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*.	No: 1:17-cv-00133-ARS PUBLIC REDACTED VERSION

PLAINTIFFS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Authorities

GLOSSARY OF ABBREVIATED OR DEFINED TERMS

1. Exhibits and Transcripts

App'x	Appendix
Dep. Tr.	Deposition Transcript
DX	Defendants' Exhibit
Fig.	Figure
Hrg. Tr.	Preliminary Injunction Hearing Transcript
IH Tr.	Investigational Hearing Transcript
JX	Joint Exhibit
PDX	Plaintiffs' Demonstrative Exhibit
PX	Plaintiffs' Exhibit
Tbl.	Table
Vol.	Volume

2. Documents and Filings

Complaint	Complaint for Temporary Restraining Order and Preliminary Injunction Pursuant to Section 13(b) of the Federal Trade Commission Act (June 22, 2017) (ECF No. 3)
MDC Answer	Defendant Mid Dakota Clinic, P.C.'s Answer To Complaint For Temporary Restraining Order And Preliminary Injunction (July 6, 2017) (ECF No. 27)
Merger Guidelines	U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines (August 19, 2010)
Sanford Answer	Defendants Sanford Health And Sanford Bismarck's Answer To Complaint For Temporary Restraining Order And Preliminary Injunction (July 5, 2017) (ECF No. 25)

3. Names and Terms

APM	Alternative Payment Model
APP	Advanced Practice Providers (e.g., Nurse Practitioner, Physician Assistant)
ASC	Ambulatory Surgery Center
BCBS	Blue Cross Blue Shield of North Dakota

Bismarck-Mandan Area	Four-county Bismarck, ND Metropolitan Statistical Area, which includes Burleigh, Morton, Oliver, and Sioux Counties
CHI	CHI St. Alexius Health
CMS	Centers for Medicare & Medicaid Services
Deloitte	Deloitte LLP
DSH	Disproportionate Share Hospital
EMR	Electronic Medical Record
FTC	Federal Trade Commission
HHI	Herfindahl-Hirschman Index
HMT	Hypothetical Monopolist Test
IT	Information Technology
MDC	Mid Dakota Clinic
MFM	Maternal Fetal Medicine
MGMA	Medical Group Management Association
NDPERS	North Dakota Public Employees Retirement System
NISC	National Information Solutions Cooperative
OB/GYN	Obstetrics/Gynecology
OB/GYNs	Obstetrics/Gynecology physicians
PCMH	Patient-Centered Medical Home
PCP	Primary Care Physician
PrimeCare	PrimeCare health group
Proposed Transaction	The proposed acquisition of Mid Dakota Clinic by Sanford
Relevant Market(s)	Four distinct markets: (1) adult PCP services sold to commercial insurers and their members in the Bismarck-Mandan Area; (2) pediatrician services sold to commercial insurers and their members in the Bismarck-Mandan Area; (3) OB/GYN physician services sold to commercial insurers and their members in the Bismarck-Mandan Area; and (4) general surgeon services sold to commercial insurers and their members in the Bismarck-Mandan Area
Relevant Service(s) or Relevant Services Markets	Four distinct physician services: (1) Adult PCP services; (2) pediatrician services; (3) OB/GYN physician services; and (4) general surgeon services
Sanford	Sanford Health or Sanford Bismarck
SSNIP	Small but Significant and Non-Transitory Increase in Price

UND CFM	University of North Dakota Center for Family Medicine
UPP	Upward Pricing Pressure
WTP	Willingness-to-Pay

4. Hearing Witnesses (in order of appearance)

Kurt Schley	CHI St. Alexius Health
Michael Lenz	Medica
Chelsey Matter	Blue Cross Blue Shield of North Dakota
Jan Bury, MD	Mid Dakota Clinic
Seth Sacher, Ph.D.	Plaintiffs' expert
Kari Reichert	National Information Solutions Cooperative
Thomas Respess III, Ph.D.	Plaintiffs' expert
Ashish K. Jha, MD, MPH	Plaintiffs' expert
Kelby Krabbenhoft	Sanford
Michael LeBeau, MD	Sanford
Marvin Lein	Mid Dakota Clinic
Martha Leclerc	Sanford
Matthew Hocks	Sanford
Lisa Ahern	Deloitte
Robert Town, Ph.D.	Defendants' expert
Shelly Seifert, MD	Mid Dakota Clinic

5. Deponents and Declarants

Duncan Ackerman, MD	The Bone & Joint Center, P.C.
Biron Baker, MD	Baker Family Medicine
Darrold Bertsch	Sakakawea Medical Center and Coal Country Community Health Centers
Michelle Bruhn	Sanford
Hugh Carlson, MD	Pain Treatment Center Anesthesiologists
Kirk Cristy	Sanford
Keith Happel, MD	Mid Dakota Clinic (retired)
Brandon Helbling, MD	Mid Dakota Clinic
Bruce Hetland, MD	Mid Dakota Clinic (retired)

Jared Hinkelman	Bain Agency, Inc.
D'Arcy Honeycutt, MD	Advanced Surgical Arts Center
Pamela Hopkins	Sanford
Jeff Hostetter, MD	University of North Dakota Center for Family Medicine
Alan Hurley	Sanford
Rosemarie Kuntz	Mid Dakota Clinic
Craig Lambrecht, MD	Sanford
Kelly Link	UnitedHealthcare
Bill Marion	Dakota Surgery & Laser Center and Dakota Eye Institute
Denise McDonough, MD	Independent Doctors, P.C.
Stephen McDonough, MD	Independent Doctors, P.C.
Jeff Neuberger	Mid Dakota Clinic (formerly)
Aaron Olson, MD	Mid Dakota Clinic (retired)
Shawna Piatz	Basin Electric Power Cooperative
Brian Ritter	Bismarck Mandan Development Association
Craig Schaaf	Mid Dakota Clinic
Don Schott	Sanford
Jeffrey Smith, MD	Jeffrey Smith, MD, P.C.
Theo Stoller	Jacobson Memorial Hospital Care Center
Robert Tanous, MD	Mid Dakota Clinic

PLAINTIFFS' PROPOSED FINDINGS OF FACT

I. THE PROPOSED TRANSACTION

1. Sanford, a vertically integrated multi-state healthcare delivery system, is seeking to acquire MDC, a large multi-specialty physician group with clinics throughout Bismarck, North Dakota. The Proposed Transaction would combine the two largest providers of adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services in the Bismarck-Mandan Area. Complaint ¶¶ 1, 17, 19; MDC Answer ¶¶ 1, 17, 19; Sanford Answer ¶¶ 1, 17, 19.

2. In early 2015, MDC initiated discussions with Sanford regarding a potential affiliation. Complaint ¶ 22; MDC Answer ¶ 22; Sanford Answer ¶ 22.

3. On August 22, 2016, Defendants signed a Term Sheet, according to which Sanford would purchase MDC's practice assets, including its clinics, ASC, laboratory, and diagnostic imaging equipment, as well as the real estate and other assets owned by the Mid Dakota Medical Building Partnership and leased by MDC. Complaint ¶ 22; MDC Answer ¶ 22; Sanford Answer ¶ 22. Defendants finalized a Stock Purchase Agreement on approximately June 19, 2017. JX00042 at 001. The Proposed Transaction's total value is approximately [redacted]. JX00038 at 004.

4. 56 of MDC's 61 physicians, and nearly all of its APPs, will join Sanford as part of the Proposed Transaction. Complaint ¶ 22; MDC Answer ¶ 22; Sanford Answer ¶ 22; JX00010 (Tanous) IH Tr. 145.

II. THE PARTIES TO THE PROPOSED TRANSACTION

A. Sanford

5. Sanford is a vertically integrated healthcare delivery system headquartered in Sioux Falls, South Dakota. PX08139 at 001; PX04128 at 012; Complaint ¶ 17; Sanford Answer ¶ 17.

6. Sanford includes 45 hospitals and 289 clinics in 9 U.S. states and 3 countries, but its operations are focused in North Dakota, South Dakota, and Minnesota. PX08139 at 001; *see* PX04198 at 007. Sanford employs over 28,000 people, including more than 1,300 physicians. PX08139 at 001.

7. In Bismarck and Mandan alone, Sanford operates Sanford Bismarck Medical Center (a 217-bed general acute care hospital and Level II trauma center) offering inpatient and outpatient services; eight clinics that provide primary care services; and a number of specialty clinics. Complaint ¶ 17; Sanford Answer ¶ 17.

8. Sanford employs approximately 160 physicians who work in Bismarck or Mandan, including 37 adult PCPs, 5 pediatricians, 8 OB/GYNs, and 4 general surgeons. PX06000 ¶ 34; *see* PX04052 at 002–005; PX01013 at 001–002.

9. Sanford is the largest private employer in the Bismarck-Mandan Area. Complaint ¶ 17; Sanford Answer ¶ 17; PX08143 at 001.

10. Sanford's health insurance entity, Sanford Health Plan (and its subsidiaries), sells health insurance in four states, including North Dakota. Complaint ¶ 18; Sanford Answer ¶ 18; PX04130 at 007. Sanford Health Plan, the second-largest commercial insurer in North Dakota, has approximately [redacted] in North Dakota. Complaint ¶ 18; Sanford Answer ¶ 18; JX00009 (Schott) IH Tr. at 42–43; PX04255 at 001.

B. Mid Dakota Clinic

11. Founded in 1971, MDC is a multispecialty medical practice that provides primary care services and specialty medical and surgical services in Bismarck, North Dakota. PX05010 at 002; JX00002 (Lein) IH Tr. 63. Its roots in Bismarck trace back to the early 20th century. PX08140 at 003; PX05010 at 002.

12. MDC employs 61 physicians and 19 APPs. Complaint ¶ 19; MDC Answer ¶ 19; JX00035 at 106–107. MDC's physicians include 23 adult PCPs, 6 pediatricians, 8 OB/GYNs, and 6 general surgeons. Complaint ¶ 19; MDC Answer ¶ 19.

13. MDC operates six clinics in Bismarck as well as a Center for Women and an ASC called the MDC SurgiCenter. Complaint ¶ 19; MDC Answer ¶ 19; JX00035 at 106–107; JX00038 at 015.

14. MDC physicians provide services at CHI Medical Center through professional service agreements, particularly for specialty physician services not available from CHI's employed physicians. Schley (CHI) Hrg. Tr. Vol. 1 at 81; PX03009 ¶ 4.

15. MDC PCPs have also historically referred patients to CHI's specialists (i.e., for services that MDC physicians do not offer) and admit patients to CHI Medical Center. Schley (CHI) Hrg. Tr. Vol. 1 at 82; PX03009 ¶ 9.

16. MDC is a founding member and 25% owner of PrimeCare, a physician-hospital organization established in 1994 that negotiates and contracts with commercial insurers on behalf of its members, including MDC physicians. Complaint ¶ 21; MDC Answer ¶ 21; DX6034; PX03009 ¶ 29. CHI owns the remaining 75% of PrimeCare. Complaint ¶ 21; MDC Answer ¶ 21; *see* Schley (CHI) Hrg. Tr. Vol. 1 at 82.

17. MDC markets itself as "the doctors you know and trust." PX08140 at 001; JX00024 (Lein) Dep. Tr. 169.

18. For the fiscal year ending on December 31, 2015, MDC generated [redacted] in revenue. Complaint ¶ 19; MDC Answer ¶ 19.

III. PROCEDURAL HISTORY OF THE LITIGATION

19. Following an eight-month investigation, on June 21, 2017, the FTC voted unanimously to authorize staff to obtain preliminary injunctive relief under Section 13(b) of the FTC Act. Complaint ¶¶ 23–24. The North Dakota Attorney General, following a parallel investigation, joined the FTC in seeking preliminary injunctive relief. Complaint ¶ 25. Also on June 21, 2017, the FTC initiated an administrative proceeding on the antitrust merits of the Proposed Transaction that will begin on December 12, 2017. Complaint ¶ 23; Commission Order Granting 14-Day Continuance, *In the Matter of Sanford Health, et al.*, Dkt. No. 9376 (FTC Nov. 3, 2017).

IV. FUNDAMENTALS OF PHYSICIAN SERVICES COMPETITION AND PRICING

20. Most healthcare provided to patients is covered by some form of health insurance. The two primary forms of health insurance are commercial health insurance and public health insurance (usually Medicare and Medicaid). Commercial health insurance is typically obtained through an individual's employer, through a family member's employer, or through an organization such as a union. Commercial health insurers, unlike Medicare and Medicaid, negotiate price (i.e., rates) and other terms with healthcare providers, such as physicians, on behalf of employers and other subscribers. Commercial insurers are therefore the direct purchasers of healthcare services. As a result, economists incorporate the perspective of commercial health insurers when analyzing the potential competitive effects of a merger of healthcare providers. *See* PX06000 ¶¶ 45–46; Sacher Hrg. Tr. Vol. 2 at 50–52, 60–61.

A. Competition Among Physicians Occurs in Two Stages

21. Competition among physicians for commercially insured patients occurs in two distinct but interrelated stages. Sacher Hrg. Tr. Vol. 2 at 51–52; PX06000 ¶ 47.

1. Stage 1: Physicians compete for inclusion in commercial insurers' provider networks, leading to lower rates

22. In the first stage of competition, physicians compete to be "in-network" providers for commercial insurers. Physicians are incentivized to be in network with an insurer's health plan products in order to gain access to that health plan's members. Lenz (Medica) Hrg. Tr. Vol. 1 at 171–172; Sacher Hrg. Tr. Vol. 2 at 52; PX06000 ¶ 48; [redacted]; JX00003 (Kuntz) IH Tr. 99–100, 105, 140–141; PX05022 at 001. Patients are incentivized to use in-network providers because commercial insurers generally limit benefits and increase patients' out-of-pocket payments for using out-of-network physicians. Lenz (Medica) Hrg. Tr. Vol. 1 at 170–172; Sacher Hrg. Tr. Vol. 2 at 52; JX00007 (Leclerc) IH Tr. 142–143.

23. A critical aspect of first-stage competition between providers involves the negotiations that providers enter into with commercial insurers. Lenz (Medica) Hrg. Tr. Vol. 1 at 172–173; PX06000 ¶¶ 4, 51; JX00003 (Kuntz) IH Tr. 78–79. Reimbursement rates are the most significant negotiated term. Lenz (Medica) Hrg. Tr. Vol. 1 at 172–173; *see* JX00007 (Leclerc) IH Tr. 135, 152–153; JX00003 (Kuntz) IH Tr. 61–62.

24. Commercial insurers and providers also negotiate over non-price terms, such as the length of the agreement, the timeliness of reimbursement, and "out clauses." Providers view these non-price terms as "important" when negotiating with commercial insurers. JX00024 (Lein) Dep. Tr. 138–140; JX00007 (Leclerc) IH Tr. 135–136.

25. The rates and terms of the contracts negotiated by commercial insurers and providers are a function of each party's bargaining leverage in negotiations. PX06000 ¶¶ 54–55; PX06003 ¶ 13. Each side's bargaining leverage is determined by how each party would fare if no agreement were reached, also known as a "walk-away point." PX06003 ¶ 16; Town Hrg. Tr. Vol. 4 at 110.

26. In the context of negotiations between a commercial insurer and a provider, each side's walk-away point is determined by how well off each would be if the provider is not included in the insurer's network. PX06003 ¶ 16. The value of the commercial insurer's provider network to its subscribers without the provider determines the commercial insurer's walk-away point; if a commercial insurer can still offer a relatively attractive network without the provider, then the commercial insurer has a relatively better walk-away point. PX06003 ¶ 16; Sacher Hrg. Tr. Vol. 2 at 53; *see* Town Hrg. Tr. Vol. 4 at 110–111. The provider's walk-away point will be determined by how many of the commercial insurer's subscribers will still seek care from the provider if the provider is no longer in the commercial insurer's network. Sacher Hrg. Tr. Vol. 2 at 54; *see* Town Hrg. Tr. Vol. 4 at 111.

27. In negotiations, a party has stronger bargaining leverage the better its own walk-away point or the worse its counterparty's walk-away point. The better off a party is without an agreement, the better is its walk-away point, and the greater bargaining leverage it brings to a negotiation. Sacher Hrg. Tr. Vol. 2 at 54. Similarly, the worse off the counterparty is in the absence of an agreement, the worse its walk-away point, and the greater the other party's bargaining leverage. *See* Sacher Hrg. Tr. Vol. 2 at 54.

28. From a commercial insurer's perspective, the attractiveness and marketability of a health plan product depends in large part on its members' ability to access a variety of in-network healthcare services that are both high quality and geographically convenient for subscribers. All else being equal, the more geographically convenient and high quality in-network providers a health plan product can offer, the more attractive and marketable that health plan product is to prospective subscribers. Lenz (Medica) Hrg. Tr. Vol. 1 at 169–170; [redacted].

29. If there are many alternative providers in a geographic area, commercial insurers have more bargaining leverage over providers in determining reimbursement rates and other contract terms. Lenz (Medica) Hrg. Tr. Vol. 1 at 174–175; [redacted]; *see also* Leclerc (Sanford) Hrg. Tr. Vol. 3 at 173 ([redacted]); JX00007 (Leclerc) IH Tr. 41.

30. If there are relatively few alternative providers in a geographic area, larger providers that control many physicians and facilities have more bargaining leverage over insurers, and those providers therefore have greater ability to seek reimbursement rate increases and other contract terms that providers deem favorable to them. Lenz (Medica) Hrg. Tr. Vol. 1 at 172–176; [redacted] PX03016 ¶ 5; [redacted]; PX03010 ¶ 12; JX00018 (Neuberger) Dep. Tr. 255–256; PX05022 at 001; PX08003 ¶ 7 (Sanford testified in a South Dakota state court that a "provider will command a higher reimbursement rate than Sanford Health Plan would otherwise agree to in . . . the absence of competing providers within the same service area.").

31. If a commercial insurer loses a large provider as an in-network option in a geographic area where few alternatives exist, the insurer risks losing subscribers to other insurers. Lenz (Medica) Hrg. Tr. Vol. 1 at 176–177; [redacted]

32. Employers rely on commercial insurers to negotiate rates and terms with physicians and other healthcare providers. Reichert (NISC) Hrg. Tr. Vol. 2 at 158; PX03008 ¶ 6; *see also* PX06000 ¶ 60; Sacher Hrg. Tr. Vol. 2 at 57–58.

2. Stage 2: In-network providers compete with other in-network physicians for patients

33. In the second stage of healthcare competition, in-network providers compete with other in-network providers to attract patients. Sacher Hrg. Tr. Vol. 2 at 58–59. Second-stage competition generally focuses on non-price features, such as office hours, convenience, service, technology, and quality. Sacher Hrg. Tr. Vol. 2 at 58–59; PX06000 ¶ 50; LeBeau (Sanford) Hrg. Tr. Vol. 3 at 80, 82; Town Hrg. Tr. Vol. 4 at 141; JX00021 (LeBeau) Dep. Tr. 233–239; JX00029 (Botsford) Dep. Tr. 72–74; JX00030 (S. McDonough) Dep. Tr. 89–90. This is largely because most health insurance products eliminate or limit out-of-pocket price variation among in-network physicians. Sacher Hrg. Tr. Vol. 2 at 58–59; PX06000 ¶ 50.

34. Competition between providers improves the quality of service patients receive, and results in better patient outcomes. JX00014 (Bury) IH Tr. 96; JX00021 (LeBeau) Dep. Tr. 235–237; JX00028 (Krabbenhoft) Dep. Tr. 178–80, 187–88.

35. Patients benefit from more convenient access to providers. Offering convenient patient access is important to providers and helps providers attract new patients and retain existing patients. Providers try to improve convenient patient access if another provider offers better patient access. JX00022 (Seifert) Dep. Tr. 133–134; *see also* JX00030 (S. McDonough) Dep. Tr. 90–91.

B. The Effect of Provider Mergers on Healthcare Competition

36. A merger of providers that are close substitutes reduces the number of alternatives that a commercial insurer can use to offer an attractive provider network. PX06000 ¶¶ 52, 59.

Economic theory predicts that a provider merger eliminating a close substitute improves the combined provider entity's bargaining leverage, resulting in higher prices and other terms more favorable to the provider. PX06000 ¶¶ 56, 59; Sacher Hrg. Tr. Vol. 2 at 99–100; *see also* Lenz (Medica) Hrg. Tr. Vol. 1 at 174–175. The providers' bargaining leverage increases with: (1) the market share of the merging providers in an area; (2) the extent to which health plan subscribers regard the merging parties as close substitutes; and (3) patients' perception of non-merging providers as ineffective substitutes. PX06000 ¶¶ 53–59; *see* Sacher Hrg. Tr. Vol. 2 at 99–100.

37. Provider rate increases can cause both fully insured and self-insured employers to increase premiums and other out-of-pocket costs to their employees. PX06000 ¶ 60; *see* Sacher Hrg. Tr. Vol. 2 at 57–58, 97–98. Fully insured employers may see an increase in their premiums because of an increase in provider rates, and their employees may potentially face higher cost-sharing, such as higher copays and deductibles. [redacted]; *see* JX00007 (Leclerc) IH Tr. 132–134. PX06000 ¶ 60; *see* Sacher Hrg. Tr. Vol. 2 at 57–58, 97–98. Self-insured employers are financially responsible for paying the healthcare claims of their employees, and therefore increased rates immediately affect such employers. Reichert (NISC) Hrg. Tr. Vol. 2 at 156–157; [redacted]; PX03008 ¶ 4; [redacted]; JX00007 (Leclerc) IH Tr. 132–133; PX06000 ¶ 60; *see* Sacher Hrg. Tr. Vol. 2 at 57–58, 97–98.

V. THE RELEVANT ANTITRUST MARKETS

38. A relevant antitrust market identifies both a set of products and a geographic area of competition in which to analyze the potential effects of a proposed transaction. The primary analytic tool used to define relevant antitrust markets is the HMT. The HMT is an iterative process that first requires identification of a candidate market and then asks whether a hypothetical monopolist of the candidate market likely could impose at least a SSNIP. If a

hypothetical monopolist would find it profitable to impose at least a SSNIP, then the conditions of the HMT are satisfied and the candidate market is the relevant market for purposes of the antitrust analysis. If not, the candidate market is expanded and the analysis applied to the expanded market. The process continues until the conditions of the HMT are satisfied. The HMT is the appropriate test to apply in defining both a relevant product market and a relevant geographic market. PX06000 ¶¶ 61–64; Sacher Hrg. Tr. Vol. 2 at 61–65; Town Hrg. Tr. Vol. 4 at 91.

39. In analyzing healthcare provider mergers, relevant antitrust markets are defined in the context of the two-stage model of healthcare competition. Accordingly, the relevant question is whether a hypothetical monopolist of a candidate physician services market (or a candidate geographic market) could negotiate at least a SSNIP from commercial insurers. Sacher Hrg. Tr. Vol. 2 at 61–62; PX06000 ¶ 64.

40. The purpose of market definition is to identify the options available to consumers. Market definition therefore focuses on the ability of consumers to substitute products or sellers in other geographies outside the candidate market in order to defeat a price increase. This is also called "demand-side" substitution. In the context of the two-stage model of competition, the immediate purchasers of physician services are commercial insurers. It is therefore appropriate to consider commercial insurers' perspectives in building provider networks when defining relevant markets. Because commercial insurers must market their products to health plan purchasers, insurers' views will in turn be informed by the needs and preferences of employers, employees, and their families. Sacher Hrg. Tr. Vol. 2 at 60–61; PX06003 ¶ 56; PX06000 ¶¶ 64–67, 110–111; Town Hrg. Tr. Vol. 4 at 112.

A. There Are Four Distinct Relevant Physician Service Product Markets

41. There are four distinct and relevant physician service product markets in which to analyze the Proposed Transaction: (1) adult PCP services sold and provided to commercial insurers and their members; (2) pediatrician services sold and provided to commercial insurers and their members; (3) OB/GYN physician services sold and provided to commercial insurers and their members; and (4) general surgeon services sold and provided to commercial insurers and their members (collectively, the "Relevant Services" or "Relevant Services Markets"). PX06000 ¶ 109.

1. Adult PCP services sold to commercial insurers and their members constitute a relevant product market

a) Adult PCPs offer services distinct from other providers

42. Both Sanford and MDC offer adult PCP services. PX06000 ¶ 69. Adult PCP services include services provided to patients age 18 and over by physicians who are board-certified in family medicine, internal medicine, or general practice ("adult PCPs"). [redacted]; JX00021 (LeBeau) Dep. Tr. 27; JX00011 (Seifert) IH Tr. 125; PX03001 ¶ 3. Adults generally receive most or all of their PCP services from family medicine physicians, internal medicine physicians, or general practice physicians. [redacted]

43. Adult PCPs typically serve as the first point of contact for adult patients, offering routine medical services including physical exams, wellness visits, basic medical procedures, treatments of common illnesses and injuries, and long-term management of chronic conditions such as diabetes and hypertension. Complaint ¶ 27; MDC Answer ¶ 27; Sanford Answer ¶ 27.

44. Adult PCPs typically see patients in a clinic setting and will diagnose, treat, and refer patients to other healthcare specialists, but generally will not perform any invasive surgical procedure themselves. Schley (CHI) Hrg. Tr. Vol. 1 at 83.

b) Other physicians and APPs are not viable substitutes for adult PCPs

45. Hospitalists are not substitutes for adult PCPs in a marketable health plan because hospitalists [redacted] JX00004 (Lambrecht) IH Tr. 131; PX03006 ¶ 17; JX00001 (Hurley) IH Tr. 72–73; JX00027 (Kyaw) Dep. Tr. 206–207. Hospitalists' training is focused specifically on the patient in the hospital, minimizing the length of stay, and ensuring the best possible outcome while a patient is being treated in a hospital. Schley (CHI) Hrg. Tr. Vol. 1 at 86–87.

46. Insurers and physicians view the services offered by an OB/GYN as complementary to, rather than a replacement for, adult PCP services, although some women may opt to see an OB/GYN for their primary care needs. JX00010 (Tanous) IH Tr. 11–12, 180–181; PX03007 ¶ 8; PX03002 ¶ 11; [redacted]; PX03016 ¶ 7; JX00014 (Bury) IH Tr. 31–32. OB/GYNs do not typically see male patients. JX00014 (Bury) IH Tr. 31.

47. Although pediatricians offer similar services as adult PCPs, they typically treat only patients under age 18, and do not compete with adult PCPs for patients over age 18. JX00004 (Lambrecht) IH Tr. 147; JX00010 (Tanous) IH Tr. 167, 172, 179–180; [redacted]

48. APPs and physicians provide some overlapping services, but a health plan that included nurse practitioners and other APPs but excluded adult PCPs would not be marketable to a broad base of employers in Bismarck and Mandan. *See* Lenz (Medica) Hrg. Tr. Vol. 1 at 181–182; [redacted]; Schley (CHI) Hrg. Tr. Vol. 1 at 85; JX00007 (Leclerc) IH Tr. 94; PX03016 ¶ 9; PX03008 ¶¶ 13–14. PCPs have considerably more training than APPs, and patients often prefer being seen by an adult PCP over an APP. JX00004

(Lambrecht) IH Tr. 165–168; JX00011 (Seifert) IH Tr. 61; PX03007 ¶ 5; PX03008 ¶ 13. APPs cannot provide all of the services an adult PCP can provide. Schley (CHI) Hrg. Tr. Vol. 1 at 85.

49. Empirical analysis confirms that other physician specialties are not substitutes for adult PCPs. Patient claims data indicate that adult PCPs have a strikingly different breakdown of services relative to specialist physicians. Over 74% of adult PCP services spending is associated with well visits or "evaluation & management visits" (e.g., office visits or annual physical exams) as opposed to just under 26% for specialists. PX06000 ¶ 73 & App'x II, Fig. 1.

50. Analysis of claims data also confirms that nurse practitioners are not substitutes for adult PCPs in commercial insurers' health plans. Dr. Sacher considered the extent to which patients rely exclusively on nurse practitioners for adult primary care evaluation & management visits or well visits. He found that approximately 6% of patients in the Bismarck-Mandan Area saw exclusively nurse practitioners for these primary care services in 2016, as opposed to 80% of patients who saw exclusively adult PCPs. Sacher Hrg. Tr. Vol. 2 at 69–70; PX06000 ¶ 107 & App'x I, Tbl. 4.

c) Commercial insurers could not successfully market a health plan that did not include adult PCPs

51. [redacted] Medica must include adult PCPs "as in-network providers in order to market successfully a health plan to employers and their employees . . . ." PX03016 ¶ 7; Lenz (Medica) Hrg. Tr. Vol. 1 at 179. Sanford Health Plan would find it difficult to market a health plan that did not include in-network adult PCPs. Leclerc (Sanford) Hrg. Tr. Vol. 3 at 185–186; *see also* Krabbenhoft (Sanford) Hrg. Tr. Vol. 3 at 46.

52. Employers in the Bismarck-Mandan Area could not offer a health plan network to their employees that excluded adult PCPs as in-network physicians. Reichert (NISC) Hrg. Tr. Vol. 2 at 162 ("that would not be a valuable network"); *see also* PX03008 ¶ 13.

d) Commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a network that omits adult PCP services

53. If adult PCPs were excluded, commercial insurers could not turn to specialists or other provider types for building a provider network. Likewise, given a strong patient preference for seeing an adult PCP versus a nurse practitioner, a network that did not include adult PCPs would not be marketable from a commercial insurer's perspective, even if it included nurse practitioners. Therefore, an insurer would accept a hypothetical monopolist's SSNIP rather than market a network that did not include adult PCP services. Sacher Hrg. Tr. Vol. 2 at 69-70; PX06000 ¶¶ 73–74, 107.

2. Pediatrician services sold to commercial insurers and their members constitute a relevant product market

a) Pediatricians specialize in providing primary care services to children

54. Both Sanford and MDC offer pediatrician services. PX06000 ¶ 80. Pediatricians typically treat patients 18 years of age or younger and receive specialized training to treat medical conditions affecting pediatric patients. Schley (CHI) Hrg. Tr. Vol. 1 at 88; [redacted]; Complaint ¶ 29; MDC Answer ¶ 29; Sanford Answer ¶ 29; PX03021 ¶ 2; PX03008 ¶ 15. Pediatricians generally compete only with other pediatricians. PX03010 ¶ 3.

b) Other physicians and APPs are not viable substitutes for pediatricians

55. Although some family medicine physicians may treat patients under the age of 18, pediatricians are trained to treat more complex medical conditions affecting pediatric patients,

and many families prefer to bring their children to a pediatrician. Schley (CHI) Hrg. Tr. Vol. 1 at 89; Lenz (Medica) Hrg. Tr. Vol. 1 at 179–180; [redacted] JX00030 (S. McDonough) Dep. Tr. 108–109; JX00010 (Tanous) IH Tr. 178–179; PX03008 ¶ 15; PX03006 ¶ 8; *see also* JX00030 (S. McDonough) Dep. Tr. 106–107 (services provided by internists are "very different" from those provided by pediatricians).

56. Even if parents use a family medicine physician as the primary physician for their children, they may still expect in-network access to pediatricians to treat more complex conditions or for consultation by their family medicine physician. *See, e.g.*, JX00002 (Lein) IH Tr. 72–74 ("the knowledge held by a pediatrician is more distinct, specific, deeper than the knowledge, for instance, of the general family medicine physician"); JX00011 (Seifert) IH Tr. 130; JX00010 (Tanous) IH Tr. 178–179.

57. Pediatric hospitalists treat pediatric patients in a hospital, not in a clinic setting. Schley (CHI) Hrg. Tr. Vol. 1 at 89–90; JX00030 (S. McDonough) Dep. Tr. 110–111; JX00004 (Lambrecht) IH Tr. 144–146. Pediatric hospitalists do not have their own patient panels. Instead, they treat either newborns or patients who require hospitalization. JX00030 (S. McDonough) Dep. Tr. 111.

58. Dr. Sacher's analysis of patient claims data confirms that there is a strong consumer preference for in-network access to pediatricians. In the Bismarck-Mandan Area in recent years, families have used family medicine physicians less—and pediatricians more—to treat their children. PX06000 ¶ 83 & App'x II, Fig. 2 (indicating that from 2012 to 2016, an increasing fraction of physician services for children under 14 were provided by pediatricians). Pediatricians perform the vast majority of well-child visits (e.g., routine annual exams, immunizations, and preventative care visits), particularly for younger children, in the Bismarck-

Mandan Area. PX06000 ¶ 84 & App'x II, Figs. 3-4 (showing that nearly 80% of well-child visits for children 14 and younger are currently performed by pediatricians in the Bismarck-Mandan Area).

c) Commercial insurers could not market a health plan that did not include pediatricians

59. [redacted]

60. Medica must include pediatricians "as in-network options in order to market a health plan to employers and their employees successfully." PX03016 ¶ 8; Lenz (Medica) Hrg. Tr. Vol. 1 at 179–180.

61. Sanford Health Plan would not market a health plan that excluded pediatricians. *See* JX00028 (Krabbenhoft) Dep. Tr. 196; JX00009 (Schott) IH Tr. 77–78.

62. Employers expect that a network will include pediatricians because many employees prefer their children see a pediatrician. *See* Reichert (NISC) Hrg. Tr. Vol. 2 at 163; PX03008 ¶ 15; [redacted].

d) Commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a network that omits pediatrician services

63. Commercially insured families have a strong preference for access to in-network pediatricians, and adult PCPs are not a complete substitute for pediatricians. Therefore, an insurer would accept a hypothetical monopolist's SSNIP rather than market a network that did not include pediatrician services. PX06000 ¶¶ 82, 85-86.

3. OB/GYN physician services sold to commercial insurers and their members constitute a relevant product market

a) OB/GYNs specialize in the female reproductive system

64. Both Sanford and MDC offer OB/GYN physician services. PX06000 ¶ 87. OB/GYNs specialize in obstetrics and gynecology and provide services that focus on prenatal care, management of labor and delivery, well-woman checkups, contraceptive options, evaluation of disease, and treatment of disease that might require surgical interventions, management of menopause, and diagnosis of gynecological cancers. JX00014 (Bury) IH Tr. 22; *see also* Bury (MDC) Hrg. Tr. Vol. 2 at 10; Schley (CHI) Hrg. Tr. Vol. 1 at 90; JX00004 (Lambrecht) IH Tr. 148. OB/GYNs generally compete only with other OB/GYNs. PX03010 ¶ 3; *see also* JX00014 (Bury) IH Tr. 30, 33.

b) Other physicians and APPs are not viable substitutes for OB/GYNs

65. Adult PCPs do not have the same training in obstetrics and gynecology as OB/GYNs. JX00014 (Bury) IH Tr. 30, 33. Further, although adult PCPs and APPs may provide some OB/GYN physician services, OB/GYNs perform gynecologic and obstetric surgeries and more complicated obstetrical care that adult PCPs and APPs are not trained to perform. Bury (MDC) Hrg. Tr. Vol. 2 at 11–13; JX00004 (Lambrecht) IH Tr. 151–152; PX03008 ¶ 16; JX00014 (Bury) IH Tr. 27–28, 31–32, 53–56; Schley (CHI) Hrg. Tr. Vol. 1 at 90.

66. Without OB/GYN physicians, "there would be no providers who could fulfill the obligation for every service that might be required by a woman during her reproductive lifetime." Bury (MDC) Hrg. Tr. Vol. 2 at 14–15; *see also* JX00014 (Bury) (MDC) IH Tr. 63.

67. Other surgeons do not provide the same services as OB/GYNs. JX00014 (Bury) IH Tr. 63; *see also* JX00025 (Helbling) Dep. Tr. 31; Bury (MDC) Hrg. Tr. Vol. 2 at 14 (general

surgeons are not trained to provide the directed, specialized care of female patients that OB/GYNs provide).

68. Services provided by laborists are limited to hospital-based OB/GYN services. Bury (MDC) Hrg. Tr. Vol. 2 at 13–14; JX00004 (Lambrecht) IH Tr. 109–110; JX00011 (Seifert) IH Tr. 140, 143. Laborists do not provide obstetric services throughout a pregnancy and do not perform any clinic work. Bury (MDC) Hrg. Tr. Vol. 2 at 13; JX00014 (Bury) IH Tr. 58.

69. Dr. Sacher's empirical analyses of insurer claims data confirm that other providers are not substitutes for OB/GYN physician services. For example, while adult PCPs may provide a subset of OB/GYN physician services, OB/GYN physicians perform significantly more surgeries than adult PCPs. PX06000 ¶ 89 & App'x II, Fig. 5. Further, OB/GYNs perform almost 98% of gynecological surgeries. PX06000 ¶ 90. These empirical analyses indicate that a provider network would need to include OB/GYNs even if it included surgical specialists and adult PCPs. PX06000 ¶ 91.

c) Commercial insurers could not market a health plan that did not include OB/GYNs

70. [redacted]. Employers with female employees or employees who are married to women of child-bearing age expect access to in-network OB/GYNs. [redacted] In-network OB/GYNs are necessary in order for Medica to market a health plan to employers and employees successfully. Lenz (Medica) Hrg. Tr. Vol. 1 at 180–181; PX03016 ¶ 8. Sanford Health Plan would not market a health plan that excluded OB/GYNs. *See* JX00028 (Krabbenhoft) Dep. Tr. 197; JX00009 (Schott) IH Tr. 77–78. An insurer's plan that did not include OB/GYN physicians in-network would not be attractive to most female members. PX03002 ¶ 12.

71. Employers could not offer a health plan network to their employees that excluded in-network access to OB/GYNs. Reichert (NISC) Hrg. Tr. Vol. 2 at 163; PX03008 ¶ 16.

d) Commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a network that omits OB/GYN physician services

72. Given the unique mix of services provided by OB/GYNs, insurers would not be able to substitute adult PCPs, surgeons, or other providers for OB/GYNs. Consequently, commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a plan without OB/GYNs. PX06000 ¶ 91.

4. General surgeon services sold to commercial insurers and their members constitute a relevant product market

a) General surgeons focus their services on distinct types of surgery

73. Both Sanford and MDC offer general surgeon services. PX06000 ¶ 92. General surgeons typically perform basic surgical procedures from the sternum to the abdomen, including hernia repair surgeries, gallbladder surgeries, colonoscopies, bowel resections, and appendectomies. Schley (CHI) Hrg. Tr. Vol. 1 at 92; [redacted] JX00021 (LeBeau) Dep. Tr. 17–18; JX00014 (Bury) IH Tr. 62–63; PX03001 ¶ 9.

74. General surgeons complete a five-year residency program in general surgery and are board certified in general surgery. PX03007 ¶ 7; JX00025 (Helbling) Dep. Tr. 20–21. General surgeons typically compete only with other general surgeons for patients. PX03010 ¶ 5; *see also* JX00025 (Helbling) Dep. Tr. 33.

b) Other physicians are not viable substitutes for general surgeons

75. General surgeons provide services and surgeries that gastroenterologists, orthopedic surgeons, vascular surgeons, and cardiothoracic surgeons do not perform. Schley (CHI) Hrg. Tr. Vol. 1 at 92; JX00021 (LeBeau) Dep. Tr. 18–19; JX00010 (Tanous) IH Tr. 263–265.

76. Adult PCPs, pediatricians, and OB/GYNs refer patients to a general surgeon because the general surgeon provides services that those physicians do not provide. JX00025 (Helbling) Dep. Tr. 30.

77. Dr. Sacher's analysis of patient claims data supports the qualitative evidence that other physicians are not substitutes for general surgeons. First, Dr. Sacher estimated that less than 5% of adult PCP services spending in the Bismarck-Mandan Area involve surgical procedures, whereas over 80% of general surgeons' service spending involves surgical procedures. PX06000 ¶ 94. Second, general surgeons have very little overlap with other surgical specialists in terms of the organ systems on which they operate. PX06000 ¶ 96 & App'x II, Fig. 7. Consequently, other surgical specialists are not substitutes for general surgeons. Third, to the extent general surgeons and gastroenterologists both perform surgical procedures on the digestive system, Dr. Sacher's analysis confirms that gastroenterologists perform mainly diagnostic (or scoping) procedures, whereas general surgeons perform more invasive and diverse procedures. PX06000 ¶¶ 99–100 & App'x II, Fig. 7; *id.* App'x IV.

c) Commercial insurers could not market a health plan that did not include general surgeons

78. Insurers do not view general surgeons and specialty surgeons as substitutes, and must contract with both groups to adequately serve their members' needs. JX00002 (Lein) IH Tr. 81; JX00009 (Schott) IH Tr. 77–78; [redacted] PX03016 ¶ 10.

79. [redacted] Medica must "include general surgeons as in-network options in order to successfully market a health plan to employers and their employees . . . ." PX03016 ¶ 10; *see*

also Lenz (Medica) Hrg. Tr. Vol. 1 at 180–181. Sanford Health Plan would not market a health plan that excluded general surgeons. *See* JX00028 (Krabbenhoft) Dep. Tr. 197; JX00009 (Schott) IH Tr. 77–78. Employers likewise view in-network general surgeons as an important component of a health plan. *See, e.g.*, PX03008 ¶ 17.

d) Commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a network that omits general surgeons

80. Quantitative and qualitative evidence confirms that general surgeons perform distinct procedures and are necessary to form a marketable health insurance network. Consequently, commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a health plan without general surgeons. PX06000 ¶ 102.

B. The Relevant Geographic Market for Each Relevant Service is No Broader than the Bismarck, North Dakota Metropolitan Statistical Area (the "Bismarck-Mandan Area")

81. Both Sanford and MDC provide each of the Relevant Services in the Bismarck-Mandan Area. All of MDC's clinics are located within an eight-mile radius of central Bismarck. *See* PX06000 App'x II, Figs. 8A & 8B.

82. The Bismarck-Mandan Area includes the cities of Bismarck and Mandan, as well as rural areas and farming communities extending 40 to 50 miles outside of the two cities in every direction. Complaint ¶ 32; MDC Answer ¶ 32; Sanford Answer ¶ 32. Approximately 130,000 people live in the Bismarck-Mandan Area, including approximately 72,000 who live in Bismarck and 21,000 who live in Mandan. *See* PX08017 at 001.

83. The closest cities to Bismarck and Mandan are Dickinson to the west, Jamestown to the east, and Minot to the north, all of which are between 90 and 110 miles away (about an hour-and-a-half drive) and all of which lie outside the Bismarck-Mandan Area. PX03002 ¶ 4; JX00009 (Schott) IH Tr. 34; PX06000 ¶ 119 & App'x II, Fig. 10.

84. Almost all of the clinics in the Bismarck-Mandan Area are located within an eight-mile radius (about a ten-minute drive) around central Bismarck. PX06000 ¶ 116 & App'x II, Figs. 8A & 9.

1. Patients located in the Bismarck-Mandan Area prefer to receive the Relevant Services locally

85. Defendants' executives and physicians testified that Bismarck-Mandan Area residents prefer to receive each of the Relevant Services close to home. JX00006 (Hopkins) IH Tr. 72–74, 95–98; Krabbenhoft (Sanford) Hrg. Tr. Vol. 3 at 45–46; JX00028 (Krabbenhoft) Dep. Tr. 127, 164–166; JX00014 (Bury) IH Tr. 72-74; JX00003 (Kuntz) IH Tr. 260–261; *see also* JX00011 (Seifert) IH Tr. 89, 98; JX00004 (Lambrecht) IH Tr. 174–175, 192–193.

86. Third-party physicians, employers, and executives confirm that people residing in the Bismarck-Mandan Area prefer to receive the Relevant Services close to where they live and work. Reichert (NISC) Hrg. Tr. Vol. 2 at 160–161; Schley (CHI) Hrg. Tr. Vol. 1 at 80–81; PX03008 ¶¶ 9, 10; PX03007 ¶ 6; PX03001 ¶ 11; PX03003 ¶ 10; PX03000 ¶ 8; PX03006 ¶ 18; PX03002 ¶ 6; PX03013 ¶ 6.

87. Insurers and an insurance broker confirm that people living in the Bismarck-Mandan Area prefer to receive the Relevant Services close to where they live. [redacted] Medica (Lenz) Hrg. Tr. Vol. 1 at 182–183 ("people want[] to be within six minutes or six miles of their primary care physician . . ."); JX00009 (Schott) IH Tr. 88; PX03016 ¶ 12; [redacted] PX03002 ¶ 6.

88. When selecting a health plan to offer their employees, Bismarck-Mandan Area employers prioritize a health plan that provides access to a large number of in-network local providers of the Relevant Services. Reichert (NISC) Hrg. Tr. Vol. 2 at 160–161; PX03002 ¶¶ 6–7; PX03008 ¶ 9; [redacted]

89. According to Mandan-based NISC, offering its employees a health plan network that did not include any in-network physicians in Bismarck and Mandan "would be equivalent to not having a network." Reichert (NISC) Hrg. Tr. Vol. 2 at 162.

2. Commercial insurers could not market health plan to customers located in the Bismarck-Mandan Area that did not include local physicians providing each of the Relevant Services

90. [redacted] Medica could not successfully sell a health plan to employers with employees living in Bismarck or Mandan that did not include providers of the Relevant Services located in Bismarck or Mandan. Lenz (Medica) Hrg. Tr. Vol. 1 at 182–183; PX03016 ¶ 12.

91. Commercial insurers seek to offer in-network access to physicians located close to where their members live. JX00009 (Schott) IH Tr. 88–89; [redacted] PX03016 ¶ 12.

3. The Bismarck-Mandan Area is consistent with how Defendants view the geography in which the Relevant Services are provided

92. MDC's CFO testified that MDC considers Burleigh and Morton counties and several border counties as MDC's primary care area and that "the further out from Bismarck that you get, the less primary care we have." JX00012 (Schaaf) IH Tr. 202–203. Sanford's Martha Leclerc confirmed that Burleigh, Morton, and Oliver counties are Sanford's "core geography around the Bismarck service area" and an area from which "most of the patients in the Bismarck area come . . . ." JX00007 (Leclerc) IH Tr. 118. A research study commissioned by Sanford's marketing team concluded that [redacted] are Sanford's "primary service area" for family medicine when evaluating consumer preferences and public opinion. PX04034 at 009.

4. Quantitative evidence confirms that patients within the Bismarck-Mandan Area prefer to receive the Relevant Services within the Bismarck-Mandan Area

93. Dr. Sacher's empirical analyses confirm that patients in the Bismarck-Mandan Area have a strong preference to receive care locally. First, over 95% of patients living in the Bismarck-Mandan Area stay within the Bismarck-Mandan Area for each of the Relevant Services. Sacher Hrg. Tr. Vol. 2 at 77; PX06000 ¶¶ 126–128 & App'x I, Tbl. 6.

94. Second, Dr. Sacher analyzed the commuting patterns of Bismarck-Mandan Area residents and found that patients do not travel long distances to access any of the Relevant Services. For all of the Relevant Services, the median distance traveled by Bismarck-Mandan Area patients was 4 miles and the median drive time was under 10 minutes. These travel patterns corroborate the qualitative evidence that Bismarck-Mandan Area patients today have a strong preference to receive the Relevant Services locally. Sacher Hrg. Tr. Vol. 2 at 78; PX06000 ¶¶ 130–131 & App'x I, Tbl. 7; *id.* App'x II, Figs. 11–20.

95. Third, Dr. Sacher used a "discrete choice model" to conduct a diversion ratio analysis. Sacher Hrg. Tr. Vol. 2 at 78–80. The "discrete choice model" is a widely accepted tool among economists that estimates patients' preferences for the various healthcare providers they use for the Relevant Services. Sacher Hrg. Tr. Vol. 2 at 79–80; PX06000 ¶¶ 142–145. The consumer preferences modeled using the discrete choice model may then be used to calculate "diversion ratios" for healthcare providers. Sacher Hrg. Tr. Vol. 2 at 78–80; PX06000 ¶ 142.

96. A diversion ratio is the percentage of a single provider's patients who would switch to another provider if the former is no longer available. Sacher Hrg. Tr. Vol. 2 at 79; PX06000 ¶¶ 135–136. Diversion ratios can be used to inform geographic market definition by aggregating diversion ratios for providers in a candidate geographic market and assessing the extent to which patients within a candidate geographic market would stay in that candidate geographic market if

their preferred provider is no longer available. This method is called "*aggregate* diversion ratio analysis." Sacher Hrg. Tr. Vol. 2 at 80; PX06000 ¶ 137 ("[T]he aggregate diversion ratio *for a candidate market* measures the percentage of patients who would switch from a provider in the market to another provider in the market if their preferred provider were no longer available.").

97. Dr. Sacher's estimates of aggregate diversion ratios for each of the Relevant Services indicates that between 94% and 98% of Bismarck-Mandan Area residents seeking care from Bismarck-Mandan Area physicians view another physician provider in the Bismarck-Mandan Area as their second best alternative physician. PX06000 ¶ 151 & App'x I, Tbls. 8–12; Sacher Hrg. Tr. Vol. 2 at 80-81. These high aggregate diversion ratios indicate that Bismarck-Mandan Area patients would not leave the Bismarck-Mandan Area to receive care if their first choice physician provider were no longer available. Sacher Hrg. Tr. Vol. 2 at 81.

5. Commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a network that omits each of the Relevant Services in the Bismarck-Mandan Area

98. Patients' strong preference for local care, as reflected in the qualitative and empirical evidence, indicates that commercial health plans that exclude Bismarck-Mandan Area physicians would not be attractive to Bismarck-Mandan Area employers or residents. Commercial insurers that wish to market health plans to employers or residents in the Bismarck-Mandan Area would accept a hypothetical monopolist's SSNIP rather than try to market a health plan that did not include Bismarck-Mandan Area physicians providing the Relevant Services. Accordingly, the Bismarck-Mandan Area satisfies the HMT and constitutes a relevant geographic market for each of the Relevant Services. Sacher Hrg. Tr. Vol. 2 at 81–82; PX06000 ¶ 156.

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

A. The Proposed Transaction Is Presumptively Illegal in Each Relevant Market

99. Sanford and MDC are the two largest providers of adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services in the Bismarck-Mandan Area. Complaint ¶¶ 1, 5, 36; MDC Answer ¶¶ 1, 36; Sanford Answer ¶¶ 1, 5, 36; *see also* JX00028 (Krabbenhoft) Dep. Tr. 169–170.

100. In antitrust cases, market concentration is measured using HHIs, which is calculated from market shares. HHIs range anywhere from zero (representing an infinite number of very small providers) to 10,000 (representing a pure monopoly market). Sacher Hrg. Tr. Vol. 2 at 84–85; *see* Merger Guidelines § 5.3. The Merger Guidelines provide thresholds for evaluating the increases in market concentration caused by a merger of competitors. Mergers that result in an increase in the HHI of more than 200 points and markets with a post-merger HHI above 2,500 are "presumed to be likely to enhance market power." Sacher Hrg. Tr. Vol. 2 at 85–86; *see* Merger Guidelines § 5.3.

101. The HHIs and changes in HHIs that result from the Proposed Transaction far exceed the thresholds established in the Merger Guidelines as triggering a presumption that the Proposed Transaction is "likely to enhance market power." Sacher Hrg. Tr. Vol. 2 at 86–87; PX06000 ¶¶ 162–173; *see* Merger Guidelines § 5.3.

102. Dr. Sacher measured market shares and concentration using three different measures of physician services volume: office visits, encounters, and relative value units. His estimates of market shares and concentration were consistent across the three measures. *See* PX06000 ¶ 160 & App'x I, Tbls. 14–28. The shares and concentration figures summarized below are based on the encounter-based measure of market shares. A single "encounter" is defined as all services a

patient received from a single provider on any given day regardless of the type or number of services performed. PX06000 ¶¶ 131 n.170, 160 n.198.

1. The merged entity will control 85.7% of adult PCP services in the Bismarck-Mandan Area

103. Within the Bismarck-Mandan Area, Sanford and MDC are the largest providers of adult PCP services with shares of 34.4% and 51.3%, respectively, ***leading to a post-merger share of 85.7%.*** The next largest provider of adult PCP services is CHI (7.9%). The remaining providers each have market shares of 2% or less. *See* PX06000 App'x I, Tbl. 15.

104. These market shares lead to a pre-merger HHI of 3,891. The Proposed Transaction would cause an HHI increase of 3,531, resulting in a post-merger HHI of 7,422. PX06000 App'x I, Tbl. 15.

105. The post-merger HHI and the change in HHI both exceed the presumptive levels indicated in the Merger Guidelines. PX06000 ¶ 162. The Relevant Market of adult PCP services provided in the Bismarck-Mandan Area is therefore already highly concentrated and will be even more concentrated as a result of the Proposed Transaction. PX06000 ¶¶ 158, 162, 173.

2. The merged entity will control 98.6% of pediatrician services in the Bismarck-Mandan Area

106. Sanford and MDC are by far the largest providers of pediatrician services within the Bismarck-Mandan Area, with shares of 34.0% and 64.6%, respectively, ***leading to a post-merger share of 98.6%***. The next largest provider of pediatrician services is the UND CFM (1.4%). PX06000 App'x I, Tbl. 21.

107. The pre-merger HHI for the pediatrician services market is 5,333. The Proposed Transaction would cause an HHI increase of 4,393, resulting in a post-merger HHI of 9,726. PX06000 App'x I, Tbl. 21.

108. The post-merger HHI and the change in HHI both exceed the presumptive levels indicated in the Merger Guidelines. PX06000 ¶ 164. The Relevant Market of pediatrician services provided in the Bismarck-Mandan Area is therefore already highly concentrated and will be even more concentrated as a result of the Proposed Transaction. PX06000 ¶¶ 158, 164, 173.

3. The merged entity will control 84.6% of OB/GYN physician services in the Bismarck-Mandan Area

109. Sanford and MDC are by far the largest providers of OB/GYN physician services in the Bismarck-Mandan Area, with shares of 23.9% and 75.1%, respectively. The only other current provider of OB/GYN physician services in the Bismarck-Mandan area is the UND CFM, which has a 1% share. ***Post-merger, Sanford would control 84.6% of OB/GYN physician services.*** This post-merger share conservatively assumes that Dr. Bury, a current MDC OB/GYN, will move to CHI following the Proposed Transaction. PX06000 ¶ 165 & App'x I, Tbl. 24.

110. These market shares lead to a pre-merger HHI of 6,211. The Proposed Transaction would cause an HHI increase of 1,152, resulting in a post-merger HHI of 7,363. PX06000 App'x I, Tbl. 24.

111. The post-merger HHI and the change in HHI both exceed the presumptive levels indicated in the Merger Guidelines. PX06000 ¶ 165. The Relevant Market of OB/GYN physician services provided in the Bismarck-Mandan Area is therefore already highly concentrated and will be even more concentrated as a result of the Proposed Transaction. PX06000 ¶¶ 158, 165, 173.

4. The merged entity will control 99.8% of general surgeon services in the Bismarck-Mandan Area

112. Sanford and MDC employ all of the general surgeons in the Bismarck-Mandan Area, with shares of 36.1% and 63.7%, respectively, ***leading to a post-merger share of 99.8%.*** PX06000 App'x I, Tbl. 26.

113. These market shares lead to a pre-merger HHI of 5,362. The Proposed Transaction would cause an HHI increase of 4,602, resulting in a post-merger HHI of 9,964. PX06000 App'x I, Tbl. 26.

114. The post-merger HHI and the change in HHI both exceed the presumptive levels indicated in the Merger Guidelines. PX06000 ¶ 166 & App'x I, Tbl. 26. The Relevant Market of general surgeon services provided in the Bismarck-Mandan Area is therefore already highly concentrated and will be even more concentrated as a result of the Proposed Transaction. PX06000 ¶¶ 158, 166, 173.

B. Analyses of Broader Markets and Using Alternative Methods of Calculating Shares Does Not Meaningfully Alter the Concentration Levels

115. Dr. Sacher measured market shares and concentration using several additional approaches, such as increasing the boundaries of the geographic market and expanding the providers included in the Relevant Services Markets, to ensure his results were not sensitive to the method of calculating shares, the definition of the product markets, or the precise boundaries of the geographic market. Sacher Hrg. Tr. Vol. 2 at 87-88; PX06000 ¶¶ 168-173. These additional analyses reinforced Dr. Sacher's conclusion that the Proposed Transaction would significantly increase market concentration in each of the Relevant Markets and trigger the Merger Guidelines' presumption that the Proposed Transaction is "likely to enhance market power." Sacher Hrg. Tr. Vol. 2 at 87–88; PX06000 ¶¶ 168–173; *see* Merger Guidelines § 5.3.

VII. THE PROPOSED TRANSACTION WOULD SUBSTANTIALLY LESSEN COMPETITION IN ALL OF THE RELEVANT MARKETS

A. Sanford and MDC Are Close Competitors in the Relevant Markets

1. Qualitative analysis confirms that Sanford and MDC are close competitors

116. Sanford and MDC view each other as one another's closest competitor in the Relevant Services Markets. Sanford describes MDC as its "major competitor for primary care in Bismarck." PX04019 at 001; PX04018 at 005 (describing MDC as Sanford's "main clinical competitor in Bismarck"). Sanford's market research identifies MDC's OB/GYN department as its "top competitor" for delivering babies in the Bismarck-Mandan Area and MDC as its only competitor for pediatrician services. *See* PX04031 at 001; PX04029 at 004; JX00006 (Hopkins) IH Tr. 149–150, 178–179; Bury (MDC) Hrg. Tr. Vol. 2 at 21 (MDC competes with Sanford's OB/GYNs). Sanford's internal marketing materials identify MDC's general surgeons as Sanford's "primary competition in Bismarck" for bariatric procedures. PX04150 at 004; *see also* PX04101 at 001.

117. Sanford's Vice President of Clinics for Bismarck testified that "Sanford Bismarck primarily competes with Mid Dakota Clinic to attract patients for OB/GYN, primary care physician, pediatricians, and general surgery services . . . ." LeBeau (Sanford) Hrg. Tr. Vol. 3 at 81.

118. Similarly, MDC perceives Sanford to be the most significant threat to MDC's market share in MDC's service lines. PX05163 at 003 ("Success encourages stronger competition. Sanford et al. have put a large target on our finances and market share."); PX05174 at 002 ("Sanford has pretty aggressive advertising and an endless bucket of money to do so. We certainly know they have gone after the [pediatrics] market with the 'castle clinic' up north. . . . Sanford has been making some inroads into OB and although it isn't by much – we can no longer

say '2 out of 3' babies are born at MDC/St. A's so we need to work on retaining the market share."); PX05159 at 001 ("As Sanford pumps millions of dollars into their OB program, our ability to dominate the market will become more difficult."). MDC's CFO observed that "Sanford is going to be a demon to deal with competitively & insurance wise until about 2025. . . . Combining with them would put us in the dominant health care system for quite a while." PX05119 at 007–008.

119. Market studies and strategy assessments conducted in 2015 by MDC's marketing consultant, Odney, focused on Sanford as MDC's closest competitor in the Bismarck-Mandan Area. *See generally* PX05162 at 006–007. Odney found that Sanford had made gains since acquiring MedCenter One and that, by 2014, Sanford was "the first clinic recommended for some healthcare services [for which] Mid Dakota Clinic traditionally held a stronger position in the market." PX05175 at 003. Odney concluded that the services provided by MDC's TODAY Clinic were [redacted] PX05162 at 009.

120. In April 2015, MDC's Director of Marketing wrote to Odney that Marvin Lein "feels this is essentially a 50/50 market" and that "Sanford can't touch Brand messaging, which [MDC] did well over the past couple of years, because they don't have the quality and longevity of docs we do. . . ." PX05238 at 001; *see also* PX05230 at 001 (Mr. Lein wrote that it was important for MDC to "[redacted]" if the Proposed Transaction fails so that MDC can preserve its "[redacted]

121. Sanford and MDC closely monitor the development of each other's practices, including the addition of services, physicians, and technology. *See, e.g.*, PX04102 at 004 (noting Bismarck

Tribune article describing MDC's new MonaLisa Touch® technology); JX00011 (Seifert) IH Tr. 142–43 (Sanford's weight loss program, Sanford Profile, was first in the market and was cheaper and more successful than MDC's); PX05136 at 001 (describing MDC's desire to have a pediatric presence in north Bismarck "for obvious reasons (Sanford North and Bismarck growth is north)"); PX04084 at 023 (Sanford Competitive Brief discussing [redacted]); PX04118 at 005 (noting MDC added MonaLisa Touch laser and a general surgeon); PX05157 at 001 (MDC monitors the price charged and services included in Sanford's sports physical exams).

122. Sanford and MDC track each other's marketing practices and advertisement campaigns. *See, e.g.*, PX05168 at 002 (MDC should advertise to MDC's existing patients the availability of same-day access to their MDC primary care providers just as Sanford does); PX04027 at 004 [redacted] with own campaign); PX05176 at 001 (MDC warned Sanford to stop using advertising language "the providers you know and trust" because it was too similar to MDC's tagline "the doctors you know and trust"); PX04020 at 003; JX00011 (Seifert) IH Tr. 145; PX04094 at 001.

123. Similarly, Sanford [redacted] PX04099 at 003 [redacted]

124. MDC reacted to Sanford's extensive advertising of 3D mammography and patients choosing to go to Sanford for their mammograms by asking MDC physicians to inform patients that MDC did have 3D mammography. PX05145 at 001.

125. Sanford and MDC also seek to correct each other's claims regarding their service offerings. For example, in January 2015, MDC challenged Sanford on its advertised claims that Sanford was the only provider to offer 3D mammography in North Dakota, causing Sanford to stop those ads. *See* PX05177 at 003. Sanford simultaneously alerted MDC that MDC's advertised claim that two out of three births occur with MDC OB/GYNs was no longer valid based on then-recent data. *See* PX05177 at 003; *see also* PX04001 at 090; PX04093 at 001.

2. Quantitative analysis confirms that Sanford and MDC are close competitors

126. Dr. Sacher employed an "interfirm diversion ratio analysis" that confirmed the closeness of competition between Sanford and MDC for patients in the Bismarck-Mandan Area for each of the Relevant Services. Sacher Hrg. Tr. Vol. 2 at 90–93. The interfirm diversion ratio between two providers is the percentage of a provider's patients that would switch to the other provider if the former were no longer available. Sacher Hrg. Tr. Vol. 2 at 90. Diversion ratios accordingly "measure the extent to which patients of a particular provider view another provider as their second best option." Sacher Hrg. Tr. Vol. 2 at 90. Dr. Sacher calculated the interfirm diversion ratios for Sanford and MDC for each of the Relevant Services. PX06000 ¶¶ 183–189 & App'x I, Tbls. 46–50.

127. Dr. Sacher's interfirm diversion ratio analyses show that patients of Sanford in the Bismarck-Mandan Area overwhelmingly regard MDC as their next best option for each Relevant Service, and *vice versa*. Sacher Hrg. Tr. Vol. 2 at 90–92. The table below summarizes the interfirm diversions between Sanford and MDC for each of the Relevant Services:

	Inter-Firm Diversion	
	From Mid Dakota to Sanford	From Sanford to Mid Dakota
Adult Primary Care Physicians	71.3%	76.3%
Pediatricians	95.1%	96.1%
OB/Gyn	63.9%	78.2%
General Surgery	96.0%	96.9%

PX06000 App'x I, Tbls. 46–50, 58; *see also* Sacher Hrg. Tr. Vol. 2 at 90–92; PX06000 ¶¶ 188–189 & App'x I, Tbl. 58.

128. The diversion ratios also illustrate that Sanford and MDC compete more closely with each other than they do with other market participants. PX06000 ¶ 230. For example, for adult PCP services, Dr. Sacher calculated that the diversion ratios from MDC to CHI and from Sanford to CHI are 8.8% and 8.9%, respectively, indicating that few of Sanford and MDC's adult PCP patients view CHI as their second-best option. *See* PX06000 App'x I, Tbl. 46.

129. Defendants' expert, Dr. Town, testified that patients view Sanford and MDC as substitutes. Town Hrg. Tr. Vol. 4 at 113. Dr. Town agreed that diversion ratios are commonly used metrics that quantify the extent of substitution between firms, and had no criticism of the mechanics of Dr. Sacher's diversion ratio analysis. Town Hrg. Tr. Vol. 4 at 113.

130. Dr. Sacher compared the diversion ratios between Sanford and MDC to the diversion ratios between merging healthcare providers in recently litigated provider merger cases. PX06000 ¶¶ 190–191. The diversion ratios in this case far exceed the diversion ratios in those other matters, "an indication of the closeness of competition between the merging parties and the near monopoly situation [the Proposed Transaction] would create." Sacher Hrg. Tr. Vol. 2 at 92–93. For example, diversion ratios in *Saint Alphonsus Med. Ctr.–Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015)—a similar case involving a large health system's acquisition of a PCP practice—ranged from 33% to 50%. PX06000 ¶ 191.

131. Sanford and MDC compete more closely with each other than they do with other market participants, as reflected in the diversion ratios. *See* PX06000 ¶ 230.

B. The Proposed Transaction Significantly Reduces First Stage Competition and Will Likely Result in Increased Prices

1. Sanford and MDC are closest substitutes for insurer networks

132. At present, Sanford and MDC serve as the key providers of each of the Relevant Services for consumers living in the Bismarck-Mandan Area, and either one can support a marketable health insurance product. *See* JX00009 (Schott) IH Tr. 98; JX00003 (Kuntz) IH Tr. 43.

133. [redacted]

134. A narrow network product consists of a smaller subset of available providers in a market, and is typically priced lower than a broad network. JX00026 (Leclerc) Dep. Tr. 46, 80; JX00007 (Leclerc) IH Tr. 110, 119. Sanford Health Plan markets a narrow network product, Sanford TRUE, to individuals and employers in the Bismarck-Mandan Area today that comprises almost exclusively Sanford providers and excludes MDC. JX00009 (Schott) IH Tr. 96; JX00026 (Leclerc) Dep. Tr. 47; JX00007 (Leclerc) IH Tr. 85.

135. Sanford Health Plan has developed a Medicare cost product with a narrow network that also excludes MDC. JX00007 (Leclerc) IH Tr. 102–106; PX04073 at 002.

136. Sanford offers its employees a group health insurance plan that excludes MDC from the network. JX00004 (Lambrecht) IH Tr. 220–221; JX00007 (Leclerc) IH Tr. 87.

137. Similarly, BCBS markets "point of service" health plans (BlueChoice and SelectChoice) to employers in the Bismarck-Mandan Area that are similar to narrow networks. [redacted] For these point of service plans, a subscriber affiliates with either Sanford physicians or PrimeCare (including MDC) physicians, but cannot affiliate with both. [redacted]

[redacted] JX00003 (Kuntz) IH Tr. 148-149, 253-254. The physicians with whom the subscriber affiliates are "in-network," while the non-affiliated physicians are "out-of-network." [redacted] Employers receive a [redacted] premium discount [redacted] in exchange for choosing one of these plans. [redacted]

138. [redacted]

139. [redacted]

140. [redacted] PX03016 ¶ 13.

141. For example, [redacted]

[redacted]

142. [redacted] were not aware of any health plan offered today or in the past in the Bismarck-Mandan Area that excluded both Sanford and MDC physicians as in-network physicians. [redacted] Lenz (Medica) Hrg. Tr. Vol. 1 at 176–178.

2. Other physicians in the Relevant Markets are distant, inadequate substitutes and will not constrain Sanford following the Proposed Transaction

143. The likelihood of anticompetitive effects arising from the Proposed Transaction is reinforced if third-party providers are not perceived by commercial insurers or their members as effective substitutes for constructing a health plan due to their geographic location, reputation, or other factors relating to their services. PX06000 ¶ 230.

144. [redacted]

145. After the Proposed Transaction, the remaining competitors, including CHI, "would possess only a small share of Medica's spend on adult PCP, pediatric, general surgery, and OB/GYN physician services . . . ." PX03016 ¶ 15.

146. [redacted]

3. The Proposed Transaction would immediately increase Sanford's bargaining leverage

147. The Proposed Transaction would immediately increase the merged entity's bargaining leverage because there would be little demand for a health plan network that excluded the combined health system. [redacted] JX00007 (Leclerc) IH Tr. 89, 95–97; [redacted] PX03016 ¶¶ 16–17.

148. [redacted]

149. [redacted]

150. Medica would not be able to offer an attractive network to employers without physicians from a combined Sanford-MDC. Lenz (Medica) Hrg. Tr. Vol. 1 at 177–178; PX03016 ¶ 16. Because of this, Sanford would have a "substantial amount of leverage" with Medica post-Transaction because "Sanford already has a big club when it comes to negotiation . . . [and the Proposed Transaction] would just make their club even bigger." Lenz (Medica) Hrg. Tr. Vol. 1 at 184–186.

151. Even Sanford Health Plan recognizes that employers in Burleigh and Morton County would not be "interested in buying a product" that excluded both Sanford and MDC PCPs. Leclerc (Sanford) Hrg. Tr. Vol. 3 at 186; *see also* JX00007 (Leclerc) IH Tr. 89.

152. In the Bismarck-Mandan Area, the post-Transaction Sanford [redacted] Sanford's bargaining leverage will increase as a result of the consolidation of any one of the Relevant Services (not only as a result of its near-monopoly of all four). *See* PX06000 ¶ 218 & App'x I, Tbl. 57 (measuring Sanford's increased bargaining leverage for each of the Relevant Services). [redacted]

4. Sanford's increased bargaining leverage will likely result in increased prices

a) Insurers are concerned that Sanford's increased bargaining leverage will lead to higher prices

153. Medica expects Sanford's increased bargaining leverage post-Transaction will allow Sanford to "secure better reimbursement terms" because "Medica would have to agree to the reimbursement if they wanted to maintain a network in this area." Lenz (Medica) Hrg. Tr. Vol. 1 at 184, 196–197; *see also* PX03016 ¶ 17. Medica would have to pass a post-Transaction rate increase through to employers and their members. Lenz (Medica) Hrg. Tr. Vol. 1 at 185–186; PX03016 ¶ 18.

154. [redacted]

b) UPP analysis predicts likely annual price increases of 6% to 22%

155. Dr. Sacher used a UPP analysis to measure the changes in Defendants' post-Transaction pricing incentives. *See* PX06000 ¶¶ 192–209. A UPP analysis assesses the incentive for the post-Transaction Sanford to increase price due to elimination of competition between Sanford and MDC as independent substitutes for commercial insurers and their patients. Pre-Transaction, if a MDC patient switches to Sanford (e.g., if MDC is no longer an in-network provider for that patient's insurer), that patient represents a lost sale to MDC (and the profits from serving that patient represent lost profits). Post-Transaction, since MDC and Sanford would be part of the same entity, a patient switching from MDC to Sanford would no longer represent a lost sale. The substitution has therefore been "internalized." The UPP analysis illuminates the merged firm's improved bargaining leverage and the corresponding incentive to raise price due to the internalization of substitution. *See* PX06000 ¶¶ 192–195; Sacher Hrg. Tr. Vol. 2 at 93–96; *see* Merger Guidelines § 6.1.

156. The key inputs in the UPP analysis are the interfirm diversion ratios between the Defendants and the Defendants' incremental margins. Sacher Hrg. Tr. Vol. 2 at 94; PX06000 ¶¶ 192–194. The interfirm diversion ratio "measures how many patients turn from one firm to the merger partner. The greater is the interfirm diversion ratio, the greater is that internalization of substitution, [and] the greater is the [UPP]." Sacher Hrg. Tr. Vol. 2 at 94–95; PX06000 ¶ 196.

157. "[T]he incremental margin is essentially just the profit margin" on the diverted patients. Sacher Hrg. Tr. Vol. 2 at 95. Higher incremental margins indicate increased value from the internalized substitution caused by the Proposed Transaction (i.e., higher incremental margins mean that internalized substitution is more profitable). *See* Sacher Hrg. Tr. Vol. 2 at 95–96; PX06000 ¶ 196. The greater the value of the internalized substitution, the greater the Defendants' incentive to increase price. "Put differently, there will be a greater upward pressure

on price the more substitution there is between the merging parties to internalize (the inter-firm diversion ratio) and the more profitable that internalized substitution is (as measured by the incremental margins)." PX06000 ¶ 196; *see also* Sacher Hrg. Tr. Vol. 2 at 93–96.

158. Calculating margins based on financial information provided by Defendants and the interfirm diversion ratios, Dr. Sacher estimated that the Proposed Transaction is likely to cause predicted price increases of 6% to 22%. Sacher Hrg. Tr. Vol. 2 at 97; PX06000 ¶¶ 197–206. Expressed in dollars, the UPP from the Proposed Transaction ranges from approximately $16 million to $27 million annually. PX06000 ¶ 212; *id.* App'x IX.

c) Willingness-to-Pay analysis confirms that the Proposed Transaction will substantially increase Sanford's leverage with commercial insurers

159. Dr. Sacher also assessed how the Proposed Transaction improves Defendants' bargaining leverage using a widely accepted measure known as WTP analysis. Sacher Hrg. Tr. Vol. 2 at 98–103; PX06000 ¶¶ 214–219. WTP measures the value that consumers place on having a particular provider in their insurer's network. Sacher Hrg. Tr. Vol. 2 at 98–99; PX06000 ¶ 214. The change in bargaining leverage can be measured by comparing insurers' WTP for the post-Transaction combined entity (i.e., Sanford and MDC jointly) against the sum of the insurers' WTP for the individual pre-Transaction entities (i.e., Sanford and MDC separately). Sacher Hrg. Tr. Vol. 2 at 100–101; PX06000 ¶ 218.

160. Dr. Sacher found that for each of the Relevant Services Markets, the Proposed Transaction would cause the following significant increases in WTP for the post-Transaction entity: 80% increase for adult PCP services; 177% increase for pediatrician services; 68% for OB/GYN physician services; and 183% for general surgeon services. Sacher Hrg. Tr. Vol. 2 at 101; PX06000 ¶ 218 & App'x I, Tbl. 57.

161. These estimated increases in WTP far exceed the estimated increases in WTP in recent litigated cases where courts blocked healthcare provider mergers. Sacher Hrg. Tr. Vol. 2 at 102; PX06000 ¶ 219. For example, in the recent *FTC v. Advocate Health Care Network* litigation, the Commission's economic expert found WTP increases of approximately 8%. PX06000 ¶ 219.

162. The WTP increases are very high, confirming "the closeness of competition between [Defendants]" and "reflect[ing] the fact that the other providers in this area are far more distant substitutes." Sacher Hrg. Tr. Vol. 2 at 101–102.

C. The Proposed Transaction Would Eliminate Beneficial Second Stage Non-Price Competition

1. Sanford and MDC compete with each other on non-price dimensions

163. Sanford and MDC compete for patients by investing in technology, improving access and convenience, and offering patients new services and amenities. LeBeau (Sanford) Hrg. Tr. Vol. 3 at 80–83; PX06000 ¶¶ 239–241; PX06003 ¶¶ 120–121; PX05206 at 002 (MDC "will need a north [clinic] to compete with Sanford," which "has the goal of capturing 70% market share."); PX03010 ¶ 4; PX03021 ¶ 5; *see also* JX00029 (Botsford) Dep. Tr. 83. This non-price competition between Sanford and MDC benefits patients. Bury (MDC) Hrg. Tr. Vol. 2 at 17–23; LeBeau (Sanford) Hrg. Tr. Vol. 3 at 80–83; PX06000 ¶¶ 238–241; PX06003 ¶¶ 117, 120–121; PX03010 ¶ 4; PX03021 ¶ 5; JX00018 (Neuberger) Dep. Tr. 262–263; PX04071 at 001 (Sanford "can't force patients into our system, but we can sure influence them with access, quality, and convenience, etc."); PX05300 at 001.

a) Defendants compete with each other by investing in technology

164. Sanford and MDC competed to attract patients by adopting 3D mammography. JX00002 (Lein) IH Tr. 221–222; JX00011 (Seifert) IH Tr. 75; PX04092 at 001; PX04099 at 003; PX05160 at 001; PX06003 ¶¶ 121–122. Both Sanford and MDC consider 3D mammography an

improvement over 2D mammography that improves the quality of care provided to patients. Bury (MDC) Hrg. Tr. Vol. 2 at 18–19; PX04283 at 002.

165. In February 2014, Sanford concluded that it [redacted] PX04283 at 002–003; *see also* PX04312 at 002 [redacted]. Since acquiring 3D mammography, Defendants have continued to compete for 3D mammography patients along several dimensions, including price, access, and breast care services. Complaint ¶ 56; MDC Answer ¶ 56; *see also* PX06000 ¶ 244; PX04028 at 003 [redacted]

166. Sanford also invested in a tower-free hysteroscopy system to transition certain gynecological procedures from an operating room to a clinical setting because it was at a competitive disadvantage to MDC. PX04023 at 061; JX00004 (Lambrecht) IH Tr. 241–242; PX06000 ¶ 245; *see* JX00021 (LeBeau) Dep. Tr. 174–176; JX00048 at 001 ([redacted]

167. Sanford promotes its use of the da Vinci robotic surgery system for gynecological surgeries as a differentiator between Sanford and MDC's OB/GYN departments. *See* PX04029 at 001 [redacted] PX04097 at 001 (describing the da Vinci Surgical System as a differentiator); PX06000 ¶ 245.

168. In March 2016, Sanford Bismarck [redacted] PX04067 at 002.

b) Defendants compete with each other by improving access and convenience

169. MDC opened a pediatrics clinic in north Bismarck in February 2016 to improve its patient access because Sanford's pediatric presence in north Bismarck was offering better patient access. Seifert (MDC) Hrg. Tr. Vol. 4 at 193–195; PX05136 at 001 ("The [pediatrics] department was initially informed that we wished to have a [pediatrics] presence in north Bismarck for obvious reasons (Sanford North and Bismarck growth is north) . . . .").

170. Sanford and MDC use the convenience of their walk-in or urgent care clinics to compete for new patients. PX05144 at 002; PX04021 at 001; *see* PX05169 at 001; JX00029 (Botsford) Dep. Tr. 70; JX00030 (S. McDonough) Dep. Tr. 89–92; PX03021 ¶ 5.

171. MDC created urgent care clinics called TODAY clinics to "answer [MedCenter One's] walk ins; to increase our market share and to provide [patient] access." PX05181 at 001.

172. Competition between Sanford's and MDC's walk-in clinics led to increased accessibility and service. Seifert (MDC) Hrg. Tr. Vol. 4 at 195–198; JX00018 (Neuberger) Dep. Tr. 258–262; PX05190 at 005 [redacted] *see also* JX00010 (Tanous) IH Tr. 182–184; PX05249 at 002 (MDC sought to accommodate patients by seeing their own primary care physicians on a walk-in basis, because "facilities like Sanford are already doing this.").

173. MDC considers its Center for Women, a building designated for women's services, as a competitive advantage. Bury (MDC) Hrg. Tr. Vol. 2 at 17–20. This "one-stop shopping" facility allows patients to access multiple services in one location, including ultrasound testing,

lab work, and drive-up pharmacy. Bury (MDC) Hrg. Tr. Vol. 2 at 17–18; JX00014 (Bury) IH Tr. 104-105; *see also* PX06000 ¶ 244.

174. MDC offered sports physicals in its TODAY clinic in response to competition from MedCenter One (now Sanford). PX05181 at 001–002; PX05279 at 001; *see* PX06000 ¶ 246.

2. The Proposed Transaction would reduce Sanford's incentive to compete on non-price dimensions

175. The Proposed Transaction would eliminate the existing beneficial non-price competition between MDC and Sanford. Sacher Hrg. Tr. Vol. 2 at 104–106; PX06000 ¶¶ 176, 236–246.

176. Dr. Jan Bury testified that competition is healthy for patients because it "sets the bar a little higher" and "if you remove competition, you're doing a disservice to the community and the patients in the community by taking away from them the right to choose, and possibly making the care not as good as it should be." Bury (MDC) Hrg. Tr. Vol. 2 at 21–22; *see also id.* at 28–29 (testifying that the Proposed Transaction "goes against everything that we all know about competitive edge"). Sanford's CEO, Kelby Krabbenhoft, testified that "competition keeps you on your toes. I think it keeps you always ascribing and aspiring to provide a better product at a more competitive price . . . . I think competition adds another level of intensity to that and focus to that effort." Krabbenhoft (Sanford) Hrg. Tr. Vol. 3 at 38.

D. Market Participants, Including Defendants, Acknowledge that the Proposed Transaction Raises Antitrust Concerns and Would Be Bad for the Community

177. Dr. Shelley Seifert, MDC's Board Chair, suggested there would be [redacted] if Sanford purchased MDC. PX05180 at 001; *see also* PX05179 at 001 (Dr. Shannon Bradley, a MDC OB/GYN, inquired if selling MDC to Sanford was "not an option because of ND monopoly law stuff."); PX05183 at 002 [redacted]

[redacted] PX05178 at 002 [redacted] PX05205 at 001 [redacted]

178. [redacted]. JX00029 (Botsford) Dep. Tr. 158–160; *see also* PX04291 at 001(describing how [redacted]). MDC sent proposed term sheets to CHI and Sanford in August 2015. In the proposed term sheet sent to Sanford, MDC included a provision that [redacted] DX2013 at 005. No such provision was included in the proposed term sheet MDC sent to CHI. *See generally* DX4078.

179. A MDC board member stated that, "one could say that to corner the market we are worth X amount of dollars to Sanford." PX05288 at 001; *see* JX00029 (Botsford) Dep. Tr. 164.

180. In June 2015, during an MDC physician staff meeting, [redacted] PX05221 at 002.

181. Dr. Jan Bury testified that "monopoly in health care is not a good thing," and that the Proposed Transaction would adversely impact the quality of healthcare services available in Bismarck or Mandan by creating a monopoly. JX00014 (Bury) IH Tr. 113–115.

182. In June 2017, MDC's CEO, Marvin Lein, wrote that "Sanford is known as the monster that gobbles up communities," and MDC must "[redacted]" because, if the Proposed

Transaction fails, MDC needs to preserve its "[redacted] PX05230 at 001.

183. MDC's CFO wrote the Proposed Transaction "will be bad for our community and many of our patients." PX05119 at 006.

184. Former Sanford and MDC physicians expressed concerns that the Proposed Transaction would create a "near monopoly" in healthcare in the Bismarck-Mandan Area and eliminate options for patients. *See* JX00030 (S. McDonough) Dep. Tr. 24, 104–105; PX03019 ¶ 4 (Proposed Transaction "will create a near-monopoly of clinical providers of adult primary care, pediatrics, OB/GYN, and general surgery [and] will eliminate the competition that exists between Sanford and Mid Dakota Clinic, and all of the resulting improvements in quality generated by this competition."); PX03017 ¶¶ 1, 3 (Proposed Transaction "will have a negative impact on the Bismarck-Mandan community and on the provision of health care," "reduce competition," and "create one large and powerful system in the Bismarck-Mandan area.").

185. Other market participants are concerned the Proposed Transaction would be bad for the community. [redacted] If Sanford increased rates post-Transaction, [redacted]

VIII. DEFENDANTS HAVE FAILED TO REBUT THE STRONG PRESUMPTION OF HARM TO COMPETITION IN ANY OF THE RELEVANT MARKETS

A. BCBS Will Not Be Able to Prevent Harm from the Proposed Transaction

186. Defendants' expert Dr. Town relies upon what he describes as BCBS's "bargaining power" to prevent Sanford from using its increased bargaining leverage post-Transaction to obtain higher prices. Dr. Town's definition of bargaining power is ambiguous. Town Hrg. Tr. Vol. 4 at 123–128 ("bargaining power" defined as "stuff that's kind of included in the specific negotiations you're examining," which includes "stuff that's not captured in the bargaining leverage"). "Bargaining power" (or bargaining skill or ability) reflects the relative negotiating skills of the parties to a negotiation and is affected by each parties' experience in negotiation, preparation, communication skills, patience, and risk aversion. PX06003 ¶ 21; Sacher Hrg. Tr. Vol. 2 at 55. Dr. Town's rationale for assigning "all of the bargaining power" to BCBS is undermined by other evidence in the record. PX06003 ¶¶ 27–42; Sacher Hrg. Tr. Vol. 4 at 212-213. For example, Dr. Town attributes all of the bargaining power to BCBS in part because of its deployment of a statewide rate schedule. [redacted] Dr. Town also agrees that Medica could utilize a uniform rate schedule as well, and that in that event, his analysis could not distinguish between an insurer with all the bargaining power and one without all the bargaining power. JX00034 (Town) Dep. Tr. 243–244.

1. [redacted]

187. Sanford represents about [redacted] Leclerc (Sanford) Hrg. Tr. Vol. 3 at 183; PX04228 at 001.

188. [redacted] Leclerc (Sanford) Hrg. Tr. Vol. 3 at 178; *see also* JX00007 (Leclerc) IH Tr. 223 [redacted]; [redacted] *See* PX04227 at 001 [redacted] Leclerc (Sanford) Hrg. Tr. Vol. 3 at 180.

2. The Proposed Transaction increases Sanford's size, while BCBS's size remains unchanged

189. The Proposed Transaction would increase the merged entity's bargaining leverage, and the WTP for BCBS. Town Hrg. Tr. Vol. 4 at 112; *see also supra* Section VII.B.3. To the extent that Dr. Town believes that BCBS's size gives it bargaining power, the Proposed Transaction increases Sanford's size while leaving BCBS's size unchanged. Sacher Hrg. Tr. Vol. 4. at 212–214 ("[T]o the extent, again, these things influence bargaining power, which is not something I concede, this merger creates greater bargaining power on Sanford's behalf. It really gives it the potential to punch a real hole in Blue Cross's network in a way that didn't exist before.").

3. [redacted]

190. [redacted]

[redacted]

191. [redacted]

4. ***Other providers have*** [redacted]

192. [redacted]

P[redacted]).[redacted].

193. [redacted]

5. [redacted]

194. A July 2015 [redacted] circulated by Sanford's corporate contracting department noted that [redacted] and

concluded that following the process, [redacted] PX04158 at 001–002; *see also* PX04157 at 001, 003 (internal Sanford email from Sanford's Project Manager in the Strategic Reimbursement and Office of Health Reform department circulates a [redacted]; PX04081 at 001, 003, 005.

195. BlueAlliance is a value-based program launched by BCBS in July 2016 that reimburses providers based on a variety of quality-based metrics. [redacted] In 2016, Torrey Sundall, Sanford's Senior Director of Corporate Contracting, informed his department that he "was successful in negotiating more favorable terms" for Sanford's BlueAlliance contract with BCBS. PX04075 at 001–002. As a result of these negotiations, Sanford "received a [redacted]" in a potential shared savings bonus and BCBS "[redacted]" PX04075 at 001–002. Sanford was also able to get BCBS "to agree to about 95% of [Sanford's] redlines to the contract" as a result of these negotiations. PX04075 at 001–002; *see also* PX04156 at 001 (internal July 21, 2016 Sanford email notes that Sanford has [redacted] PX04080 at 001 (Sanford [redacted]

196. In 2016, PrimeCare [redacted] PX05236 at 001; PX05025 at 001–002; JX00024 (Lein) Dep. Tr. 151–152; JX00003 (Kuntz) IH Tr. 191–195; *id.* at 210–217; *see also id.* at 202–204; [redacted]

compare PX05021 at 029 ( ) *with* JX00049 at 037 ( )

197. Defendants regularly describe . *See, e.g.*, PX04075 at 001 ; PX04081 at 005); PX04156 at 001 ; PX04157 at 001 (email attaching ; PX04158 at 002 (email attaching); PX04160 at 001 ; PX04161 at 001–002 ; PX04162 at 001 ; PX05098 at 001 ; PX05190 at 002 ; PX05192 at 001 ; PX05202 at 001 (; *see also* PX04222 at 001); PX04225 at 002 ; PX04221 at 001 ;

[redacted]

[redacted]

6. BCBS's market share is declining, both statewide and in the Bismarck-Mandan Area

198. To the extent Dr. Town attributes BCBS's bargaining power to its size, BCBS's market share has declined in recent years. PX06000 ¶ 270, n. 344; PX06003 ¶¶ 30–35; DX6000 ¶ 35, Tbl. IV.1.

199. Statewide, BCBS's commercial insurance market share is [redacted] PX04308 at 004 (Sanford Health Plan comparison document shows that [redacted]; PX04318 at 009 (based on premiums written, Sanford Health Plan calculated BCBS's statewide market share at [redacted], with Sanford Health Plan's market share as [redacted]); DX6000 ¶ 35, Tbl. IV.1 (BCBS's share in 2016 was [redacted].

200. [redacted]

201. Sanford and MDC have acknowledged that BCBS's market share is declining. *See, e.g.*, PX05064 at 001 (MDC's CFO wrote in April 2016 that BCBS is [redacted] JX00028 (Krabbenhoft) Dep. Tr. 183–184 [redacted]); PX04316 at 001 (Sanford Health Plan's Executive Vice President acknowledges in

January 2017 that BCBS [redacted]).

202. By comparison, Sanford Health Plan's commercial membership has [redacted] since [redacted]. In the Bismarck-Mandan Area, Sanford Health Plan gained approximately [redacted] commercially insured members from [redacted] Statewide, Sanford Health Plan has more than [redacted] commercially insured members, compared to approximately [redacted]. PX06000 ¶ 270, n.344; PX04255 at 001.

203. North Dakota's largest employer group, NDPERS (with approximately 65,000 members), switched its health insurance carrier from BCBS to Sanford Health Plan in July 2015, and NDPERS renewed its contract with Sanford Health Plan in September 2016 for two more years to run through June 2019. DX6000 App'x A ¶ 7; [redacted] PX08113 at 001; PX08142 at 001. NDPERS is a contract that "goes through an RFP process on a regular basis," and Sanford Health Plan had [redacted]. Leclerc (Sanford) Hrg. Tr. Vol. 3 at 182. [redacted]

204. [redacted]

7. BCBS's bargaining power does not protect other insurers or ameliorate quality harm

205. Even if BCBS's bargaining power did prevent price harm to BCBS, that would not limit harm to other insurers and their enrollees and families. PX06000 ¶¶ 277–278. Any ability to constrain pricing still leaves the loss of incentive to compete on quality, which affects not only

BCBS's customers but also other insurers' members, and government-insured as well as uninsured patients. PX06000 ¶ 236; *see* Sacher Hrg. Tr. Vol. 2 at 59, 106.

B. The [redacted] in the Sanford-Medica Agreement Is Insufficient to Mitigate Harm

206. [redacted]. JX00083. [redacted] Lenz (Medica) Hrg. Tr. Vol. 1 at 189–190.

207. NISC obtains their health insurance through United, and United leases the Medica network, including Medica's rate agreements with providers. Reichert (NISC) Hrg. Tr. Vol. 2 at 158. The [redacted] Reichert (NISC) Hrg. Tr. Vol. 2 at 183–185.

208. The merged entity could also exercise its increased leverage post-Transaction even while the [redacted] is in place. For example, the Proposed Transaction may [redacted] Lenz (Medica) Hrg. Tr. Vol. 1 at 190 [redacted] *see also* *id.* at 184–185; Jha Hrg. Tr. Vol. 4 at 238 (describing how cardiologists perform more invasive and higher cost procedures when concentration increases); PX06005 ¶¶ 11–15.

C. Entry or Repositioning by CHI or Others Would Not Be Timely, Likely, and Sufficient to Deter or Counteract Competitive Harm

209. The potential for entry to counteract or deter the competitive effects arising from the Proposed Transaction must be considered in the context of the two-stage model of healthcare competition. Sacher Hrg. Tr. Vol. 2 at 107; PX06003 ¶ 134. For entry to offset the competitive harm from the Proposed Transaction, the new entrant must be of sufficient size and scope for commercial insurers to be able to credibly threaten to exclude the post-merger Sanford from their provider networks. Sacher Hrg. Tr. Vol. 2 at 107–108; PX06003 ¶ 137.

1. Any entity seeking to enter or reposition to replace or replicate MDC's competitive significance will face a number of challenges

a) Physician recruitment to the Bismarck-Mandan Area generally is difficult and takes a long time

210. Recruiting physicians to the Bismarck-Mandan Area is challenging because of its cold weather and geographic isolation. JX00010 (Tanous) IH Tr. 40 ("[W]e're, obviously in this geographical location in North Dakota where it's very hard to recruit physicians."); JX00002 (Lein) IH Tr. 225–226; PX03009 ¶ 39; JX00025 (Helbling) Dep. Tr. 113; JX00027 (Kyaw) Dep. Tr. 159-161, 209; *see also* JX00022 (Seifert) Dep. Tr. 145-146 (recruiting physicians to Bismarck is difficult because "[t]he location is not ideal[,] [t]he weather is not ideal").

211. It is difficult to recruit physicians to work in the Bismarck-Mandan Area who do not already have ties to the area or at least to North Dakota. Schley (CHI) Hrg. Tr. Vol. 1 at 106–107; *see also* JX00010 (Tanous) IH Tr. 43; JX00027 (Kyaw) Dep. Tr. 160–161, 164; JX00025 (Helbling) Dep. Tr. 116–117 (difficult to recruit a good quality general surgeon to the Bismarck-Mandan Area that is going to stay in the Bismarck-Mandan Area because not many people want to move to North Dakota).

212. North Dakota lacks an OB/GYN residency program and a pediatrician residency program, which makes it difficult for all providers in Bismarck to recruit OB/GYNs and pediatricians. JX00022 (Seifert) Dep. Tr. 144–145.

213. Sanford's own internal recruiting plans estimate it will take [redacted] to recruit new physicians to Bismarck. *See* PX04056 at 001; PX04124 at 001.

214. Sanford begins recruiting physicians [redacted] and often begins recruiting during a physician's medical school or residency. JX00008 (Hocks) IH Tr. 361. Similarly, MDC starts recruiting some physicians right after medical school and before they enter residency. JX00024 (Lein) Dep. Tr. 180. Physician residencies can take three years and sometimes as long as five years. *See, e.g.*, JX00021 (LeBeau) Dep. Tr. 29; JX00025 (Helbling) Dep. Tr. 20–21.

b) Call coverage poses an additional hurdle to hiring pediatricians, OB/GYNs, and general surgeons

215. For specialties with call coverage requirements, it is more difficult to recruit to a group with less than four physicians than to recruit to a larger group. JX00025 (Helbling) Dep. Tr. 113–115. Moreover, it is easier to recruit physicians for specialty practices that require call coverage, such as pediatricians, OB/GYNs, and general surgeons, if the practice already has more physicians in the practice to help spread out call coverage. Bury (MDC) Hrg. Tr. Vol. 2 at 24–25; JX00028 (Krabbenhoft) Dep. Tr. 212–213; JX00010 (Tanous) IH Tr. 49–51.

216. A sustainable OB/GYN practice needs a minimum of four to five OB/GYNs. A solo OB/GYN would have to be on call all the time—even if a new entrant was willing to do so, it would likely lower the quality of care. Bury (MDC) Hrg. Tr. Vol. 2 at 24–25; JX00014 (Bury) IH Tr. 138–139, 148–149; *see also* PX04285 at 001 (referring to how Dr. Bury would not want to be on call by herself at CHI post-Transaction); JX00025 (Helbling) Dep. Tr. 115 (difficult to recruit to a group of OB/GYNs in Bismarck that only had one or two OB/GYNs).

217. General surgeon call requirements make it unlikely that a general surgeon would operate a solo practice or that a hospital or physician group would recruit a single general surgeon to start a general surgery group. JX00010 (Tanous) IH Tr. 50–51; JX00008 (Hocks) IH Tr. 59–60 (very difficult to recruit to a practice of one because of call coverage); JX00025 (Helbling) Dep. Tr. 114–115. Having a small number of partners makes call coverage onerous for general surgeons. JX00025 (Helbling) Dep. Tr. 114.

c) General surgeons also require a referral source, posing an additional recruitment challenge

218. In addition to the challenges set forth above, general surgeons also require referral sources. JX00011 (Seifert) IH Tr. 150. That is, general surgeons need a referral base to provide enough patients to make their practice profitable and depend on PCPs to provide referrals and post-surgery care. JX00011 (Seifert) IH Tr. 150; JX00027 (Kyaw) Dep. Tr. 88–89, 190–191.

219. An independent general surgeon in the Bismarck-Mandan Area would be unlikely to receive referrals because PCPs and other physicians are likely to refer patients to affiliated general surgeons. JX00011 (Seifert) IH Tr. 150.

d) Building an independent practice requires space, other personnel, equipment, and insurance

220. The costs to establish an independent PCP practice in the Bismarck-Mandan Area include office space and equipment, personnel, EMR, and insurance. JX00011 (Seifert) IH Tr. 150–151; PX03007 ¶¶ 13-14; PX03001¶ 14; PX03006 ¶ 23; PX03003 ¶ 15; PX03000 ¶ 10. Establishing a new independent practice, such as an OB/GYN practice, would require a "huge financial outlay." Bury (MDC) Hrg. Tr. Vol. 2 at 24; *see also* PX03018 ¶¶ 16, 17 (citing startup costs of $1.2 million financed with debt and personal assets). A new PCP practice would also need to advertise to build a patient base. PX03001 ¶ 14. A local labor shortage makes starting an independent practice even more challenging. JX00004 (Lambrecht) IH Tr. 94 (the "shortage in

workforce and labor" poses a "significant risk and problem area" for starting an independent practice in Bismarck or Mandan).

2. It will take CHI many years to hire physicians providing the Relevant Services and to build the space and patient base to replace MDC

221. Historically, CHI has not employed adult PCPs, pediatricians, OB/GYNs, or general surgeons in the Bismarck-Mandan Area. JX00027 (Kyaw) Dep. Tr. 20–21. CHI's employed physicians are primarily inpatient-based, except for five PCPs practicing in a clinic in Mandan. Schley (CHI) Hrg. Tr. Vol. 1 at 77–78.

222. CHI's recruiting process [redacted]. Schley (CHI) Hrg. Tr. Vol. 1 at 109–110; *see also id.* at 83–84 (CHI's five PCPs in Mandan are operating at [redacted]).

223. It is difficult for CHI to recruit physicians to join a new clinic offering a service it has not offered before. *See* JX00027 (Kyaw) Dep. Tr. 159–160; *see also* JX00030 (S. McDonough) Dep. Tr. 125–126 (Dr. McDonough chose not to join CHI in part because he would have been the only pediatrician there).

224. In order to replace the lost MDC PCPs after the Proposed Transaction, CHI would first need to recruit physicians. It would take, conservatively, [redacted] just to recruit those physicians. Schley (CHI) Hrg. Tr. Vol. 1 at 108. Even after recruitment, CHI [redacted] Schley (CHI) Hrg. Tr. Vol. 1 at 108. CHI would have to [redacted] Schley (CHI) Hrg. Tr. Vol. 1 at 108. As a result, CHI estimates that it may take [redacted]

to hire enough PCPs, open sufficient clinic space, and establish a patient base large enough to replace the PCP services currently offered by MDC. Schley (CHI) Hrg. Tr. Vol. 1 at 108; PX03009 ¶¶ 41–42.

225. CHI does not currently employ any pediatricians. It is difficult for a provider group to recruit a pediatrician if that provider group does not already employ other pediatricians. JX00027 (Kyaw) Dep. Tr. 167–170. CHI would need to hire a critical mass of pediatricians to share call coverage and build a reputation to compete with MDC and Sanford for pediatric patients. CHI estimates it could take [redacted] to create an equivalent practice. Schley (CHI) Hrg. Tr. Vol. 1 at 114–116, 148 ([redacted]). CHI does not currently employ any OB/GYNs. Having fewer than four OB/GYNs will likely hinder CHI's efforts to recruit OB/GYNs. JX00014 (Bury) IH Tr. 138. CHI's [redacted] Schley (CHI) Hrg. Tr. Vol. 1 at 116; PX03009 ¶ 46; JX00014 (Bury) IH Tr. 121–126, 150.

226. CHI has [redacted]. Schley (CHI) Hrg. Tr. Vol. 1 at 117–118. Dr. Bury, a current MDC OB/GYN, has signed a letter of intent to join CHI, but she may retire instead of joining CHI. Schley (CHI) Hrg. Tr. Vol. 1 at 117, 157; Bury (MDC) Hrg. Tr. Vol. 2 at 23. [redacted] Schley (CHI) Hrg. Tr. Vol. 1 at 117–118 ([redacted]).

227. CHI does not currently employ any general surgeons. It is difficult for a provider group to recruit a general surgeon if that provider group does not already employ other general

surgeons. JX00027 (Kyaw) Dep. Tr. 186–187; JX00010 (Tanous) IH Tr. 50–51 (easier to recruit general surgeons when practice has more physicians to share call coverage).

228. In order to build up a general surgeon practice group, CHI will need to recruit approximately [redacted] general surgeons to share call duties, and those general surgeons will need to build up their reputations in the community. It will take CHI [redacted] to recruit [redacted] general surgeons. Schley (CHI) Hrg. Tr. Vol. 1 at 118–120, 151; PX03009 ¶ 48; JX00027 (Kyaw) Dep. Tr. 185–86.

229. CHI currently [redacted] JX00027 (Kyaw) Dep. Tr. 170, 198. This factor, coupled with the fact that CHI does not currently employ any pediatricians or general surgeons, may further dissuade pediatricians or general surgeons from joining CHI. JX00030 (S. McDonough) Dep. Tr. 125–126; JX00027 (Kyaw) Dep. Tr. 218.

230. *Locum tenens* are physicians contracted out on a temporary basis to fill in for other physicians. JX00010 (Tanous) IH Tr. 109; PX03009 ¶ 45. They are not, however, a substitute for employed physicians. *Locum tenens* are approximately [redacted] more expensive than employed physicians and are [redacted]. Patients prefer seeing employed physicians who have built a reputation and have practiced in the community as opposed to seeing *locum tenens*. Schley (CHI) Hrg. Tr. Vol. 1 at 120–121; PX03018 ¶ 20.

3. CHI's existing resources do not address challenges

231. CHI [redacted] Schley (CHI) Hrg. Tr. Vol. 1 at 110–111; JX00027 (Kyaw) Dep. Tr. 205–207. Hospitalists do not typically work in the primary care or outpatient setting. Schley (CHI) Hrg. Tr. Vol. 1 at 111; *see also* JX00016 (Schley) Dep. Tr. 79 ([redacted]").

Moreover, if CHI shifted hospitalists to work in the primary care setting, CHI would then face a shortage in the supply of hospitalists. Schley (CHI) Hrg. Tr. Vol. 1 at 111.

232. CHI, like other providers, generally [redacted] JX00027 (Kyaw) Dep. Tr. 98, 164; *see also* LeBeau (Sanford) Hrg. Tr. Vol. 3 at 83 (Sanford Bismarck does not force physicians to relocate, and LeBeau is unfamiliar with any other health system forcing physicians to relocate); JX00008 (Hocks) IH Tr. 349–350; JX00028 (Krabbenhoft) Dep. Tr. 200–203.

233. CHI [redacted] Schley (CHI) Hrg. Tr. Vol. 1 at 111–113. CHI [redacted]. Schley (CHI) Hrg. Tr. Vol. 1 at 113. [redacted] JX00016 (Schley) Dep. Tr. 66.

4. Sufficient expansion by other providers, or new entry, is even less likely

234. Other existing Bismarck-Mandan Area practices are significantly smaller and lack the resources or ability to sufficiently expand. PX03018 ¶ 18; PX03006 ¶ 24; PX03001 ¶ 14.

235. PCPs new to Bismarck face the burden of establishing a patient base, which is "critical" for a new practice and can take a number of years to build. JX00001 (Hurley) IH Tr. 178; PX03007 ¶ 14 (Dr. Smith practiced family medicine in Bismarck for 20 years before opening his independent practice); PX03001 ¶ 14 (Dr. Baker provided primary care services at MedCenter One for 10 years before opening his independent practice); JX00030 (S. McDonough) Dep. Tr.

116–117 ("[i]t was critical" for Independent Doctors' two co-owners to have existing patient bases before opening the practice).

D. Defendants Failed to Substantiate Cognizable Efficiencies Sufficient to Prevent Harm from This Merger

1. Defendants failed to present verifiable, merger-specific cost efficiencies

236. Based on the Deloitte Report, Defendants claim that the Proposed Transaction would result in [redacted] in net cost savings in the first [redacted] after closing and [redacted] annually thereafter. PX06001 ¶ 38. [redacted] Respess Hrg. Tr. Vol. 2 at 194; *see* Ahern (Deloitte) Hrg. Tr. Vol. 4 at 32.

237. Deloitte's projected [redacted] net annual cost savings figure includes approximately [redacted] in net annual laboratory savings that were already achieved by MDC independently before Deloitte completed its analysis. Respess Hrg. Tr. Vol. 2 at 205. Lisa Ahern, Defendants' testifying consultant from Deloitte, only learned about these savings after reading the report of Dr. Thomas Respess, Plaintiffs' efficiencies expert, and has not provided an updated analysis to counsel for any party in this litigation reducing the total net savings figure by the amount of lab savings MDC achieved independently. Ahern (Deloitte) Hrg. Tr. Vol. 4 at 37.

238. All of Defendants' claimed cost savings are either not substantiated or not merger specific. Respess Hrg. Tr. Vol. 2 at 192–193; PX06001 ¶ 18.

a) The largest category of claimed cost savings, cancer care, is not related to any of the Relevant Services Markets, is not substantiated, and is speculative, and will not be passed through to customers

239. The largest category of claimed net annual cost savings in the Deloitte Report is cancer care, amounting to approximately [redacted] annual savings beginning in [redacted] post-transaction. Respess Hrg. Tr. Vol. 2 at 195; PX06001 ¶ 43.

240. The claimed cancer care cost savings are unrelated to any of the Relevant Services Markets, and neither Deloitte nor Defendants have shown why the acquisition of MDC's physician practices in the Relevant Services Markets is necessary to accomplish these savings. PX06001 ¶ 52. Deloitte did not analyze whether the claimed cost savings could be achieved if, instead of acquiring MDC's entire practice, Sanford hired only MDC's oncologists. Ahern (Deloitte) Hrg. Tr. Vol. 4 at 33.

241. Further, the claimed cancer care savings are not substantiated and are speculative, and the estimated offsetting costs to achieve the purported savings in this area are not substantiated. Respess Hrg. Tr. Vol. 2 at 196; PX06001 ¶ 44.

242. Deloitte's cost savings estimates in the cancer care area are premised on the key assumption that Sanford Bismarck will continue to qualify for its current DSH status under the 340B drug pricing program post-transaction. PX06001 ¶ 47. However, the shift of MDC patients from CHI to Sanford Bismarck could cause Sanford Bismarck to move from DSH status to Rural Referral Center status under the 340B program and thus lose approximately [redacted] it achieves as a DSH, entirely offsetting the annual cancer care savings contemplated by Deloitte. Respess Hrg. Tr. Vol. 2 at 197–200; PX06001 ¶ 47; PX04256 at 001, 004.

243. Deloitte has not analyzed the potential impact of the transaction on Sanford Bismarck's DSH status. Ahern (Deloitte) Hrg. Tr. Vol. 4 at 33. Although Sanford's Ms. Leclerc testified that she conducted such an analysis after her deposition, her method was at best unclear and at worst incorrect, and the written results of her analysis have not been provided to counsel for any party to this litigation or to Deloitte. *See* Leclerc (Sanford) Hrg. Tr. Vol. 3 at 132, 134–135, 187–189; Jha Hrg. Tr. Vol. 4 at 234, 236–237. As best as can be determined, the calculation Ms.

Leclerc described focused only on the increase in commercially insured patients that would affect Sanford Bismarck's DSH status, but failed to account for the change in Medicare and Medicaid patients that would also affect Sanford Bismarck's DSH status. Jha Hrg. Tr. Vol. 4 at 234–237 (explaining that the DSH formula has additional variables such as Medicare patients or Medicaid patients that Ms. Leclerc did not appear to consider); *see also* PDX005-001. Thus, Deloitte's oncology drug purchasing cost savings claim has not been substantiated. *See* Respess Hrg. Tr. Vol. 2 at 197–200; Leclerc (Sanford) Hrg. Tr. Vol. 3 at 188–189.

244. The magnitude of the claimed savings from oncology supply purchasing is also speculative given the uncertainty surrounding the future of the 340B program. Respess Hrg. Tr. Vol. 2 at 202; PX06001 ¶ 49; *see* PX04224 at 002–003, 005; PX04231 at 001–003; PX08030 at 001–002; *see also* Ahern (Deloitte) Hrg. Tr. Vol. 4 at 33–34 (Deloitte has not updated its analysis to account for the final CMS rule reducing reimbursements to 340B hospitals).

245. The Deloitte Report's estimated one-time costs and timeframe to consolidate infusion services facilities at Sanford Bismarck—a necessary condition to achieve the projected cancer care cost savings—are based on "rough[]", "preliminar[y]", and "tentative[]" estimates provided by Sanford personnel that have not been substantiated. Respess Hrg. Tr. Vol. 2 at 203; PX06006 ¶ 3; PX07043 at 001; *see also* PX07053 at 001. A longer timeline for infusion center consolidation would delay the realization of Deloitte's projected oncology drug purchasing cost savings beyond the timeframe in the Deloitte Report, and any additional costs required to build the combined infusion center would reduce Deloitte's total net claimed cost savings. Respess Hrg. Tr. Vol. 2 at 203–204.

246. Defendants and their expert, Dr. Town, have not conducted an analysis sufficient to show that any of the projected 340B savings will be passed through to healthcare consumers.

PX06003 ¶¶ 164–172; *see also* Lenz (Medica) Hrg. Tr. Vol. 1 at 217 ("[T]ypically the 340B results in savings to the system, not necessarily the health plan . . . so if there's a 340B savings, that generally accrues to the provider.").

b) The majority of Defendants' other claimed cost savings, as set forth in the Deloitte Report, are not substantiated or verifiable

247. Deloitte's projected cost savings in the human resources area are based on flawed methodologies and are highly speculative because they are largely based on cost savings opportunities that may not be available post-transaction, that is, appropriate open back office positions at Sanford for duplicative MDC personnel. PX06001 ¶¶ 56–59; PX06006 ¶ 5; *see* JX00013 (Ahern) IH Tr. 220–222, 233–234; JX00023 (Ahern) Dep. Tr. 102–106, 111–113.

248. Deloitte's asserted cost savings for revenue cycle, IT, and infrastructure rely on Sanford personnel's high-level estimates of the cost to bring MDC onto Sanford's third-party IT and EMR contracts, but those costs were not independently substantiated by Deloitte or verified by the third parties who will be providing services to the combined entity post-transaction. Respess Hrg. Tr. Vol. 2 at 205; PX06001 ¶ 68; JX00013 (Ahern) IH Tr. 284–285; *see also* JX00069 at 002; JX00070 at 002. Due to the significant one-time costs of the proposed changes in revenue cycle, IT, and infrastructure, it will take approximately [redacted] for net annual savings to be realized. Respess Hrg. Tr. Vol. 2 at 205–206; PX06001 ¶ 67.

249. The purported cost savings in pathology, inpatient services, marketing and promotional services, printing, physician recruiting, and radiology service areas are not substantiated. PX06001 ¶¶ 30-32, 63, 77–78, 81–82, 86-88, 136–137, 139; PX06006 ¶¶ 6–9, 12–13.

c) Defendants' remaining cost savings claims, as set forth in the Deloitte Report, are not merger specific

250. The asserted cost savings in the laundry, collection agency, risk management, and employee benefit areas are not merger specific because the collection agency and employee

benefit savings could be achieved by MDC independently, and the laundry and risk management savings could be achieved by MDC through an alternative transaction. Respess Hrg. Tr. Vol. 2 at 210; PX06001 ¶¶ 33, 61, 74, 122–123, 128–130.

251. CHI would potentially be an alternative purchaser of MDC. Schley (CHI) Hrg. Tr. Vol. 1 at 95 (CHI would be interested in reopening merger discussions with MDC).

d) Sanford's synergy claims from past transactions do not substantiate Defendants' cost savings claims for the Proposed Transaction

252. Sanford's Medcenter One acquisition is not an analogous past experience for Sanford to cite to substantiate Defendants' efficiency claims, as the purported synergies Sanford claims from the Medcenter One acquisition do not appear to be merger-specific efficiencies. PX06001 ¶ 35. Rather, the majority are cost expenditures or financial investments—as opposed to resource savings—and did not require a merger or acquisition by Sanford to be achieved. PX06001 ¶ 35; *see* JX00037 at 002–003; Krabbenhoft (Sanford) Hrg. Tr. Vol. 3 at 18–19.

e) Defendants' claimed cost efficiencies do not offset the competitive harm from the Proposed Transaction

253. Even if ***all*** of Defendants' claimed cost efficiencies are merger-specific and verifiable, they would be insufficient to offset the likely increase in prices resulting from the Proposed Transaction. Dr. Sacher calculated that the Proposed Transaction will result in UPP in the range of [redacted] annually. Even the lower bound of the UPP far outweighs the [redacted] cost efficiencies claimed by Defendants. PX06000 ¶¶ 210–213 & App'x IX; Sacher Hrg. Tr. Vol. 2 at 112–114.

2. Defendants failed to present verifiable, merger-specific quality efficiencies

a) Benefits claimed in Stronger Together *are speculative*

254. Defendants' counsel drafted the short document called *Stronger Together*. *See* Hocks (Sanford) Hrg. Tr. Vol. 3 at 230–231; JX00008 (Hocks) IH Tr. 25; PX06002 ¶ 16. The document contains less than eight text pages of high-level discussion of theoretical gains purported to arise as a result of the Proposed Transaction, and was created after the parties decided to merge. *See* Jha Hrg. Tr. Vol. 2 at 243; Hocks (Sanford) Hrg. Tr. Vol. 3 at 230–233; PX06002 ¶ 16. *Stronger Together* contains very few details concerning how any alleged efficiencies would be achieved. Jha Hrg. Tr. Vol. 2 at 243. Defendants have not identified any strategies to improve quality following the Proposed Transaction. JX00008 (Hocks) IH Tr. 250.

255. Defendants undertook little to no analysis concerning quality efficiencies. *See* JX00008 (Hocks) IH Tr. 218–219; Seifert (MDC) Hrg. Tr. Vol. 4 at 202–203 (synergy team has not done any "practical work"); LeBeau (Sanford) Hrg. Tr. Vol. 3 at 85–86 (no future planning done at synergy meetings); PX06002 ¶ 16; *see also* JX00022 (Seifert) Dep. Tr. 16–17 (process outlined "conceptual plans"). MDC's medical director described the meeting behind *Stronger Together* as "a get-together, if you will, to know who was who, but that's about it." JX00010 (Tanous) IH Tr. 267–268. Sanford Bismarck's Executive Vice President described synergy efficiencies as "conjecture." JX00004 (Lambrecht) IH Tr. 124. Defendants failed to conduct any analysis noting where one defendant might be deficient in some area, or where the Proposed Transaction might result in benefits. Hocks (Sanford) Hrg. Tr. Vol. 3 at 239–240; PX06002 ¶ 18. In any event, Defendants could improve quality without the Proposed Transaction. *See* Hocks (Sanford) Hrg. Tr. Vol. 3 at 233.

b) Defendants currently offer or plan to offer many claimed benefits

256. Defendants' historical service expansions suggest the Proposed Transaction is not necessary to bring additional services to the Bismarck-Mandan Area. *See* Jha Hrg. Tr. Vol. 2 at 247–248; PX06002 ¶¶ 20–23; LeBeau (Sanford) Hrg. Tr. Vol. 3 at 71–73. Defendants have purchased new equipment, updated technology, expanded services, recruited physicians, and provided patients with convenient and accessible health care without the Proposed Transaction. Complaint ¶ 3; Sanford Answer ¶ 3; MDC Answer ¶ 3. Sanford recently constructed its Sanford Children's North Clinic. Jha Hrg. Tr. Vol. 2 at 247; PX06002 ¶ 20; *see* PX08036 at 001. MDC recently expanded and added pediatric services to its Gateway Mall clinic. Seifert (MDC) Hrg. Tr. Vol. 4 at 193-194; Jha Hrg. Tr. Vol. 2 at 247; PX06002 ¶ 20; *see* PX05136 at 001–002. Both defendants acquired and implemented 3D mammography to benefit patients. Jha Hrg. Tr. Vol. 2 at 248; PX06002 ¶ 21; JX00014 (Bury) IH Tr. 86–88.

257. MDC already offers a PCMH model, another synergy claimed in *Stronger Together*, and MDC's model has earned the highest distinction nationally—only 4% of physician practices nationwide have achieved this distinction. Jha Hrg. Tr. Vol. 2 at 259–260; PX06002 ¶ 52; JX00024 (Lein) Dep. Tr. 229; PX05071 at 001; PX08001 at 001. Mr. Hocks was unaware of whether MDC had a PCMH model. JX00008 (Hocks) IH Tr. 30–31.

258. *Stronger Together* also identifies a comprehensive diabetes program as a potential benefit, but Sanford plans to develop such a program regardless of the Proposed Transaction. JX00008 (Hocks) IH Tr. 70. MDC could offer one independently or in conjunction with CHI—similar to an existing joint bariatric program between MDC and CHI. *See* PX06002 ¶ 24; JX00025 (Helbling) Dep. Tr. 13-15.

259. Defendants already offer same-day access or scheduling, another synergy claimed in *Stronger Together*. *See* PX06002 ¶ 57; Hocks (Sanford) Hrg. Tr. Vol. 3 at 195–196; JX00010

(Tanous) IH Tr. 165–166. Many physician practices across the nation offer same-day access or scheduling with far fewer physicians than MDC. *See* PX06002 ¶ 58. Independent Doctors, a physician practice in Bismarck smaller than MDC, offers same-day access with only a few full-time physicians. PX06002 ¶ 59; PX03018 ¶¶ 4–5, 10. Several third parties and other resources also provide assistance with same-day access and scheduling. *See* PX06002 ¶ 60. Mr. Hocks was unaware that MDC already offers same-day access. JX00008 (Hocks) IH Tr. 47.

260. The Proposed Transaction is unnecessary for MDC to clinically integrate and coordinate care. Jha Hrg. Tr. Vol. 2 at 252–258. Clinical integration and care coordination allow healthcare providers to facilitate care for patients across different settings through communication and information flow. Jha Hrg. Tr. Vol. 2 at 252; *see* PX06002 ¶ 36; PX08038 at 001–002. Clinical integration and care coordination do not require merging, and do not require using the same EMR. Jha Hrg. Tr. Vol. 2 at 253; PX06002 ¶ 35–42; PX08069 at 001; PX03006 ¶ 19; PX03001 ¶ 16; JX00005 (Cristy) IH Tr. 128. Independent physician groups clinically integrate and coordinate care successfully around the country. *See* PX06002 ¶¶ 43–45.

261. MDC and CHI already clinically integrate and coordinate care today by sharing data and information. *See* Jha Hrg. Tr. Vol. 2 at 255–258; PX06002 ¶ 39; JX00010 (Tanous) IH Tr. 187–191; JX00011 (Seifert) IH Tr. 157–158; PX05003 at 001. Readmission rates reflect clinical integration and care coordination because they reflect information flow and communication between a hospital and physician groups. Jha Hrg. Tr. Vol. 2 at 254–255; PX06002 ¶ 40. Readmission rates are good proxies for clinical integration and care coordination between MDC and CHI because MDC physicians provide a large portion of outpatient care for CHI's patients. *See* Jha Hrg. Tr. Vol. 2 at 254–258; PX06002 ¶ 41; JX00025 (Helbling) Dep. Tr. 89-90; PX03009 ¶¶ 32–35. A review of readmission rates shows that MDC and CHI clinically integrate

and coordinate care as independent entities more effectively than Sanford does with its own physicians. Jha Hrg. Tr. Vol. 2 at 256–257; PX06002 ¶ 42.

c) Defendants could pursue other claimed benefits independently

262. The Proposed Transaction is unnecessary for Defendants to recruit the subspecialists identified in *Stronger Together*. Jha Hrg. Tr. Vol. 2 at 249–252. A subspecialist has further training and expertise within a specialty, such as an MFM physician, a subspecialist that focuses on high-risk pregnancies. Jha Hrg. Tr. Vol. 2 at 249–250. The number of patients in a given area and their clinical needs determine whether an area can support a subspecialist. Jha Hrg. Tr. Vol. 2 at 250; PX06002 ¶¶ 28–30; *see* JX00008 (Hocks) IH Tr. 185–190; PX03021 ¶ 4. Since the Proposed Transaction will not affect the number of patients in the Bismarck-Mandan Area or their clinical needs, there is no effect on the ability to recruit subspecialists. Jha Hrg. Tr. Vol. 2 at 250–251; PX06002 ¶ 30.

263. Defendants are currently recruiting subspecialists identified in *Stronger Together*. *See* PX06002 ¶ 32. Sanford recently hired an MFM physician. JX00021 (LeBeau) Dep. Tr. 64–66; Hocks (Sanford) Hrg. Tr. Vol. 3 at 215; Jha Hrg. Tr. Vol. 2 at 251. MDC is independently considering hiring *Stronger Together*-identified subspecialists even if the Proposed Transaction does not occur. *See* JX00014 (Bury) IH Tr. 164–165. Sanford could recruit the other *Stronger Together* subspecialists without the Proposed Transaction. Hocks (Sanford) Hrg. Tr. Vol. 3 at 215–216; JX00005 (Cristy) IH Tr. 192.

264. MDC does not need the Proposed Transaction to offer other benefits identified in *Stronger Together*, such as Imagenetics, a genetic testing and genetic medicine project, and embedded behavioral health in primary care. *See* Jha Hrg. Tr. Vol. 2 at 261–264. Regarding Imagenetics, dozens of companies already offer genetic testing—including Athena, MDC's EMR—and the majority of healthcare providers in the country use genetic testing and genetic

medicine to benefit their patients. *See* Jha Hrg. Tr. Vol. 2 at 261–262; Jha. Hrg. Tr. Vol. 4 at 232–233. Mr. Hocks was unfamiliar with other EMR systems offering the same benefits as Imagenetics. Hocks (Sanford) Hrg. Tr. Vol. 3 at 237–238. Embedding behavioral health into primary care clinics also does not require the Proposed Transaction. *See* Jha Hrg. Tr. Vol. 2 at 262–264; PX06002 ¶¶ 54–56. This practice is common and many third parties offer assistance to embed behavioral health. Jha Hrg. Tr. Vol. 2 at 263–264; PX06002 ¶ 56. Several physician practices, including many smaller than MDC, have successfully embedded behavioral health into primary care. *See* Jha Hrg. Tr. Vol. 2 at 263–264; PX06002 ¶ 55. Mr. Hocks testified that MDC could independently employ and embed behavioral health therapists without the Proposed Transaction. JX00008 (Hocks) IH Tr. 33.

E. MDC is Financially Sound and Will Remain a Viable Competitor

1. MDC is profitable today, its revenues are increasing, and its outlook is positive

265. MDC is profitable today and has strong operating net income and volumes. JX00005 (Cristy) IH Tr. 86–87 (MDC is profitable today and will continue to be profitable); JX00012 (Schaaf) IH Tr. 57 (MDC was profitable in 2016); Seifert (MDC) Hrg. Tr. Vol. 4 at 201–202 ("there are plenty of patients" for MDC physicians who want to increase productivity).

266. MDC's revenue growth, bill collection rates, profit margins, physician compensation, debt, net working capital, and cash flows all show that MDC is financially stable. PX06001 ¶¶ 19, 110-118. MDC's net working capital and current and total liabilities show that it has a favorable liquidity and operates with little debt. PX06001 ¶ 113; PX05270 at 004; PX05269 at 004. From 2014 through 2016, MDC's total revenues showed healthy growth, and MDC's operating profit margin before physician compensation was stable and healthy. PX06001 ¶ 112; PX05269 at 005; PX07032 at 005. MDC's total revenues increased for each of the last three years despite

MDC's CFO predicting a 27% decrease in ancillaries and other revenues beginning in 2014. Seifert (MDC) Hrg. Tr. Vol. 4 at 164–165, 204–206. MDC had a strong 2016 financial performance based on increased billed and collected revenues since the prior year. PX06001 ¶ 114; PX05109 at 001–003; PX05114 at 002; PX05272 at 001–003; PX05158 at 002 (August 2016 financials "included a record setting collected receipt amount" and "strong productivity data").

267. In 2016, MDC physician compensation represented [redacted] of the MGMA benchmark, meaning that MDC physicians were compensated at [redacted] above the national industry benchmark. JX00012 (Schaaf) IH Tr. 57; PX05114 at 002. Dr. Bury testified that her salary has gone up each of the 23 years she has worked at MDC. Bury (MDC) Hrg. Tr. Vol. 2 at 8, 23.

268. Two different independent consultants, HDH Advisors and Wipfli, reached the same conclusion in 2016 that "[redacted]." Both consultants also projected [redacted]." PX05244 at 017; JX00045 at 28; *see also* JX00012 (Schaaf) IH Tr. 207–208. Sanford and MDC executives relied on the HDH and Wipfli valuations as part of their consideration for the Proposed Transaction. Krabbenhoft (Sanford) Hrg. Tr. Vol. 3 at 56–60 (Wipfli valuation was taken into "consideration"); Seifert (MDC) Hrg. Tr. Vol. 4 at 189–190; JX00020 (Bruhn) Dep. Tr. 69–71.

269. MDC is selling now to maximize shareholder value, not because of a prospect of imminent decline. PX05224 at 001 (sale was MDC Board's [redacted]); PX05284 at 001 [redacted]; JX00029 (Botsford) Dep. Tr. 132, 138; JX00012 (Schaaf) IH Tr. 182–183.

2. MDC has successfully recruited and replaced physicians

270. From January 2012 to May 2017, MDC hired 18 new physicians to replace 17 departing physicians. JX00010 (Tanous) IH Tr. 130, 141–142; *see also* Seifert (MDC) Hrg. Tr. Vol. 4 at 198–199.

271. Since the beginning of the year, MDC has hired three physicians—Dr. Gordon Leingang as an urgent care physician, Dr. Heather Sandness-Nelson as an OB/GYN, and Dr. Ashley Pierson as a laborist—and signed Dr. Johnson, a general surgeon, to an employment contract to start practicing at MDC in 2019. JX00024 (Lein) Dep. Tr. 188–192; PX08148 at 001. Based on "rigorous conversations" with MDC, Deloitte assumed that MDC would successfully recruit physicians going forward absent the Proposed Transaction. Ahern (Deloitte) Hrg. Tr. Vol. 4 at 38.

272. As an independent, physician-owned practice, MDC offers features that give MDC an advantage over Sanford and CHI in physician recruitment. JX00022 (Seifert) Dep. Tr. 151–152; PX03010 ¶ 8; JX00010 (Tanous) IH Tr. 131–132. These features include physicians' ability to set their own schedule, control of how many patients they see in a given day, and flexibility in choosing which days of the week to work. JX00022 (Seifert) Dep. Tr. 154–155. Many physicians prefer the autonomy of an independent practice. PX05167 at 001; PX03020 ¶ 2; PX03017 ¶ 2; JX00014 (Bury) IH Tr. 157–158. In the past four years, MDC successfully hired three physicians away from Sanford. JX00010 (Tanous) IH Tr. 116–119, 128.

273. As opposed to small practices, larger independent practices across the country, such as MDC, have experienced growth in recent years. PX06002 ¶¶ 70, 72. In multiple surveys, physician owners report greater satisfaction and other benefits associated with independent practice. PX06002 ¶ 92. Physicians frequently view the physician-owned model as more

rewarding than hospital or health system employment and continue to seek independent practice opportunities. PX06002 ¶¶ 89–92; *see also* PX03017 ¶ 2; PX03020 ¶ 2; PX05167 at 001.

3. As an independent practice, MDC has been successful with alternative payment models and is positioned to continue to succeed

274. APMs aim to (1) reimburse providers for the value rather than the volume of healthcare they render and (2) promote quality improvement and cost reduction by tying payment to quality and/or cost metrics. PX06002 ¶¶ 73–74. MDC has succeeded under both commercial and public APMs and is positioned to succeed in the future as an independent practice. *See* Jha Hrg. Tr. Vol. 4 at 243–245; JX00022 (Seifert) Dep. Tr. 121–126, 158–159; PX06002 ¶¶ 77–78. MDC is able to participate in the APMs it desires, considers itself better positioned than hospitals to participate in such programs, and has a plan to succeed in new healthcare environments absent the Proposed Transaction. *See* JX00022 (Seifert) Dep. Tr. 128; PX05091 at 002; PX05167 at 001; *see generally* PX05280 at 001–002.

4. MDC continues to provide high-quality care and outperforms Sanford on certain quality metrics

275. MDC's performance in two APM programs administered by BCBS, MediQHome and BlueAlliance, as well as its performance on quality metrics under federal quality-of-care programs, indicate MDC is a high-quality provider today and expects to be so going forward. Jha Hrg. Tr. Vol. 4 at 243–45; PX06002 ¶¶ 81–88. In addition to achieving the highest quality tier status under both MediQHome and BlueAlliance, MDC outperforms Sanford Bismarck on a number of [redacted] quality measures. Jha Hrg. Tr. Vol. 4 at 243–245; PX06002 ¶¶ 76, 83; [redacted]).

276. Sanford and MDC physicians both agree that MDC offers high-quality care today. *See, e.g.*, Bury (MDC) Hrg. Tr. Vol. 2 at 15; JX00004 (Lambrecht) IH Tr. 285.

IX. [redacted] ATTEMPTED TO INFLUENCE TESTIMONY

277. [redacted]

278. [redacted]

279. [redacted] Dr. Bury issued a formal complaint against Mr. Lein to MDC's Board of Directors in April 2017 after Mr. Lein refused to provide her with her investigational hearing subpoena in relation to the FTC's investigation of the Proposed Transaction. PX05315 at 001; Bury (MDC) Hrg. Tr. Vol. 2 at 31–34. In July 2015, former MDC physician Dr. Jayaram Bharadwaj filed a Charge of Discrimination with the North Dakota Department of Labor and Human Rights [redacted]

[redacted]." PX05318 at 004. In December 2015, [redacted] *See* PX05219 at 002. Also in December 2015, [redacted] PX05307 at 001.

PLAINTIFFS' PROPOSED CONCLUSIONS OF LAW

I. NATURE OF THE ACTION, JURISDICTION, VENUE

1. This is a civil action arising under Acts of Congress protecting trade and commerce against restraints and monopolies, and is brought by an agency of the United States authorized by an Act of Congress to bring this action. The Proposed Transaction is alleged to violate Section 7 of the Clayton Act, 15 U.S.C. § 18, and Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45.

2. This Court has subject matter jurisdiction pursuant to Section 13(b) of the FTC Act, 15 U.S.C. § 53(b), and Section 16 of the Clayton Act, 15 U.S.C. § 26, and upon 28 U.S.C. §§ 1331, 1337, and 1345.

3. The FTC is an administrative agency of the United States established, organized, and existing pursuant to the FTC Act, 15 U.S.C. §§ 41–58. The FTC is vested with authority and responsibility for enforcing, *inter alia*, Section 7 of the Clayton Act, 15 U.S.C. § 18.

4. The State of North Dakota is a sovereign state of the United States. This action is brought by and through its Attorney General, who is the chief law enforcement officer of North Dakota, with the authority to bring this action on behalf of North Dakota pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, N.D. CENT. CODE §§ 32-06-02 and 51-15-07, and the Uniform State Antitrust Act, N.D. CENT. CODE §§ 51-08.1-07, 51-08.1-08.

5. At all relevant times, Defendants have been engaged in activities in or affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12.

6. Defendants transact business in the District of North Dakota and are subject to personal jurisdiction therein. Venue is proper. 28 U.S.C. § 1391(b)–(c); 15 U.S.C. § 53(b).

7. This Court has jurisdiction to issue a preliminary injunction pending the conclusion of an administrative proceeding that will determine whether the Proposed Transaction violates Section 7 of the Clayton Act. 15 U.S.C. § 53(b).

II. THE 13(B) STANDARD FOR A PRELIMINARY INJUNCTION

8. Plaintiffs "seek a preliminary injunction to prevent a merger pending the Commission's administrative adjudication of the merger's legality." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001) (citation and internal quotation marks omitted). Preliminary injunctions are "readily available" under 15 U.S.C. § 53(b) "to preserve the status quo while the FTC develops its ultimate case." *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1036 (D.C. Cir. 2008); *see FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 337 (3d Cir. 2016); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999).

9. Section 13(b) of the FTC Act authorizes this Court to grant a preliminary injunction if, upon "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); *see also Tenet*, 186 F.3d at 1051.

10. "Therefore, in determining whether to grant a preliminary injunction under section 13(b), a district court must (1) determine the likelihood that the FTC will ultimately succeed on the merits and (2) balance the equities." *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1073 (N.D. Ill. 2012) (quoting *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 (11th Cir. 1991)) (internal quotation marks omitted); *see also FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *53 (N.D. Ohio Mar. 29, 2011).

11. To evaluate the FTC's "likelihood of success" at the administrative trial, this Court need only "measure the probability that, after an administrative hearing on the merits, the Commission will succeed in proving that the effect of the [proposed] merger '*may be* substantially to lessen competition, or to tend to create a monopoly' in violation of section 7 of the Clayton Act."

Heinz, 246 F.3d at 714 (quoting 15 U.S.C. § 18) (emphasis added); *see also FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 22 (D.D.C. 2015). The Commission "is not required to *establish* that the proposed merger would in fact violate Section 7 of the Clayton Act." *Heinz*, 246 F.3d at 714 (citations omitted). In fact, the district court "'is not authorized to determine whether the antitrust laws . . . are about to be violated.' That responsibility lies with the FTC." *Whole Foods*, 548 F.3d at 1035 (citations omitted); *see also ProMedica*, 2011 WL 1219281, at *53 ("The ultimate determination as to a Section 7 violation of the Clayton Act is an adjudicatory function [] vested in the FTC.") (citations and internal quotation marks omitted).

12. The second prong of Section 13(b) requires the Court to "weigh the equities" to determine whether a preliminary injunction is in the public interest. *Heinz*, 246 F.3d at 726. "The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws." *Id.* (citation omitted). The Commission's showing of a likelihood of success on the merits "weighs heavily in favor of a preliminary injunction blocking the acquisition." *FTC v. PPG Indus., Inc.*, 798 F.2d 1500, 1508 (D.C. Cir. 1986) (citation and internal quotation marks omitted). Absent such relief, it would be extremely difficult, if not impossible, for competition to be restored to its previous state if the Commission ultimately finds the merger unlawful. *FTC v. Weyerhaeuser Co.*, 665 F.2d 1072, 1085–86 n.31 (D.C. Cir. 1981). In fact, "[n]o court has denied relief to the FTC in a [Section] 13(b) proceeding in which the FTC has demonstrated a likelihood of success on the merits." *ProMedica*, 2011 WL 1219281, at *60.

13. Where a plaintiff demonstrates a likelihood of ultimate success, private equities alone do not justify denying a preliminary injunction. *Weyerhaeuser*, 665 F.2d at 1083; *see also ProMedica*, 2011 WL 1219281, at *60. The "risk that the transaction will not occur at all . . . is

a private consideration that cannot alone defeat the preliminary injunction." *Whole Foods*, 548 F.3d at 1041 (citation and internal quotation marks omitted); *see Heinz*, 246 F.3d at 726–27; *Sysco*, 113 F. Supp. 3d at 87.

III. CLAYTON ACT SECTION 7 STANDARD AND CONCLUSIONS

14. Plaintiffs' underlying antitrust claims—which will be adjudicated in the administrative trial on the merits—are brought under Section 7 of the Clayton Act and Section 5 of the FTC Act. Section 7 of the Clayton Act prohibits mergers "the effect of [which] may be substantially to lessen competition, or to tend to create a monopoly" in "any line of commerce." 15 U.S.C. § 18.

15. Section 7 of the Clayton Act is intended to prevent anticompetitive mergers "in their incipiency," *before* they create anticompetitive harm. *See United States v. Phila. Nat'l Bank*, 374 U.S. 321, 362 (1963) (citation and internal quotation marks omitted). "Congress used the words '*may* be substantially to lessen competition' . . . to indicate that its concern was with probabilities, not certainties"—even on the ultimate merits. *Heinz*, 246 F.3d at 713 (internal quotation marks omitted). "[C]ertainty, even a high probability, need not be shown, and any doubts are to be resolved against the transaction." *Penn State Hershey*, 838 F.3d at 337 (quoting *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989)) (internal quotation marks omitted). "All that is necessary is that the merger create an appreciable danger of such consequences in the future." *FTC v. Advocate Health Care Network*, 841 F.3d 460, 467 (7th Cir. 2016) (citations and internal quotation marks omitted).

16. Courts employ a burden-shifting approach to determine if the FTC has shown a likelihood of success on the merits of its Section 7 claim. *Saint Alphonsus Med. Ctr.–Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 783 (9th Cir. 2015) ("*St. Luke's*"); *Chi. Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008); *OSF Healthcare Sys.*, 852 F. Supp. 2d at

1074. Under this framework, a plaintiff establishes a *prima facie* case by defining a relevant product and geographic market and showing that the transaction will lead to undue concentration in that market. *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982–83 (D.C. Cir. 1990); *In re ProMedica Health Sys., Inc.*, No. 9346, 2012 WL 1155392, at *12 (F.T.C. Mar. 28, 2012).

17. An acquisition that causes undue market share and significantly increases concentration "is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." *Phila. Nat'l Bank*, 374 U.S. at 363. "[I]f the government makes this [prima facie] showing, a presumption of illegality arises." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1074 (quoting *Univ. Health*, 938 F.2d at 1218) (internal quotation marks omitted).

18. Defendants bear the burden of rebutting the *prima facie* case. *United States v. Marine Bancorporation Inc.*, 418 U.S. 602, 631–32 (1974). Indeed, a presumptively unlawful merger "must be enjoined," *Phila. Nat'l Bank*, 374 U.S. at 363, unless Defendants provide rebuttal evidence demonstrating "that the prima facie case inaccurately predicts the relevant transaction's probable effect on future competition." *Baker Hughes*, 908 F.2d at 991. The "more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Heinz*, 246 F.3d at 725 (citation and internal quotation marks omitted); *see United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 72 (D.D.C. 2011). If, and only if, Defendants come forward with evidence sufficient to rebut the presumption, does the burden of producing additional evidence of anticompetitive effects shift back to the government. *H & R Block*, 833 F. Supp. 2d at 50; *Sysco*, 113 F. Supp. 3d at 23.

A. The Relevant Services Markets Are Four Distinct Physician Services: Adult PCP Services, Pediatrician Services, OB/GYN Physician Services, and General Surgeon Services

19. A relevant product market "for antitrust purposes is the one relevant to the particular legal issue at hand." *H & R Block*, 833 F. Supp. 2d at 51 n.8 (emphasis omitted) (quoting 5C PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 533 (3d ed. 2007)). In a merger case, a relevant product market is the line of commerce in which competition may be substantially lessened because of the merger. *See Phila. Nat'l Bank*, 374 U.S. at 355–56; *Brown Shoe Co. v. United States*, 370 U.S. 294, 324–25 (1962).

20. The "reasonable interchangeability, or cross-elasticity of demand, between the product itself and possible substitutes for it" determine the boundaries of a relevant product or service market. *Se. Mo. Hosp. v. C.R. Bard, Inc.*, 642 F.3d 608, 613 (8th Cir. 2011); *see also H & R Block*, 833 F. Supp. 2d at 50–51. That is, courts look at whether "consumers will shift from one product to the other in response to changes in their relative costs." *SuperTurf, Inc. v. Monsanto Co.*, 660 F.2d 1275, 1278 (8th Cir. 1981) (citation omitted); *see also ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 565 (6th Cir. 2014).

21. "An analytical method often used by courts to define a relevant market is to ask hypothetically whether it would be profitable to have a monopoly over a given set of substitutable products." *H & R Block*, 833 F. Supp. 2d at 51. If such a hypothetical monopolist could profitably impose a SSNIP—typically five percent—over particular products or services, then those products or services constitute a relevant antitrust market. *Id.*; Merger Guidelines §§ 4.1.1–4.1.3.

22. This approach—the "hypothetical monopolist test"—is endorsed by the Merger Guidelines and has been widely used by courts. *See Sysco*, 113 F. Supp. 3d at 33–37; *H & R Block*, 833 F. Supp. 2d at 51–52; Merger Guidelines §§ 4.1.1–4.1.3.

23. It may be appropriate to define a relevant market based on distinct categories of customers, such as commercial insurers. *See Advocate*, 841 F.3d at 468; *Penn State Hershey*, 838 F.3d at 338; *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1075; *ProMedica*, 2011 WL 1219281, at *8–9 (all finding relevant markets focused on services sold to commercial insurers).

24. In a case with multiple relevant markets, should the FTC meet its burden with respect to even one of the proposed markets, it would nonetheless result in issuance of a preliminary injunction and, as a practical matter, would preclude Defendants from consummating the Proposed Transaction and implementing the affiliation in all respects. *See OSF Healthcare Sys.*, 852 F. Supp. 2d at 1075–76.

25. The four relevant service markets in which to analyze the competitive effects of the Proposed Transaction are the following physician services sold or provided to commercial insurers and their members: (1) adult PCP services, (2) pediatrician services, (3) OB/GYN physician services, and (4) general surgeon services. Federal court decisions embrace physician services markets consistent with those identified here. *See St. Luke's*, 778 F.3d at 784 (adult PCPs); *Sidibe v. Sutter Health*, 4 F. Supp. 3d 1160, 1168 (N.D. Cal. 2013) (OB/GYN, general surgery); *see also Woman's Clinic, Inc. v. St. John's Health Sys., Inc.*, 252 F. Supp. 2d 857, 867 (W.D. Mo. 2002) (OB/GYN); *HTI Health Servs., Inc. v. Quorum Health Grp., Inc.*, 960 F. Supp. 1104, 1115–16 (S.D. Miss. 1997) (pediatrics, general surgery).

B. The Relevant Geographic Market Is the Bismarck-Mandan Area

26. Section 7 of the Clayton Act prohibits acquisitions that are likely to lessen competition in "any section of the country," otherwise known as a geographic market. *Phila. Nat'l Bank*, 374 U.S. at 355–56. The ultimate question for geographic market definition is "where, within the area of competitive overlap, the effect of the merger on competition will be direct and

immediate." *Phila. Nat'l Bank*, 374 U.S. at 357; *see also In re Polypore Int'l, Inc.*, No. 9327, 2010 WL 9549988, at *16 (F.T.C. Nov. 5, 2010).

27. "The relevant geographic market is the area of effective competition where buyers can turn for alternate sources of supply. . . . Put differently, a market is the group of sellers or producers who have the actual or potential ability to deprive each other of significant levels of business." *St. Luke's*, 778 F.3d at 784 (citations and internal quotation marks omitted); *see also OSF Healthcare Sys.*, 852 F. Supp. 2d at 1076 ([T]he relevant geographic market "is the area in which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition.") (citation and internal quotation marks omitted).

28. As with the relevant product market, the case law and Merger Guidelines prescribe analyzing the geographic market by asking whether a hypothetical monopolist controlling all of the services in that geographic market could profitably impose—or in the healthcare context, negotiate—a SSNIP. *See Advocate*, 841 F.3d at 468–73; *St. Luke's*, 778 F.3d at 784–85; *Penn State Hershey*, 838 F.3d at 338; Merger Guidelines § 4.2.

29. A properly defined geographic market must reflect "the commercial realities of the industry." *Advocate*, 841 F.3d at 468 (citing *Brown Shoe*, 370 U.S. at 336) (citations and internal quotation marks omitted); *see also Penn State Hershey*, 838 F.3d at 338. In the healthcare industry, insurance companies effectively channel consumer preferences and thus are the appropriate subject of the hypothetical monopolist test. *See Penn State Hershey*, 838 F.3d at 342 ("Patients are relevant to the analysis, especially to the extent that their behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates. But patients, in large part, do not feel the impact of price increases. Insurers do.") (footnote omitted); *Advocate*, 841 F.3d at 470–71; *St. Luke's*, 778 F.3d at 784 ("[T]he district court correctly focused on the

'likely response of insurers to a hypothetical demand by all the PCPs in a particular market for a [SSNIP].'") (footnote omitted).

30. The analysis of patient flow data, such as the Elzinga-Hogarty method, is "not an appropriate method to define geographic markets in the [healthcare provider] sector." *Penn State Hershey*, 838 F.3d at 340 (quoting *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 WL 2286195, at *64 (F.T.C. Aug. 6, 2007)). Extensive legal and economic research showed that this test was inappropriate for defining relevant markets in healthcare provider mergers. *See Advocate*, 841 F.3d at 471–72, 476 ("As economists have identified the limits of the Elzinga-Hogarty test, courts and the Commission have begun to adjust their approaches to the problem. . . . That adjustment is necessary."), *remanded to* 2017 WL 1022015, at *3–4, *7, *16 (enjoining merger); *Penn State Hershey*, 838 F.3d 327 at 341–42; *see also In re Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *64–66 (summarizing the history of the Elzinga-Hogarty test and rejecting its use in hospital cases); *St. Luke's*, 778 F.3d at 784–85 & n.10, 793 (holding that "the district court correctly focused on the 'likely response of insurers to a hypothetical demand by all the PCPs in a particular market for a [SSNIP].'"). Professor Elzinga himself testified that "that the E-H test was not an appropriate method to define geographic markets" for healthcare provider mergers. *See In re Evanston Nw. Healthcare Corp.*, 2007 WL 2286195, at *64–66. The reliance on Elzinga-Hogarty "produced relatively large geographic markets in hospital merger cases." *Advocate*, 841 F.3d at 471 (discussing, among others, *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999), *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995), and *United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995)).

31. The relevant geographic market within which to analyze the competitive effects of the Proposed Transaction is the Bismarck, North Dakota Metropolitan Statistical Area (the "Bismarck-Mandan area"), which includes the counties of Burleigh, Morton, Oliver, and Sioux.

C. The Proposed Transaction Is Presumptively Unlawful Based on Market Shares and Market Concentration Thresholds

32. A merger that significantly increases market shares and concentration is presumed unlawful under Section 7 of the Clayton Act. *See Phila. Nat'l Bank*, 374 U.S. at 363. Such a merger "is so inherently likely to lessen competition substantially that it *must be enjoined*" unless Defendants can rebut the presumption. *Id.* (emphasis added); *see also Heinz*, 246 F.3d at 715.

33. Market concentration can be measured using HHIs, as adopted by the federal antitrust enforcement agencies. Merger Guidelines § 5.3. Courts have likewise adopted and relied on the HHI as a measure of market concentration. *See, e.g.*, *Univ. Health*, 938 F.2d at 1211 n.12; *ProMedica*, 2011 WL 1219281, at *56; *PPG Indus.*, 798 F.2d at 1502–03; *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 53–54 (D.D.C. 1998); *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1081–82 & n.12 (D.D.C. 1997). The HHI is calculated by summing the squares of the individual market share of each market participant. *See Penn State Hershey*, 838 F.3d at 346.

34. A merger is presumptively unlawful if it increases the HHI by more than 200 points and results in a post-merger HHI exceeding 2,500. *See Penn State Hershey*, 838 F.3d at 346–47; *ProMedica*, 749 F.3d at 568.

35. "Market concentration is a useful indicator of the likely competitive, or anticompetitive, effects of a merger." *Penn State Hershey*, 838 F.3d at 346 (citing Merger Guidelines § 5.3); *see also Heinz*, 246 F.3d at 715–16; *Baker Hughes*, 908 F.2d at 982–83 & n.3. Plaintiffs "can establish a prima facie case simply by showing a high market concentration based on HHI

numbers." *Penn State Hershey*, 838 F.3d at 347; *see also St. Luke's*, 778 F.3d at 788; *Heinz*, 246 F.3d at 715–16.

36. The Proposed Transaction is presumptively unlawful in each of the four relevant service markets. In adult PCP services, the Proposed Transaction would result in a post-merger HHI of 7,422 points, an HHI increase of 3,531 points, and a post-merger market share of 86%. In pediatrician services, the Proposed Transaction would result in a post-merger HHI of 9,726 points, an HHI increase of 4,393 points, and a post-merger market share of 99%. In OB/GYN physician services, the Proposed Transaction would result in a post-merger HHI of 7,363 points, an HHI increase of 1,152 points, and a post-merger market share of 85%. In general surgeon services, the Proposed Transaction would result in a post-merger HHI of 9,964 points, an HHI increase of 4,602 points, and a post-merger market share of 100%. The market concentration shares and HHI levels here far exceed levels found to be unlawful by the Supreme Court and other courts. *See, e.g.*, *Phila. Nat'l Bank*, 374 U.S. at 364–65 (merger resulting in a single firm controlling at least 30% of relevant market was sufficient to "raise an inference that the effect of the contemplated merger . . . may be substantially to lessen competition" and violated the Clayton Act); *Penn State Hershey*, 838 F.3d at 347 (76% post-merger market share, post-merger HHI of 5,984, and HHI increase of 2,582 demonstrated that proposed merger was "presumptively anticompetitive"); *FTC v. Advocate Health Care*, No. 15 C 11473, 2017 WL 1022015, at *7 (N.D. Ill. Mar. 16, 2017) (60% post-merger market share, post-merger HHI of 3,943, and HHI increase of 1,782 resulted in market concentration "well beyond the level . . . presumptively likely to enhance market power"); *St. Luke's*, 778 F.3d at 786 (district court correctly found post-merger HHI of 6,219 and HHI increase of 1,607 to be "well above the thresholds for a presumptively anticompetitive merger"); *ProMedica*, 749 F.3d at 568 (post-

merger HHI of 4,391 and HHI increase of 1,078 "blew through those barriers in spectacular fashion"); *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1078 (court "ha[d] no trouble finding" that proposed merger was presumptively anticompetitive where merged entity would control 59% of relevant market).

D. Competitive Effects Evidence Bolsters the Strong Presumption of Harm and Illegality

37. Courts have repeatedly held that transactions that would eliminate significant head-to-head competition are likely to result in anticompetitive effects. *See, e.g.*, *Sysco*, 113 F. Supp. 3d at 61; *H & R Block*, 833 F. Supp. 2d at 88–89; *FTC v. Swedish Match*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000); *Staples*, 970 F. Supp. at 1083. "The elimination of competition between two firms that results from their merger may alone constitute a substantial lessening of competition" leading to unilateral anticompetitive effects. Merger Guidelines § 6. "A merger is likely to have unilateral anticompetitive effect if the acquiring firm will have the incentive to raise prices or reduce quality after the acquisition, independent of competitive responses from other firms." *H & R Block*, 833 F. Supp. 2d at 81. "The extent of direct competition between . . . the merging parties is central to the evaluation of unilateral effects." *ProMedica*, 749 F.3d at 569 (quoting Merger Guidelines § 6.1).

38. "A merger between two competing sellers prevents buyers from playing those sellers off against each other in negotiations." Merger Guidelines § 6.2. The elimination of that competition "alone can significantly enhance the ability and incentive of the merged entity to obtain a result more favorable to it, and less favorable to the buyer, than the merging firms would have offered separately absent the merger." Merger Guidelines § 6.2. Thus, where a merger "eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage," the merger is likely to cause competitive harm. Merger Guidelines § 8.

39. Courts have also recognized that enhanced market power can harm consumers through non-price effects. *See Phila. Nat'l Bank*, 374 U.S. at 368; *H & R Block*, 833 F. Supp. 2d at 82 (identifying potential diminishments in quality as possible anticompetitive effects); *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1285 (N.D. Ill. 1989); *Sysco*, 113 F. Supp. 3d at 65; *ProMedica*, 2011 WL 1219281, at *29; *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 46 (D.D.C. 2017).

40. To prevail under Section 7, Plaintiffs need only establish that the merged firm will have the ability to raise prices or reduce quality after the Proposed Transaction. *See H & R Block*, 833 F. Supp. 2d at 81. "[A]ll that is necessary is that the merger create an appreciable danger of [anticompetitive] consequences in the future. A predictive judgment, necessarily probabilistic and judgmental rather than demonstrable is called for." *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1082 (quoting *Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986)).

41. The Proposed Transaction will eliminate close competition between Sanford and MDC for adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services in the Bismarck-Mandan Area and thus leaves "little doubt" that the Proposed Transaction "will tend to harm competition in [those] market[s]." *Whole Foods*, 548 F.3d at 1043.

E. Defendants Cannot Rebut the Strong Presumption of Illegality or Plaintiffs' Showing of Likely Competitive Harm

42. With the presumption of illegality established, the burden shifts to Defendants to rebut the presumption by "produc[ing] evidence that 'show[s] that the market-share statistics [give] an inaccurate account of the [merger's] probable effects on competition' in the relevant market. *Heinz*, 246 F.3d at 715 (quoting *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975)); *Univ. Health*, 938 F.2d at 1218; *ProMedica*, 2011 WL 1219281, at *56. Defendants

must produce evidence that "clearly show[s]" that no anticompetitive effects are likely in order to overcome Plaintiffs' *prima facie* case. *Phila. Nat'l Bank*, 374 U.S. at 363. Defendants bear a heavy burden given the strength of Plaintiffs' *prima facie* case. *See Sysco*, 113 F. Supp. 3d at 23 (explaining that the stronger the *prima facie* case, the more evidence defendants must present to rebut the established presumption); *Heinz*, 246 F.3d at 725 ("[T]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully.") (internal citation and quotation marks omitted); *see also OSF Healthcare Sys.*, 852 F. Supp. 2d at 1082.

1. The existence of a large insurer cannot prevent the competitive harm

43. "Even buyers that can negotiate favorable terms may be harmed by an increase in market power." Merger Guidelines § 8. The "loss of one competitor . . . alters the . . . negotiating dynamic, even with strong advocates on the other side." *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 221 (D.D.C. 2017). "[T]he economic argument for even partially rebutting a presumptive case, because a market is dominated by large buyers, is weak." *Chi. Bridge*, 534 F.3d at 440. Recent provider merger cases appropriately focus instead on the shift in leverage on the provider side that results from the proposed merger. *See, e.g., Penn State Hershey*, 838 F.3d at 346 ("No one disputes that the parties both have bargaining leverage when negotiating reimbursement rates. The question here, however, is whether the merger will cause such a significant increase in the *Hospitals'* bargaining leverage that they will be able to profitably impose a [price increase] . . . .").

44. Courts consistently implement the powerful buyer analysis as part of the evaluation of competitive effects, not when defining a market. *See, e.g., Chi. Bridge*, 534 F.3d at 423–24, 439–40 (analyzing relevant market before addressing powerful buyer defense); *Cardinal Health*, 12 F. Supp. 2d at 45–53, 58–62 (same); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1409–13, 1416–19 (S.D. Iowa 1991) (same); *see also United States v. Country Lake*

Foods, Inc., 754 F. Supp. 669, 675–80 (D. Minn. 1990) (same, ultimately crediting powerful buyers' ability to easily turn to distant suppliers or vertically integrate as one factor preventing anticompetitive effects). Indeed, this order of analysis is appropriate, as the powerful buyer inquiry is used to *rebut* the government's *prima facie* case, an element of which is a properly defined relevant market. *See Chi. Bridge*, 534 F.3d at 439–40.

45. A powerful buyer may be characterized by the ability to leverage its size or sophistication to sponsor entry or vertically integrate. Merger Guidelines § 8; *see Cardinal Health*, 12 F. Supp. 2d at 58–60; *Chi. Bridge*, 534 F.3d at 439. A powerful buyer could also be a buyer who uses certain tactics to obtain lower prices from suppliers, *Archer-Daniels-Midland*, 781 F. Supp. at 1422, but this ability to use a variety of tactics to drive lower prices is not relevant where there is a lack of alternative suppliers available to the buyer post-merger, *see Sysco*, 113 F. Supp. 3d at 48.

46. Defendants have not met either application of the powerful buyer defense to counteract the competitive harm of the Proposed Transaction.

2. A private rate agreement will not ameliorate the competitive harm

47. Courts strongly disfavor private "remedies" like Sanford's [redacted] agreement with Medica because they are temporary and fail to address effects arising from the loss of competition. *See Cardinal Health*, 12 F. Supp. 2d at 64–65, 67; *H & R Block*, 833 F. Supp. 2d at 82; *Commonwealth v. Partners Healthcare Sys., Inc.*, No. SUCV2014-02033-BLS2, 2015 WL 500995, at *22–24 (Super. Ct. Mass., Suffolk Cty. Jan. 30, 2015) (rejecting proposed "price caps" as resolution of hospital merger case because they were "limited in time" and "[do] not directly address the problem, which is a loss of competition"); *see also Penn State Hershey*, 838 F.3d at 343-344 (enjoining merger despite five- and ten-year rate agreements with largest payers,

and noting that pricing agreements "have no place in the antitrust analysis we engage in today" concerning the relevant geographic market).

48. Such private agreements permit future anticompetitive effects, ignoring the reality of the changed competitive environment once the agreements expire, and may be subject to clever circumventions. *See H & R Block*, 833 F. Supp. 2d at 82 (despite commitment to freeze rates for three years, "the merged firm could accomplish what amounts to a price increase through other means"); *Partners Healthcare*, 2015 WL 500995, at *23 ("once [price caps] expire, there is no reason to believe that the market will be any more competitive[.]").

3. Entry, expansion, or repositioning will not be timely, likely, and sufficient to rescue this anticompetitive merger

49. Entry must be "timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects" of a proposed merger. Merger Guidelines § 9; *see also Cardinal Health*, 12 F. Supp. 2d at 54–58 (adopting and applying "timely, likely, and sufficient" test). Defendants must show both that entry is likely—meaning technically possible and economically sensible—and that it will replace the competition that existed prior to the merger. *See Cardinal Health*, 12 F. Supp. 2d at 56–58; *In re Chi. Bridge & Iron Co.*, 138 F.T.C. 1024, 1071–72 (2004), *aff'd sub nom. Chi. Bridge & Iron Co. v. FTC*, 534 F.3d 410, 440 (5th Cir. 2008).

50. To counteract the competition lost through the Proposed Transaction, any "reposition[ing]" by competitors must be the "equivalent to new entry." *See FTC v. CCC Holdings, Inc.*, 605 F. Supp. 2d 26, 57 (D.D.C. 2009).

51. A finding of "high entry barriers 'eliminates the possibility that the reduced competition caused by the merger will be ameliorated by new competition from outsiders and further strengthens the FTC's case.'" *St. Luke's*, 778 F.3d at 788 (citing *Heinz*, 246 F.3d at 717). The

higher the barriers to entry, as in this case, the less likely it is that the "timely, likely, and sufficient" test can be met. *United States v. Visa U.S.A., Inc.*, 163 F. Supp. 2d 322, 342 (S.D.N.Y. 2001), *aff'd*, 344 F.3d 229 (2d Cir. 2003).

52. Entry, expansion, or repositioning will not be timely, likely, and sufficient to counteract the competition lost through the Proposed Transaction.

4. Defendants' purported efficiencies are not cognizable and do not outweigh competitive harm

53. Defendants bear a heavy burden of demonstrating cognizable efficiencies. *Advocate*, 2017 WL 1022015, at *12 ("Where the merger would result in high market concentration levels, as in this case, the defendants must provide proof of 'extraordinary efficiencies' based on a 'rigorous analysis' that ensures that the proffered efficiencies represent more than 'mere speculation and promises about post-merger behavior.'") (citing *Heinz*, 246 F.3d at 720–21). Defendants must meet the criteria set forth in the Merger Guidelines. *See Sysco*, 113 F. Supp. 3d at 82 ("[T]he court must determine whether the efficiencies are merger specific—meaning they represent a type of cost saving that could not be achieved without the merger—and verifiable—meaning the estimate of the predicted saving must be reasonably verifiable by an independent party.") (internal citation and quotation marks omitted); *FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 137 n.15 (D.D.C. 2016); *H & R Block*, 833 F. Supp. 2d at 89.

54. Any claimed efficiencies also must enhance competition and be passed through to consumers. *See, e.g.*, *Univ. Health*, 938 F.2d at 1223; *St. Luke's*, 778 F.3d at 790; *see also Aetna*, 240 F. Supp. 3d at 94 ("[T]he companies must 'demonstrate that their claimed efficiencies would benefit customers,' and, more particularly, the customers in the challenged markets.") (citing *Sysco*, 113 F. Supp. 3d at 82); *Penn State Hershey*, 838 F.3d at 351 ("An efficiencies

analysis requires more than speculative assurances that a benefit enjoyed by the Hospitals will also be enjoyed by the public.").

55. "Anticompetitive effects in one market" cannot be justified by "procompetitive consequences in another." *Phila. Nat'l Bank*, 374 U.S. at 370. Courts have rejected claims of efficiencies that are outside any relevant market. *See United States v. Anthem, Inc.*, 855 F.3d 345, 363–64 (D.C. Cir. 2017) (rejecting savings claims that, among other "analytic flaws," were "unmoored from the actual market at issue"); *Aetna*, 240 F. Supp. 3d at 98 (expressing "serious concerns" where the claimed efficiencies have not been attributed "to the particular markets challenged in the complaint"); *see also St. Luke's*, 778 F.3d at 789–90 (discussing earlier case in which it rejected argument that "the merger would allow the defendant to compete more efficiently *outside* the relevant market"); *Penn State Hershey*, 838 F.3d at 348; Merger Guidelines § 10 & n.14.

56. "Efficiencies almost never justify a merger to monopoly or near-monopoly." *St. Luke's*, 778 F.3d at 790 (quoting Merger Guidelines § 10); *see id.* at 792 (defendants' showing that they "*might* provide better service to patients after the merger" is "a laudable goal, but the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations") (emphasis added).

57. Defendants cannot "overcome a presumption of illegality based solely on speculative, self-serving assertions." *Univ. Health*, 938 F.2d at 1223. "While reliance on the estimation and judgment of experienced executives about costs may be perfectly sensible as a business matter, the lack of a verifiable method of factual analysis resulting in the cost estimates renders them not cognizable by the Court." *H & R Block*, 833 F. Supp. 2d at 91. Courts "must undertake a

rigorous analysis" to ensure that Defendants' claimed efficiencies are not just "promises about post-merger behavior." *Heinz*, 246 F.3d at 721.

58. "[D]elayed benefits from efficiencies (due to delay in the achievement of, or the realization of customer benefits from, the efficiencies) will be given less weight because they are less proximate and more difficult to predict." *CCC Holdings*, 605 F. Supp. 2d at 73 (citations and internal quotation marks omitted); Merger Guidelines § 10 n.15.

59. "No court in a [Section] 13(b) proceeding, or otherwise, has found efficiencies sufficient to rescue an otherwise illegal merger." *ProMedica*, 2011 WL 1219281, at *57 (citations omitted); *see also Sysco*, 113 F. Supp. 3d at 82 (stating that the court was unaware of a case where the merging parties have "successfully rebutted the government's *prima facie* case on the strength of the efficiencies") (citing *CCC Holdings*, 605 F. Supp. 2d at 72); *FTC v. Procter & Gamble Co.*, 386 U.S. 568, 580 (1967) ("[P]ossible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies but it struck the balance in favor of protecting competition."). "[T]he Clayton Act is in full force, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment." *Saint Alphonsus Med. Ctr.–Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, Nos. 1:12–CV–00560–BLW, 1:13–CV–0016–BLW, 2014 WL 407446, at *25 (D. Idaho Jan. 24, 2014).

60. Defendants' purported efficiencies are not cognizable and do not overcome the anticompetitive effects of the Proposed Transaction.

5. Defendants do not meet weakened competitor defense

61. The weakened competitor defense that current market shares may overstate a firm's future competitive role is "probably the weakest ground of all for justifying a merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339 (7th Cir. 1981). "[T]his argument is the

Hail–Mary pass of presumptively doomed mergers." *ProMedica*, 749 F.3d at 572. Defendants must make a "substantial showing" to meet the defense, *Univ. Health*, 938 F.2d at 1221; *Kaiser Aluminum*, 652 F.2d at 1341, such as an "imminent departure . . . from the relevant market." *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 700 (8th Cir. 1979).

62. Defendants have not established the substantial showing required to meet the weakened competitor defense.

6. Defendant MDC's effort to influence testimony constitutes an admission of the weakness of Defendants' case

63. Witness-tampering evidence can be used against the entity attempting to influence testimony. *Great Am. Ins. Co. v. Horab*, 309 F.2d 262, 264 (8th Cir. 1962) ("[E]vidence that a litigant, or his agent, has attempted to influence or suppress a witness is receivable as an admission or as an indication of the litigant's consciousness that his case is weak or unfounded . . . .") (citations omitted); *see also Catipovic v. Turley*, 68 F. Supp. 3d 983, 1003–08 (N.D. Iowa 2014) (finding that a letter in which defendant attempted to persuade a witness to testify favorably constitutes evidence of his consciousness of the weakness of his case).

IV. THE EQUITIES FAVOR A PRELIMINARY INJUNCTION

64. A preliminary injunction is in the public interest. *See Heinz*, 246 F.3d at 726–27. Because Plaintiffs have shown a likelihood of success on the merits, there is "a presumption in favor of injunctive relief." *Sysco*, 113 F. Supp. 3d at 86 (citation omitted).

65. The strong interests weighing in favor of injunctive relief include "(i) the public interest in effectively enforcing antitrust laws and (ii) the public interest in ensuring that the FTC has the ability to order effective relief if it succeeds at the merits trial." *Sysco*, 113 F. Supp. 3d at 86; *see also Heinz*, 246 F.3d at 726; *Swedish Match*, 131 F. Supp. 2d at 173.

66. "The equities will often weigh in favor of the FTC, since 'the public interest in effective enforcement of the antitrust laws' was Congress's specific 'public equity consideration' in enacting [Section 13(b)]." *Whole Foods*, 548 F.3d at 1035 (quoting *Heinz*, 246 F.3d at 726). Indeed, "[n]o court has denied relief to the FTC in a [Section] 13(b) proceeding in which the FTC has demonstrated a likelihood of success on the merits." *ProMedica*, 2011 WL 1219281, at *60; *see also PPG Indus.*, 798 F.2d at 1508 (The "likelihood of success finding weighs heavily in favor of a preliminary injunction.") (quoting *Weyerhaeuser*, 665 F.2d at 1085).

67. An equally important public equity is the preservation of the Commission's ability to obtain effective relief if the Proposed Transaction is ultimately found to violate Section 7 of the Clayton Act. Without a preliminary injunction, Defendants can combine their operations and make it extremely difficult, if not impossible, for competition to be restored to its previous state. *Heinz*, 246 F.3d at 726 (citing *FTC v. Dean Foods Co.*, 384 U.S. 597, 606 n.5 (1966) ("Administrative experience shows that the Commission's inability to unscramble merged assets frequently prevents entry of an effective order of divestiture.")); *Penn State Hershey*, 838 F.3d at 352–53; *Weyerhaeuser*, 665 F.2d at 1085–86 n.31; *Whole Foods*, 548 F.3d at 1034.

68. Defendants have offered no valid equities weighing against a preliminary injunction. "Private equities are not proper considerations for granting or withholding injunctive relief under [S]ection 13(b)." *ProMedica*, 2011 WL 1219281, at *60 (quoting *FTC v. Food Town Stores, Inc.*, 539 F.2d 1339, 1346 (4th Cir. 1976)) (internal quotation marks omitted); *see also Nat'l Tea*, 603 F.2d at 697; *Elders Grain*, 868 F.2d at 903. "Moreover, if the benefits of a merger are available after the trial on the merits, they do not constitute public equities weighing against a preliminary injunction." *ProMedica*, 2011 WL 1219281, at *60 (citation omitted); *see also Penn State Hershey*, 838 F.3d at 353 ("We see no reason why, if the merger makes economic

sense now, it would not be equally sensible to consummate the merger following a FTC adjudication on the merits that finds the merger lawful."); *OSF Healthcare Sys.*, 852 F. Supp. 2d at 1095; *Heinz*, 246 F.3d at 726.

69. The equities decisively favor a preliminary injunction.

Dated: November 13, 2017

Respectfully submitted,

/s/ Thomas J. Dillickrath

Thomas J. Dillickrath
Kevin K. Hahm
Elizabeth C. Arens
Emily C. Bowne
Alexander J. Bryson
Christopher J. Caputo
Stephanie R. Cummings
Jamie E. France
Melissa C. Hill
Laura K. Krachman
David E. Owyang
Rohan K. Pai
Cathleen V. Williams

Federal Trade Commission
Bureau of Competition
600 Pennsylvania Ave., NW
Washington, DC 20580
Telephone: (202) 326-3286
Facsimile: (202) 326-2286
tdillickrath@ftc.gov
khahm@ftc.gov

Counsel for Plaintiff Federal Trade Commission

/s/ Parrell D. Grossman

Parrell D. Grossman, ND ID 04684
Elin S. Alm, ND ID 05924

Assistant Attorneys General
Consumer Protection & Antitrust Division
Office of Attorney General
Gateway Professional Center
1050 E. Interstate Ave., Ste. 200
Bismarck, ND 58503-5574
Telephone: (701) 328-5570
Facsimile: (701) 328-5568
pgrossman@nd.gov
ealm@nd.gov

Counsel for Plaintiff State of North Dakota

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 13th day of November, 2017, I served the foregoing on the following counsel via electronic mail:

Robert M. Cooper, Esq.
Hershel A. Wancjer, Esq.
James Kraehenbuehl, Esq.
Boies Schiller Flexner LLP
1401 New York Avenue, NW
Washington, DC 20005
Telephone: (202) 237-2727
rcooper@bsfllp.com
hwancjer@bsfllp.com
jkraehenbuehl@bsfllp.com

Attorneys for Defendants Sanford Health and Sanford Bismarck

Gregory Merz, Esq.
Loren L. Hansen, Esq.
Gray Plant Mooty
500 IDS Center
80 South Eighth Street
Minneapolis, MN 55402
Telephone: (612) 632-3208
Gregory.merz@gpmlaw.com
Loren.hansen@gpmlaw.com

Attorney for Defendant Mid Dakota Clinic, P.C.

/s/ Christopher J. Caputo
Christopher J. Caputo
Attorney for Plaintiff Federal Trade Commission