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

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION
FOR A PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTRODUCTION

"[The acquisition] will be bad for our community and many of our patients."[1]

The Federal Trade Commission and the State of North Dakota seek a preliminary injunction to halt this merger, which, if consummated, would immediately and permanently eliminate competition in four critical physician services, raising prices and reducing the incentive to improve quality, all to consumers' lasting detriment. Sanford, the "dominant" healthcare system in the Bismarck-Mandan area of North Dakota,[2] seeks to acquire Mid Dakota Clinic ("MDC"), the largest multispecialty physician practice in Bismarck and Sanford's *only* meaningful rival in providing those four critical physician services to patients living in and around Bismarck and Mandan. MDC itself acknowledged that affiliating with Sanford would create "a monopoly in Bismarck."[3]

Sanford and MDC are by far each other's closest competitor in: (1) adult primary care, (2) pediatrics, (3) obstetrics and gynecology, and (4) general surgery (collectively, the "relevant services"). In each, Sanford would have a near-monopoly if it acquires MDC, giving it leverage to demand price increases from insurers and eliminating the powerful incentive to increase quality that competition with MDC currently imposes. Plaintiffs therefore seek a preliminary injunction pursuant to Section 13(b) of the Federal Trade Commission Act, 15 U.S.C. § 53(b), and Section 16 of the Clayton Act, 15 U.S.C. § 26, to preserve the status quo pending the full administrative proceeding on the merits scheduled to begin next month, on November 28, 2017.

[1] PX05119 at 006.
[2] PX05119 at 008.
[3] PX05178 at 002; *see also* PX05180 at 001.

BACKGROUND: "THE MONSTER THAT GOBBLES UP COMMUNITIES"[4]

Sanford is an integrated health system that operates a general acute care hospital in Bismarck, and employs approximately 160 physicians in its Bismarck division, including 37 adult primary care physicians, 5 pediatricians, 8 OB/GYNs, and 4 general surgeons. Sanford's corporate parent also operates a health insurance plan (Sanford Health Plan), which is the second-largest health insurer in the state of North Dakota after Blue Cross Blue Shield of North Dakota ("BCBS-ND"). The third-largest commercial health insurer in the state and in the Bismarck-Mandan area is Medica.

MDC is a multispecialty physician group with 61 physicians, including 23 adult primary care physicians, 6 pediatricians, 8 OB/GYNs, and 5 general surgeons. Most of MDC's physicians are shareholders of the company, all of whom will individually profit from the practice's [redacted] sale to Sanford.

Sanford and MDC today face little competition in providing the relevant services. Bismarck and Mandan are at least 90 miles away from the next closest significant population center in any direction. Competition in the area is generally limited to service providers that practice within Bismarck and Mandan.

A third healthcare system, Catholic Health Initiatives ("CHI"), operates a general acute care hospital in Bismarck but has virtually no presence in three of the four relevant services, and in the other, adult primary care, offers only a clinic in Mandan with a small handful of providers. CHI and MDC largely offer different services,[5] and, along with other local independent physicians, together constitute PrimeCare, a "physician hospital organization" that allows

[4] PX05230 at 001.
[5] *See* PX02011 at 181-82.

commercial insurers to efficiently contract with a full spectrum of healthcare service providers in the Bismarck-Mandan area.

The only other adult primary care, OB/GYN, or pediatric service providers in the Bismarck-Mandan area are a small number of independent practitioners. There are no independent practitioners for general surgery: Sanford and MDC employ every general surgeon in the Bismarck-Mandan area.

ARGUMENT

Where, as here, the Commission has reason to believe that a corporation is about to violate Section 7 of the Clayton Act, Section 13(b) of the FTC Act authorizes it to file suit in federal district court to seek to preliminarily enjoin the merger pending an FTC administrative adjudication. 15 U.S.C. § 53(b); *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). The district court may grant the request "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b). "In sum, the Court 'must balance the likelihood of the FTC's success against the equities, under a sliding scale.'" *FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 115 (D.D.C. 2016) (quoting *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1035 (D.C. Cir. 2008)).

To evaluate the likelihood of success on the merits, a court must first measure the probability that the Commission will prove that the proposed merger may substantially lessen competition in violation of the Clayton Act. *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 714 (D.C. Cir. 2001). Courts and the Commission evaluate Section 7 claims under a burden-shifting framework. *In re ProMedica Health Sys., Inc.*, No. 9346, 2012 WL 1155392, at *30 (F.T.C.

Mar. 28, 2012); *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). Under this framework, a plaintiff may establish 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).

Because a merger to near-monopoly, as here, is presumptively illegal, *see United States v. Phila. Nat'l Bank*, 374 U.S. 321, 364 (1963), under the burden-shifting framework defendants "seeking to rebut a presumption of anticompetitive effect must show that the *prima facie* case inaccurately predicts the relevant transaction's probable effect on future competition." *Baker Hughes*, 908 F.2d at 991. The stronger the *prima facie* case, the greater defendants' burden of production on rebuttal. *Id.* Defendants cannot meet that burden here. Recent healthcare-provider merger decisions underscore the FTC's likelihood of prevailing on the merits in this action. *See, e.g.*, *FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016); *Penn State Hershey*, 838 F.3d at 327 (decided 2016); *St. Luke's*, 778 F.3d at 775 (decided 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014), *aff'g In re ProMedica*, 2012 WL 1155392; *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012).

The second prong of Section 13(b) of the FTC Act requires the court to "weigh the equities" to determine whether a preliminary injunction serves 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.* Were Defendants here permitted to consummate the transaction, the merging of their operations would make it difficult, if not impossible, to order effective relief should it be warranted following the merits

trial. *See FTC v. Weyerhaeuser Co.*, 665 F.2d 1072, 1085-86 (D.C. Cir. 1981). Where a plaintiff demonstrates a likelihood of ultimate success, private equities alone do not justify denying a preliminary injunction. *Id.* at 1083; *see also FTC v. ProMedica Health Sys., Inc.*, No. 3:11-cv-47, 2011 WL 1219281, at *60 (N.D. Ohio Mar. 29, 2011) ("[I]f the benefits of a merger are available after the trial on the merits, they do not constitute public equities weighing against a preliminary injunction."). Defendants cannot override the strong public equities favoring preliminary relief.

1. The FTC is Likely to Succeed in Its Challenge at the Merits Trial

The Commission will likely prevail at the merits trial because this acquisition meets the standard that it may substantially lessen competition. An acquisition is illegal under Section 7 of the Clayton Act "where in any line of commerce . . . the effect of such acquisition *may be* substantially to lessen competition, or tend to create a monopoly." 15 U.S.C. § 18 (emphasis added). Section 7 requires "a prediction of [the acquisition's] impact upon competitive conditions in the future." *Phila. Nat'l Bank*, 374 U.S. at 362. The words "may be" underscore the fact that Section 7 deals with "probabilities, not certainties." *See St. Luke's*, 778 F.3d at 783 (quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962)). In what is inherently a forward-looking analysis, "certainty, even a high probability, need not be shown." *FTC v. Elders Grain Inc.*, 868 F.2d 901, 906 (7th Cir. 1989). In other words, Section 7 requires a prediction, and "doubts are to be resolved against the transaction." *Penn State Hershey*, 838 F.3d at 337 (quoting *Elders Grain*, 868 F.2d at 906).

A. Sanford's Acquisition of MDC Is Presumptively Illegal

"[M]onopoly in health care is not a good thing."[6]

The merger at issue here would not just substantially lessen competition—it would almost completely eliminate it. Plaintiffs establish their *prima facie* case—and a presumption of illegality—by showing that the transaction will lead to undue concentration in a relevant product and geographic market. *In re ProMedica*, 2012 WL 1155392, at *12 & n.12 (citing *Phila. Nat'l Bank*, 374 U.S. at 363; *Baker Hughes*, 908 F.2d at 982-83). Plaintiffs here establish a presumption of illegality in *four* markets, but need only make this showing in a single market to prevail.

In the healthcare context, "[c]oncerns about potential misuse of market power resulting from a merger" must take into account the two-stage process in which most healthcare services are purchased in the United States today. *See Advocate*, 841 F.3d at 465; *Penn State Hershey*, 838 F.3d at 342 (citing *St. Luke's*, 778 F.3d at 784 n.10). The first stage consists of insurers and healthcare providers negotiating to determine whether the providers will be in the insurers' networks and how much the insurers will pay them. *Advocate*, 841 F.3d at 465; *Penn State Hershey*, 838 F.3d at 342. In stage two, healthcare providers compete to attract patients, mostly on non-price factors such as convenience and reputation for quality. *Advocate*, 841 F.3d at 465. Relevant market definition and the assessment of the competitive effects of a merger will be impacted by this two-stage model: "Patients are largely insensitive to healthcare prices because they utilize insurance, which covers the majority of their healthcare costs. Because of this, our analysis must focus, at least in part, on the payors who will feel the impact of any price

[6] PX02013 at 112, 114.

increase." *Penn State Hershey*, 838 F.3d at 342. This focus informs the definition of relevant product and geographic markets.

i. The Relevant Service Markets Are Four Distinct Physician Services

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) (citing *Brown Shoe*, 370 U.S. at 325). 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*, 749 F.3d at 565 (discussing customer substitution as a step in defining relevant product markets). In the healthcare context, this means looking at whether health insurers—again, the ones who will feel the initial impact of any price increase—could switch to other provider types in the event of a price increase for one type of provider. A well-established analytical approach to this question, often referred to as the hypothetical monopolist test (or "HMT"), considers whether a hypothetical monopolist of a given set of substitutable services could profitably impose—or, as in a healthcare market, negotiate—a "small but significant and non-transitory increase in price" (also referred to as a "SSNIP"). If so, i.e., if customers could not turn to alternative products to defeat the hypothetical monopolist's price increase (typically a price increase of 5% is used for the test), the set of services constitutes a relevant service market. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 4.1.1 (2010) ("Merger Guidelines").[7]

[7] The Merger Guidelines "describe the standards applied by the Government in exercising its prosecutorial discretion in the anti-trust realm." *Chi. Bridge*, 534 F.3d at 431. "Although the Merger Guidelines are not binding on the courts, they are often used as persuasive authority." *St. Luke's*, 778 F.3d at 784 n.9 (citations and internal quotation marks omitted).

Defendants compete in the following service lines: (1) adult primary care physician services, (2) pediatrician services, (3) OB/GYN services, and (4) general surgeon services.[8] Each of these four services meets the hypothetical monopolist test, and therefore is a relevant market in which to analyze the transaction's competitive effects. For each of these four services, customers—in this case, health insurers—would not switch away from that service because they could not market a product that omitted it entirely, which they would be forced to do should they not agree to the hypothetical monopolist's SSNIP.[9] Given the distinct characteristics of each service line, including both the physicians' specialized training and qualifications and the unique services provided by each of these four physician types, patients demand in-network access to each of these types of providers. Therefore, a hypothetical monopolist of each service could profitably negotiate a SSNIP. 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); *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).

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

The appropriate geographic market in which to analyze the effects of the transaction is the Bismarck, North Dakota Metropolitan Statistical Area (the "Bismarck-Mandan area"), which includes the counties of Burleigh, Morton, Oliver, and Sioux. The case law and Merger

[8] Consistent with prior cases, the relevant markets focus on patients who have commercial health insurance and the rates negotiated with commercial health plans because government payors, such as Medicare and traditional Medicaid, generally do not negotiate reimbursement rates. *See Advocate*, 841 F.3d at 468; *Penn State Hershey*, 838 F.3d at 338; *OSF Healthcare*, 852 F. Supp. 2d at 1075; *ProMedica*, 2011 WL 1219281, at *8-9.
[9] PX03014 ¶¶ 27-33; PX03016 ¶¶ 7-10; *see also* PX02006 at 94-95.

Guidelines prescribe analyzing the geographic market the same way the relevant service market is analyzed, namely by asking whether a hypothetical monopolist controlling all of the services in that geographic market could profitably impose—or again, in the healthcare context, negotiate—a SSNIP. *See Advocate*, 841 F.3d at 468; *St. Luke's*, 778 F.3d at 784; *Penn State Hershey*, 838 F.3d at 338; Merger Guidelines § 4.2.[10]

Geographic market definition is a prospective exercise. Similar to evaluating whether consumer behavior regarding a product would change in the face of a SSNIP, geographic market definition predicts consumers' willingness to travel in response to a hypothetical price increase. *St. Luke's*, 778 F.3d at 785; *Tenet*, 186 F.3d at 1053-54. 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) (internal quotation marks and citations 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 471; *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 [primary care physicians] in a particular market for a [SSNIP].'") (emphasis added).

[10] The analysis of patient flow data, with the Elzinga-Hogarty method being one well-known form, 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) (summarizing Professor Elzinga's testimony)); *see also Advocate*, 841 F.3d at 471-72 ("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."). 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. Freeman Hospital*, 69 F.3d 260 (8th Cir. 1995)).

The geographic market question essentially asks, how many doctor's offices "can insurers convince most customers to drive past to save a few percent on their health insurance premiums?" *See Advocate*, 841 F.3d at 476. Patient preference is certainly relevant to the SSNIP analysis—a defendant might, in some circumstances, be able to establish that enough patients would buy a commercial insurer's health plan with no in-network providers in the proposed geographic market to allow insurers to avoid a SSNIP from providers in the area. *FTC v. Advocate Health Care*, No. 15-C-11473, 2017 WL 1022015, at *5 (N.D. Ill. Mar. 16, 2017). But this is not the case in the Bismarck-Mandan area.

The provision of healthcare services in the Bismarck-Mandan area is decidedly local. This preference for local care is borne out by testimony from Defendants, other market participants, and customers in the area,[11] as well as patient data. Approximately 95% of patients living in the Bismarck-Mandan area stay in the Bismarck-Mandan area to receive the relevant services.[12] For patients traveling to receive the relevant services, the median drive time is less than ten minutes and the median distance is four miles.[13] [redacted][14] Healthcare consumers pay only a small percentage of healthcare costs out of pocket, meaning that the impact of a SSNIP likely

[11] PX02000 at 16-18, 111, 140; PX02001 at 99-100; PX02003 at 174-75, 180; PX02005 at 95-98; PX02008 at 88; PX02010 at 89, 98; PX02013 at 72; PX03000 ¶ 8; PX03001 ¶ 11; PX03003 ¶ 10; PX03007 ¶ 6; PX03009 ¶ 10; PX03014 ¶¶ 27, 29, 31; PX03008 ¶ 9; PX03002 ¶ 6; *see also* PX05019 at 009 [redacted] PX06000 ¶ 127. The low patient outflows support the conclusion that the relevant services are inherently local and that, in turn, insurers would be unable to market a network to Bismarck-Mandan area residents that does not include Bismarck-Mandan area providers. *See Penn State Hershey*, 838 F.3d at 341.

[13] PX60000 ¶ 131.

[14] *See* PX02008 at 88-92; PX03014 ¶¶ 27-29, 31; PX03016 ¶ 12.

would not register immediately or directly on individual patients.[15] Thus, a hypothetical monopolist of each of the relevant services within the Bismarck-Mandan area could successfully impose a SSNIP. The exercise is not affected by the presence of a health insurer with pre-existing leverage, as a hypothetical monopolist of Bismarck-Mandan providers would unarguably have increased bargaining leverage vis-à-vis any insurer, and economic theory confirms there is no reason to think that this leverage would not manifest in higher prices.[16]

The Bismarck-Mandan area also corresponds to how Defendants and their customers analyze the market. MDC's primary care area includes Burleigh and Morton counties and parts of McLean and Oliver counties; [redacted][17] [redacted][18] [redacted][19]

Plaintiffs' economic expert, Dr. Seth Sacher, used healthcare claims data to conduct an empirical analysis, which confirmed the strong preference of local residents for providers within the Bismarck-Mandan area. He calculated diversion ratios, which represent the percentage of patients who would turn to each of the other available providers if their first-choice provider

[15] PX06000 ¶ 111 (application of hypothetical monopolist test requires assessing health insurers' response to SSNIP, not patients).
[16] PX06000 ¶¶ 59, 111. BCBS-ND's existing leverage in negotiations with providers would not defeat any hypothetical monopolist's attempt to impose a SSNIP, and in fact is analogous to the long-term rate agreements between insurers and providers on which the *Penn State Hershey* District Court erroneously relied to inform its market definition analysis. The Third Circuit clarified: "In determining the relevant market, we look[] not to the contractual restraints assumed by a particular plaintiff, but instead we answer whether a *hypothetical* monopolist could profitably impose a SSNIP. . . . The hypothetical monopolist test is exactly what its name suggests: hypothetical." 838 F.3d at 344 (citation and internal quotation marks omitted).
[17] PX02011 at 202-03.
[18] PX02006 at 118-19.
[19] *See, e.g.*, PX04034 at 005, 008-12 [redacted]; PX05162 at 006, 008 [redacted]

were not available, and are a measure of the substitution (and, thus, the competitive intensity) between providers. By aggregating diversion ratios for a given geographic area, it is possible to determine the preference of local patients for providers within that area. Dr. Sacher's analysis demonstrates that 94% to 98% of patients of Bismarck-Mandan area providers view another provider within the Bismarck-Mandan area as their second-best alternative provider.[20] This is further strong support for defining the relevant geographic market as the Bismarck-Mandan area.

iii. Market Concentration Levels Easily Trigger a Presumption of Illegality

Market concentration levels in *each* of the four relevant markets easily trigger a presumption of competitive harm and, thus, a presumption of illegality. Market concentration is typically measured using the Herfindahl-Hirschman index ("HHI"), which is calculated by summing the squares of individual firms' market shares. This well-established method appropriately accounts for the greater competitive significance of participants with larger market shares. The analysis considers both the post-merger level of the HHI and the increase in the HHI resulting from the merger. *St. Luke's*, 778 F.3d at 786 (citing Merger Guidelines § 5.3). Under the Merger Guidelines, a market is considered highly concentrated if its HHI exceeds 2,500. Merger Guidelines § 5.3. Mergers that increase the HHI more than 200 points and result in highly concentrated markets are "presumed to be likely to enhance market power." *Id.*; *see also ProMedica*, 749 F.3d at 568.

"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*

[20] PX06000 ¶¶ 141, 146, 151, 155. Compare this to the results of the same test performed by the FTC's expert, Dr. Steven Tenn, in *Advocate*: "Dr. Tenn calculated that for 48 percent of patients in the North Shore Area, both their first and second choice hospitals were inside the Commission's proposed market." 841 F.3d at 466. The Commission's proposed market met the test for a relevant geographic market in that case. *See Advocate*, 2017 WL 1022015, at *2-7.

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 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 788-89; *Heinz*, 246 F.3d at 715-16.

In this case, each of the four relevant markets is *already* highly concentrated, and post-merger concentration levels and HHI increases far exceed the thresholds required to establish the presumption that the transaction is anticompetitive.[21]

Healthcare Provider Cases
Market Shares & Concentration Levels[22]

Case	Combined Share	Pre-Merger HHI	HHI Increase	Post-Merger HHI	Holding
OSF Healthcare (N.D. Ill. 2012)	59%	3,411	1,767	5,179	Enjoined
ProMedica (6th Cir. 2014)	58%	3,313	1,078	4,391	Enjoined
St. Luke's (9th Cir. 2015)	80%	4,612	1,607	6,219	Enjoined
Advocate (7th Cir. 2016)	60%	2,161	1,782	3,943	Enjoined
Penn State Hershey (3d Cir. 2016)	76%	3,402	2,582	5,984	Enjoined
Sanford/MDC[23]					
Adult PCPs	**86%**	**3,891**	**3,531**	**7,422**	**TBD**
Pediatricians	**99%**	**5,333**	**4,393**	**9,726**	
OB/GYN	**85%**	**6,211**	**1,152**	**7,363**	
General Surgeons	**100%**	**5,362**	**4,602**	**9,964**	

[21] In a non-merger case, the 8th Circuit observed that 80% market share "is within the permissible range from which an inference of monopoly power can be drawn." *Morgenstern v. Wilson*, 29 F.3d 1291, 1296 n.3 (8th Cir. 1994).
[22] *OSF Healthcare*, 852 F. Supp. 2d at 1079; *ProMedica*, 2011 WL 1219281, at *12; *ProMedica*, 749 F.3d at 568; *Saint Alphonsus Med. Ctr. – Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, No. 1:12-CV-00560-BLW & 1:13-CV-00116-BLW, 2014 WL 407446, at *8 (D. Idaho Jan. 24, 2014), *aff'd*, *St. Luke's*, 778 F.3d at 775; *Advocate*, 2017 WL 1022015, at *7; *Penn State Hershey*, 838 F.3d at 347.
[23] PX06000 Table 1.

In *ProMedica*, the court opined that a post-merger HHI of 4391 and an HHI increase of 1078 "blew through those barriers in spectacular fashion." 749 F.3d at 568. As a result of Sanford's acquisition of MDC, the concentration levels in the Bismarck area will not just "blow through" those barriers—they will skyrocket to levels nearly twice those barred in *ProMedica*.

iv. Additional Evidence Bolsters Strong Presumption of Harm and Illegality

Plaintiffs would likely succeed on the merits based on market shares and concentration alone. But a wealth of additional, direct evidence confirms and strengthens the presumption that the proposed merger violates Section 7 and would significantly harm local consumers.

a. The Merger Eliminates Close Competition Between Sanford and MDC

The "extent of direct competition" between the merging parties is a "central" part of evaluating the unilateral competitive effects from an acquisition. *ProMedica*, 749 F.3d at 569 (quoting Merger Guidelines § 6.1). "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." *United States v. H&R Block*, 833 F. Supp. 2d 36, 81 (D.D.C. 2011); *see St. Luke's*, 778 F.3d at 787 ("Because St. Luke's and Saltzer had been each other's closest substitutes . . . the district court found the acquisition limited the ability of insurers to negotiate with the merged entity."); *see also FTC v. Swedish Match*, 131 F. Supp. 2d 151, 169 (D.D.C. 2000) ("a unilateral price increase by Swedish Match is likely after the acquisition because it will eliminate one of Swedish Match's primary direct competitors").

The proposed merger would eliminate the existing vigorous competition between Sanford and MDC. They are currently roughly equal players in each relevant service, facing little if any other competition. Thus, the combination removes the *only* meaningful source of competition each Defendant faces today in each of the relevant services. The Defendants' own ordinary

course documents bear this out. Sanford identifies MDC as its "main clinical competitor in Bismarck,"[24] and MDC believes Sanford has "put a large target on our finances and market share."[25] One MDC physician [redacted] does not "think it is in the best interest of our patients or our community to force everybody to have their care in one institution . . . monopoly in health care is not a good thing."[26]

Defendants are by far one another's closest competitor in each of the relevant services. Sanford's internal marketing materials describe MDC as "our major competitor for primary care in Bismarck,"[27] MDC's OB/GYN department as Sanford's "top competitor" in delivering babies,[28] and MDC as its *only* competitor for general pediatric services.[29] MDC likewise worried that Sanford has "gone after the [pediatrics] market" and "has been making some inroads into OB . . . so we need to work on retaining the market share."[30] MDC feared Sanford's efforts in OB services would make "our ability to dominate the market . . . more difficult."[31] An MDC consultant identified Sanford as MDC's closest clinical competitor,[32] and concluded that "Sanford was the first clinic recommended for some healthcare services [for which] Mid Dakota Clinic traditionally held a stronger position in the market."[33]

Sanford and MDC also respond to each other's marketing campaigns, monitor each other's offerings, and seek to gain the competitive advantage over each other.[34] Their own

[24] PX04018 at 005.
[25] PX05163 at 003.
[26] PX02013 at 112, 114.
[27] PX04019 at 001.
[28] PX04029 at 004.
[29] PX04031 at 001; *see also* PX02005 at 149.
[30] PX05174 at 002.
[31] PX05159 at 001.
[32] *See* PX05162 at 006-07.
[33] PX05175 at 003 (MDC's reduced favorability ratings came in OB/GYN, family medicine, pediatrics, adult medicine, and general surgery).
[34] *See, e.g.*, PX04118 at 005; PX04151 at 004; PX04028 at 014-15; PX04027 at 004 [redacted]; PX04099 at 003 [redacted]

executives[35] and other market participants[36] agree that Sanford and MDC are each other's closest competitor in the relevant services in the Bismarck-Mandan area.

This ordinary course evidence is consistent with a diversion ratio analysis performed by Dr. Sacher, which, using patient claims data in North Dakota, assessed the closeness of competition specifically between Sanford and MDC. Dr. Sacher's results confirm that Sanford and MDC are by far the number one and number two healthcare providers in each relevant service in the Bismarck-Mandan area.[37] As the top two choices for a large majority of consumers, Sanford and MDC are very close substitutes for patients in the Bismarck-Mandan area—and their merger would remove the major competitive constraint on one another that exists today, putting the post-merger entity in a position to raise prices and reduce competition-related quality enhancements.

b. The Merger Would Lead to Higher Healthcare Costs and Reduce Sanford's Incentive to Invest in Quality

Insurers and patients benefit from the direct competition between Sanford and MDC. Defendants both seek to be included in the health plan networks that insurers market to employers and individuals. The reimbursement rates and terms negotiated between healthcare providers and insurers reflect each side's bargaining leverage. Bargaining leverage depends, in large part, on the severity of the impact on either party of failing to reach agreement. The presence of competing providers within an area reduces the severity of the impact of failing to reach an agreement for the insurer, and thus limits the leverage of the provider, as the insurer can

[redacted]; PX05176 at 001; PX05177 at 003.

[35] *See, e.g.*, PX02000 at 142, 144; PX02001 at 158-61; PX02005 at 149, 159, 179-80; PX02010 at 139.

[36] *See, e.g.*, PX03001 at ¶ 17; PX03009 ¶¶ 6, 18, 20, 22; PX03014 ¶¶ 24-26, 31; *see also* PX03005 ¶ 9; PX03017 ¶ 3.

[37] PX06000 ¶ 188, Table 58.

continue to offer a viable network using other providers.[38] Conversely, a provider gains leverage when the insurer has few meaningful alternatives in an area, as the insurer would then have a significantly less attractive network if they do not come to terms with that "must have" provider.[39]

At present, Sanford and MDC serve as the key providers of the relevant services for consumers living in the Bismarck-Mandan area, and an insurer has few meaningful alternatives to these two when creating a viable network. Neither Sanford nor MDC can negotiate excessive reimbursement rates from insurers, because the insurer retains the ability to contract with one or the other for a network with sufficient coverage in the area. For example, when developing a provider network for a large group contract bid, Sanford Health Plan [redacted][40] [redacted][41] Other health plan products in the area offer only Sanford or MDC/PrimeCare as an in-network provider,[42] thus demonstrating the viability of such a network. But no plan is marketed in Bismarck today that does not offer at least one or the other Defendant in its network.

If the proposed merger is consummated, insurers will lose this important source of bargaining leverage. Insurers need not have explicitly played Sanford or MDC off each other to

[38] Sanford's testimony in front of a South Dakota state court confirms this understanding of bargaining dynamics from its perspective as a health insurer: a "provider will command a higher reimbursement rate than Sanford Health Plan would otherwise agree to in the absence of network adequacy requirements and the absence of competing providers within the same service area." PX08003 ¶ 7; *see also* PX02006 at 41, 45-48.
[39] *See* PX08003 ¶ 7; PX02006 at 41, 45-48; PX02008 at 137-38.
[40] *See* PX02008 at 137-38; PX04000 at 001.
[41] *See* PX02008 at 132-33, 137.
[42] PX02008 at 96; PX02006 at 104-06, 108-10; PX02011 at 270, 272-73 [redacted] PX05107 at 001; PX02002 at 164-65; *see also* PX03014 ¶¶ 6, 10-13; PX03010 ¶ 12.

have benefitted from the very real implicit threat that they could exclude one and still have a viable network so long as they included the other. The impact on an insurer of failing to reach agreement with Sanford *and* MDC is significantly more severe than a failure to reach agreement with only one of the two, increasing the merged system's bargaining leverage and enhancing its ability to negotiate higher reimbursement and other more favorable contract terms.

Insurers are concerned that once Sanford owns MDC, [redacted][43] They [redacted][44] [redacted][45]

In addition to the documentary and testimonial evidence above, Dr. Sacher has performed a "willingness to pay" (or "WTP") analysis that confirms the proposed acquisition will substantially increase Sanford's bargaining leverage.[46] Willingness to pay analysis measures a healthcare provider's bargaining leverage in negotiations with health plans. A provider's WTP value is the difference between the value of an insurer's network when it includes the provider and the value when it does not. The WTP values for two independent, closely substitutable providers can be low, because each is a viable alternative to the other, whereas those two providers together, post-acquisition, may have a high WTP value if—as here—other providers are not close substitutes in the eyes of consumers. The change in WTP following a merger is a measure of the change in the providers' bargaining leverage due to their merger. The results of Dr. Sacher's analysis in this case demonstrate that the acquisition would increase the combined

[43] PX03014 ¶¶ 42-44, 47; PX03016 ¶ 17.
[44] PX03014 ¶ 44; PX03016 ¶ 18.
[45] PX03014 ¶ 44; PX03008 ¶ 4.
[46] PX06000 ¶¶ 214-19.

entity's value to a health plan's network by anywhere from 58% to 183%, depending on the service line, relative to what Sanford and MDC currently possess.[47] The estimated changes in WTP here are considerably larger than other healthcare mergers that courts have enjoined.[48]

The merger will also end the intense non-price competition between Sanford and MDC that benefits *all* Bismarck-Mandan area patients, including those covered by Medicare and Medicaid and uninsured patients. For example, competition between Sanford and MDC has improved the quality of service for OB/GYN patients in the area because "it makes [the physician] step up and try to be better and provide excellent quality without just settling for average, which you can get away with when there is no one to compete with."[49]

As competitors, Defendants have spurred each other to acquire new technology, expand services, and improve access to attract patients. MDC "put a million dollars into 3D [mammography] . . . [b]ecause [patients] were walking over to Sanford."[50] Sanford extended its 3D mammography advertising campaign based on "competitive data" that MDC would be acquiring the technology.[51] Similarly, Sanford invested in a tower-free hysteroscopy system to transition certain gynecological procedures from an operating room to a clinical setting because

[47] PX06000 ¶ 218, Table 57.
[48] PX06000 ¶ 219. For example, in the Advocate/NorthShore matter, the FTC's economic expert found WTP changes of approximately 8%. *See* Pls.' Post-Hr'g Br. at 14, *FTC v. Advocate Health Care*, No. 15-cv-11473, 2016 WL 3387163 (N.D. Ill. June 20, 2016), *rev'd*, 841 F.3d 460 (7th Cir. 2016), ECF No. 464. In the ProMedica/St. Luke's matter, the FTC's economic expert estimated a post-merger change in WTP of 13.5%. *In re ProMedica*, 2012 WL 1155392, at *42. In the OSF Healthcare/Rockford matter, the government's expert determined that the merger between two hospitals would result in a post-merger increase in the WTP of 19%. Compl. Counsel's Pre-Trial Br. at 44, *In re OSF Healthcare Sys. and Rockford Health Sys.*, No. 9349, *available at* https://www.ftc.gov/sites/default/files/documents/cases/2012/04/120404ccpretrialbrief.pdf.
[49] PX02013 at 96-97.
[50] PX02001 at 221-23; *see also* PX05145 at 001.
[51] PX04092 at 001.

it was at a competitive disadvantage to MDC, which offered these procedures in an office setting.[52]

Competition has also inspired Sanford and MDC to improve patient access and convenience. Defendants operate walk-in clinics to provide patients with convenient options for acute care episodes, a critical way to attract and retain primary care patients.[53] Sanford believes its walk-in clinic brand helped it achieve "success in our market (both from a volumes and market position standpoint)" vis-à-vis MDC.[54] MDC opened its TODAY Clinic specifically "to answer [Sanford]'s walk ins: to increase our market share and to provide [patient] access."[55]

Although healthcare providers generally, and Sanford specifically, may have organization-wide quality initiatives and requirements that provide a sort of general performance target or strategy, patients nonetheless accrue incremental benefits from the presence of two eager competitors situated in close proximity seeking to attract patient volume away from each other and who prioritize quality improvements due to that competition. Patients in the Bismarck-Mandan area benefit immensely today from this head-to-head rivalry, but the incentive to invest in such improvements will disappear should the merger occur.

B. Defendants Cannot Rebut the Strong Presumption of Illegality

Once a plaintiff has established a presumption of illegality, the burden shifts to defendants to rebut that presumption by producing evidence that market shares inaccurately predict the merger's probable effects on competition in the relevant market. *Heinz*, 246 F.3d at 715; *see also FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1218 (11th Cir. 1991). Defendants'

[52] PX04023 at 061; PX02003 at 241-42.
[53] *See, e.g.*, PX05249 at 002; PX04021 at 001; *see also* PX05169 at 001 ("Sanford consistently promotes their Same Day [program]. We would like to do at least a little bit of the same – since if we are the first touch a new patient has for medical services in the area, there's a good chance we will retain that patient.").
[54] PX04021 at 001.
[55] PX05144 at 002; *see also* PX02010 at 135-137.

evidence must "clearly show[]" that no anticompetitive effects are likely in order to overcome the Commission's *prima facie* case. *OSF Healthcare*, 852 F. Supp. 2d at 1074 (quoting *Phila. Nat'l Bank*, 374 U.S. at 363). The more compelling the *prima facie* case, the more evidence defendants must present to rebut it successfully. *Heinz*, 246 F.3d at 725 (citing *Baker Hughes*, 908 F.2d at 991); *OSF Healthcare*, 852 F. Supp. 2d at 1082. Here, Defendants cannot even begin to meet this heavy burden.

Defendants may argue that the fundamental shift in market structure is rendered harmless by the existence of a large buyer, but both BCBS-ND and other commercial insurers will face a post-merger Sanford with substantially increased leverage and the ability to demand higher rates. Entry or repositioning in the Bismarck-Mandan area remains a challenging prospect, and the competitive significance of MDC will not be replaced in a timeframe sufficient to mitigate the anticompetitive harm from the merger. Defendants' purported cost and quality efficiencies are not substantiated and the companies already are achieving and could achieve many of the claimed benefits without the merger. Finally, MDC remains a strong rival to Sanford, at little risk of any near-term diminishment of its competitive significance.

i. BCBS-ND's Purported Leverage Cannot Prevent the Competitive Harm

Defendants' only real challenge to the overwhelming evidence of anticompetitive effects is their claim that BCBS-ND is, by virtue of its size, immune to post-merger price increases. This argument fails as a matter of law and fact.

"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.*, No. 16-cv-1493, 2017 WL 685563, at *37 (D.D.C. Feb. 21, 2017); *see also Chi. Bridge*, 534 F.3d at 440

("Moreover, the economic argument for even partially rebutting a presumptive case, because a market is dominated by large buyers, is weak.").

The sophistication and market power of one large buyer alone are not sufficient conditions to make out the "powerful buyer" defense. There are two ways in which the powerful buyer defense could apply, but neither is met here. First, a powerful buyer may be characterized by the ability to leverage its size or sophistication to sponsor entry or vertically integrate. Merger Guidelines § 8;[56] *see FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 58-60 (D.D.C. 1998); *Chi. Bridge*, 534 F.3d at 439. Here, significant challenges face any entrant seeking to build a practice offering physician services in the Bismarck-Mandan area, and there is no history of an insurer sponsoring such entry to suggest that this is likely to occur.

Second, a powerful buyer could be a buyer who uses certain tactics to obtain lower prices from suppliers. *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1422 (S.D. Iowa 1991). But this ability to use a variety of tactics to drive lower prices—including, notably, utilizing the presence of an alternative provider as leverage during negotiations—is not relevant in this circumstance, given the complete lack of alternative providers available to BCBS-ND post-merger. *See FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 48 (D.D.C. 2015).

Rather than focusing on the technical definition of a power buyer, recent provider merger cases appropriately focus on the shift in leverage on the *provider* side that results from the proposed merger. For example, in response to an argument advanced by the *Penn State Hershey* defendants that the insurers' threat to exclude them from the network—which would cause them to lose significant numbers of patients—would defeat a price increase, the court observed: "No

[56] This section of the Merger Guidelines also provides that a powerful buyer may constrain the ability of the merging parties to raise prices if the "conduct or presence of large buyers undermines coordinated effects." Merger Guidelines § 8. Coordinated effects are not alleged here.

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] . . . ." 838 F.3d at 346.[57] The court concluded that, "whatever leverage the payors will have after the merger, they have that leverage now." *Id.* The same is true here.

The appropriate inquiry here, therefore, is whether the acquisition increases *Sanford's* bargaining leverage such that it could exercise market power once MDC is no longer an independent option for constructing a network in the Bismarck-Mandan area. On this point, [redacted][58] This is buttressed by the economic evidence revealing the significant impact on the bargaining dynamic between providers and insurers following such a fundamental restructuring of the market.[59] Sanford's vice president of corporate contracting acknowledges that [redacted][60]

In addition to failing on all counts to meet the powerful buyer legal test, Defendants' factual predicates—that BCBS-ND maintains a single statewide rate schedule and does not negotiate—are misleading and inaccurate. Moreover, such factual predicates are not, as a matter of economic theory, inconsistent with providers nonetheless having leverage. First, there is a

[57] In *Penn State Hershey*, the court framed this as a hypothetical monopolist test question, using the term SSNIP, but actually applied the test to only the merging defendants and not all providers within the proposed geographic market. Thus, the court was in fact conducting a form of effects analysis; it observed later that this was a narrower question than the geographic market question. 838 F.3d at 346.
[58] PX03014 ¶ 42; *see* PX02016 at 233-42.
[59] PX06000 ¶¶ 192-219 (discussion of Upward Pricing Pressure Analysis and Willingness to Pay Analysis).
[60] PX04228 at 001; PX02025 at 125. In fact, Defendants' own witnesses credit BCBS-ND's "dominance" to its market share, which is approximately 80%. This is *lower* than the share Defendants will have in each relevant service following the merger. PX02023 at 156-57; PX02025 at 148; PX02006 at 258.

record of deviations from BCBS-ND's supposedly "standard" statewide rate schedule.[61] As Sanford's head of contracting put it, [redacted][62] [redacted][63] [redacted][64] While BCBS-ND may have offered fairly uniform fee-for-service terms across the state at the conclusion of these negotiations, Sanford, and other large providers, nonetheless exercise some degree of leverage today—BCBS-ND's statewide schedule reflects prices that ensure that it will have the largest providers in the state in network. That provider-side leverage will only grow significantly with Sanford's takeover of the Bismarck-Mandan area.

Further, this defense completely fails to address the harm likely to result from the loss of non-price competition, which would affect BCBS-ND members as well as others. Courts have recognized that enhanced market power can harm consumers through non-price effects. *See*

[61] *See* PX05190 at 002; PX03010 ¶ 14; PX05098 at 001; PX02011 at 251-53; PX04158 at 001-02; PX04081 at 001, 003, 005.

[62] PX04228 at 001. [redacted] *See* PX04222 at 001 [redacted] PX04225 at 002 [redacted] ; PX04221 at 001 [redacted] *See, e.g.*, PX04161 at 001-02 [redacted] ; PX04162 at 001 [redacted] ; PX04158 at 002 [redacted] ; PX05098 at 001 [redacted] ; PX05190 at 002 [redacted] ; PX05193 at 008 [redacted] *See* PX04075 at 001 [redacted] ; PX04156 at 001 [redacted] ; PX04160 at 001 [redacted] ; PX05192 at 001 [redacted] ; PX05236 at 001 [redacted] ; PX02002 at 191-95, 202-04, 209-17; PX05025 at 001-02.

H&R Block, 833 F. Supp. 2d at 82; *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1285 (N.D. Ill. 1989). The reduction in competition on non-price terms that will result from this merger occurs independent of the contracts negotiated between Sanford and commercial insurers. Importantly, any reduction in quality competition affects the Defendants' incentives to continue focusing on innovation, service levels, and investments that have an impact on *all* patients in the area, not only the commercially insured.

Finally, nothing about Defendants' powerful buyer argument offers any refuge from Sanford's post-merger monopoly power for other, smaller insurers—but that is required for the defense. *See* Merger Guidelines § 8. Nor is Sanford's recent [redacted] contract with Medica sufficient to ameliorate the competitive concerns; such a temporary rate agreement constitutes only a short-term, legally insufficient patch. *See Penn State Hershey*, 838 F.3d at 343-45 (enjoining merger despite five- and ten-year rate agreements with largest payers); *Cardinal Health*, 12 F. Supp. at 67; *Commonwealth v. Partners Healthcare Sys., Inc.*, No. SUCV2014-02033-BLS2, 2015 WL 500995, at *22-23 (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").[65]

ii. Entry Will Not Be Timely, Likely, and Sufficient to Counter the Anticompetitive Harm Resulting from the Proposed Merger

The entry of a new competitor, or expansion into the relevant services by an existing competitor, in the Bismarck-Mandan area cannot offset the consumer harm threatened by the proposed merger. To establish a defense, Defendants must show that entry by competitors will

[65] Even were Defendants correct that BCBS-ND meets the criteria for a powerful buyer, it is only a partial defense at best. "Courts have not yet found that power buyers *alone* enable a defendant to overcome the government's presumption of anti-competitiveness." *Cardinal Health*, 12 F. Supp. 2d at 58-63 (emphasis added); *see Chi. Bridge*, 534 F.3d at 440.

be "timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects" of the proposed transaction. Merger Guidelines § 9; *see FTC v. Procter & Gamble, Co.*, 386 U.S. 568, 579 (1967). 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).

Current market participants (such as CHI) looking to reposition, as well as potential new entrants, would face significant financial challenges and practical difficulties building a practice that replicates or even roughly approximates MDC's. Bismarck-Mandan's cold climate and distance from larger metropolitan areas make it difficult to attract and retain physicians.[66] Even for existing providers in the area, recruiting physicians to the Bismarck-Mandan area takes substantial time and resources, and providers often need to expend additional resources to construct or refurbish facilities to accommodate new physicians. Moreover, expansion would be expensive, as Sanford's recent [redacted] investment to accommodate [redacted] new physician recruits demonstrates.[67] CHI estimates it may take [redacted] for it to hire enough primary care physicians, open sufficient clinic space, and establish a patient base large enough to replace the primary care physician services currently offered by MDC.[68] Although CHI has [redacted] [69] these hurdles remain substantial, and CHI [redacted] alternative to Sanford in the near-term.

[66] PX02009 at 40-42; PX02001 at 225-26; PX03009 ¶ 39.
[67] PX04124 at 001.
[68] PX03009 ¶¶ 41, 42.
[69] *See* PX02015 at 14-19, 50.

The hurdles for new entrants would be even higher. There is little recent evidence of *de novo* entry to the area, as most of the area's small independent practices are operated by physicians with many years of experience in the community who spent time building patient bases at one of the existing providers (Sanford (or its predecessor entity MedCenter One) or MDC).[70] Defendants themselves have been successful in recruiting physicians due to the well-established and sizeable practices they offer, but this is not relevant when assessing the likelihood that any third party not currently serving patients in the relevant services in the community today could successfully start a practice in the area.[71]

Further, certain practice types require call coverage or referral sources, making independent entry even less likely. OB/GYNs and general surgeons, for example, must participate in or provide for call coverage of hospitalized patients. A reasonable call rotation requires at least four to five physicians; otherwise the practice is not attractive to new recruits.[72] General surgeons also require referral sources, and independent or newly recruited general surgeons in the Bismarck-Mandan area would lack the necessary source of referrals, as Sanford would employ almost all primary care physicians in the area. Given the size and breadth of MDC's physician group, no entity could plausibly step in to replace the competition that MDC provides today within a timeframe sufficient to prevent harm from the merger's anticompetitive effects.

[70] *See* PX03007 ¶ 1; PX03001 ¶¶ 1-2; PX03018 ¶¶ 1, 4-5, 17; PX03021 ¶ 1; *see also* PX03006 ¶¶ 22-23.
[71] PX06000 ¶ 283.
[72] PX02013 at 138-39, 148-49; *see* PX02024 at 23-24, 116, 146-47 ("Being on call less than . . . one in five is miserable.").

iii. Defendants' Purported Efficiencies Are Not Cognizable, and Do Not Outweigh the Competitive Harm In Any Event

Defendants' flawed argument that the proposed merger will benefit healthcare consumers through cost savings and quality improvements also cannot save this presumptively unlawful transaction. Far from the proof of "extraordinary efficiencies" required under the case law where (as here) sky-high market-concentration levels exist, *St. Luke's*, 778 F.3d at 790 (citing *Heinz*, 246 F.3d at 720-22), Defendants offer "mere speculation and promises about post-merger behavior." *See OSF Healthcare*, 852 F. Supp. 2d at 1088 (quoting *H&R Block*, 833 F. Supp. 2d at 89); *see also Univ. Health*, 938 F.2d at 1223.

To be credited, the claimed efficiencies "must be verifiable, not speculative." *Penn State Hershey*, 838 F.3d at 348 (quoting *St. Luke's*, 778 F.3d at 791). In addition to being verifiable, claimed efficiencies must be merger specific, meaning that they are unlikely to be achieved in the absence of the proposed merger or another similarly anticompetitive means. *See St. Luke's*, 778 F.3d at 790-91; *see also United States v. Anthem, Inc.*, 855 F.3d 345, 356 (D.C. Cir. 2017); *Cardinal Health*, 12 F. Supp. 2d at 62. Importantly, any claimed efficiencies also must enhance competition and be passed along to consumers. *See, e.g.*, *Univ. Health*, 938 F.2d at 1223; *St. Luke's*, 778 F.3d at 790. Defendants' claimed cost savings do not satisfy the "demanding scrutiny that the efficiencies defense requires." *See Penn State Hershey*, 838 F.3d at 349. As the Ninth Circuit observed in *St. Luke's*, "[e]fficiencies almost never justify a merger to monopoly or near-monopoly." 778 F.3d at 790 (quoting Merger Guidelines § 10).

Defendants' consultant Deloitte tabulated purported cost savings, identifying [redacted] in the first three years after closing and [redacted] annually thereafter. By Deloitte's own calculation, these purported savings amount to only [redacted] of the merged entity's annual operating

costs.[73] Further, serious flaws permeate Deloitte's analysis, leading Plaintiffs' efficiencies expert, Dr. Thomas Respess, to conclude that "all of Deloitte's claimed cost savings are either not substantiated or not merger specific."[74]

For example, *more than half* of Defendants' projected ongoing cost savings [redacted] are attributed to alleged efficiencies in the cancer-care service line. These savings are not verifiable.[75] Moreover, Defendants offer no evidence that they need to obtain monopolies in primary care, pediatrics, OB/GYN, or general surgery in order to obtain savings in cancer care, which is not a relevant product market in this action. Thus, these (unverifiable) efficiencies are not inextricably intertwined with the merger's harms, *see* Merger Guidelines § 10 n.14, and therefore are not cognizable. *See Penn State Hershey*, 838 F.3d at 348; *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"); *Anthem*, 855 F.3d at 363-64 (rejecting savings claims that, among other "analytic flaws," were "unmoored from the actual market at issue"); *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 98 (D.D.C. 2017) (expressing "serious concerns" where the claimed efficiencies have not been attributed "to the particular markets challenged in the complaint").

Other flaws abound as well: for example, Deloitte did not account for newly negotiated [redacted] achieved independently by MDC when estimating savings from moving MDC's [redacted] to Sanford.[76] This failure not only results in over-estimating any cost savings, but it casts further doubt on Deloitte's verification process for its entire analysis, which also showed a lack

[73] PX07001 at 005.
[74] PX06001 ¶ 18.
[75] PX06001 ¶¶ 43-53.
[76] PX06001 ¶¶ 92-94.

of vetting with third-party vendors and MDC stakeholders.[77] Further, as is apparent from its [redacted], MDC could achieve many of the remaining purported efficiencies independently.[78] Other purported savings could be obtained through agreement or merger with another entity that does not create the same anticompetitive effects.

Likewise, Defendants' vague and *post hoc* claims regarding anticipated quality improvements are similarly unconvincing and fall far short of the rigorous standards required by law. Where there is ample evidence that Defendants could—and in some cases do—independently pursue many of the purported service enhancements today,[79] their quality claims should be viewed skeptically. *See St. Luke's*, 778 F.3d at 791 (other independent physicians' adoption of risk-based reimbursement and access to sophisticated electronic medical records system undermined defendants' claim of merger specificity); *Penn State Hershey*, 838 F.3d at 351 ("the District Court's finding that both [defendants] are capable of independently engaging in risk-based contracting contravenes its conclusion that this is a cognizable efficiency because the benefit is not merger specific."); *OSF Healthcare*, 852 F. Supp. 2d at 1093-94 (defendants' claims that the merger "will enable them to be better able to recruit specialists and subspecialists . . . is somewhat belied by their history of successful recruitment of specialty physicians"). Even a conclusion that the merged entity might "provide better service to patients" after the merger "does not excuse mergers that lessen competition or create monopolies." *See St. Luke's*, 778 F.3d at 791-92; *see also OSF Healthcare*, 852 F. Supp. 2d at 1094. Here Defendants fail to even substantiate such alleged service improvements.

[77] *See, e.g.*, PX06001 ¶¶ 26, 28, 68, 71.
[78] PX02012 at 205-06, 247-48, 280-81.
[79] *See, e.g.*, PX02007 at 144, 167-68, 205-07.

Defendants identified certain categories of purported quality synergies during several pre-acquisition planning meetings—adding new services; hiring new subspecialists; clinical integration and care coordination; and sharing and implementing best practices[80]—but none of these efficiencies require the proposed merger. In fact, examples abound of Defendants recently achieving some of these alleged benefits independently. For instance, among other recent expansions and investments, Sanford opened its Sanford Children's North Clinic[81] and MDC expanded its Gateway Mall clinic to add pediatric services.[82] And, notably, Sanford has already independently hired a maternal fetal medicine subspecialist to join Sanford, although recruitment of this subspecialist was identified as a supposed benefit of the transaction.[83]

Further, although Defendants claim that uniting Sanford and MDC will facilitate clinical care coordination, Plaintiffs' quality expert, Dr. Ashish Jha, examined certain quality measures that reflect the quality of care coordination and outpatient care that a patient receives and concluded that MDC and CHI—as independent entities on different EMR systems—perform better together than Sanford does with its own doctors.[84] In other words, the comparison supports the conclusion that a merger is not necessary to improve care coordination between Sanford and MDC. Finally, while Sanford points to its patient-centered medical home model as a best practice that will benefit MDC following the merger, MDC (not Sanford) is the recipient of the National Committee for Quality Assurance Level 3 Recognized PCMH designation, an achievement claimed by only 4% of physician practices nationwide.[85]

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[80] PX04045 at 021-36.
[81] *See* PX08036.
[82] *See* PX05136 at 001-02; PX08007 at 001.
[83] *See* PX02020 at 64-66; PX02007 at 144.
[84] PX06002 ¶¶ 38-42.
[85] PX08000 at 001-02.

These examples are characteristic of the general weakness of Defendants' quality efficiencies claims. In virtually every case, the merger is either unnecessary or insufficient to make a difference in Defendants' ability to achieve the alleged synergies. Subspecialist recruitment, for example, which is dependent on the population of an area rather than the number of employed physicians, will be no easier or harder thanks to the proposed acquisition.[86] Both firms are already high-quality providers, and this acquisition does not meaningfully enhance their ability to improve care in Bismarck.

iv. MDC Is a Robust Competitor and Its Competitive Significance Remains Strong

MDC may argue it will have trouble keeping and recruiting physicians and adapting to the changing healthcare reimbursement landscape and so its current market shares do not predict its future competitive significance. But its weakened competitor defense is the "Hail-Mary pass of presumptively doomed mergers," *ProMedica*, 749 F.3d at 572, and falls well short. In *United States v. General Dynamics Corp.*, 415 U.S. 486, 497-98 (1974), the Court found that in certain rare cases, current market shares may overstate a firm's future competitive role. But this defense requires a "substantial showing," *Univ. Health*, 938 F.2d at 1221; *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1341 (7th Cir. 1981), like the "imminent departure . . . from the relevant market" that persuaded the court in *FTC v. National Tea Co.*, 603 F.2d 694, 700 (8th Cir. 1979). MDC does not come close.

Today, MDC successfully meets quality and financial targets, and compensates its physicians [redacted][87] In fact, a third-party valuation firm, in an independent valuation of MDC, projected a stable and healthy financial outlook for MDC for the

[86] PX06002 ¶¶ 26-33.
[87] PX06001 ¶¶ 110-118.

next five years and beyond.[88] MDC has had recent success recruiting physicians, including the complete replacement of all departing physicians over the past five years.[89] Indeed, many physicians still appreciate the autonomy of independent practice, despite the presence of CHI and Sanford as alternatives offering the employment model to recruits considering the Bismarck-Mandan area. In fact, over the past four years, MDC successfully hired three family practice physicians away from Sanford.[90]

Defendants appear to make the unsubstantiated argument that MDC, as a large independent physician practice, will struggle as the healthcare delivery and reimbursement landscape shifts. However, Dr. Jha concludes that, to the contrary, large independent physician groups (MDC qualifies as such) excel in alternative payment models, continue to attract physicians, and offer high-quality care in the changing healthcare environment.[91]

Finally, as noted, MDC has already begun pivoting to respond to the changing reimbursement landscape. MDC today captures additional revenue under alternative payment models, including [redacted][92] MDC's competitive relevance over the next several years is simply not in doubt.

v. Defendant MDC's Recognition of Its Weak Case Prompted Effort to Influence Testimony

Defendant MDC appears to recognize the weakness of the merging parties' arguments and has worked to shore them up by threatening a key witness in order to skew his testimony.

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[88] PX06001 ¶ 117; PX04192 at 028 [redacted] PX02009 at 130, 141-42.
[90] PX02009 at 116-19, 128.
[91] PX06002 ¶¶ 68-96.
[92] *See* PX03014 ¶ 41; PX02002 at 177-78, 181-82; PX02006 at 237.

But that merely provides evidence that MDC is aware of the weakness of its case. In *Great American Insurance Co. v. Horab*, the Eighth Circuit endorsed the principle that witness-tampering evidence can be used against the entity attempting to influence testimony:

> It is generally held that, in a civil case, evidence 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 or that his claim is false or fraudulent. Specifically, an attempt to persuade a witness not to testify is admissible against the party responsible for that attempt.

309 F.2d 262, 264 (8th Cir. 1962); *see also Catipovic v. Turley*, 68 F. Supp. 3d 983, 1003-08 (N.D. Iowa 2014) (letter in which defendant attempted to persuade a witness to testify favorably constitutes evidence of his consciousness of the weakness of his case).

In this case, [redacted][93] [redacted][94]

2. The Equities Heavily Favor a Preliminary Injunction

No court has ever denied injunctive relief under Section 13(b) where a plaintiff has demonstrated a likelihood of success on the merits. *OSF Healthcare*, 852 F. Supp. 2d at 1094-95; *ProMedica*, 2011 WL1219281, at *60. The strong interests weighing in favor of injunctive

[93] PX02015 at 21-26, 29, 31, 166; *see also* PX07040.
[94] PX02015 at 26, 166-67.

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; *Univ. Health*, 938 F.2d at 1225. These equities must prevail on the facts of this case. Private equities are afforded less weight in the balance, *Nat'l Tea*, 603 F.2d at 697, and cannot outweigh effective enforcement of the antitrust laws. *Weyerhaeuser*, 665 F.2d at 1083. Once the court has determined that the proposed merger is likely to substantially lessen competition, defendants "face a difficult task in justifying the nonissuance of a preliminary injunction." *See Penn State Hershey*, 838 F.3d at 352 (citing *Univ. Health*, 938 F.2d at 1255) (internal quotation marks omitted).

Where, as here, a plaintiff has demonstrated a likelihood of success on the merits, allowing the merger to close before the merits proceeding is complete would irreparably harm the public interest, as the merger would allow defendants to combine operations in a way that would be "extraordinarily difficult" to undo if the Commission ultimately determines the merger to be unlawful. *Penn State Hershey*, 838 F.3d at 353; *see also Univ. Health*, 938 F.2d at 1217 n.23 ("[O]nce an anticompetitive acquisition is consummated, it is difficult to 'unscramble the egg.'"). It will be too late to preserve competition if no injunctive relief issues. *See Heinz*, 246 F.3d at 727.

In this case, Defendants offer no reason why the alleged benefits of the transaction would not remain available after a full administrative trial, and there is therefore little to weigh against the public equity. As the Third Circuit observed in *Penn State Hershey*, "[w]e 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." 838 F.3d at 353. The same is true here.

CONCLUSION

For the reasons described above, Plaintiffs FTC and the State of North Dakota respectfully request that the Court grant a preliminary injunction to prevent consummation of this presumptively illegal proposed merger. Sanford's acquisition of MDC would create a near-monopoly in four relevant services in the Bismarck-Mandan area, eliminating close, consumer-benefitting competition and leading to increased prices and a reduced incentive to invest in quality. The merger negatively alters the market structure for the provision of healthcare services in the Bismarck-Mandan area, and this will have inevitable consequences for the area's patients, health insurers, and other customers in the Bismarck-Mandan community. Because the merger would produce immediate anticompetitive effects, the Court should preliminarily enjoin it.

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Respectfully Submitted,

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