IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA
WESTERN DIVISION

FEDERAL TRADE COMMISSION

and

STATE OF NORTH DAKOTA,

Plaintiffs,

v.

SANFORD HEALTH,

SANFORD BISMARCK,

and

MID-DAKOTA CLINIC, P.C.,

Defendants.

Case No. 1:17-cv-00133-ARS

UNDER SEAL

DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

The Government seeks to enjoin a merger that will bring myriad benefits to the Bismarck-Mandan community with no realistic prospect of adverse competitive effects. Its contention to the contrary elevates flawed theory over market reality, ignores critical facts, and rests on a fundamental misunderstanding of the past, present, and future delivery of, and payment for, healthcare in central and western North Dakota.

While purporting to define the relevant market in terms of services "sold and provided to commercial payers and their insured members," the Government ignores the dominance, resulting bargaining power, and practices of by far the largest commercial payer in North Dakota, Blue Cross Blue Shield of North Dakota (BCBS-ND), which holds [redacted] of the commercial payer market. [redacted]. This includes providers with shares in the physician services here at issue for similarly constructed geographic markets that are the same as or higher than those the Government claims will result from this merger. Rather than account for this actual marketplace dynamic in North Dakota, the Government assumes it away with economic opinions that rely on indicia that either ignore the impact of payer bargaining power entirely or assign it an arbitrary value that treats BCBS-ND no differently than commercial payers orders of magnitude smaller.

Bereft of any ability to show that the merger will result in a price increase to payers, the Government speculates that quality could decline. It does not even mention the absence of any case where a merger has been enjoined based on such speculation. But the flaws in this contention run deeper. It ignores Sanford's repeatedly demonstrated commitment to system-wide quality standards that do not depend on or arise out of the level of local competition. It

ignores the fact that Sanford and MDC will continue to face a highly motivated and well-resourced competitor in CHI—one of the largest non-profit health providers in the country—and does not even try to justify its implicit assumption that Sanford and MDC would rest on their competitive laurels in the face of such a threat. And it ignores that the commitment of Bismarck-Mandan physicians to provide high-quality care does not depend on who owns MDC.

Far from resulting in a decline in quality, the merger will enhance it, unlocking millions of dollars in cost savings and a variety of merger-specific synergies that will expand healthcare innovation in a wide range of areas and provide services to the community that would not be provided absent the merger. And Sanford will do this while employing any MDC physician or staff member that chooses to join its team.

The Eighth Circuit has never upheld a preliminary injunction against a merger and has rejected various attempts by the Government to obtain such relief. The Government offers no reason why this Court should be the first.

FACTUAL BACKGROUND

In 2014, after years of consideration, Mid Dakota Clinic (MDC) concluded that it needed to sell its practice. PX2021, Seifert Dep. 180:23-181:5. MDC is a physician-owned multispecialty clinic in Bismarck with over 60 physicians and almost 500 other healthcare professionals and employees. DX6000, Town Rpt. ¶23. MDC's largest commercial relationship is [redacted] *Id.* ¶ 39.

MDC's sale arises from concerns about its ability to remain viable and competitive over the long-term. *See* Section II(E), *infra*. MDC began this process by requesting proposals from the two integrated systems in Bismarck: CHI St. Alexius and Sanford. PX2010, Seifert IH Dep.

234:20-235:15. Both responded. *Id*. at 228:15-229:5; *see also* DX2007 at 007, MDC-Sanford Correspondence. MDC initially chose to pursue a transaction with CHI. DX4008, Letter from S. Seifert to M. Parrington; PX2015, Schley Dep. 112:9-11. But in March 2016, [redacted], in 2016, MDC's shareholders concluded again that they should sell the practice and inquired whether Sanford was still interested in purchasing MDC. DX2007, MDC-Sanford Correspondence.

Sanford is a not-for-profit integrated health care system headquartered in the Dakotas that provides healthcare services and insurance products. Through its Health Services Division, Sanford employs over 1,300 physicians and operates hospitals in five states. *About Sanford Health*, Sanford Health, http://www.sanfordhealth.org/about (last visited Oct. 15, 2017). Sanford provides high quality care through standards that "set performance expectations in the areas of clinical quality, operational excellence, communication, professionalism, and patient experience" that are "vetted, developed, and implemented across Sanford's [multi-state] footprint." DX2001 at 4296; DX2002 at 4308. These standards and ongoing practices have made Sanford a center of excellence for numerous aspects of patient care and put it at the forefront of medical research and development.

On August 22, 2016, MDC and Sanford signed a term sheet to merge. DX2014, Sanford and MDC Term Sheet. During negotiation of the final agreement, they identified numerous synergies and efficiencies the merger will enable them to achieve. PX4045 at 24-31, Mid Dakota Clinic Board of Directors March 2017 Presentation; PX7001-04, Deloitte Efficiency Summary; *see also* section II(D) *infra*. On June 19, 2017, the parties executed their stock purchase agreement. DX2015, Final Stock Purchase Agreement; DX2016, Signature Pages for

Final Stock Purchase Agreement. In September 2016, MDC and Sanford announced the merger. On June 22, 2017, the Government filed suit in this Court and in the FTC's administrative court to block the transaction.

STANDARD OF REVIEW

A preliminary injunction may be granted in a Clayton Act case where the Government shows that "'weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest.'" *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999) (quoting 15 U.S.C. § 53(b)). "In order to demonstrate such a likelihood of ultimate success, 'the FTC must raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation, and determination by the FTC in the first instance and ultimately by the Court of Appeals.'" *Id*. (quoting *FTC v. Freeman Hosp.*, 69 F.3d 260, 267 (8th Cir. 1999)). "A showing of a fair or tenable chance of success on the merits will not suffice for injunctive relief." *Id*. "Such a standard runs contrary to congressional intent and reduces the judicial function to a mere 'rubber stamp' of the FTC's decisions." *Id*. "Because Congress expected courts to use independent judgment in reviewing preliminary injunction applications under Section 13(b)," the Eighth Circuit has "adopted a more stringent standard." *Id*. "Section 7 deals in probabilities not ephemeral possibilities." *Tenet*, 186 F.3d at 1051.

Courts in this Circuit strictly apply this standard. Despite numerous attempts, the Government has never obtained a preliminary injunction against a merger in this Circuit. *See Freeman Hosp.*, 69 F.3d 260, 273 (8th Cir. 1999) (denying motion to enjoin a merger of two hospitals); *Tenet*, 186 F.3d at 1055 (denying motion to enjoin a merger of two hospitals); *FTC v. Nat'l Tea Co.*, 603 F.2d 694 (8th Cir. 1979) (upholding denial of motion for preliminary

injunction); *U.S. v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *dismissed as moot on other grounds, U.S. v. Mercy Health Services*, 107 F.3d 632 (8th Cir. 1997); *U.S. v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 681 (D. Minn. 1990).

To demonstrate a likelihood of success on the merits, the Government bears the burden to establish "(1) a relevant market within which (2) the effect of the acquisition in question may be to substantially lessen competition." *Freeman*, 69 F.3d at 268. If the Government proves a highly concentrated relevant market, it is entitled to "a presumption that a *prima facie* violation of Section 7 has been established, unless defendants present clear evidence that the proposed acquisition is not likely to have such anticompetitive effects." *Country Lake*, 754 F. Supp. at 674; *see also id*. at 675 (citing "lack of entry barriers," "the power of the fluid milk buyers in the area, the possibility of vertical integration, and efficiencies" as examples of such "clear evidence"); *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1135 (S.D. Miss. 1997) (finding no Section 7 violation based on an absence of barriers to entry in the primary care market). In weighing the equities under 15 U.S.C. §53(b), the Court "must emphasize the public equities," but it was not "the intention of the statute's drafters to totally shield from judicial view the private equities which may merit inclusion in the courts' equitable overview." *Nat'l Tea*, 603 F.2d at 697 n.4.

I. THE GOVERNMENT HAS NOT MET ITS BURDEN TO ESTABLISH ITS ALLEGED RELEVANT MARKETS

To obtain a preliminary injunction, the Government must first satisfy its burden to establish the relevant markets it has alleged. *See Tenet*, 186 F.3d at 1052-53 & n.12 ("[T]he burden is on the government to establish the relevant market."); *see also Freeman Hosp.*, 69 F.3d at 268 n.12 (holding that it is "essential that the FTC identify a credible relevant market before a preliminary injunction may issue" and rejecting the FTC's argument that it need only "present

'serious, substantial, difficult and doubtful' questions about the relevant market at the preliminary injunction stage"). This Circuit has rejected FTC attempts to enjoin healthcare mergers based solely upon the Government's failure to satisfy its burden as to market definition. *See Tenet*, 186 F.3d at 1052 ("The FTC's failure to prove its relevant geographic market is fatal to its motion for injunctive relief."); *Freeman Hosp.*, 69 F.3d at 268-72 (upholding denial of an FTC motion for preliminary injunction for failure to define a proper relevant market).

Here, the Government recognizes that the standard test for establishing a relevant product market is identifying "the set of services for which a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price ('SSNIP')," and centers its market definition arguments on the SSNIP test. Compl. ¶¶ 26, 28-31. Similarly, the Government defines its alleged relevant geographic market as "the area where a hypothetical monopolist of the relevant services could profitably impose a SSNIP." Compl. ¶¶ 33-34.[1]

The Government has failed to meet the SSNIP test with regard to any of its proposed markets. It claims that a hypothetical monopolist could impose a SSNIP in the Bismarck-Mandan area in asserted markets for adult primary care physician services, pediatric physician services, OB/GYN services, and general surgery physician services that are "sold and provided to commercial payers and their insured members." *See* Compl. ¶¶ 27-35. It fails, however, to account for the high bargaining power of the dominant commercial payer in North Dakota—

[1] *See also* DX6003, Merger Guidelines § 4.1.1 (describing the hypothetical monopolist test as "requir[ing] that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products ('hypothetical monopolist') likely would impose at least a small but significant and non-transitory increase in price ('SSNIP') on at least one product in the market, including at least one product sold by one of the merging firms"). PX6000, Report of Seth Sacher ¶ 62-63 (Government economist identifying the "'hypothetical monopolist test' ('HMT') as the primary analytic tool used to define relevant antitrust markets" and asserting that if "the hypothetical monopolist would not impose at least a SSNIP, the candidate market is not a relevant market for antitrust purposes").

BCBS-ND. Because of this dominance, there is no basis to find that a hypothetical provider monopolist could impose a SSNIP on commercial payers in the asserted markets.[2]

Instead, the evidence shows that providers with shares at or above the level that the Government claims will amount to an effective monopoly here have not imposed a SSNIP on BCBS-ND in the relevant product markets within areas comparable to the Government's proposed geographic market. For example, Trinity Health ("Trinity")—a non-profit integrated health system—holds the following shares in the asserted product markets in the Minot area [redacted]. DX6000, Town Rpt. ¶ 99.[3] [redacted] *Id.* ¶ 100. Similarly, Altru is a community-owned, nonprofit, integrated health system that primarily operates in the Grand Forks CBSA. *Id.* ¶ 30. [redacted]

[2] The evidence and economic theory establishing BCBS-ND's high bargaining power and its implications are addressed in section II below. For purposes of market definition, however, what matters is that the Government cannot show that a hypothetical monopolist could impose a SSNIP in the alleged relevant markets due to BCBS-ND's high bargaining power. *See* DX6000, Town Rpt. ¶ 95 ("If the hypothetical monopolist cannot translate its bargaining leverage into a SSNIP, then the candidate market does not constitute a relevant market.").

[redacted]

[redacted] *Id.* ¶ 100, Table V.5.

Dr. Town's analysis [redacted] *Id.* ¶¶ 101-103. This further confirms that providers lack the ability to impose a SSNIP on North Dakota commercial payers [redacted] simply by having a high share of the relevant physician services.

Although not entirely clear, the Government appears to argue that it can sidestep the impact of payer bargaining power at the market definition stage. *See* Gov't Br. at 11 n.16. It further argues that it can obtain the benefits of a structural presumption of illegality based on its proposed market definition and concentration levels within those markets, again without addressing whether a hypothetical monopolist actually could impose a SSNIP in those markets in light of high payer bargaining power. Gov't Br. at 12-14.

The Government's argument is wrong and squarely conflicts with the SSNIP test as the Government, its economist, and the Merger Guidelines have described it, as well as with its own market definition. Section 4.1.4 of the Merger Guidelines explains that so-called "price discrimination markets" are "*defined around those targeted customers, to whom a hypothetical monopolist would profitably and separately impose at least a SSNIP*." DX6003, Merger Guidelines § 4. The appropriateness of the Government's proposed market definition thus

[4] [redacted]

depends on whether a hypothetical monopolist could impose a SSNIP on the targeted customers as it has defined its market—here, commercial payers.[5] The Government cannot define a market based on the ability to impose a SSNIP on a class of customers while arguing that the inability to impose a SSNIP on the customer accounting for [redacted] class is irrelevant.

This point was further confirmed in the FTC's decision in *In the Matter of Evanston Northwestern Healthcare Corp.*, No. 9315, 2007 WL 2286195, at *49-53 (Aug. 6, 2007), involving a challenge to a consummated merger between two hospitals. In that case, the FTC found the actual price impact of the merger on commercial payers to be pertinent to resolving issues of market definition, explaining that there is a "fundamental relationship between market definition and competitive effects analysis in unilateral effects cases involving differentiated product markets." *Id.* at *49; *see also In the Matter of ProMedica Health System, Inc.*, No. 9346, 2012-2 Trade Cases P 77840, 2012 WL 1155392, at *13 (March 28, 2012) (explaining that "evidence of competitive effects can often inform market definition"); *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 596-98 (8th Cir. 2009) (rejecting a market narrowed to commercial payers for hospital services for a monopolization claim brought by a competitor).[6]

[5] Moreover, as the Government explains, it excluded government payers from the targeted customer category of its market because they "generally do not negotiate reimbursement rates." Gov't Br. at 8 n.8. [redacted]

[6] In the context of defining a price discrimination market for commercial payers, the Commission further noted the importance of bargaining dynamics in defining the market:

> In a bargaining market, a merger may allow the merged firm to exercise market power against a subset of customers who view the merging parties as their first and second choices, while the transaction will have no effect on other customers who do not view the merging firms as close alternatives or who have substantial "buy-side" market power. One or both of these possibilities likely explains, for example, why ENH appears to have been unable to exercise market power against BCBS after the merger.

Evanston, 2007 WL 2286195, at *52. The Commission went on to note that reliance on unilateral effects in defining a bargaining market "creates sticky and unsettled issues for merger analysis, most

The only support the Government offers for its effort to avoid consideration of the actual ability of commercial payers to prevent a SSNIP at the market definition stage is footnote 16 of its brief, which argues that BCBS-ND's bargaining power "is analogous to the long-term rate agreements between insurers and providers on which the *Penn State Hershey* District Court erroneously relied to inform its market definition analysis." Gov't Br. at 11 n.16. As the Government's description reflects, the agreements in that case applied to specific providers and, thus, would not affect the ability of a hypothetical provider monopolist to impose a SSNIP. There was no issue of high *payer* bargaining power.[7] By contrast, the Government here asks the Court *to invent a hypothetical commercial* ***payer*** *universe—i.e.,* one without a dominant payer with high bargaining power—and thereby ignores the actual markets it has alleged and in which it must establish a hypothetical monopolist's ability to impose a SSNIP.

II. THE PROPOSED TRANSACTION WILL NOT SUBSTANTIALLY LESSEN COMPETITION IN THE GOVERNMENT'S ASSERTED MARKETS

Even if the Government had met its burden to demonstrate a relevant market—which it has not and cannot—and established a *prima facie* case based on increased post-merger concentration, the Government cannot establish that the proposed transaction will "substantially lessen competition" in its proposed markets.

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significantly, determining the percentage of a merged firm's revenues that must come from customers who are harmed by the merger for the transaction to violate Section 7." *Id.* The Commission concluded, however, that it did not need to address this issue because the record demonstrated that the average price across all commercial payers as a group increased significantly. *Id.*

[7] Similarly, payer bargaining power was not an issue in other cases cited by the Government, and there was no dispute in those cases that the product market was properly defined to include certain services purchased by commercial payers. *FTC v. Advocate Health Care Network*, 841 F.3d 460, 468 (7th Cir. 2016); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 338 (3d Cir. 2016); *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 784 (9th Cir. 2015); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1075–76 (N.D. Ill. 2012); *FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *8–9 (N.D. Ohio Mar. 29, 2011).

The Government begins its discussion of competitive effects with a chart of cases from outside this Circuit where certain mergers were preliminarily enjoined. This list is misleading. To begin with, and as noted above, there is *no* case from this Circuit upholding any such injunction. Additionally, the realities in North Dakota are very different from the facts in any of those prior cases. In particular, none involved a single commercial payer with BCBS-ND's high bargaining power (*see* section II(A)). None involved the low barriers to entry present here, including a well-established, local competitor with the intent, incentive, resources, preexisting facilities, and ability to compete in the relevant service areas (*see* sections II(B)(2) and (C)). And none involved the considerable efficiencies and synergies that this transaction will bring (*see* section II(D)). Further, only one enjoined a merger based on a service area here at issue, and in that case (*St. Luke's*) there were direct admissions by the merging parties—that do not exist here—that the transaction would enable them to raise prices (*see* section II(A)).

Indeed, while enjoining a hospital merger—which involves competitive concerns distinct from those relating to physician practices—one of the cases listed by the Government expressed doubt that the Government could establish anticompetitive effects in the market for primary care physicians. The court's reasons for such doubt were the types of bargaining power and entry issues present here and absent from the markets in the cases in the Government's chart. *See OSF Healthcare System*, 852 F. Supp. 2d at 1076 (observing that "the PCP market *is not subject to the same prohibitive barriers to entry that exist in the GAC [hospital] market*, and *the bargaining leverage held by large insurance companies* with respect to physician contracting is different than what would exist in contracting for GAC services if the merger were to take place" and that these and other features made it "less likely that the FTC will prevail on its claim involving the PCP market") (emphasis added); *see also HTI Health Services, Inc.*, 960 F. Supp. at 1144

(denying motion for preliminary injunction to enjoin merger of the two largest physician clinics notwithstanding high concentration in primary care, pediatrics, and general surgery).

In sum, this case must be judged on the realities in North Dakota under the law of this Circuit, not charts of past and inapposite FTC successes in other courts that do not illuminate those realities.

A. The Proposed Transaction Will Not Increase Prices

1. Unlike Healthcare Merger Cases Relied On By The Government, There Is No Evidence That Sanford Intends To Increase Prices Or That It Believes It Will Be Able To Do So

The Government fails to identify any evidence that any potential ability to raise prices paid by health insurers has played any role in Sanford or MDC's decision to merge. Nor has it identified any evidence that Sanford expects that it can do so. By contrast, certain cases relied on by the Government involved just such evidence. For example, in *ProMedica Health System, Inc. v. FTC*, 749 F.3d 559, 563 (6th Cir. 2014) (brackets in original), the CEO of one of the merging hospitals stated that "a merger with ProMedica 'ha[d] the greatest potential for higher hospital rates.'" *See id*. at 571 (citing such statements and explaining that "the Commission's best witnesses were the merging parties themselves").[8]

Given BCBS-ND's longstanding practice of setting uniform statewide rates with no negotiations with individual providers and the large portion of Sanford and MDC revenues attributable to BCBS-ND claims, one would expect to see at least some mention in the

[8] *See also Saint Alphonsus Med. Ctr.– Nampa, Inc. v. St. Luke's Health System, Ltd.*, Nos. 1:12-CV-00560, 1:13-CV-00116, 2014 WL 407446, *10-11 (D. Idaho Jan. 24, 2014) (identifying similar internal documents); *In the Matter of ProMedica Health System, Inc.*, 2012 WL 1155392 at *34 ("St. Luke's own documents make it clear that one of the chief benefits expected from the Joinder was obtaining the significantly higher rates that the ProMedica hospitals were able to command."); *FTC v. University Health, Inc.*, 938 F.2d 1206, 1220 n.27 (11th Cir. 1991) (pointing to evidence showing that the "appellees, *by their own admissions*, intend[ed] to eliminate competition through the proposed [hospital] acquisition") (emphasis in original); *FTC v. Cardinal Health*, 12 F. Supp. 2d 34, 63-64 (D.D.C. 1998) (pointing to statements of senior executives that the merger would reduce downward pricing pressures).

documents or testimony if the parties expected the merger to alter that dynamic. While not dispositive, the Government's inability to identify any such evidence here is a telling sign that it has not properly accounted for the realities of this transaction.

2. Sanford Will Be Unable To Secure Increased Rates From The Dominant Commercial Payer (BCBS-ND)

a. [redacted]

[redacted] DX6000, Town Rpt. at ¶¶ 35-36. *See* Gov't Br. at 23 n.60 ([redacted]).[9] [redacted] DX6000, Town Rpt. ¶ 35. Notably, the FTC itself found in a post-merger challenge that the post-merger provider had been unable to raise prices on BCBS of Illinois because of its bargaining power [redacted].[10]

Sanford has [redacted] of which [redacted]

[9] [redacted] DX6000, Town Rpt. ¶ 35.

[10] *See Evanston*, 2007 WL 2286195 at *52; *see also In the Matter of Evanston Nw. Healthcare Corp.*, No. 9315, 2005 WL 2845790, at *138 (Oct. 20, 2005) ("Blue Cross Blue Shield is the largest managed care organization in Chicago, and accounts for approximately twenty percent of ENH's business. Thus, Blue Cross Blue Shield has the power to limit ENH's price increases.") (citation omitted); *Evanston*, Respondent's Proposed Post-Trial Findings of Fact at 18 (FTC May 27, 2005) https://www.ftc.gov/sites/default/files/documents/cases/2005/05/050527respproppostialfof.pdf. The Commission ultimately ruled against the merger based on its finding that it had substantially increased prices for the remaining half of the commercial-payer market by such a large amount that average net prices were still substantially increased across all payers. *Evanston*, 2007 WL 2286195 at 53-54, 66.

[redacted] DX6000, Town Rpt. ¶ 21. Sanford and MDC's combined total 2016 revenue [redacted] *Id.* ¶¶ 21, 26. [redacted] PX2016, Matter Dep. 87:6-88:21, 171:7-172:12. [redacted] PX2025, Leclerc Dep. at 147:10-14 [redacted]). *See* DX6000, Town Rpt. ¶¶ 55-67 (explaining the sources of BCBS-ND's high bargaining power). Indeed, this is the reality for all providers, [redacted] PX2016, Matter Dep. 166:17-167:1.

[redacted] the revenues in the four challenged service areas in the Bismarck-Mandan region. In 2016, Sanford received just [redacted] DX6000, Town Rpt. ¶ 22. Thus even a significant price increase in these services in this geographic area would be only a tiny fraction of the overall amount that Sanford would have to put at risk in order to attempt to achieve such a fee increase. DX6000, Town Rpt. ¶ 22. A threat to terminate must be credible for it to be effective, and it would not be credible for Sanford to threaten to withdraw all of its physicians and facilities statewide from the BCBS-ND network for the possibility that it could change longstanding BCBS-ND practices and, even then, gain only a comparatively small amount.

b. [redacted]

The result of BCBS-ND's dominance and providers' associated need to be in-network for BCBS-ND is that BCBS-ND has high bargaining power that counteracts even the leverage of providers that have monopoly positions with regard to the physician services here at issue.[11]

[redacted] PX3014, Matter Dec. ¶ 20. [redacted] PX2016, Matter Dep. 108:13-109:12, 171:7-172:12. [redacted]. *Id.* at 120:9-19 [redacted]; *see* DX4000, [redacted] Email [redacted]). Further, [redacted] PX3014, Matter Dec. ¶ 20; PX2016, Matter Dep. 120:21-121:5. [redacted]

[11] As discussed in Dr. Town's report, while in common parlance, "'bargaining leverage' and 'bargaining power' are often used interchangeably, they have distinct meanings in the academic literature and in the standard provider-payer bargaining model used by economists and antitrust agencies, including the FTC." DX6000, Town Rpt. ¶ 50. The former is based on the degree of difficulty a commercial payer would have in marketing a network without the provider. *Id.* ¶ 51. The latter "determines whether or not providers can exploit their bargaining leverage into higher reimbursement rates." *Id.*

PX2016, Matter Dep. 120:21-121:10.

Id. at 149:24-150:18, 152:3-153:6, 164:18-165:5, 184:9-185:11, 188:10-23.

Id. at 153:16-154:10.

Id. at 162:6-163:1.

Id. at 165:19-166:15, 165:7-17

Id. at 186:5-187:6

Id. at 140:22-143:8.

[12]

[redacted]:

[redacted]

PX2008, Schott IH Dep. 13:3-11. [redacted] DX2000 at 3027, [redacted] PX2025, Leclerc Dep. at 147:1-5.

c. The Government's Brief Discussion [redacted] Misstates The Record

The Government disregards the foregoing and, as discussed more fully below, ignores basic economic theory. For example, the Government claims [redacted] Gov't Br. at 24. Four relate to the claim of an MDC executive fired many years ago [redacted] *See* PX3010, Neuberger Decl.; PX5098, Scheets Email; PX5190, November 19, 2012 MDC Board of Directors Meeting; PX2011, Schaaf Dep 246:9-247:17. [redacted] DX4001 at 8072, May 16, 2017 Rovner Email. This is confirmed by the

Government's own sources and other evidence.[13] The only other documents cited for this proposition [redacted] PX4158 at 002-003, Schimmelpfennig Email. *See also* PX4081, Schimmelpfennig Email (calculating effects of the corrections discussed in PX4158).

Similarly misleading is the Government's footnote suggesting that there is "evidence" [redacted] Gov't Br. at 24 n.62. The documents cited there say no such thing. PX4222 merely refers [redacted] (as described in PX4158), [redacted], and PX4221 involves [redacted]. PX2025, Leclerc Dep. 114:16-118:5; *see also id*. at 107:14-108:10 ([redacted]). [redacted]

[13] PX2011, Schaaf IH Dep. 251:21-253:5 [redacted]); PX5098, December 12, 2012 Schaaf Email [redacted]; PX5190 at 002, November 19, 2012 MDC Board of Directors Meeting (noting that the "increase" was linked to quality measures and likely paid to other providers); DX4002, Schott Email; DX3000, Schaaf Email [redacted]; DX3001, Letter re: [redacted]

The Government also omits key language from the comment of Sanford executive Martha Leclerc that it quotes regarding "opportunities to crack that wall." As Ms. Leclerc explained, and as the full statement reflects, she was referring to [redacted].[14] [redacted] PX2016, Matter Dep. 195:7-199:4 [redacted]; 72:20-73:8 [redacted]; 69:9-71:9 [redacted]; PX2006, Leclerc IH Dep. 239:17-241:18. [redacted]

[14] The Government omits the end of the sentence. *See* PX4028, [redacted] PX2025, Leclerc Dep. 120:11-12 [redacted]

d. [redacted]

e. Economic Analysis Confirms That There Is No Relationship Between High Provider Concentration In North Dakota [redacted]

Dr. Town's analysis demonstrates that there [redacted] DX6000, Town Rpt. ¶¶ 68-70. Similarly, there is no relationship between a standard measure of bargaining leverage used by the FTC in prior cases (known as "willingness to pay" or "WTP") [redacted]. *Id.* ¶ 71. [redacted] *Id.* ¶ 65.

As discussed above with regard to the Government's alleged market definition, [redacted].[15] [redacted]

[15] [redacted] PX2016, Matter Dep. 181:6-182:7.

[redacted]. That market concentration levels of [redacted] in each of the four service areas [redacted] clearly demonstrates that there is no reason to believe that a rate increase will result from similar shares in Bismarck. *See Id.* at 241:6-242:22; 247:14-248:18 ([redacted]).

Indeed, [redacted] *Id.* at 124:9-125:19; 142:8-23. This refutes the Government's theory in two ways. *First*, [redacted] *Second*, [redacted]. [redacted] *See* DX4003 at 3845, [redacted]

Dr. Town's analysis squarely aligns with the evidentiary record. [redacted] PX2016, Matter Dep. 184:9-185:11; 188:10-23. [redacted] *Id*. at 187:20-188:23. [redacted] *Id*. at 178:4-180:14.[16]

This evidence is consistent with the economic literature—which the Government's submissions also ignore—establishing both an association between higher payer concentration and lower provider reimbursement rates as well as "generally find[ing] that more concentrated payer markets can counteract the rate-increasing effect of concentrated provider markets." DX6000, Town Rpt. ¶¶ 88-89.

The Government's economist seeks to measure the effects of this transaction by either ignoring payer bargaining power or assuming [redacted]. The Government's use of HHI, which simply measures changes in market concentration, is not informative because there is no empirical support for the proposition that higher concentration necessarily causes higher reimbursement rates for all payers. DX6001, Town Rebuttal Rpt. ¶¶ 18-20. Instead, there is no statistically significant relationship between the two. *Id*.; DX6000, Town Rpt. ¶¶ 68-70. Similarly,

[16] [redacted] PX2016, Matter Dep. 178:4-180:14.

diversion ratios used by the Government's economist—which seek to estimate the portion of a provider's patients who would go to another provider if the first was not available—by definition, says nothing about payer bargaining power. DX6000, Town Rpt. ¶¶ 76-89; DX6001, Town Rebuttal Rpt. ¶¶ 21-24.

The Government's economist also employs a measure known as WTP (willingness to pay) but misapplies the model. Dr. Town (who previously applied this model as the FTC's testifying expert in the ProMedica merger) explains that it requires two steps. DX6001, Town Rebuttal Rpt. ¶¶ 25-33. *First*, it is necessary to measure the change in WTP which is the change in provider leverage as measured by the value that the payer's subscribers place on having the provider in-network. *Id*. ¶ 25; *see also* DX6000, Town Rpt. ¶¶ 76-89. At this step, the Government economist's estimates are inflated because he ignores the fact that contracts between payers and providers in North Dakota encompass at least a statewide relationship, lowering WTP from that calculated if the provider contracted with payers only in the Government's proposed geographic market. DX6001, Town Rebuttal Rpt. ¶ 33.

Second, it is necessary to analyze the relationship between WTP and historical prices to assess whether an increase in WTP actually will affect prices. *Id*. ¶ 27. If the historical relationship between price and WTP is close to 0, then the predicted price effect also will be close to 0. *Id*. ¶¶ 27-28. The Government's economist fails here by simply assuming that WTP would have the same relationship to price as in prior mergers *in entirely different markets. See Id*. ¶ 32 (explaining that "such comparisons are meaningless").

Finally, the Government's economist relies on an Upward Pricing Pressure analysis that similarly rests on unwarranted and result-oriented assumptions and is rife with methodological errors. This includes assigning arbitrary numbers to the bargaining power of payers and

providers which assume that all payers in North Dakota have equal bargaining power—nonsensically assuming away the very question requiring analysis in a manner that both the evidence and data show to be unfounded. *Id*. ¶¶ 54-55 (such an approach "is far removed from the approach typically employed by economists and regulators.").[17]

3. Sanford's Contract With Medica [redacted] Years, And Any Potential Rate Increase After That Would Be Small, Well Offset By Efficiencies, And Further Reduced Or Eliminated By Entry From CHI And Other Providers

Potential effects on reimbursement rates for Medica—the only payer other than BCBS-ND and Sanford's Health Plan for which the Government obtained documents or data—similarly provide no basis for finding likely substantial anticompetitive effects from the transaction. For the next [redacted] years, the transaction will have, at most, a small impact on reimbursement rates [redacted]. DX6000, Town Rpt. ¶ 112 (citing DX4004, Medica Analysis). This is because Sanford and Medica agreed to [redacted]. DX4009, Letter of Agreement between Sanford Health and Medica, July 6, 2017. As a result, [redacted] *Id.*; DX6000, Town Rpt. ¶ 112. At the same time, as MDC physicians transition to Sanford reimbursement rates, Medica estimates that the transaction will [redacted] DX4004, Medica Analysis of Sanford-MDC Merger; DX6000, Town Rpt. ¶ 112.

[17] The analysis also erroneously (1) assumes that the merging parties will negotiate with payers separately even after the merger, (2) ignores that Sanford contracts with payers on a statewide—or broader—basis and thus incorrectly assumes that a failure to contract with a payer would only have an impact in Bismarck, and (3) overestimates commercial revenues in calculating the purported price effect of the transaction by including, *inter alia*, millions of dollars from government payers. DX6001, Town Rebuttal Rpt. ¶¶ 38-67.

Even beyond that [redacted] period, any potential price impact would not be substantial. Sanford and MDC together received [redacted] from Medica in Bismarck in 2016 for services in the four specialties at issue here. *Id*. ¶¶ 35, 111. In addition, Medica negotiates with Sanford on an enterprise-wide basis, not by region or even by state; the negotiation covers all Sanford facilities and physicians in North Dakota, Minnesota, South Dakota, and Iowa. DX7000, Lenz Dep. 30:19-31:8; 61:24-62:4, 62:18-63:6, 76:11-18. This further diminishes the value to Sanford of any asserted increased leverage as the negotiation inevitably involves trade-offs across and among locations and services. *Id*. at 64:5-19, 69:19-71:9; 72:11-19. Even assuming no entry by other providers in the four physician services at issue, application of the WTP model previously used by the FTC in this context predicts, at most, an increase in Medica's annual spending on physician services of [redacted] in the Government's alleged market, and then not [redacted]. DX6001, Town Rebuttal Rpt. ¶¶ 137, 138, Table III.7.

Further, as discussed in greater detail below, *see infra* section II(C), there is sure to be increased competition in the service areas at issue from other providers, including CHI, already a well-established and well-known healthcare system in the Government's alleged geographic market. [redacted]

[redacted] Accounting for CHI's expected expansion in that time leads to an estimate that Medica's annual payments four years after the merger would increase by [redacted] in the Government's alleged markets as a result of the transaction. DX6001,Town Rebuttal Rpt. ¶ 137. This minimal price increase—which assumes no expansion by CHI beyond Mr. Schley's estimates and no other entry or expansion—is dwarfed by the transaction's likely efficiencies and synergies, *see infra* Section II(D), and does not account for any other dynamic in the four-state Sanford/Medica relationship that may influence their negotiations [redacted].

B. The Proposed Transaction Will Not Decrease Healthcare Quality

With no basis for arguing that the transaction will lead to increased prices, the Government briefly argues that it will substantially decrease non-price competition. Gov't Br. 19-20. As an initial matter, defendants are unaware of any case in which a court enjoined a merger based solely on reductions in non-price competition. *See Mercy Health Services*, 902 F. Supp. at 986 (rejecting Government's argument that hospital merger would be able to lower quality and declining to enjoin a merger on that basis). Even assuming a merger could appropriately be enjoined on such a basis, this argument necessarily depends upon two interrelated, unsupported, and erroneous assumptions: (1) that "[p]atients in the Bismarck-Mandan area benefit immensely today from this head-to-head rivalry [between MDC and Sanford]" as a result of non-price competition and, (2) that "the incentive to invest in such improvements will disappear should the merger occur." Gov't Br. at 20. Neither is correct.

1. The Record Does Not Support The Government's Assertions Of "Immense" Quality Benefits Driven By Local Competition

The Government first disregards that Sanford establishes quality and service initiatives on a system-wide basis and sets standards for "performance expectations in the areas of clinical quality, operational excellence, communication, professionalism, and patient experience" that are

"vetted, developed and implemented across Sanford's [multi-state] footprint." DX2001 at 4296, Sanford Health Quality Cabinet Report June 2014; DX2002 at 4308, Sanford Quality Cabinet and Nurse Executive Council 2017 Annual Report. Diverse groups throughout the enterprise develop, implement, and track the progress of all Sanford locations in meeting these standards and performing these initiatives.

For example, the Sanford Quality Cabinet sets performance goals, identifies enterprise strategies, analyzes standardized data to monitor and track the progress of initiatives, and communicates initiatives to improve, *inter alia*, "the patient experience of care" and "the health of the individual as well as the populations" they serve. DX2001 at 4287, Sanford Health Quality Cabinet Report June 2014. The Nurse Executive Council, another enterprise-wide group, addresses "enterprise clinical and care management standardization." DX2002 at 4321, Sanford Quality Cabinet and Nurse Executive Council 2017 Annual Report. The Enterprise Clinical Practice Committee works "collectively as a health system to develop enterprise guidelines addressing proactive, consistent methods to address patient care." DX6009, Sanford Health's Enterprise Clinical Practice Committee Charter. The Council of Governors is responsible for approving and endorsing all quality initiatives before implementation, meets regularly with the above groups, and includes leaders from each Physician Executive Council, which are physician-driven groups from each local Sanford entity. In setting these standards and developing these initiatives, Sanford benchmarks itself as a system against top academic medical centers or other top community hospitals, not local competition. DX2003 at 7081, Quality Report May 17, 2017.

The Government attempts to dismiss Sanford's system-wide healthcare quality and technology initiatives with no support or citation as providing merely "a sort of general

performance target or strategy." Gov't Br. at 20. To the contrary, such protocols, standards, and quality initiatives are quite specific and are as varied as the rollout of new technologies such as 3D mammography throughout the Sanford footprint, to uniform policies on posting wait-times at walk-in clinics to enable consumers to know where they can obtain care most quickly across Sanford providers. DX6000, Town Rpt. ¶¶ 167-68, 172. Sanford also implements standardized processes to ensure assessment in less than 30 minutes in Sanford Emergency Departments and convenient clinic scheduling for patients. DX2002 at 4308, Sanford Quality Cabinet and Nurse Executive Council 2017 Annual Report. The Council of Governors sets target scores for various quality standards at the system level, including for diabetes, vascular, hypertension, and mammography screenings; Sanford then has a system-wide "Quality Accountability Structure for Low Performers" program to assist physicians in meeting these enterprise-wide initiatives. DX6010 at 3417, Minutes from Council of Governors Meeting, August 6, 2015; DX6011, Quality Performance and Upcoming Strategies; *see also* Section II(D)(2) *infra* (discussing other system-wide initiatives).

Sanford's approach is reinforced by incentives that also are unrelated to local competition from MDC. These include statewide and national programs initiated by payers that link financial incentives to the quality of care. *See* PX3014, Matter Dec. ¶ 34. [redacted] *Id*. The parameters and standards by which quality is measured are set [redacted]. PX2016, Matter Dep. ¶¶ 195:7-199:4. Payer reimbursement policies are also central to whether providers

adopt new technologies. DX6000, Town Rpt. ¶ 185 (citing academic literature). Such programs and practices incentivize providers to improve care independent of any local competition.

The Government cites a generic statement by [redacted] that competition makes physicians "step up and try to be better" rather than "settling for average." Gov't Br. at 19. It is unclear whether the Government actually means to suggest that doctors would provide different quality care to their patients based on who owns MDC. If so, such a proposition is unsupported and contradicted by the evidence, and ignores the motivations that actually prompt doctors at MDC and Sanford to provide high quality care, including professional commitment to their patients, the desire to perform better relative to peers within the same practice group, and the system-wide quality measures on which Sanford measures the performance of all of its physicians. As one of the Government's declarants stated, his concern in deciding what care to provide a patient was "not so much that I would lose that patient" to a competitor but "that I might harm or not do as good a job as I could." DX7001, [redacted] Dep. 34:5-35:3 (asserting he would do what he "thought the patient needed regardless of whether there was another podiatrist or someone out there that might take that patient away from" him).[18]

Empirical evidence and academic literature confirm this. Using available data, Dr. Town examined whether there was a relationship between provider concentration and quality of care in North Dakota using quality metrics [redacted] and/or by Sanford's Enterprise Quality Initiatives and that could be measured using the data available in

[18] *See also* PX2024, Helbling Dep. 98:16-99:2 ("I think we're always seeking to provide the best high-quality care that we possibly can. Again, it's—to me, it's not a competition. It's a we are providing service and we want to give the best service we possibly can. You can't worry about what other people are doing as long as you know you're doing the best you possibly can."); PX2021, Seifert Dep. 96:5-12 ("I would say every physician in our clinic cares about taking good care of patients, and if a patient is falling down, we would want to know about that and try to remedy that."); DX7003, Botsford Dep. 203:16-204:2; PX2016, Matter Dep. 276:14-277:22 (Blue Alliance measures were [redacted]

this case—specifically, Breast Cancer Screening, Comprehensive Adult Diabetes Care, Eye Exam, Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life, and Colorectal Cancer Screening. DX6000, Town Rpt. ¶¶ 177-80. That analysis found no relationship between provider concentration and quality of care. *Id*. ¶¶ 178-81. The Government's putative quality expert asserts that other measures could have been analyzed, but did not do so. DX6007, Jha Rebuttal Rpt. at ¶ 9. As further explained by Dr. Town, these results are consistent with academic literature finding that intrinsic desire to provide high quality care was four times more important to quality performance than financial motivation. *See* DX6000, Town Rpt. ¶¶ 181-82.

The Government fails to offer any credible examples of quality improvements that were actually driven by competition with MDC, and its attempts to do so, at most, demonstrate the minimal role that local competition plays, the many other factors that are far more significant drivers, and Sanford's system-wide approach to these issues. The primary technology the Government mentions—3D mammography—is a paradigmatic example. That technology was adopted across the Sanford system in a sequence that did not correspond to the significance of local competition. *See Id*. ¶¶ 159, 167-68; DX2004, Mammography Units Spreadsheet (describing seven of the highest priority markets as non-competitive "Mamo markets" including areas where Sanford has low competition such as Bemidji, Minnesota). The only other technology the Government mentions—a tower free hysteroscopy system allowing certain gynecological procedures to be performed in an office setting rather than at the hospital—was a $15,000 system ordered for seven locations in addition to Bismarck. DX2005, Sanford Summary of FY15 Capital Commitments; DX2006 at 7285, Capital Request Form; DX6012, Minutes of Women's Health Medical Staff Meeting, Sanford Bismarck, September 23, 2014, p. 1. The form requesting this equipment stated that patients had gone to both MDC and Fargo for

the procedure, but justified the request because it would "free up the O.R. and generate revenue for our clinic." DX2006 at 7285, Capital Request Form.

Finally, it is inaccurate to describe the pre-merger situation as somehow involving quality competition among general surgeons that will be lost with the joinder of Sanford and MDC. Instead, as CHI's declarant admitted, a patient now either finds a general surgeon by a referral from a primary care provider or due to an emergency when the patient will simply arrive at the hospital and be cared for by the attending surgeon. PX2015, Schley Dep. 85:1-86:1. Nothing about that dynamic will change as a result of the merger. Patients will continue to see a general surgeon either because he or she is on duty at the hospital or because of a referral from a primary care provider. Patients will also continue to have the option to have their surgery performed at whichever hospital they choose.

2. Current And Future Post-Merger Competition Would, In Any Event, Maintain The Incentive For Vigorous Quality Competition

Even assigning a more important role to local competition in driving quality benefits than the evidence warrants, there is no basis to say that "the incentive to invest in such improvements will disappear should the merger occur." Gov't Br. at 20. Even without all of the other factors that drive Sanford's quality and service improvements, Sanford still will have to compete with other providers, including CHI, one of the largest non-profit healthcare systems in the country. As discussed in the next subsection, CHI alone (not even accounting for other providers) is a large, heavily resourced competitor with a loyal patient base and ample economic incentive, resources, intent, ability, and available capacity to compete with Sanford in the relevant service areas post-merger. There is no reason to believe that any asserted competitive pressure from MDC will not continue through CHI or that Sanford would respond to competition from CHI any less than to competition from MDC.

C. CHI And Other Independent Providers Have The Incentive And Ability To Compete With Sanford In The Relevant Services Areas

1. CHI Has The Incentive And Ability To Compete In The Relevant Service Areas

The record establishes that CHI St. Alexius has the incentive, ability, and intent to compete with Sanford in each of the practice areas at issue. In other words, the proposed transaction will not lessen competition. If anything, it will enhance competition by incentivizing CHI to provide services for which it previously depended on MDC, thereby increasing overall output, and substituting a much stronger competitor for MDC. *See* subsection II(E), *infra* (discussing why MDC can be expected to weaken as a competitor to Sanford over time in the absence of the merger); *see also OSF Healthcare System*, 852 F. Supp. 2d at 1076 (observing that "the PCP market is not subject to the same prohibitive barriers to entry that exist in the GAC [hospital] market"); *HTI Health Services, Inc.*, 960 F. Supp. at 1133 (denying motion for preliminary injunction seeking to enjoin the merger of the area's two largest physician clinics based in part on evidence of lack of barriers to entry).

CHI has ample ability and incentive to compete in the relevant service areas. It is the fourth largest non-profit hospital system in the country by revenue and is in merger talks with Dignity Health, the fifth largest such system. *See* Laura Dyrda, 10 Largest US Health Systems: Which Had The Biggest Revenue Increase In 2016?, Becker's Hospital Review (March 03, 2017), available at https://www.beckershospitalreview.com/hospital-finance/10-largest-us-health-systems-which-had-the-biggest-revenue-increase-in-2016.html (detailing the 2016 revenues of the ten largest health systems in the United States). Its most recent financial statement reported $15.5 billion in annual revenue and $21.9 billion in assets, with a 16.4% improvement ($114.5 million) in EBIDA (Earnings Before Interest, Depreciation, and Amortization) over the prior fiscal year. DX6008, CHI Financial Statement at 1, 2. CHI

operates in 18 states with over 100,000 employees, including 4,300 physicians and advanced practice clinicians.[19] CHI also has a loyal patient following, in part due to its religious affiliation. PX2015, Schley Dep. 39:9-12; DX7004, S. McDonough Dep. 63:10-18.

CHI will be highly motivated post-merger to add clinicians in the services at issue. Approximately [redacted] of inpatient admissions at CHI St. Alexius in the past five years have come from MDC referrals. PX2015, Schley Dep. 32:2-33:1. This is about [redacted] in annual revenue. *Id*. at 158:8-21. While MDC doctors can still refer to CHI if the patient requests it or if the referral is merited in their professional judgment, CHI is concerned that it will lose referrals to Sanford as a result of the merger [redacted] *Id*. at 36:10-13. *See* PX2010, Seifert IH Dep. 128:1-11, 213:1-14, 214:16-215:4, DX3002 at 4384, Employment Agreement; PX2013, Bury Dep. 190:20-191:14.

For this and other reasons, when the transaction with Sanford was announced, CHI began engaging in what the senior vice president for the Fargo region (which includes Bismarck) referred to as [redacted] with high priority on [redacted].[20] CHI opted to [redacted] and took a [redacted] because the transaction was

[19] *See* "Overview 2016," Catholic Health Initiatives, available at http://www.catholichealthinitiatives.org/documents_public/Overview%20Brochure/2016%20Overview%20Brochure.pdf, accessed on September 24, 2017; "Financial Report 2016," Catholic Health Initiatives, available at http://chiannualreport.net/pdf/Financial-Report.pdf, accessed on September 24, 2017; "2016 Community Benefit Annual Report," Sanford, available at http://www.sanfordhealth.org/~/media/2016%20community%20benefit%20annual%20report%20(1).pdf?la=en, accessed on September 24, 2017.

[20] PX2015, Schley Dep. 40:25-42:18; 43:15-21; DX7002, Kyaw Dep. 20:4-21:5, 22:22-23:3, 61:18-63:5, 112:13-114:5; [redacted]

delayed by the Government's investigation and these proceedings. PX2015, Schley Dep. 43:15-46:9; 50:16-24; DX7002, Kyaw Dep. 123:4-125:20.

Even with this [redacted], CHI has demonstrated that it can and will compete with Sanford. For example, CHI already has a fully staffed family medicine clinic in Mandan in which three physicians have at least [redacted] available capacity, in addition to 12 non-CHI PCPs in Bismarck. PX2015, Schley Dep. 55:1-18; DX7002, Kyaw Dep. 131:9-132:20; DX4010, FY17 Mandan Clinic Visits; Compl. ¶ 38. [redacted] PX2015, Schley Dep. 63:23-64:12; DX7002, Kyaw Dep. 69:15-71:13.[21] CHI also can recruit new physicians to its existing practice groups through a variety of sources, including the family medicine residency program at the University of North Dakota, various websites, physician recruiting services, and current MDC physicians.[22] CHI also is exploring [redacted] PX2015, Schley Dep. 64:23-67:1; DX7002, Kyaw Dep. 130:3-23, 226:16-227:17. It also is in talks with [redacted] which provides primary care [redacted] PX2015, Schley Dep. 73:12-75:13; PX2023, Lein Dep. 238:9-16

CHI is similarly primed to compete in OB-GYN services. As an initial matter, over the next two to three years, MDC OB-GYNs will continue to practice at CHI St. Alexius facilities

[21] Nurse practitioners in North Dakota may practice without supervision. PX2015, Schley Dep. 58:7-10. [redacted]

[22] Employment contracts for MDC physicians joining Sanford have a non-compete clause preventing practice independently or with another physician group in Burleigh County for three years. *See, e.g.*, DX3002 at 4400, Employment Agreement. However, they could practice in Morton, Oliver, and Sioux Counties, all in the geographic market alleged by the government.

because Sanford lacks capacity to accommodate their facility needs. PX2013, Bury IH Dep. at 136:4-137:22, 185:11-186:15; PX2021, Seifert Dep. 209:21-210:18. Meanwhile, [redacted]. PX2015, Schley Dep. 90:4-14; PX2013, Bury Dep. 139:7-141:6; *See* DX7002, Kyaw Dep. 224:1-4 [redacted]); *see also* PX2015, Schley Dep. 90:4-16 [redacted] DX7004, S. McDonough Dep. 79:19-80:3. [redacted] herself says that she can take on "[a]s many" patients "as want to come." PX2013, [redacted] PX2015, Schley Dep. 91:5-12; PX2013, Bury Dep. 124:1-22; DX7002, Kyaw Dep. 120:13-22. [redacted] *See* DX7002, Kyaw Dep. 126:4-23, 212:7-25; 121:21-122:18 [redacted]). Thus, as with primary care, CHI will have ample capacity to compete immediately with Sanford and MDC and [redacted] PX3009, Schley Dec. ¶ 47.

[redacted]

[redacted] *Id.* ¶ 5; *see also* DX8002, D. McDonough Dec. ¶ 4 (declarant's practice employs three family medicine physicians and one NP who [redacted]); PX2010, Seifert IH Dep. 17:3-6, 130:12-23; DX7004, S. McDonough Dep. 45:22-47:13. In other words, CHI's replacement of MDC pediatricians can start, as a practical matter, immediately.

Finally, CHI can recruit general surgeons to replace the MDC surgeons who will join Sanford. It already has the space for them, and as with the OB-GYN group, for the next 2-3 years the MDC surgeons will be doing call at CHI St. Alexius, thus removing one of the claimed difficulties in recruiting surgeons. PX2010, Seifert IH Dep. 209:11-20; PX2024, Helbling Dep. 143:8-144:5; PX2013, Bury Dep. 136:4-137:22, 185:11-186:15. During that period, CHI could recruit more general surgeons and by its own admission, could retain *locum* providers to make up for any near-term shortfall. PX2015, Schley Dep. 87:16-89:20; PX3009, Schley Dec. ¶ 48 (estimating [redacted]).[23]

2. Sanford's Experience Demonstrates The Absence Of Barriers To Entry To Competing In The Relevant Service Areas

Sanford's own experience recruiting physicians in North Dakota, including Bismarck-Mandan and far smaller communities, further refutes the Government's suggestion that factors

[23] Notably, the Government mentions none of these estimates from CHI's declarant. [redacted] *See also* Compl. ¶ 38 (stating that 23% of post-merger Bismarck-Mandan physicians adult PCPs (18) will be non-Sanford even without any new entry).

indigenous to North Dakota are a barrier to entry. *See HTI Health Services, Inc.*, 960 F. Supp. at 1133 ("[T]he Court is not persuaded by Columbia's attempts to prove that factors indigenous to the Vicksburg market act as a deterrent to new primary care entrants."). Examples include greatly increasing recruitment of physicians in Fargo by over 20 per year since Sanford's merger with Meritcare in 2009, increasing recruitment of physicians in Bismarck by 30% since its acquisition of MedCenter One, and [redacted][24] MDC also successfully recruited 15 physicians to Bismarck in 2013 and 2014. PX2012, Ahern IH Dep. 208:22-210:2; PX7001 at 23, Deloitte Efficiency Summary. These efforts further show that nothing about North Dakota precludes the recruitment of new physicians in the relevant service areas, particularly by a larger and even more well-resourced system like CHI.

D. Far From Decreasing Quality Or Increasing Price, The Proposed Transaction Will Generate A Range Of Significant Efficiencies And Synergies That Will Substantially Benefit Consumers

As stated in section 10 of the Merger Guidelines, "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products." The parties agree that to be cognizable, such efficiencies must be merger-specific (*i.e.*, "unlikely to be accomplished in the absence of" the proposed merger) and

[24] *See* DX6000, Town Rpt. ¶¶ 136, 138; Jodi Schwan, *Sanford's record-setting Fargo hospital ready to open*, Sioux Falls Business, June 2017, available at http://siouxfalls.business/sanfords-record-setting-fargo-hospital-ready-to-open/, accessed on September 14, 2017; DX2011, Resp. to Civil Investigative Demand Issued to Sanford Health FTC File No. 171-0019, *Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C.*, pp. 49, 54; DX2009, Sanford Press Release, "Sanford Health announces new clinic in Minot, expands services," March 31, 2016, available at https://www.sanfordhealth.org/newsroom/2016/03/sanford-health-announces-new-clinic-in-minot, accessed on September 15, 2017; DX2010, Sanford West Minot Strategy.

verifiable. *See* DX6003, Merger Guidelines § 10; Gov't Br. at 28. In this case, the merger will generate considerable efficiencies and synergies that must be considered in evaluating its overall competitive effects. *See Tenet*, 186 F.3d at 1054 ("[A]lthough Tenet's efficiencies defense may have been properly rejected by the district court, the district court should nonetheless have considered evidence of enhanced efficiency in the context of the competitive effects of the merger."); *see also FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1301-02 (W.D. Mich. 1996), *aff'd sub nom. FTC v. Butterworth Health Corp.*, 121 F.3d 708 (6th Cir. 1997); *U.S. v. Carillon Health System*, 707 F. Supp. 840, 846 (W.D. Va. 1989) (both concluding that hospital mergers would increase quality based on increased synergies and efficiencies and declining to enjoin mergers). This is consistent with prior Sanford acquisitions that have resulted in significant efficiencies and community benefits.[25] These pro-competitive effects include: (1) significant merger-specific cost savings; (2) the expansion of beneficial services to more patients that would not occur but for the merger; and (3) the ability to create new services.

1. The Merger Will Generate Millions Of Dollars In Annual Cost Savings

Efficiencies that will result from the merger include substantial ongoing cost savings. To calculate these efficiencies, Sanford counsel retained Deloitte. PX2012, Ahern IH Dep. 7:25-8:14.[26] To perform its calculations, Deloitte conferred with various Sanford and MDC personnel, toured the parties' facilities, and requested and reviewed detailed information from both Sanford and MDC. PX2012, Ahern IH Dep. 28:14-37:13. Deloitte identified both savings

[25] DX2011, Resp. to Civil Investigative Demand Issued to Sanford Health FTC File No. 171-0019, *Federal Trade Commission and State of North Dakota v. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C.*, Specification No. 21; Sanford Objections and Resp. to FTC's First Set of Interrog. Resp. No. 4.

[26] It was necessary to retain a third party to perform the calculations to avoid antitrust concerns that could otherwise potentially arise from Sanford and MDC sharing cost and other necessary information prior to consummation of the merger.

and potential incremental costs and calculated net savings of [redacted] over the first three years after closing, and [redacted] in recurring annual savings thereafter. PX7001-04, Deloitte Efficiency Summary; PX2012, Ahern IH Dep. at 38:21-39:6.[27] The total saved costs are about [redacted] of MDC's operating expenses. PX7001-005, Deloitte Efficiency Summary.

These net savings arise in a variety of clinical, ancillary and non-clinical areas, PX7001-05, Deloitte Efficiency Summary, including millions of dollars resulting from the ability of MDC cancer patients to benefit from chemotherapy infusion drug pricing available under a program known as 340B that allows qualifying facilities to purchase certain drugs at lower prices. *Id*. at 09. MDC currently cannot qualify for that program, but Sanford's Bismarck Medical Center does. PX2012, Ahern IH Dep. at 57:20-58:3. Such savings are inherently merger-specific because Sanford is eligible for this program and MDC is not.

The Government argues that these savings should not be considered because there is "no evidence" that the merger is necessary "to obtain savings in cancer care, which is not a relevant product market in this action." Gov't Br. at 29. To the contrary, the *only* way to achieve these savings is through the acquisition because MDC otherwise cannot qualify. Relatedly, the Government's argument that millions of dollars in savings should not be considered because cancer care "is not a relevant product market in this action" makes no sense in a merger involving an integrated healthcare system acquiring a multi-specialty clinic, both of which enable patients to obtain services in multiple areas based on their needs. Such savings need not be reinvested in cancer care but rather are fungible and can benefit the patient population as a whole (including those not receiving cancer treatment) in a variety of ways. The commercial payers that the FTC has defined as the customers purportedly harmed by this transaction do not

[27] As discussed below, about $200,000 of this total is no longer attributable to the merger due to MDC's new contract for lab services. *See infra* at 41.

have a separate agreement for cancer care. Rather, they have global contracts covering payments for all services. *See also* DX6000, Town Rpt. ¶¶ 123-25 (explaining the various benefits of 340B savings).[28] As a result, payers that could (in the Government's view) be negatively affected by the merger also have the potential to benefit from these savings as part of the overall tradeoffs in the economic terms of their relationships with Sanford.

The Government also asserts that the 340B savings are "unverifiable," Gov't Br. at 29, relying on Dr. Respess' report, which primarily speculates that Sanford might not qualify for the 340B program post-transaction. PX6001, Respess Rpt. ¶¶ 43-53. To the contrary, eligibility for 340B is assessed using a formula focused on the percentage of low-income individuals served by the qualifying hospital on an inpatient basis.[29] MDC can only affect this percentage through changes in its referrals to Sanford's hospital post-merger. As explained by a Sanford witness familiar with Sanford's qualification for the program, there would have to be both a substantial influx of new referrals *and* the composition of the referred patient population "would have to be substantially different, very substantially different," for the MDC transaction "to even have an impact, and I can't imagine a situation where there would be enough volume to create an issue with meeting the benchmark." PX2025, Leclerc Dep. 166:12-23.

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[28] By contrast, the Government cites cases that involved alleged efficiencies in one market that, at best, would have benefited a completely different set of consumers. *See United States v. Anthem, Inc.*, 855 F.3d 345, 363 (D.C. Cir. 2017) (efficiencies calculated based on market for large group employers of 50+ or 100+ employers rather than the definition adopted of national accounts with 5,000+ employees); *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 98 (D.D.C. 2017) ("[T]he Court cannot be confident that the consumers who are likely to be harmed by the merger"—individual Medicare Advantage Plans and individual commercial health insurance plans—would also share in its benefits.).

[29] The formula is the percentage of Medicare SSI hospital days / number of Medicare patient days + number of Medicaid patient days / total inpatient days, multiplied by an adjustment factor. *See* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Disproportionate_Share_Hospital.pdf.

Apart from 340B, the only specific efficiency discussed in the Government's brief is about [redacted] in lab savings that Deloitte calculated, but that the parties agree is no longer a savings because MDC has negotiated an improved contract with a different lab. The Government then argues, with no evidentiary support, that "as is apparent from its renegotiated lab prices, MDC could achieve many of the remaining purported efficiencies independently." Gov't Br. at 30. To the contrary, MDC's new lab contract proves that, if MDC could achieve other savings, as a rational actor, it would have taken steps to do so. The Government's focus on this undisputed non-issue further highlights that it cannot identify examples where MDC has been able to improve its position as to any of the other savings calculated by Deloitte.

The Government also argues, without citation, that MDC could obtain savings "through agreement or merger with another entity." *Id.* No such entity is named. The only logical candidate—CHI—had the opportunity, [redacted] PX2010, Seifert IH Dep. 236:15-21; PX2015, Schley Dep. 114:21-117:9. As a result, there is no evidence CHI would acquire MDC if the current transaction does not occur. The Government thus has no basis for asserting that another entity would merge with MDC, let alone one that would allow it to achieve the same efficiencies.

2. The Merger Will Give MDC Patients Access To A Wide Range Of Beneficial Programs And Services To Which They Otherwise Would Not Have Access And Enable The Merged Entity To Achieve Results That Neither Sanford Nor MDC Could Achieve On Its Own

As explained above, the Sanford system is constantly innovating to improve primary care and benefit patients system-wide. The merger will significantly extend to MDC patients a wide range of innovations and improvements that are currently unavailable to them.

One example is Sanford's Imagenetics and genetics counseling programs. Imagenetics integrates genetic medicine into primary care through precision medicine research and Sanford-developed protocols and tests that are integrated into its electronic medical records system ("EMR") to enable more precise diagnosis of conditions and identification of the best treatment options for patients. PX4045 at 24, Mid Dakota Clinic Board of Directors March 2017 Presentation; PX2007, Hocks IH Dep. 91:10-95:21. The results of genetic testing are integrated into the patient's EMR so that physicians who examine the patient in the future will have immediate access to information that will improve their ability to provide the highest quality care. *Id*. at 93:6-94:3. This program is only available to Sanford patients and, thus, is merger-specific because MDC patients cannot access it unless their physicians are part of Sanford. *Id*. Sanford also offers genetic counseling services to help patients determine appropriate genetic testing and ensure that the tests are covered by insurance. *Id*. at 242:22-244:12. Again, MDC does not offer such services, but its patients will have access to Sanford's services post-merger. *Id*. at 243:7-23. The Government's brief does not address these synergies. Nor do its experts.

Another example is the expansion of Sanford's model for embedding behavioral-health therapists into primary care to assist in screening and treating patients to avoid the downstream impact of undiagnosed and undertreated behavioral health issues. PX4045 at 024, Mid Dakota Clinic Board of Directors March 2017 Presentation. Sanford's model won a CMS Innovation award and was the result of a five-year development and three-year testing process that resulted (as measured by a CMS report card) in an 18% increase in optimal diabetes care, 11% increase in optimal asthma care, 28% increase in identification of anxiety disorders, 18% increase in identification of depression, 9% increase in avoidable hospitalizations, and a 13% decrease in

total cost of care. *Id*.; PX2007, Hocks IH Dep. 33:25-34:23, 41:14-42:15.[30] MDC does not employ behavioral therapists, there is no evidence that it intends to, and even if it chose to do so, MDC would lack the benefit of Sanford's experience and model. *Id*. at 41:19-42:20. Thus, MDC physicians were excited to learn about this model and believe it to be a good solution to recognized problems in primary care. *Id*. at 44:23-45:19.

Again, the Government's brief does not address this issue. Dr. Jha, the Government's putative quality expert, asserts that MDC "could independently undertake" such a practice "without the proposed merger" because he is aware of literature on integrating behavioral health into primary care. PX6002, Jha Rpt. ¶¶ 53-56. Reading about a model and actually developing, testing, and implementing one are very different things. What matters for determining whether there is a merger-specific efficiency is what is likely to happen in the real world. *See* DX6003, Merger Guidelines § 10 ("The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and *unlikely to be accomplished* in the absence of [] the proposed merger."). There is no evidence that MDC had any intention of implementing such a model, as evidenced by the fact that it currently employs no behavioral health therapists. PX2007, Hocks IH Dep. 41:3-13. Sanford's model is readily available to MDC physicians once they are part of the Sanford system and will give them immediate access to a product of years of development and testing that has demonstrated success according to CMS' independent assessment.

As another example, joining with Sanford would give MDC's patients access to new cancer treatments and protocols. This includes over 75 clinical trials—*i.e.*, new protocols to care for cancer patients—and brings MDC's oncologists into Sanford's multidisciplinary approach to

[30] CMS describes its innovation awards as given "to organizations that implemented *the most compelling new ideas* to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs." *See* https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/ (emphasis added).

cancer care, which MDC currently lacks. *Id*. at 124:17-125:11. Again, the Government's brief does not address this synergy, nor do any of its experts.

The transaction also will give Sanford and MDC the ability to do things together that neither has done, including providing currently unavailable but needed subspecialties. For example, an MDC physician has expertise in cosmetic gynecology but is too busy covering call and her own patients to offer these services. *Id*. at 149:16-152:23. Sanford's excess OB/GYN capacity can pick up some of her call obligations so she can devote time to this area. *Id*.; PX4045 at 025, Mid Dakota Clinic Board of Directors March 2017 Presentation. Again, the Government does not address this synergy, nor do its experts.

The combined entity also will be better positioned to recruit subspecialists that neither offers today but for which there is local need. This includes urogynecology, reproductive endocrinology, pediatric critical care, pediatric endocrinology, pediatric gastroenterology, and pediatric neurology. PX4045 at 027, MDC Board of Directors Presentation. There is no dispute that the community would benefit from this recruitment, and that a subspecialist will not come to a community without assurance of a sufficient patient base. *See* PX2007, Hocks IH Dep. 145:5-8; PX6002, Jha Rpt. ¶ 28. The Government argues that Sanford or MDC could readily recruit without the merger because doctors from different practices would still refer to the subspecialist once he or she is locally available. *Id*. ¶ 31. It ignores that neither has done so, and wrongly assumes that Sanford or MDC would make the necessary investment (and that the subspecialist would agree to come) without assurance that the other set of doctors would refer to the recruited

subspecialist.[31] Following the merger, a subspecialist can be recruited with far greater confidence that he or she will have sufficient patient volume.

The Government makes no serious attempt to dispute the actual synergies and improvements that the merger will generate. Instead, it seeks to avoid them by describing them generically as "adding new services," "clinical integration and care coordination" and "sharing and implementing best practices"—and then claiming that "examples abound" of Defendants already doing "some" of them. The examples offered—opening of one clinic and expansion of another—do not address the myriad and specific synergies that Sanford and MDC have identified.[32] Gov't Br. at 31. The point is not that Sanford or MDC are currently incapable of *any* improvements without the merger; the point is that the specific synergies that they have identified and that the Government ignores will not occur absent the merger.

The Government otherwise asserts only that its putative quality expert Dr. Jha "examined certain quality measures" and "concluded that MDC and CHI—as independent entities on different EMR systems—perform better together than Sanford does with its own doctors." Gov't Br. at 31. But Dr. Jha based this assertion on just one quality measure—hospital readmission rates—where Sanford Bismarck is a mere 1.2% higher than CHI. The suggestion that this proves better coordination between MDC and CHI is so bereft of support and any credible methodology (including ignoring the fact that only a minority of CHI's patients are referred by MDC primary

[31] *See* PX2021, Seifert Dep. at 25:7-17 (decision of MDC doctor to refer to a Sanford subspecialist would depend upon "their best judgment is that person qualified and are the services equal to something that could be obtained at a distance"); *see also* DX7004, McDonough Dep. at 56:11-24 (stating that previous experience with a physician is important in determining whether to refer a patient to that provider).

[32] The only example the Government mentions that was identified in the Sanford/MDC synergy document is recruitment of a maternal fetal medicine specialist. But this physician was not hired because Sanford set out to recruit such a specialist. Rather a scholarship student who was slated to work at Sanford as an OB/GYN decided to obtain additional training. PX2007, Hocks IH Dep. 146:18-147:7. As a result, it does not address the enhanced ability and incentive to recruit new subspecialists that would result from the merger, let alone the broader set of synergies that Sanford and MDC have identified.

care doctors) that it would likely be barred under the *Daubert* standard were this a jury trial.[33] It also does not address the specific synergies identified by the parties.

E. [redacted]

Evaluation of the competitive benefits of the transaction also must take into account the evidence that [redacted]. As this Circuit has recognized, "when examining a merger, a court must necessarily compare what may happen if the merger occurs with what may happen if the merger does not occur." The prospective loss of one of the merging parties "from the relevant market if the merger is enjoined is a relevant factor in this comparison." *Nat'l Tea Co.*, 603 F.2d at 700; *see also id*. at 700 n.8 (recognizing that this argument is distinct from a failing company defense).

MDC witnesses have observed that [redacted] due to reimbursement changes by government and commercial payers.[34] There is also evidence of declining [redacted]. PX2010, Seifert IH Dep. 39:7-40:1, 68:1-8, 110:13-23, 253:22-254:4; PX2011, Schaaf Dep. 58:19-59:22. [redacted]. PX2010, Seifert IH Dep. 110:13-23, 111:15-112:4, 181:8-25, 205:12-206:17; PX2001, Lein IH Dep. 210:20-212:15; PX2024,

[33] Dr. Jha asserts only that poor care coordination is one reason why readmissions occur and otherwise cites testimony that does not even remotely support his assertions. PX6002, Jha Rpt. ¶ 40. Dr. Helbling states only that hospital readmission rates are one among many measures that *general surgeons* track to determine if they have provided good quality care, not that it is an effective measure of comparative care coordination between primary care doctors and hospitals. *See* PX6002, Jha Rpt. ¶ 41 n.80; PX2024, Helbling Dep. 55:2-13; s*ee also id*. at 88:23-89:1, 90:19-22 ("Q: Would you agree that one of the common reasons patients are re-admitted is due to poor care coordination? A: No. . . . Q: You have no opinion on whether poor care coordination may contribute to re-admissions? A: No."). Similarly, cited testimony from Dr. Seifert does not address patient readmission rates at all and also states that she was unfamiliar with Hospital Compare from which he drew the measure. *See* PX2021, Seifert Dep. at 113:21-114:4.

[34] *See* PX2010, Seifert IH Dep. 39:21-40:1, 67:7-25, 68:9-24, 69:18-70:1, 110:13-111:14, 159:14-15, 253:22-254:4; PX2021, Seifert Dep. 161:7-17; PX2001, Lein IH Dep. 154:19-156:22,157:10-158:18.

Helbling Dep. 168:19-170:12. MDC thus sought to sell its practice [redacted] to take advantage of its current value before its financial viability deteriorates.[35]

The Government ignores this evidence. Instead, it points to a valuation that did not purport to address the longer-term issues that MDC executives have identified if MDC was not acquired. In addition, it attempts to counter an argument that defendants have not made. Specifically, the Government, with no citation, asserts that "Defendants appear to make the unsubstantiated argument that MDC, as a large independent physician practice, will struggle as the healthcare delivery and reimbursement landscape shifts." Gov't Br. at 33. The Government thus constructs and attacks a strawman, ignoring the actual reasons for concern about MDC's future identified by its own executives. As reflected in that testimony, MDC's difficulties do not rest on a generalized concern about large independent physician practices. Instead, they rest on thoroughly considered MDC-specific factors that prompted MDC to try to sell its practice.

F. The Government's Attempt To Rely On [redacted] To Avoid The Realities Of This Transaction Is Unavailing

The Government asserts that [redacted] "attempted to influence testimony" and did so based on "recognition of its weak case." The Government's error is twofold. First, in testimony elicited by the Government, [redacted]. PX2023, [redacted]. [redacted]

[35] *See* PX2010, Seifert IH Dep. 110:15-25, 112:1-4, 118:21-25, 205:20-206:17; PX2001, Lein IH Dep. 152:21-155:4, 157:10-158:4; DX7003, Botsford Dep. 86:13-88:15, 118:3-7; PX2011, Schaaf Dep. 28:13-29:18; 180:23-187:21.

[redacted] PX2010, Seifert IH Dep. 209:11-210:18; PX2024, Helbling Dep. 143:8-144:5; PX2013, Bury Dep. 136:4-137:22, 185:11-186:15.

In contrast to [redacted] categorical refutation of the Government's allegation, [redacted] Moreover, [redacted] contemporaneous notes make no mention of any statement by [redacted] PX7040, [redacted] Handwritten Notes, dated July 5, 2017.

Second, even if the conversation occurred as the Government contends, it offers no link to MDC's considered judgment of how the Clayton Act applies to the facts of this case. As the Government well knows, [redacted] Indeed, [redacted] testified that [redacted]

The Government cannot avoid the fundamental flaws in its case by relying on a conversation as to which the participants have very different recollections and that (whatever its

content, no matter whose account is credited, and no matter how inappropriate) sheds no light on the disputed factual, economic and legal issues in this case.[36]

III. THE BALANCE OF EQUITIES FAVORS DENIAL OF THE GOVERNMENT'S MOTION

A district court may issue a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b). Here, even apart from the Government's unlikelihood of success, the equities favor denial of the Government's motion. *See Nat'l Tea Co.*, 603 F.2d at 697 (upholding conclusion of the District Court that the balance of equities weighed against enjoining a proposed merger).

If the injunction is granted and upheld on appeal, Defendants have advised the FTC (in seeking a stay of the FTC proceeding) that they will abandon the transaction. The parties have filed sworn declarations from the Chief Legal Officer of Sanford and the Chief Executive Officer at MDC that for "a variety of reasons, including concerns about issues arising from the delay of the transaction," the parties have agreed that they "will not seek to further litigate the matter in the administrative proceeding" if an injunction is granted and upheld on appeal. DXs 2017-18, *In the Matter of Sanford Health*, Dkt. 9376, Expedited Motion for a Two-Month Stay of Administrative Proceedings, Exhibits A, B. An injunction thus will permanently deprive the public of the benefits of the transaction, including those discussed above in section II(D). *FTC v. Heinz Co.*, 246 F.3d 708, 726 (D.C. Cir. 2001) ("[P]ublic equities include 'beneficial economic effects and procompetitive advantages for consumers.'") (citing *FTC v. Pharmtech Research, Inc.*, 576 F.Supp. 294, 299 (D.D.C.1983)). The Government is therefore wrong in asserting that

[36] The two cases cited by the Government only go to admissibility of such statements against the party who made the alleged statement; they do not require the Court to draw untenable inferences even assuming the conversation was as the Government claims.

"Defendants offer no reason why the alleged benefits of the transaction would not remain available after a full administrative trial." Gov't Br. at 35 (citing *FTC v. Heinz Co.*, 246 F.3d 708 (D.C. Cir. 2001)). Instead, it is *certain* that the "benefits would *not* remain available" if the transaction is preliminarily enjoined and affirmed by the Eighth Circuit. In *Heinz*, by contrast, the appellees failed "to support the finding that the merger would never be consummated were an injunction to issue." *Heinz*, 246 F.3d at 726.

By contrast, there would be no harm to the public from denying the injunction. The potential harms that the Government claims would arise if the transaction moves forward could not realistically materialize prior to the administrative resolution of this case, even assuming, contrary to the evidence, that such harms would arise. Rather than identify any harms that would occur if the injunction is denied, the Government asserts only that it would be "extraordinarily difficult to undo" if the FTC ultimately were to order divestiture following an administrative trial. Unlike the facts of the cases they cite, the Government fails to offer a single fact to support that proposition here. *See Heinz*, 246 F.3d at 726 ("[I]f the merger were allowed to proceed," subsequent administrative proceedings would not matter "because Beech-Nut's manufacturing facility 'will be closed, the Beech-Nut distribution channels will be closed, the new label and recipes will be in place, and it will be impossible as a practical matter to undo the transaction.'"). Nor is there any basis for the assertion that the transaction would be difficult to unravel given that, *inter alia*, for the immediate future, the parties will maintain their own facilities, and MDC will remain a separate corporate subsidiary of Sanford.

CONCLUSION

For the foregoing reasons, the Government's motion for preliminary injunction should be denied and the temporary restraining order should be dissolved.

Dated: October 16, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on October 16, 2017, I electronically filed the foregoing document on all parties via the Court's electronic filing system, which will automatically send e-mail notification of such filing to all attorneys of record in this action.

/s/ James A. Kraehenbuehl
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