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

REPLY MEMORANDUM IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTRODUCTION

Plaintiffs Federal Trade Commission and the State of North Dakota demonstrated in their opening brief that this merger to monopoly is likely to be enjoined in the full merits trial set to begin on November 28. If Defendants are allowed to consummate their illegal transaction, consumers in the Bismarck-Mandan area would suffer a dramatic loss of competition for the four physician services at issue here. Defendants rely almost exclusively on one key argument: that the presence [redacted] can somehow save this illegal merger, an argument that flies in the face of standard antitrust analysis and legal precedent.

Defendants' novel assertions about the implication of [redacted] would lead to the absurd result that *no* antitrust market could be defined, and *no* provider combination in North Dakota could ever be anticompetitive. On the other hand, Plaintiffs' antitrust analysis, conducted in accordance with the Horizontal Merger Guidelines ("Merger Guidelines"), yields results that are informative and consistent with the qualitative evidence about the closeness of competition and the likely impact of this merger. In fact, for all their circular reasoning, Defendants have failed to show *anything* except that the [redacted]

Despite the lack of any serious supporting evidence or legal precedent, Defendants ask this Court to take the unprecedented step of allowing this merger to monopoly to proceed, resulting in an immediate reduction of competition. This Court should preserve the status quo by enjoining this transaction through the pendency of the trial on the merits and preserve competition for the benefit of Bismarck-Mandan area consumers.

ARGUMENT

The standard applicable to Plaintiffs' Motion is well-settled and uncontroversial. The FTC Act provides that a district court may grant a preliminary injunction upon a proper showing that, "weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999) (quoting 15 U.S.C. § 53(b)). Here, Plaintiffs easily meet the applicable standard: the FTC is very likely to succeed on the merits of its Section 7 claim, and the public interest in maintaining competition pending a full administrative hearing far outweighs any potential harm caused by a preliminary injunction. Other courts considering recent provider mergers, all with lower concentration levels than the instant merger to monopoly, have found them to be anticompetitive and granted preliminary injunctions in favor of the FTC. *See, e.g.*, *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 346-47, 353-54 (3d Cir. 2016); *FTC v. Advocate Health Care*, No. 15 C 11473, 2017 WL 1022015, at *7, *16 (N.D. Ill. Mar. 16, 2017); *see also ProMedica Health System, Inc. v. FTC*, 749 F.3d 559, 573 (6th Cir. 2014) (affirming FTC opinion that hospital merger was anticompetitive).

Unable to cite any recent favorable decisions, Defendants reach back two decades to cite a series of Eight Circuit cases. But these older decisions are easily distinguishable. Those hospital merger cases used the so-called "Elzinga-Hogarty test" to define geographic markets.[1] But after extensive legal and economic research showed that this test was inappropriate for defining relevant markets in healthcare provider mergers, recent cases have

[1] *E.g.*, *FTC v. Freeman Hosp.*, 69 F.3d 260, 264-66, 271-72 (8th Cir. 1995) (finding no abuse of district court's discretion in adopting defendant hospitals' 54-mile geographic market); *Tenet*, 186 F.3d at 1050-54 (finding plaintiffs' proposed geographic market too narrow); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 976-78, 987 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997) (finding the government's proposed geographic market inappropriately failed to include regional hospitals located 70-100 miles from merging hospitals).

uniformly rejected it and instead applied the methodology Plaintiffs use here. *See Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health Sys., Ltd.* ("*St. Luke's*"), 778 F.3d 775, 784-85 & n.10, 793 (9th Cir. 2015); *FTC v. Advocate Health Care Network*, 841 F.3d 460, 471-72, 476 (7th Cir. 2016), *remanded to* 2017 WL 1022015, at *3, *4, *7, *16 (enjoining merger); *Penn State Hershey*, 839 F.3d 327 at341-42; *see also In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 WL 2286195, at *64-66 (F.T.C. Aug. 6, 2007) (summarizing the history of the Elzinga-Hogarty test and rejecting its use in hospital cases). Professor Elzinga himself testified that "that the E-H test was not an appropriate method to define geographic markets" for healthcare provider mergers.[2] *See In re Evanston*, 2007 WL 2286195, at *64-66. Applying the well-accepted methodology used in all recent provider merger cases to this transaction leads to a clear finding of anticompetitive harm, and a strong likelihood that Plaintiffs will prevail at the merits stage.

1. Plaintiffs Are Likely to Succeed on the Merits

Plaintiffs have shown that the FTC is likely to succeed on the merits of its Section 7 claim by showing that the merger will lead to a substantial lessening of competition or tend to create a monopoly. *See* 15 U.S.C. § 18. Section 7 forbids mergers and other acquisitions the effect of which may be substantially to lessen competition. *See Advocate*, 841 F.3d at 467. "Congress used the words '*may be* substantially to lessen competition' to indicate that its concern was with probabilities, not certainties." *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962) (emphasis added and footnote omitted). "All that is necessary is that the merger

[2] *See also* Memorandum in Support of Plaintiffs' Motion for a Preliminary Injunction ("Plaintiffs' Opening Br.") at 9 n.10.

create an appreciable danger of such consequences in the future. [D]oubts are to be resolved against the transaction." *Advocate*, 841 F.3d at 467 (internal quotations and citations omitted). The Clayton Act thus forbids the acquisition of market power that *may* harm competition—no immediate or specific price increase or quality reduction is required for the violation.

A. Plaintiffs' Markets Are Valid

Plaintiffs apply the market definition methods that are now routinely used in provider mergers to delineate sound and intuitive relevant markets that reflect the actual competition between Defendants and other providers. Those markets—markets for adult primary care physician, OB-GYN, pediatrician, and general surgery physician services in the Bismarck-Mandan area—are plainly correct; insurers seeking to contract with an adult primary care physician group in the Bismarck-Mandan area certainly could not choose instead to contract with, for example, a provider in Sioux Falls, or with an orthopedic surgeon practice. These relevant markets, and the resulting shares and concentrations, result in a presumption in favor of Plaintiffs—a presumption that the merger will cause anticompetitive effects. *See Penn State Hershey*, 838 F.3d at 346-47.

Defendants make no response to Plaintiffs' proposed markets using *any* accepted legal or economic theory. Instead, Defendants fall back on their one and only argument [redacted] and use that argument to create a new and unprecedented "test" for market definition, which they dub the "Actual Monopolist Test."[3] In this "test," Defendants argue that because [redacted] has, to date, [redacted], a hypothetical monopolist of the Bismarck-Mandan area could not

[3] DX6000 ¶ 100 & n.140, ¶ 101.

actually negotiate a SSNIP,[4] and so, they contend, Plaintiffs' markets are invalid. Defendants' analysis is fatally flawed. [redacted] says nothing about how an increase in provider leverage in the Bismarck-Mandan area would affect [redacted]. It only confirms that [redacted]—a fact that is not in dispute.

A hypothetical monopolist of the Bismarck-Mandan area could negotiate a SSNIP from [redacted]. If the hypothetical monopolist required higher reimbursement rates for provider services in Bismarck-Mandan, [redacted] or it could [redacted]. If it chooses the former, then the price increase that the hypothetical monopolist would negotiate would be manifested [redacted]. If it chooses the latter, then the SSNIP would [redacted] area. Either way, the hypothetical monopolist of the Bismarck-Mandan area could negotiate a SSNIP from [redacted] because [redacted] would lack other provider options for its network and subscribers in that area.

Most importantly, Defendants' reliance on insurer bargaining power would render the market definition exercise pointless. Such an approach would lead to the absurd conclusion that in the state of North Dakota, it may not ever be possible to define a geographic market, as there is nothing in Defendants' framework that would limit [redacted]

[4] Defendants' Memorandum in Opposition to Plaintiffs' Motion for a Preliminary Injunction ("Defs' Opp.") at 7. Dr. Town also looked more broadly at the relationship between market concentration and [redacted] reimbursement rates in all specialties and similarly found [redacted] *Id.* at 8. This analysis fails for the same reasons described above, i.e., renders cross-market comparisons uninformative.

[redacted], no matter how formidable the provider leverage. The inferences Defendants draw from their "Actual Monopolist Test" contradict basic economic principles. Their approach, invented by their expert solely for this case, has never been applied by a court and is not endorsed by the Merger Guidelines.[5] Defendants' test yields results that are inconsistent with the Clayton Act's intent to prevent mergers that would lessen competition or tend to create a monopoly.

Defendants' attempt to invent a new test for market definition makes a fundamental error by conflating two separate exercises in merger analysis. As instructed by the Merger Guidelines, the market definition test is designed to frame the context within which competitive effects are to be examined; in other words, to identify *where* one should look when assessing the potential competitive impact of a merger. Separately, a competitive effects analysis considers whether anticompetitive effects are in fact likely to arise from this particular merger. The Merger Guidelines squarely address the impact a powerful buyer may have on the analysis following the discussion of competitive effects, not market definition. *See* Merger Guidelines §§ 4, 6-8.

Courts have consistently applied this approach. Only after analyzing the relevant markets have courts considered whether a powerful buyer has the ability to prevent the merged entity from exercising market power. *See, e.g.*, *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423-24, 439-40 (5th Cir. 2008) (analyzing the relevant market before addressing the powerful buyer defense); *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 45-53, 58-62 (D.D.C. 1998) (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, 675-678, 679-80 (D. Minn. 1990) (same, ultimately crediting powerful buyers' ability to easily turn to

[5] *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 4 (2010) ("Merger Guidelines").

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 Chicago Bridge*, 534 F.3d at 439-40.

The Supreme Court has articulated that relevant market definition examines the "reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it." *Brown Shoe*, 370 U.S. at 325. As discussed in Plaintiffs' initial brief, a well-established approach to this question, often referred to as the hypothetical monopolist test, considers whether a hypothetical monopolist of a given set of substitutable services could profitably impose a "small but significant and non-transitory increase in price." Defendants' formulation of the hypothetical monopolist test, however, conspicuously avoids the inquiry into what customers would view as viable alternatives to the services sold by the merging parties.[6] In pointing to BCBS-ND's bargaining power as sufficient to overcome any exercise of provider bargaining leverage, Defendants completely fail to consider which—if any—functional substitutes commercial insurers could contract with to avoid a price increase by a hypothetical monopolist provider.[7] In other words, Defendants never directly address the question that

[6] Defs' Opp. at 6-7 & n.2.

[7] Defs' Opp. at 7 n.2 ("For purposes of market definition, however, what matters is that the Government cannot show that a hypothetical monopolist could impose a SSNIP in the alleged relevant markets due to BCBS-ND's high bargaining power.") (citation omitted). Further, Defendants' reliance on *Little Rock Cardiology* is misplaced. *See* Defs. Br. at 9. *Little Rock Cardiology* was an exclusive dealing case in which a cardiology group alleged that a competitor foreclosed it from serving patients covered by Blue Cross & Blue Shield of Arkansas by inducing that Blue Cross plan to exclude the cardiology group from its network. *Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591 (8th Cir. 2009). The Eighth Circuit found the plaintiff cardiology group's alleged product market was improperly defined ("rejecting a market narrowed to commercial payers" as Defendants contend) because it did not address possible alternative choices available to the party claiming antitrust injury—i.e., whether there were alternative *patients* available to the excluded *cardiologists*. *Id.* at 595, 597. The central teaching of *Little Rock Cardiology* was that market definition should consider options available to the persons who could be injured by the alleged anticompetitive conduct. That is precisely consistent with Plaintiffs' analysis here: the alleged merger would harm commercial insurers serving patients in the Bismarck-Mandan area. And so, the market definition

market definition is designed to answer: what is the locus of competition that may be affected by the merger. Rather, Defendants try to end the inquiry before it has ever begun.

Defendants frame their inquiry into [redacted] as a price discrimination analysis. Such an approach is not required in this case, however, as price discrimination markets are identified only where there is a realistic prospect of an adverse competitive effect on a group of targeted customers who face distinct competitive options. *See* Merger Guidelines § 4.1.4; *FTC v. Staples, Inc.*, 190 F. Supp. 3d 100, 117-18 (D.D.C. 2016). Here, the merger would result in an adverse competitive effect on *all* commercial insurers. Commercial insurers in the Bismarck-Mandan area do not face distinct competitive options: BCBS-ND, Sanford Health Plan, and Medica all have the same set of healthcare providers available when constructing provider networks for subscribers to their respective health insurance products.[8]

B. The Merger Will Harm BCBS-ND, Medica, and Local Patients

Plaintiffs' opening brief demonstrated that eliminating the competition between these two significant physician service providers is likely to substantially harm competition and lead to higher prices and reduced quality of services,[9] evidence which bolsters the presumption of harm. Defendants do not dispute that Sanford and MDC are direct competitors. Defendants' own expert acknowledges that "the merger increases the merged entity's bargaining leverage,"[10] a key

---

analysis must consider the alternatives available to commercial insurers (and thus, to patients) in the face of a hypothetical monopolist of services provided by the merging parties in the Bismarck-Mandan area.

[8] *See* DX6000 at n.148 ("all insurers in North Dakota face the same availability of providers and substitutability between providers . . ."). Logically, even if analyzed separately, each insurer should still pass the hypothetical monopolist test given the lack of reasonable alternatives to providers in the Bismarck-Mandan area for patients in that area.

[9] *See* Plaintiffs' Opening Br. at 14-20.

[10] DX6000 ¶ 81.

conclusion when analyzing a healthcare provider merger, and reflective of the extent of Defendants' competition as independent entities.

i. Defendants' Arguments Rely on Standards that Do Not Exist

Defendants fault Plaintiffs for not uncovering documents or testimony in which Defendants admit to a specific plan to raise prices, but Defendants are asserting a standard that no court has ever adopted. Intent to reduce competition, or increase prices, is not a precondition to finding a violation of Section 7, nor is expectation on the part of merging parties regarding their ability to wield post-merger market power. *United States v. Bazaarvoice, Inc.*, No. 13-CV-00133-WHO, 2014 WL 203966, at *11 (N.D. Cal. Jan. 8, 2014) ("intent is not an element of a Section 7 violation"). Plaintiffs need only establish that the acquiring firm will have the ability to raise prices or reduce quality after the acquisition to prevail on a unilateral effects claim. *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 81 (D.D.C. 2011). "All 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." *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 719 (D.C. Cir. 2001) (citation omitted); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1082 (N.D. Ill. 2012) (citation omitted); *see also United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 171 (1964) (a Section 7 violation is shown when "the 'reasonable likelihood' of a substantial lessening of competition in the relevant market is shown") (citing *United States v. E. I. du Pont de Nemours & Co.*, 353 U.S. 586, 592 (1957).

ii. The Merger Will Increase Defendants' Bargaining Leverage, and [redacted]

Defendants do not dispute that this merger will, as an economic matter, increase Sanford and MDC's bargaining leverage.[11] Instead, they argue that the [redacted] will allow it to resist post-merger price effects.[12] While Defendants point to the FTC's opinion in *Evanston* that "the post-merger provider had been unable to raise prices on BCBS of Illinois because of its bargaining power," they mischaracterize the finding. The FTC found that BCBS-IL's "market power" was just one "possibilit[y]" for Defendants' failure to raise prices to BCBS-IL post-merger. *In re Evanston*, 2007 WL 2286195, at *52. The comparison is also inapt: that case involved a consummated merger, which provides historical *post-merger* evidence that is not available here. *See In re Evanston*, 2007 WL 2286195, at *2. Ultimately, the FTC found the *Evanston* merger to be unlawful *despite* the apparent absence of price harm to BCBS-IL. Notably, the section of the Administrative Law Judge's opinion cited by Defendants also observes, "That ENH has not, to date, imposed price increases on Blue Cross Blue Shield does not undermine the conclusion that ENH gained market power through the merger." *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2005 WL 2845790, at *138 (F.T.C. Oct. 20, 2005).

Defendants suggest that [redacted], but this figure contradicts Defendants' own ordinary-course documents and expert, all of which confirm [redacted]

[11] *See, e.g.*, DX6000 ¶ 81.

[12] Note that "bargaining power" is not clearly defined by Defendants' expert, who in fact describes it as "stuff that's not kind of included in the specific negotiations that you're examining. And some mergers might change that stuff . . . ." JX00034 at 92; *id.* at 101 (the factors that are attributable to bargaining power "gets back to this stuff issue and that's kind of highlighting stuff that's not captured in the – you know in the bargaining leverage . . .").

[redacted].[13] [redacted] in the Bismarck-Mandan area, [redacted] [redacted] in the number of covered lives since 2014.[14] Defendants arrive at a higher market share for BCBS-ND by arguing that Sanford Health Plan's NDPERS agreement be excluded from statewide commercial insurance market share calculations, but the NDPERS plan functions in all relevant ways like a commercial plan—i.e., it is put out to bid, and involves insurer-provider negotiations over rates to be included in network.[15] Further, like the NDPERS account, [redacted], suggesting that *even under Defendants' framework* its ability to resist price increases would be compromised.

[redacted], it would at most [redacted] the market share of the largest commercial insurer in Illinois at the time the court in *Advocate* enjoined a proposed merger between two hospital systems in Illinois. *See Advocate*, 2017 WL 1022015, at *16. Based on figures cited by the court in the initial (ultimately reversed) district court decision, Health Care Services Corp. (BCBS-IL) controlled approximately 62% of the total insurance market in the Chicago area in 2016. *See FTC v. Advocate Health Care*, No. 15 C 11473, 2016 WL 3387163, at *1 (N.D. Ill.

[13] *See* DX6000 ¶ 35 (BCBS-ND's 2016 market share in North Dakota [redacted] PX04255 at 003 (BCBS-ND's 2015 market share in North Dakota was [redacted]; PX4318 at 009 (based on premiums written, [redacted]; PX04316 at 001 (BCBS-ND started [redacted] PX05064 at 001 (BCBS-ND is [redacted] Plaintiffs' opening brief erroneously stated that [redacted] which was intended to refer only to the testimony cited as PX02006 at 258 where Sanford's [redacted], they still have quite a bit of market power." *See* Plaintiffs' Opening Br. at n.60.

[14] *See* PX06000 ¶ 270.

[15] *See* DX6000 ¶ 36; PX04000 at 001. Dr. Town's argument that NDPERS should be excluded relies on a misunderstanding of the law as well as one conversation he had with a Sanford executive in which he took no notes. *See* DX6005 ¶ 8 & n.33.

June 20, 2016). The commercial insurance shares were portrayed as being even higher by defendants in that case,[16] lending even more validity to the comparison.

Defendants err when they assert that [redacted].[17] Relying on what the [redacted] suggest about the relationship between concentration and prices to infer that [redacted], as Dr. Town does, is circular logic with no analytic validity. Defendants make another basic error. Dr. Town's static cross-sectional analysis fails to take account of [redacted] and providers' bargaining leverage. In other words, the [redacted] may account for provider leverage in a way that is not visible in data from a single point in time.

[redacted]"[18] Defendants would like this Court to view [redacted], but significant differences thwart the comparison. First, the rates paid [redacted] of Medicare.[19] [redacted]

[16] *See* Transcript of Proceedings – Preliminary Injunction Hearing at 56, *FTC v. Advocate Health Care Network*, No. 15-cv-11473 (N.D. Ill.) (ECF No. 502) (defendants' opening statement described BCBS-IL as "dominant" and as having "about 70 percent of the commercial business"); *id.* at 419 (ECF No. 504) (Defendant Advocate's CEO testified that "First of all, nobody raises prices in Chicago. We are all price-takers. Blue Cross has 75 percent market share. So on this upward pricing pressure, we just don't see it at all."); *id.* at 710 (ECF No. 505) (Defendant NorthShore's CEO testified that "Blue Cross in the Chicago marketplace has something like 75 percent market share . . . . There's no way, absolutely no way we can live without a Blue Cross contract."); *id.* at 1032-33 (ECF No. 506) (Defendants' Survey Expert testified that after looking at the data on the market share of BCBS-IL in the relevant geographic market, they "found some indications that [BCBS] is – represents 70 percent of the market.").

[17] JX00017 at 48.

[18] Defs' Opp. at 16, citing JX00017 at 162-163.

[19] *See* PX06003 ¶ 39.

[redacted][20] [redacted],[21] [redacted][22] [redacted]

[redacted]"[23] Medicare does not.

When confronted with a demand for rate increases from the post-merger Sanford, [redacted]

[redacted]"[24] [redacted] avoids the consumer harm that Defendants insist BCBS-ND's bargaining power will prevent.

iii. Harm to Medica Is Not Ameliorated by the [redacted]

Defendants' own expert agrees that [redacted].[25] While Defendants argue that they have signed a private contract to cap Medica's rates, courts strongly disfavor private "remedies" like Defendants' 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; *H & R Block*, 833 F. Supp. 2d at 83; *Commonwealth v. Partners Healthcare Sys., Inc.*, No.

[20] *See, e.g.*, PX04225 at 001-002; *see also* JX00017 at 138, 141) [redacted]
JX00017 at 162; PX03014 ¶ 20; JX00009 at 145; PX04228 at 001.
[22] PX04228 at 001 [redacted] PX05065 at 001 ([redacted].
JX00017 at 162-65.
[24] PX03014 ¶ 44.
[25] *See* DX6000 ¶ 110.

SUCV2014-02033-BLS2, 2015 WL 500995, at *22-24 (Super. Ct. Mass., Suffolk Cty. Jan. 30, 2015); *see also Penn State Hershey*, 838 F.3d at 344 (noting that pricing agreements "have no place in the antitrust analysis we engage in today" concerning the relevant geographic market).

Further, these types of 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[.]"). In this case, Sanford's temporary [redacted] letter agreement with Medica is inadequate to address anticompetitive price effects and fails to address the harm that Medica's subscribers will face through lost quality competition.

Moreover, Defendants' attempts to minimize the impact on Medica using a model that it characterizes as "previously used by the FTC in this context" is misleading.[26] Defendants note that Medica [redacted].[27] But [redacted], likely resulting in higher health insurance costs for Medica's members in the Bismarck-Mandan area.[28] The Clayton Act and the Merger Guidelines do not carve out a *de minimis* safe harbor.

[26] *See* Defs' Opp. at 25.
[27] Defs' Opp. at 25.
[28] *See* DX6001 Table III.7. Even in the unlikely event that CHI successfully repositions to combat anticompetitive effects as Defendants allege, they still estimate [redacted] Defs' Opp. at 25-26; *see* DX6001 Table III.7.

iv. Lost Quality Competition Is Inevitable

The irrefutable evidence that local competition affects the investment and provision of services in the Bismarck-Mandan area—benefitting all patients today, and undeniably at risk following the loss of that competition—is an appropriate cause for concern regarding the merger's effects. The case law is clear that diminishing non-price competition can be anticompetitive under the Clayton Act. In *United States v. Philadelphia National Bank*, the Supreme Court noted the importance of competition on both price and non-price factors. 374 U.S. 321, 368 (1963) ("Competition among banks exists at every level—price, variety of credit arrangements, convenience of location, attractiveness of physical surroundings, credit information, investment advice, service charges, personal accommodations, advertising, miscellaneous special and extra services—and it is keen."); *see also H & R Block*, 833 F. Supp. 2d at 82 (identifying potential diminishments in quality as possible anticompetitive effects); *FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 65 (D.D.C. 2015) ("Sysco and USF compete aggressively against one another on price; non-price incentives, such as signing bonuses; service; and other value-added offerings.").

Specific to the healthcare industry, courts have highlighted the relationship between competition and quality. In *ProMedica*, the court found that competition among healthcare providers led to "increased quality of care, additional service offerings, and other non-financial benefits[.]" *FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *29 (N.D. Ohio Mar. 29, 2011); *see also United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 46 (D.D.C. 2017) ("[S]ignificant head-to-head competition between Aetna and Humana . . . drives improvements to plan cost and quality[.]"). In *Aetna*, the court also considered whether federal regulations pertaining to price and quality "'set the boundaries' for competition between Medicare Advantage organizations," concluding that "competition between [the] plans remains

the motor driving the creation and constant improvement of attractive plans . . . ." *Aetna*, 240 F. Supp. 3d at 52.

The lost quality competition between Sanford and MDC will negatively affect patients in the Bismarck-Mandan area. Competition may not be the only factor that determines quality of care, but it is an important factor. [redacted]"[29] Defendants suggest that Plaintiffs' examples of head-to-head competition do not prove the impact of local competition on either provider's efforts, but the documents speak for themselves. A group of doctors at Sanford informed management that [redacted][30] and Sanford's executives noted, in recommending investment in another new technology, [redacted]"[31] If the proposed merger occurs, the significant head-to-head competition between Sanford and MDC, and its associated non-price benefits, would be lost.

C. Defendants' Arguments on Rebuttal Are Unavailing

i. CHI Entry Is Not Likely to Be Timely nor Sufficient to Mitigate Harm

Entry conditions are highly case-specific, and as such, courts evaluate entry conditions on a case-by-case basis, taking into account factors relevant to the particular market at hand.

[29] JX00028 at 179-180, 187 (also testifying that competition leads to higher quality care for consumers and better outcomes for patients); *see also* JX00022 at 74-75 (describing how MDC competes for patients by providing high-quality care). Sanford's Dr. Michael LeBeau also agrees. *See* JX00021 at 233-45 (describing the benefits of competition and testifying that MDC is either one or the only primary competitor to Sanford Bismarck for adult PCP, OB-GYN, pediatric, and general surgeon physician services).
[30] PX04283 at 002-003.
[31] PX04294 at 001.

Defendants cite two cases as examples of courts finding low barriers to entry in physician mergers, but neither addresses the strong evidence of high entry barriers here. Defendants rely on *FTC v. OSF Healthcare System* for its discussion about the lower entry barriers for the primary care physician market versus the general acute care hospital market, but the court there expressly found "it unnecessary to analyze the PCP market." *See* 852 F. Supp. 2d at 1085. The court in *HTI Health Services, Inc. v. Quorum Health Group, Inc.* evaluated evidence of a lack of entry barriers in that specific time and place, issuing findings that have no relevance for the present matter. *See* 960 F. Supp. 1104, 1133-34 (S.D. Miss. 1997) (entry analysis did not contemplate two-stage model of competition, and relied heavily upon analysis of physician saturation levels in the area).

Defendants ignore more recent and relevant precedent in a case where a physician services merger was enjoined in part because the court found that entry into the adult primary care physician market "would not be timely to counteract the anticompetitive effects of the Acquisition." *St. Luke's*, 778 F.3d at 786. The court further noted that this finding of "high entry barriers" in the adult primary care physician market eliminated the possibility that entry would replace the competition ended by the merger. *Id.* at 788. Notably, the merger at issue involved the combination of an 8-doctor adult primary care physician practice with a 16-doctor practice, *id.* at 781, whereas Sanford's practice employs 37 adult primary care physicians and its acquisition of MDC would add another 23.[32] Moreover, this merger would also result in Sanford acquiring a monopoly over general surgery services and pediatrician services, and a near monopoly of OB/GYN services, requiring entry by an even greater number of physicians than was considered by the court in *St. Luke's*.

[32] *See* PX06000 ¶¶ 34, 36.

Defendants rely on CHI's hypothetical entry to sustain competition in the Bismarck-Mandan area, but even CHI's best efforts would not sufficiently replace MDC's competitive force immediately or in the near-term. CHI estimates that it will take a minimum of [redacted] to get any OB/GYN, pediatrics, and general surgery practice groups up and running, [redacted] *See Bazaarvoice*, 2014 WL 203966, at *70 (finding two years is the appropriate time-frame to evaluate whether entry will be timely); *Sysco*, 113 F. Supp. 3d at 81 (finding entry not timely where it would "take years"). The success of any entry may also be affected by patient preferences for practice groups that have been serving the community for years. *See H&R Block*, 833 F. Supp. 2d at 75 (finding that "importance of reputation and brand in driving consumer behavior" limited an existing competitor's ability to expand). Putting together a practice group that even somewhat approximates MDC's primary care group size and attractiveness (much less the combined Sanford-MDC's) would require a significant investment of money and time.

ii. Defendants Fail to Meet Their Burden on Demonstrating Cost or Quality Efficiencies Sufficient to Mitigate Harm

The burden of demonstrating efficiencies falls squarely on the merging parties, and it is significant. *Advocate*, 2017 WL 1022015, at *12 ("[w]here 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'") (citation omitted). Defendants must meet the criteria set forth in the Merger Guidelines. *See Staples*, 190 F. Supp. 3d at 137 n.15 ("Defendants bear the burden of showing . . . that their claimed efficiencies are: (1) merger specific; and (2) reasonably verifiable by an independent party."). Defendants also must show that their claimed efficiencies will be passed through to consumers in the relevant markets. *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."); *Aetna*, 240 F. Supp. 3d at 94 ("the companies must 'demonstrate that their claimed efficiencies would benefit customers,' and, more particularly, the customers in the challenged markets") (internal citation omitted). Defendants have not met their burden.[33]

At the threshold, Defendants present superficial and implausible arguments regarding their purported cost and quality efficiencies, while misrepresenting the clear testimony from Plaintiffs' cost and quality efficiency experts regarding the shortcomings of those flawed arguments. For example, Defendants cite no legal precedent for their argument that the out-of-market claimed savings in cancer care should be considered in evaluating the effects of the proposed merger. Critically, Defendants do not demonstrate that *this* acquisition is necessary to achieve the claimed savings, as opposed to an acquisition that does not include physicians in the four relevant markets, such as an arrangement in which Sanford simply hires MDC's oncologists. Whether Defendants *may* spend the claimed cancer care savings in areas other than cancer care does not change the analysis. Moreover, Defendants have not shown that *any* patients or insurers will benefit from the claimed savings, because they have not demonstrated, in Dr. Town's report or otherwise, that the claimed savings will be passed through. Regarding laboratory savings, Defendants' new admission that Deloitte's calculation contains an error is not mitigated by their reference to it as an "undisputed non-issue"[34]; rather, it underscores the flaws in the analysis that affect the other purported savings as well. The legal standard requires more than the vague possibilities Defendants offer.

[33] Defendants point to the *Tenet* decision, but there the court merely stated that, "although Tenet's efficiencies defense may have been properly rejected by the district court, the district court should nonetheless have considered evidence of enhanced efficiency in the context of the competitive effects of the merger." *Tenet*, 186 F.3d at 1054. That is indeed the proper context in which to consider efficiencies, because "[t]he Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate." *St. Luke's*, 778 F.3d at 791.

[34] Defs' Opp. at 41.

Defendants' quality enhancement claims also fall far short of meeting their burden. For quality efficiencies, Defendants have put forth one document, *Stronger Together*, containing five pages of bullet points pertaining to alleged clinical benefits.[35] MDC's Dr. Robert Tanous described the *Stronger Together* meeting as "a get-together, if you will, to know who was who, but that's about it."[36] Sanford Bismarck's CEO Dr. Craig Lambrecht labeled any capital commitments arising from the transaction as "conjecture."[37] Plaintiffs nonetheless thoroughly explored these alleged efficiencies through witness testimony, and had an expert analyze these efficiencies through available evidence and public data to determine the merit of these claims. Dr. Jha's report and rebuttal report rely upon his expertise and analysis to determine that the proposed merger is unnecessary for Defendants to realize any of the vague and speculative claims identified in *Stronger Together*. Defendants' arguments do nothing to render their claims cognizable under the Merger Guidelines and the relevant case law.

iii. [redacted]

Testimony and ordinary course documents demonstrate that MDC's motivation for this transaction is, and always has been, [redacted]—not, [redacted]. Prior to initiating sale discussions with either CHI or Sanford, MDC obtained two valuations of the clinic and its assets, [redacted], prompting shareholder "excitement" and the desire to sell.[38] MDC has expressly and repeatedly confirmed that this transaction is about its shareholders' financial gain. MDC board

[35] PX04045 at 024-031. For example, *Stronger Together* contained a total of two sentences of discussion on Imagenetics. *Id.* at 024-025. Defendants now spend over half a page on the issue. Defs' Opp. at 42.
[36] JX00010 at 267-268. MDC's Dr. Shelly Seifert described the process of forming *Stronger Together*: "We didn't do any practical work." JX00022 at 229-231.
[37] JX00004 at 124.
[38] *See* JX00012 at 182-83 ("Well that obviously – [redacted] when you have about 50 partners made a lot of physicians excited because their share is all of a sudden [redacted]."); *id.* at 189-191 ("Our physicians decided to cash in their equity, once we got the Wipfli evaluation[.]").

chair Dr. Shelly Seifert stated the board's responsibility with respect to the proposed merger is to "maximize shareholder return on investment" and that "there's nothing wrong with taking some cash off the table while it's available[.]"[39]

But while MDC's current goal is to complete the transaction with Sanford and cash out its physician owners' investment, MDC has had the intention—

[redacted].[40]

Defendants point to MDC's [redacted]

[redacted].[41] [redacted]

[redacted].[42]

To suggest now that failure to permit this merger's consummation will somehow deprive the Bismarck-Mandan *community* of benefits is simply wrong. [redacted]

[redacted]

[39] JX00011 at 110, 178, 181; *see also* PX05224 at 001 [redacted]

See, e.g., PX05281 at 001 [redacted] JX00029 at 152-54 [redacted] *see also* JX00011 at 240 [redacted]; *id.* at 241 [redacted]; JX00022 at 190 [redacted]

Defs' Opp. at 37 ("MDC also successfully recruited 15 physicians to Bismarck in 2013 and 2014.") (citation omitted). In fact, MDC executives instructed Deloitte, Defendants' efficiencies consultant, to assume that in the absence of a merger MDC would independently maintain a stable level of physician recruitment comparable to the number of physicians it recruited "historically." JX00013 at 208-210.

[42] *See, e.g.*, PX05165 at 001-002.

[redacted][43]

[redacted][44]

[redacted][45]

iv. Witness Tampering Constitutes Admission of Weakness

[redacted], testified that [redacted], attempted to influence [redacted] testimony in this matter by threatening [redacted] Defendants' only response is to [redacted]. The Court can judge the validity of their assertion. [redacted]

[redacted][46]

It is not surprising that, lacking any response, Defendants claim that [redacted] attempt to intimidate a witness into changing his testimony "sheds no light on the disputed factual,

[43] *See* PX07081; JX00022 at 190; PX05221 at 002; *see also* JX00022 at 191-92 ("[T]his was a list of the nonnegotiables.").
[44] *See, e.g.*, PX07081; PX04266.
[45] *See, e.g.*, PX07081; PX04266; PX05081 (discussing, among other things, structure of the transaction, sale price, and employment terms). Arguably, the terms ensuring full scope of practice and adequate space and operating room time are also financial terms because any limitations likely would impact physician productivity and compensation.
[46] PX07040 at 001.

economic and legal issues in this case."[47] But it does. The law is clear that an attempt to influence testimony is tantamount to a party's admission of the weakness of its position, *see Catipovoic v. Turley*, 68 F. Supp. 3d 983, 1006-07 (N.D. Iowa 2014) (citing *Great American Insurance Co. v. Horab*, 309 F.2d 262, 264 (8th Cir. 1962)), which goes to the very heart of the issues before this Court.

2. The Equities Strongly Favor the Injunction

Defendants' assert that this Court should factor into its weighing of the equities that "[a]n injunction . . . will permanently deprive the public of the benefits of the transaction," as Defendants represent that they will abandon the transaction in the face of an appellate court loss.[48] But their own commitment to abandon the transaction is entirely within their control, and not a valid rationale for allowing them to consummate this merger in advance of the conclusion of the trial on the merits. The benefits of this transaction are too thinly supported to play any significant role in balancing the equities. A merger will irreparably alter the *status quo* and immediately harm consumers—Defendants will immediately be able to combine operations, negotiate jointly with insurers, and share competitively sensitive strategic information. Other problematic healthcare provider mergers caused consumer harm following consummation, and proved that restoring competition after the fact is exceedingly difficult to accomplish in a timely and effective way.

For example, in *St. Luke's*, it took almost three-and-a-half years after the district court decision for the divestiture to occur, with the merging parties themselves concluding that, "what may have seemed like a simple, straightforward process at the time that divestiture was ordered,

[47] Defs' Opp. at 49.
[48] Defs' Opp. at 49.

has proven not to be so."[49] Similarly, in *ProMedica*, the divestiture was not approved until mid-2016, over five years after the district court issued its opinion.[50] In *FTC v. Phoebe Putney Health System*, the district court denied a request for preliminary injunctive relief, allowing the merger to close. 793 F. Supp. 2d 1356, 1381 (M.D. Ga.), *aff'd*, 663 F.3d 1369, 1378 (11th Cir. 2011), *rev'd*, 568 U.S. 216, 236 (2013). Although the FTC ultimately prevailed in reversing the preliminary injunction decision two years later, divestiture remained too difficult to achieve, and the parties ultimately remained merged.[51]

Other post-merger remedies have also proven ineffective at protecting consumers from consummated anticompetitive healthcare mergers. For example, in *In re Evanston*, the FTC concluded that Evanston Northwestern Healthcare Corporation's ("ENH") acquisition of Highland Park Hospital was anticompetitive, and found that ENH quickly increased prices immediately after the merger. Despite this harm, the FTC believed ordering a divestiture would be too costly and risky given that the merger had closed over six years earlier, instead ordering ENH to contract separately for Highland Park Hospital. *In re Evanston*, 2007 WL 2286195, at *78-79. However, since the order, no insurer has availed itself of this opportunity, proving the remedy ineffective.[52]

---

[49] Lisa Schencker, *Court-Ordered Breakup is Still Hard to Do*, MODERN HEALTHCARE (July 17, 2015), *available at* http://www modernhealthcare.com/article/20150717/NEWS/150719929; *see also* Order Approving the Divestiture of the Saltzer Assets and Business (May 2, 2017), No. 1:13-cv-00116-BLW, Dkt. No 710, *available at* https://www ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa.
[50] Commission Letter Approving Application for Approval of Proposed Divestiture of the St. Luke's Hospital Assets, *In the Matter of ProMedica Health Sys., Inc.*, Docket No. 9346, June 24, 2016, *available at* https://www ftc.gov/enforcement/cases-proceedings/101-0167/promedica-health-system-inc-corporation-matter.
[51] *See* https://www ftc.gov/news-events/press-releases/2015/03/phoebe-putney-health-system-inc-hospital-authority-albany.
[52] Rick Archer, *Chicago Hospitals Aim for Win in Price-Hike Suit*, LAW360 (May 11, 2017), *available at* https://www.law360.com/articles/922840/chicago-hospitals-aim-for-win-in-price-hike-suit (quoting NorthShore's counsel). Evanston Northwestern Healthcare Corporation changed its name to NorthShore University Healthsystem in 2008.

CONCLUSION

Plaintiffs seek to preliminarily enjoin this merger of the two largest providers of certain critical physician services in the Bismarck-Mandan area. This merger would virtually eliminate competition in these service lines, to the immediate and lasting detriment of consumers. This merger to monopoly is not saved by Defendant's novel economic theories concerning BCBS-ND and its bargaining power. Instead, the standard antitrust analysis used by the courts to evaluate mergers demonstrates that this case involves highly concentrated markets and a strong likelihood of anticompetitive effects. The quantitative and qualitative evidence points in the same direction, and Defendants do not dispute that for patients in the Bismarck-Mandan area, there are no other meaningful alternatives. There is no reason for the Court to deviate from well-established precedent and invite the very dangers that the FTC Act and the Clayton Act are intended to prevent. Plaintiffs request that this Court grant the preliminary injunction and allow the community to continue to benefit from competition between Defendants until the merits proceeding has concluded.

Dated: October 23, 2017

Respectfully Submitted,

/s/ Thomas J. Dillickrath
THOMAS J. DILLICKRATH
KEVIN K. HAHM
CHRISTOPHER CAPUTO
MELISSA C. HILL
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
ccaputo@ftc.gov
mchill@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