No. 17-3783

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

FEDERAL TRADE COMMISSION; STATE OF NORTH DAKOTA,

Plaintiffs-Appellees,

v.

SANFORD HEALTH; SANFORD BISMARCK; MID DAKOTA CLINIC, P.C.,

Defendants-Appellants,

Appeal from the United States District Court for the District of North Dakota
Case No. 1:17-cv-00133-ARS, Hon. Alice R. Senechal

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SUMMARY OF THE CASE

On December 13, 2017, the District Court entered a preliminary injunction preventing Sanford Bismarck from acquiring Mid Dakota Clinic, P.C. This appeal addresses whether the District Court applied the correct legal standards or committed clear error in entering that injunction and assessing the likely competitive effects of the transaction.

Appellants believe that oral argument would aid the consideration of this appeal, and respectfully request that thirty minutes be allotted per side to allow sufficient time for the presentation of the case. Because of the public interest in an expeditious resolution to this dispute, Appellants request that the Court hold oral argument during one of the two sittings being held from May 14 to May 18 in St. Paul, Minnesota and Omaha, Nebraska.

CORPORATE DISCLOSURE STATEMENT

Sanford Health and Sanford Bismarck: Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1A, Sanford Health and Sanford Bismarck state: Sanford Bismarck and Sanford Health are subsidiaries of Sanford. Sanford does not have any parent company, and no publicly held company owns more than 10 percent of Sanford's stock.

Mid Dakota Clinic: Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1A, Mid Dakota Clinic, P.C. states: Mid Dakota Clinic, P.C. does not have any parent corporation, and no publicly held corporation owns more than 10 percent of its stock.

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JURISDICTIONAL STATEMENT

The District Court had jurisdiction under 15 U.S.C. §§ 18, 26, 53(b) and 28 U.S.C. §§ 1331, 1337, and 1345. Add.-055. It granted Plaintiffs' motion for a preliminary injunction on December 13, 2017, A0020, which Defendants appealed on December 15, 2017, A0145. This Court has jurisdiction under 28 U.S.C. § 1292.

STATEMENT OF ISSUES

Whether the District Court erred by evaluating Sanford and Mid Dakota Clinic's evidentiary showing under a legal standard that imposed the ultimate burden of persuasion on Defendants.

- *United States v. Baker Hughes Inc.*, 908 F.2d 981 (D.C. Cir. 1990)
- *Kaiser Aluminum & Chemical Corp. v. F.T.C.*, 652 F.2d 1324 (7th Cir. 1981)

Whether the District Court applied the wrong legal standard or committed clear error in evaluating (a) the transaction's asserted anti-competitive effects, (b) entry of new competitors and expansion of existing competition in the relevant service areas if the transaction is consummated, (c) pro-competitive efficiencies and synergies from the transaction, and (d) Mid Dakota Clinic's future ability to compete absent the transaction.

- *United States v. Baker Hughes Inc.*, 908 F.2d 981 (D.C. Cir. 1990)
- *Kaiser Aluminum & Chemical Corp. v. F.T.C.*, 652 F.2d 1324 (7th Cir. 1981)
- *F.T.C. v. National Tea Company*, 603 F.2d 694 (8th Cir. 1979)
- *United States v. Citizens & S. Nat. Bank*, 422 U.S. 86 (1975)

Whether the District Court erred in defining an antitrust market by misapplying the hypothetical monopolist test.

- *F.T.C. v. Lundbeck*, 650 F.3d 1236, 1240 (8th Cir. 2011)
- *F.T.C. v. Freeman Hosp.*, 69 F.3d 260, 267 (8th Cir. 1995)
- U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines §§ 4.1.1-4.1.3 (2010)

STATEMENT OF THE CASE

I. Introduction

This case involves the Government's attempt to enjoin Sanford Bismarck's ("Sanford") acquisition of Mid Dakota Clinic, P.C. ("MDC"). MDC's physician-shareholders decided in 2015 to sell their practice, after determining that various interrelated factors threatened MDC's long-term viability. It first entered into a letter of intent with CHI St. Alexius ("CHI") with whom MDC had a long-term relationship. CHI is one of two hospital systems in Bismarck and part of Catholic Health Initiatives, one of the largest hospital systems in the country. But CHI reneged on its letter of intent, leading MDC to turn to Sanford, which owns the other hospital system in Bismarck. CHI publicly opposed Sanford's acquisition of MDC ("the transaction") and testified for the Government below.

There is no dispute that the transaction will, prior to entry into and expansion of certain practices by CHI, significantly increase concentration in four relevant service areas—adult primary care, OB/GYN, pediatrics, and general surgery. The undisputed evidence, however, also established that, in North Dakota, concentration is not predictive of competitive harm and the transaction is not likely to have substantial adverse competitive effects in violation of section 7 of the Clayton Act. *See* 15 U.S.C. §18. Rather, the transaction is fundamentally pro-competitive and will augment MDC's indisputably excellent practice with

innovation in genetic medicine, cancer treatment, behavioral health, and electronic medical records resulting from Sanford's system-wide investments. The transaction also will incentivize CHI to expand its competitive presence in Bismarck by hiring physicians who otherwise would not be hired by CHI to replace the patient referrals MDC currently provides to CHI. Further, the transaction permits MDC to determine its own fate, allowing MDC's shareholders to sell their practice when they concluded it was the right time to do so in light of their best judgment as to its long-term prospects.

The reflexive assumption by the Government—that increased concentration will result in competitive harm—demonstrably fails here. Despite longstanding and significant provider concentration throughout North Dakota, including in the relevant service areas, the undisputed evidence establishes that there is no relationship between market concentration and provider prices. This is due to the overwhelming dominance of Blue Cross Blue Shield of North Dakota ("BCBS-ND") and consequent inability of providers to do without a BCBS-ND contract. As a result of that dominance, BCBS-ND has long been able to issue statewide provider fee schedules, with rates based on evidence of provider costs, [redacted]. The Government's case thus rests on a false premise. Moreover, it failed to analyze *any* aspect of the relationship between concentration and price in North Dakota. Instead, its expert

conceded that he assumed that all payers and providers in North Dakota have the same bargaining power regardless of the evidence of the payer's dominance.

The District Court's decision does not account for the absence of any relationship between concentration and price in North Dakota and rests on a series of legal errors, including the misapplication of the framework for analyzing such transactions. Under that framework, the Government must first meet its burden to establish a relevant antitrust market. If it does so, and can establish significant and undue increased concentration in that market, it obtains a presumption of illegality that can be rebutted with evidence that the market share statistics are not predictive of anticompetitive effects. If the defendants produce such evidence, the burden of production shifts back to the Government and merges with the ultimate burden of persuasion, which remains with the Government at all times.

The District Court imposed a legal standard for rebutting the presumption that various courts have rejected, failed to account for the absence of any relationship between concentration and price as well as other undisputed evidence, and improperly imposed on Defendants the burden of persuasion to eliminate any doubt about the competitive impact of the transaction. The District Court decision also rests on additional legal errors regarding assessment of the transaction's competitive effects and market definition. The District Court's decision should

therefore be reversed, and the Government's motion for preliminary injunction denied.

II. Background.

A. The Transaction.

In 2015, after years of deliberation, the physician owners of MDC decided to sell their business. Add.-012. MDC is a multispecialty physician group in Bismarck, North Dakota consisting of 60 physicians. Add.-007. The decision to sell was prompted by declining physician productivity, a strategic review projecting declining ancillary revenues, and concerns about the impact of those factors on MDC's future ability to replace departing physicians. Add.-052; A0415-16; A0417-19; A0421.

MDC solicited acquisition proposals from Sanford and CHI, Add.-012, which own the two hospitals in Bismarck. Both are part of broader integrated systems. Sanford Bismarck is part of Sanford, a not-for-profit integrated health system operating primarily in South Dakota, North Dakota, and Minnesota, including 45 hospitals, 289 clinics, and employing more than 1,300 physicians. Add.-006. CHI St. Alexius is part of Catholic Health Initiatives, an integrated

health system operating in 18 states, owning 101 hospitals, and employing approximately 4,300 physicians and advanced practice clinicians. Add.-007.[1]

Sanford and CHI both submitted proposals. Add.-012. In February 2016, MDC executed a letter of intent with CHI. Add.-012. On March 28, 2016, however, CHI terminated the letter of intent and discontinued negotiations. Add.-012. MDC subsequently reinitiated discussions with Sanford and, on August 22, 2016, the organizations signed a term sheet for Sanford's purchase of MDC. Add.-012. Sanford and MDC signed a final stock purchase agreement on June 19, 2017. Add.-012.

B. The North Dakota Commercial Health Insurance Market.

This case is focused on patients covered by commercial health insurance (*i.e.*, those patients not covered by government programs such as Medicare and Medicaid). Add.-014. Commercial health insurers are typically the direct purchasers of healthcare services. *Id*. Commercial insurers and healthcare providers enter into contracts that set rates and other terms under which the

[1] *See also* Catholic Health Initiatives, *Who We Are*, http://www.catholichealthinitiatives.org/about-us-39752 (visited Jan. 28, 2018). In December 2017, CHI announced its agreement to merge with Dignity Health, which would create the nation's largest non-profit hospital chain. *See* Dignity Health, Press Release, *Dignity Health and Catholic Health Initiatives to Combine to Form New Catholic Health System Focused on Creating Healthier Communities* (Dec. 7, 2017), *available at* https://www.dignityhealth.org/about-us/press-center/press-releases/dignity-health-and-catholic-health-initiatives-announcement (visited Jan. 28, 2018).

insurers—also referred to as "payers"— reimburse providers for services provided to patients. *Id*.

BCBS-ND is by far the largest commercial health insurer in North Dakota. It has a statewide share of at least 55 to 65%. Add.-038-39. If the North Dakota Public Employees Retirement System ("NDPERS") contract is not considered a "commercial" plan, then BCBS-ND's share of the market is [redacted]. A1220. Accordingly, BCBS-ND is by far the largest commercial payer relationship for both Sanford and MDC. For Sanford, BCBS-ND provided [redacted] of its $1.2 billion in annual revenue in 2016. A0318; A1213; Add.-007. Similarly, for MDC, BCBS-ND provided [redacted] of its $107 million in revenue that year. A1304-05; Add.-007.

Sanford Health Plan ("SHP") is a commercial insurer and division of Sanford distinct from Sanford's Health Services Division in which Sanford Bismarck operates. Add.-010-011. The majority of SHP's 31% share of the North Dakota commercial market is the NDPERs contract that SHP won in a competitive bidding process in 2015. Add.-010-011; A1219. If that contract is excluded, SHP's share of the commercial market is 7%. A1220.

Medica is a regional health insurer with between 8 and 11% of the North Dakota insurance market. A1219-20. Of the [redacted] covered by Medica insurance plans in seven states, approximately [redacted] are in the

Bismarck-Mandan area. A0177-78; A1115-16. Medica does not track any metrics separately for Bismarck-Mandan. A0181.

III. Procedural History.

On June 22, 2017, the Government filed a complaint alleging that the transaction would violate §7 of the Clayton Act, 15 U.S.C. §18, and requesting a temporary restraining order and preliminary injunction under §16 of the Clayton Act. A0097. The parties stipulated to a temporary restraining order barring Sanford and MDC from completing the transaction until the District Court ruled on the Government's request for a preliminary injunction. A0126-27.

Following the recusal of Chief Judge Hovland, the case was assigned to Magistrate Judge Senechal. A0010; A0130; A0131. All parties consented to the jurisdiction of the Magistrate. A0132.

After discovery, the District Court held a four-day evidentiary hearing on the Government's motion for a preliminary injunction between October 30, 2017, and November 3, 2017. A0137. On December 13, 2017, the District Court granted the Government's motion for a preliminary injunction. A0020. Defendants appealed that order on December 15, 2017. A0145.

The day prior to filing suit, Complaint Counsel for the Federal Trade Commission ("FTC" or "Commission") initiated an action before an administrative law judge ("ALJ") at the FTC. Discovery in that proceeding was completed

concurrently with discovery in the District Court case. The Commission repeatedly stayed the commencement of any hearing before the ALJ pending resolution of the federal court proceeding. Most recently, the Commission stayed the hearing and all other deadlines until 21 days after the Eighth Circuit "renders its judgment" in this appeal. A0149. This is in keeping with the longstanding reality that the federal court proceeding effectively decides whether the merger will go forward. Indeed, for at least 25 years, no unconsummated transaction challenged by the FTC in both district court and its own administrative process has resulted in a hearing before an FTC ALJ. Instead, the Circuit Court's ruling on appeal from the District Court has been the final word on whether the transaction would proceed.

SUMMARY OF ARGUMENT

The District Court decision to grant the Government's preliminary injunction motion rests on several legal errors. Even assuming the Government established a market and prima facie case of illegality, the Court erred as a matter of law in concluding that Sanford and MDC failed to rebut that presumption, and thus in not requiring the Government to meet its ultimate burden of persuasion. To rebut the presumption, Sanford and MDC were only required to provide credible evidence that called into question the predictive value of the market share statistics on which the Government based its prima facie case. There is no question that they did so. They presented unrebutted evidence of, *inter alia*, (1) the absence of any relationship between price and market concentration in North Dakota due to the dominance of BCBS-ND, (2) contractual prohibitions that prevent Sanford from raising prices paid by Medica for [redacted], (3) the incentive, ability and intent of CHI to enter and/or expand in all of the relevant service areas during the period of that contract, (4) the *de minimis* nature of any potential price increase even assuming no entry, and (5) significant offsetting competitive benefits that the transaction will bring to healthcare services in the Bismarck-Mandan area.

The District Court applied the wrong legal standard in analyzing Defendants' rebuttal case first by expressly applying a "clear showing" standard that numerous courts have held amounts to shifting the ultimate burden of

persuasion to defendants. This was evident throughout the District Court's analysis of the evidence. The law, however, is clear that Sanford and MDC's burden, as defendants, is only one of production and that the ultimate burden of persuasion rests with the Government at all times.

The Court compounded this basic analytical flaw with additional legal errors including:

- failing to account for undisputed evidence establishing an absence of any relationship between provider concentration and price in North Dakota, including in the relevant service areas, *see* §§ I(B)(1)-(2) *infra*;

- viewing the market power of BCBS-ND as relevant only insofar as BCBS-ND could sponsor entry and treating the issue as a defense, *see* § I(B)(2)(b) *infra*;

- concluding that any potential anti-competitive effect, no matter how *de minimis*, requires the entry of an injunction, *see* § I(B)(2)(b) *infra*;

- failing to account for unrebutted evidence concerning entry, *see* § I(B)(3) *infra*;

- failing to offer any legal or factual basis for its finding that certain synergies were not merger-specific, *see* § I(B)(4)(a);

- evaluating the transaction's considerable synergies in light of a generalized assertion about mergers to monopoly rather than considering the actual and likely competitive effects of this transaction, *see* § I(B)(4)(a), and

- concluding that the concerns about MDC's continuing ability to operate as a stable, financially successful, independent physician practice were irrelevant absent proof that it would imminently exit the market. *See* § I(B)(4)(b).

Finally, the District Court erred as a matter of law in concluding that the Government established a relevant antitrust market. The Government relied on a test designed to assess whether a hypothetical monopolist could impose a price increase without ever analyzing the relationship between price and provider concentration in the asserted markets. Instead, the Government relied on data and third-party testimony this Court has previously found to be insufficient to establish a relevant market.

STANDARD OF REVIEW

To obtain a preliminary injunction, the Government must show that "weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." *F.T.C. v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999). "A showing of a fair or tenable chance of success on the merits will not suffice for injunctive relief[,]" because that would be "contrary to congressional intent and reduce[] the judicial function to a mere 'rubber stamp' of the FTC's decisions." *Id*; *F.T.C. v. Freeman Hosp.*, 69 F.3d 260, 267 (8th Cir. 1995) (stating that the Eighth Circuit has adopted a "more stringent standard"). Instead, to demonstrate the required likelihood of success, "'the FTC must raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation and determination by the FTC in the first instance and ultimately by

the Court of Appeals.'" *Tenet Health*, 186 F.3d at 1051 (quoting *Freeman*, 69 F.3d at 267).

To demonstrate a likelihood of success on the merits, the Government bears the burden to establish "(1) a relevant market within which (2) the effect of the acquisition in question may be to substantially lessen competition." *Freeman*, 69 F.3d at 268. "By showing that a transaction will lead to undue concentration in the market for a particular product in a particular geographic area, the government establishes a presumption that the transaction will substantially lessen competition." *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990). "The burden of producing evidence to rebut this presumption then shifts to the defendant." *Id*. "If the defendant successfully rebuts the presumption, the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *Id*. at 983.

This Court applies "*de novo* review to the district court's conclusions of law," which includes whether the district court applied the "proper standard of proof under 13(b) of [the Clayton Act]." *F.T.C. v. H.J. Heinz Co.*, 246 F.3d 708, 713 (D.C. Cir. 2001) (discussing the standard applied in *F.T.C. v. National Tea Co.*, 603 F.2d 694, 696 (8th Cir. 1979)). The District Court's factual findings are reviewed for clear error. *Id*. If this Court's review "reveals that [the District Court

order] rests on an erroneous premise as to the pertinent law, however, [the Circuit Court] must examine the decision in light of the legal principles [the Circuit Court] believe[s] proper and sound." *Id*.

ARGUMENT

I. THE DISTRICT COURT ERRED AS A MATTER OF LAW IN CONCLUDING SANFORD AND MDC FAILED TO REBUT THE PRESUMPTION OF ILLEGALITY.

In *United States v. Philadelphia National Bank*, 374 U.S. 321, 363 (1963), the Supreme Court established a presumption that transactions leading to firms "controlling an undue percentage share of the relevant market" are illegal. The presumption of illegality, however, is rebuttable. *Baker Hughes*, 908 F.2d at 982. "If the defendant successfully rebuts the presumption, the burden of producing additional evidence of anticompetitive effect shifts to the government, and merges with the ultimate burden of persuasion, which remains with the government at all times." *Id*. at 83.

The District Court concluded that the transaction is presumptively unlawful based on the Herfindahl-Hirschman Index ("HHI")—a measure of market concentration—which the Government asserted would increase in its proposed markets of primary care, OB/GYN services, pediatrics, and general surgery. Add.-029, 064 ("Based on the HHI evidence of market concentration, the proposed

transaction is presumptively unlawful."). It then concluded that Sanford and MDC failed to rebut that presumption.

As discussed in § I(A), the standard expressly applied by the District Court erroneously shifted the burden of persuasion to Defendants in two ways that independently warrant reversal.

Further, as discussed in § I(B), the District Court's analysis of evidence confirms that the District Court, in fact, shifted the burden of persuasion to Sanford and MDC on the ultimate issue. In addition, the District Court made several other legal and clear factual errors that warrant reversal, as explained below.

A. The District Court Applied the Wrong Legal Standard in Evaluating Sanford and MDC's Rebuttal Case.

It is well established that under the Clayton Act the ultimate burden of persuasion remains with the Government at all times. *Baker Hughes*, 908 F.2d at 983; *Kaiser Aluminum & Chemical Corp. v. F.T.C.*, 652 F.2d 1324, 1340 (7th Cir. 1981) ("The government continues to bear the burden of persuasion even after it has made out a prima facie case through statistical evidence."). Thus, courts must take care not to apply a standard that effectively shifts the burden of persuasion to the defendant.

The District Court required Sanford and MDC to "produce evidence that *clearly shows* that no anticompetitive effects are likely in order to overcome the

plaintiffs' prima facie case." Add.-065 (citing *Philadelphia Nat'l Bank*) (emphasis added). This legal standard applied by the District Court for rebutting the presumption expressly and improperly shifted the burden of persuasion to Sanford and MDC in two ways.

First, "by stating that the defendant can rebut a prima facie case only by a *clear* showing, the standard in effect shifts the government's ultimate burden of persuasion to the defendant." *Baker Hughes*, 908 F.2d at 983 (emphasis in original). As the D.C. Circuit explained, subsequent decisions "discarded *Philadelphia Bank's* insistence that a defendant 'clearly' disprove anticompetitive effect, and instead described the rebuttal burden simply in terms of a 'showing.'" *Baker Hughes*, 908 F.2d at 990-91. The difference is important because § 7 "gives a court the uncertain task of assessing probabilities" such that if "the burden of production imposed on a defendant is unduly onerous, the distinction between that burden and the ultimate burden of persuasion—always an elusive distinction in practice—disintegrates completely," *id*. at 991. *See also United States v. Anthem, Inc.*, 855 F.3d 345, 350 (D.C. Cir. 2017), ("because the burden of persuasion ultimately lies with the plaintiff, the burden to rebut" the presumption created by the Government's concentration based prima facie case "must not be 'unduly onerous.'").

Second, the District Court's standard also erroneously required a clear showing *of the ultimate issue in the case*: whether the transaction is likely to substantially lessen competition. *See Baker Hughes*, 908 F.2d at 991 (a "defendant required to produce evidence 'clearly' disproving future anticompetitive effects must essentially persuade the trier of fact on the ultimate issue in the case—whether a transaction is likely to lessen competition substantially").

The Supreme Court has made clear that rebutting the presumption of illegality requires only the presentation of evidence "that the market-share statistics [give] an inaccurate account of the acquisition['s] probable effect[] on competition." *United States v. Citizens & S. Nat. Bank*, 422 U.S. 86, 120 (1975). This follows from how the presumption is established and the assumption on which it depends. The presumption of illegality is established by "showing that a transaction will lead to undue concentration in the market for a particular product in a particular geographic area." *Baker Hughes*, 908 F.2d at 982. The presumption is based on an assumed relationship between concentration and competition: as concentration increases, competition decreases. *Philadelphia Nat'l Bank*, 374 U.S. at 363. Thus, in this case, the District Court concluded that "[b]ased on the HHI evidence of market concentration, the proposed transaction is presumptively unlawful." Add.-029, -066.

A defendant can rebut the presumption by presenting evidence undermining the predictive value of the market concentration data on which the presumption rested, here by showing an absence of a relationship between provider concentration and price. The prima facie case does not shift the "burden of persuasion" but instead shifts the burden of "going forward with the evidence" to show that "the statistics do not accurately depict competitive conditions." *Kaiser Aluminum*, 652 F.2d at 1340 n.12; *id.* at 1341 ("evidence which casts doubt on the persuasive quality of the statistics to predict future anticompetitive consequences may be offered to rebut the prima facie case made out by the statistics"). *See also F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206, 1218 (11th Cir. 1991) ("the defendant may demonstrate unique economic circumstances that undermine the predictive value of the government's statistics"); *Anthem*, 855 F.3d at 349 (defendant rebuts the presumption by "provid[ing] sufficient evidence that the prima facie case 'inaccurately predicts the relevant transaction's probable effect on future competition'") (quoting *Baker Hughes*, 908 F.2d at 991). By requiring Defendants to make a clear showing that the transaction was not anticompetitive, the District Court applied the wrong legal standard and shifted the Government's burden to Defendants.

B. The District Court Improperly Shifted The Burden Of Persuasion In Analyzing The Various Components of Defendants' Rebuttal Case.

The District Court's analysis of the evidence further confirmed that the District Court required Defendants to prove the ultimate issue in the case, including by the Court's failure to account for unrebutted statistical and other evidence directly undermining the predictive value of provider concentration. The District Court also made additional legal errors in assessing evidence regarding price effects, market entry, synergies, and MDC's prospects.

1. The District Court Erred By Ignoring Evidence Directly Showing That Provider Market Concentration Is Not Predictive Of Anti-Competitive Effects In North Dakota.

Defendants first rebutted the Government's presumption by presenting statistical analysis demonstrating that market concentration, measured using the same HHI statistics used by the Government to establish the presumption, is not predictive of price effects in North Dakota. *See F.T.C. v. National Tea Company*, 603 F.2d 694, 701 (8th Cir. 1979) (affirming the denial of a preliminary injunction in part on the basis that "[t]here was considerable conflict in the evidence as to whether increases in" relevant market concentrations "implied more than marginal increases in price, that is, decreases in competition"). Professor Robert Town—an economist retained by Defendants who previously testified on behalf of the FTC in a healthcare merger case (*see ProMedica Health Sys. Inc. v. F.T.C.*, 749 F.3d 559 (6th Cir. 2014)), and had been retained by the Department of Justice and FTC on

multiple occasions—evaluated the relationship between market concentration and price and found that "Blue Cross's reimbursement rates for physician services do not vary by market concentration." A0390; A1234; A1408. The lack of relationship between market concentration and price held true in geographic areas with HHIs in the relevant service areas that are the same or higher than the HHIs that the District Court found would result from the transaction.

Specifically, in Minot, Trinity Health has 75% of primary care, 90% of pediatrics, 100% of OB-GYN, and 91% of general surgery. A1249-50. In Grand Forks, Altru has 83% of primary care, 100% of pediatrics, 84% of OB/GYN, and 96% of general surgery. *Id*. Despite these concentrations, these providers receive rates identical to those paid by BCBS-ND to providers in less concentrated areas. A1234 ("Markets that exhibit high HHIs (*e.g.*, Grand Forks and Minot) do not exhibit higher reimbursement rates on average relative to markets that are less concentrated, such as Williston."); A0407-11; A1438-44. The absence of any relationship between concentration and price throughout the state also held true despite the absence of competing hospital systems in all but Fargo and Bismarck. A0455. Professor Town also presented an analysis showing no relationship between provider concentration and quality of care in North Dakota. A0401-05; A1288-93.

The Government did not dispute the accuracy of these analyses or present any countervailing evidence regarding the relationship between HHI and competition in North Dakota. To the contrary, the Government's expert admitted he "did not" "perform any empirical analysis of the relationship between HHI measurements and physician reimbursement in North Dakota." A0255.

The demonstrated absence of any relationship between market concentration and anticompetitive effects directly negates the predictive value of the concentration metric the Government relied upon to establish the presumption of illegality in the first instance and thus is sufficient to rebut that presumption. The presumption is based on measuring the change in market concentration from the transaction and an assumption that concentration has a direct relationship with competition. *Philadelphia Nat'l Bank*, 374 U.S. at 363; *Baker Hughes*, 908 F.2d at 982-83. Accordingly, directly showing that concentration of a particular market lacks predictive value regarding the alleged anti-competitive consequences of the transaction rebuts the presumption and requires the burden of production to shift back to the Government and merge with its ultimate burden of persuasion. *United States v. General Dynamics Corp.*, 415 U.S. 486, 501 (1974) (holding that § 7 was not violated solely on basis that "the statistics relied on by the Government" were "insufficient to sustain its case"); *Kaiser Aluminum*, 652 F.2d at 1335 (explaining that, in *General Dynamics*, the Court affirmed the lower court's "finding no

violation of § 7" by "reach[ing] only the ground that the statistics on concentration resulting from the merger did not accurately forecast competitive conditions in the coal market").

Despite this uncontroverted evidence that there is no relationship between concentration and price or quality in North Dakota, the District Court did not consider this evidence when assessing whether Sanford and MDC rebutted the presumption of unlawfulness. Add.-065-071. The Court mentioned that evidence only in listing allegations made by the parties without accounting for its implications for the predictive value of the Government's metrics upon which the Court found the presumption had been established. Add.-043-044, 065-071. *See also* § I(B)(2)(b) *infra* (addressing in greater detail the District Court's discussion of pricing evidence). The "presumption, however, does not allow a court to ignore [non-concentration] evidence tending to show that the market shares do not accurately reflect the likelihood that the merger will substantially affect competition adversely." *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 275 (7th Cir. 1981). Its failure to account for uncontroverted statistical evidence of the lack of predictive value of market share in this case was legal error that requires reversal.

2. Additional Evidence Related To Pricing Rebutted The Presumption.

In addition to presenting unrebutted statistical evidence, Defendants further rebutted the presumption by demonstrating that the undisputed need of providers to contract with North Dakota's dominant commercial payer, and BCBS-ND's resultant bargaining power, have enabled BCBS-ND to establish and impose a system of statewide rates that are determined by BCBS-ND, rather than individually negotiated based upon provider concentration and leverage. As a result, notwithstanding historically high provider concentration throughout North Dakota, [redacted]. Defendants further showed that the ability to impose such a system both reflects and is a source of BCBS-ND's high bargaining power and the absence of competitive effects.

The evidence further showed that Sanford is contractually precluded from increasing Medica's rates for [redacted] and that any price increase beyond that time will be precluded by intervening expansion and entry, at most *de minimis*, and well offset by the considerable synergies that the transaction will generate. The District Court's treatment of this evidence included several critical legal errors and further demonstrates that, in evaluating the evidence in this case, the Court improperly shifted the burden of persuasion to Defendants.

a. Sanford and MDC Presented Substantial Evidence Demonstrating That The Transaction Would Not Lead To Higher Prices.

As the District Court recognized, "[t]here is no question that BCBSND is a powerful buyer in the Bismarck-Mandan area and throughout the state." Add.-038. Its statewide share of the commercial market is at least 55-65%. Add-039. For this reason, 100% of hospitals and 98% of physicians in North Dakota contract with BCBS-ND. Add.-009. Sanford and MDC earned [redacted] in 2016 from BCBS-ND commercial plans, and BCBS-ND is by far the largest payer over Sanford's multi-state footprint, accounting for more than [redacted] in revenue. A0318; A1213-15; Add.-007. As a result, Sanford cannot risk losing its contract with BCBS-ND. A0290-91; A0315.

BCBS-ND's dominance and resultant bargaining power explain why there is no relationship between provider concentration and price, including in areas where providers hold a monopoly or near-monopoly share. Rather than reach individually negotiated agreements with providers—or even with just the largest providers—that vary based on provider leverage and concentration, BCBS-ND establishes one set of rates for all North Dakota providers that are set to "'make sure the providers can continue to offer services in North Dakota'" – *i.e.*, based on provider costs, not leverage. Add.-040.

First, BCBS-ND [redacted]. Add.-040. [redacted]. *Id*.

Second, BCBS-ND establishes its uniform statewide fee schedules. During that process, it solicits input from providers [redacted]—*i.e.*, situations at which the rates are not high enough to "make sure the providers can continue to offer" the service in question—based on evidence of provider costs. Add.-040. [redacted]. A0206. As explained by BCBS-ND's representative in unrebutted testimony, BCBS-ND's willingness to adjust its fee schedule over time depends upon "the type of evidence" that a provider is "able to provide to support their position." A1157-58 ("We look for solid evidence that there is a need to make a modification."). [redacted]. Add.-040; A0206. [redacted]. Add.-040; A0210-12.

As a result, even though there is high provider concentration throughout North Dakota both in the relevant service areas and due to an absence of competing hospital systems, the Government [redacted], A0212, [redacted]. *See* § I(B)(1) *supra*.

Defendants provided additional unrebutted economic testimony and documentary evidence that the District Court did not address demonstrating that BCBS-ND's use of statewide rates is both a reflection and an additional source of its high bargaining power. A0392-94. Sanford's expert economist Professor Town explained that only a payer with high bargaining power could set statewide rates at a level that would be economically rational from the payer's perspective. *Id*. Thus, BCBS-ND is able to impose such pricing while Medica and SHP are not. A0393-94. Moreover, documentary evidence from BCBS-ND itself reflected that it adopted statewide pricing to negate the bargaining leverage of the many health

care providers in North Dakota in markets with only one hospital system. A0455 ("*As a method to offset the leverage associated with lack of competition in our market (only Fargo and Bismarck have competing systems) we deployed a uniform payment system that essentially pays all providers the same amount for the services rendered*.") (emphasis added).

Professor Town also explained why the evidence of BCBS-ND high bargaining power further rebutted the presumption that increased HHIs following the transaction would lead to higher prices: payers with sufficiently high bargaining power can offset provider bargaining leverage. As Professor Town explained, while "bargaining power" and "bargaining leverage" are often used interchangeably in common parlance, they have distinct meanings in the economic literature. Bargaining leverage refers to the respective walk-away points of the negotiating parties, sets the price range within which the negotiating parties could reach agreement, and can change based on provider concentration. A0382-83. By contrast, bargaining power consists of the various factors that determine the price the parties agree on within that range and whether leverage can be translated into increased rates. A0382; A0384-85.

The District Court thus clearly erred in finding that "[e]xperts for both sides agreed that each side's bargaining leverage determines the reimbursement and non-monetary terms to which the commercial insurers and healthcare providers agree."

Add.-030. In fact, *neither* expert agreed with that proposition. Professor Town devoted much of his testimony to explaining that price and other terms are a function of both bargaining power *and* bargaining leverage and that because of BCBS-ND's bargaining power, there is no relationship between provider leverage and price. A0382-83; A0384-85. Moreover, the Government's expert agreed that bargaining power was distinct from bargaining leverage and necessary for determining price. A0231. The difference between the experts (unaddressed and thus unresolved by the District Court) was that the Government's expert simply assumed that provider and payer bargaining power were equal for all participants in North Dakota and thus that all payers—BCBS-ND, SHP, and Medica—have the same bargaining power. A0244; A0389. By contrast, Professor Town did not assume that all North Dakota payers have the same bargaining power or that their power was equal to the power of all North Dakota providers; instead, he measured it by examining the relationship between provider concentration and price. A0378-79, A0389.

b. The District Court's Analysis Of Pricing Evidence Rested On Errors Of Law And Improperly Shifted The Burden Of Persuasion To Appellants.

The District Court's conclusion that Defendants failed to rebut the Government's presumption notwithstanding all of the foregoing, effectively imposed on Defendants the very burden that various courts have held to be

inappropriate. The District Court credited the Government's assertion that what the District Court referred to as a "power buyer defense," and thus evidence about BCBS-ND's ability to resist price increases, was only cognizable in situations where a buyer can sponsor entry or vertically integrate or where there are alternative suppliers post-merger. Add.-067-068. The District Court, by so cabining the evidence regarding BCBS-ND, erred as a matter of law. While the ability to sponsor entry would be relevant, there is no basis to limit the relevance of evidence of BCBS-ND bargaining power to that one scenario. The U.S. Department of Justice and the Federal Trade Commission Horizontal Merger Guidelines ("Merger Guidelines") cite the scenarios identified by the District Court only as examples, not an exhaustive list, of instances where a power buyer can be relevant. *See* Merger Guidelines §8 ("This can occur, *for example*, if powerful buyers have the ability and incentive to vertically integrate upstream or sponsor entry, or if the conduct or presence of large buyers undermines coordinated effects.") (emphasis added).

The Supreme Court has made clear that, after considering market share statistics, "only a further examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger." *General Dynamics*, 415 U.S. at 498. As a result, both the Government and various courts (including this one)

have specifically recognized the importance of accounting for powerful buyers to assess the competitive effects of a transaction for reasons other than their ability to sponsor entry, including their ability to prevent price increases. *See, e.g., Tenet Health*, 186 F.3d at 1045 ("In spite of their testimony to the contrary, *the evidence shows that large, sophisticated third party buyers can [and] do resist price increases*, especially where consolidation results in cost savings to the merging entities") (emphasis added).[2]

Moreover, the District Court's characterization of the BCBS-ND evidence as a "power buyer *defense*" is inconsistent with case-law making clear that the presumption of illegality does *not* shift the ultimate burden of persuasion to the defendant. Add.-021 ("this court finds it appropriate to consider BCBSND's dominance as a defense"); Add.-062; Add.-067-68. *See also Kaiser Aluminum*,

[2] *See also In the Matter of Evanston Nw. Healthcare Corp.*, No. 9315, 2005 WL 2845790, at *138 (F.T.C. October 20, 2005) (stating in assessing a consummated merger that BCBS-IL "has the power to limit ENH's price increases" because it "had a very strong bargaining position"); *F.T.C. v. R.R. Donnelley & Sons Co.*, No. CIV. A. 90-1619 SSH, 1990 WL 193674, at *4 (D.D.C. Aug. 27, 1990) ("Well-established precedent and *the United States Department of Justice Merger Guidelines* recognize that the sophistication and bargaining power of buyers play a significant role in assessing the effects of a proposed transaction" and that "even if these customers constituted a separate market, their own size and economic power, and the other characteristics of the 'market,' make any anti-competitive consequences very unlikely"); *United States v. Archer-Daniels-Midland Co.*, 781 F. Supp. 1400, 1422 (S.D. Iowa 1991) ("There is no question that the size and sophistication of buyers in the HFCS industry is a powerful 'other factor' that strongly mitigates against the possibility of any attempt by HFCS suppliers to raise prices anticompetitively.").

652 F.2d at 1340 (explaining that a defendant's rebuttal case is not a defense and that the "government continues to bear the burden of persuasion even after it has made out a prima facie case through statistical evidence"); *Baker Hughes*, 908 F.2d at 983 ("the ultimate burden of persuasion [ ] remains with the government at all times").

The District Court relied on the testimony of a BCBS-ND representative that, if Sanford threatened to terminate its contract if it did not receive higher rates, BCBS-ND would be forced to pay higher rates. Add.-041, 044. As an initial matter, BCBS-ND's representative also acknowledged that her conclusions about the transaction rested upon the assumption that CHI would not add physicians in the relevant service areas and thus, that BCBS-ND would have no alternative to Sanford in the Bismarck-Mandan area. A0201. As discussed in § I(B)(3) *infra*, that assumption is demonstrably incorrect in light of CHI's own estimates as to its ability and intent to enter the market.

Moreover, and apart from entry, there was no evidence that Sanford would or credibly could issue such an ultimatum. Rather, and as discussed above, all evidence was to the contrary. Sanford had never given indication of the intent to do so, Add.-043, and has no realistic ability to even threaten to terminate its contract with BCBS-ND given the proportion of its revenue from BCBS-ND. Further, the North Dakota provider market has long been highly concentrated, both

in terms of the relevant service areas and by the absence of competing hospital systems anywhere but Bismarck and Fargo. If highly concentrated providers could issue an ultimatum to obtain increased rates, there is no explanation of why the various highly concentrated providers in North Dakota have been unable either to use their leverage to obtain increases in overall statewide reimbursement rates or to obtain special increases for themselves. Instead, as discussed above, [redacted].

The District Court pointed only to a single instance five years ago [redacted]. Add.-044. But as the undisputed evidence reflected, this did no more [redacted]. A0213, A0215; A0429. It did not reflect the ability of monopoly providers to secure from BCBS-ND unique rate increases or to cause increases in

statewide rates paid to all providers through threats of termination. There is literally no precedent for that despite the fact that North Dakota has long exhibited high concentration in the relevant service areas and has lacked competing hospital systems in most of the state. *Cf. Baker Hughes*, 908 F.2d at 986 (affirming the denial of a preliminary injunction in part because "the trial judge found that concentration has existed for some time in the [relevant market] but there is no proof of overpricing, excessive profit or any decline in quality, service or diminishing innovation").

The District Court thus required Defendants to prove that higher concentration following the transaction will not result in either an increase in BCBS-ND statewide rates or special BCBS-ND rates for Sanford, [redacted]. In doing so, the District Court thereby both ignored the undisputed evidence regarding the unique circumstances in North Dakota and improperly shifted the burden of proof to Defendants to eliminate any doubt about the competitive impact of the transaction in violation of the consistent admonition of courts that this is improper and that the ultimate burden of persuasion is retained by the Government.

Appellants similarly rebutted any presumption with respect to Medica. Sanford and Medica's current contract precludes Sanford from raising rates on

Medica for the [redacted]. A1109. [redacted]. *See* § I(B)(3), *infra*.

Appellants also showed that the nature of the Sanford-Medica relationship would preclude price increases in the asserted markets beyond the [redacted] simply as a result of the transaction. The asserted markets represent less than 5% of the overall Medica-Sanford relationship. A0180. Those markets are, therefore, a small fraction of a multi-state negotiation in which both sides make tradeoffs within the context of a fixed budget that applies to the entire relationship. A0183; A0324-25. Thus, as explained by Sanford's Vice President of Corporate Contracting, Martha Leclerc, Sanford does not use its relationship as a dominant provider in one area to leverage a higher rate in that area because it would jeopardize its relationship in other areas where Medica's presence is more significant. A0324-35; A0576. Moreover, even ignoring CHI's entry estimates and the multi-state nature of the Sanford-Medica relationship, Professor Town's merger simulation estimates a price increase of only [redacted] in the markets found by the District Court, approximately [redacted] for each of Medica's [redacted] members in the Bismarck-Mandan area should Medica pass through the entirety of the hypothetical price increase. A0177-78; A0397-98; A1373-75.

The District Court stated without citation in reference to Medica that Sanford and MDC acknowledged that healthcare spending in the Bismarck area "would increase as a result of the proposed transaction" and that "Antitrust law does not recognize a de minimis exception." Add.-021. This assertion first fails to account for the language of the Clayton Act, which condemns only mergers that are predicted to "*substantially* lessen competition." Further, it is precisely when anti-competitive effects are *de minimis* that synergies become most significant. See Merger Guidelines § 10 ("In the Agencies' experience, efficiencies are most likely to make a difference when the likely adverse competitive effects, absent the efficiencies, are not great.") Here, Sanford and MDC have shown concrete, competitive benefits from the synergies that will result from the transaction which vastly outweigh the potential *de minimis* increase in price to Medica that would not under any circumstance occur for at least [redacted]. *See* § I(B)(4)(a) *infra*. The District Court nowhere purported to weigh the at most *de minimis* impact on Medica against the significant synergies that the transaction will generate. *Id*. Further, the estimated price increase that the District Court cited assumed ***no*** additional entry during the [redacted], contrary to CHI's own estimates as discussed in the next section and even though the District Court found that the presence of alternatives increases payer bargaining leverage. Add.-046, 047. A0398. The District Court also made no attempt to account for the evidence

Sanford presented that the nature of the Sanford-Medica relationship would preclude *any* price increase.[3]

Finally, it bears emphasis that notwithstanding a lengthy investigative process resulting in the production of over a million documents and 149 hours of pre-hearing testimony, there was no evidence suggesting Sanford and MDC intended to raise prices or believed the transaction would give them the opportunity to do so. While not dispositive, the absence of such evidence further differentiates this case from many cases relied on by the District Court.[4]

3. The District Court Failed To Account For Undisputed Evidence Concerning The Ability Of CHI To Enter, Expand, And Compete In The Relevant Service Areas.

The ability and incentive of competitors to enter a relevant market are "crucial considerations in a rebuttal analysis." *Baker Hughes*, 908 F.2d at 987 (citing numerous cases). "Predicting future competitive conditions in a given market, as the statute and precedents require, calls for a comprehensive inquiry." *Id*. Here, the District Court's analysis of Sanford and MDC's rebuttal case failed to account appropriately for the role and likelihood of entry or expansion by

[3] The District Court described Sanford witness Ms. LeClerc's testimony without making a judgment as to its credibility. Add.-046, 047.

[4] Cases cited by the District Court where there was direct evidence of an intent to raise prices and/or eliminate competition include *ProMedica Health Sys., Inc. v. F.T.C.*, 749 F.3d 559, 571 (6th Cir. 2014); *Saint Alphonsus Med. Ctr. – Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, Nos. 1:12-CV00560, 2014 WL 407446, *10-11 (D. Idaho Jan. 24, 2014); *F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206, 1218 (11th Cir. 1991); *F.T.C. v. Cardinal Health*, 12 F. Supp. 2d 34, 63-64 (D.D.C. 1998).

competitors to Sanford in ensuring that there would be no competitive harm from the transaction. In particular, despite undisputed evidence of CHI's ability and incentive to expand and compete in these service areas (including CHI's own estimates), the District Court improperly imposed a burden on Defendants to eliminate any doubt that such entry would occur.

In this case, CHI St. Alexius, Sanford's chief competitor in the Bismarck area and a fierce opponent of the transaction, [redacted]. *See* A0156-57 ([redacted]); A1106 ([redacted]); *id*; A0171-74 ([redacted]); A0174; A1148-49 ([redacted]); *see also F.T.C. v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1076 (N.D. Ill. 2012) (observing that "the PCP market *is not subject to the same prohibitive barriers to entry that exist in the GAC [hospital] market, and the bargaining leverage held by large insurance companies* with respect to physician contracting is different than what would exist in contracting for GAC

services if the merger were to take place" and that these and other features made it "less likely that the FTC will prevail on its claim involving the PCP market") (emphasis added); *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104, 1134-35 (S.D. Miss. 1997) (rejecting claims about regional barriers to recruiting new primary care physicians).

CHI also made clear it was amply incentivized to do so. It expressed concern that the transaction will cause it to lose a substantial number of referrals from MDC doctors to CHI St. Alexius, which have previously accounted for [redacted] of hospital admissions and approximately [redacted] in annual net revenue. A0159; A0552; A1123-24; A1128; A1150; A1153. The District Court itself concluded that the "anticipated decline in referrals to CHI St. Alexius would indeed incentivize and motivate CHI to add physicians in the four service areas." Add.-051.

Further, unrefuted documents and testimony established that upon announcement of the transaction, [redacted]. A1128-30, A1131, A1175-76; A0551 ([redacted]), A0554 ([redacted]). [redacted]

[redacted]. A0162; A1131-34; A1138.

Indeed, there was substantial evidence that CHI will enter and expand sooner than its own estimates. CHI already has made plans to utilize excess capacity in its existing primary care practice in Mandan by expanding to a new Bismarck clinic that it is opening in January 2018. A0162-64; A0164; A0165; A1108; A1141; A1144-45; A1181-82; A1190. [redacted]. A0164; A0165; A0166; A1182; A1189-90; A1196-97. [redacted]. A0166; A0167-68; A1193. [redacted]. A0082; A0228; A1187-89. [redacted]. A0304-06; A0314; A0424-25; A0556; A0841; A0883-84; A0890; A1167; A1171; A1118-20. CHI has various other advantages that

enable it to attract physicians to expand and build practices in each of the four service areas. As the fourth largest non-profit healthcare system in the United States, CHI has significant resources that can be used to recruit physicians nationwide. Moreover, in Bismarck, it has a well-established reputation in the community and a loyal patient base in part due to its Catholic affiliation. A0225; A0891; A1127; A1310. Sanford's success in recruiting numerous physicians to the Bismarck area as well as smaller North Dakota communities further demonstrates that a healthcare system such as CHI has the ability to do so. A0573 (showing the recruitment of 24 physicians a year in Bismarck since 2012); A0953 (planning for the recruitment of 136 physicians between fiscal year 2018 and 2022); A0349-50; *see also* A1200 (Sanford CEO describing task of CHI in recruiting primary care doctors as "among the easier tasks that I, as a CEO, know exists in healthcare today").

Such evidence demonstrated both that payers would have alternatives to a post-merger Sanford and that Sanford's incentive to compete in other ways would if anything be amplified by enhanced competition from CHI. The District Court, however, did not make the requisite "comprehensive inquiry" on the issue of entry. Instead, the Court shifted the burden of proof to the Defendants to eliminate any doubt that entry would occur. The Court found that while the "anticipated decline in referrals to CHI St. Alexius would indeed incentivize and motivate CHI to add

physicians in the four service areas," the "hearing evidence did not establish that the Bismarck-Mandan area's population is sufficient to support a significant increase in total numbers of physicians in each of the four service lines." Add.-051. This ignored the fact that ***CHI specifically testified*** as to its intent and ability to expand or enter in each of the relevant service areas in a specified period of time if the transaction occurs. It also is contrary to the District Court holding that there is an "increasing demand" for MDC's services because there are "plenty of patients" for physicians. Add.-052. The District Court could have concluded that CHI-St. Alexius's CEO had ***overstated*** the amount of time it would take to expand or enter the market in the various service areas given evidence presented by Sanford and MDC and CHI's admitted incentives. There was no basis, however, for the District Court to conclude that it would not be possible for CHI to do so ***at all*** because of insufficient demand, when even CHI believed it could do so in just [redacted].

The District Court's ultimate disregard for the estimates of Sanford's chief competitor as to when it would be equipped to replace the services now provided by MDC (as well as the other evidence presented) is all the more noteworthy given the rarity with which such evidence is available. As the D.C. Circuit explained in rejecting the requirement that defendants clearly show that competitors' entry will be "quick and effective," evidence concerning "specific competitors and their

plans" is "rarely available," and "potential competitors have a strong interest in ***downplaying*** the likelihood that they will enter a given market." *Baker Hughes*, 908 F.2d at 987 (emphasis added). By demanding ***more*** evidence on the subject of entry than the estimates of Sanford's chief competitor, the District Court improperly imposed on Defendants the burden of eliminating any possible doubt about the impact of entry on the competitive effect of the transaction. In doing so, it improperly imposed the ultimate burden of persuasion on Defendants. *See Baker Hughes*, 908 F.2d at 991 ("If the burden of production imposed on a defendant is unduly onerous, the distinction between that burden and the ultimate burden of persuasion—always an elusive distinction in practice—disintegrates completely"). Further, by ignoring CHI's actual estimates and requiring the elimination of any doubt about entry, it ignored this Circuit's recognition that "Section 7 deals in probabilities, not ephemeral possibilities." *Tenet Health*, 186 F.3d at 1051.

4. Evidence Of The Substantial Pro-Competitive Effects Of The Transaction Rebutted The Presumption.

a. The District Court Erred In Evaluating The Various Pro-Competitive Synergies and Efficiencies That The Transaction Will Generate.

The District Court similarly erred as a matter of law in analyzing the pro-competitive effects of the transaction. There was ample uncontested evidence of concrete and significant quality improvements for the Bismarck-Mandan population that would not occur but for the transaction and that will therefore be

lost if the transaction is blocked. These improvements include: (1) Sanford's comprehensive program for integrating genetic medicine into primary care (known as Imagenetics); (2) expanded cancer protocol and treatment options for MDC patients; (3) expanding Sanford's model for embedding behavioral health therapists in its primary care clinics; (4) putting MDC on the electronic medical records system used by both hospitals in the Bismarck-Mandan area (known as EPIC); and (5) increasing the ability to recruit needed subspecialists to the Bismarck-Mandan area.

As the District Court recognized, there was no dispute that "the claimed quality efficiencies, if implemented, would in fact result in increased quality of care for patients in the Bismarck-Mandan area." Add.-038. The District Court, however, found that the claimed quality efficiencies were insufficient to overcome the presumption of illegality for two reasons. *First*, while recognizing that the "claimed quality efficiency in the Imagenetics program" is "merger-specific," the Court found that "the defendants have not demonstrated that the other claimed quality efficiencies are merger specific." Add.-038. *Second*, the District Court concluded that because "the proposed transaction would result in near-monopoly, the claimed quality efficiencies are insufficient to overcome the presumption of illegality." Add.-038.

Nothing in the District Court's opinion explains how it reached the conclusion that four of these five quality synergies were not merger-specific. The District Court does not identify the legal standard it applied to determine the merger-specificity of a quality efficiency, nor does it make any factual findings regarding any of the claimed efficiencies or otherwise explain the factual basis for its conclusion that any (let alone all) of the claimed efficiencies other than Imagenetics were not merger-specific. Moreover, the evidence on these issues (most of which was undisputed) leaves no doubt that the District Court applied the wrong legal standard, committed clear error, or both.

The Merger Guidelines explain that a merger-specific efficiency is one that is "likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects." Merger Guidelines, §10. The focus of this standard on what is likely or unlikely to occur but for the merger is consistent with this Circuit's recognition that "§ 7 deals in probabilities not ephemeral possibilities." *Tenet Health*, 186 F.3d at 1051. As the following demonstrates, there was no dispute that the remaining claimed quality efficiencies were likely to be implemented if the transaction proceeds and no basis for disputing that they are unlikely to be implemented if it does not.

Imagenetics

As already discussed, the District Court found that Sanford's Imagenetics program is merger-specific. Add.-038. Imagenetics is a $125 million program that integrates genetic medicine into primary care through precision medical research, Sanford-developed tests that identify 139 genetic mutations and various other risk factors, and embedded genetic counselors. A0335-36; A0364; A0336-37.

Cancer Care

Appellants demonstrated that the transaction would expand to MDC patients access to over 75 cancer trials and treatments. These trials are Sanford-specific, as part of its work in medical research. A0832. MDC patients would only have access to them if it developed these same clinical trials, but that is not a realistic possibility absent the transaction because MDC does not have a research function. *Id*; A1164. The synergy is therefore demonstrably merger-specific.

The Government has never disputed this or even responded on this point. It did not address the enhanced availability of cancer trials and treatments in its briefs or proposed findings, and none of its witnesses addressed this subject at the hearing or in any of its expert reports. There was accordingly no basis for the District Court's unexplained conclusion that this synergy was not merger-specific.

Integrating Behavioral Health Into Primary Care

There was no dispute that Sanford has developed a model for embedding behavioral health therapists throughout its primary care clinics that won a CMS Innovation Award and was the product of five years of development and three years of testing. A0341; A0823. There also was no dispute that such a program expanded to MDC patients would result in increased quality of care for those patients. Add.-038. Indeed, the Government's expert referred generally to the practice of embedding behavioral health specialists as a "really great clinical practice" and expressed his wish that it was "more commonplace." A0277; A0279. Further, undisputed evidence demonstrated that Sanford's program achieved a 15% increase in quality composite scores relative to clinics without behavioral health specialists, and showed significant and measurable improvements in patient health and cost of care in a wide range of areas ranging from a 9% decrease in avoidable hospitalizations to a 117% increase in optimal asthma care. A0341; A0742.

As with the other quality efficiencies, the District Court did not explain the legal or factual basis for its conclusion that expansion of the Sanford model to MDC patients was not a merger-specific benefit. In testimony not mentioned or credited by the District Court, the Government's expert asserted that the transaction was not "necessary to embed behavioral health providers" because it is

"not a unique or new practice," but rather something that he "personally encountered" 20 years ago. A0278-79. But, as discussed above, what matters is what is likely or unlikely, not what is theoretically possible. The claim of the Government's expert that the practice was "common" notably was not specific to North Dakota where, undisputed testimony established, mental health care is "very limited" and "in the lowest third of the nation." A0426.

Moreover, MDC has no behavioral health therapists. A0825; A0844. No witness testified that MDC was likely to implement a program with embedded behavioral therapists in the future if the transaction does not occur. Instead, MDC's Chairman of the Board (who is a practicing family medicine physician) testified that MDC had limited ability to help patients with their mental health issues, and that Sanford's program was "one of the things I'm most excited about." A0426. And it was still more unlikely that MDC would implement such a program independently given that it had already made the determination that it needed to sell its clinic because of concerns about its long-term viability.

At the same time, Sanford's award-winning model is the product of years of testing and development and has shown concrete success in improving health outcomes. Further, Sanford's program now consists of dozens of behavioral health therapists working together with primary care physicians on a system-wide basis. A0360-61. Thus, all evidence was that it was highly improbable that MDC would

implement independently an embedded behavioral health program but for the transaction, let alone one of the caliber of Sanford's.

Electronic Medical Records

An electronic medical record ("EMR") system is a repository for a patient's medical information that ensures the information is available wherever a patient goes within the EMR system. A0365. Sanford and CHI use versions of the EPIC EMR system. A0835-36. MDC uses the Athena system. A0836. Sanford spends approximately $40 million per year supporting its system and outfitting it with best practice alerts. A0367. There was no dispute that if the transaction proceeds, MDC would move to Sanford's EPIC system or that Sanford has significant experience in achieving such integration, having done so with over 300 other clinics. A0366, A0835-36.

Further, the District Court found that, as with the other quality efficiencies identified, there was no dispute that this would in fact result in improved quality of care for patients in the Bismarck-Mandan area. Add.-038.

The District Court again did not explain either the legal standard applied or the factual basis for its conclusion that this efficiency was not merger-specific.[5] Nor was there any evidence that MDC would move to the EPIC system absent the

[5] EMR was not addressed in the block of testimony cited by the District Court to describe the Government's contentions that the claimed quality efficiencies were not merger-specific. Add.-037-038.

transaction. The Government never made such a claim, nor did any witness, and the cost alone would be prohibitive. Upkeep alone would cost $2-3 million per year for MDC, above and beyond sizeable initial installation costs, yet MDC was concerned that it would be unable to support even its current $1 million per year cost for the Athena system going forward. A0366; A0836-37. There was accordingly no question that the adoption of the Sanford version of the EPIC system was merger-specific, and that the District Court's conclusion to the contrary was based on an incorrect legal standard and constituted clear error as well.

Recruitment of Subspecialists

Finally, the transaction would increase the ability to recruit subspecialists to the Bismarck-Mandan area that the community currently lacks and needs, including in such areas as pediatric gastroenterology, pediatric neurology, pediatric critical care, reproductive endocrinology, and urogynecology. A1271. In determining where to practice, subspecialists look to the clinical needs and size of the population and the number of physicians who practice in the healthcare system that is recruiting them to ensure that there will be sufficient referrals to maintain their practice. A0351-53; A0370-71. By increasing the number of doctors in the Sanford system in Bismarck, the merger will therefore increase the ability to recruit badly needed subspecialists to that community.

As with the other quality efficiencies, there was no dispute that recruiting more subspecialists to the community would increase the quality of care or that the particular subspecialists identified are needed. And again, the District Court did not explain the basis for its conclusion that this synergy was not merger-specific, nor did the Court identify the legal standard it was applying to make that determination.[6]

Weighing of Efficiencies

The District Court similarly erred as a matter of law in weighing the claimed efficiencies against the asserted competitive effects of the transaction. The Court's analysis was limited to the assertion that because "the proposed transaction would result in near-monopoly, the claimed monetary and quality efficiencies are insufficient to overcome the presumption of illegality." Add.-067. This assertion obscures far more than it illuminates. Even if one assumes that the transaction increases market share to near-monopoly levels in a relevant antitrust market, Sanford presented substantial evidence (detailed above) to show that the

[6] The Government's quality expert offered testimony (which the District Court did not cite even in describing the parties' contentions) that the size and clinical need of a population are factors but offered no basis for disputing that the size of the practice is *also* an important factor that subspecialists in reality look to in determining where to practice. Nor did the District Court address the issue. Further, whereas Sanford's witness had recruited hundreds of subspecialists, the Government expert's only experience in the area had been helping those with actual responsibility for recruiting to the Brigham and Women's and VA hospitals in Boston, a very different community than Bismarck-Mandan. A0282-83.

transaction will not result in anticompetitive effects given the realities of this market.

The District Court thus was obliged but failed to examine the efficiencies and synergies in the context of Defendants' rebuttal to the presumption and the likely competitive realities of this transaction. *Tenet Health*, 186 F.3d at 1054 ("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"). In this case, that would require an assessment of whether the transaction will result in meaningful expansion of services to thousands of people in what are undisputedly important areas of healthcare services – *i.e.*, genetic medicine, behavioral health, cancer care, electronic medical records, and various subspecialties. It then requires considering those benefits, not against a general assertion about merger to monopoly, but in the context of (a) the demonstrable absence of any relationship between provider concentration and prices of by far the dominant payer, (b) CHI's admitted ability, incentive, and intent to expand in and enter the service areas, (c) the contractual prohibition on Sanford raising rates paid by Medica for [redacted], and (d) the at most *de minimis* potential price increase to Medica even beyond that [redacted] and even assuming no entry by CHI. By failing

to do so, the District Court failed to conduct the inquiry that the law requires in evaluating the pro-competitive impact of the transaction.

b. The District Court Erred In Evaluating MDC's Likely Future Weakness As A Competitor.

The District also failed to apply the relevant legal standard in evaluating the concerns over MDC's long-term competitive viability that led it in the first instance to seek to sell its practice. This Circuit has held that "when examining a merger, a court must necessarily compare what may happen if the merger occurs with what may happen if it does not occur." *Nat'l Tea Co.*, 603 F.2d at 700. The Court therefore recognized in *Nat'l Tea* that in "scrutinizing the 'probable future' of the market," it was relevant to consider the "imminent departure of National" – *i.e.*, the party being acquired – "and the increased concentration that would result." *Id.*

Similarly, an additional relevant factor in this case is that the owners of MDC determined after "a very long process" that they needed to sell their business to preserve its long-term viability and prevent its steady weakening over time. A0416. They made this determination for interrelated reasons, including, as the District Court recognized, declining physician productivity and a projected further decline of 20% in ancillary revenues from sources such as lab and MDC's surgery center. Add.-052, A0402; A0406. These factors in turn will deprive MDC of its primary recruiting advantage—the ability to pay well above the national average—

leading to the inability to recruit and replace departing and retiring physicians and the departure of its current physicians as their call coverage burdens increase and as their pay decreases. *Id*.

Evidence cited by the District Court that MDC's shareholders wanted to sell while the share price was high confirmed this account by demonstrating the anticipation of shareholders that the value of their practice would decline. Indeed, the same February 2015 document cited by the District Court stated that "[c]ontinuing as is means facing rapidly changing reimbursement model and risk alone" if MDC "continues to see decreases overall as projected." A0577. This trend was confirmed by a later January 2017 document that MDC's chief financial officer presented to shareholders concerning the firm's present and anticipated future financial condition and the loss of the contribution that ancillary revenues such as lab and imaging had customarily made to its bottom line. A0564.

The District Court concluded that Appellants "have not made sufficient showing to consider" a 'weakened competitor' defense' because MDC's "current financial status is strong" and "[t]here is no evidence that it would 'imminently depart' from the market if the merger were not consummated." Add.-053. As a result, the District Court concluded, "Evidence questioning MDC's long term viability is not sufficient to counteract anticompetitive effects of the proposed transaction." Add.-054.

These conclusions did not address Appellants' argument. Appellants did not assert MDC's condition as a freestanding "defense," and did not assert that MDC would imminently depart from the market. This is not a so-called "failing firm" defense. Nor were Appellants required to make such assertions for the evidence that was submitted to be relevant under the law of this Circuit. Instead, MDC's projected difficulties were an additional factor to be considered alongside all of the other factors discussed herein. *See Nat'l Tea*, 603 F.2d at 700 n.8 ("Although the FTC argues that National is attempting to assert a 'failing company defense,' we do not agree. The evidence was merely another factor going into the conclusion that the FTC was ultimately unlikely to succeed on the merits.").

In light of all of these factors, MDC's long-term prospects were relevant for two reasons. *First*, they further confirmed the lack of any basis for asserting that MDC would likely duplicate independently the various synergies that will result from the transaction.

Second, it was also relevant that MDC was likely to weaken as a going concern during the period that CHI itself estimated it would be able to enter the market and compete in the relevant areas. *Nat'l Tea* thus requires the comparison between two scenarios: (1) the transaction generates various pro-competitive synergies, and CHI enters and expands in the service areas at issue, and (2) CHI

has no incentive to compete in the relevant service areas, MDC is weakened over time, and no pro-competitive synergies are generated.

II. THE DISTRICT COURT ERRED IN DEFINING THE ANTITRUST MARKET WITHOUT EVIDENCE OF CROSS-ELASTICITY OF DEMAND.

The foregoing assumes that the Government has properly defined an antitrust market, which it has not. *See* Merger Guidelines §4 ("Evidence of competitive effects can inform market definition, just as market definition can be informative of competitive effects."). The Government has the burden to define a relevant market. This requirement is essential to any merger analysis: "[W]ithout a well-defined relevant market, a particular transaction's effect on competition cannot be evaluated." *Freeman*, 69 F.3d at 268 n.12.

Defining a product or geographic market requires assessment of the cross-price elasticity of demand of potential alternatives, *i.e.*, the extent to which consumers will be able to practically turn to alternatives in response to an anticompetitive price increase as a result of the merger. *F.T.C. v. Lundbeck*, 650 F.3d 1236, 1240 (8th Cir. 2011) (noting that "cross-price elasticity is essential to market definition") (citing *H.J., Inc. v. International Tel. & Tel. Corp.*, 867 F.2d 1531, 1538, 1540 (8th Cir.1989)); *Freeman,* 69 F.3d at 268 (holding that the "the critical question" is where consumers "could practicably turn should . . . hospital prices become anticompetitive."); *Tenet Health,* 186 F.3d at 1052 ("The FTC must

present evidence on the critical question" of where consumers would be able to turn "should the merger be consummated and prices become anticompetitive.").

Both the District Court and the Government relied on the "hypothetical monopolist test" ("HMT") set forth in the Horizontal Merger Guidelines to define the relevant markets. Add-025. The HMT assesses cross-price elasticity by asking whether a hypothetical monopolist of the proposed market could impose on customers a "small but significant nontransitory increase in price" ("SSNIP"). If so, then the merging parties' products constitute a relevant product market. If not, then additional products or locations identified as alternatives should be added until a relevant market is defined. The District Court found that the evidence was sufficient to find that the SSNIP test had been satisfied with regard to the Government's proposed markets.

However, the Government's economist never analyzed the variability of pricing in the alleged markets, a necessary first step to assess a "SSNIP." A0247; A0249. Instead, he relied solely on testimony, documents, and analyses he performed using patient claims data, A0234; A0236-37; A0241. This is the same kind of evidence that this Court rejected in *Tenet* and *Freeman*.

The District Court held that BCBS-ND's status as a power buyer (and thus actual data about pricing in North Dakota) was irrelevant to market definition. Add.-061-062. As discussed, however, the hypothetical monopolist

test applied by the District Court and relied on by the Government demands a showing of the ability of a hypothetical monopolist to impose a SSNIP. Where the Government conducts no analysis of the relationship between concentration and price, and where there in fact is no such relationship, the Government has failed to satisfy its burden, wholly apart from the reasons for why there is no relationship. *Freeman*, 69 F.3d at 269 ("zip code data illustrating current patient flow"—in other words, claims data—provided insufficient evidence to support elasticity because the "analysis gives a static, rather than a dynamic, picture of the acute care market"). Here, the only analysis of a likely response to an attempt by the merging parties to impose a SSNIP was performed by Professor Town, who concluded that a hypothetical monopolist would not be able to impose a SSNIP on BCBS-ND. A0411-12. The Government thus failed to meet its threshold burden to establish a relevant market.

CONCLUSION

For the foregoing reasons, this Court should reverse the District Court's preliminary injunction and order that the motion for a preliminary injunction be denied.

Respectfully submitted,

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CERTIFICATES OF COMPLIANCE

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Appellants' Opening Brief, and the addendum required by Circuit Rule 28A(g), were scanned with Symantec Endpoint Protection, Version 14, which found no viruses.

Respectfully,

Dated: January 29, 2018

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No. 17-3783

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

FEDERAL TRADE COMMISSION *et al.*,

Plaintiffs-Appellees,

v.

SANFORD HEALTH *et al.*,

Defendants-Appellants,

Appeal from the United States District Court for the District of North Dakota
Case No. 1:17-cv-00133-ARS, Hon. Alice R. Senechal

CERTIFICATE OF SERVICE

I hereby certify, pursuant to Federal Rule of Appellate Procedure 25(c) and Circuit Rule 25A, that on January 18, the Redacted Version of the Opening Brief of Appellants Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C. was electronically filed with the Clerk of the Court using the CM/ECF system, which will send a notification to the attorneys of record in this matter.

Respectfully,

January 18, 2019

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