No. 21-2603

IN THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

FEDERAL TRADE COMMISSION,

Plaintiff-Appellee

V.

HACKENSACK MERIDIAN HEALTH, INC. AND ENGLEWOOD HEALTHCARE FOUNDATION,

Defendants-Appellants

On Appeal from the United States District Court for the District of New Jersey, Case No. 2:20-cv-18140 The Honorable John Michael Vazquez

BRIEF OF THE STATES OF PENNSYLVANIA, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, IDAHO, ILLINOIS, INDIANA, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, VIRGINIA, WASHINGTON, WISCONSIN, THE DISTRICT OF COLUMBIA, AND THE TERRITORY OF GUAM AS AMICUS CURIAE IN SUPPORT OF THE APPELLEE

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IDENTITY AND INTEREST OF AMICUS CURIAE

Pursuant to Fed. R. App. P. 29(a), the Commonwealth of Pennsylvania and the State of California respectfully submit this brief, joined by the States of Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, Virginia, Washington, Wisconsin, the District Of Columbia, and the Territory of Guam (hereinafter States). The States have a strong interest in ensuring the availability of affordable and accessible quality healthcare for their citizens. This interest is best served by protecting vibrant competition in local healthcare markets. Mergers that substantially increase provider market share in local markets lead to increased healthcare costs in local communities and raise the overall cost of healthcare within the States.[1] Moreover, the States have a responsibility for safeguarding competition in their respective state healthcare markets. This responsibility positions them uniquely to elucidate on the appropriate standards to apply in healthcare merger reviews under the federal antitrust law.

[1] *See, e.g.*, Steve Tenn, *The Price Effect of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, FEDERAL TRADE COMMISSION WORKING PAPER NO. 293, 1–2 (Nov. 2008) *available at* https://www.ftc.gov/sites/default/files/documents/reports/price-effects-hospitalmergers%C2%A0-case-study-sutter-summit-transaction/wp293_0.pdf

SUMMARY OF ARGUMENT

States plays a significant role in reviewing healthcare transactions and understanding the impact of consolidation in our states. This role uniquely situates the States to offer views on the impact of anticompetitive healthcare provider mergers and conduct within our respective states. It is this knowledge and experience in healthcare markets, which supports why the States respectfully ask this Court to affirm the district court's opinion and uphold the preliminary injunction.

The States know the importance of maintaining vibrant competitive healthcare markets to control costs while ensuring quality healthcare is affordable and available to our States' citizens. Many of the States have seen the growth of large healthcare systems through the systematic acquisition of hospitals and physician groups, while experiencing the effects of the systems' increased bargaining power in negotiations between insurers and providers regarding insurance plan networks offered to employers in our States. These same potential bargaining effects and concerns correctly formed the basis of the district court's conclusion that: (1) Employers and their employees want access to healthcare that is geographically convenient to the employees; (2) For insurers to compete effectively for employers' business, the commercial health insurers must offer provider networks of hospitals and physician groups that are located near the homes of their employees; (3) Most employees are unwilling or unable to travel great distances for medical care; and (4) The employee demand for nearby network healthcare providers enhances the bargaining

power of large healthcare systems. Taken together, mergers increasing the bargaining power of large healthcare systems result in higher prices without any substantial improvements in quality for consumers.

The two-stage model of competition used by Plaintiff-Appellee Federal Trade Commission ("FTC") to assess the market impact of Defendants-Appellants' merger properly focuses on the price effects of the increased bargaining leverage that Defendants-Appellants would gain from their merger. The localized geographic market resulting from this methodology accurately models the market dynamic that we see in our States today and is consistent with this Court's decision in *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016). Further, the district court properly evaluated the evidence presented regarding the harm that would be caused by the merger, and regarding any potential benefits and efficiencies, in its decision to preliminary enjoin the merger.

For all these reasons, the district court reached the correct result based on the proper antitrust analysis of this merger.

ARGUMENT

I. HEALTHCARE COMPETITION IS A MATTER OF LOCAL CONCERN

Healthcare is viewed traditionally as a local matter falling well within the police powers of the States. *See, e.g., Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996). The "inherently local" preference for healthcare services is recognized in the federal circuit courts, which have concluded that "patients generally have a strong preference for local

hospitals, at least for GAC [General Acute Care] services". *FTC v. Advocate Health Care Network*, 841 F.3d 460, 473–74 (7th Cir. 2016); *Hershey*, 838 F.3d at 341.

Competition is an important piece of a robust local healthcare market; thus the States frequently review healthcare transactions under both state and federal antitrust laws. Indeed, recent history has seen numerous examples of States reviewing healthcare transactions under state and federal antitrust laws.[2] Through these reviews, the States have acquired a sophisticated understanding of their local hospital markets. Accordingly, we have come to see how large healthcare systems can acquire market power and successfully impose price increases on payors without risking significant patient defection to markets located farther away, because patients prefer to receive their care locally. *See,*

[2] *See, e.g., California v. Providence Group et al*., Case No. 3:21-cv-07331 (N.D. Cal. Sept. 21, 2021) (California Attorney General settles lawsuit brought under federal antitrust law against prospective merger of skilled nursing facility operators with divestiture of facility); *People of the State of California v. Sutter Health*, No. CGC 18-565398 (Cal. Sup. S.F. Ct. August 27, 2021) (Final Judgment entered for consent decree on antitrust action against Sutter Health for anticompetitive conduct in leveraging providers with market power to charge higher prices system-wide); *New Hampshire v. Concord Hospital, Inc., et al.*, No. 217-2021-cv-00225 (New Hampshire Superior Court April 20, 2021) (New Hampshire Attorney General settles lawsuit brought as parens patriae on behalf of and to protect the health and welfare of its citizens and its general economy from proposed hospital acquisition.); *Washington v. Franciscan Health System*, No. 3:17-cv-05690 (W.D. Wa. May 13, 2019) (Washington Attorney General settles antitrust lawsuit challenging health system's anticompetitive contract affiliation with a multi-specialty physician practice); *Massachusetts v. Beth Israel Lahey Health, Inc.*, No. 2018-3703 (Massachusetts Superior Court, November 29, 2018) (Massachusetts Attorney General enters Assurance of Discontinuance addressing proposed hospital merger); *Commonwealth v. Geisinger Med. Ctr.*,, No. 1:13 CV-02647-YK (M.D. Pa. Nov. 1, 2013) (Pennsylvania Attorney General settles antitrust lawsuit involving health system's acquisition of community hospital and its employed physicians).

e.g., Tenn, *The Price Effect of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, , *supra*, at 2–3.

The States have seen the consequences of acquisitions that substantially lessen competition in local provider markets. The wave of hospital consolidation over the past decades has resulted in market concentration and the creation of large healthcare systems that wield substantial market power to the detriment of patients.[3] Once these systems acquire one or more providers with market power that are must-haves for insurers, not only can they charge higher prices to insurers for those providers, but also they can force the insurers to pay higher prices for all of the other provider-members of the system. These systems impose system-wide price increases through all or nothing contracting, where an insurer must contract with either every provider in a system, no matter the cost, or risk having to market economically unviable networks that lack must-have providers within that system. *See, e.g.*, Gudiksen et al, *Preventing Anticompetitive Contracting Practices in Healthcare Markets*, SOURCE ON HEALTHCARE PRICE AND COMPETITION at 22 (September 2020), *available at* https://sourceonhealthcare.org/profile/preventing-

[3] *See, e.g.*, Nicolas C. Petris Center on Healthcare Markets and Consumer Welfare, School of Public Health, University of California, Berkeley, Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums, at 9 (Mar. 31, 2018), available at https://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf; Glenn Melnick and Katya Fonkych, Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-hospital Systems, 53 J. of Healthcare Purchasing and Financing, 1-7 (available at https://journals.sagepub.com/doi/full/10.1177/0046958016651555).

anticompetitive-contracting-practices-in-healthcare-markets/. In addition to insurers, increased healthcare costs are also detrimental to employers: employers may need to reduce their workforce or workforce's hours, forego expansion or expand or relocate employees to other areas with lower healthcare costs. *See* Arnold and Whaley, *Who Pays for Health Care Costs? The Effect of Health Care Prices on Wages*, RAND, Santa Monica, CA (2020).

In view of those realities, the States submit that the district court properly enjoined the merger on a preliminary basis, and in particular, submit that hospitals with market power (and healthcare systems that include such hospitals) can and successfully do raise the prices charged to payors as the condition for their inclusion in payors' networks. In evaluating the anticompetitive impact of the proposed merger, the district court properly used the two-stage model of competition to assess the anticompetitive effect of the merger as well as properly considered the prior anticompetitive conduct of the healthcare system at issue. Moreover, the district court properly found that the claimed benefits do not amount to extraordinary efficiencies that offset the likely anticompetitive effects of this hospital merger.

II. PROVIDER CONSOLIDATION HAS RESULTED IN LARGE HEALTHCARE PROVIDERS WITH MARKET POWER WHO HAVE BEEN ABLE TO RAISE PRICES TO PAYORS AS A CONDITION FOR THEIR INCLUSION IN PAYORS' NETWORKS

There is a general correlation between market concentration, higher prices, and higher health insurance premiums. In fact, some studies have found price increases

exceeding twenty percent when mergers occur in concentrated markets. *E.g.*, Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Reponses*, HEALTH AFFAIRS 36, No. 9 at 1531 (2017). Additional research has found that hospital markets with high hospital concentrations also had higher premiums than hospital markets with low hospital concentrations. Boozary, Reinhard, and Jha, *The Association Between Hospital Concentration and Insurance Premiums in ACA Marketplaces*, 38 HEALTH AFFAIRS 68, 671 (2019). Thus, hospitals facing less competition have an ability to charge higher prices to private payors, without accompanying them with gains in efficiency or quality. Further, lack of competition can harm the quality of care that is provided. For example, Professor Gaynor's testimony points to several studies involving cardiac care. One study shows that risk-adjusted one year mortality for Medicare heart attack (acute myocardial infarction, or AMI) patients is significantly higher in more concentrated markets. Other studies found that hospital mergers in New York state and California led to increases in mortality for patients suffering from heart attacks, failure or heart disease. Hospital market concentration is strongly associated with multiple measures of negative patient satisfaction. *See Antitrust Applied: Hospital Consolidation Concerns and Solutions*: Hearings before the Subcommittee on Competition Policy, Antitrust and Consumer Rights, of the Senate Judiciary Committee, 11-12 (May 19, 2021) (testimony of Professor Martin Gaynor), *available at*

https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf.

Once a provider has obtained market power, it may be incentivized to maintain or enhance it, leading to an increased risk of anticompetitive conduct. Dominant providers can exert market power through various contracting provisions with insurers. For example, a dominant health system can require that insurers contract with all the dominant system's hospitals and physicians in order to get access to any part of the system. They can also demand higher payment rates for the entire system. *See People of the State of California v. Sutter Health*, No. CGC 18-565398 (Cal. Sup. S.F. Ct. August 27, 2021) (court granting final judgment in settlement of claims that such anticompetitive conduct led to higher prices); *see also* 2 HEALTH CARE AND ANTITRUST L., Analyzing hospital mergers—Unilateral effects, § 12:14 (2021) (discussing negotiation process between commercial health plans and providers generally and noting the phenomenon of "must have" providers for commercially viable network plans); *cf.* Horizontal Merger Guidelines § 6.2 (2010) ("A merger between two competing sellers prevents buyers from playing those sellers off against each other in negotiations. This alone can significantly enhance the ability and incentive of the merged entity to obtain a result more favorable to it . . .").

Quality can also be impacted negatively in concentrated markets as hospitals face less competition. *See Examining the Impact of Health Care Consolidation*: Hearings before the Subcommittee on Oversight and Investigations of the Committee on Energy

and Commerce of the House of Representatives, 115th Cong. 99 (February 14, 2018) (Testimony of Professor Martin Gaynor).

III. THE DISTRICT COURT CONDUCTED A PROPER ANALYSIS AND CORRECTLY APPLIED THE TWO-STAGE MODEL OF COMPETITION TO DEFINE THE RELEVANT GEOGRAPHIC MARKET

The district court properly defined the relevant geographic market as Bergen County. Op. 35-36. The States urge this Court to sustain the district court's application of the two-stage model of competition to define the relevant geographic market and reject the Appellants' argument that price discrimination must also be used. Hospital. Brief. 25-32.

In reaching the decision, the district court properly defined the relevant geographic market as the county for the purpose of assessing the competitive effects of this merger. Courts commonly use the "hypothetical monopolist test" to define a relevant geographic market for examining the effects of a merger. *See Hershey*, 838 F.3d at 342 ("A common method employed by courts and the FTC to determine the relevant geographic market is the hypothetical monopolist test"—"if a hypothetical monopolist could impose a small but significant non-transitory increase in price ('SSNIP') in the proposed market, the market is properly defined."). Changes in payor provider bargaining positions, as the hypothetical monopolist test measures, properly predict the geographic area where a merger may have anticompetitive effects. *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd*., 778 F.3d 775, 784 n.10 (9th Cir. 2015). The district court properly followed this approach,

using the two-stage model of competition in defining the relevant geographic market as Bergen County, and the area in which a hypothetical monopolist could raise prices for hospital services.

The two-stage model of competition looks at the impact on payors and patients and recognizes that patient non-price preferences are important to the bargaining on price and access between insurers and providers. *See, e.g., Hershey*, 838 F.3d at 342; *see also* Capps, Kmitch, Zabinski, and Zayats, *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L.J. 441, 484 (2019) (noting appellate courts' "consistent and strong recognition" of the two-stage model). In the first stage of competition, hospitals compete to be included in an insurance plan's hospital network based on price, quality, and accessibility. In the second stage, patients choose hospitals within a provider network put together by their insurers based on non-price considerations such as ease of access. *See, Hershey*, 838 F.3d at 342. Patients are relevant to the analysis to the extent that their behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates. *Id*. Patients, in large part, do not feel the impact of price increases; insurers do. It is not until insurers pass on those price increases to patients in the form of higher premiums that patients feel the impact of the price increases. Even then those increases will be spread among many insured patients. *Id*. Looking only at insurers or only at patients in isolation will not give an accurate picture of a hospital market, you have to look at them in combination.

Under the two-stage model, the relevant geographic market accounts for patient preferences. It also reflects that the more options insurers have for choosing among providers in building a network that caters to patient preferences, the more insurers can obtain a better price. Conversely, the fewer the options insurers have in choosing among providers to cater to patient preferences, the more the remaining providers can command a higher price. Under the two-stage model, providers with market power, can raise prices for insurers without having to price discriminate between the substantial number of patients living close by those providers versus those living farther away. This holds true even if there are a substantial number of patients who travel to those hospitals from farther away and have other options. *See, e.g., Hershey*, 838 F.3d at 339–41.

In applying the two-stage model, the district court correctly focused on insurer testimony that insurers could not successfully market health plans in Bergen County without access to Bergen County hospitals. The insurers recognized that individuals prefer to receive care close to home and that they must consider the preferences of Bergen County residents in the construction of their networks (Op. 38-40). *See Hershey*, 838 F.3d at 352 (crediting "extensive testimony by payors that 'there would be no network' without Hershey and Pinnacle."); *Advocate*, 841 F.3d at 460, 464, 471 ("Insured patients are usually not sensitive to retail hospital prices, while insurers respond to both prices and patient preferences…").

The district court also correctly factored in the prior history of the acquiring healthcare system in successfully implementing system-wide price increases with insurers as a result of an anticompetitive contract provision requiring an increase in prices for all acquired providers to the higher system-wide price. That provision placed insurers in an untenable position: either accept the higher system-wide price for the acquired provider or, if not, lose the entire healthcare system with all of its providers as part of the insurers' provider network. Op. 50–52. The district court properly considered that demonstrated history of anticompetitive conduct, while, at the same time, properly discounting post-litigation efforts by the merging parties to suggest that they would not engage in similar conduct by omitting the to-be-acquired hospital from a list of proposed system-wide price increases. Op. 52. As the district court recognized, such prior anticompetitive conduct by an acquiring party is highly germane to assessing future anticompetitive effects of a proposed merger. *See, e.g.,* United States Department of Justice & Federal Trade Commission, Horizontal Merger Guidelines, § 2.2.1 (2010).

IV. THE PURPORTED BENEFITS ARE NOT EXTRAORDINARY AND DO NOT OUTWEIGH THE LIKELY ANTICOMPETITIVE EFFECTS OF THIS PROPOSED MERGER

The district court also properly concluded that the proposed merger would not result in extraordinary efficiencies. Merging hospitals often claim that any anticompetitive effects resulting from the merger will be outweighed by the merger's benefits. Thus far, there is no evidence that the many benefits claimed by merging hospitals are actually

realized post-merger. *See*, The Impact of Hospital Consolidation on Medical Costs, NCCI Insights, July 11, 2018, available athttps://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx#. The merging parties here also make claims of benefits that outweigh the anticompetitive merger effects. The merging parties claim that Hackensack Meridian Health ("HMH") will be able to offer more advanced care and Englewood Healthcare Foundation ("EHF") could grow its volume and increase its case mix index – optimize services between the 2 organizations. Op. 20, 24, 58, 62. The parties also claim that the merger addresses Hackensack University Medical Center's ("HUMC") capacity constraints. Op. 25–28, 61. Further the parties claim that HMH will provide operational and capital commitments to EHF. Op. 23. Finally, the merging parties claim the merger will result in cost savings. Op. 28–29. As the district court properly held, the asserted procompetitive benefits and efficiencies claimed by the merging parties are speculative and do not outweigh the anticompetitive effects resulting from the merger. The district court applied the proper standard from *Hershey* that the efficiencies benefits must be "extraordinary" to overcome any anticompetitive effects from the merger after the FTC made a prima facie case.

This Court has questioned whether an efficiencies defense even exists, but to the extent it does, this Court has said it must be "extraordinary" and passed through to consumers. "Irrespective of whatever benefits the merger may bestow upon the Hospitals .

. . [they] must demonstrate that such a benefit would ultimately be passed on to consumers. It is not clear from the record how this would be so beyond the mere assertion that it would save the Hospitals money and such savings would be passed on to consumers." *See Hershey*, 838 F.3d at 351. Here, the district court observed that HMH has a history of mergers and acquisitions, but failed to present any evidence of its historical performance of passing on any cost savings. Op. 29. The past is often prologue, and the district court properly looked at whether health systems have passed merger savings on to consumers in prior transactions. The States have been unable to identify any data supporting Appellants' argument that claimed efficiencies, if they arise at all, are passed on to consumers.

The district court did recognize that capital contributions constituted an efficiency, but it also properly recognized that this efficiency was not extraordinary enough to counterbalance the likely anticompetitive effects of this merger. After all, there is no point to recognizing the capital contribution of a healthcare system to a to-be-acquired hospital as a benefit if that contribution is going to be recouped in the form of higher prices, without a commensurate increase in quality, and with all of the indirect costs that follow a merger like the one proposed here. And insofar as Appellants try to avoid this conclusion by characterizing the FTC's prima facie case as a "weak showing" on account of its post-merger HHI of "just 2,835" and its HHI delta of "only 841," Hosp. Br. 38–39 (emphasis added), the district court correctly found that these numbers well exceed the

minimum thresholds under the Guidelines to create a presumption of a likely enhancement of market power and are therefore sufficient—without more—to establish a prima facie case. Op. 45. Indeed, these figures are sufficient to require proof of "extraordinary" efficiencies in rebuttal. *See,* Areeda and Hovenkamp, ANTITRUST LAW FOURTH EDITION, volume 4 para 971f at 44 (2016) (requiring "extraordinary" efficiencies where the "HHI is well above 1800 and the HHI increase is well above 100") (cited with approval by *F.T.C. v. H.J. Heinz Co.*, 246 F.3d 708, 721–22 (D.C. Cir. 2001)); *see also In the Matter of Evanston N.W. Healthcare Corp.*, No. 9315, 2007 WL 2286195 at *73 (F.T.C. Aug. 6, 2007) (applying "extraordinary" standard for post-merger HHI of 2,739 and HHI delta of 384).

One merging party's use of the other party's excess capacity instead of adding its own capacity is an output reduction, not a merger benefit. As this Court reasoned in *Hershey* under similar circumstances, but for the transaction, there would be more capacity added to the market. *See Hershey*, 838 F.3d at 350 ("Hershey's ability to forego building the 100-bed tower is a reduction in output. The Merger Guidelines expressly indicate that the FTC will not consider efficiencies that 'arise from anticompetitive reductions in output or service.'"). This Court's decision in *Hershey* proved to be correct. After the proposed merger was enjoined, Penn State Hershey Medical Center expanded its capacity as did Pinnacle Health (now "UPMC Pinnacle"). In particular, Penn State Hershey expanded its campus at Hershey Medical Center and built an entirely new

hospital located one mile from UPMC Pinnacle's West Shore Hospital, which UPMC Pinnacle also recently expanded with a new tower and beds due to robust competition from Penn State Hershey. Charles Thompson, *Penn State Health shows off newest pearl in growing strand of midstate hospitals*, Sept. 22, 2021, *available at* https://www.pennlive.com/business/2021/09/penn-state-health-shows-off-newest-pearl-in-growing-strand-of-midstate-hospitals.html; Ioannis Pashakis, *UPMC Pinnacle West Shore to finish expansion in November*, Aug. 19, 2020, *available at* https://www.cpbj.com/upmc-pinnacle-west-shore-finish-expansion-november. HMH is similarly situated to Hershey, as it has demonstrated a present ability to expand capacity without a merger. Op. 61.

The merging parties' plans here to redirect care to another facility are speculative and should not be counted as a benefit of the merger absent proof that it will benefit patients when looking at the services to be added, versus the services to be lost. *See, St. Luke's*, 778 F.3d at 790-91. Given that patients choose providers based on proximity to their homes or employers, the merging parties' plans to consolidate healthcare services to one merging parties' location may substantially burden the patient.[4] In many cases, redirecting care creates a significant burden if a patient does not have transportation to

[4] *In re Evanston Nw. Healthcare*, No. 9315, 2007 WL 2286195, at **7-8, 63-66 (employers need to offer health care plans that are attractive to their employees and employees prefer health plans that are geographically convenient for them and their families).

obtain services at a different location, public transit does not run to a convenient alternate location, or geographic barriers and/or traffic jams impede driving.[5] While service line consolidation may benefit the merging parties, it does not always benefit patients.

Elimination of jobs by a healthcare provider is common following its merger with another provider, and analysis is ongoing to determine whether or not this is truly a benefit to consumers. Although this may reduce costs to the provider, there is nothing so far to demonstrate that the cost savings are passed on to consumers. In fact, these reductions can lead to reduced area employment, a smaller tax base, and reduced services as there are fewer providers. Fewer employers translate to less competition for employees that can lead to lower wages and less opportunity for employee growth, in particular among skilled employees such as nurses, who have fewer or no alternatives to turn to in their local market. *See Antitrust Applied: Hospital Consolidation Concerns and Solutions*: Hearings

[5] Cf., e.g., Consent Decree, *Commonwealth v. Urology of Central Pennsylvania, Inc.*, No. 1:11-CV01625-JEJ (M.D. Pa. Aug. 31, 2011) (because some treatments are extended or ongoing, such as radiation oncology for cancer patients, which must be received five days a week for eight to nine weeks, it is important for such patients who work, are elderly or infirm, rely on public transit, or have family responsibilities to have such alternatives close by); Heaps et al, *Public Transportation in the US: A Driver of Health and Equity*, HEALTHAFFAIRS (July 29, 2021), *available at* https://www.healthaffairs.org/do/10.1377/ hpb20210630.810356/full/ ("Although patterns differ somewhat on the basis of whether an area is a 'transit-heavy metro area" or not, in general, some groups rely more on public transportation for commuting than others, including women, young adults (those ages 25–29), Black workers, and low-income workers.

before the Subcommittee on Competition Policy, Antitrust and Consumer Rights, of the Senate Judiciary Committee, (May 19, 2021) (testimony of Professor Martin Gaynor).

Here the district court correctly concluded that the claimed efficiencies and public benefits are insufficient to render this anticompetitive merger procompetitive and beneficial to consumers. While this Court has questioned whether an efficiencies defense may exist, it has also held, recently and in the context of a hospital merger, that efficiencies must be merger-specific, verifiable, or do not arise from anticompetitive reductions in output or service. *Hershey,* 838 F.3d at 349-351. For reasons that the district court expressed well in its opinion, the States urge this Court to affirm the preliminary injunction and hold that Appellants have not met their burden of establishing efficiencies to support their proposed merger.

CONCLUSION

For all of the foregoing reasons, States of Pennsylvania, California, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, Virginia, Washington, Wisconsin, the District of Columbia, and the Territory of Guam respectfully submit that this Court should affirm the district court's opinion and uphold the preliminary injunction.

Respectfully submitted,

November 5, 2021

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CERTIFICATE OF COMPLIANCE

Pursuant to the Federal Rules of Appellate Procedure and this Court's Rules, I certify the following:

1. The foregoing brief complies with the volume limitations of Fed. R. App. P. 27(d)(2)(A) because it contains **4,435** words, as created by Microsoft Word, excluding the items that may be excluded under Fed. R. App. P. 32(f).
2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.
3. This brief complies with Local Rule 31.1(c). A virus detection program was run on the electronic brief and no viruses were detected.
4. This brief complies with Local Rule 31.1(c), the electronic version of this brief is identical to the version sent in hard copy to this Court.

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CERTIFICATE OF SERVICE

I certify that on November 5, 2021, I filed the foregoing with the Court's appellate CM/ECF system. Both appellees and appellants are Filing Users with the court's electronic docketing system (CM/ECF) and therefore all parties, through below counsel of record, will be served by the CM/ECF system, per L.R. 113.4.

Dated: November 5, 2021

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