IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
STATESVILLE DIVISION
CIVIL ACTION NO. 5:24-cv-00028-KDB-SCR

FEDERAL TRADE COMMISSION,

Plaintiff,

v.

NOVANT HEALTH, INC.

and

COMMUNITY HEALTH SYSTEMS, INC.,

Defendants.

REDACTED VERSION OF DOCUMENT FILED UNDER SEAL (ECF 212)

PLAINTIFF'S PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

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GLOSSARY OF ABBREVIATED OR DEFINED TERMS

1. Exhibits and Transcripts

App'x	Appendix
DX	Defendants' Exhibits
fig.	Figure
Tr.	Preliminary Injunction Hearing Transcript
PX	Plaintiff's Exhibits
tbl.	Table

2. Documents and Filings

Novant Answer	Answer and Defenses of Defendant Novant Health, Inc. (February 8, 2024) (ECF No. 45)
CHS Answer	Answer and Defenses of Defendant Community Health Systems (February 8, 2024) (ECF No. 46)
Mem.	Memorandum in Support of Preliminary Injunction (ECF No. 80)
Opp.	Defendants' Opposition to Plaintiff's Request for Preliminary Injunction (ECF No. 91)
Reply	Plaintiff's Reply in Further Support of Preliminary Injunction (ECF No. 99)
Jha MIL	Memorandum in Support of Plaintiff's Motion to Exclude Expert Testimony of Dr. Ashish Jha (ECF No. 116-2)
Opp. Tenn MIL	Plaintiff's Opposition to Defendants' Motion to Exclude Portions of Expert Testimony of Dr. Steven Tenn (ECF No. 169)
Guidelines	U.S. Dep't of Justice & Fed. Trade Comm'n, *Merger Guidelines* (2023)
HMG	U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* (2010)
FOF	Plaintiff's Proposed Findings of Fact
COL	Plaintiff's Proposed Conclusions of Law

3. Names and Terms

ACO	Accountable Care Organization
Aetna	Aetna, Inc.
Ambetter	Centene Corporation's Ambetter of North Carolina
ASC	Ambulatory Surgical Center

Atrium	Advocate Health (d/b/a Atrium Health)
Atrium CMC	Atrium Health Carolinas Medical Center
Atrium Cabarrus	Atrium Health Cabarrus
Atrium Lake Norman	Atrium Health Lake Norman
Atrium Mercy	Atrium Health Mercy
Atrium University City	Atrium Health University City
BCBS	Blue Cross Blue Shield North Carolina
CaroMont	CaroMont Health, Inc.
Catawba	Catawba Valley Health System
CHS	Community Health Systems, Inc.
Cigna	Cigna Healthcare
CON	Certificate of Need
Davis	Davis Regional Medical Center
EMR / EHR	Electronic Medical Record / Electronic Health Record
ER	Emergency Room
GAC	General Acute Care
HHI	Herfindahl-Hirschman Index
HMT	Hypothetical Monopolist Test
Iredell	Iredell Health System
Iredell Memorial	Iredell Memorial Hospital
Kaufman Hall	Kaufman Hall & Associates LLC
LNR	Lake Norman Regional Medical Center
LifePoint	DLP Healthcare, LLC
Morgan Stanley	Morgan Stanley & Co LLC
NCCON	Healthcare Planning and Certificate of Need Section, N.C. Department of Health & Human Services
Novant	Novant Health, Inc.
Novant Ballantyne	Ballantyne Medical Center
Novant Charlotte Orthopedic	Charlotte Orthopedic Hospital
Novant Huntersville	Huntersville Medical Center
Novant Matthews	Matthews Medical Center
Novant Mint Hill	Mint Hill Medical Center
Novant New Hanover	New Hanover Regional Medical Center
Novant Presbyterian	Presbyterian Medical Center
Novant Rowan	Rowan Medical Center
PHM	Population Health Management

Transaction	Proposed Transaction
SSNIPT	Small but Significant and Non-Transitory Increase in Price or Other Worsening of Terms
UNC Health	UNC Health Care System
United	UnitedHealth Group Inc.
VBC	Value-Based Contracts

4. Hearing Witnesses (in Order of Appearance)

Troy Page	BCBS
Matthew Littlejohn	CHS (Former)
Nicola DiPace	CHS
Stephen Daniels	United
Joel Portman	Ambetter
Michael Riley	Novant
David Cyganowski	Kaufman Hall
Kenneth Haynes	Atrium
Miguel Benet	CHS
John Green	Iredell
Tina Music	CHS
Saad Ehtisham	Novant
Dr. Lawton Robert Burns	FTC Expert
Frank del Murphy	CaroMont
Dr. Steven Tenn	FTC Expert
Carl Armato	Novant
Dr. Ashish Jha	Defendants' Expert
Dr. Pamela Oliver	Novant
Ronald Wyatt	Town Manager, Troutman, North Carolina
Kevin Hammons	CHS
Jason Keibler	Aetna
Farley Reardon	LifePoint
Dr. Lawrence Wu	Defendants' Expert

5. Deponents Cited in Proposed Findings of Fact (in Alphabetical Order)

Carl Armato	Novant	PX7023 (IH Tr.); PX7045 (Dep. Tr.)
Bruce Belland	Cigna	PX7013 (IH Tr.); PX7058 (Dep. Tr.)
Michael Berwanger	CHESS	PX7052 (Dep. Tr.)

Craig Conti	CHS	PX7015 (IH Tr.)
Stephen Daniels	United	PX7006 (IH Tr.)
Lili Driggs	Morgan Stanley	PX7060 (Dep. Tr.)
John Gizdic	Novant	PX7047 (Dep. Tr.)
John Green	Iredell	PX7003 (IH Tr.)
Dr. Philip Greene	LifePoint	PX7007 (IH Tr.)
Andrea Gymer	Novant	PX7017 (IH Tr.); PX7041 (Dep. Tr.)
Kenneth Haynes	Atrium	PX7009 (IH Tr.); PX7029 (Dep. Tr.)
Erik Helms	Novant	PX7022 (IH Tr.); PX7032 (Dep. Tr.)
Dr. Ashish Jha	Defendants' Expert	PX7064 (Dep. Tr.)
Dennis Johnson	Catawba	PX7008 (IH Tr.)
Jason Keibler	Aetna	PX7005 (IH Tr.); PX7044 (Dep. Tr.)
Matthew Littlejohn	CHS	PX7024 (Dep. Tr.)
Mark Medley	CHS	PX7021 (IH Tr.); PX7031 (Dep. Tr.)
Michaela Mitchell	NCCON	PX7043 (Dep. Tr.)
Frank Delmar Murphy	CaroMont	PX7001 (IH Tr.); PX7034 (Dep. Tr.)
Paul Novak	Novant	PX7039 (Dep. Tr.)
Troy Page	BCBS	PX7037 (Dep. Tr.)
Joel Portman	Ambetter	PX7057 (Dep. Tr.)
Lisa Qualls	Town Commissioner, Mooresville, NC	PX7049 (Dep. Tr.)
Farley Reardon	LifePoint	PX7004 (IH Tr.); PX7055 (Dep. Tr.)
Dr. Lawrence Wu	Defendants' Expert	PX7063 (Dep. Tr.)

EXECUTIVE SUMMARY

Following a six-day evidentiary hearing, the core facts about the Transaction are no longer in dispute. The evidence overwhelmingly shows that Novant Huntersville and LNR are close competitors and that their rivalry has benefited residents through increased investments and improved services. FOF ¶¶ 54-77. The evidence also confirms that the FTC's alleged geographic markets reflect commercial realities, FOF ¶¶ 24-46, and that the Transaction is presumptively illegal by wide margins under various scenarios, FOF ¶¶ 47-53. These facts go far beyond what is necessary for the Court to maintain the status quo until the Transaction can be adjudicated in a full trial on the merits. In fact, the evidence reflects a straightforward case of hospital consolidation that closely mirrors numerous mergers preliminarily enjoined over the past decade. *See, e.g.*, *FTC v. Hackensack Meridian Health, Inc.*, 30 F.4th 160 (3d Cir. 2022); *FTC v. Sanford Health*, 926 F.3d 959 (8th Cir. 2019); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016); *FTC v. Advocate Health Care*, 841 F.3d 460 (7th Cir. 2016); *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys.*, 778 F.3d 775 (9th Cir. 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014).

To avoid this straightforward outcome, Defendants argue that LNR is purportedly in decline and Novant would allegedly improve LNR's quality of care. There is no dispute, however, that such claims should be evaluated under the rigorous standards for "efficiencies" and "weakened competitors." COL ¶¶ 27-38. To date, no federal court has accepted claims of quality improvements or deteriorating facilities to overcome prima facie evidence that a hospital merger will eliminate competition. *See* COL ¶ 27. And for good reason: in enacting the antitrust laws, Congress resolved that competition will presumptively provide superior public benefits than could be achieved by even a benevolent monopolist. *See NCAA v. Bd. of Regents*, 468 U.S. 85,

104 n.27 (1984) ("[T]he unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress.").

Defendants seek to corner this Court into choosing between Novant—which offered unsupported promises to invest (albeit less than CHS did pre-merger)—and CHS—which has offered unsupported promises to minimize investment in the event the Transaction is enjoined. But this is a false choice. In the first instance, Defendants ignore the impact of lost competition between Novant and CHS if the Transaction goes through. The hearing revealed that the Transaction has already dampened Novant's and CHS's incentives to compete with one another: CHS chose to dramatically reduce its investment in LNR following the Transaction, FOF ¶¶ 74, 77, 97, and, after the deal was announced, Novant discontinued plans for $190 million in capital expansions that would have added 100 beds to Novant Huntersville, FOF ¶ 76. That aside, evidence also shows that CHS is capable of, and would be incentivized to, invest to ensure patient safety as well as to maintain its facilities to attract an alternative buyer if it so chooses. FOF ¶¶ 91-99. Second, the choice is not between Novant and CHS at all; rather, CHS has many potential buyers that it either chose not to pursue or pursued only fleetingly. FOF ¶¶ 108-09.

Regardless, in this action under Section 13(b) of the FTC Act, the Court need not speculate about what the future will hold or even whether the Clayton Act has in fact been violated. Rather, the Court need only determine whether the FTC has shown "preliminarily, by affidavits or other proof, that it has a fair and tenable chance of ultimate success on the merits." *In re Sanctuary Belize Litig.*, 409 F. Supp. 3d 380, 396 (D. Md. 2019), *aff'd*, 795 F. App'x 184 (4th Cir. 2020). The FTC has amply met its burden here and the Transaction should be preliminarily enjoined.

PLAINTIFF'S PROPOSED FINDINGS OF FACT

I. THE TRANSACTION

1. In response to an [redacted] at 1, CHS began soliciting bids for LNR and related assets in July 2022. PX7015 111-12 (Conti); PX1010 (Novant) at 2. CHS's "decision to sell or not [was to] be based on the expressions of interest [CHS] receive[d]." DX312 (LifePoint) at 4; *see generally* PX2060 (CHS).

2. Novant has wanted to acquire LNR for years. PX7015 110 (Conti); Tr. 534-35 (Kaufman Hall); PX7023 65-66 (Armato). Since 2016, though, CHS has worried that selling LNR to Novant would result in drawn-out antitrust scrutiny. Tr. 534-35, 540 (Kaufman Hall); *see also* PX3045 (Kaufman Hall) at 1.

3. Kaufman Hall advised—and Novant ultimately agreed—that Novant needed to "submit a 'wow' initial bid to offset the anti-trust risk . . . ," PX3045 (Kaufman Hall) at 1, to "send a crystal-clear signal to [CHS] that Novant is prepared to pay a premium to offset" that risk, PX3047 (Kaufman Hall) at 3, and "to beat out other bidders," Tr. 527 (Kaufman Hall). *See also* PX3047 (Kaufman Hall) at 1; PX3090 (Kaufman Hall) at 1.

4. In September 2022, Novant proposed to acquire LNR and related assets for $300 million. PX2217 (CHS) at 2. In October, Novant and CHS executed a letter of intent. *See generally* PX2218 (CHS). Novant signed a second letter of intent to acquire Davis for an additional $20 million in January 2023. PX1172 (Novant) at 1. On February 28, Novant and CHS entered into a purchase agreement, whereby Novant would acquire LNR, Davis, and related assets for $320 million. Novant Answer ¶ 22; CHS Answer ¶ 22; *see generally* PX1004 (Novant).

II. THE PARTIES TO THE TRANSACTION

5. Novant is one of the largest non-profit health systems in the southeast United States with

$7.6 billion in 2022 revenue, 19 hospitals, approximately 800 outpatient facilities and physician offices, and over 2,000 employed or affiliated physicians. Novant Answer ¶¶ 17-18; PX5069 (Public) at 1; PX1006 (Novant) at 6. Novant has six hospitals located in or near Charlotte: Huntersville, Presbyterian, Mint Hill, Matthews, Ballantyne, and Rowan. Novant Answer ¶ 18; PX1166 (Novant) at 4. Huntersville, a 151-bed GAC community hospital located in northern Mecklenburg County, is the closest operating hospital to LNR. Novant Answer ¶ 18; PX1166 (Novant) at 4; Tr. 480 (Riley); [redacted]

6. CHS is a publicly traded company and one of the nation's largest for-profit health systems with $12.5 billion in 2023 net operating revenue, 71 hospitals, and more than 1,000 additional sites of care across 15 states. CHS Answer ¶ 20; PX5042 (Public) at 3, 8; PX5043 (Public) at 1. CHS operates two hospitals in North Carolina: LNR and Davis. CHS Answer ¶ 21; PX5042 (Public) at 49. LNR is a 123-bed GAC community hospital located in southern Iredell County. CHS Answer ¶ 21; Tr. 480-81 (Riley). In 2022, CHS converted Davis, located in Statesville, from a GAC hospital to a behavioral health hospital. CHS Answer ¶ 21. CHS also employs about 24 physicians in North Carolina, has a majority interest in an endoscopy center in Mooresville, and holds a CON to build a new ASC in Mooresville. *See* PX1010 (Novant) at 2; PX1004 (Novant) at 36; PX4004 (Advocacy) at 1.

III. PROCEDURAL HISTORY

7. On January 25, 2024, the Commission voted unanimously to authorize staff to obtain preliminary injunctive relief under Section 13(b) of the FTC Act. PX5045 (Public) at 1.

IV. FUNDAMENTALS OF HOSPITAL COMPETITION AND PRICING

8. Hospital competition occurs in two stages. First, hospitals compete for inclusion in insurers' networks. Tr. 1110 (Tenn). Second, hospitals compete for patients. Tr. 1110 (Tenn).

9. ***Stage 1 Competition***: Within a given geography, insurers contract with hospitals (and other providers) whose services are demanded by the insurer's current or prospective members. Tr. 98 (BCBS); Tr. 1110-12 (Tenn); PX0001 (Tenn Rpt.) ¶ 47; Tr. 345 (United). These contract negotiations determine the reimbursement rates and other non-price terms for a hospital treating the insurer's members. PX0001 (Tenn Rpt.) ¶ 47; Tr. 459 (Ambetter).

10. The relative bargaining leverage of an insurer and a hospital determines the contracted reimbursement rate and non-price terms. Tr. 1110-11 (Tenn); PX0001 (Tenn Rpt.) ¶¶ 48-49. All else equal, a hospital has bargaining leverage if its absence would make the insurer's provider network less attractive and marketable. Tr. 1111 (Tenn); PX0001 (Tenn Rpt.) ¶ 49; Tr. 115-16 (BCBS); Tr. 461 (Ambetter). A hospital's leverage depends largely on whether other proximate hospitals could serve as viable in-network substitutes in the eyes of the insurer's members. Tr. 1111-12 (Tenn); PX0001 (Tenn Rpt.) ¶ 49; Tr. 115 (BCBS); Tr. 353-54 (United).

11. The presence of competing hospitals limits a hospital's bargaining leverage with insurers and thus constrains the hospital's ability to obtain higher rates. Tr. 115 (BCBS); Tr. 352-53 (United). A merger of close substitute hospitals may lead to higher reimbursement rates because it eliminates an alternative that an insurer could otherwise turn to, which increases the merged entity's bargaining leverage. PX0001 (Tenn Rpt.) ¶¶ 48, 56-57; *see also* Tr. 355-56 (United); Tr. 144 (BCBS). Higher rates result in higher premiums and out-of-pocket expenses for members. PX0001 (Tenn Rpt.) ¶¶ 40-41; Tr. 100 (BCBS); PX3028 (BCBS) at 1; Tr. 352-53 (United); Tr. 453-56 (Ambetter); Tr. 1670-71 (Aetna).

12. ***Stage 2 Competition***: Once in network, hospitals compete to attract patients by offering better quality, broader services, or more convenient care. PX0001 (Tenn Rpt.) ¶¶ 63-67; Tr. 1112-13 (Tenn); Tr. 554, 588 (Atrium).

13. A merger between competing hospitals also harms patients by lessening Stage 2 competition. Tr. 1114-17 (Tenn); PX0001 (Tenn Rpt.) ¶ 67. More intense competition provides hospitals with a stronger economic incentive to increase their attractiveness to patients. PX0001 (Tenn Rpt.) ¶ 65; Tr. 460 (Atrium).

V. THE RELEVANT ANTITRUST MARKETS

14. Because insurers, not their members, are the direct buyers of healthcare services, relevant markets are properly analyzed from the insurer's perspective. Tr. 1111-12 (Tenn). Patient perspectives are also important because insurers develop health plans that are attractive to employers and want to include hospitals that patients value. PX0001 (Tenn Rpt.) ¶¶ 54, 89; Tr. 345 (United). Because patients go to hospitals to receive inpatient services, the relevant antitrust markets in this case are defined by hospital locations. PX0001 (Tenn Rpt.) ¶ 89.

A. A Relevant Product Market Is Overlapping Adult Inpatient GAC Services Sold to Commercial Insurers and Their Members

15. A relevant product market is the cluster of adult inpatient GAC services sold to commercial insurers and their members and offered by both Novant Huntersville and LNR. PX0001 (Tenn Rpt.) ¶¶ 76-84. Inpatient GAC services are medical and surgical services that require a hospital admission (generally an overnight stay), such as cardiac surgery. Tr. 100-01 (BCBS); Tr. 176-77 (Littlejohn); PX0001 (Tenn Rpt.) ¶ 76. Commercial insurers must offer inpatient GAC services as an in-network benefit to meet network adequacy requirements and to be marketable. *See* Tr. 98-99, 103 (BCBS); Tr. 345-46 (United); Tr. 451-52 (Ambetter).

i. Outpatient Services Are Not Substitutes for Inpatient Services

16. Insurers could not market, and patients would not purchase, a health plan that included only outpatient services in lieu of inpatient services. *See* Tr. 101-02 (BCBS); [redacted] [redacted] Outpatient services, such as MRI scans, do not require an overnight stay. Novant

Answer ¶ 30; PX0001 (Tenn Rpt.) ¶ 85. Physicians determine whether a patient should receive care on an inpatient or outpatient basis. Novant Answer ¶ 30; Tr. 684-85, 715-16 (Iredell); Tr. 177 (Littlejohn); PX0001 (Tenn Rpt.) ¶ 85. And although some services can be provided on either basis, certain procedures cannot be safely performed on an outpatient basis. Tr. 101 (BCBS); [redacted] PX7023 120-22 (Armato); PX7024 45 (Littlejohn).

17. Because competitive conditions for inpatient GAC services are similar, it is appropriate to analyze the effect of the Transaction on these services as a cluster. COL ¶¶ 7-9. Insurers take a similar approach, negotiating rates for inpatient services categorically because separately negotiating for each service would be too onerous. Tr. 362-63 (United).

18. Outpatient services are also offered under different competitive conditions. Unlike inpatient services, outpatient services can be offered at many facilities, including hospitals, imaging centers, ASCs, and clinics. Novant Answer ¶ 30; Tr. 173, 200-01, 238 (Littlejohn).

ii. The Relevant Product Market Excludes Non-Overlapping Services Because the Merging Parties Do Not Compete for Those Services

19. The proper focus in a merger analysis is on whether, and if so how, the merging parties compete, because competition cannot be eliminated by the Transaction where Defendants do not compete. Tr. 1892-93 (Tenn). Thus, the proper focus here is on the services for which Novant Huntersville and LNR compete. Tr. 1043, 1056-57, 1150-51 (Tenn).

20. Novant Huntersville and LNR provide nearly the exact same set of inpatient GAC services and do so under similar competitive conditions. PX0001 (Tenn Rpt.) ¶ 78; *see* Tr. 101 (BCBS); Tr. 210 (Littlejohn); PX2226 (CHS) at 3; PX4022 (Wu) at 1. These overlapping services comprise 94.2% of LNR's commercial inpatient discharges and 95.6% of Novant Huntersville's commercial inpatient discharges. Tr. 1043 (Tenn); PX0005 (Tenn Rebuttal Rpt.) tbl. 2. Although the number of overlapping services may vary minimally each year, the core set

of services that these two hospitals provide has been stable over time. Tr. 1894-95 (Tenn).

21. Neither LNR nor Novant Huntersville offer high-acuity services. Tr. 604 (Atrium); Tr. 1279-80 (Armato); PX0005 (Tenn Rebuttal Rpt.) ¶ 11. And community hospitals like LNR, Novant Huntersville, and Iredell Memorial do not generally view themselves as competing for higher-acuity services that they do not offer. *See* Tr. 690 (Iredell).

iii. Services Sold to Government Payors Are in a Distinct Market from Services Sold to Commercial Insurers

22. Unlike for services sold to commercial insurers, reimbursement rates for Medicare and Medicaid are set by the government. Tr. 1047-48 (Tenn); PX0001 (Tenn Rpt.) ¶ 83. Even for government insurance managed by third parties, like Medicare Advantage and Medicaid Managed Care, reimbursement rates are negotiated within an extremely narrow range of rates set by the government. Tr. 358-60 (United); PX0005 (Tenn Rebuttal Rpt.) ¶ 38.

23. To participate in government insurance programs, consumers must meet eligibility requirements, such as age, income, and disability. Ineligible consumers cannot switch from commercial insurance to a government program. Tr. 102 (BCBS); Tr. 344-45 (United); Tr. 1048 (Tenn); PX0005 (Tenn Rebuttal Rpt.) ¶ 38. In contrast, employer-based and individual marketplace commercial plans permit broad participation. Tr. 477 (Ambetter).

B. The Eastern Lake Norman Area Is a Relevant Geographic Market

24. The Eastern Lake Norman Area is an appropriate geographic market because it reflects the commercial realities of the industry and illuminates the competitive impact of the Transaction. PX0005 (Tenn Rebuttal Rpt.) ¶¶ 48, 50; Tr. 1039-40, 1049-50, 1052-53 (Tenn); Tr. 480-81 (Riley); Tr. 1273-74 (Armato); Tr. 546, 554, 556 (Atrium); PX3018 (Atrium) at 3; Tr. 1655-56 (Aetna); Tr. 346-47 (United).

25. The Eastern Lake Norman Area is in the northern suburbs of Charlotte along Interstate 77

and includes Iredell County and northern Mecklenburg County. PX0001 (Tenn Rpt.) ¶ 90. To the south, the Eastern Lake Norman Area is bordered by Interstate 485. PX0001 (Tenn Rpt.) ¶ 33; *see also* Tr. 559 (Atrium). To the west, Lake Norman forms a natural boundary that impedes east-west travel, causing most people to seek healthcare services on their side of the lake. Tr. 560 (Atrium); PX2227 (CHS) at 5.

26. The Eastern Lake Norman Area has among the fastest rates of population growth in the Charlotte region and is economically significant to both providers and insurers. DX111 (CaroMont) at 1 (dubbing the Lake Norman area a "Highly Affluent Growth Market"); Tr. 1007 (CaroMont); Tr. 204 (Littlejohn); PX1295 (Novant) at 5; Tr. 1519 (Oliver); Tr. 94 (BCBS); Tr. 362-66 (United); PX2060 (CHS) at 9, 11; PX1152 (Novant) at 2.

27. The Eastern Lake Norman Area contains four inpatient GAC hospitals: LNR, Novant Huntersville, Iredell Memorial, and the soon-to-be-open Atrium Lake Norman. PX0001 (Tenn Rpt.) ¶¶ 34, 94; *see also* PX1295 (Novant) at 9; Tr. 1520 (Oliver).

i. Patients Residing in the Eastern Lake Norman Area Prefer to Receive Inpatient GAC Services Locally

28. Community hospitals and micro-hospitals primarily offer lower-acuity services closer to where people live. *See, e.g.*, PX7023 125-26 (Armato); PX7021 34 (Medley); PX1221 (Novant) at 14-15; PX1203 (Novant) at 5; PX2195 (CHS) at 2; PX3018 (Atrium) at 2-3. Novant Huntersville and LNR are both community hospitals that provide local care to patients residing near their hospitals. Tr. 480-81 (Riley); Tr. 1274 (Armato); PX7021 34 (Medley).

29. Patients seek inpatient GAC services close to where they live because they value convenience, familiarity with local hospitals, and the ability for friends and family to visit during a hospital stay. Tr. 98, 103 (BCBS); Tr. 345, 350 (United); Tr. 1655-56 (Aetna); Tr. 687-88 (Iredell); [redacted] PX7022 75 (Helms).

30. Residents of the Eastern Lake Norman Area are sensitive to traffic, which dissuades many from traveling into center-city Charlotte for healthcare. *See* Tr. 346-47 (United); Tr. 714 (Iredell); PX2227 (CHS) at 5; *see also* Tr. 554 (Atrium); [redacted]

31. A geographic market of the Eastern Lake Norman Area reflects the commercial reality that nearly two-thirds of residents (64.6%) stay in the Eastern Lake Norman Area for inpatient services offered by both Novant Huntersville and LNR. PX0005 (Tenn Rebuttal Rpt.) tbl. 4. Only 17% of patients travel from the Eastern Lake Norman Area into center-city Charlotte for inpatient services offered by both hospitals. PX0005 (Tenn Rebuttal Rpt.) tbl. 4.

32. Novant Huntersville, LNR, Iredell Memorial, [redacted] draw, or expect to draw, a significant portion of their patients from the Eastern Lake Norman Area. Tr. 479-80 (Riley); PX1076 (Novant) at 6; Tr. 187 (Littlejohn); PX2060 (CHS) at 10; Tr. 686-87 (Iredell); [redacted]

ii. The Merging Parties, Non-Party Providers, and Insurers All View the Eastern Lake Norman Area as a Distinct Area of Competition

33. CHS describes a similar area as the "Lake Norman Market," the "Lake Norman Area," or the "North Charlotte Market." *See, e.g.*, Tr. 175 (Littlejohn); PX2227 (CHS) at 5; PX2195 (CHS) at 2; PX2123 (CHS) at 20, 22.

34. LNR tracks inpatient market shares and develops strategic plans specifically for the "Lake Norman Area." *See, e.g.*, Tr. 195-96 (Littlejohn); PX2008 (CHS) at 14-16, 18-19; PX2020 (CHS) at 7-11, 56; PX2082 (CHS) at 12. It strives to be the leader in, and primarily analyzes hospitals within, the Lake Norman Area. *See, e.g.*, PX2172 (CHS) at 9; Tr. 206-07 (Littlejohn); PX2082 (CHS) at 34-35; PX2350 (CHS) at 3.

35. Novant has a "North Market," which largely tracks—but is not identical to—CHS's Lake Norman Area. Tr. 481-82 (Riley); PX1151 (Novant) at 9; PX1295 (Novant) at 5, 11; *see also* Tr.

1515-16, 1523-24 (Oliver).

36. Novant Huntersville is Novant's only inpatient GAC hospital in its "North Market" and Novant considers it part of the "Lake Norman Area." PX0001 (Tenn Rpt.) ¶ 99; Tr. 482 (Riley); PX5133 (Public) at 38, 45.

37. Novant tracks inpatient market shares and develops strategic plans specifically for the "North Market." Tr. 483-84 (Riley); Tr. 799-800, 802, 808-09, 811-12 (Ehtisham); PX1022 (Novant) at 1-2; *see generally* PX1151 (Novant); PX1042 (Novant); PX1222 (Novant).

38. Non-party providers also use the term "Lake Norman Area" and view Novant Huntersville and LNR as serving this area. Tr. 548-49, 551 (Atrium); [redacted] Tr. 977 (CaroMont); PX7055 93-4, 112-13 (LifePoint).

39. CaroMont and [redacted] do not view hospitals within the Eastern Lake Norman Area as competitors because they do not attract many patients from that area. Tr. 973, 980 (CaroMont); [redacted]

40. North Carolina's [redacted] commercial insurers recognize the importance of the Eastern Lake Norman Area when forming networks. Tr. 104 (BCBS); Tr. 366 (United); [redacted] Tr. 1656 (Aetna). This area is important to insurers because patients strongly prefer to receive care close to home. PX0005 (Tenn Rebuttal Rpt.) § IX; Tr. 457 (Ambetter); Tr. 1655-56 (Aetna); Tr. 345 (United); Tr. 546 (Haynes); [redacted] Accordingly, insurers consider network marketability at a local level that does not correspond to the entire area in which plans are sold or the entire area from which providers draw patients. Tr. 457 (Ambetter); Tr. 1655 (Aetna); *cf.* Tr. 156-57 (BCBS); Tr. 1632-33 (Aetna).

41. The Eastern Lake Norman Area reflects the commercial reality that insurers must provide access to Eastern Lake Norman Area hospitals if they want to offer a marketable plan to

residents throughout that area. Tr. 104, 107 (BCBS); Tr. 454, 457-58, 464 (Ambetter), Tr. 1656 (Aetna); Tr. 350-51 (United). Hospitals located in the surrounding areas are not sufficient substitutes for Eastern Lake Norman Area hospitals. Tr. 347 (United); Tr. 457-58, 464 (Ambetter); [redacted] Narrow networks further substantiate this commercial reality; no narrow network serving the Eastern Lake Norman Area excludes LNR, Novant Huntersville, and Iredell Memorial. Tr. 350-51 (United); Tr. 105-07 (BCBS); Tr. 457-58, 464 (Ambetter); [redacted]

iii. The Eastern Lake Norman Area Satisfies the Hypothetical Monopolist Test

42. Dr. Tenn identified the Eastern Lake Norman Area as a candidate geographic market using qualitative and empirical evidence that reflects the following commercial realities: (1) healthcare competition is local and (2) insurers and patients both view Eastern Lake Norman Area hospitals as competitors and close substitutes. PX0001 (Tenn Rpt.) ¶ 91.

43. The HMT determines whether the Eastern Lake Norman Area is a relevant antitrust market by assessing whether the level of patient substitution across the area's hospitals is sufficiently high that a hypothetical monopolist that owned all of them would be able to negotiate a SSNIPT for at least one of the merging parties' hospitals. PX0001 (Tenn Rpt.) ¶¶ 109, 113; *Guidelines* § 4.3.A. The HMT accounts for Atrium's competitive significance because if Atrium hospitals outside the Eastern Lake Norman Area were sufficient competitive constraints on the in-market hospitals, the Eastern Lake Norman Area would not pass the HMT. PX0005 (Tenn Rebuttal Rpt.) ¶ 18; Tr. 1072-73 (Tenn).

44. Dr. Tenn's analysis shows that a hypothetical monopolist of Eastern Lake Norman Area hospitals would negotiate a 25.2% price increase for LNR and a 6.3% price increase for Novant Huntersville. PX0005 (Tenn Rebuttal Rpt.) tbl. 12A. By following the standard practice of defining a SSNIPT as a 5% price increase, Dr. Tenn's analysis confirms that a hypothetical

monopolist would negotiate a SSNIPT for both Novant Huntersville and LNR. PX0005 (Tenn Rebuttal Rpt.) tbl. 12A. The Eastern Lake Norman Area also passes the HMT according to Dr. Wu's results. PX0007 (Wu Rebuttal Rpt.) Ex. 7.

C. A Broader Geographic Area Is Less Probative of the Competitive Impact of the Transaction but Is Still a Relevant Geographic Market

45. Dr. Tenn defined a broader geographic market—the Center-City/Northern Charlotte Region—as a robustness check, capturing the hospitals that over 90% of Eastern Lake Norman Area residents visit and including all meaningful substitutes for Novant Huntersville or LNR. PX0001 (Tenn Rpt.) ¶¶ 135-36; PX0005 (Tenn Rebuttal Rpt.) tbl. 4. The Center-City/Northern Charlotte Region includes Novant's Presbyterian and Charlotte Orthopedic, along with Atrium's CMC, Mercy, Cabarrus, and University City. PX0001 (Tenn Rpt.) ¶¶ 128-29, 135-36.

46. This broader geographic market also passes the HMT and is therefore a relevant antitrust market. PX0001 (Tenn Rpt.) ¶ 139; PX0005 (Tenn Rebuttal Rpt.) tbl. 12A.

VI. HIGH MARKET SHARES AND CONCENTRATION LEVELS ESTABLISH A STRONG PRESUMPTION OF HARM TO COMPETITION

47. Dr. Tenn calculated market shares and HHIs, a market concentration measure, using a hospital choice model, which infers patient preferences from real hospital discharge data (i.e., if a patient went to a given hospital, that is the hospital they prefer). PX0005 (Tenn Rebuttal Rpt.) tbls. 4 & 5; Tr. 1087-88 (Tenn). Dr. Tenn assumed that Atrium Lake Norman was already open and operating at near full capacity with 30 GAC inpatient beds. Tr. 1089-90 (Tenn).

48. Novant would have 67% market share in the Eastern Lake Norman Area after the Transaction. PX0005 (Tenn Rebuttal Rpt.) tbl. 5. Even in Dr. Tenn's robustness-check market—the Center-City/Northern Charlotte Region—Novant would hold 37% market share. PX0005 (Tenn Rebuttal Rpt.) tbl. 5.

Hospital	Eastern Lake Norman Area Share of Discharges	
	Pre-Merger	Post-Merger
Novant Huntersville	44.6%	67.0%
Lake Norman Regional	22.3%	
Atrium Lake Norman	13.8%	13.8%
Iredell Memorial	19.3%	19.3%

Hospital	Center-City/Northern Charlotte Region Share of Discharges	
	Pre-Merger	Post-Merger
Novant Presbyterian	22.9%	37.0%
Novant Huntersville	8.8%	
Novant Charlotte Orthopedic	0.8%	
Lake Norman Regional	4.4%	
Atrium CMC	23.7%	59.2%
Atrium Cabarrus	18.8%	
Atrium Lake Norman	2.7%	
Atrium Mercy	5.9%	
Atrium University City	8.0%	
Iredell Memorial	3.8%	3.8%

49. Calculating HHIs using Eastern Lake Norman Area hospital discharges results in an HHI increase of 1,994 and a post-acquisition HHI of more than 5,000. PX0005 (Tenn Rebuttal Rpt.) tbl. 5. Calculating HHIs using discharges from all ten hospitals in the robustness-check market of the Center-City/Northern Charlotte Region yields an HHI increase of 288 points and a post-acquisition HHI of 4,886. PX0005 (Tenn Rebuttal Rpt.) tbl. 5.

Market	Pre-Merger HHI	Post-Merger HHI	Change (Δ) in HHI
Eastern Lake Norman Area	3,052	5,046	1,994
Center-City/Northern Charlotte	4,599	4,886	288

50. Dr. Tenn's market share and concentration statistics for each market exceed the structural presumption thresholds in both the 2023 and 2010 *Merger Guidelines*. Tr. 1098-99 (Tenn).

51. To confirm his results, Dr. Tenn calculated patient-based shares, counting discharges from all hospitals, even those outside the Eastern Lake Norman Area, that any resident of the Eastern Lake Norman Area visits. Using this approach, the combined firm would hold 49.3%

market share, with a change in concentration of 1,147 and post-merger HHI of 3,795. PX0005 (Tenn Rebuttal Rpt.) tbl. 4. While revenue-based shares are less probative, Dr. Tenn calculated such shares restricted to overlapping inpatient GAC services which show that the Transaction is still presumptively illegal using this approach. PX0005 (Tenn Rebuttal Rpt.) ¶¶ 154-57.

52. To the extent Atrium funnels patients out of the Eastern Lake Norman Area through its freestanding ERs, outpatient clinics, and patient transfer practices, Dr. Tenn's analysis accounts for this in multiple ways. Dr. Tenn's broadest market share calculations would account for any patient referred to any of the five Atrium hospitals included in this market. Further, Dr. Tenn's patient-based shares account for patients who visit Atrium's ERs and are transferred outside of the Eastern Lake Norman Area. Tr. 1137-39 (Tenn); *cf.* DDX11 (Defs' Closing) at 50. Dr. Tenn also testified that Atrium's ERs and outpatient clinics are not alternatives for inpatient services. Tr. 1138 (Tenn). Accordingly, Atrium's outpatient presence does not mitigate Novant's post-merger increase in bargaining leverage for inpatient services with insurers.

53. Furthermore, although not supported by the record, Dr. Tenn conservatively modeled a 54-bed Atrium Lake Norman and still found that the Transaction exceeds the *Merger Guidelines* structural presumption thresholds in both the Eastern Lake Norman Area and Center-City/Northern Charlotte Region. PX0005 (Tenn Rebuttal Rpt.) ¶¶ 256-57.

VII. THE TRANSACTION WOULD ELIMINATE SUBSTANTIAL HEAD-TO-HEAD COMPETITION

A. LNR and Novant Huntersville Are Close Competitors

54. Hospitals consider the geographic proximity and similarity of services offered when assessing competition and making strategic plans. *See, e.g.*, Tr. 486 (Riley); Tr. 186-88 (Littlejohn); Tr. 690-91, 693-94 (Iredell); Tr. 552 (Atrium); PX2226 (CHS) at 3-4; PX2008 (CHS) at 16-17. Novant Huntersville and LNR are roughly 12 miles apart, serve similar patient

populations, and offer nearly identical inpatient services. Tr. 480-81, 486-88 (Riley); Tr. 1651-52 (Aetna); Tr. 376-78 (United); Tr. 195-96 (Littlejohn); PX0001 (Tenn Rpt.) ¶ 81.

55. LNR often refers to Novant Huntersville as its primary competitor, compares market shares, and analyzes Novant Huntersville's competitive activity and rates. *See, e.g.*, Tr. 187-88, 195-96 (Littlejohn); PX2009 (CHS) at 13; PX2080 (CHS) at 18, 24. LNR identified Novant Huntersville as its "largest [out-of-network] competitor," PX2009 (CHS) at 13, launched a "Defending the PSA" plan to "[p]rotect against Novant," PX2227 (CHS) at 8, and identified Novant Huntersville as the only hospital posing a "[h]igh risk" to LNR, PX2003 (CHS) at 75.

56. Novant Huntersville likewise recognizes LNR as an important competitor, analyzes LNR's competitive activity, PX1068 (Novant) at 2, and compares market shares. Tr. 489, 496-98 (Riley); PX1208 (Novant) at 5; PX7023 144-46 (Armato). Novant Huntersville has justified millions of dollars of capital expenditure requests based on its "constant competition with [LNR] to meet the needs of our community and to be the hospital of choice in the Northern market." Tr. 496-98 (Riley); PX1208 (Novant) at 5-7. Novant also expanded its Huntersville campus, in part, to "have the capacity to continue to compete with . . . [LNR]." PX1204 (Novant) at 2.

57. Other providers view LNR and Novant Huntersville as competitors. S*ee* Tr. 693 (Iredell); [redacted] PX7055 94 (LifePoint); [redacted] For example, in evaluating an acquisition of LNR, LifePoint characterized Novant Huntersville as a competitive threat to LNR. PX7055 94 (LifePoint).

58. Insurers also view LNR and Novant Huntersville as close competitors due to their geographic proximity and similarity of services. Tr. 1651-52 (Aetna); Tr. 376-78 (United); Tr. 135-36 (BCBS). Insurers expect that if LNR went out of network, their members would likely choose to receive inpatient GAC services at Novant Huntersville or Iredell Memorial. Tr. 454

(Ambetter); Tr. 1656 (Aetna). Similarly, if Novant Huntersville went out of network, members would likely go to LNR, Iredell Memorial, or nearby Atrium facilities. Tr. 376-81 (United);

[redacted]

59. Dr. Tenn's diversion analysis confirms LNR and Novant Huntersville are close substitutes. Diversions from Novant Huntersville to LNR are 14.2%. PX0005 (Tenn Rebuttal Rpt.) tbl. 7A. According to Dr. Tenn's results, only Atrium CMC and Atrium Cabarrus have higher diversions from Novant Huntersville than LNR. PX0005 (Tenn Rebuttal Rpt.) tbl. 7A; Tr. 1053-54, 1082-84 (Tenn). Diversions from LNR to Novant Huntersville are 24.8%—the highest of any single hospital. PX0005 (Tenn Rebuttal Rpt.) tbl. 7A. Diversions from LNR to the Novant system are even higher at 39.2%. PX0005 (Tenn Rebuttal Rpt.) tbl. 7A.

B. The Transaction Substantially Reduces Stage 1 Competition and Will Likely Result in Increased Prices

60. Insurers recognize the Transaction will enhance Novant's bargaining leverage. *See* Tr. 355-56, 382 (United); Tr. 135-36, 144-45 (BCBS); Tr. 462 (Ambetter); Tr. 1656 (Aetna). Insurers would likely accept higher rates demanded by the merged entity to keep it in network. Tr. 462-63 (Ambetter); Tr. 1116-17 (Tenn); Tr. 144-45 (BCBS).

i. The Transaction Will Increase Novant's Bargaining Leverage

61. Novant currently has contracting leverage, and part of this leverage is derived from Novant's size. PX1280 (Novant) at 1. Larger providers have more leverage in negotiations, which allows them to demand higher reimbursement rates. Tr. 1652-53 (Aetna). In fact, Novant's CEO challenged Novant's payor contracting lead to "leverage [Novant's] size to achieve" higher reimbursement rates. PX1280 (Novant) at 1; Tr. 1529-31 (Oliver).

62. Individual hospitals provide value to an insurer's network and contribute to a provider's overall leverage. Tr. 1228-29 (Tenn); Tr. 354-56 (United); Tr. 135 (BCBS). This is so regardless

of the contracting mechanism. Even though Novant opts to contract statewide with uniform pricing across the "Greater Charlotte Market," this reflects a business decision rather than an unchangeable market reality. In fact, certain insurers may prefer different rates for different hospitals, *see* Tr. 1657 (Aetna), but, as Novant's former Chief Payor Performance Officer explained, Novant generally does "not afford that option to payers," PX7022 122 (Helms). In contrast, [redacted] hospitals within [redacted] and Novant has contracted individually for New Hanover following its acquisition, PX7022 122-23 (Helms). CHS recognizes that the Transaction will increase Novant's leverage. After the Transaction was announced, CHS's lead payor negotiator in North Carolina asked internally whether he should continue negotiations with insurers because "Novant will have more contracting leverage and would not want to be tied into contracts we negotiated." PX2004 (CHS) at 2; Tr. 315-16 (DiPace). Drawing on his decades of experience negotiating payor contracts, that negotiator used the prospect of the Transaction as a negotiating tactic, stating that Cigna "can work with [CHS] for a reasonable increase now or [Cigna] will have to negotiate with Novant next year." PX2081 (CHS) at 3-4; Tr. 318-20 (DiPace).

ii. Novant's Increased Leverage Will Likely Lead to Increased Prices

63. Novant has previously exercised its bargaining leverage to add a contract clause with insurers that allows Novant to increase rates after acquiring a hospital. Tr. 137, 144-45 (BCBS); Tr. 1657-58 (Aetna); Tr. 386-87 (United); [redacted] Insurers have unsuccessfully tried to negotiate this clause out of their contracts with Novant. [redacted] PX7022 172-73 (Helms) (acknowledging the "specific amount of energy" spent negotiating acquisition clauses with insurers). Novant has used this clause to extract higher rates following hospital acquisitions. Tr. 137, 143-44 (BCBS); PX3028 (BCBS) at 1; Tr. 1660-62 (Aetna); Tr. 386-87, 439-40 (United); [redacted]

64. Novant has also used its bargaining leverage and related contract clauses to extract a worsening of terms for insurers that are not always focused on the newly acquired hospital. *See*, *e.g.*, Tr. 1660-62 (Aetna); Tr. 143-44 (BCBS). Following Novant's acquisition of New Hanover, for example, Novant used several different mechanisms to increase its earnings. Rather than impose [redacted] on Blue Cross's rates at Novant New Hanover, Novant instead spread the increase across all its North Carolina hospitals. PX3028 (BCBS) at 1; Tr. 140, 143-44 (BCBS). Additionally, Novant extracted a lump sum payment of "more than 10 million" from Aetna in negotiations after its acquisition of New Hanover. Tr. 1660-62 (Aetna).

65. Novant is also willing to [redacted] PX1045 (Novant) at 7. When preparing for its most recent negotiations after acquiring Novant New Hanover, Novant sought [redacted] PX1045 (Novant) at 7. Novant recognized its [redacted] and sought [redacted] PX1045 (Novant) at 11. It also expected that achieving those targets [redacted] PX1045 (Novant) at 11, meaning [redacted] PX7022 151-53 (Helms). While Novant did not [redacted] Novant [redacted] PX7022 168 (Helms).

66. Insurers predict that rates will increase post-merger. Tr. 144-45 (BCBS); Tr. 463 (Ambetter); Tr. 1658 (Aetna); Tr. 356 (United). For example, BCBS estimates the Transaction will increase LNR's reimbursement by [redacted] and Davis's by [redacted] equating to an increase of over [redacted] just for BCBS. PX3029 (BCBS) at 2; Tr. 145-48 (BCBS).

67. Novant will lose the incentive to offer volume discounts in response to competition from

LNR. Novant tracks its "leakage," which refers to patients who could have received care at Novant but instead went to another hospital. PX7022 77 (Helms). Novant views hospitals that capture its leakage as its competitors, and Novant attempts to reduce leakage to increase revenue. PX7022 78-81 (Helms). In early 2023, LNR received the second highest orthopedic leakage from Novant. PX1102 (Novant) at 20. In response, Novant offered [redacted] to insurers and successfully reduced orthopedic leakage. PX7032 111-14 (Helms). If the Transaction closes, this and other leakage to LNR will be immediately recaptured by Novant, which will reduce its incentive to discount going forward. *See* PX1024 (Novant) at 1.

68. Dr. Wu claims the Transaction will reduce healthcare costs for insurers by reducing Atrium's bargaining leverage, suggesting that when Novant constructed a new hospital, Mint Hill, it led to a reduction in Atrium's prices. Tr. 1734-35 (Wu); DDX8 31 (Wu). Dr. Wu, however, provides no evidence that opening Mint Hill reduced Atrium's bargaining leverage. Tr. 1882-83 (Tenn). Further, Dr. Wu's methodology is flawed because he conflates this case (the *elimination* of a competitor by acquisition) with Novant's construction of a new hospital (the *addition* of a competitor). Whatever lessons can be drawn from Novant Mint Hill are not relevant here as competition is being eliminated rather than added anew. Tr. 1884-85 (Tenn).

iii. Dr. Tenn's Analyses Corroborate that the Transaction Will Likely Increase Prices

69. Econometric analysis corroborates insurers' view that the Transaction will likely increase healthcare costs for consumers. Dr. Tenn quantified the impact of the Transaction on Defendants' bargaining leverage with insurers using widely accepted economic tools. Tr. 1114 (Tenn); PX0005 (Tenn Rebuttal Rpt.) tbl. 12B. Dr. Tenn estimates a 19.9% to 25.2% price increase at LNR, a 3.0% to 3.7% price increase at Novant Huntersville, and an approximately 0.5% price increase at Novant Presbyterian. PX0005 (Tenn Rebuttal Rpt.) tbl. 12B; Tr. 1120-21

(Tenn). Dr. Tenn estimates this will result in a $4.6 to $5.9 million increase in reimbursement for overlapping commercial inpatient GAC services each year. PX0005 (Tenn Rebuttal Rpt.) ¶ 245.

70. Dr. Tenn's model, which is independent of geographic market definition, shows that approximately 80% of the post-merger change in bargaining leverage is driven by patients residing in the Eastern Lake Norman Area. Tr. 1119-20 (Tenn); PX0005 (Tenn Rebuttal Rpt.) tbl. 8B, fig. 3.

C. The Transaction Would Eliminate Beneficial Non-Price Competition

71. As Novant recognizes, "lack of competition can hurt patients . . . . Competition and choice can lead to higher quality, lower costs, and greater innovation." PX1290 (Novant) at 2-3. Today, Novant Huntersville and LNR compete for patients by routinely making investments, increasing patient access, recruiting physicians, and improving quality. Tr. 196-97, 200-04 (Littlejohn); Tr. 489-90, 496-98 (Riley); PX2082 (CHS) at 20-21, 39; PX1208 (Novant) at 5-7. For example, in a July 2022 board meeting, LNR's CEO noted they had lost share to Novant Huntersville and presented a plan to "outflank Novant Health – Huntersville." PX2226 (CHS) at 3; Tr. 208-12 (Littlejohn). This plan included "growing primary care," "adding access points," investing in cardiology, and "growing our acuity." PX2226 (CHS) at 3; Tr. 208-12 (Littlejohn); PX2009 (CHS) at 24-26 (considering various investments).

72. STEMI services provide a concrete example of how competition benefits patients. When Novant Huntersville launched an enhanced heart attack service, CHS observed the hospital had "continue[d] to pick up ground" and that cardiology was one of Novant Huntersville's "Largest Growth Service Lines." PX2009 (CHS) at 11, 22. CHS responded by investing in STEMI care, which it saw as a "huge market differentiator." PX2199 (CHS) at 1; Tr. 206-07, 211, 213-15 (Littlejohn); PX2008 (CHS) at 17; PX2226 (CHS) at 3.

73. This triggered a cardiology arms race between Novant Huntersville and LNR. In 2021,

LNR identified expanding cardiac services as its "largest priority" to allow it to compete with Novant Huntersville. PX2199 (CHS) at 1. LNR successfully recruited a cardiologist from Novant Huntersville, and sought to recruit another, Dr. Cantor. PX1225 (Novant) at 1. Had Dr. Cantor also left, it would have threatened Novant Huntersville's ability to offer 24/7 STEMI coverage. PX1225 (Novant) at 1; Tr. 817-20 (Ehtisham). In response, Novant offered revised compensation and a leadership role to retain Dr. Cantor to "put a dent into [LNR's] plan and solidify [Novant's] position in market," "impact [LNR's] ability to be successful in establishing a 24/7 lab," PX1225 (Novant) at 1-2, and "stabilize [Novant's] STEMI program at Huntersville Medical Center," Tr. 820-21 (Ehtisham).

74. LNR was placed on a "freeze/emergency only" capital request status due to the Transaction, which paused its efforts to expand cardiology. PX2363 (CHS) at 1; *see also* PX1004 (Novant) at 39; Tr. 85 (CHS Opening) (explaining "of course" CHS has not approved any "major new capital investments at Lake Norman since it signed the agreement to sell these hospitals"). Regardless, because of this competition before deciding to sell, LNR invested in its cardiology practice, hired in-house cardiologists, and expanded its STEMI coverage from 8:30AM-4PM to 8AM-midnight, *see, e.g.*, Tr. 215-16 (Littlejohn); PX2199 (CHS) at 1, while Novant was simultaneously making investments to fend off LNR's increased competition, PX1225 (Novant) at 1-2; Tr. 820-21 (Ehtisham).

75. In another example from 2023, Novant-affiliated primary care physicians were referring patients to LNR-affiliated specialists because they were uncomfortable sending patients to certain Novant specialists. Tr. 824-25 (Ehtisham); PX1024 (Novant) at 1. Novant tried to recapture some of these lost referrals through "service recovery" efforts but noted that "[i]f the FTC approves the [LNR] merger, this should solve the leakage even if Dr. Berry-Candelario's

service recovery efforts are not received well." PX1024 (Novant) at 1-2; Tr. 821-23 (Ehtisham).

D. The Transaction Has Likely Already Impacted Competition

76. The Transaction has likely already had anticompetitive effects. Prior to the FTC's complaint, Novant represented to the FTC that "the Transaction will enable it to save over $190M by downsizing a planned capital expansion project at Huntersville . . . ." PX4004 (Advocacy) at 25; *see also* PX1130 (Novant) at 6-7; Tr. 1129-30 (Tenn). "[A]bsent this Transaction, Novant plans to apply for a CON in 2024 and to begin construction in 2026 on a major capital expansion project at Huntersville that would include a new, 3-floor patient bed tower, a new women's birthing center, additional ICU beds, a medical office building ("MOB") and zoning-mandated parking deck." PX4004 (Advocacy) at 25; *see also* PX1082 (Novant) at 5. Novant's Vice President of Strategic and Business Planning analyzed two versions of the project—a full expansion absent the Transaction and a substantially downsized expansion if the Transaction is completed. PX7041 156-69 (Gymer); PX1130 (Novant) at 6-7. The cancellation of the project, which would have expanded Novant Huntersville's capacity, demonstrates a decrease in investment and competition driven directly by the Transaction. Tr. 1129-30 (Tenn).

77. Additionally, CHS's investment in LNR has plummeted since the announcement of the Transaction, with CHS choosing to forgo investments in mid- and long-term growth strategies such as expanding access points and pursuing partnerships. Tr. 85 (CHS Opening); Tr. 1128-29 (Tenn); *see also* PX2363 (CHS) at 1; PX2194 (CHS) at 20-21; Tr. 1603-07 (Hammons). Defendants' purchase agreement actually limits CHS's purchase of capital assets at LNR to $250,000 while the Transaction is pending. PX1004 (Novant) at 39.

VIII. DEFENDANTS CANNOT REBUT THE STRONG PRESUMPTION OF HARM TO COMPETITION

A. Purported Quality and Cost Efficiencies Are Not Cognizable or Sufficient to Prevent Harm from the Transaction

78. Defendants have not quantified their purported quality- or cost-related efficiencies or assessed whether they will offset anticompetitive harm. Tr. 1506-07 (Oliver); Tr. 1400-01 (Jha).

i. Alleged Quality Improvement Efficiencies Are Not Cognizable

79. Novant highlights four primary quality efficiencies, claiming it will improve LNR's quality by increasing: (1) patient volume, (2) risk-based VBC and ACO participation with population health management ("PHM"), (3) clinical integration, and (4) investment, in particular an upgraded Epic EMR system. Tr. 910-11 (Burns); PX0006 (Burns Rebuttal Rpt.) § III.

80. The Transaction is neither necessary nor likely to achieve these claimed quality improvements. Tr. 936-38 (Burns); PX0006 (Burns Rebuttal Rpt.) ¶¶ 11-38, 190-205. Dr. Jha did not assess whether Novant's claimed quality improvements were cognizable efficiencies or account for how the loss of competition between LNR and Novant Huntersville would impact quality. Tr. 1407-08, 1470 (Jha).

a. Each alleged quality benefit is speculative, unsubstantiated, and unverifiable

81. *Increase in Patient Volume*: Increasing patient volumes is not directly correlated with improvements in quality. Tr. 933-35 (Burns); PX0006 (Burns Rebuttal Rpt.) ¶¶ 296-97. As both Novant and CHS executives admit, low volume hospitals can provide good quality care. Tr. 626 (Benet); Tr. 1288 (Armato); Tr. 1602 (Hammons). Dr. Jha did not estimate how much volumes might increase post-transaction, and he did not provide any specificity regarding how these volume increases might occur. Tr. 1450 (Jha).

82. *VBCs/ACOs/PHM*: Participation in a risk-based VBC or ACO does not by itself improve quality or allow hospitals to engage in PHM. Tr. 924-27 (Burns); PX0006 (Burns Rebuttal Rpt.) ¶¶ 239-46; Tr. 626-27 (Benet); Tr. 1288-89 (Armato). Even if it did, Novant does not currently

participate in "downside risk" contracts with commercial insurers, which Dr. Jha argues is the best way to incentivize quality improvements and achieve PHM. PX0004 (Jha Rpt.) ¶¶ 36, 52, 62-63, 68; PX7022 189, 191-92 (Helms) (explaining that Novant recently chose to exit from its BCBS downside risk contract); PX7032 166 (Helms); Tr. 1667 (Aetna) (testifying that Aetna tried and failed to get Novant to accept downside risk); Tr. 109 (BCBS). Further, Dr. Jha did not analyze, and thus cannot show, that the quality of care at Novant hospitals improved after entering VBC contracts. Tr. 1425-26 (Jha).

83. *Clinical Integration*: Dr. Jha has not shown that Novant's clinical integration has improved quality at Novant hospitals or analyzed whether Novant was effective at clinically integrating New Hanover Regional. Tr. 1445-47 (Jha); PX7064 265 (Jha). Novant offered no evidence that it would conduct the types of integration activities that the academic literature indicates can improve quality. PX0006 (Burns Rebuttal Rpt.) ¶¶ 282-87; Tr. 930-32 (Burns).

84. *Electronic Medical Records*: Defendants acknowledge that transitioning LNR's EMR to Epic would not by itself improve quality. Tr. 680 (Benet); Tr. 1392-93, 1433 (Jha). Dr. Jha did not analyze whether Novant's quality performance changed after implementing Epic at its hospitals or whether CHS was able to improve quality at their hospitals after implementing Cerner. Tr. 1433-34 (Jha).

85. *Other Alleged Quality Efficiencies*: Other claimed quality improvements are also unverified. Novant's purported plans to improve safety and quality at LNR, including its goal to upgrade LNR's NICU, are speculative given both the lack of specificity regarding how it seeks to achieve each benefit as well as the made-for-litigation nature of its claims. Tr. 1500, 1508-09 (Oliver); *see generally* DX700. As of March 2024, Novant possessed "no specific plans" for quality improvements at LNR and Novant's Chief Medical Officer had done nothing more than

review LNR's public Leapfrog score. Tr. 1506 (Oliver). In fact, Novant did not consult either Ms. Music or Dr. Benet about possible quality improvements at LNR before entering into the Transaction. Tr. 759 (Music); Tr. 679 (Benet); *see also* Tr. 1626 (Hammons) (was not asked to provide any information about efficiencies or benefits relating to the Transaction). Defendants have not conducted a root cause analysis to understand LNR's quality metrics and what can be done to improve them. Tr. 1402-03 (Jha). And Defendants have not assessed the extent to which competition between LNR and Novant Huntersville currently impacts quality, or how the loss of that competition might impact quality. PX7064 60 (Jha).

1. Defendants' claims ignore LNR's quality today

86. LNR already has comparable quality performance to Novant. PX0006 (Burns Rebuttal Rpt.) § IV.B; *see also* Tr. 725 (Music). Dr. Burns analyzed LNR and eight Novant hospitals and found no statistically significant differences in performance across nearly all 20 quality outcome metrics that he and Dr. Jha analyzed. Tr. 914-15, 921-22 (Burns). Even setting aside statistical significance and considering only the point estimates provided by CMS, LNR outperforms a number of Novant hospitals on a variety of outcome metrics, including Novant Rowan—a hospital that has been subject to Novant's suite of purported quality improvement tools for over a decade. Tr. 919; 938-40 (Burns); PX0006 (Burns Rebuttal Rpt.) §§ IV-V.

87. LNR has maintained quality independent of Novant, as is recognized by commercial insurers and third-party accreditors. Tr. 742-45 (Music); PX5125 (Public) at 1-3. LNR has been recognized by insurers for meeting patient quality and safety standards and currently participates in quality incentive contracts with Aetna, United, and BCBS. Tr. 111-13 (BCBS); Tr. 745-49 (Music); PX5125 (Public) at 1-2; Tr. 1664-65 (Aetna). LNR has succeeded in these arrangements, for example it recently earned the maximum possible quality-based fee increase from BCBS. Tr. 746-48 (Music); PX2299 (CHS) at 1. LNR has also had only one serious safety

event since 2018. Tr. 756 (Music).

2. Novant has a poor record of improving quality at hospitals it acquires

88. Defendants' quality claims are further unsubstantiated because they do not explain either why Novant has failed to improve quality after past acquisitions or how the Transaction differs. PX0006 (Burns Rebuttal Rpt.) § V; Tr. 937-41 (Burns); PX0002 (Burns Rpt.) § VII.

89. Novant's New Hanover acquisition in 2021 illustrates the challenges of integrating a hospital into Novant's system. PX0006 (Burns Rebuttal Rpt.) § V.B. New Hanover had maintained an "A" Leapfrog rating but fell to (and stayed at) a "B" shortly after being acquired by Novant. Tr. 1314-15 (Armato). Dr. Burns's review of quality metrics confirmed that New Hanover's performance declined across five CMS patient experience metrics following Novant's acquisition. PX0002 (Burns Rpt.) ¶¶ 81-84. A year and a half after Novant acquired New Hanover, the hospital was placed on immediate jeopardy status by CMS, putting its Medicare and Medicaid contracts at risk. PX1278 (Novant) at 3; Tr. 1527-28 (Oliver). And three years after its acquisition, New Hanover's conversion to Novant's Epic EMR is not yet complete. Tr. 1316 (Armato); PX7047 121 (Gizdic).

90. Novant Rowan's performance similarly declined following its acquisition by Novant, and even seven years after it was acquired it still received "stubbornly low" patient satisfaction scores. Tr. 1317-18 (Armato); *see generally* PX5149 (Public). Despite ownership for over a decade and access to all of Novant's alleged quality-improving practices, contracts, and tools, Novant Rowan's performance is worse than LNR's and is not improving across multiple quality outcome metrics. PX0006 (Burns Rebuttal Rpt.) ¶ 47; Tr. 937-40 (Burns).

b. Alleged quality benefits are not merger-specific

91. LNR has been able to improve its quality independently, without being acquired. For example, LNR improved its Leapfrog patient safety grade from "C" to "B" in the most recent

reporting period. Tr. 628 (Benet); PX5262 (Public) at 1.

92. LNR can also improve its quality absent the Transaction, through partnerships with independent physician groups, third-party ACOs and aggregators, or other health systems. Tr. 190 (cardiac and oncology partnerships with Novant), 222-24 (partnering with an orthopedic provider) (Littlejohn); PX1364 (Novant) at 1-2 (partnering to elevate LNR to NICU Level II); PX2194 (CHS) at 20-22; PX2009 (CHS) at 26; PX2164 (CHS) at 1; PX2033 (CHS) at 1 (OrthoCarolina refraining from a partnership "until the FTC made a determination" about the divesture); [redacted] Tr. 697-98 (Iredell); Tr. 1668 (Aetna).

93. Novant did not evaluate whether it could improve quality at LNR without full ownership, Tr. 1504 (Oliver), even though Novant purchased a minority interest in Conway Medical Center in the last year and hopes to "bring safety and quality" to that facility without a full acquisition. Tr. 1300-01 (Armato); PX7023 23 (Armato). LNR could join Novant's clinically integrated network to enter VBCs or engage in PHM absent the Transaction. PX1295 (Novant) at 15; Tr. 1521-22 (Oliver); Tr. 1647-48, 1665 (Aetna). In 2021, for example, Novant recommended pursuing a service line partnership with LNR and Davis and discussed a "strategic affiliation" or acquiring an "equity stake." Tr. 1299-1301 (Armato); PX1142 (Novant) at 2; PX1295 (Novant) at 10, 15 (providing a continuum of partnership options for LNR). Novant has service line partnerships with independent acute care facilities today, including tele-stroke and tele-psyche services—both of which Defendants claim will be added by the Transaction. Tr. 1522 (Oliver); PX1295 (Novant) at 10; DX677 (Novant) at 3. Novant already includes independent providers like CaroMont in its clinically integrated network and considered adding LNR and Davis. Tr. 1522, 1524 (Oliver); PX1295 (Novant) at 15; Tr. 1648 (Aetna); Tr. 1307-08 (launching Novant Health Enterprises to partner with other health systems), 1310-11 (taking judicial notice that

Novant can engage in partnerships without a merger) (Armato); PX1342 (Novant) at 10, 29.

94. CHS offers its hospitals many of the same initiatives as Novant, including AI Technology, Do No Harm, Telehealth, Infection Prevention, Root Cause Analysis, and a Safety Coach Program. PX2330 (CHS) at 22-23; PX2331 (CHS) at 12-13; Tr. 1510-11 (Oliver). LNR can improve its own quality through these tools and processes. Tr. 1589-91 (Hammons) (CHS provides centralized nurse recruiting tools, telemedicine support, and AI-enabled maternal-fetal remote monitoring to its hospitals); PX2331 (CHS) at 13; Tr. 629-31 (Benet). CHS is an early adopter of innovative technologies and services to improve patient care and outcomes at its hospitals, such as its partnership with Google Cloud to unify patient data and allow for faster remote clinical interventions. Tr. 1591 (Hammons); Tr. 635-38 (Benet); PX5255-F (Public); PX5255-G (Public).

95. CHS also has the financial means to execute these plans. CHS can fund these investments by accessing available capital and refinancing its debt. Tr. 1581 (Hammons). Elsewhere across its health system, CHS invested over $1.3 billion in its facilities over the past three years to expand inpatient capacity and acuity, develop access points and outpatient services, and engage in joint ventures. Tr. 1584-85 (Hammons); PX2330 (CHS) at 10. CHS has increased its capital investments annually despite reducing the number of hospitals it owns. Tr. 1585 (Hammons); PX2330 (CHS) at 11.

96. But for the Transaction, CHS planned to continue investing in LNR. Tr. 198-200 (projecting capital investments), 216-17 (requesting $1 million for cardiology services) (Littlejohn); PX2082 (CHS) at 20, 21, 24; Tr. 1595-96 (Hammons) (planning EMR upgrade).

97. CHS chose to dramatically reduce its investment in LNR following its agreement to sell to Novant. PX2363 (CHS) at 1 (describing investment in LNR as on “freeze/emergency only”);

PX7039 77 (Novak); PX0002 (Burns Rpt.) ¶¶ 64-67. While LNR received $8.7 million in capital investment from CHS in 2021, that dropped to $703,000 in 2023. Tr. 740-41 (Music); PX2250 (CHS) at 27; PX5195 (Public) at 1. Nonetheless, LNR is well-positioned to capitalize on renewed investment from CHS if the Transaction is enjoined. CHS confirmed it "would do the work" to complete its planned EMR upgrade if the Transaction does not go through. Tr. 672 (Benet); Tr. 1593-96 (Hammons); PX2128 (CHS) at 1; PX7039 77 (Novak); Tr. 1435-36 (Jha). The hospital is profitable and has hard-working and dedicated staff that, as Defendants recognize, strive to improve LNR. Tr. 233-34 (Littlejohn), Tr. 1283-84 (Armato), Tr. 51 (Novant Opening), Tr. 1395-96 (Jha).

98. LNR has a well-established track record of using CHS's performance improvement tools and SMART goals to improve quality performance. Tr. 640-44 (Benet); Tr. 728 (Music); PX2342 (CHS) at 42 (applying "SMART" goals to enhance care quality at CHS facilities). Even with CHS's "freeze" on investment during the pendency of the Transaction, LNR continues to provide quality care and even expanded its surgical capabilities. PX2363 (CHS) at 1; Tr. 787 (Music); PX5195 (Public) at 1. LNR can improve its quality processes and performance, including its risk-adjusted mortality index performance. Tr. 675-77 (Benet).

99. Defendants acknowledge that single-hospital health systems can "compete vigorously." Tr. 55 (Novant Opening). Iredell Memorial, a single-hospital health system of similar size, employed physician count, and occupancy as LNR, improved its Leapfrog rating from a "C" to an "A" in 18 months. Tr. 683, 703-04 (Iredell); DDX8 (Wu) at 11. CHS successfully operates healthcare systems in other markets built around single acute care hospitals that rely on partnerships to expand services. Tr. 1597-98 (operating systems around single acute care hospitals), 1606-07 (discussing a partnership with Novant) (Hammons); PX2194 (CHS) at 21;

PX5042 (Public) at 4; Tr. 644-45 (Benet).

ii. Alleged Cost Efficiencies Are Not Cognizable

100. Defendants do not claim that any cost-savings efficiencies will result from the Transaction. Pre-Hrg. Tr. 10-12 (Defs); Tr. 1141 (Tenn). Dr. Wu did not calculate or independently verify any cost efficiencies. PX7063 283-87, 294-95 (Wu). Similarly, Dr. Jha did not calculate what cost savings would be realized from implementing Epic at LNR, PX7064 256-58 (Jha), did not calculate whether or to what extent the Transaction would result in lower total cost of care, and did not account for any claimed reductions in cost of care against increases in reimbursement rates or increased costs for service line changes at LNR. Tr. 1400 (Jha); PX7064 255-58 (Jha); *see also* Tr. 169 (BCBS) (reimbursement rates are a "big input" into cost of care). Further, no evidence was presented from insurers measuring whether the Transaction would lower cost of care at LNR. *See, e.g.*, Tr. 432 (United) (has not measured Transaction's effect on total cost of care); Tr. 1673-74 (Aetna) (has not analyzed whether Transaction would impact cost of care at LNR).

101. Dr. Wu also claims that post-merger improvements at LNR will allow it to retain patients that would otherwise go to higher-priced Atrium hospitals, Tr. 1695, 1735-36 (Wu), but this analysis is flawed because Dr. Wu assumes substantially higher diversion from LNR to Atrium than his own results support and relies on the false premise that LNR's occupancy is declining. Tr. 1885-88 (Tenn). LNR's occupancy rate has changed 0% since 2017 and has remained generally stable since CHS acquired the hospital in 2014. Tr. 1145-48, 1885-88 (Tenn). In other words, Dr. Wu has not established that any theoretical cost savings are cognizable efficiencies.

B. LNR Is Not a "Weakened Competitor"

102. LNR is profitable. PX7055 44-45, 47-48, 114 (LifePoint) (played Tr. 1677); Tr. 233, 277-78 (Littlejohn); Tr. 1307 (Armato); DX111 (CaroMont) at 1 ("[LNR] has been 'cash cow'

for CHS for extended period . . . ."); Tr. 1007-08 (CaroMont) ("'cash cow' for CHS" means the hospital has "[r]eally high cash flow margins").

103. Prior to the Transaction, LNR developed plans to invest and compete with Novant Huntersville. *See supra* ¶¶ 55, 71-74, 77. LNR and CHS both continue to have the financial means, and the tools and strategies, necessary to execute these plans. *See supra* ¶¶ 91-99, 102.

104. LNR's inpatient occupancy has been stable since 2017 at approximately 33%. Tr. 1145-50, 1885-88 (Tenn) (most of LNR's occupancy decline occurred when Novant held a minority stake in the hospital); PX0005 (Tenn Rebuttal Rpt.) ¶ 121. LNR's inpatient occupancy is similar to other community hospitals, like Iredell Memorial. DX015 at 1. LNR's occupancy also reflects the local demography because it treats a younger population that relies more on preventive care. Tr. 691-93, 723-24 (Iredell). Lastly, looking at staffed rather than licensed beds, LNR has an occupancy rate of at least 57%. *See* Tr. 178 (Littlejohn) (40-70 staffed beds); PX0005 (Tenn Rebuttal Rpt.) tbl. 1 (40 ADC) (40 ADC divided by 70 staffed beds equals ~57%).

105. LNR's market share is stable, and far above the structural presumption of illegality. PX0005 (Tenn Rebuttal Rpt.) ¶¶ 121-23, 129. Even if LNR's commercial discharges declined around 4% annually, an assumption unsupported by evidence, it would take many decades for LNR's Eastern Lake Norman Area market share to drop enough (from 22.3% to below 1.5%) to fall below the structural presumption. *See* PX0005 (Tenn Rebuttal Rpt.) ¶ 129 & tbl. 5.

106. Dr. Tenn's analysis shows that, today, LNR is by far the most popular hospital in the area where it draws most of its patients. PX4025 (Tenn) at 2. In those two ZIP codes (28115, 28117), LNR has a 46.7% and 45.9% market share, respectively. PX4025 (Tenn) at 2. In the same ZIP codes, Novant Huntersville has the second highest share, with 19.6% and 21.8%, respectively. No other hospital has a greater than 10% share in these two ZIP codes. PX4025 (Tenn) at 2.

107. Dr. Wu calculates similar results, though Defendants draw a different conclusion, suggesting that "a majority of Mooresville residents avoid Lake Norman Regional." DDX11 (Defs' Closing) at 85. This characterization is misleading. Notably, Novant Huntersville has a lower share in the two ZIP codes where it draws the greatest number of patients (28078, 28269), with 44.3% and 18.4% share, respectively, than LNR's share in the two ZIP codes where LNR draws the greatest number of its patients. PX4025 (Tenn) at 3. Finally, Defendants suggest that LNR was more popular in 2004 than today. DDX11 (Defs' Closing) at 86. But in 2004, Novant Huntersville had just opened. A more plausible explanation is that LNR's share decline from 2004 to 2023 was largely the result of competition with Novant Huntersville.

108. CHS was only willing to sell LNR if the price was right. PX7031 57-58 (Medley); [redacted] PX7055 112 (LifePoint) (played Tr. 1677). CHS's executive overseeing mergers and acquisitions told one potential buyer that CHS "received multiple calls over the years, but [LNR is] not an asset we're thrilled about potentially selling." Tr. 1617-18 (Hammons) (discussing PX2018 (CHS) at 1).

109. CHS only started its limited sales process for LNR after receiving an [redacted] CHS then provided a Confidential Information Memorandum to only four local health systems: Novant, LifePoint, CaroMont, and UNC Health. PX7015 150-51 (Conti); PX2104 (CHS) at 5. CHS's CEO testified that he was not aware of CHS contacting any out-of-state health systems such as HCA or Tenet, or other in-state systems like Iredell. Tr. 1619 (Hammons); *accord* PX2104 (CHS) at 4; PX7015 150-51 (Conti).

110. LifePoint believed its bid would not be competitive and opted to pass on the opportunity. PX7055 84-85 (LifePoint) (played Tr. 1677). But LifePoint believed it would have been "more

than a sustainable strategy" to operate LNR. PX7055 33-35, 38 (LifePoint) (played Tr. 1677); *see also* PX7055 84-85, 88-89, 91, 100 (LifePoint) (played Tr. 1677) (LNR is not a distressed asset that should be sold in a fire sale; LifePoint modeled that LNR will continue to be profitable after Atrium Lake Norman's entry). [redacted] LifePoint had concluded that $161 million would be a market-competitive bid for LNR. PX7055 108 (LifePoint) (played Tr. 1677).

111. Similarly, CaroMont and [redacted] viewed LNR as attractive. CaroMont understood that LNR operates in a highly affluent growth market and remains open to considering opportunities related to LNR in the future. Tr. 1007-08 (CaroMont); DX111 (CaroMont) at 2. [redacted]

C. Entry or Expansion Are Unlikely to Be Timely, Likely, and Sufficient

112. Opening a new GAC hospital is an [redacted] that can take several years and [redacted] *see* Tr. 814 (Ehtisham).

113. This is partly attributed to North Carolina's CON process, which governs whether hospitals can open or add inpatient beds and services. PX7043 28-30, 168-69 (NCCON). The CON application process (for new hospitals or expansions) is lengthy, and approval is uncertain. *See* PX4027 (Joint Stip.) ¶ 9. Depending on the type of application, the initial phase can take 150 days, and, if the application is denied, a final decision may not be rendered for an additional nine months. PX4027 (Joint Stip.) ¶¶ 11, 18.

114. Other hospital operators are not likely to respond to the Transaction by opening a new hospital or expanding hospital services in the Eastern Lake Norman Area. *See* [redacted]

[redacted] PX7017 103-04 (Gymer); [redacted]

115. Atrium Lake Norman's construction is not in response to the Transaction, and also illustrates the high barriers to entry for a new hospital. Atrium Lake Norman's CON application was denied twice, its planned opening is over six years after Atrium began the project, and it has faced substantial cost overruns. *See* Tr. 561-63 (Atrium) (planning began early 2019, CON denied in 2020 and 2021, approval in 2021); [redacted]

116. Atrium projects Atrium Lake Norman will begin accepting patients in mid-2025 [redacted] Tr. 563-64 (Atrium) ("about five years" to reach capacity); [redacted]

117. Expansion beyond 30 inpatient beds at Atrium Lake Norman is speculative. [redacted] *see* Tr. 564-65 (Atrium) (no current plans to increase beyond 30 beds). [redacted] Further, any expansion beyond 54 beds would require new construction, and thus is highly unlikely in the next two or three years. Tr. 612 (Atrium); [redacted]

D. The Transaction Is Not Necessary to Address Davis

118. CHS's decision to convert Davis to a behavioral health facility serves an important community need, and Statesville does not have sufficient demand to support two inpatient GAC

hospitals. PX7049 42-43 (Qualls); Tr. 718-19 (Iredell).

119. If CHS wants to sell Davis, it can do so. Davis was not originally included in the Transaction but added after Novant expressed interest. Tr. 1621 (Hammons); PX2070 (CHS) at 1. Acadia Healthcare, a behavioral health facilities operator, also expressed interest in acquiring Davis, and CHS recognized Acadia as "a backstop" if negotiations with Novant failed. Tr. 1621-22 (Hammons); PX2070 (CHS) at 1. In a letter to Defendants, FTC staff expressed they have no competitive concern with Novant acquiring Davis and invited Defendants to present an amended asset purchase agreement for just Davis. PX4026 (FTC) at 1.

120. Novant has not developed a concrete plan concerning Davis if the Transaction goes through. Tr. 867 (Ehtisham); Tr. 1328-29 (Armato).

E. Novant's Public "Commitments" Are Illusory, Unenforceable, and Made for Litigation

121. While the Transaction was pending, Novant sent a letter to the North Carolina Attorney General outlining certain "commitments" concerning LNR and Davis. Tr. 862-63 (Ehtisham) (discussing DX677 (Novant) ("NCAG Letter")). Although the letter is signed by Saad Ehtisham, it was drafted by Novant's attorneys more than a month after the FTC filed this suit. Tr. 870-71 (Ehtisham). Mr. Ehtisham has not discussed the letter with the Attorney General's office and is not aware of any response to the letter. Tr. 871 (Ehtisham).

122. Mr. Ehtisham is similarly unaware of Novant seeking input from CHS when drafting the NCAG Letter. Tr. 873 (Ehtisham). Though the NCAG Letter contains representations about how Novant will contract with insurers, Mr. Ehtisham is unaware of anyone seeking or receiving input from insurers about the adequacy of the letter. Tr. 896 (Ehtisham).

123. Nothing in the NCAG Letter makes it legally binding. Tr. 873 (Ehtisham). Novant would simply be responsible for monitoring its own compliance with promises it made in the NCAG

Letter. Tr. 874 (Ehtisham); *see also* PX7045 109-10 (Armato).

124. Though the NCAG Letter proposes a non-binding three-year commitment not to raise rates at LNR beyond certain levels, nothing prevents Novant from using its post-transaction leverage to raise rates at its other hospitals such as Novant Huntersville, [redacted] obtain a lump sum from insurers as it did from Aetna after acquiring the New Hanover hospital, Tr. 1660-62 (Aetna), or raise rates at LNR after three years, DX677 (Novant) at 4.

125. In the NCAG Letter, Novant promises to maintain no more than current levels of staffed beds at LNR. Tr. 887-88 (Ehtisham). Novant also claims it will invest more than the roughly $1.3 million annually that it claims CHS has invested in LNR and Davis. DX677 (Novant) at 1; Tr. 875 (Ehtisham). But that estimated amount is dwarfed by CHS's annual investment of $3.8 million averaged across the decade leading up to the Transaction. PX2248 (CHS) at 9; *see also* PX2252 (CHS) at 1 (LNR 2020 community benefit data); PX2250 (CHS) at 27 (LNR 2021 update to Board of Trustees).

126. Novant also promises to start programs or investments that CHS already offers or would implement absent the Transaction. *Compare* DX677 (Novant), *with, e.g.*, Tr. 737 (Music) (no-harm policy); PX5099 (Public) (charity care programs); Tr. 895 (Ehtisham) (open staff); Tr. 1591 (Hammons) (AI support); PX7039 77 (Novak); Tr. 672 (Benet) (EMR upgrade).

IX. THE EQUITIES WEIGH IN FAVOR OF A PRELIMINARY INJUNCTION

A. If the Transaction Closes, a Subsequent Divestiture Would Be Costly, Difficult, and Disruptive, if Possible at All

127. Upon acquiring LNR, Novant plans to make immediate changes that will be costly, difficult, and disruptive to undo in the event the Commission finds the Transaction to be unlawful and orders a divestiture. *See* Tr. 1327 (Armato).

128. Novant intends to integrate LNR into its system. Tr. 1500 (Oliver). In doing so, Novant

plans to transition LNR to Novant's Epic EMR. DX677 (Novant) at 1-2; Tr. 1502 (Oliver). Any later divestiture may require transitioning LNR off of Novant's EMR. As Novant's New Hanover acquisition shows, EMR transitions can take many years. Tr. 877-79 (Ehtisham).

129. Novant intends to make significant staffing changes: e.g., altering compensation, replacing independent staff, and causing LNR to use Novant-affiliated nurses and physicians. *See, e.g.*, Tr. 845-47 (Ehtisham); DX677 (Novant) at 5. Novant laid off key local leaders as soon as it was permitted to following its acquisition of New Hanover, PX5216 (Public) at 1, and makes no representation that it will not immediately carry out layoffs at LNR.

130. Any such changes would be disruptive to undo in the event of a divestiture at the conclusion of the Commission's administrative proceeding.

B. If Not Enjoined, the Transaction Will Eliminate Critical Tax Revenue and Harm North Carolinians While the Merits Proceeding Is Ongoing

131. After closing, Novant would have a strong financial incentive to raise prices and eliminate discounts. *Supra* § VII.B. Novant would be entitled to renegotiate rates and terms at LNR or its other hospitals as soon as 90 days after the Transaction closes. *See, e.g.*, Tr. 114 (BCBS); [redacted] Novant could also immediately start steering LNR patients to higher-priced sites of care. Tr. 1125 (Tenn). These harms cannot be undone after a merits ruling. Converting LNR to a non-taxable, non-profit entity will also eliminate tax revenues from Iredell County's seventh-largest taxpayer. PX5192 (Public) at 2, 5. LNR's annual tax contribution was $7.6 million in 2023. PX5195 (Public) at 1; *see also* PX2195 (CHS) at 3; ECF No. 98.

C. Alleged Benefits Remain Available After a Merits Decision

132. LNR will remain profitable and attractive to Novant following a Commission merits decision. *Supra* ¶¶ 102, 111. A short delay to allow the Commission to determine the legality of the Transaction will not eliminate Novant's years-long interest in LNR. *Supra* ¶ 2.

PLAINTIFF'S PROPOSED CONCLUSIONS OF LAW[1]

I. THE § 13(B) STANDARD FOR A PRELIMINARY INJUNCTION

1. Section 13(b) of the FTC Act authorizes a preliminary injunction pending an administrative merits proceeding. 15 U.S.C. § 53(b). Courts consider two factors to determine if the public interest warrants preliminary relief: "(1) the likelihood of success, and (2) a balancing of public equities." *FTC v. Food Town Stores, Inc.*, 539 F.2d 1339, 1344 (4th Cir. 1976).

2. First, "the FTC demonstrates the likelihood of success on the merits if it shows preliminarily, by affidavits or other proof, that it has a fair and tenable chance of ultimate success on the merits." *Sanctuary Belize*, 409 F. Supp. 3d at 396; *FTC v. Agora Fin., LLC*, 447 F. Supp. 3d 350, 359 (D. Md. 2020). Some circuits frame the burden differently, holding the FTC succeeds if it raises "serious and substantial questions" as to the merits. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 727 (D.C. Cir. 2001). These standards are largely interchangeable. *FTC v. IQVIA Holdings*, 2024 WL 81232, at *8 (S.D.N.Y. Jan. 8, 2024). However phrased, it is clear that the "likelihood of success" showing is lighter for Plaintiff in a § 13(b) context than in other preliminary injunction cases. *FTC v. CCC Holdings*, 605 F. Supp. 2d 26, 36 n.11 (D.D.C. 2009). The FTC is not required "to prove the merits of its case or to establish a violation of the Clayton Act. That inquiry is reserved for the administrative proceeding." *IQVIA*, 2024 WL 81232, at *9.

3. Second, courts balance the equities implicated by a preliminary injunction. *Hershey*, 838 F.3d at 353; *see Food Town*, 539 F.2d at 1345-46.

II. THE FTC HAS SHOWN A LIKELIHOOD OF SUCCESS ON THE MERITS

4. The FTC has established a likelihood of success in the merits proceeding, where it will

[1] Except as noted, citations omit internal quotation marks, citations, and brackets, and all emphasis in quotations is original.

show that the Transaction is illegal on two grounds: unduly concentrating a relevant market and eliminating substantial competition between Defendants. Mem. 2-3.

A. The Transaction Is Presumptively Illegal

5. The Transaction is presumptively illegal because it would "result in a significant market share and an undue increase in concentration within [a] relevant market," *IQVIA*, 2024 WL 81232, at *32, which consists of a product market and a geographic market, Mem. 8-9.

i. Inpatient GAC Services Constitute a Relevant Product Market

6. A relevant product market consists of products "that are reasonably interchangeable" such that "purchasers are willing to substitute one for the other." *ProMedica*, 749 F.3d at 565.

7. Each individual inpatient service is, in principle, a distinct relevant product market because patients cannot substitute between them. *Id.* ("[I]f you need your hip replaced, you can't decide to have chemotherapy instead."). Yet, courts analyze multiple inpatient services together as a "cluster" because "there is no need to perform separate antitrust analyses for separate product markets when competitive conditions are similar for each." *Id.* at 565-66.

8. Competitive conditions are similar for inpatient GAC services sold to commercial insurers. FOF § V.A. Courts thus have overwhelmingly approved of a product market cluster of inpatient GAC services sold to commercial insurers when assessing hospital mergers. *See, e.g.*, *Hackensack*, 30 F.4th at 166; *Advocate*, 841 F.3d at 467-68; *Hershey*, 838 F.3d at 338; *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075-76 (N.D. Ill. 2012); *FTC v. ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *9 (N.D. Ohio Mar. 29, 2011).

9. The cluster regularly excludes (i) inpatient services not offered by Defendants' most comparable hospitals, and (ii) outpatient services. Reply 11-12. These services are not substitutes for the inpatient GAC services at issue and are provided under dissimilar competitive conditions. *Id.* It is also proper to exclude (iii) services sold to government-sponsored health plans (e.g.,

Medicare, Medicaid) because of their eligibility criteria and dissimilar process for determining prices. *See FTC v. Sanford Health*, 2017 WL 10810016, at *10 (D.N.D. Dec. 15, 2017), *aff'd*, 926 F.3d 959 (8th Cir. 2019).

ii. The Eastern Lake Norman Area Is a Relevant Geographic Market

10. A relevant geographic market "is not where the parties to the merger do business or even where they compete, but where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." *United States v. Phila. Nat'l Bank* ("*PNB*"), 374 U.S. 321, 357 (1963); *see* Mem. 8-9.

11. Multiple geographic markets may coexist, and the existence of a broader market "does not render the one identified by the government unusable." *United States v. Bertelsmann SE & Co.*, 646 F. Supp. 3d 1, 28 (D.D.C. 2022). Courts apply the "narrowest market principle" to avoid underestimating competitive harm, *IQVIA*, 2024 WL 81232, at *12, *24, and have found relevant markets for inpatient services as narrow as one county even though healthcare providers and insurers often negotiate at a regional or statewide level, *FTC v. Hackensack Meridian Health, Inc.*, 2021 WL 4145062, at *6, *17 (D.N.J. Aug. 4, 2021), *aff'd*, 30 F.4th 160 (3d Cir. 2022); *ProMedica Health Sys., Inc.*, 2011 WL 1219281, at *10. Competitive harm in a single relevant market is sufficient to enjoin an entire transaction because "the Clayton Act prohibits mergers that may substantially lessen competition 'in *any* line of commerce or in *any* activity affecting commerce.'" *Bertelsmann*, 646 F. Supp. 3d at 28.

12. Markets "cannot be measured by metes and bounds," and a "relevant market need not include all potential customers or participants." *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 193 (D.D.C. 2017). Moreover, as the § 13(b) standard "pertains to the market definition inquiry," it is "not necessary at this point for the FTC to *prove* the existence of the . . . market." *IQVIA*, 2024 WL 81232, at *77.

13. Courts use the HMT to identify relevant geographic markets. Mem. 14-15; Reply 10-11. Circuit courts in healthcare mergers routinely hold that passing the HMT is sufficient to establish a relevant geographic market. Mem. 10; *see Sanford*, 926 F.3d at 964; *St. Luke's*, 778 F.3d at 784; *accord FTC v. Syngenta Crop Prot. AG*, 2024 WL 149552, at *10 (M.D.N.C. Jan. 12, 2024). A market passes the HMT if a hypothetical monopolist would impose a SSNIPT on at least one merging hospital in that market; a SSNIPT across *all* the hospitals is not needed. *FTC v. Advoc. Health Care*, 2017 WL 1022015, at *4 (N.D. Ill. Mar. 16, 2017); *Guidelines* § 4.3.A; *HMG* § 4.1.1. The Eastern Lake Norman Area and Center-City/Northern Charlotte Region both satisfy the HMT. FOF ¶¶ 44, 46.

14. The results of the HMT reflect the commercial realities of the market. Courts have remarked upon a discrete set of such realities, including: (1) patients' preference to receive care at nearby hospitals, (2) whether a "silent majority" of patients would not travel farther for care in response to a price increase, (3) the two-stage model of hospital competition, and (4) insurers' inability to successfully market health plans if they excluded all hospitals in the market from their provider networks. *See Advocate*, 841 F.3d at 464-65; *Hershey*, 838 F.3d at 343.

iii. Market Shares and Concentration Far Exceed a Presumption of Illegality

15. An acquisition is presumptively illegal if it raises market concentration as measured by HHI by at least 100 points and results in either (a) the merged firm having a share of at least 30% or (b) a market-wide HHI of at least 1,800 points. Mem. 15-17; Opp. Tenn MIL 3-5. When making this showing, "[t]he FTC need not present market shares and HHI estimates with the precision of a NASA scientist." *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 54 (D.D.C. 2015).

16. The Fourth Circuit has enjoined mergers based on market concentration figures lower than those in the *Merger Guidelines*. *See Liggett & Myers, Inc. v. FTC*, 567 F.2d 1273, 1275 (4th Cir. 1977) (merger unlawful when it combined shares of 10.99% and 4.41%); *Food Town*, 539

F.2d at 1344 (merger presumptively illegal when it combined shares of 8.3% and 2.7%).

17. "Where concentration is already great, the importance of preventing even slight increases in concentration and so preserving the possibility of eventual deconcentration is correspondingly great." *IQVIA*, 2024 WL 81232, at *44 (relying on *PNB*, 374 U.S. at 365 n.42).

18. Defendants' Transaction far exceeds the thresholds for presumptive illegality in the Eastern Lake Norman Area or any plausible market, FOF § VI, creating a "strong presumption" of illegality, *e.g.*, *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1220 (11th Cir. 1991); *Bertelsmann*, 646 F. Supp. 3d at 37.

B. The Transaction Would Eliminate Substantial Head-to-Head Competition

19. A transaction violates the Clayton Act if it "eliminates head-to-head competition between close competitors." *FTC v. Peabody Energy Corp.*, 492 F. Supp. 3d 865, 903 (E.D. Mo. 2020); *see ProMedica*, 749 F.3d at 569; *see also Guidelines* § 2.2. "The acquired firm need not be the other's *closest* competitor to have an anticompetitive effect." *Anthem*, 236 F. Supp. 3d at 216 (emphasis added).

20. Courts have found that a hospital merger would eliminate substantial competition where evidence shows that insurers expect anticompetitive effects from the transaction, and where merging hospitals "view each other as competitors," monitor each other's offerings, and "draw their patients from a similar area." *Hackensack*, 30 F.4th at 173. Although it is unnecessary to show an intent to use increased market power, a history of price increases following past mergers "is often indicative of future behavior." *Id.* at 175. Those features are present here. FOF § VII.

21. Additionally, investments or expansion plans delayed or canceled due to the Transaction, FOF § VII.D, are direct evidence of harm to competition. Mem. 30; *cf. Hershey*, 838 F.3d at 350 ("[A]bility to forego building the 100-bed tower is a reduction in output.").

22. Diversion ratios are an economic measure of closeness of competition. Mem. 22-23. Dr.

Tenn calculated that if LNR were unavailable, 39% of its patients would divert to Novant; conversely, if Novant Huntersville were unavailable, 14% of its patients would divert to LNR. FOF ¶ 59. Defendants compete comparably to—if not more closely than—the hospitals in *Hackensack*, in which the merger was enjoined in part because diversion ratios showed a "strong competitive constraint." *Hackensack*, 2021 WL 4145062, at *22 (40% and 10%).

23. The March 2024 NCAG letter does not change the analysis. Courts disregard pledges not to exercise market power because they do not effectively remedy a loss of competition, particularly when unenforceable, easily circumvented, made for litigation, or not profit-maximizing. *See Bertelsmann*, 646 F. Supp. 3d at 50-51; *Hackensack*, 2021 WL 4145062, at *23-24 (letter to insurers); *United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 82 (D.D.C. 2011) (3-year price freeze).

III. DEFENDANTS CANNOT REBUT THE FTC'S PRIMA FACIE CASE

24. Because the FTC has elicited substantial evidence that the Transaction is illegal, Defendants face an imposing burden to rebut the FTC's case in the merits trial. "[T]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Heinz*, 246 F.3d at 725; Mem. 31-34; Reply 5, 14-15.

25. Under § 13(b), Defendants' burden is to leave the Court with no "substantial questions" about the legality of the Transaction. *Heinz*, 246 F.3d at 725. Preliminary relief under § 13(b) is appropriate even if the Court believes that "post-hearing, the FTC may accept the rebuttal arguments proffered by the [Defendants]." *Id.*

26. In antitrust litigation, courts recognize the "extremely limited" value of evidence created while a lawsuit is "threatened or pending," *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 504-05 (1974), which can be "dripping with motivations to misrepresent," *Certain Underwriters*

at Lloyd's, London v. Sinkovich, 232 F.3d 200, 204 n.2 (4th Cir. 2000); *see Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 434-35 (5th Cir. 2008) (discounting actions that even "*could arguably* be subject to manipulation"); *see also United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 80-81 (D.D.C. 2017); *Hackensack*, 2021 WL 4145062, at *27. Similarly, "subjective corporate testimony" by executives of merging firms is "deemed self-serving and entitled to low weight." *FTC v. Meta Platforms Inc.*, 654 F. Supp. 3d 892, 937 (N.D. Cal. 2023).

A. Defendants Cannot Show that Their Alleged Procompetitive Benefits Establish an Efficiencies Defense

27. While no circuit court has held that claimed efficiencies have justified an otherwise unlawful merger, *Hackensack*, 30 F.4th at 176, to the extent courts analyze claims that a merger would improve quality of healthcare services, reduce costs, or produce other procompetitive benefits, they do so by applying the efficiencies defense framework, *id.* at 175-79; *see Sanford*, 926 F.3d at 965-66; *Hershey*, 838 F.3d at 347-51; *St. Luke's*, 778 F.3d at 791-92; *cf. Anthem*, 236 F. Supp. 3d at 243 (new services including "population health"); Mem. 32.

28. Under an efficiencies defense, Defendants must show their efficiencies are (1) verifiable, (2) merger specific, (3) sufficient to "offset any anticompetitive effects of the merger," and (4) not due to "anticompetitive reductions in output or service." *Hershey*, 838 F.3d at 348-49.

29. Defendants' vague claims that Novant would improve quality at LNR, or could reduce total cost of care, are not verifiable because they have not been quantified or supported with a reliable methodology. *See Illumina, Inc. v. FTC*, 88 F.4th 1036, 1060-61 (5th Cir. 2023) ("Illumina made no attempt to quantify these claimed efficiencies."); Jha MIL 8-9. Defendants cannot rely on the "estimation and judgment of experienced executives" to substantiate efficiencies: "the lack of a verifiable method of factual analysis . . . renders them not cognizable by the Court." *H&R Block*, 833 F. Supp. 2d at 91; *see also Heinz*, 246 F.3d at 721 (Efficiencies

must "represent more than mere speculation and promises about post-merger behavior.").

30. Defendants do not assert merger-specific benefits that "cannot be achieved by either company alone. . . . without the concomitant loss of a competitor." *Hershey*, 838 F.3d at 348. The issue is not if CHS "*offer[s]* these quality improvements," but if it is "*capable* of developing them without the merger." *Sanford*, 926 F.3d at 966; *see* Jha MIL 9-10.

31. If any of Defendants' efficiencies are cognizable, they are inadequate to "clearly demonstrate that the proposed merger enhances rather than hinders competition because of the increased efficiencies." *St. Luke's*, 778 F.3d at 790; Jha MIL 6-8. "[A] merger the effect of which 'may be substantially to lessen competition' is not saved because, on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial." *Hershey*, 838 F.3d at 348 (quoting *PNB*, 374 U.S. at 371). Further, lost competition in one market cannot "be justified by procompetitive consequences in another." *PNB*, 374 U.S. at 370.

32. Courts have recently considered—and rejected—claimed quality efficiencies remarkably similar to those Defendants assert here. These include claims that a merger would allow merging healthcare providers to better "engage in risk-based contracting," *Hershey*, 838 F.3d at 350-51 (not merger-specific, no offset to competitive harm, benefit not passed to consumers), implement the Epic EMR and "integrated care and risk-based reimbursement," *St. Luke's*, 778 F.3d at 791 (not merger-specific, no offset to competitive harm), improve the quality of clinical offerings, *Hackensack*, 30 F.4th 160, 177 (3d Cir. 2022) (speculative, not merger-specific), and recruit more subspecialists while adding a new EMR system "that would better integrate and coordinate patient care," *Sanford*, 926 F.3d at 965-66 (not merger-specific).

B. Defendants Cannot Satisfy the Weakened Competitor Defense

33. Defendants' claimed "downward trajectory" at LNR, Opp. 30-31, must be evaluated under the rubric of the "weakened competitor" defense, *see Steves & Sons, Inc. v. JELD-WEN,*

Inc., 290 F. Supp. 3d 507, 515-16 & n.5 (E.D. Va. 2018). The stringent requirements of this defense make it "the Hail-Mary pass of presumptively doomed mergers." *Steves & Sons, Inc. v. JELD-WEN, Inc.*, 988 F.3d 690, 714 (4th Cir. 2021).

34. Defendants' argument is insufficient for two reasons. First, Defendants do not assert that concentration levels are on the verge of dropping below those that trigger "a presumption of illegality." *Id.* at 715; *see also Univ. Health*, 938 F.2d at 1225. To fall below that presumption based on HHI thresholds, Defendants would need to show a plunge in LNR's market share in the Eastern Lake Norman Area from 22.3% to below 1.5%, which the evidence does not support. *See JELD-WEN*, 988 F.3d at 715 & n.11; FOF ¶ 105.

35. Second, Defendants cannot show that LNR's claimed "weakness . . . cannot be resolved by any competitive means." *JELD-WEN*, 988 F.3d at 714; *see also Univ. Health*, 938 F.2d at 1221 ("substantial showing" required). Many challenges that Defendants contend LNR faces could be remedied by reinvesting the hospital's profits, external financing, collaborating with Novant or others, or an acquisition by a different firm. FOF ¶¶ 95, 102, 110-11.

36. CHS has ample resources to devote to LNR. FOF ¶¶ 94-97, 103; *cf. Univ. Health*, 938 F.2d at 1221 (defense unavailable to "fiscally sound" firm). CHS may prefer to sell to a close competitor at a "wow" price rather than invest. FOF ¶ 3. But if the deal falls through, CHS would likely return to its prior course of investment in LNR. FOF ¶¶ 95-97. "Antitrust cases presume the existence of rational economic behavior" by "profit-maximizing compan[ies]." *In re Zetia (Ezetimibe) Antitrust Litig.*, 2022 WL 4362166, at *9 (E.D. Va. Aug. 15, 2022).

37. Defendants cannot justify an anticompetitive deal by declaring they no longer wish to compete. "A preference to sell a subsidiary and invest the proceeds more profitably elsewhere does not prove that the subsidiary is failing or that its assets would otherwise be withdrawn from

the market." Areeda & Hovenkamp, *Antitrust Law* ¶ 963 (2024); *see United States v. Greater Buffalo Press, Inc.*, 402 U.S. 549, 555 (1971) (holding a presumptively unlawful merger is not justified just because a profitable firm's "owners wished to sell rather than raise the capital needed for modernization and expansion"); *FTC v. Warner Commc'ns Inc.*, 742 F.2d 1156, 1164-65 (9th Cir. 1984) ("[A] company's stated intention to leave the market . . . does not in itself justify a merger."). Antitrust law does not reward a firm turning its viable "subsidiary into an ineffective competitor." *United States v. UPM-Kymmene Oyj*, 2003 WL 21781902, at *11 (N.D. Ill. July 25, 2003). "To allow such conduct to be used to justify an otherwise anti-competitive merger seems to be bad policy," *id.*, creating dire results for healthcare consumers.

38. Defendants also did not make a sufficient showing that CHS made "good faith efforts to elicit reasonable alternative offers" that would "pose a less severe danger to competition," defined as any "price above the liquidation value of those assets." *United States v. Energy Sols., Inc.*, 265 F. Supp. 3d 415, 445-46 (D. Del. 2017); *see* FOF ¶¶ 108-11. "[M]erely proving that some or all of the most logical purchasers have declined is not enough to prove that the challenged purchaser was the only prospective purchaser." *FTC v. Harbour Grp. Invs.*, 1990 WL 198819, at *3 (D.D.C. Nov. 19, 1990); *see also Guidelines* § 3.1 & n.62. The burden described in these "failing firm" cases (an argument that the firm would collapse entirely without the merger, and a claim Defendants do not make) is even heavier in the weakened competitor context. "[A] nonfailing firm would have to seek alternatives in some cases where a failing firm with the same market share would not. . . . Impending failure raises unique grounds for liberality." Areeda & Hovenkamp, *Antitrust Law* ¶ 963 (2024).

C. Defendants Cannot Show Timely, Likely, and Sufficient Entry or Expansion

39. To justify an otherwise anticompetitive transaction, entry or expansion must be "timely, likely and sufficient in its magnitude, character, and scope." *Sanford*, 926 F.3d at 965. Only

entry or expansion induced by the merger affects the competitive analysis. *Guidelines* § 3.2.

40. The planned Atrium Lake Norman cannot support an entry argument: "entrants' existing plans to compete are already baked into the world without the merger . . . [and] do not count toward filling the void created by the merger." *United States v. JetBlue Airways Corp.*, 2024 WL 162876, at *33 (D. Mass. Jan. 16, 2024). Any conceivable future expansion by Atrium would not be timely. *Bertelsmann*, 646 F. Supp. 3d at 53 (time frame for entry analysis is "two to three years"); FOF ¶¶ 116-17.

IV. THE EQUITIES WEIGH IN FAVOR OF A PRELIMINARY INJUNCTION

41. Finally, the Court must balance the public equities. *Food Town*, 539 F.2d at 1344. "Private equities 'are not proper considerations for granting or withholding injunctive relief under section 13(b)'—instead, public equities are paramount." *ProMedica*, 2011 WL 1219281, at *60 (quoting *Food Town*, 539 F.2d at 1346).

42. "[T]he FTC's showing of likelihood of success creates a presumption in favor of preliminary injunctive relief." *Heinz*, 246 F.3d at 726. Additionally, the "equities will often weigh in favor of the FTC, since the public interest in effective enforcement of the antitrust laws was Congress's specific public equity consideration in enacting [§ 13(b)]." *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1035 (D.C. Cir. 2008). "[N]o court has denied a Section 13(b) motion for a preliminary injunction based on weight of the equities where the FTC has demonstrated a likelihood of success on the merits." *Peabody*, 492 F. Supp. 3d at 918.

43. A preliminary injunction is critical to the Commission's ability to order effective relief. It would be "extraordinarily difficult to 'unscramble the egg'" if the transaction is deemed unlawful after Defendants have integrated their operations, shared competitively sensitive confidential information, and laid off staff. *Hershey*, 838 F.3d at 352-53 & n.11; *see* FOF §

IX.A. If Defendants are to be believed, Novant may struggle to find a willing divestiture buyer who could restore competition. "Congress intended that if divestiture is practicable and necessary to avoid a § 7 violation, it must be undertaken before the merger is consummated." *Food Town*, 539 F.2d at 1345; *see Heinz*, 246 F.3d at 726 (divestiture often "inadequate").

44. Interim harms that will accrue to North Carolinians, such as increases to healthcare costs and the loss of more than $7 million in annual tax revenue, are also public equities weighing in favor of a preliminary injunction. *See ProMedica*, 2011 WL 1219281, at *61; FOF ¶ 131.

45. The equities analysis is scoped to the time period of an injunction. Courts "consider whether the *injunction*, not the *merger*, would be in the public interest." *Hershey*, 838 F.3d at 353. The FTC seeks only to temporarily maintain the status quo. The injunction would expire with a final Commission order, *see* 15 U.S.C. § 53(b), seven to nine months after the upcoming merits trial, per FTC rules, *see* 16 C.F.R. §§ 3.44(c), 3.46(a), 3.51(a)(1), 3.52(a)(1), 3.56(a).

46. "[I]f the benefits of a merger are available after the trial on the merits, they do not constitute public equities weighing against a preliminary injunction." *ProMedica*, 2011 WL 1219281, at *60; *Heinz*, 246 F.3d at 726-27. Often, courts must look past defendants' assertions to see that "[a]ll of the Hospitals' alleged benefits will still be available" if the merger is enjoined and then held to be lawful. *Hershey*, 838 F.3d at 353. Here, Novant confirmed that litigation risk does not dampen its interest, saying the company is "willing to take on the risk" of a full legal process it believes could take years, and to defend its position "as vigorously as we possibly can," through to an appellate decision. Tr. 2045, 2048 (Closing); *see id.* 1329-30 (Armato).

47. Harm to Defendants, such as CHS accepting a lower sale price, "is at best a 'private' equity." *Heinz*, 246 F.3d at 727. "[P]rivate equities alone cannot override the FTC's showing of likelihood of success." *Whole Foods*, 548 F.3d at 1034-35.

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Respectfully submitted,

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