IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Federal Trade Commission and **Commonwealth of Pennsylvania**, Appellants, v. **Penn State Hershey Medical Center** and **PinnacleHealth System**, Appellees.	Case No. 16-2365

Appellees' Opposition to
Emergency Motion for Injunction Pending Appeal

After extensive discovery and a five-day evidentiary hearing, the district court denied the Government's request to preliminarily enjoin the combination of the Penn State Hershey Medical Center and PinnacleHealth System ("the Hospitals"). The court held that the Government "failed to set forth a relevant geographic market"—an essential requirement for challenging the combination's legality. Op. 11-12. The court also found that the evidence "overwhelmingly indicates that procompetitive advantages would be generated for the Hospitals' consumers." *Id.* 19-20.

The Government is not entitled to an injunction during its appeal—essentially the same relief that the district court denied. This Court's merits decision is unlikely to order that the combination be preliminarily enjoined. The district court's denial of the injunction was well within its broad discretion, and the Government challenges only the court's underlying findings of fact, which were correct and are subject to deferential "clear error" review.

As to the geographic market, the evidence "controvert[ed] the FTC's assertion that [inpatient hospital] services are 'inherently local'" and that only a four-county area is relevant. *Id.* 9-10. Indeed, it was an "uncontroverted fact that, in 2014, 43.5% of Hershey's patients … and several thousand of Pinnacle's patients reside[d] outside" of those four counties, with many traveling 30 minutes to over an hour for hospital care. *Id.* 9. Contrary to the Government's motion, the district court did not "ignore[]" payor-hospital bargaining or otherwise "clearly err[]" by considering patients who live outside of the alleged market but go to hospitals within it. Mot. 2. Market definition requires courts to identify hospitals that provide reasonable alternatives to patients, and those patients' preferences drive payor-hospital negotiations. In trying to limit the market to just four counties, the Government itself relied on the alleged

preferences of patients—but only those living in that area. It was proper—and certainly permissible—for the district court to consider *all* patients, whether they live inside or outside the Government's alleged market, in determining that hospitals outside that area provide reasonable alternatives for patients.

In addition, the Government does not even challenge the accuracy of several other findings by the district court—beyond market definition—that independently supported the court's decision to deny an injunction. After the combination: patients will benefit immediately from the relief of capacity constraints at Hershey (Op. 14-20), ongoing repositioning by competitors will constrain the combined hospitals (*id.* 20-22), and patients will further benefit from the Hospitals' enhanced ability to adapt to risk-based contracting (*id.* 22-24). Furthermore, it is "extremely compelling that the Hospitals have already taken steps to ensure that post-merger rates do not increase with … payors[] representing 75-80% of Hospitals' commercial patients." *Id.* 10-11.

Nor can the Government meet any of the other three prerequisites for an injunction. The Government claims that it might be "difficult" to unwind the combination in the event that it is later held unlawful. Mot. 19. But mere difficulty in obtaining full relief, or a mere possibility that relief will not be fully effective, does not establish *irreparable* harm. In addition, the Hospitals will be substantially harmed if the combination—which the Government's investigation and litigation already have delayed by over a year—is put on hold even longer. Finally, the Government cannot overcome the district court's finding that many public-interest considerations—especially the need to relieve Hershey's harmful capacity constraints—weigh strongly in favor of allowing the combination to proceed.

BACKGROUND

A. *The Hospitals And Their Planned Combination*

Hershey is an academic medical center ("AMC") and the primary teaching hospital of the Penn State College of Medicine. Op. 2. It specializes in more complex care, offering a wide range of high-acuity services not available at other area hospitals. *Id.* Pinnacle is a not-for-profit community health system with three campuses in or near Harrisburg. *Id.* 2-3. It provides cost-effective acute care and a limited number of higher-level services. *Id.* 3.

Hershey lacks sufficient space to care for all those needing its services. *Id.* 15-16. Hershey explored the possibility of addressing its capacity constraints by building a new bed tower, which was projected to cost roughly $277 million (a cost that would be passed on to patients). *Id.* 16-17. Soon, however, a more efficient option came to light: combine with Pinnacle and use Pinnacle's available beds to optimize capacity across all four campuses. Hrg. 560:14-19. Through an extensive planning process, the Hospitals concluded that combining would also yield many other significant benefits for patients. Hrg. 502:5-503:4, 559:20-561:10. In May 2015, the Hospitals executed the combination agreement at issue here. Op. 3.

B. *The Proceedings Below And The District Court's Opinion*

The FTC began investigating the combination in March 2015. On December 7, it filed an administrative complaint claiming the combination would violate the Clayton Act, 15 U.S.C. § 18. Two days later, the FTC and the Commonwealth filed this action to enjoin the combination pending an administrative hearing. Op. 3.

In the district-court proceedings, the parties took nearly forty depositions and produced tens of thousands of documents. Beginning on April 11, the district court

held a five-day hearing. Sixteen witnesses testified (Op. 3), including Hershey and Pinnacle executives and employees directly responsible for planning the combination. Despite its central thesis that the combined entity would extract price increases from commercial payors, the Government called only one such payor to testify: a company that represents just 1% of the market and whose parent company also owns hospitals that compete with Hershey and Pinnacle. Hrg. 195:20-197:6, 233:5-14.

The hearing ended on April 15. The court committed to "mak[ing] every effort to render a determination by" May 17 (the scheduled start date of the administrative hearing), and ordered expedited post-hearing briefing. Hrg. 994:23-995:10.

On May 9, the district court issued its opinion and order denying the preliminary injunction.[1] The court held that the Government had "failed to set forth a relevant geographic market"—a prerequisite to determining that a transaction will likely diminish competition unlawfully—and therefore was not entitled to relief. Op. 11-12. The court also held that, even if the Government *had* identified a valid market, the Hospitals had "presented ample evidence" that the combination would yield a number of procompetitive benefits. *Id.* 12, 14-15.

ARGUMENT

"[A] stay pending appeal … is an extraordinary remedy." *Conestoga Wood Specialties Corp. v. Sec'y of U.S. Dep't of Health & Human Servs.*, No. 13-1144, 2013 WL 1277419, at *1 (3d Cir. Feb. 8, 2013). To obtain this relief, the Government must establish: (1) a "strong showing that [it] is likely to succeed on the merits"; (2) that it

[1] Three days after the district court issued its decision, the FTC continued the administrative hearing's start date until June 1.

would be "irreparably injured" absent an injunction; (3) that granting the injunction would not "substantially injure" other interested parties; and (4) that the public interest favors such relief. *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987). "[A]ll four factors" must be satisfied for an injunction to issue. *Conestoga Wood*, 2013 WL 1277419, at *1 (quoting *N.J. Hosp. Ass'n v. Waldman*, 73 F.3d 509, 512 (3d Cir. 1995)).

I. The District Court's Denial Of An Injunction Pending An Administrative Decision Is Correct And Is Not Likely To Be Reversed.

The decision below is not "likely to be overturned on appeal." *Conestoga Wood*, 2013 WL 1277419, at *3. The Government comes nowhere near showing that this Court, while paying the requisite deference to the district court's decision denying a preliminary injunction, will likely reverse and order the combination to be enjoined.

The Government agrees that, to obtain a preliminary injunction, it needed to establish that the combination "*likely* is unlawful." Mot. 10. But the district court correctly found that the Government had not even shown an ability to prove the geographic market upon which its claim is based. The court further found—also correctly—that several other factors weighed against enjoining the combination during the administrative proceeding. These included the benefits of relieving Hershey's capacity constraints without additional costs, and increasing the Hospitals' ability to adapt and continue providing high-quality care as the healthcare market evolves. These findings—independently, but especially when taken together—make it exceedingly unlikely that the Government will succeed on appeal.

A. *The District Court Correctly Found That The Government Did Not Establish A Valid Geographic Market.*

The Government bore the burden of establishing a relevant geographic market, which is a "necessary predicate" to injunctive relief in section 13(b) cases. *F.T.C. v.*

Tenet Health Care Corp., 186 F.3d 1045, 1051 (8th Cir. 1999). "Without a well-defined relevant market, a merger's effect on competition cannot be evaluated." *Id.* "The relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks." Op. 6 (quoting *Hanover 3201 Realty, LLC v. Vill. Supermarkets, Inc.*, 806 F.3d 162, 183-84 (3d Cir. 2015)).

Here, the Government tried to establish that the relevant geographic market is a four-county region it labeled the "Harrisburg Area," notwithstanding the substantial number of the Hospitals' patients who reside outside that area and the many alternative hospitals to which their patients could turn. The district court rejected this position, concluding, "based on the hours of testimony and thousands of pages of exhibits presented by the parties and considered by th[e] Court, that the FTC's four county 'Harrisburg Area' relevant geographic market is unrealistically narrow and does not assume the commercial realities faced by consumers in the region." *Id.* 11.

Because "[d]etermination of the relevant geographic market is highly fact sensitive" (*id.* 7 (citing *Tenet*, 186 F.3d at 1052)), it is subject to clear-error review. A finding of fact is not clearly erroneous unless it is "completely devoid of a credible evidentiary basis or bears no rational relationship to the supporting data." *F.T.C. v. Lane Labs-USA, Inc.*, 624 F.3d 575, 582 (3d Cir. 2010). Such findings are set aside only if this Court, "giving all deference to the opportunity of the trial judge to evaluate the credibility of witnesses and to weigh the evidence," is "left with a definite and firm conviction that a mistake has been committed." *McNeil Nutritionals, LLC v. Heartland Sweeteners, LLC*, 511 F.3d 350, 360 (3d Cir. 2007).

1. The district court's factual finding that the Government failed to establish a geographic market was correct, and the Government falls well short of showing that it

was clearly erroneous. That finding is overwhelmingly supported by the testimony, contemporaneous business documents, and data presented at trial.

For instance, the court heard Hershey's CEO and COO testify about the "broad geographic area" in which Hershey competes, with 90% of its patients spread across 21 counties. Hrg. 437:5-11, 614:4-8. Hershey's CEO also explained that Hershey's "primary competitors" are other AMCs "in the urban centers [in] closest proximity to Hershey": Philadelphia, Baltimore, and Pittsburgh. Hrg. 435:7-14. Similarly, Pinnacle's CFO testified that Pinnacle's "primary service area [] includes Lancaster and York County"—both of which were excluded from the Government's market—and that these counties "include[] six other hospitals" that compete with Pinnacle. Hrg. 537:21-25. Commercial payors likewise recognized, in deposition testimony admitted at trial, that the Hospitals compete with a large number of hospitals outside the Harrisburg Area. DX1670 237:5-23, 246:5-20; DX1650 97:12-23; DX0064-013; DX0095 ¶8. And this all was corroborated by ordinary-course documents reflecting the Hospitals' competition with many hospitals outside the Harrisburg Area. *See, e.g.*, DX0522-010-011 (Hershey competitors outside Harrisburg Area: UPMC, Penn, Thomas Jefferson, Temple, Johns Hopkins, Geisinger, Lancaster General, Summit, WellSpan); DX0198-0014 (Pinnacle competitors outside Harrisburg Area: WellSpan York, Reading Health System, Lancaster General); DX0172-025; DX0493-024-040.

The district court also heard "hours of economic expert testimony" regarding the proper market definition. Op. 10. As the Hospitals' economic expert explained, the "big red flag" in the Government's market analysis is the fact that "so much of the revenue comes from patients who themselves are outside" the Harrisburg Area, which "means … the combined entity is vulnerable to competition from outside" that area.

Hrg. 863:8-11. The Government's economic expert, by contrast, acknowledged that he failed to account for a substantial body of evidence demonstrating the broader market in which the Hospitals compete. Hrg. 351:21-363:12.

The implications of the foregoing evidence are striking. As the court found, fully 43.5% of Hershey's patients—over 11,000 people—and "several thousand of Pinnacle's patients" reside outside the Harrisburg Area. Op. 9. And contrary to the Government's repeated claim (Mot. 9, 12, 14), this was far from the only evidence the court relied upon in holding that the Government had not met its burden. The court found that, despite the Government's assertion that patients prefer local care, "half of Hershey's patients travel at least thirty minutes for care"—*double* the median time for Harrisburg Area patients—"and 20% travel over an hour." Op. 9. It noted that "over half of Hershey's revenue originat[es] outside of the Harrisburg area." *Id.* And it considered the many entities the Hospitals compete with, including the 19 hospitals within 65 minutes of Harrisburg—"many of [which] are closer to patients who now come to Hershey." *Id.* 10. The court further grounded its conclusion in the realities of central Pennsylvania, "which is largely rural and requires driving distances for specific goods or services." *Id.*; *see also* Hrg. 487:10-15 (Pinnacle's CFO: "[I]t's very common to have people move and travel, particularly these days with greater consumer choice."). The court did not err—much less clearly err—in finding that "[t]hese salient facts controvert[ed] the FTC's assertion that [general acute-care ("GAC")] services are 'inherently local.'" Op. 9-10. Nor did it err in finding that the many hospitals near the Harrisburg Area "provide a realistic alternative that patients would utilize." *Id.* 10.

2. The Government challenges these findings by mischaracterizing the decision below. For example, the Government claims that the court "disregarded a principal

tool of geographic market definition": "[t]he hypothetical monopolist test." Mot. 12. To the contrary, the court recognized that the "*Horizontal Merger Guidelines* 'provide[] guidance' in defining a geographic market"; it explained the *Guidelines'* hypothetical-monopolist test; and it specifically viewed the evidence through this prism. Op. 7. The court thus concluded—correctly—that "if a hypothetical monopolist such as the combined Hospitals imposed a SSNIP [a small but significant non-transitory increase in price], these other hospitals [outside the Harrisburg Area] would readily offer consumers an alternative." *Id.* 10. In finding that the Government had failed to justify its exclusion of those hospitals from the market, the court applied the right standard and reached the right result.

3. The Government's attack on the district court's geographic-market analysis is premised on its claim that there is no connection between *patients'* hospital alternatives on the one hand, and *payors'* ability to resist a SSNIP on the other. But even if it were true that patients "do not directly bear price increases" (Mot. 14-15), that would not mean patients' preferences are unimportant to geographic-market definition. The Government admits that payors "must take into account the preferences of [their] customers"—i.e., patients. Mot. 4-5. As the Government's economic expert put it, payors and patients are "intimately linked," such that patients' "preferences are ultimately a major driver" of payors' negotiating positions. Hrg. 306:14-20. This is precisely why courts—despite recognizing that payors "are to a large extent, the true consumer of acute inpatient services"—nevertheless conclude that proper geographic-market analysis requires "identify[ing] other hospitals to which patients residing in the service areas could turn if they were dissatisfied with the prices or services of the merging hospitals." *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1120, 1129

(N.D. Cal. 2001).[2] Indeed, the Government's theory for why a *payor's* network allegedly must include a Harrisburg hospital is that a subset of *patients* allegedly "demand" it. Mot. 6-7; *see also id.* 13 (noting that the Government's economic expert emphasized "the demand for local health care").

The district court thus was correct that patient-choice data was "[o]f particular import," because it refuted the Government's central allegation of "inherently local" GAC services and supported a finding that hospitals outside the Harrisburg Area provide realistic alternatives for patients. Op. 9-10. This analysis did not—and did not need to—suggest patients would choose outside hospitals in *direct* response to a SSNIP imposed by a Harrisburg Area hypothetical monopolist. It instead recognized only the obvious inference that the presence of "readily" available alternatives for *patients* would help *payors* resist a SSNIP. Nothing about this analysis "fundamentally misunderst[ands] the economics of the healthcare marketplace." Mot. 14.[3]

4. The Government's own emphasis on patient-choice data not only precludes its attack on the decision below but also highlights another fatal defect in its position.

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[2] *See also, e.g.*, *Tenet*, 186 F.3d at 1049, 1053-54 (noting that payors bear the risk of price increases, but also concluding that the "proximity of many patients to hospitals in other towns … shows that the FTC's proposed market is too narrow"); *F.T.C. v. Freeman Hosp.*, 69 F.3d 260, 269-70 n.14 (8th Cir. 1995) (acknowledging that "the term 'consumers' often means … third-party payors," but still looking to "where patients could practicably turn for alternative sources of acute care inpatient hospital services"); *Gordon v. Lewistown Hosp.*, 272 F. Supp. 2d 393, 422, 428 (M.D. Pa. 2003) (recognizing that "a majority of [healthcare] costs … are paid by third-party payers," but rejecting a market that did not account for "what patients could have done in the event the Hospital attempted to lower quality or output"), *aff'd,* 423 F.3d 184 (3d Cir. 2005).

[3] The court's analysis is thus entirely consistent with decisions the Government cites for the notion that "health care mergers are properly analyzed by scrutinizing the relative bargaining power of healthcare providers and insurers." *Id.* 15 n.2.

The Government focuses on the alleged preferences only of "commercially insured patients *in the Harrisburg area*," while insisting that patients who travel into that area for care are irrelevant. Mot. 6 (emphasis added); *id.* 11. This is indefensible, because the Hospitals do not set different prices based on where patients reside. Hrg. 492:25-493:12, 586:2-14; DX0230 155:15-156:5. Given that a hospital's prices apply to *all* of a payor's members, the payor's negotiating positions are driven by the preferences of *all* members who might seek care at the hospital. Thus, a substantial number of patients cannot be ignored solely because they live farther from the hospital.

In addition to defying commercial realities, the Government's theory has no limiting principle. According to the Government, it matters only whether a subset of patients—however small—lives close to a group of hospitals and prefers to receive care there. If so, the Government's approach treats the area encompassing the hospitals and those nearby patients as a relevant market, regardless of whether 50%, 75%, or even 95% of the hospitals' patients come from outside the area. Such a "gerrymander[ed]" market, based only on a subset of patients, is untenable:

> Using [this] logic, we could delineate the relevant geographic market as the square mile surrounding a hospital, the block on which a hospital sits, or even a hospital building where the relevant procedure takes place. Surely a sufficiently large percentage of people in this area use the hospital's services. These "geographic markets," however, are obviously too narrow.

Little Rock Cardiology Clinic PA v. Baptist Health, 591 F.3d 591, 599 (8th Cir. 2009).[4] As this reasoning confirms, the Government failed to establish its narrow market by alleging merely that patients living in the Harrisburg Area prefer local care.

[4] The district court, in relying on *Little Rock*, did not "defin[e] the geographic market based on patient in-flow." Mot. 15 n.2. The court merely noted *Little Rock*'s common-sense recognition that patient preferences are relevant to geographic-market

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5. Because the Government cannot say the district court misunderstood the roles of payors and patients, it has no support for the notion that the court "disregarded [] evidence from insurers." Mot. 15. The court made clear that its fact-specific rejection of the Government's proposed geographic market was "based on the hours of testimony and thousands of pages of exhibits presented by the parties." Op. 11. *Even if* select pieces of evidence from payors provided some support for the Government's position, it was "well within the purview of the district court" to "require[] more than that evidence in order to accept the FTC's proffered geographic market." *Freeman Hosp.*, 69 F.3d at 270 n.14. That approach does not mean that the court "ignored the FTC's evidence on these issues." *Id.*

In any case, evidence from payors further supports the decision below. The Government misleadingly cites payor testimony while failing to note other testimony by these same payor representatives—for example, that the Hospitals would risk losing "25 to 30 percent of the marketplace" if they attempted to impose a SSNIP. DX0230 125:19-126:13. Even more to the point, these payor representatives testified that they are "no more … concerned" about the Hospitals raising rates than about other hospitals—both inside and outside the Harrisburg Area—attempting to do the same thing. DX0230 143:23-144:22, 153:12-154:2; DX1650 77:15-78:7. Indeed, no significant commercial payor opposes the combination. This explains why the

(continued…)
analysis and that it is improper to focus solely on patients who reside inside an alleged market. And the FTC's reported "rejection" of the "Elzinga-Hogarty" test in the *Evanston* decision—which was issued two years before *Little Rock*—does not negate this point. Mot. 15 n.2. Indeed, *Little Rock* rejected the plaintiff's overly narrow proposed market without purporting to rely on Elzinga-Hogarty. And even before *Evanston*, courts considered patient preferences while recognizing the limits of the Elzinga-Hogarty test. (See cases cited *supra* at 9-10 & n.2.)

Government called only one such payor representative at the evidentiary hearing: an employee of a payor that accounts for just 1% of the market and is affiliated with a competitor of both Hospitals.[5] Evidence from payors—all the evidence, not just that which the Government is willing to invoke—buttresses the district court's decision.

The Government also fails in its claim that the district court committed "reversible analytical error"—whatever that means—by citing actual payor–hospital contracts. Specifically, the region's two largest payors entered agreements with the Hospitals that prohibit rate increases for the next five to ten years. Mot. 16. The Government claims that the court wrongly "rel[ied] on [those] price cap agreements as an element of the geographic market analysis." *Id.* 17. But that is not what the court did. Instead, it said only that, "when considering *the import* of the hypothetical monopolist test," one "simply cannot be blind to th[e] reality" that "the Hospitals cannot walk away from these payors and that rates *cannot increase* for at least 5 years." Op. 11 (first emphasis added). The court did not clearly err by considering this reality.

6. Changing course, the Government argues that the district court "fail[ed] to consider whether a hypothetical monopolist could impose a SSNIP at Pinnacle alone." Mot. 16. If the Government truly believed the district court made a "fundamental error" by overlooking this issue (*id.*), it would have said as much in its motion asking *that* court for an injunction pending appeal—but it did not do so. And anyway, the argument has no merit. Again, the district court plainly employed the hypothetical-

[5] The Government makes much of the fact that this small payor has had difficulty marketing a product without Hershey or Pinnacle. Mot. 7-8. But this payor had only 1% market share with Pinnacle (but not Hershey) in-network, and it has that same share today without Pinnacle or Hershey. Hrg. 233:5-14.

monopolist analysis, and any suggestion that its analysis applies only to Hershey would be incorrect. The Government's position as to Pinnacle is premised on the same "patients prefer local care" mantra that underlies its other attacks on the court's geographic-market analysis. But the court squarely rejected that premise, concluding that "the FTC has created a geographic market that is too narrow because it does not appropriately account for where *the Hospitals* … draw their business." Op. 10 (emphasis added). The fact that this was "particularly" true for Hershey (*id.*) reinforces that it was true for Pinnacle as well. In fact, the court specifically cited evidence that "several thousand of Pinnacle's patients reside outside of the Harrisburg Area." *Id.* 9. And there are many community hospitals around Pinnacle, including several in York and Lancaster Counties that the Government gerrymanders out of its market. Pinnacle's patients therefore could easily turn to at least some of the "realistic alternative[s]" that the district court recognized. Op. 10; Hrg. 487:1-25. The court's reasoning more than adequately satisfies any need to assess Pinnacle on its own.

For all of these reasons, far from committing clear error, the district court was correct in finding that the Government failed to establish its proposed market.

B. *The District Court Correctly Held That The Combination's Procompetitive Benefits Also Warranted Denial Of Injunctive Relief.*

Even if the Government *had* defined a valid geographic market, that would not have been enough to warrant an injunction. Merely proving a geographic market does not suffice to secure injunctive relief; as the district court recognized, a court must also consider the real-world competitive effects a merger will have. Op. 12. And in this case, "the Hospitals presented ample evidence demonstrating that anticompetitive effects would not arise" through the combination. *Id.* The Government largely

ignores this evidence, which would support the decision below even if the Government *had* established a valid geographic market.

Tellingly, the Government says nothing of the fact that Hershey has long operated under severe capacity constraints, which the combination will enable it to eliminate. As the district court found, these constraints "[o]bviously … result[] in negative consequences for patients." Op. 15 n.5. The combination, however, will "*immediately* make additional capacity available to Hershey," as the Hospitals have identified certain types of lower-acuity cases that would be shifted to Pinnacle, which "has sufficient capacity available" to accommodate those cases. Op. 17-18 (emphasis added). Enabling the Hospitals to optimize capacity across all four campuses of the combined system will "caus[e] near instantaneous benefits," enabling "both hospitals' physicians to treat more people" and freeing Hershey to "admit more high-acuity patients who will benefit from Hershey's greater offering of complex treatments and procedures." *Id.* And in so doing, the court found, the combination will also free Hershey from pursuing its only alternative means of increasing capacity: spending up to five years and roughly $277 million building a new bed tower, an expenditure that "undoubtedly" would "negatively impact patients." Op. 17.[6] As a result, the

[6] In claiming that *not* building the tower constitutes an anticompetitive output reduction (Mot. 18-19), the Government uses the wrong baseline. If the Hospitals combine, output will immediately *increase* as Hershey capitalizes on Pinnacle's available capacity. If they do not combine, output will remain at current levels for roughly five years while Hershey builds the tower. In the interim, Hershey's patients would continue suffering from its lack of sufficient capacity—all while perfectly good Pinnacle beds remain open. Hrg. 819:24-821:4. The district court rightly rejected the Government's "impermissibl[e]" invitation to "second guess Hershey's business decision in building the tower" in the event that the combination is enjoined. Op. 18.

combination will simultaneously enable the treatment of more patients and "generate *downward*" pressure on Hershey's prices. Op. 19 (emphasis added). The court did not err—and certainly did not clearly err—in concluding that this counsels strongly in favor of letting the combination proceed.

That is not all that the Government ignores. The district court also took note of "escalating" competition for healthcare services in central Pennsylvania, as major health systems have recently affiliated with the Hospitals' competitors. Op. 20-21. This is relevant for two reasons. First, the combination will strengthen the Hospitals' ability to remain competitive in an evolving and dynamic marketplace. *Id.* 22. Second, the increasing strength of the Hospitals' competitors "will result in a meaningful constraint" on the combined entity. *Id.* These unchallenged factual findings undermine the Government's claim that the combination "will eliminate hospital competition in the area surrounding Harrisburg." Mot. 1.

The court also concluded that the combination will better position the Hospitals to accommodate insurer demands that hospitals bear greater financial risk for the costs of patient care, via risk-based contracts. Op. 22-23. The Government neither disputes that the market is undergoing this transition nor challenges the court's finding that the combination "will have a beneficial impact" by improving the Hospitals' ability to navigate this shift. Op. 23.[7]

[7] The closest the Government comes is its argument that "[n]othing in the [Affordable Care Act] compels anticompetitive consolidation among competing hospitals." Mot. 19. But neither the parties nor the district court ever suggested anything to the contrary. Instead, the court found only that the "evolving landscape of healthcare"—"includ[ing], among other changes, the institution of the [ACA]"—supports the Hospitals' decision to combine. Op. 25.

Finally, there is the "extremely compelling" fact that the Hospitals have entered rate agreements with the area's two largest payors, thereby contracting away—for five to ten years—any purported increased leverage they would otherwise gain by combining. Op. 10.[8] These agreements cover 75-80% of the Hospitals' commercially insured patients. And although the agreements do not cover other payors, their members could simply switch to the protected payors in the event of a rate increase. DX1698 ¶ 147. In any event, representatives from both Hospitals testified that they remain willing to negotiate similar agreements with other payors—and the Hospitals even offered to memorialize such agreements in a consent decree with the Pennsylvania Attorney General before this action was filed. Hrg. 516:25-517:14, 586:15-587:4. The rate agreements are proof that the Hospitals are not pursuing this combination as a means of increasing prices, thus undermining the concern animating the Government's entire opposition to the combination.[9]

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[8] Even without these agreements, rate increases would be unlikely because the hospitals' bargaining leverage will not substantially increase as a result of the combination. DX0230 125:7-125:18; Hrg. 845:13-848:8. That is true—regardless of geographic-market definition—because the differences between Hershey, as an academic medical center, and Pinnacle, as a community hospital, keep payors from leveraging the Hospitals against each other in bargaining. *E.g.*, DX1650 97:24-98:19; Hrg. 823:16-824:9. The district court did not need to reach this issue because the Government's failure to prove its alleged geographic market was dispositive. But this point, which the Government does not address, would preclude an injunction even if the Government could overcome everything in the district court's decision.

[9] The Government claims that under the district court's analysis, rate agreements will always allow merging entities "to escape antitrust scrutiny." Mot. 17-18. But the existence of such agreements will not immunize transactions from regulatory or judicial review; to the contrary, the agencies and courts will—as here—have to examine the facts of each case to determine whether and how any rate agreements impact competition in an appropriately drawn market.

In short, the Government has largely ignored the many considerations supporting the district court's conclusion that "[t]he patients of Hershey and Pinnacle stand to gain much" from the combination. Op. 25. The combination's substantial procompetitive benefits would support the decision below *even if* the Government had established a valid market. Given these benefits—and, more fundamentally, given the Government's failure to establish a valid geographic market—the Government cannot show that it is likely to succeed in securing the reversal of the district court's decision.

II. The Government Will Not Suffer Irreparable Injury In The Absence Of An Injunction Pending Appeal.

The Government's motion also fails for the independent reason that it will not suffer irreparable harm without an injunction. "The law … is clear in this Circuit: 'In order to demonstrate irreparable harm the plaintiff must demonstrate potential harm which cannot be redressed by a legal or an equitable remedy ….'" *Campbell Soup Co. v. ConAgra, Inc.*, 977 F.2d 86, 91 (3d Cir. 1992) (citation omitted). In other words, granting the injunction "must be the *only* way of protecting the plaintiff from harm." *Id.* And "the risk of irreparable harm must not be speculative." *Adams v. Freedom Forge Corp.*, 204 F.3d 475, 488 (3d Cir. 2000).

The Government's four-sentence argument comes nowhere near satisfying this high standard. The Government claims that "[i]t will be *difficult* to obtain adequate relief" in the absence of an injunction. Mot. 19 (emphasis added). But the standard requires irreparable harm, not harm that is reparable with some effort or harm that *might* not be reparable. The Government thus effectively concedes that it cannot satisfy the standard. And for good reason: in the antitrust context, "[o]nly in a rare case [is] a transaction … truly irreversible, for the courts are 'clothed with large

discretion' to create remedies 'effective to redress antitrust violations and to restore competition.'" *F.T.C. v. Whole Foods Market, Inc.*, 548 F.3d 1028, 1033 (D.C. Cir. 2008) (citation omitted). Thus, as the district court observed, "it is by no means unheard of" for the FTC to separate already-merged entities. Op. 24. In fact, the FTC recently approved the forced divestiture of an acquired firm more than five years after the acquisition was consummated. F.T.C., *Un-consummated Merger* (Dec. 18, 2013), https://goo.gl/Glebt1; *In re Polypore Int'l, Inc.*, No. 9327, 2010 WL 9933413, at *1 (F.T.C. Dec. 13, 2010) (ordering the "complete divestiture of all of the acquired … assets, as well as … other ancillary relief necessary to restore competition"). The Government cannot show that it was irreparably harmed in prior cases where it ordered divestiture, nor can it explain how it would be irreparably harmed by taking similar steps here.

III. An Injunction Pending Appeal Would Perpetuate The Existing Harms That The Court Recognized.

The Government cannot deny that an injunction would substantially harm the Hospitals and their patients. It notes only that the Hospitals "began to pursue the merger in October 2013," apparently suggesting that continued delay is no problem. Mot. 20. But the fact that the Government has already held up the combination for over a year (through its investigation and this litigation) counsels *against* added delay—particularly given that the district court has now held that the Government is unlikely to succeed in its challenge. Every day the combination is put off, the Hospitals and their patients lose out on the many benefits that inspired this combination—including the elimination of capacity constraints that harm patients. Op. 15 n.5. There is no basis for keeping the Hospitals and their patients in this harmful holding pattern.

IV. Enjoining The Combination Is Not In The Public Interest.

Finally, the Government cannot show that an injunction is in the public interest. The district court concluded, "[a]fter a thorough consideration of the equities," that the public interest supports allowing the combination to proceed. Op. 25. The Government makes no attempt to show why this determination was wrong. Instead, it offers only a half-hearted assertion that, absent an injunction, payors will "pay higher rates," and "patients will suffer higher insurance premiums." Mot. 20. But this completely ignores the fact that the combination will trigger the Hospitals' rate-protection agreements, which will be in effect during—and, if the combination proceeds, well after—this appeal. It also entirely overlooks the many other factors the district court relied upon in concluding that the combination will be to the public's great benefit. *Supra* I.B. The public should reap these benefits as soon as possible.

CONCLUSION

The Court should deny the Government's motion for an injunction pending appeal.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 18, 2016, the foregoing was electronically filed with the Clerk of the Court using the CM/ECF system. Notice of this filing will be sent to all attorneys of record by operation of the Court's electronic filing system.

/*s*/ Louis K. Fisher

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