703:9-1704:10 (Wu); DX 013; DX 014. As Lake Norman's Chief Quality Officer explained, "with the population growth in the area," Lake Norman "should be full;" instead, it is two-thirds empty. Tr. 770:4-11 (Music); *see also* DX 015 (occupancy rates for Charlotte hospitals showing most (and all Novant hospitals) above 60%).

8. As described more below, Lake Norman is "in a very fragile, vulnerable state." Tr. 725:25-726:6 (Music). For years, CHS has failed to invest in the hospital, and it has struggled to maintain services. From 2007 to 2023, for example, the number of services offered, as measured by Medicare Severity Diagnosis-Related Groups ("MS-DRGs"), declined by approximately 30%. DX 016. (The MS-DRGs offered by Novant Huntersville, in contrast, have remained steady throughout that time period. PX 4022.) Per-bed capital expenditures at Lake Norman are significantly below Novant and other area hospital systems, DX 018, a trend that has persisted for years, DX 017. From 2017-2022, for example, Novant invested an average of $127,909 per licensed bed while Lake Norman invested an average of $35,431 per bed. DX 017;

DX 001 at 222 (Wu). As a standalone hospital without a meaningful network of employed or affiliated medical providers, Lake Norman also has had difficulty recruiting and retaining physicians and nursing staff, and maintaining its quality of care, resulting in large swaths of unused spaces and service line closures. *Infra* ¶¶ 22-32.

9. **Davis**, located in Statesville in Iredell County, was formerly a 144-bed general acute care hospital. It struggled for years with low volume and reduced service lines. Tr. 1574:15-1575:2 (Hammons); Tr. 236:7-237:6 (Littlejohn). In 2022, Davis shut down all of its acute care offerings; it now operates only 42 behavioral health beds. Tr. 236:4-6 (Littlejohn).

B. The Charlotte Area Healthcare Landscape

10. The Charlotte area is growing rapidly. Tr. 567:24-569:3 (Haynes); Tr. 204:16-20 (Littlejohn); Tr. 770:8-12 (Music). That growth will continue to increase demand for healthcare services offered by Atrium, Novant, CaroMont, and other Charlotte-area providers.

11. **Atrium Health** is the largest health system in North Carolina. According to a 2018 statement filed by the United States and the State of North Carolina, Atrium is the "dominant hospital system in the Charlotte area," with a market share of "more than 55 percent." DX 493 at 006. Atrium is approximately twice as large as Novant in the Charlotte area, whether measured by number of hospitals, licensed beds, outpatient sites, or patient volume. Tr. 574:10-25 (Haynes); DX 001 at 188 (Wu); Tr. 239:15-16 (Littlejohn).

12. Atrium operates more than a dozen hospitals in the Charlotte area. Its flagship facility, Carolinas Medical Center ("CMC"), is the largest hospital in Charlotte with over 1,000 beds. DX 001 at 014, 036 (Wu). Atrium's other Charlotte-area hospitals include University City, Cabarrus, Mercy, Union West, Pineville, and several others. *Id*. Atrium attracts patients to its many nearby hospitals with its "front door" strategy, Tr. 571:10-575:19, 585:16-586:22 (Haynes), and has more ambulatory surgery centers, employs more physicians, and treats more

patients than all other Charlotte-area hospital competitors combined, DX 001 at 23-24, 188 (Wu). Atrium also operates a number of freestanding emergency departments, including ones located in Huntersville and Mountain Island. Tr. 507:8-18 (Riley); Tr. 572:4-574:9 (Haynes); Tr. 837:24-838:7 (Ehtisham). As two separate witnesses put it: "They're everywhere." Tr. 507:10 (Riley); Tr. 775:14-16 (Music).

13. Atrium Lake Norman will open in Cornelius in 2025—between Novant Huntersville and Lake Norman—initially with 30 inpatient beds and 8 observation beds. Tr. 555:5-6 (Haynes); Tr. 1241:22-1242:5 (Armato). Atrium Lake Norman [redacted] Tr. 596:2-17 [redacted]; DX 100 at 026 [redacted] ("[W]e have 30 beds approved [redacted] Atrium plans to "expand [Atrium Lake Norman] as needed with the population" and already has zoning approval for up to 140 beds at that facility. Tr. 596:18-597:20. Atrium's representative testified that the building site has even further capacity for Atrium "to do a whole lot more than that" and "go extremely large." Tr. 597:1-16 (Haynes).

14. Atrium will need Certificate of Need ("CON") approval to expand. However, Mecklenburg County has identified a need for new beds every year for the past five years, and Atrium has applied for every bed every year. Tr. 598:9-18 (Haynes). Atrium also can move beds between its existing facilities. Tr. 837:24-839:10 (Ehtisham); Tr. 990:13-991:14 (Murphy).

15. **CaroMont Health** operates a 439-bed general acute care hospital in Gastonia and a facility in Mount Holly with a free-standing emergency department. Tr. 969:24-970:14, 994:12-19 (Murphy). CaroMont is building a new 54-bed hospital in Belmont—less than a 30-minute drive from Novant Huntersville—which will open this year. Tr. 974:21-975:21 (Murphy). CaroMont has CON approval to add 24 more beds to the Belmont hospital. *Id*. CaroMont also

has an affiliated medical group of over 400 providers covering 50 locations. Tr. 996:13-19.

16. CaroMont considers Atrium and Novant to be its competitors, particularly Novant Presbyterian and Atrium CMC, even though both hospitals are located outside of CaroMont's service area. Tr. 984:18-985:20 (Murphy). CaroMont's service area includes Lincoln County, where Novant Huntersville also competes for patients. Tr. 993:6-994:7 (Murphy).

17. **Iredell Health System** operates a general acute care hospital in Statesville. Tr. 682:10-15 (Green). Iredell opened Iredell Mooresville, a 68,000 square foot facility offering 24-hour urgent care, imaging, surgery, rehab, occupational medicine, and primary care. Tr. 682:16-683:2 (Green). Iredell has two ambulatory surgery centers, an urgent care in Statesville, and around 25 physician or provider practices. *Id*. Iredell is closer to Hickory and Winston-Salem than to Charlotte. Tr. 715:1-20 (Green).

18. Other health systems in the area include (1) Catawba Valley Health System, which operates Catawba Valley Medical Center in Hickory; and (2) Duke LifePoint, which operates Frye Regional Medical Center in Hickory. Tr. 715:6-8 (Green). There are also other hospitals, including Atrium-Wake Forest Baptist, in Forsyth County. DX 001 at 024 (Wu).

19. The four largest insurance companies in the Charlotte area are Blue Cross Blue Shield of North Carolina ("Blue Cross"), United Healthcare ("United"), Cigna HealthCare of North Carolina ("Cigna"), and Aetna. DX 001 at 031 (Wu). In the ordinary course of its business, Blue Cross identifies a "Charlotte" market, which includes Mecklenburg County and six other counties, but not Iredell County. Tr. 154:2-13 (Page). United, Cigna, and Aetna refer to Charlotte and the surrounding counties as the "Charlotte area" market. Tr. 368:24-369:5 (Daniels); Tr. 1632:4-18 (Keibler); Pruski Decl. Ex. 1 (DX 218 (Cigna)).[1]

[1] Exhibits not admitted at trial are attached to the Declaration of Carol J. Pruski, filed herewith.

C. The Proposed Acquisition and Rationale

1. CHS's Troubled Financial Condition

20. CHS has struggled financially for years. Tr. 706:6-20 (Green). It carries approximately $11.5 billion in debt and owes $1 billion in debt payments in every year except one between 2026 and 2032. Tr. 1564:7-9 (Hammons); PX 5042 at 79, 95, 103. Interest payments on its debt alone have amounted to roughly $800 million per year in each of the past few years. PX 5042 at 79, 95, 103. Over $2 billion of debt payment is due as early as 2026. *Id*. CHS's debt rating is a CCC, which carries junk bond status. Tr. 1565:1-3 (Hammons).

21. CHS does not generate enough cash flow to cover its costs. Tr. 1564:10-15 (Hammons). In 2023, CHS was forced to borrow $400 million to fund its operations. Tr. 1564:16-25 (Hammons). Due to high interest rates and CHS's poor credit rating, refinancing, when possible, is extremely expensive. Tr. 1615:16-22 (Hammons). CHS therefore prioritizes investments in regions where it has a network of facilities and healthcare providers. Tr. 1570:15-1572:8 (Hammons). North Carolina has not been a priority for CHS investments for years, and would not be in the future. Tr. 1570:15-1572:8; 1628:21-1629:11 (Hammons); DX 017; DX 018.

2. Lake Norman Regional's Competitive Condition

22. Lake Norman operates in "the most hotly contested hospital market in the entire metro region." DX 111 (CaroMont). While Novant, Atrium, Iredell, and CaroMont have invested to keep up with the growing population—and thrived as a result—Lake Norman has not.

23. Lake Norman has declined in nearly every metric. Its former CEO could not remember "a time at Lake Norman where [its] shares did anything other than fall." Tr. 243:17-19 (Littlejohn). Its patient volume has declined precipitously and remains far below what hospital operators acknowledge is the "target" occupancy for financial viability. Tr. 769:16-23 (Music); Tr. 848:20-12, 868:22-869:2 (Ehtisham); Tr. 988:5-989:2 (Murphy); DX 013; DX 014. Large

areas of the hospital are now empty and unused—including a 30-bed med-surg unit, 6 beds in the oncology unit, an overflow obstetrics unit, and 18 beds in the ortho/neuro/spine medical unit—leading to an "eerie" atmosphere where patients "wonder what's going on." Tr. 767:13-24, 768:10-19, 769:16-770:13 (Music); Tr.1367:1-17 (Jha); DX 485.

24. Capital expenditures at Lake Norman are the lowest among Charlotte-area health systems by a wide margin. DX 017; DX 018; *see also* Tr. 268:7-12, 276:18-272:3 (Littlejohn). Instead of making routine investments, Lake Norman's practice was to "operate equipment that was beyond its end of life" and typically replace it only "when it broke." Tr. 271:17-21 (Littlejohn); *cf.* Tr. 518:7-15 (Riley) (Novant's practice to approve such expenditures). For years before the transaction, CHS failed to approve even the most routine capital expenditures, including anesthesia machines past their life span, stretchers, fire alarm systems, and HVAC upgrades. Tr. 270:9–277:3 (Littlejohn); DX449 at 036-038 (CHS). When one of several beyond-end-of-life anesthesia machines caught on fire in an operating room, for example, CHS decided to rent one instead of upgrading the outdated equipment. Tr. 274:17-274:9 (Littlejohn). In the words of Lake Norman's former CEO, he was "playing small ball." Tr. 261:22-262:13.

25. Lake Norman has for years requested that CHS upgrade its electronic medical records ("EMR") system, but the system remains fragmented and antiquated. Tr. 772:9-773:25 (Music); Tr. 671:10-16 (Benet); Tr. 1507:22-1508:14, 1499:2-1500:3 (Oliver). The patchwork infrastructure does not allow for integration or communication across systems, risks loss of patient data, and does not allow for patient health- and safety-related monitoring. Tr. 671:20-672:04 (Benet); Tr. 772:09-773:05, 785:25-786:09 (Music); Tr. 1378:5-1379:17 (Jha). CHS put Lake Norman on a list for EMR upgrades year after year, but never made the investment. Tr. 785:18-19 (Music); Tr. 1433:2-6, 1435:21-1436:23 (Jha). Although CHS discussed

implementing a Cerner EMR system at Lake Norman, CHS has not allocated adequate capital to do so. DX 004 at 051-052 (Jha).

26. Significant cuts in services have followed from CHS's lack of investment. Three examples are: *First*, Lake Norman no longer offers neonatal intensive care ("NICU") services, so mothers, obstetricians, and neonatal nurses choose other hospitals that provide skilled care when births are premature to not risk "separat[ion of] the mom and the baby." Tr. 778:20-780:11 (Music). *Second*, despite robust efforts, Lake Norman only sporadically offers ST-elevation myocardial infarction ("STEMI") services—it was "STEMI red" 30 out of 90 days in the first quarter of 2024—so EMS bypasses the facility because Lake Norman "[is]n't reliable." Tr. 774:8-15, 780:21-783:15 (Music); Tr. 259:25-262:16 (Littlejohn). *Third*, Lake Norman no longer has intensivists supporting its critical care unit, forcing hospitalists to cover those patients instead and increasing the risk of mortalities. Tr. 776:21-778:19 (Music); Tr. 1373:1-10 (Jha) ("[Y]ou don't want [hospitalists] taking care of an ICU patient.").

27. Unsurprisingly, Lake Norman has struggled to meet CHS's quality standards, lags behind most hospitals in the nation on safety benchmarks, and has "significant opportunity for improvement" in virtually every quality and safety metric. Tr. 656:5-20, 664:10-22 (Benet). It is ranked 60 out of 70 CHS hospitals for quality and patient experience. Tr. 652:15-653:04 (Benet); DX 488 (CHS); DX 486 at 018 (CHS). It has a significantly higher than expected risk-adjusted mortality rate, placing it in the bottom 10% of hospitals nationwide. Tr. 658:16-659:15 (Benet). It has only two CMS stars and has bounced between a C and a B in Leapfrog grades. Tr. 662:23–663:20 (Benet); *see also* Tr. 754:21-755:14, 763:19-764:19, 765:2-12 (Music). Its reputation and patient satisfaction scores are very low, as are provider satisfaction and views on quality at the hospital. Tr. 282:9-283:2 (Littlejohn); *see also* Tr. 510:13-17 (Riley); Tr. 884:13-23 (Ehtisham);

Tr. 1543:8-1544:22, 1547:4-20 (Wyatt); Tr. 664:10-22 (Benet); DX 488 (CHS).

28. As a result, Lake Norman has struggled to recruit and retain physicians and staff. Tr. 774:16-23, 778:20-780:11, 782:21-783:6 (Music). More than 30% of its nurses leave their positions in their first year. Tr. 660:14-661:14 (Benet); Tr. 768:10-19 (Music); DX 488 (CHS). It has staffing vacancies of 50% in its emergency room, 50% in its med-surg unit, and 30% in its obstetrics unit. Tr. 772:9-773:5 (Music). At night, the only physician in the building is in the emergency room; a nurse practitioner services the inpatient beds upstairs. Tr. 778:3-13 (Music).

29. Patients have largely stopped going to Lake Norman for care, as evidenced by its occupancy rate. *Supra* ¶ 7. For Mooresville's two zip codes—where patients are hyper-proximate to Lake Norman and farther from other options—a majority of residents still choose to go elsewhere for care. Pruski Decl. Ex. 2 ¶¶ 7-10 (Wu). That has not always been true; in 2004, over 60% of patients in those two zip codes went to Lake Norman. *Id*. These numbers are for *overlapping* services—i.e., services that Lake Norman still provides today. *Id*.

30. Lake Norman has tried to increase patient access points, to no avail. When it identified three potential primary care clinics, CHS funded only one: a location near Statesville, which CHS then scrapped after it terminated Davis's acute care services. Tr. 252:8-253:6 (Littlejohn). This lack of investment has prevented Lake Norman from hiring primary care physicians, resulting in it operating the smallest affiliated primary care provider network in its primary service area. Tr. 249:13-21 (Littlejohn); PX 2082 at 016 (CHS).

31. Lake Norman also considered a partnership with OrthoCarolina to open an ambulatory surgery center, for which Lake Norman had been awarded a CON. Tr. 256:11-18 (Littlejohn). OrthoCarolina walked away once North Carolina repealed its outpatient CON laws. Tr. 1606:9-12 (Hammons). As Lake Norman's then-CEO recognized: "having that paper of the

CON was very valuable, but then when CON went away, there was no value to the CON." Tr. 256:8-10 (Littlejohn).

32. Lake Norman has been "profitable" historically, largely because of its outpatient volume and failure to make capital investments. But it faces competitive dynamics that put its future profitability at risk. Tr. 278:7-12 (Littlejohn); Tr. 1571:5-1572:8, 1574:6-18 (Hammons); Tr. 1003:17-1004:11 (Murphy). CHS's lack of an affiliated physician network in North Carolina means that it will continue to lag behind its competitors who are building more "front doors" because "whoever has the doctors has the patients by default." Tr. 238:21-239:4 (Littlejohn); Tr. 673:15-674:10, 676:23-677:7 (Benet) (safety and quality challenges cannot be solved without integrated physician network, even if EMR system were upgraded); Tr. 774:1-23 (Music) (same). Profitability based on outpatient revenue also is at risk due to forthcoming changes to the CON process. Tr. 278:7-23 (Littlejohn) ("I would say CON reform would be one of the greatest threats to Lake Norman"). And the opening of Atrium Lake Norman will take even more volume from Lake Norman. Tr. 1574:6-14 (Hammons); DX 111 (CaroMont).

3. CHS's Search for a Buyer

33. Given its debt, CHS has engaged in a public divestiture program. Tr. 1565:15-1566:19 (Hammons); PX 5042 at 55-56 (CHS). Where unable to find a buyer, it has closed hospitals, as it did in Florida when a competitor opened a nearby hospital. Tr. 1578:3-19 (Hammons). CHS identified Lake Norman and Davis as divestment candidates. Tr. 1563:7-17.

34. In 2022, CHS began a diligent search for potential buyers, which included outreach to Novant, LifePoint, UNC Health, and CaroMont. PX 2104 at 005 (CHS); Tr. 1578:24-1580:2, 1627:19-1628:18 (Hammons). LifePoint, CaroMont, and UNC requested and received confidential information on the hospitals but none submitted an offer, at any price. *Id*.

35. Their reasons for not bidding mirrored CHS's competitive concerns. LifePoint

concluded that Atrium already had a "significant presence" in the area, the opening of Atrium Lake Norman would take another 20-30% market share (conservatively) from Lake Norman, and this would result in a $20 million decline in Lake Norman's earnings. Pruski Decl. Ex. 3 at 29:16-30:1, 32:18- 33:18; 53:20-55:15, 56:12-58:04 (Reardon); DX 313 (LifePoint). Thus, LifePoint opted not to submit a bid, even when urged by CHS to bid at any "comfortable" price. *Id*; Pruski Decl. Ex. 3 at 22:13-17, 34:11-15, 59:15-19, 62:3-19, 63:15-21 (Reardon).

36. CaroMont identified a long list of concerns as reasons not to bid on Lake Norman, including: declining EBITDA margins; the opening of Atrium's new hospital which "will take significant market share" at a time when Lake Norman was already "experiencing sustained market share losses"; changing CON laws for outpatient services, which "expos[es] them to great risk;" and that the local market was "saturated with already aligned provider networks." Tr. 996:20-997:5, 1001:9-1002:9, 1004:12-14 (Murphy); DX 111 (CaroMont).

37. Novant was the only entity that submitted a bid. Tr. 1579:24-1580:2 (Hammons).

4. The Importance of the Acquisition to the Community

38. For years prior to its closure, Davis had low occupancy rates and poor financial performance. Tr. 710:2-13 (Green); Tr. 1574:20-24 (Hammons). In 2020, Davis stopped taking pediatric patients. Tr. 707:7-23 (Green). In 2021, Davis stopped offering certain service lines. Tr. 708:1-709:4 (Green). In July 2022, CHS announced it was transitioning Davis to a behavioral-health facility; it ceased all acute care services 35 days later. Tr. 709:5-18 (Green); *see also id*. 709:19-711:22 (explaining "shock" to the community). The sudden transition of Davis to a behavioral health facility increased wait times for emergency services in Statesville. Tr. 1543:8-17, 1543:18-25, 1544:23-1545:20, 1549:8-1550:3 (Wyatt); Tr. 711:23-713:11 (Green). Community members are concerned that Davis's story portends what is to come if the Court enjoins the transaction. *See, e.g.*, DX 008 (Iredell County Board); DX 006 (FeedNC).

39. A wide array of community members has expressed support for this transaction and its potential to improve the quality of care and expand services at both Lake Norman and Davis. Tr. 1546:1-17, 1547:18-1548:4, 1549:8-1550:3, 1550:4-1551:3 (Wyatt); DX 008 (Iredell County Board); DX 009 (Professor of Nursing); DX 010 (Mitchell Community College President); DX 011 (Dr. Korrapati); DX 005 (Charlotte Regional Business Alliance); DX 012 (Dr. Sturgess); DX 037 (Dr. Gross, Chief of Staff at Lake Norman); DX 006 (FeedNC).

D. The Future With and Without the Transaction

40. If this transaction is enjoined, CHS will close Davis immediately. Tr. 1575:10-1577:8 (Hammons). Indeed, during the pendency of the FTC's investigation, in light of the "continued delay in getting approval," CHS considered closing Davis to avoid continued losses of $1 million per month; the transaction with Novant is the reason Davis remains open today. DX 460 (CHS); Tr. 1575:18-1577:8 (Hammons). The future for Lake Norman is far from certain. Tr. 1577:13-22 (Hammons). CHS will continue to allocate funds towards required maintenance of the facility, but will not allocate any meaningful growth capital. Tr. 1630:6-10 ("Q: And if this transaction is prohibited, what will be the devotion of growth revenue to Lake Norman Regional? A: I think it will continue to be limited."). Its competitive significance, quality, service lines, and patient satisfaction will all continue to decline.

41. If the transaction is not enjoined, Novant will keep Davis open and continue offering the behavioral-health services currently available there. Tr. 886:14-888:02 (Ehtisham). Novant also will work with regulators to return emergency services to the Statesville area within two years. Tr. 1260:19-1261:17 (Armato); DX 677 at 003 (Novant). And Novant will engage the community to determine what additional services it should provide at Davis and/or in Statesville going forward. Tr. 1260:19-1261:17 (Armato).

42. Novant also will make significant investments in Lake Norman right away. For

example, Novant has already (before the deal closes and it is able to understand additional needs) committed to: *One*, fund the capital projects that leaders at Lake Norman have requested for years, including a cardiac catherization laboratory expansion ($850,000), building a cardiac care unit ($1,000,000), replacing an end-of-life HVAC system ($300,000), replacing end-of-life anesthesia machines ($360,000), and upgrading an outdated fire alarm system ($150,000). Tr. 1256:9-1257:20 (Armato). *Two*, restore Lake Norman's well baby nursery into a Level II NICU. Tr. 1257:21-1258:8 (Armato); Tr. 857:24-859:3 (Ehtisham); DX 689. *Three*, recruit the cardiologists and staff necessary to offer STEMI services around the clock, every day. Tr. 842:20-843:16 (Ehtisham); Tr. 1373:20-1374:3 (Jha). *Four*, recruit an intensivist. Tr. 846:24-847:17 (Ehtisham). And, *five*, staff a colorectal surgeon rotation and enhance surgery call coverage. Tr. 1257:21-1258:8 (Armato); Tr. 846:24-847:17 (Ehtisham); DX 677 (Novant).

43. In addition, at both hospitals, Novant has committed to: *One*, implement the Epic EMR system, with a plan to "go live" at clinic locations on day one after closing and within six months after closing at both Lake Norman and Davis. Tr. 877:20-878:19 (Ehtisham); DX 677 (Novant).[2] *Two*, provide tele-stroke, tele-ICU, and tele-psychiatry coverage, along with AI-enabled clinical support services. Tr. 846:24-847:17, 857:24-859:3 (Ehtisham). *Three*, implement Novant's "First Do No Harm" safety program and centralized clinical improvement department oversight, as well as its Clinical Improvement Plan, Infection Prevention Plan, and Risk Management Plan. *See, e.g.*, DX 677; Tr. 1326:23-1327:11 (Armato). And, *four*, implement

[2] Novant already has a "playbook" to do so. Tr. 1392:17-20 (Jha); DX 706 (Novant). The benefits of Epic include giving providers immediate access to patients' medical history, allowing for electronic medication reconciliation, monitoring data analytics and outcomes, and access to Vizient tools that drive improvements in real time. Tr. 861:13-862:20 (Ehtisham); Tr. 1380:20-1381:12 (Jha); Tr. 509:1-21 (Riley); Tr. 1326:23-1327:11 (Armato); Tr. 1488:11-1489:17, 1502:13-24 (Oliver); Tr. 1383:1-1384:16 (Jha); DX 668; DX 721.

the Novant Health Safety Management Program and the Novant Health Quality Management Program. *See* Tr. 1501:11-1502:12 (Oliver); *see also* DX 700 (Novant); DX 689 (Novant).

44. For patients that want high-quality care "close to home," this transaction is the best way to provide it. As Troutman's Town Manager explained: "A lot of people … [are] taking their life in danger by driving on to Forsyth … or driving down to Charlotte so that what they think may be a heart attack can get treated properly. … I think, by [Novant] coming, it certainly gives a lot more opportunity for people to get immediate quality healthcare." Tr. 1550:4-1551:3.

45. Novant leaders are committed to improving Lake Norman and Davis and have concrete plans to do so. Tr. 1499:2-1500:3, 1503:9-23 (Oliver); Tr. 1251:23-1252:8 (Armato); Tr. 865:25-866:23 (Ehtisham). For example, in addition to leveraging materials and processes developed and refined during prior acquisitions, DX 601, DX 706, Novant has created an Executive Steering Committee and twelve different workstreams with leaders and support partners, DX 688; *see also* Tr. 863:10-865:3 (Ehtisham); Tr. 1291:16-22 (Armato). Novant has met with individuals from Lake Norman to further refine the quality-improvement plans at the hospital. Tr. 1496:2-1497:1 (Oliver); Tr. 1391:4-1393:20 (Jha). (The FTC's quality expert, in contrast, never visited Lake Norman or Davis or spoke to any CHS or Novant patient, physician, or healthcare provider. Tr. 945:13-946:25 (Burns).) And Novant's integration plans detail specific initiatives designed to integrate Lake Norman and Davis, and to improve safety and quality at those facilities. Tr. 1496:2-23 (Oliver).

46. Novant has committed to fulfilling these commitments despite the threat of ongoing litigation. When the Court asked Novant's CEO whether the commitments are "dependent upon the successful resolution of all of those litigation risks," Mr. Armato responded: "Your Honor, if the Court gives us permission, I will begin implementing all that I

have agreed to and what we've committed to *right away*." Tr. 1329:21-1330:2 (emphasis added).

47. Indeed, Novant would face reputational harm if it failed to deliver on its promises. DX 677; PX 5026; Tr. 865:25-866:23 (Ehtisham); Tr. 1249:21-1250:10 (Armato). Novant is putting its name on these hospitals, so it has strong incentive to improve them. Tr. 1245:6-13, 1251:23-1252:8 (Armato); Tr. 1503:9-23 (Oliver); Tr. 865:25-866:23 (Ehtisham). And Novant has a history of doing so: when it acquired Brunswick Medical Center, Mr. Armato spent $10 million to replace broken equipment the first day he visited. Tr. 1246:9-21. Mr. Armato committed, under oath, to a variety of similar investments here. Tr. 1254:3-1258:14.

48. Novant also has significant economic incentive to fulfill these commitments due to its participation in value-based contracting ("VBC"). Witnesses uniformly recognized that such participation provides an economic incentive to reduce the total cost of care by improving quality, coordination, and efficient delivery of care. Tr. 327:2-25 (DiPace); Tr. 159:21-161:9 (Page); Tr. 421:4-11 (Daniels); Tr. 667:20-25 (Benet); Tr. 698:23-699:6 (Green); Tr. 1643:6-15, 1645:4-11 (Keibler); Tr. 1493:17-1494:6 (Oliver); Tr. 1346:23-1349:3 (Jha); Tr. 474:21-475:12 (Portman). Insurers also recognized that a high-quality system—one focused on lowering readmission and infection rates, and managing utilization—reduces costs, and analyzing only the unit price of a given procedure does not show the total cost of care. Tr. 417:18-421:11 (Daniels); Tr. 160:10-14 (Page); Tr. 1696:17-22, 1738:14-17 (Wu); Tr. 1642:22-1643:5 (Keibler).

49. Lake Norman's minimal network of employed or affiliated physicians, coupled with its employee retention issues and outdated IT infrastructure, have severely limited its ability to participate in value-based contracting. Tr. 1372:5-1373:10 (Jha); DX 002 at 024 (Jha). For example, Lake Norman tried to participate in Blue Premier, but could not join directly because its patient population was too small. Tr. 329:24-330:14 (DiPace); Tr. 1389:15-1390:18 (Jha).

Lake Norman tried to use a third-party aggregator, CHESS Health Solutions, but CHESS determined that Lake Norman did not have the "resources in place" to participate. Tr. 330:15-17, 331:05-332:04 (DiPace); DX 300 (CHESS); DX 489 (CHESS); Pruski Decl. Ex. 4 at 58:13-63:2, 96:7-23 (CHESS) (CHESS did not move forward with Lake Norman [redacted]. Other insurers do not plan to use VBC programs with CHS in North Carolina for similar reasons. Tr. 334:8-11 (DiPace); Pruski Decl. Ex. 5 at 117:8-120:7 (Cigna).

50. Novant, in contrast, successfully participates in VBC programs with all of the major insurers in North Carolina. DX 002 at 034 (Jha). With Blue Cross, for example, Novant accounts for a "significant fraction" of the approximately $650 million that Blue Premier has achieved in savings. Tr. 160:15-161:09 (Page); DX 214. Novant also has achieved savings with Aetna and United. Tr. 1645:12-18 (Keibler); DX 221 (United). If this transaction were allowed to proceed, Lake Norman's patients would be included in Novant's VBC programs, giving Novant a significant economic incentive to improve quality and reduce costs. Tr. 1385:7-1386:15, 1388:22-1389:14, 1471:7-21 (Jha); Tr. 1494:7-13 (Oliver); Tr. 1646:23-1647:11 (Keibler); Pruski Decl. Ex. 5 at 117:8-120:7 (Cigna).

II. THE FTC HAS NOT ESTABLISHED A *PRIMA FACIE* CASE AND IS NOT ENTITLED TO A PRESUMPTION OF ILLEGALITY

A. The FTC Has Failed to Establish A Relevant Geographic Market

51. The FTC's primary claimed geographic market is the "Eastern Lake Norman Area." According to the FTC, this area includes Iredell County and three zip codes in northern Mecklenburg County, and includes just three hospitals today: Lake Norman, Novant Huntersville, and Iredell Memorial. Tr. 1055:2-24 (Tenn). It also will include a "small" Atrium Lake Norman, when that hospital opens next year. Tr. 1055:2-17, 1089:1-2 (Tenn).

52. The FTC's economist identified an alternative "market" called the "Eastern Lake

Norman Area plus Center City," which includes the "Eastern Lake Norman Area" plus "four hospitals in [C]enter [C]ity." Tr. 1079:20-1080:8 (Tenn). It omits three hospitals located *between* the "Eastern Lake Norman Area" and Center City. Tr. 1752:6-1753:14 (Wu). The FTC did not define the geographic area for this alleged market. Tr. 1160:10-1161:22 (Tenn). Nor was it alleged in the FTC's complaint, or in the FTC's pre-hearing briefing. ECF 2 at 15; ECF 80 at 8.

53. The FTC identified a third candidate market, the "[C]enter [C]ity/Northern Charlotte region" market, which includes the eight hospitals in the FTC expert's other candidate markets, plus two additional Atrium hospitals: Cabarrus and University City. Tr. 1082:22-1083:6 (Tenn). According to the FTC's expert, this is the only one of the FTC's three candidate markets that includes all "meaningful substitutes" for Lake Norman and Novant Huntersville. PX 0001 at 009 (Tenn); Tr. 1095:19-22 (Tenn). Yet, it still excludes CaroMont's new hospital in Belmont and several other Charlotte area hospitals. DX 003 at 86 (Wu). And here, too, the FTC did not define the geographic area for this alleged market. Tr. 1160:10-1161:22 (Tenn).

1. The FTC's Purported "Eastern Lake Norman Area" Market

54. The FTC's claimed "Eastern Lake Norman Area" market does not reflect commercial realities for many reasons, including:

55. *First*, by excluding all *current* Atrium facilities, it drastically understates the competitive impact of Atrium today, assigning a 0% share of the alleged market to the dominant health system in the Charlotte area. Tr. 1740:5-11 (Wu); Tr. 1178:16-1181:12 (Tenn). That cannot be squared with the fact that, today—before Atrium Lake Norman opens—Atrium already is Novant's (including Novant Huntersville's) and Lake Norman's most significant competitor. Tr. 800:13-19, 836:17-837:23 (Ehtisham); Tr. 507:4-18 (Riley); Tr. 266:21-267:1 (Littlejohn); Tr. 1732:11-13 (Wu). It simply ignores the numerous "front doors" Atrium has in those zip codes today, which funnel patients to its existing hospitals. Tr. 571:16-573:19, 585:16-

586:21, 591:20-592:20 (Haynes).

56. The FTC's expert, Dr. Tenn, claims to account for the opening of Atrium Lake Norman by attributing that hospital a 13.8% share of this alleged market once it opens. Tr. 1055:2-17, 1055:18-24 (Tenn). However, that share still only accounts for *Atrium Lake Norman* (not any other Atrium hospital) and only accounts for Atrium Lake Norman's *initial* capacity (ignoring its future expansion). Tr. 1740:12-25 (Wu). As such, it contradicts the understanding of every market participant and the Department of Justice, who all acknowledged Atrium's dominance *today*. *See, e.g.,* Tr. 507:4-7 (Riley); Tr. 398:19-21 (Daniels); Tr. 979:20-980:1 (CaroMont); Tr. 167:7-168:2 (BCBS); DX 493 at 004; Pruski Decl. Ex. 3 at 35:4-13 (Reardon). Indeed, in May 2023—a full year ago—Atrium itself calculated its existing "patient selection" in the area around its forthcoming Lake Norman hospital as [redacted] Tr. 574:13-18, 594:1-4 [redacted] DX 100 at 026[redacted] [3]

57. *Second*, discharge data, witness testimony, and ordinary course documents confirm that most patients located within this alleged market seek care outside of it. Based on discharges, over half of the patients in the alleged "Eastern Lake Norman Area" receive care from hospitals outside that area, Tr. 1743:22-1744:4 (Wu), and the number remains high (about 45%) even when limited to services offered by both Lake Norman and Novant Huntersville, i.e., "overlapping" services, Pruski Decl. Ex. 2 ¶¶ 19-20 (Wu). Based on revenues, which more accurately account for quality of care, the percentage of patients leaving rises to over 70% for all services, Tr. 1744:5-9 (Wu), and over 56% for "overlapping" services, Pruski Decl. Ex. 2 ¶¶ 19-20 (Wu).

[3] Dr. Wu's analysis similarly found that Atrium treats [redacted] for patients residing in this alleged market. DX 003 at 047-048, 193 (Wu).

58. Hospital operators, who track this "outmigration" as part of their business, agreed. Atrium estimated that almost [redacted] of patients were leaving to obtain care elsewhere. Tr. 595:3-12 [redacted]; DX 100 at 026 [redacted] *see also* PX 1058 at 006 (Novant) (attributing significant market share in Novant Huntersville's service area to CMC, Presbyterian, University City, and CaroMont). And witnesses acknowledged that patients seek not only higher acuity care, but also routine primary care in Charlotte. Tr. 986:19-987:18 (Murphy); Tr. 245:15-24 (Littlejohn).

59. *Third*, the FTC's "Eastern Lake Norman Area" market excludes several local hospitals that patients already turn to. Tr. 1742:18-1745:5 (Wu). In concrete terms: The FTC's alleged market includes Iredell Memorial, which is approximately 38 minutes away from the average Huntersville patient. DX 001 at 243 (Wu). But the FTC's alleged market *excludes* 13 hospitals that are a shorter drive time from Novant Huntersville, Tr. 1747:12-20 (Wu), and 3 that are a shorter drive time from Lake Norman, DX 001 at 244 (Wu). Including Iredell while excluding more than a dozen closer hospitals does not correspond to the reality of how patients in the area seek care. As Iredell's representative explained, Huntersville, Cornelius, and Mooresville are "bedroom communities" or "suburbs" of Charlotte. Tr. 714:11-23 (Green). Statesville is not. Tr. 714:24-25 (Green). But the "Eastern Lake Norman Area" excludes the Charlotte-area hospitals in favor of one closer to Hickory and Winston-Salem. Tr. 715:1-20 (Green); *see also* Tr. 977:17-25 (Murphy) (including Huntersville, Cornelius, and Mooresville—but not Statesville—in "Lake Norman area"); Tr. 551:6-12 (Haynes) (same). Even Blue Cross puts Iredell in its "Hickory/Statesville Market"—not in its "Charlotte Market." Tr. 154:22-155:9.

60. *Fourth*, this alleged market excludes several hospitals that patients consider to be closer substitutes than the hospitals that the FTC included in its alleged market. For example, the FTC's expert, Dr. Tenn, estimated that diversion ratios (which measure a patient's "second

choice") are higher from Novant Huntersville to two Atrium hospitals excluded from Plaintiff's market—CMC (33.8%) and Cabarrus (17.8%)—than diversion to either Lake Norman (15.2%) or Iredell Memorial (2.5%). PX 0001 at 107 (Tenn). United's analysis reached a similar conclusion: CMC and Atrium University City—neither of which are included in the FTC's "Eastern Lake Norman Area" market—each had [redacted] Tr. 427:10-16 (Daniels); PX 3125 (United).

61. Dr. Tenn's diversion ratios also show that diversion from Novant Huntersville to CaroMont (4.4%), which the FTC excludes from all of its proposed markets, is higher than diversion to Iredell Memorial (2.5%), which the FTC includes in all of its claimed markets. PX 0001 at 107 (Tenn). And Dr. Tenn did not even estimate diversions from Novant Huntersville (or Lake Norman) to CaroMont's Belmont hospital, Tr. 1177:21-1178:10 (Tenn), which was strategically located to draw more patients from Mecklenburg County, Tr. 976:23-977:4 (Murphy), and is closer to Novant Huntersville than Iredell is to Novant Huntersville.

62. *Fifth*, the "Eastern Lake Norman Area" does not reflect how competition for inclusion in health insurance networks occurs. Hospitals and insurers negotiate at the system-wide level. Tr. 1713:21-1714:24, 1715:13-1716:6 (Wu). And reimbursement rates are negotiated for the "Charlotte market"—an area that insurers define as covering all of Mecklenburg and surrounding counties—not for the "Eastern Lake Norman Area" alone. *Supra* ¶ 19; *infra* ¶ 64.

63. *Finally*, those that compete for patients in this area do not view the "Eastern Lake Norman Area" as a distinct geographic area in the ordinary course of business. Nor does the community. Tr. 1546:21-1547:3 (Wyatt). Tellingly, Dr. Tenn could not point to a single piece of evidence that recognized the "Eastern Lake Norman Area" as the FTC defined it—Dr. Tenn called it an "amalgamation." Tr. 1174:3-13 (Tenn).

64. Blue Cross's representative testified that he had "never heard [Eastern Lake Norman] used as a pricing region or a product region." Tr. 155:23-156:1 (Page). Ambetter's representative agreed that it does not use that geographic area to assess networks. Tr. 470:2-4 (Portman). And not a single insurer has tried to develop, or market, a plan focused only on that area. Tr. 1632:4-23 (Keibler) (Aetna's plans are targeted at the "Charlotte area," and it has never developed, nor thought about developing, a network for health plans in an "eastern Lake Norman area"); Tr. 469:22-470:4 (Portman) (Ambetter does not have a plan directed to those areas).[4]

65. Novant and Atrium similarly use the "Greater Charlotte Market" or "Greater Charlotte Region"—i.e., Charlotte and several surrounding counties—as the relevant geographic area for their corporate decisions and strategy. Tr. 1240:1-19 (Armato); Tr. 797:2-12 (Ehtisham); Tr. 512:9-21 (Riley); Tr. 543:5-16, 545:11-547:21, 566:20-567:13 (Haynes); *see also* Tr. 1240:1-3 (Armato) (Q: "In Novant's operations, is there anything called the Eastern Lake Norman Area market." A: "No.").[5]

66. Perhaps most tellingly, the United States and the North Carolina Attorney General also used "the Charlotte area" as the relevant market when they sued Atrium in a recent antitrust case. There, the government defined their relevant "Charlotte area" market as "Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, and Union counties in North Carolina, and Chester, Lancaster, and York counties in South Carolina." DX 493 at 005 & n.1.

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[4] At most, insurers testified that they look at *county* boundaries, and have therefore assessed plans for Iredell County as a standalone area. No insurer included Novant Huntersville or any other Mecklenburg-based hospital in such an analysis.

[5] Novant's so-called "north Charlotte submarket" varies substantially from the FTC's "Eastern Lake Norman Area" market: it includes, for example, areas to the west of Lake Norman, and south of I-485 (such as University City). Tr. 515:14-516:3 (Riley); *see also* Tr. 1170:6-17 (Tenn) (acknowledging that Atrium University City is in "the Novant North market" but is excluded from two of the FTC expert's three proposed relevant geographic markets).

2. The FTC's Purported "Alternative" Markets

67. The FTC's two alternative markets fail at the outset because they are not "geographic" markets at all. Dr. Tenn was unwilling or unable to define and draw their geographic bounds. Tr. 1160:10-1161:22. Indeed, Dr. Tenn contradicted himself repeatedly. He first explained: "[M]y markets are based on hospital location." Tr. 1160:17-18. Then he stated: "[T]he geographic market definition is about *adding geography*, not adding individual hospitals, and therefore I started with another geography and worked my way out." Tr. 1164:5-8 (emphasis added). Then he reverted to claiming, "[m]y markets are based on hospital location." Tr. 1164:23. He finally contradicted himself again, claiming that "geographic market definition is about *choosing geography* and expanding from there." Tr. 1165:18-21 (emphasis added). Neither Dr. Tenn nor anyone else ever articulated a geographic boundary for either alternative market.

68. ***Eastern Lake Norman Area Plus Center City.*** This purported market consists of one alleged geographic area (the "Eastern Lake Norman Area") plus four other hospitals in a separate "island," excluding key—and closer—competitors *between* those two areas, namely Atrium Cabarrus, Atrium University City, and CaroMont Belmont, Tr. 1752:4-1753:14 (Wu)—each of which is closer to Huntersville than Iredell Memorial. Pruski Decl. Ex. 2 ¶ 17 (Wu); Tr. 1175:8-1176:1 (Tenn). Neither the FTC nor Dr. Tenn cited any precedent for a single geographic market consisting of two separate areas, and the FTC did not even allege this market in its Complaint or pre-trial briefs. *Supra* ¶ 52. Moreover, Dr. Tenn's own diversion ratios show that this "market" still excludes closer substitutes while including less-close substitutes. PX 0005 at 113-22. Even United's analysis concluded that [redacted] *Supra* ¶ 60. And Dr. Tenn acknowledged that Atrium University City is one of the hospitals that Novant "focuses on" when evaluating competition in the region north of Charlotte. PX 0001 at 077. Finally, as noted above,

more patients *from Mooresville* obtain care at Atrium Cabarrus than at Iredell Memorial. Pruski Decl. Ex. 2 ¶¶ 9-10 (Wu).

69. ***Center City/Northern Charlotte Region.*** The FTC's "Center City/Northern Charlotte Region" market, in addition to lacking defined geography, fails to correspond with commercial realities regarding how prices are set for Charlotte area hospitals. Tr. 1695:20-1696:3, 1714:8-1715:25 (Wu). And this purported market excludes important substitutes that constrain Novant and Lake Norman. Tr. 1753:23-1754:11 (Wu). For example, Dr. Tenn's own analysis shows that diversion from Novant Huntersville to hospitals *outside* his market—like CaroMont (3.9%) and Atrium Pineville (2.9%)—are higher than diversion from Novant Huntsville to hospitals *inside* his market—like Iredell Memorial (2.5%). PX 0005 at 113 (Tenn). Again, Dr. Tenn did not estimate diversion from Novant Huntersville (or Lake Norman) to CaroMont Belmont, even though Belmont will be significantly closer to Huntersville than Iredell Memorial. *Id*. This purported market also fails to include hospitals in areas that insurers consider part of the Charlotte region in the ordinary course of business. *See supra* ¶ 19.

B. The FTC Has Failed to Establish A Relevant Product Market

70. The FTC's product market is flawed in at least two respects.

71. *First*, it includes only inpatient services, even though the very hospitals at issue here provide both inpatient and outpatient services. Tr. 1759:8-21 (Wu). Increasingly, inpatient services are provided on an outpatient basis. Tr. 800:4-12 (Ehtisham); Tr. 715:25-716:8 (Green) ("a ton of services" could be done in either inpatient or outpatient setting). The exclusion of a service when provided on an outpatient basis, but inclusion of that same service when provided on an inpatient basis, has no basis. Further, provider and insurer contracts cover both inpatient and outpatient services. Tr. 1714:5-17 (Wu). And the exclusion of outpatient services reduces the significance of Atrium, which has more outpatient ambulatory surgery centers than all other

Charlotte hospital competitors combined. DX 001 at 023-024, 190-191 (Wu).

72. *Second*, the FTC limits its proposed product market to "overlapping" services—that is, only those services that both Lake Norman and Novant Huntersville provide at any undefined point in time. Once again, this is an artificial distinction not reflected in commercial negotiations. Insurers negotiate with Novant and Lake Norman not just for the inpatient services that they both provide in common, but for all inpatient services that their hospitals provide. Tr. 1757:21-1758:3 (Wu). Novant's contracts with insurers, for example, are negotiated systemwide and include all inpatient services offered by *all* Novant hospitals, not just those inpatient services offered by Novant Huntersville, and certainly not only the services offered by *both* Novant Huntersville and Lake Norman. Tr. 1709:15-1710:1 (Wu).

73. This limitation to "overlapping" services also means that services that Lake Norman has been forced to terminate—including most inpatient oncology services, Level II NICU services, and certain critical care services (*supra* ¶ 26; Tr. 768:20-769:4, 776:21-780:11 (Music))—are artificially excluded from the FTC's calculations even though Lake Norman offered them historically. Tr. 1183:22-1184:16 (Tenn).

C. The FTC's Market Shares and Concentrations Statistics Are Overstated

74. The FTC's alleged market shares and market concentration statistics rely on an overly narrow geographic market, which excludes key competitors, *supra* ¶¶ 54-69, and an overly narrow product market, which excludes key services, *supra* ¶¶ 71-73. Beyond those critical flaws, those market share and market concentration statistics are unreliable and inconsistent with commercial realities.

75. For example, because the FTC's market share and market concentration statistics are based on historical data, they do not reflect Lake Norman's *future* competitive significance. Tr. 1695:17-1697:1 (Wu). Lake Norman's average daily census, occupancy rate, patient

volumes, and number of MS-DRGs offered all have declined. *Supra* ¶¶ 7-8. Lake Norman has difficulty retaining physicians and staff, has not made capital investments, and its quality has suffered, all of which contributes to its declining market share and inability to compete. *Supra* ¶¶ 22-32. These issues would be exacerbated both after Atrium Lake Norman opens next year and when the CON changes go into effect—facts recognized by those who considered (but declined) to bid to acquire Lake Norman. *Supra* ¶¶ 35-36; Tr. 1765:6-13 (Wu). The FTC's purported attempt to "simulate" the opening of Atrium Lake Norman attributes only a minimal share to it, despite evidence that Atrium already is dominant in the area. *See supra* ¶ 56.

76. As another example, Dr. Tenn's model would consider Lake Norman to be a meaningful competitor even if Lake Norman were serving just *two patients* a day. Tr. 1195:1-1196:7. An economic model that requires hospitals to decline so far—or, as happened with Davis, to close—before it views their competitive significance as sufficiently *de minimis* does not credibly reflect the commercial realities of healthcare competition.

77. Finally, Dr. Tenn's statistics rely on discharges rather than revenue. PX 0001 at 43. Revenue is a more accurate reflection of participants' market shares—particularly of Lake Norman's share—because revenue reflects the quality of care provided. Tr. 1765:14-1766:2 (Wu); *see also* DX 492 at 071 (FTC complaint alleging revenue-based shares because volume-based shares "may understate USAP's actual volume share to the extent USAP handles more time-consuming procedures"); *accord* DX 493 at 004.

78. Dr. Wu attempted to correct many—but was unable to correct all—of these errors. For example, Dr. Wu could not calculate shares based on where patients in the "alternative" markets reside—a key flaw in the FTC's share estimates—because geographic boundaries of these purported "markets" have not been defined. *Supra* ¶ 67; Tr. 1754:12-18 (Wu).

Nevertheless, after correcting some errors, Dr. Wu calculates that Novant and Lake Norman would have a combined share of approximately 28% and the HHI would increase by 58. Tr. 1768:12-22 (Wu). Those numbers—which more closely align with the commercial realities of competition in Charlotte—are below the thresholds in the FTC's own 2010 and 2023 Merger Guidelines and far below the benchmarks set by the other hospital merger cases that the FTC has cited. Tr. 1929:5-1930:1 (Tenn).[6]

III. THE TRANSACTION WILL NOT SUBSTANTIALLY LESSEN COMPETITION

A. The Transaction Will Enhance Price and Non-Price Competition

79. Witnesses uniformly agreed that quality is an important dimension of healthcare competition. *See, e.g.*, Tr. 841:10-22, 854:13-20 (Ehtisham); Tr. 979:14-19 (Murphy); Tr. 107:12-20, 150:14-18 (Page); Tr. 179:22-1802, 181:12-23, 231:10-20 (Littlejohn); Tr. 321:23-25, 336:9-25 (DiPace); Tr. 364:20-365:7, 419:7-22, 421:4-11, 429:16-22 (Daniels); Tr. 458:7-459:10, 475:6-12 (Portman); Tr. 489:16-22, 508:22-25 (Riley); Tr. 592:21-593:5 (Haynes); Tr. 629:12-630:8, 656:5-20, 664:10-22 (Benet); Tr. 717:8-10 (Green); Tr. 725:15-726:6, 772:2-773:5 (Music); Tr. 1245:6-13, 1249:21-1250:10, 1288:3-6 (Armato); Tr. 905:6-905:19 (Burns). With the changes Novant will immediately begin implementing, *supra* ¶¶ 41-43, Lake Norman will become more attractive to patients, physicians, and staff, thereby spurring other hospitals to compete more vigorously. Pruski Decl. Ex. 6 at 38:14-41:17 (CCH) (transaction may result in "higher quality" at Davis and Lake Norman); *accord* Tr. 1004:24-1005:7 (Murphy).

80. Iredell's President provided two concrete examples of how the transaction will

[6] The 2023 Merger Guidelines should be accorded no weight, given the political nature and timing of them. *See* ECF 95 at 29 n.111; ECF 118-2 at 1-4, 8-9. But the Court here need not address the numerous issues with those guidelines because, when Dr. Tenn's errors are corrected, the thresholds are not met under even those guidelines.

enhance competition: Novant will offer higher salaries to attract physicians and staff, which will encourage Iredell to do the same, Tr. 719:8-22 (Green), and Novant will restore emergency services in Statesville, which will require Iredell to compete for those patients, Tr. 721:7-14 (Green). No hospital witness testified that they would *reduce* their efforts to compete if the transaction goes forward. To the contrary, as Atrium's representative explained, it would continue "compete . . . vigorously" regardless. Tr. 600:6-24 (Haynes).

81. A revitalized Lake Norman also will support Novant's effort to be a more attractive alternative to Atrium. Novant and Atrium compete fiercely for inclusion in insurers' provider networks today, with some narrow-network plans featuring Novant and others featuring Atrium. Tr. 157:1-158:1 (Page); Tr. 367:10-18 (Daniels). In a contract with United, for example, Atrium agreed to a "material discount" in exchange for excluding Novant and CaroMont from its network. Tr. 406:18-407:5 (Daniels); PX 3127 (United).

82. And Novant's rates typically are significantly lower—by approximately [redacted]—than Atrium's. PX 3015 (United); Tr. 430:16-22 (United); Tr. 1733:12-17 (Wu). The more attractive Novant is as an alternative, the more leverage insurers will have to reduce Atrium's rates, thereby lowering the cost of care for patients. Tr. 1733:12-1736:3 (Wu).

B. The Transaction Will Not Eliminate Substantial Price Competition

83. There is no evidence that Novant and Lake Norman compete on price. Not a single insurer has used, or tried to use, Lake Norman to bargain for lower prices from Novant. Tr. 1639:2-9 (Keibler); Tr. 153:3-7 (Page). And insurers have not threatened to exclude Novant from their networks in favor of Lake Norman to get lower rates from Novant. Tr. 1639:6-9 (Keibler). To the contrary, Lake Norman never comes up in insurers' negotiations with Novant. Tr. 408:5-8 (Daniels); Tr. 1639:2-5 (Keibler); Pruski Decl. Ex. 5 at 77:20-78:18 (Cigna). Similarly, no insurer has used, or tried to use, Novant as a competitive constraint to bargain for

lower prices at Lake Norman. Tr. 338:13-339:13 (DiPace).

84. Lake Norman is competitively insignificant in negotiations with insurers. CHS's lead contract negotiator for Lake Norman has a hard time getting insurers to even return his phone calls. Tr. 325:25-326:5 (DiPace). Insurers place little value in having Lake Norman in their provider networks. Tr. 322:1-10 (DiPace). That is in part why no insurer in the Charlotte area has featured Lake Norman in a narrow network product, or included it in a preferred tier for tiered-network products. Tr. 337:1-337:22 (DiPace).

C. The Transaction Will Not Substantially Increase Novant's Bargaining Leverage

85. The FTC has not provided credible evidence that the transaction will substantially impact the bargaining leverage between Novant and insurers. Indeed, Aetna's representative testified that the transaction will *not* increase bargaining leverage for Novant, nor will it lead to an increase in rates. Tr. 1639:13-16 (Keibler). Ambetter's representative acknowledged it did not "have an informed opinion" on the question. Tr. 462:11-15 (Portman). And Cigna explained to the FTC previously that Lake Norman is a "smaller," "lower tiered facility" with "diminishing" services, which does not "really impact the Charlotte rating area." Pruski Decl. Ex. 7 at 30:7-31:7 (Cigna); *see also* Pruski Decl. Ex. 5 at 72:14-22, 128:4-9 (Cigna).

86. Conclusory testimony from Blue Cross and United does not establish that the transaction is likely to substantially lessen competition or lead to higher overall healthcare cost.[7]

[7] The "analysis" done by Blue Cross, for example, only shows "the contracted fee-for-service reimbursement rates in place [at Lake Norman] now with the contracted fee-for-service reimbursement rates under Novant's contracts." Tr. 149:10-16 (Page); *see also* PX 3029. This "analysis" does not account for Novant's ability to improve quality or reduce the total cost of care. Tr. 149:17-25 (Page). It shows simply the effect of moving Lake Norman to Novant's contracts—it does *not* show any price increase *as a result of* decreased competition or increased leverage. As the FTC's own expert explained, any increase in unit prices that may have resulted from these differing rates is "not due to the elimination of competition." PX 0005 at 074 n.317.

Insurers have significant bargaining leverage in negotiations and can use a number of levers to extract rate concessions from hospital systems, including by issuing notices of termination, sending letters to members notifying them of the potential termination, and giving statements to the press. Tr. 395:17-22, 396:12-397:15 (Daniels). Insurers in Charlotte are not scared to use these tactics; indeed, United terminated the much larger Atrium system in 2015. Tr. 398:10-23 (Daniels). This disparity in leverage is apparent today. In its last negotiation with Novant in 2023, for example, United estimated that, if it terminated Novant, it would [redacted] while a termination would [redacted]. DX 229 (United); Tr. 403:3-7 (Daniels).

87. That bargaining dynamic will not change, both because Lake Norman is competitively insignificant, and because insurers *already* offer viable, marketable plans that exclude both Novant and Lake Norman. Tr. 156:2-157:9 (Page); Tr. 1636:10-1637:15 (Keibler); Tr. 470:5-13 (Portman); Pruski Decl. Ex. 6 at 38:14-40:7 (CCH). For example, Blue Cross and Aetna each offer two plans that exclude both Novant and Lake Norman: Blue Local with Atrium, Blue HPN, Aetna Whole Health, and Aetna Connected NC. Tr. 154:14-21, 156:2-15, 19-24, 157:1-158:1 (Page); Tr. 337:9-22 (DiPace); Tr. 1636:10-25 (Keibler); *see also* Tr. 1638:4-11 (Keibler) (Aetna could offer narrow network plan in Iredell County without Lake Norman and Novant); Pruski Decl. Ex. 5 at 87:25-88:20, 203:3-22 (Cigna) (same). That insurers offer these plans today confirms that, if Novant were to attempt an anticompetitive price increase post-acquisition, insurers have viable alternatives.

88. Novant's inability to extract anticompetitive rate increases from insurers post-transaction is further evidenced by analysis of Novant's rates following prior acquisitions. DX 021. After Novant acquired Rowan Medical Center, reimbursement rates at Rowan continued to lag behind state and national trends. DX 021; Tr. 1724:5-21 (Wu). Before Novant acquired New

Hanover Medical Center, a United analysis put New Hanover at the very bottom for reimbursement rates out of 117 hospitals in the state. Tr. 413:24-414:7 (Daniels). After the acquisition, Novant negotiated a small rate increase to get New Hanover's rates closer to market level, but thereafter the rates trended back down. Tr. 415:21-416:7 (Daniels); DX 230 (United).

89. Post-transaction, Novant will continue to face substantial price competition from other health systems. PX 3125 (United); Tr. 425:8-22, 427:1-428:21 (Daniels). For example, Blue Cross markets two narrow networks in the Charlotte area—Blue Home and Blue Local—that feature Novant and Atrium, respectively. Tr. 157:1-158:1 (Page). When bidding to be featured in Blue Home, Novant extended a deeper discount than what Atrium provided under Blue Local. Tr. 158:8-12 (Page). Novant also competes with CaroMont and other systems when negotiating rates. Tr. 1005:3-7 (Murphy). That competition will continue post-transaction, further constraining Novant's ability to attempt an anticompetitive price increase. As such, insurer testimony about how bargaining leverage may be impacted *if* there were "no local alternatives" says nothing about the effects of this acquisition because there *are* a number of local alternatives today, and Atrium Lake Norman will open in a few months. Pruski Decl. Ex. 6 at 38:14-40:7 (CCH) (CCH "do[es]n't see any . . . direct impact to [its] members" from transaction, "especially in this geographic area, because there are . . . so many other options with coverage that Atrium provides").

90. Furthermore, as noted, per-unit prices are only part of health care costs; the total cost of care depends on many other factors, including a hospital's ability to reduce readmission rates, infection rates, length of stays, and long-term needs for care, as well as to provide preventative care to limit hospitalizations in the first place. Tr. 417:18-418:14 (Daniels); Tr. 1247:14-1248:14 (Armato) (Novant stroke detection technology means they "send people home

disability free"); Tr. 1485:6-1487:7 (Oliver) (reduction in C-section rates reduced total cost of care for Novant patients). Novant will have significant ability and economic incentive to reduce the total cost of care for Lake Norman and Davis patients—an ability and incentive that Lake Norman does not have today. *Supra* ¶¶ 48-50.

91. No insurer testified that the acquisition would increase the total cost of care. To the contrary, Blue Cross's representative agreed that, on a total cost of care basis, he could not "say whether Lake Norman Regional is a lower cost provider than Novant Huntersville." Tr. 150:8-18 (Page). Others agreed that Novant might *decrease* the total cost of care for Lake Norman patients. Tr. 474:21-475:12 (Portman) ("possible" that rates stay the same post-transaction and total cost of care decreases); Tr. 1673:21-1674:19 (Keibler) (transaction could lower total cost of care); Pruski Decl. Ex. 5 at 117:8-120:7 (Cigna) (same).

92. Finally, to address any claimed concern of rate increases at Lake Norman and Davis as a result of this transaction, Novant publicly has given insurers the option to (i) maintain existing rates at Lake Norman and Davis, or (ii) apply annual reimbursement rate escalators that are capped at the lesser of general inflation or increase in medical CPI, for three years. DX 677 at 004 (Novant); Tr. 895:17-22 (Ehtisham). These options will freeze rates at Lake Norman and Davis until well after CaroMont Belmont and Atrium Lake Norman open, the CON law changes take effect, and provides assurance of a rate lock while any potential litigation continues.

D. The Transaction Will Not Eliminate Substantial Non-Price Competition

93. The FTC also has not shown that Novant and Lake Norman are significant competitors on non-price terms. Lake Norman's former CEO agreed that Lake Norman was not "a threat" to Novant Huntersville. Tr. 267:6-8 (Littlejohn). And every Novant executive agreed that Novant does not view Lake Norman as a competitor at all. *Supra* ¶ 2.

94. The FTC has presented virtually no evidence to suggest that Novant makes

quality or service line improvements *because of* Lake Norman or that the elimination of Lake Norman as a competitor would reduce such improvements. As Dr. Tenn conceded, whatever reduction there might be in the incentive to compete, it would be *de minimis*, not substantial: "[C]ompetition will continue. . . . All I'm saying is it will be *a little bit* less vibrant." "It's *on the margin of a little bit less*." Tr. 1232:12-1233:16 (Tenn) (emphases added).

95. The FTC's reliance on a handful of documents—out of millions submitted to the FTC—to claim that Novant considers Lake Norman a competitor is misplaced. *First*, the FTC cited a single SBAR capital request authorization form authored by a radiology manager at Novant Huntersville that contains the phrase "constant competition with Lake Norman." Tr. 517:6-24 (Riley) (PX1208). The author of that document has no strategic planning role at Novant and is not involved in analyzing Novant's competitors. *Id*. The President of Huntersville, who received that request, does not recall ever discussing competition with Lake Norman as part of the several hundred SBAR requests he has received over the years. Tr. 516:15-518:6 (Riley).

96. *Second*, the FTC identified a single cardiologist—Dr. Cantor—that Novant successfully retained (by offering him a small increase in management responsibilities) after Lake Norman attempted to recruit him away. PX 1225; Tr. 820:22-821:9 (Ehtisham). Novant employs thousands of physicians in the Charlotte area. DX 001 at 188 (Wu). Moreover, Novant's efforts to retain cardiologists around Mooresville stemmed from its desire to "minimize outmigration to Sanger"—*Atrium's* heart and vascular institute—not to Lake Norman. PX 1058 at 011; Tr. 515:6-13 (Riley); *see also* Tr. 819:14-21 (Ehtisham).

97. *Third*, the FTC identified a single Novant neurosurgeon—Dr. Berry-Candelario—that Novant-affiliated physicians avoided, referring patients instead to a doctor at Lake Norman. PX 1024 (Novant). The fact that these patients went to Lake Norman in particular—as opposed

to any other hospital—did not influence Novant's response. Rather, consistent with Novant's general practice, once it identified that its affiliated physicians were unhappy with one of its doctors, Novant took steps to fix the situation without regard to where physicians were otherwise referring patients. Tr. 823:7-825:8 (Ehtisham).

98. The FTC's reliance on Lake Norman's SWOT analyses similarly show very little. Lake Norman's then-CEO explained that CHS's corporate office (in Tennessee) identified the hospitals for the SWOT analyses. Tr. 265:8-13 (Littlejohn). Moreover, the five "threats" to Lake Norman identified in the analyses include references to Atrium and Iredell, not to Novant. PX 2082 at 033 (CHS). Similarly, three of the five "threats" to Novant Huntersville are Atrium-related; none were about Lake Norman. Tr. 265:22-266:4 (Littlejohn); PX 2082 at 034 (CHS).

E. Novant Did Not Cancel Any Expansion at Huntersville Medical Center

99. The FTC claims Novant "cancelled" a "planned" 98-bed tower as a result of the transaction. The testimony established that those "plans" were drafted—and rejected—in 2019, years before the transaction was contemplated. PX 1082 (Novant); Tr. 505:14-506:9 (Riley); Tr. 881:4-7 (Ehtisham). And the "plans" were only "an overhead of the campus with a block on it." Tr. 504:24-505:13 (Riley); *compare* PX 1082 at 005, *with* PX 1156 at 007. The idea for the 98-bed tower never made it past the "conceptual" phase, let alone the several steps necessary for a project of that magnitude to be approved. Tr. 505:18-506:9 (Riley); *see also* Tr. 1258:9-1259:11 (Armato).

100. Novant continues to plan to expand Novant Huntersville. Tr. 506:20-507:3 (Riley). Plans to expand the emergency department and add beds are currently being assessed, for example, regardless of the outcome of the proposed transaction. Tr. 506:20-507:3 (Riley). Novant also has committed not to reduce capital expenditures at Novant Huntersville as a result of the proposed transaction. DX 677 at 002 n.2 (Novant); Tr. 1259:12-22 (Armato).

F. No Material Change in Tax Obligations of Acquired Hospitals

101. If the transaction is allowed to proceed, Lake Norman and Davis would be converted to non-profit entities. The conversions would have a limited impact on the hospitals' tax obligations. For example, the hospitals may be exempt from a total of $1.1 million in taxes,[8] but other tax obligations will remain unchanged.[9]

102. If the transaction is blocked, and Davis closes, there may be a loss of income taxes from the 87 Davis employees, as well as lost taxes on revenue from Davis's current vendors, and reduced sales taxes from economic activities related to Davis employees and visitors. On the other hand, if the transaction proceeds, federal and state income tax receipts may be higher from the 555 Lake Norman and 87 Davis employees' higher wages at Novant. Future taxes may also be higher with increases in employee headcounts at the acquired hospitals.

DEFENDANTS' PROPOSED CONCLUSIONS OF LAW

I. THE FTC FAILED TO SHOW A LIKELIHOOD OF SUCCESS ON THE MERITS

103. Section 13(b) permits preliminary injunctions only when the FTC shows a "substantial likelihood" of ultimately prevailing on the merits. *Atl. Richfield*, 549 F.2d at 291-92; 15 U.S.C. § 18. The standard is not, as the FTC has asserted, a "fair or tenable" chance of success. *See FTC v. Tenet Health Care*, 186 F.3d 1045, 1051 (8th Cir. 1999) ("A showing of a

[8] While the hospitals would be *eligible* to be exempt from state and county sales and use taxes up to a capped amount of $45 million, Novant already is at the cap, so the acquired hospitals would continue to pay these taxes at existing rates. The hospitals would be exempt from real and personal property taxes of approximately $1.1 million, and would be exempt from Federal Unemployment Tax Act obligations, which amount to less than $30,000 per year.

[9] For example, payroll taxes and State Unemployment Tax Act taxes would be paid at the same rates as today. The Lake Norman and Davis entities are partnerships that already pay no income taxes, so there is no change in that respect. Finally, the associated physician clinics will continue to pay property taxes at the same rates as today.

fair or tenable chance of success on the merits will not suffice for injunctive relief.").[10] The FTC also must show that "the equities" favor an injunction. *Atl. Richfield Co*., 549 F.2d at 291-92. The FTC's burden is "heavy," not "easily met," and not "highly preferential to the FTC," as it should be when the fate of the transaction hangs in the balance. *FTC v. Foster,* 2007 WL 1793441, at *50-51 (D.N.M. May 29, 2007). Indeed, a Section 13(b) injunction is "an extraordinary and drastic remedy" precisely because "it may prevent the transaction from ever being consummated." *FTC v. Microsoft Corp.*, 681 F. Supp. 3d 1069, 1084-85 (N.D. Cal. 2023) (quotation omitted).

104. To meet its burden of showing a likelihood of success on the merits, the FTC must prove the transaction is likely to "substantially . . . lessen competition" in a properly defined relevant market. 15 U.S.C. § 18; *Baker Hughes*, 908 F.2d 981, 983 (D.C. Cir. 1990) ("ultimate burden of persuasion . . . remains with the government"). The FTC has not done so. It has not proved a relevant geographic market or a relevant product market. Nor do statistical models or real-world evidence show that the transaction will substantially lessen competition.

A. The FTC Failed to Prove a Relevant Geographic Market

105. The FTC has failed to prove a relevant geographic market, which is fatal to its case. *FTC v. Thomas Jefferson Univ.*, 505 F. Supp. 3d 522, 543, 557-58 (E.D. Pa. 2020) (denying preliminary injunction when proposed market did not "correspond with commercial realities"); *see also Tenet*, 186 F.3d at 1051; *FTC v. Freeman Hosp*., 69 F.3d 260, 268 (8th Cir. 1995); *Cal. v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120 (N.D. Cal. 2001); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 975 (N.D. Iowa 1995); *United States v. Carilion Health*

[10] *See also Starbucks Corp. v. McKinney*, 22-7530 (U.S.); SCOTUSblog, https://tinyurl.com/mvu4p3we (Apr. 25, 2024) (forthcoming opinion likely to reject government's proffered, similarly lenient, preliminary injunction standard in NLRB matters).

Sys., 707 F. Supp. 840, 847 (W.D. Va. 1989), *aff'd*, 892 F.2d 1042 (4th Cir. 1989). A relevant geographic market "must both correspond to the commercial realities of the industry and be economically significant." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 123 (D.D.C. 2004) (quotation omitted). Specifically, the FTC must "present evidence on the critical question of where consumers of hospital services could practicably turn for alternative services should the merger be consummated and prices become anticompetitive." *Tenet*, 186 F.3d at 1053; *see also Freeman*, 69 F.3d at 268; *Jefferson*, 505 F. Supp. 3d at 540.

106. The FTC's "Eastern Lake Norman Area" market fails because it is not based on the commercial realities of where patients could obtain care if a combined Lake Norman/Novant were to set anticompetitive prices. Curiously, it excludes over a dozen more-proximate hospitals, many of which are closer substitutes than hospitals it includes, and from which patients seek care today. *Supra* ¶¶ 57-61. Courts reject proposed markets with such exclusions. *See, e.g.*, *Carilion*, 707 F. Supp. at 844 (where "significant number of patients from the areas that those hospitals serve choose to go to the Roanoke hospitals," which had "superior" services, those areas are relevant to competition); *Tenet*, 186 F.3d at 1053 (reversing in part because district court "discounted the fact that over twenty-two percent of people in the most important zip codes already use hospitals outside the FTC's proposed market"); *Mercy*, 902 F. Supp. at 979 ("The fact that the residents of southwest Wisconsin are willing to drive to Madison for their inpatient needs also shows the government's assumption that persons within twenty-five miles of Dubuque will only go to Dubuque … is an incorrect assumption.").[11]

[11] Contrary to the FTC's claim, Defendants did not use the Elzinga-Hogarty test, comparing patient "inflows" and "outflows," to assess the alleged geographic markets. Rather, Defendants analyzed outmigration from the FTC's alleged markets to assess "where consumers of hospital services could practicably turn for alternative services," *Tenet*, 186 F.3d at 1052; *Freeman*, 69 F.3d at 268; *Jefferson*, 505 F. Supp. 3d at 540, and where they go today.

107. As in *Carilion*, *Tenet*, and *Mercy*, the evidence here shows that patients are willing to travel for care. Indeed, this case is most similar to *Jefferson*, in which the court denied a preliminary injunction request when the FTC failed to properly define a relevant market because the fact that "numerous health systems and many more hospitals within a . . . small[] radius" meant insurers would not be forced to accept a price increase from the merging parties. 505 F. Supp. 3d at 545. Here, as there, the FTC arbitrarily included in its proposed geographic markets a hospital farther from, and viewed as less of a substitute for, a party hospital, but excluded from its proposed market closer substitutes for the parties' hospitals. *Compare Jefferson*, 505 F. Supp. 3d at 535-36, *with supra* ¶ 59.

108. In considering commercial realities to evaluate a proposed market, courts also evaluate the real-world evidence. *United States v. U.S. Sugar Corp.*, 2022 WL 4544025, at *24 (D. Del. Sept. 28, 2022), *aff'd* 73 F.4th 197 (3d Cir. 2023). Here, witnesses repeatedly testified that they do not refer to, or think in terms of, an "Eastern Lake Norman Area." Insurers look at a broader Charlotte area when they construct provider networks and negotiate rates. *Supra* ¶ 19. Novant and Atrium likewise define their respective markets as the "Greater Charlotte Market" and the "Greater Charlotte Region." *Supra* ¶ 65. And the Government recognized the same commercial reality when, along with the State of North Carolina, it sued Atrium for antitrust violations, defining the market as Mecklenburg and its surrounding counties. *Supra* ¶ 66. These facts explain why the FTC's expert, Dr. Tenn, could not point to a single piece of ordinary-course evidence that recognized an "Eastern Lake Norman Area" market. *Supra* ¶ 63.

109. Courts also look at what insurers have done, and can do, to create networks that exclude the merging hospitals. For example, courts consider whether insurers can "exclude hospitals from the plans' provider networks" when "faced with price increases." *Sutter*, 130 F.

Supp. 2d at 1129-30. The evidence demonstrated that, historically, insurers have formed networks that exclude both Lake Norman and Novant—in United's case, it secured a substantial discount from Atrium to do so. *Supra* ¶¶ 81, 87. Moreover, as in *Jefferson*, "healthcare insurer consolidation is high" in Charlotte, which gives insurers like Blue Cross and United considerable bargaining leverage. 505 F. Supp. 3d at 545; *see also supra* ¶ 19.

110. The FTC's alleged "Center City/Northern Charlotte" market also fails the commercial-reality test the case law requires. Indeed, it is not a "geographic" market at all, because Dr. Tenn was unwilling or unable to define and draw its geographic bounds. *Supra* ¶ 67. Section 7 requires identification of a "section of the country" in which competition may be substantially limited, 15 U.S.C. § 18—a provision interpreted by courts, including in the cases cited by the FTC, as requiring that the government prove a geographic market with boundaries. *See, e.g.*, *Little Rock Card. Clinic v. Baptist Health*, 591 F.3d 591, 598 (8th Cir. 2009) ("Properly defined, *a geographic market is a geographic area* in which the seller operates, and to which . . . purchaser[s] can practicably turn for supplies.") (emphasis added); *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 49 (D.D.C. 1998) ("[T]he relevant geographic market must be sufficiently defined so that the Court understands in which part of the country competition is threatened.").[12] And this market, like the "Eastern Lake Norman Area" one, still excludes relevant, nearby alternatives and does not align with how contracting occurs in the Charlotte area. *Supra* ¶ 69.

111. The FTC did not allege in the complaint, or raise in its pre-hearing briefing, Dr.

[12] The other cases cited by the FTC also defined a geographic area: *FTC v. Hackensack Meridian Health, Inc.*, 30 F.4th 160, 167 (3d Cir. 2022) (Bergen County, New Jersey); *FTC v. Penn State Hershey*, 838 F.3d 327, 346 (3d Cir. 2016) (four-county Harrisburg area); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1210-11 (11th Cir. 1991) (Augusta, Georgia); *FTC v. ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *10 (N.D. Ohio Mar. 29, 2011) (Lucas County, Ohio); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1077 (N.D. Ill. 2012) (area defined by 30-minute drive from downtown Rockford, Illinois).

Tenn's other market—the so-called "Eastern Lake Norman Area Plus Center City" market. *Supra* ¶ 68. To the extent the FTC nevertheless seeks to rely on that market now, it fails for the same reasons as the others: it fails to define any particular geographic boundaries; it excludes several hospitals directly between its two pieces, the "Eastern Lake Norman Area" and "Center City" (and several other, closer hospitals in terms of drive time and diversion ratios); and does not correspond to the realities of how commercial contracting occurs. *Supra* ¶ 68.

B. The FTC Failed to Prove a Relevant Product Market

112. The FTC also failed to prove that its proposed product market accords with commercial realities, including the strong, growing trend that blurs the lines between inpatient and outpatient services. Among other flaws, the FTC's product market ignores that hospitals and insurers contract for inpatient and outpatient services in the same contract. *Supra* ¶ 71. In "evaluating the reasonableness of the merger as a whole, and not just for a single type of service," it is appropriate to include both inpatient *and* outpatient services in a market, *United States v. Carilion Health Sys.*, 892 F.2d 1042, at *3 (4th Cir. 1989) (unpublished), because "outpatient clinics … treat medical problems for which patients might otherwise have sought treatment in an inpatient hospital setting," *Carilion*, 707 F. Supp. at 847; and the testimony here was consistent about the once-novel-but-now-current commercial reality that many services can be performed in both inpatient and outpatient settings, *supra* ¶ 71.[13]

113. The FTC's further restriction of the relevant product market to "overlapping"

[13] Writing in 1989, before the trend accelerated, the Fourth Circuit took note of the evidence that insurers "have restructured their reimbursement policies in recent years in order to encourage patients to use outpatient services," supporting its conclusion that "outpatient services compete with the defendants' hospitals to treat various medical needs." *Carilion*, 892 F.2d at *1. The same conclusion applies here, given the many, and growing number of, "front doors" opened by Atrium and other systems. *Supra* ¶¶ 12, 71.

services ignores that insurers contract for the full range of services hospitals offer. Indeed, given Lake Norman's recent history of service-line cuts, the FTC's definition does not pin down a product market at all. By the FTC's logic, if next month Lake Norman offered half the number of MS-DRG-coded services it offered last month, or just 10, or even just 1, the relevant product market would consist only of that limited number of overlapping services.

C. The FTC's Market-Share Calculations Are Overstated

114. The flaws in the FTC's geographic and product market definitions are fatal to its case. So, too, are the flaws in the FTC's market share and market concentration statistics. Historical and stagnant market share statistics—viewed apart from a market's "structure, history and probable future"—are "not conclusive indicators of anticompetitive effects." *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974) (quotation omitted). Where, as here, a firm's performance is declining with no prospect of improving, "market share statistics do not accurately reflect the [p]roposed [transaction]'s likely effects on competition." *New York v. Deutsche Telekom AG*, 439 F. Supp. 3d 179, 224 (S.D.N.Y. 2020); *see also Arch Coal, Inc.*, 329 F. Supp. 2d at 157. Yet the FTC's calculations make no effort to reflect Lake Norman's downward trajectory. The FTC instead has been the sole voice claiming the hospital is not in decline. *Compare* Tr. 36:12-20 (FTC opening claiming Lake Norman is "steady"); *with supra* ¶¶ 22-32 (collecting evidence regarding decline and future risks from Atrium Lake Norman's opening, changes in CON laws, and lack of adequate physician network). The FTC also makes no attempt to account for Atrium's current patient selection in the FTC's "Eastern Lake Norman Area," or Atrium's plans for growth there, *supra* ¶¶ 13-14, 55-56, "mak[ing] the mistake of relying too heavily on past conditions," *Mercy*, 902 F. Supp. at 978.

115. Indeed, the FTC's statistics hold no weight when its calculations are based on so-called markets that its expert economist cannot even describe; an "infinite" number of

geographies is not an antitrust market. *Supra* ¶ 67; *see also supra* ¶ 78 n.6. Nor are they credible when those calculations rely on hospital-based shares that attribute an implausible 0% share today, and a meager 13.8% share post Atrium Lake Norman opening, to the dominant health system in the region. *Supra* ¶ 56. And yet, even with all of those flaws, the FTC's *own* estimates of Herfindahl-Hirschman Index ("HHI") market concentration change for its backup market fall below the levels of every other case presented by the FTC as a benchmark. Tr. at 1928:20-1930:17 (Tenn); *e.g.*, *FTC v. Sanford Health,* 2017 WL 10810016, at *12 (D.N.D. Dec. 15, 2017) (changes in HHIs for various product markets of 3,531, 4,602, 1,152, and 4,393); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 347 (3d Cir. 2016) (change in HHI of 2,582); *Saint Alphonsus Med. Ctr. v. St. Luke's Health Sys., Ltd.*, 2014 WL 407446, at *8 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775 (9th Cir. 2015) (change in HHI of 1,607).

116. When even some of the FTC's flaws are corrected, the shares and concentration level changes fall below both the 2010 and 2023 Merger Guidelines. *Supra* ¶ 78. The FTC therefore has not established it is entitled to a presumption of anticompetitive harm.

D. The FTC Failed to Establish A Substantial Lessening of Competition

117. The FTC's case also fails because it did not establish the likelihood of a substantial lessening of competition. *Atl. Richfield*, 549 F.2d at 291; 15 U.S.C. § 18. Once again, *Jefferson* provides a useful example: there, the court concluded it was unlikely that the transaction would substantially lessen competition on grounds similar to what the evidence has shown here.

118. *First*, the *Jefferson* court highlighted the absence of "extensive evidence … showing that insurers … would have no choice but to accept a price increase." 505 F. Supp. 3d at 552. Here, too, insurers already offer plans that exclude both Novant and Lake Norman. *Supra* ¶ 87. And insurer testimony that rates may increase "does not help the Government meet its

burden of proof" where insurers do not have health plans directed to the alleged market: "It makes little sense that [an insurer] would pay higher reimbursement rates to hospitals because of their purported importance to areas [the insurer] does not believe to be distinct submarkets." *Jefferson*, 505 F. Supp. 3d at 551-52; *supra* ¶ 64. Moreover, evidence that Novant's *preexisting* contractual reimbursement rates are higher than CHS's existing contractual reimbursement rates does not satisfy the FTC's burden of showing that the merger is likely to substantially lessen competition. *Supra* ¶ 86 n.7.[14] If Novant acquired a hospital across the country, the contract provision could result in a change in unit price, but not because of a reduction in competition. Plus, networks excluding Novant and Lake Norman are viable here. This case, like *Jefferson*, thus is different from hospital merger cases enjoined by courts where insurers "genuinely believed that a plan that excluded [both merging parties] was not viable." *Jefferson*, 505 F. Supp. 3d at 543-44 (alterations accepted) (distinguishing *FTC v. Advocate Health Care Network*, 2017 WL 1022015 (N.D. Ill. Mar. 16, 2017)); *see also FTC v. Sanford Health*, 926 F.3d 959, 963-64 (8th Cir. 2019) (three largest insurers testified networks would not be marketable without inclusion of services controlled by merging parties).

119. *Second*, as in *Jefferson*, the FTC has not shown that the merging parties are substantial competitors. *Compare* 505 F. Supp. 3d. at 535-36 ("While Einstein aspires to compete with Jefferson, … Jefferson identifies its primary competition as [four other health systems]."), *with supra* ¶ 2 (Novant considers Atrium and CaroMont as its primary competition),

[14] Where an insurer has "a clear motive, other than antitrust concerns, to oppose this merger," its testimony may "merit little weight." *Jefferson*, 505 F. Supp. 3d at 550-51; *see FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302 (W.D. Mich. 1996), *aff'd* 121 F.3d 708 (6th Cir. 1997) ("[T]he interests of [insurers] pale in comparison with those of the actual health care consuming public, whose interests, this Court is convinced, would ultimately be best served by granting defendants freedom to proceed with the merger.").

and *supra* ¶¶ 83-84 (insurers do not consider Lake Norman during negotiations with Novant). Indeed, by Dr. Tenn's own admission, any reduction in the incentive to compete would be *de minimis*, not substantial: "a little bit less vibrant" and "on the margin of a little bit less." *Supra* ¶ 94. Dr. Tenn was answering a question from the Court about competition on quality. But his concession applies equally to price competition because healthcare competition involves both price and quality. *Supra* ¶ 79.

120. This case is a far cry from other hospital merger cases on which the FTC seeks to rely. When measured by the number of beds to be acquired (123), this transaction is by far the smallest of any of the FTC's cases—even putting aside that most of Lake Norman's 123 beds are empty today. *Cf., e.g.*, Compl. ¶ 21, *FTC v. Advocate Health Care Network*, 15-cv-11473 (N.D. Ill. Dec. 22, 2015) (hospital system to be acquired had 801 licensed beds); *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552, 554 (M.D. Pa. 2016) (646 licensed beds); *FTC v. Hackensack Meridian Health, Inc.*, 2021 WL 4145062, at *3 (D.N.J. Aug. 4, 2021) (531 licensed beds). Neither Novant nor Lake Norman is the largest provider in the Charlotte area. *Cf. e.g., Hackensack,* 2021 WL 4145062, at *1 (acquiring entity already "the largest health system in New Jersey"); Compl. ¶¶ 30, 38, *Saint Alphonsus Med. Ctr. v. St. Luke's Health Sys., Ltd.*, 12-cv-00560 (D. Idaho Nov. 12, 2012) (acquiring hospital already a "near monopoly" and had "dominant position … in the Boise area"). Nor are Novant Huntersville and Lake Norman two of the largest hospitals in the area. *Cf. Hershey*, 838 F.3d at 333 (proposed merger was between "the two largest hospitals in the Harrisburg, Pennsylvania area"). And this is not a case where the lower-quality hospital is acquiring the higher-quality hospital. *Cf. FTC v. ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *29-*30 (N.D. Ohio Mar. 29, 2011) (facility to be acquired was "high quality, low cost hospital," and physicians considered its "quality [to be] higher" than the

acquirer).[15] As the *Hackensack* court explained when granting a preliminary injunction: "this merger is fundamentally different than, for example, *a merger where a large successful health system acquires a small, failing hospital*." 2021 WL 4145062, at *29 (emphasis added).

E. The Transaction Will Enhance Competition

121. For all these reasons, the FTC has not met its burden to show that the transaction will substantially lessen competition. To the contrary, the evidence has shown that the transaction will likely *enhance* competition in the Charlotte area. For example, the FTC's unproven hypothesis that unit prices would rise by a total of $5 million because of this transaction does not support the proposition that the *total* cost of care would increase. The FTC has not even attempted to make such a showing. By contrast, Novant demonstrated that its value-based contracts have generated savings—benefits that would extend to Lake Norman after the transaction. *Supra* ¶ 50. And insurers uniformly testified that a higher quality hospital can provide lower *total* cost of care even if *unit* prices increase, while acknowledging Novant's superior performance in reducing the total cost of care. *Supra* ¶¶ 90-91.

122. Further, in evaluating alleged anticompetitive effects, "a court must necessarily compare what may happen if the merger occurs with what may happen if the merger does not occur." *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 700 (8th Cir. 1979). The evidence established that, if the transaction is blocked, Davis will close immediately, and Lake Norman will continue to decline. *Supra* ¶ 40. If, on the other hand, the transaction proceeds, the overwhelming weight of the evidence is that Novant's acquisition would restore services to both Lake Norman and Davis—indeed, save Davis from imminent closure—and improve the quality of care, patient

[15] The FTC's successful efforts to block the transaction in *ProMedica* ultimately led to the closure of the hospital that would have been acquired. Tr. 1197:11-1198:18 (Tenn).

safety, and healthcare outcomes for patients, thus spurring other hospitals to compete more vigorously for those patients. *Supra* ¶¶ 41-50.

123. In short, with the transaction, Lake Norman will be able to compete with Atrium, Iredell, CaroMont, and other Charlotte-area hospitals for patients—something it is unable to effectively do today. *Supra* ¶¶ 22-32. More patients will choose to receive care at Lake Norman, rather than going to higher-cost Atrium hospitals, which will reduce costs overall. *Supra* ¶ 82. Similarly, Novant, with a revitalized Lake Norman as part of its Charlotte network, will be a more attractive alternative for insurers, giving them additional leverage to negotiate lower rates from Atrium and resulting in cost savings for patients. *Supra* ¶ 82. The fact that "defendants seek to merge in order to strengthen, rather than reduce, competition" is particularly relevant because "[g]reater competitiveness—in both prices charged and the quality of services offered—serves to benefit both patients and those who pay for their health care." *Carilion*, 707 F. Supp. at 849.

124. The FTC now disputes that these benefits are "competitive effects," and demotes them to "efficiencies." The FTC's complaint specifically alleged that quality *was* a component of hospital competition, ECF 1 ¶ 61, a fact every market participant also recognized, *supra* ¶ 79. The FTC has since tried to dismiss the value of improved quality in every conceivable way, calling it "irrelevant" in earlier briefing, ECF 99 at 2, and now trying to relegate improved quality to an "efficiency" to be ignored, not a key element of competition. Cases discussing "efficiencies," however, primarily contemplate cost-avoidance measures, not the type of competition-enhancing measures at issue here. *Cf. FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1089-91 (N.D. Ill. 2012) (costs savings); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1223 (11th Cir. 1991) (reduce duplication); *Hershey*, 838 F.3d at 349-50 (capital savings and alleviation of capacity constraints).

125. Moreover, an efficiency analysis does not help the FTC's attempt to deny the benefits of the transaction. The benefits from the transaction, whatever they are labeled, rebut any claim the FTC may make regarding anticompetitive effects.[16] They also are merger-specific and verifiable. Regarding merger specificity: given its debt, CHS will not, and cannot responsibly, invest in Lake Norman or Davis. *Supra* ¶¶ 20-21, 40. The FTC's many "what if" questions—what if CHS invested growth capital, developed partnerships, or found a new buyer—are not just speculation; they are directly contracted by the record and the testimony from CHS's Chief Financial Officer. *Id*; *accord Sutter*, 130 F. Supp. 2d at 1136 (acquired hospital "sought out numerous potential partners"). The evidence established conclusively that CHS is not going to invest, and there is no other suitor waiting to take on this challenge.

126. The benefits also are verifiable. Novant has made concrete plans and commitments to invest and has a proven record of (and strong economic and reputational incentives for) delivering quality of care improvements. *Supra* ¶¶ 41-50. These prospects of enhancing competition are verifiable, not speculative, as in the cases cited by the FTC. And the Court here has had the opportunity to judge the credibility of witnesses in charge of those plans—Mr. Armato, Dr. Ehtisham, and Dr. Oliver—not experts, as in other cases. *Cf. Advocate*, 2017 WL 1022015, at *14-*15; *ProMedica*, 2011 WL 1219281, at *35; *see also FTC v. Butterworth Health Corp.*, 121 F.3d 708, at *2 (6th Cir. 1997) (unpublished) (defendant's commitment to freeze prices supported finding that merger would not have significant anticompetitive effects).

[16] *See, e.g.*, *Arch Coal, Inc.*, 329 F. Supp. 2d at 129 (benefits of transaction, though not sustaining an efficiencies or failing firm defense, "successfully rebut[] plaintiffs' fairly weak prima facie case of a Section 7 violation"); *Deutsche Telekom*, 439 F. Supp. 3d at 206-07 (weak *prima facie* case rebutted by evidence of transaction's efficiencies, that entity to be acquired was weakened competitor, and "new vigorous competitor" in alleged market).

127. The benefits will meaningfully enhance Lake Norman's competitiveness. And the benefits of higher quality and a lower total cost of care will be passed through to insurers and patients. The ultimate benefit is continued community access to these hospitals, which is not assured absent the transaction.

F. The FTC's Challenge Suffers from Constitutional Defects

128. Several constitutional defects further preclude the FTC from succeeding on the merits.[17] *First*, restrictions on removing FTC ALJs violate the President's constitutionally grounded, "unrestricted removal power." *Seila L. LLC v. CFPB*, 591 U.S. 197, 204 (2020). FTC ALJs are insulated from removal in multiple ways: they can only be removed for cause, 5 U.S.C. § 7521, and the FTC Commissioners and Merit System Protection Board members involved in removing ALJs are themselves removable only for cause. *Id.* § 1202(d); 15 U.S.C. § 41. Because FTC ALJs "perform substantial executive functions," these multi-layered tenure protections are unconstitutional. *Jarkesy v. Sec. & Exch. Comm'n*, 34 F.4th 446, 463 (5th Cir. 2022), *cert. granted*, 143 S. Ct. 2688 (2023). FTC Commissioners are principal Executive Branch officers wielding significant executive power, so their lack of at-will removal also is unconstitutional.

129. *Second*, the FTC's contemplated enforcement action seeks divestiture of property, which cannot be "assigned to agency adjudication under the public-rights doctrine." *Jarkesy*, 34 F.4th at 455. *Third*, FTC administrative proceedings violate due-process principles. The ALJ's factual and legal conclusions are subject to *de novo* review by the same Commissioners who greenlit the enforcement action, 16 C.F.R. §§ 3.11(a), 3.54(a)—improperly rendering the Commissioners "both accuser and adjudicator," *Williams v. Pennsylvania*, 579 U.S. 1, 8 (2016).

[17] Recognizing that the Court has not requested briefing on these defects, ECF 90 (order denying FTC's motion to strike, reserving further briefing), Defendants only note them briefly.

Finally, the FTC's ability to pick between proceeding in-house or in court violates nondelegation principles because "Congress did not provide the [FTC] with an intelligible principle by which to exercise that power." *See Jarkesy*, 34 F.4th at 462.

II. THE BALANCE OF EQUITIES FAVORS DENYING THE FTC'S MOTION.

130. Finally, Section 13(b) requires the Court to balance "the equities" implicated by injunctive relief. *Atl. Richfield Co.*, 549 F.2d at 292. In doing so, "[t]he Court considers whether the *injunction*, not the *merger*, would be in the public interest." *Jefferson*, 505 F. Supp. 3d at 538 (quotation omitted). "The question is whether the harm that the [h]ospitals will suffer if the merger is delayed will, in turn, harm the public more than if the injunction is not issued." *Id*.

131. Absent an injunction, Novant has committed to keep Davis open while litigation continues. It has committed to cap rate increases at both Davis and Lake Norman for three years, *supra* ¶ 92, which neutralizes any hypothetical interim harm, *Microsoft*, 681 F. Supp. 3d at 1100; *Jefferson*, 505 F. Supp. 3d at 558 (because FTC cannot "show a substantial threat to competitive hospital prices," the public equities urged by it are "substantially weakened"). And it has committed to immediately make the investments CHS has been unable to make for years, irrespective of the continuing litigation risk. *Supra* ¶ 46. While any appeal of the Court's decision is pending, Novant will get to work implementing a new Epic EMR system, restoring services, adding staff, improving the quality of care at both Lake Norman and Davis, and incorporating both hospitals into a system that achieves a lower total cost of care. *Supra* ¶ 41-50.

132. These benefits, which would only enhance the value of the hospitals if they were later subject to divestiture, would be lost entirely if the acquisition were enjoined. The harm to the parties and the public in delaying—in reality, blocking—this transaction includes the immediate closure of Davis, and the continued decline of Lake Norman. *Supra* ¶ 40. Both would "harm the public more than if the injunction is not issued." *Jefferson*, 505 F. Supp. 3d. at 538.

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