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

Federal Trade Commission and State of North Dakota,	)))

injunction.[2] At that hearing, the court received over 1600 exhibits—all admitted pursuant to stipulation by all parties—and heard testimony from sixteen witnesses.

conclusions of law. In doing so, however, the court notes that its determinations cannot all be "neatly categorized as either findings of fact or conclusions of law." FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 335 (3rd Cir. 2016).

FINDINGS OF FACT

I. Sanford, MDC, and Third-Party Medical Facilities

1. Sanford is a not-for-profit, vertically integrated healthcare system which operates in nine states and in three foreign countries. An integrated healthcare system is one comprised of both hospital services and physician services and which sometimes also includes insurance companies and research and education components. (Tr-3, p. 9). Most of Sanford's facilities are located in North Dakota, South Dakota, and Minnesota. As a result of its recent acquisitiveness, Sanford's system now includes 45 hospitals, 289 clinics, more than 1,300 physician employees, and approximately 26,700 non-physician employees. (PX 4198, p. 7; PX 4128, p. 12; PX 8139, p. 1). Kelby Krabbenhoft, Sanford CEO, described Sanford's strategies as based on a premise that larger integrated healthcare systems are more successful in providing quality care. Sanford describes itself as a physician-driven organization, which benchmarks itself against other nationally recognized healthcare systems that it considers its primary competitors. (JX 0028, pp. 21-22, 31; Tr-3, pp. 22-27).

2. Sanford entered the North Dakota healthcare market in 2009 when it acquired Meritcare—an integrated healthcare system—in Fargo. (PX 6000, p. 17). In 2012, Sanford entered the healthcare market in Bismarck through its acquisition of an integrated healthcare system—MedCenter One—now known as Sanford Bismarck. (DX 2011, p. 11). Sanford's Bismarck-Mandan operations now include a 217-bed acute care

hospital, eight primary care clinics, and several specialty clinics. (Doc #11, pp. 7-8; Doc. #25, p. 5). In the Bismarck-Mandan area, Sanford employs approximately 160 physicians. Its Bismarck-Mandan physician employees include 37 adult PCPs, five pediatricians, eight OB/GYN physicians, and four general surgeons. Sanford is the largest non-government employer in the Bismarck-Mandan area, as well as the largest non-government employer in the state of North Dakota. (PX 6000, p. 18; PX 8143, p. 1; Tr-3, pp. 10-11). In 2016, Sanford generated approximately [redacted] in total revenue in North Dakota, approximately [redacted] of which it generated through its Bismarck-Mandan operations. (DX 6004, p. 4).

3. MDC is a multispecialty for-profit physician group owned by approximately 53 of the approximately 60 physicians who practice there. (Doc. #11, p. 8; Doc. #27, p. 5). MDC's physicians include 23 adult PCPs, six pediatricians, eight OB/GYN physicians, and six general surgeons. Id. MDC also employs nineteen nurse practitioners and physician assistants as advanced practice providers (APPs). MDC operates only in Bismarck, where it has nine clinics in five locations and an ambulatory surgery center. (DX 6002, pp. 1-2). During fiscal 2016, MDC generated [redacted] in revenue. Id. at 2.

4. Catholic Health Initiatives (CHI) operates the only other acute care hospital in the Bismarck-Mandan area—CHI St. Alexius—which CHI acquired in 2014. CHI operates in eighteen states, in which it employs approximately 4,300 physicians and advanced practice clinicians.[3] In Bismarck-Mandan, CHI employs approximately 88

[3] See Catholic Health Initiatives, "Overview 2016," http://www.catholichealthinitiatives.org/documents_public/Overview%20Brochure/2016%20Overview%20Brochure.pdf; Catholic Health Initiatives, "Financial Report 2016," http://chiannualreport.net/pdf/Financial-Report.pdf.

physicians; its physician employees include five adult PCPs but no OB/GYN physicians, pediatricians, or general surgeons. (PX 3009, pp. 1-2, 4-5). Apart from the five PCPs, CHI St. Alexius's physician employees primarily work as hospitalists and in other hospital-based specialities. Id. at 3. CHI's five PCPs practice at a clinic in Mandan, id. at 2, but [redacted]. Physicians currently practicing in Mandan will [redacted].

5. For a number of years, MDC and CHI St. Alexius have had a referral relationship. MDC is the largest source of referrals for inpatient admissions at CHI St. Alexius, with MDC referrals accounting for [redacted] of the inpatient admissions. MDC's primary care physicians frequently refer their patients to CHI St. Alexius specialists. Id. MDC and CHI together own PrimeCare, a physician-hospital entity which negotiates and contracts with health insurance plans on behalf of its members, including MDC's physicians. (DX 6034; PX 3009, p. 7; Tr-1, p. 82). MDC and CHI have professional services agreements under which, for example, MDC general surgeons provide coverage for trauma cases at CHI St. Alexius. The president of CHI St. Alexius, Kurt Schley, described the services of MDC and CHI St. Alexius as complementing each other. (Tr-1, p. 81).

6. In the Bismarck-Mandan area, approximately ten primary care physicians practice with entities other than Sanford, MDC, or CHI. Of those ten, six are employed by the University of North Dakota Center for Family Medicine (UND-CFM). (PX 3009, p. 2). Apart from those employed by Sanford, MDC, or CHI, only one OB/GYN physician and one pediatrician practice in the Bismarck-Mandan area. There are no general surgeons in the Bismarck-Mandan area apart from those practicing at Sanford or MDC. (Tr-1, p. 92).

II. Health Insurance Plans

7. BCBSND is the largest health insurer operating in the Bismarck-Mandan area and is also the largest health insurer operating in the state of North Dakota as a whole. BCBSND is a not-for-profit mutual insurance company. It currently insures approximately [redacted] persons in the state—approximately [redacted] covered through employer group plans and approximately covered through individual plans or Medicare supplement plans. In the Bismarck-Mandan area, approximately persons are covered by BCBSND commercial health insurance plans. (PX 3014, p. 2).

8. BCBSND has participation agreements with every general acute care hospital in North Dakota and with 98% of the physicians practicing in the state. Id. In the Bismarck-Mandan area, BCBSND has participation agreements with both general acute care hospitals (Sanford and CHI) and with 99% of the practicing physicians. Id. at 3.

9. BCBSND offers both "fully insured" and "self-insured" plans. Under self-insured plans, employers collect premiums from their employees and pay the full cost of employees' healthcare, with employers bearing the risk that healthcare costs might exceed premiums. Under self-insured plans, an employer pays BCBSND for administration of its employees' claims. By contrast, under fully-insured plans, BCBSND collects premiums from employers and pays the cost of the employees' healthcare, with BCBSND bearing the risk that healthcare costs might exceed premiums. (Doc. #62-1, p. 4).

10. In the Bismarck-Mandan area, BCBSND markets "point of service plans" and "preferred provider plans." In its point of service plans, a subscriber must choose to affiliate with either Sanford or PrimeCare. Physicians practicing with the chosen entity

are considered to be "in-network" for the subscriber. Absent a referral, subscribers have higher out-of-pocket costs for care received from non-network physicians than for care received from in-network physicians. (Tr-1, p. 259). Employers receive a [redacted] by choosing point of service plans because the provider networks in those plans are more narrow. Approximately [redacted] persons in the Bismarck-Mandan area, including [redacted], are enrolled in one of the BCBSND point of service plans. Id. at 296.

11. BCBSND recently began offering a value-based program to primary care providers. Provider participation in the program is voluntary. Under the value-based program, BCBSND examines an insured's claims and "attributes" the insured to the provider considered most likely responsible for that insured's primary care. Providers receive a "care management fee" based on the number of insureds attributed to the provider. BCBSND then analyzes certain quality-based metrics of patient care. Dependent on results of that analysis, a provider may receive a "shared savings" payment from BCBSND. Both Sanford Bismarck and MDC currently participate in the value-based program. Sanford's Fargo region also participates in the value-based program. At Sanford's request, contracts for its participation in the two regions are separate, [redacted]. (PX 3014, pp. 9-11; Tr-1, pp. 251-55; Tr-3, pp. 162-64).

12. Sanford also operates a health insurance plan—Sanford Health Plan (SHP)—which sells health insurance in four states, including North Dakota. SHP covers approximately [redacted] insureds in North Dakota. (PX 4255, p. 1). In 2015, through a competitive bid process, Sanford was awarded a contract with the North Dakota Public

Employees Retirement System (NDPERS). Sanford had bid on the NDPERS contract twice before. For many years prior to 2015, BCBSND held the NDPERS contract. The current Sanford/NDPERS contract runs through 2019 and covers approximately 66,000 members in North Dakota. (DX 6000, p. 11; DX 6005, p. 2; PX 4255, p. 1). In addition to state employees, NDPERS covers employees of some political subdivisions within the state. Recently, the City of Fargo entered into a contract under which the City's employees will be covered by BCBSND rather than through NDPERS as they are currently. (Tr-1, p. 298). In North Dakota, SHP has approximately [redacted] members, including those covered under the NDPERS contract and North Dakota's Medicaid expansion program. (JX 0009, p. 12).

13. The parties dispute whether the NDPERS contract should be considered as commercial insurance or as a hybrid commercial/government program. Regardless of whether the NDPERS contract is considered a commercial plan, SHP is the second-largest commercial insurer in the state. (PX 6000, p. 120).

14. SHP markets "narrow network" products in the Bismarck-Mandan area—to individuals and employers, Medicare recipients, and Sanford employees—which do not include MDC as a network provider. Plans with narrower provider networks are typically priced lower than plans which include more provider options. (JX 0026, pp. 13-14; JX 0004, pp. 220-21; JX 0007, pp. 22-23, 27-78; JX 0009, pp. 25-26).

15. Medica, a regional health insurance company, is the third-largest commercial health insurer in the Bismarck-Mandan area, with approximately [redacted] members in that area. (Tr-1, p. 190). Medica currently has provider network agreements with both Sanford and PrimeCare. In July 2017, Medica and Sanford signed a [redacted] contract,

. (JX 0083;

Tr-1, pp. 190-91).

III. Proposed Transaction

16.

Sanford/MDC transaction is approximately . (JX 0042, p .1).

18. The FTC, together with the North Dakota Attorney General, investigated the proposed transaction for eight months. The FTC's work included taking testimony via investigational hearing. Three days after Sanford and MDC signed the stock purchase agreement, the FTC and the State initiated this action. On that same day, the FTC

meeting. (PX 7040; PX 7099).

21. Schley testified that CHI [redacted]. But, MDC representatives testified that MDC would no longer have an interest in merging with CHI because of CHI's termination of the LOI and because the Schley email had deteriorated the relationship between MDC and CHI.

IV. Two Stage Healthcare Competition

22. 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. Most patients covered by commercial health insurance obtain their coverage through their employer or through a family member's employer. Commercial health insurers—rather than patients who receive the services—are typically the direct purchasers of healthcare services. Commercial insurers and healthcare providers enter into contracts which set rates and other terms under which the insurers reimburse the providers for services provided to patients. (PX 6000, pp. 22-23; Tr-2, pp. 50-52, 60-61). In analyzing potential anticompetitive effects of a merger involving healthcare entities, it is therefore necessary to consider the merger's likely impact on commercial health insurers.

23. Healthcare providers compete for commercially insured patients in two stages. In the first stage, healthcare providers compete to be included as "in-network" providers in the plans which commercial insurers offer to their customers. Commercial insurance plans typically incentivize their insureds to use in-network providers by providing less coverage for care that insureds receive from out-of-network providers. In the second

stage, healthcare providers compete with other in-network providers to attract patients. (Tr-2, pp. 51-52; PX 6000, pp. 22-23).

A. First-Stage Competition

24. At the first stage of competition, healthcare providers and commercial insurers negotiate reimbursement rates and non-monetary reimbursement terms. Non-monetary terms include, e.g., length of an agreement or time frames for reimbursement. Reimbursement rates are the most significant negotiated terms, but non-monetary terms are also important to the healthcare providers. (Tr-1, pp. 172-73; JX 0007, p. 35; PX 6000, p. 23).

25. The parties' experts testified about both "bargaining leverage" and "bargaining power," though their use of the terms was not completely congruent. The plaintiffs' economic expert, Dr. Seth Sacher, refers to the strength of a parties' position in a negotiation as that party's bargaining leverage. (Tr-2, p. 54). He distinguishes bargaining leverage from bargaining power, which he also refers to as bargaining skill. He considers bargaining power/skill to include factors that make one a good negotiator, such as patience, preparation, experience, and risk aversion. Id. at 55. Dr. Sacher testified that a merger of healthcare entities increases the bargaining leverage of the merged entity and decreases the bargaining leverage of the payer but does not impact bargaining power of either party. Id. at 57.

26. The defense expert, Dr. Robert Town, states that, though often used interchangeably in common parlance, bargaining leverage and bargaining power have distinct meanings in the "standard provider-payer bargaining model." (DX 6000, p. 23). Dr. Town refers to bargaining leverage as the degree of difficulty a commercial payer

would have in marketing a network without the provider and bargaining power as determining whether providers can exploit their bargaining leverage into higher reimbursement rates. Id.

27. Experts 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. Each side's bargaining leverage is dependent on that party's "walk-away point," i.e., how well off each party would be if the healthcare provider were not included in the commercial insurer's network. The better off a party would be without an agreement, the better its walk-away point, and the greater its bargaining leverage. (Tr-2, p. 54; Tr-4, p. 110; PX 6000, pp. 25-27; PX 6003, p. 8).

28. A merged provider has increased bargaining leverage, dependent on (1) the market share of the merging providers in an area, (2) the extent to which health-plan subscribers regard the merging parties as close substitutes, and (3) the subscribers' perceptions of non-merging providers as ineffective substitutes. Experts for both sides agreed that the proposed transaction would give a post-merger Sanford increased bargaining leverage. (Tr-2, pp. 99-100, 103-04; Tr-4, p. 112; PX 6000, pp. 25-28).

29. When negotiating inclusion in a commercial insurer's network, a healthcare provider's walk-away point is determined by whether the insurer's subscribers would continue to seek care from that provider if the provider were not included in the commercial insurer's network. An insurer's walk-away point is determined by the value of the insurer's network to its insureds if the provider were not included in the insurer's network. (PX 6003, pp. 8-9; Tr-4, pp. 110-11; Tr-2, p. 53).

30. From a commercial insurer's perspective, the marketability of a health insurance

one insured receiving services from one network provider will have out-of-pocket costs equivalent to those of another insured receiving the same services from a competing network provider if both patients are insured by the same plan. Consequently, second-stage competition generally focuses on non-monetary factors which include, e.g., clinic hours, convenience of location, available services, technology, and quality. (Tr-2, pp. 58-59; Tr-3, pp. 80, 82; Tr-4, p. 141).

33. Witnesses testifying for both sides agreed that competition among providers improves the quality of services that patients receive and results in better patient outcomes. (JX 0014, p. 25; JX 0021, pp. 60-61; JX 0028, pp. 46, 187-88). More convenient access to providers is of benefit to patients. More convenient access helps providers attract and retain patients. One provider's improvements in convenient patient access may prompt a competing provider to also make its services more conveniently accessible to patients. (JX 0022, p. 35).

V. Physician Service Markets

34. Adult PCPs provide healthcare services to patients age 18 and over. Adult PCPs include board-certified family medicine physicians, internal medicine physicians, and general practice physicians. Adult PCPs are typically adult patients' first point of contact for healthcare, and they typically see patients in a clinic setting. Services provided by adult PCPs include physical exams, wellness visits, basic medical procedures, treatment of common illnesses and injuries, and long-term management of chronic conditions. Adult PCP services typically do not include invasive surgical procedures; rather, adult PCPs typically refer their patients to other healthcare specialists for those procedures. (Tr-1, pp. 83, 233; JX 0021, p. 8; JX 0011, p. 33).

35. Hearing testimony addressed whether physicians in other service lines could be substituted for adult PCPs in developing a marketable health insurance plan. Hospitalists—physicians whose training is focused on treating hospitalized patients—do not examine or treat patients in an out-patient setting. In constructing a marketable health insurance plan, hospitalists could therefore not be substituted for adult PCPs. Although some women utilize OB/GYN physicians as their primary provider, OB/GYN physicians are generally seen as complementary to adult PCPs and not as substitutes for adult PCPs. OB/GYN physicians do not see male patients. OB/GYN physicians could not be substituted for adult PCPs in constructing a marketable health insurance plan. Neither could pediatricians be substituted for adult PCPs in a marketable health insurance plan since pediatricians typically treat patients under age 18 and adult PCPs typically treat patients over age 18. (JXsPnTT0 1 ad ypievt26.3fa Rypi86-87; TT0 11ad ypi9)EMC /LBo

care services from an APP, while approximately 80% exclusively saw adult PCPs for "evaluation and management" visits. (PX 6000, pp. 32, 35-36, 49, 52-53, 214; Tr-2, pp. 69-70). Dr. Sacher's analysis confirms that neither specialist physicians nor APPs can be considered substitutes for adult PCPs in constructing a marketable health insurance plan network in the Bismarck-Mandan area.

38. Representatives of each of the three primary commercial insurers—BCBSND, SHP, and Medica—all agreed that an insurance plan's network must include adult PCPs in order to be marketable in the Bismarck-Mandan area. (PX 3014, p. 8; Tr-1, p. 179; Tr-3, pp. 185-86). Hearing testimony confirmed that a health insurance plan that did not include adult PCPs would not be valuable to an employer who provides health insurance coverage to its employees. (Tr-2, p. 162).

39. Currently, both Sanford and MDC offer adult PCP services. In the Bismarck-Mandan area, Sanford's adult PCPs provide 34.4% of the adult PCP services and MDC's adult PCPs provide 51.3% of the adult PCP services. Post-merger, Sanford would provide 85.7% of the adult PCP services in the Bismarck-Mandan area, CHI would provide 7.9%, and the other providers would each provide 2% or less of the adult PCP services. (PX 6000, p. 164).

40. Pediatricians typically treat patients younger than age 18. Some family medicine physicians also treat patients in that age group, but many families prefer that their children receive medical care from a pediatrician. Families who choose family medicine physicians as their children's primary physician expect to have access to in-network pediatricians for more complex problems. (Tr-1, pp. 88-89, 234; JX 0002, pp. 19-20). Dr. Sacher's analysis demonstrates that nearly 80% of well-child visits for children age

services as OB/GYN physicians, OB/GYN physicians perform gynecological and obstetrical surgeries and provide complex obstetrical care that adult PCPs and APPs are not trained to perform. (JX 0014, p. 7; Tr-2, pp. 10-13; JX 0004, pp. 38-39).

45. There was no evidence that physicians in any other service line could be substituted for OB/GYN physicians in developing a marketable health insurance plan network. While general surgeons may perform some of the same procedures as OB/GYN physicians, they are not trained to provide the specialized care to female patients that OB/GYN physicians provide. Nor do laborists provide services of the same scope as OB/GYN physicians; laborists' services are only hospital based.

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services available in Bismarck-Mandan are at UND-CFM. Dr. Jan Bury, one of the OB/GYN physicians currently practicing at MDC, will not practice at Sanford if the merger is consummated; she will either retire or practice at CHI St. Alexius. Assuming Dr. Bury would not practice at Sanford and would not retire, a post-merger Sanford would control 84.6% of the OB/GYN physician services in the Bismarck-Mandan area. (PX 6000, pp. 78 n.4, 173; Tr-2, p. 23).

49. General surgeons typically perform surgeries involving organ systems from the sternum to the abdomen, including hernia repairs, gallbladder removals, colonoscopies, bowel resections, and appendectomies. General surgeons receive referrals from adult PCPs, pediatricians, and OB/GYN physicians for services that the referring physician is not able to provide. The services provided by general surgeons are distinct from the services provided by gastroenterologists, orthopedic surgeons, vascular surgeons, and cardiothoracic surgeons. (Tr-1, pp. 92, 236; JX 0021, p. 6; JX 0010, pp. 67-68). There is no evidence that any other physicians would be viable substitutes for general surgeons in developing a marketable health insurance plan network in the Bismarck-Mandan area.

50. Dr. Sacher's analysis of claims data shows that less than 5% of spending in the Bismarck-Mandan area for adult PCP services involves surgical procedures while 80% of spending for general surgeon services involves surgical procedures. His analysis also demonstrates that, although gastroenterologists and general surgeons perform some of the same procedures on organs of the digestive system, the services performed by gastroenterologists are primarily diagnostic in nature, and the services performed by general surgeons are more invasive and more diverse. (Doc. #6000, pp. 46-49, 219).

a hypothetical monopolist test (HMT). The HMT is an iterative process that begins by identifying a candidate market and then asking whether a hypothetical monopolist of that candidate market could profitably impose at least a "small but significant nontransitory increase in price" (SSNIP) over particular products or services. A SSNIP is typically considered to be five percent. If a hypothetical monopolist would find it profitable to impose at least a SSNIP in that candidate market, the conditions of the HMT are satisfied and the candidate market is considered the relevant market for purposes of antitrust analysis. If conditions of the HMT are not satisfied, the candidate market is expanded and the same analysis is applied to the expanded market. The process continues until conditions of the HMT are satisfied. (PX 6000, pp. 29-30; Tr-2, pp. 61-65; Tr-4, p. 91).

57. Courts often use the HMT in defining relevant markets for purposes of antitrust analysis. _____

customers. FTC v. Advocate Health Care Network, 841 F.3d 460, 468 (7th Cir. 2016). The plaintiffs' proposed market definition includes only commercial insurers, to the exclusion of government payers—Medicare and Medicaid. There is no evidence that contracting with government payers involves the two-stage competition described above. The process of providers reaching agreements with BCBSND is not so similar to that involved in contracting with government providers that government providers should be included as customers in the relevant market. This court finds it appropriate to consider a relevant market limited to a distinct category of customers—commercial health insurance plans.

61. Since the purpose of market definition is to identify options available to consumers, the definition focuses on consumers' ability to substitute products or sellers in areas outside the geographic area in order to defeat a price increase—an inquiry referred to as "demand-side" substitution. In analyzing a healthcare merger, the demand-side substitution inquiry must be done in the context of the two-stage competition model, where the immediate purchasers of physician services are commercial insurers. Because they are the i

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the defendants do not question that fact. A health insurance plan that did not include Bismarck-Mandan area adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services would not be marketable in the Bismarck-Mandan area. The relevant geographic market is the Bismarck-Mandan area—Burleigh, Morton, Oliver, and Sioux Counties.

67. The plaintiffs established that commercial health insurers would accept a hypothetical monopolist's SSNIP rather than market a health insurance plan in the Bismarck-Mandan area that did not include Bismarck-Mandan area adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services.

68. The relevant market is adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services sold to or provided to commercial insurers and their members in the Bismarck-Mandan area.

VII. Market Shares, Market Concentration, and Presumptive Competitive Harm

69. A merger that significantly increases market shares and market concentration is presumed to be unlawful under Section 7 of the Clayton Act. Phila. Nat'l Bank, 374 U.S. at 363. Market concentration, in the antitrust context, can be measured through the Herfindahl-Hirschman Index (HHI). "The HHI is calculated by summing the squares of the individual firms' market shares, and thus gives proportionately greater weight to the larger market shares." Horizontal Merger Guidelines § 5.3 (footnote omitted). The Guidelines provide for consideration of both the post-merger HHI and the increase in

highly concentrated market, and a merger resulting in an HHI increase of over 200 is presumed likely to enhance market power. Id.

70. Dr. Sacher calculated the following HHIs and changes in HHIs:

Service Line	Pre-merger HHI	Post-merger HHI	Change in HHI
Adult PCPs	3,891	7,422	3,531
Pediatricians	5,333	9,726	4,393
OB/GYN	6,211	7,363	1,152
General Surgery	5,362	9,964	4,602

(PX 6000, p. 150). The defendants did not challenge the HHI calculations. In each of the four physician service lines, existing services in the Bismarck-Mandan area are currently highly concentrated and would be even more highly concentrated if the proposed transaction were consummated.

71. The defendants presented no evidence countering Dr. Sacher's conclusion that the proposed transaction would significantly increase market concentration in each of the four physician service lines. The post-merger HHIs demonstrate a highly concentrated market in each of the four physician service lines. The change in HHI in each of the four service lines exceeds the Merger Guidelines' threshold for presumption that the proposed transaction is likely to enhance market power.

72. Based on the HHI evidence of market concentration, the proposed transaction is presumptively unlawful in each of the four physician service lines. See Penn State Hershey, 838 F.3d at 346-47; ProMedica Health Sys., Inc. v. FTC, 749 F.3d 559, 568 (7th Cir. 2014).

VIII. Competitive Effects

A. Interfirm Diversion, Upward Pricing Pressure, and Willingness to Pay

73. In addition to the HHI evidence that leads to a presumption of illegality, the plaintiffs presented evidence that the proposed transaction would substantially lessen competition in each of the four physician service lines included in the relevant market. That evidence included analysis of interfirm diversion ratios, "upward pricing pressure"

MDC as their "next best option," and vice versa. Dr. Sacher's analysis further showed that Sanford and MDC compete with each other more closely than either competes with any other entity. (PX 6000, pp. 87, 198-202; Tr-2, pp. 90-93). The defendants' expert agreed that patients view Sanford and MDC as substitutes for each other. (Tr-4, p. 113). The diversion ratios that Dr. Sacher calculated—which the defendants did not contest—are significantly higher than those in other cases in which a healthcare merger was enjoined. See _____

proposed transaction would significantly increase WTP in each of the four physician service lines included in the relevant market. (Tr-2, pp. 98-102). The greater the value of the internalized substitution, the greater the incentive to increase price. Id. at 93-96. The WTP increases confirm the closeness of competition between Sanford and MDC and confirm that no other providers are close substitutes in any of the four relevant physician service lines.

B. Impacts on Second-Stage Competition

79. The plaintiffs contend that, in addition to anticompetitive price effects, the proposed transaction will negatively impact non-price competition. Sanford and MDC currently compete with each other to attract patients through changes in services. (Tr-3, pp. 80-83; PX 5206, pp. 1-2). Sanford and MDC currently compete to attract patients by investments in new technologies. (JX 0002, p. 57; Tr-2, pp. 18-19; PX 4283, pp. 2-3; JX 0048, p. 1; PX 4067, p. 2). Sanford and MDC currently compete with each other by making changes to improve patient access and patient convenience. (Tr-4, pp. 193-95; PX 4028, p. 3; PX 5181, p. 1; PX 5190, p. 5; JX 0010, p. 46; PX 5249, p. 2; PX 5181, p. 2).

80. There is no evidence that the quality of patient care provided by any MDC physician or by any Sanford physician would decline as a result of the proposed transaction.

81. As Krabbenhoft acknowledged, "[C]ompetition . . . . keeps you always ascribing and aspiring to provide a better product at a more competitive price[,] . . . . [and] adds another level of intensity . . . and focus to that effort." (Tr-3, p. 38). The proposed transaction would eliminate the second-stage competition that currently exists between Sanford and MDC to provide better services at a more competitive price.

had access to competitively sensitive information of both Sanford and MDC, which the parties cannot share with each other prior to consummation of the transaction.

87. Deloitte's report identified annual efficiencies of [redacted] over the first three years after consummation of the proposed transaction and [redacted] in one-time expenditures needed to achieve those efficiencies, resulting in estimated net efficiency savings of [redacted] over the first three years and [redacted] in annual savings after the first three years. (DX 4018, pp. 4, 6). The Deloitte report groups claimed efficiencies into three categories: clinical care, ancillary services, and non-clinical areas.

88. Most of the net savings which Deloitte predicted in clinical care fall under the federal "340B" program—a program which allows qualifying providers to purchase certain prescription drugs at lower prices. Deloitte predicted annual net savings of nearly [redacted] under the 340B program, beginning in the third year after the transaction is consummated. Id. at 9. Deloitte recognized a delay in the savings to allow for consolidation of Sanford and MDC facilities necessary to administer outpatient drug infusion services. In calculating net savings, Deloitte used tentative estimates of the costs of consolidation of the infusion facilities. (Tr-2, pp. 203-04; Tr-4, pp. 21-26, 32-34; DX 4018, p. 9).

89. Currently, Sanford Bismarck qualifies for the 340B program, and MDC does not. The parties dispute whether the proposed transaction could result in Sanford Bismarck losing its current 340B qualification. As a Disproportionate Share Hospital (DSH), Sanford Bismarck's 340B qualification is based on the percentage of its patients who are of low income or who are Medicare beneficiaries. (Tr-3, pp. 128-29). The plaintiffs' expert testified that a shift of MDC patients from CHI St. Alexius to Sanford Bismarck

could cause Sanford Bismarck to move from DSH status to Rural Referral Center (RRC) status under the 340B program and that Sanford's status moving from DSH to RRC status could result in an approximate in its 340B savings. (PX 6001, pp. 17-18; Tr-2, pp. 197-200).

90. Deloitte's report did not analyze how the proposed transaction might impact Sanford Bismarck's DSH status. (Tr-2, pp. 200-01; Tr-4, p. 33). At the hearing, Martha Leclerc, Sanford's vice president of corporate contracting, testified about calculations she had made to challenge the plaintiffs' allegations that a shift in MDC patients to Sanford Bismarck could impact Sanford Bismarck's DSH status. She calculated that the DSH status would be at risk only if there were a 17.4% increase in patient volume and if none of that increase were attributable to admission of low-income or Medicare patients. (Tr-3, pp. 135-36). Sanford Bismarck does not have the physical facilities to absorb an increase in patient volume that large.

91. Leclerc performed her calculations between the date of her deposition and the date of her hearing testimony, and Sanford provided no documentation supporting the

communities outside the Bismarck-Mandan area; (4) a combined and customized electronic medical record (EMR) system; and (5) recruitment of subspecialists to the Bismarck-Mandan area. The plaintiffs contend that some of the claimed efficiencies are already available at both Sanford and MDC and that others could be attained independent of the proposed transaction. (PX 6002, pp. 4-5; Tr-2, pp. 252-64).

100. The plaintiffs do not contest that the claimed quality efficiencies, if implemented, would in fact result in increased quality of care for patients in the Bismarck-Mandan area. dan would inmerger-sts tes,, bu

of the commercial health insurance market is between 55% and 65%.[6] (PX 4318, p. 9; PX 4308, p. 4; DX 6000, p. 17).

104. Over the last several years, BCBSND's market share has declined. In the Bismarck-Mandan area, BCBSND currently has approximately [redacted] insureds, down from approximately [redacted] in 2014. Statewide, since 2014, BCBSND has experienced a [redacted] decline in numbers of insureds under commercial health plans. (DX 6000, p. 17). In the Bismarck-Mandan area, since 2014, BCBSND has experienced a [redacted] decline in numbers of insured under its commercial health plans. (Tr-1, p. 257). A significant portion of the decline is attributable to BCBSND having lost the NDPERS contract to SHP, but BCBSND recently lost other large employer groups to other commercial insurers. (DX 6000, pp. 17-18; Tr-1, p. 258). The defendants acknowledge that BCBSND's market share has declined as a result of SHP's entry into the commercial health insurance market. (PX 4308, p. 4; DX 6000, pp. 17-18).

105. If a provider serves patients in more than one geographic region in North Dakota, BCBSND enters into a [redacted] participation agreement with that provider. BCBSND and Sanford have a [redacted] participation agreement. (PX 3014, p. 5) Sanford prefers to enter into payer agreements that cover all facilities within its entire system. (Tr-3, pp. 145-46).

106. Generally, BCBSND uses a statewide uniform base fee schedule, though its reimbursement rates are higher for some of the more rural facilities with which it

[6] Inconsistencies in the evidence of BCBSND's commercial insurance market share is due, at least in part, to differing views of whether NDPERS should be considered commercial insurance.

important to Sanford and Sanford is important to BCBSND. (Tr-3, pp. 32, 183). Krabbenhoft testified that Sanford would not, and credibly could not, present an ultimatum that threatened Sanford's termination of its provider agreement with BCBSND. Id. at 160-61.

117. Sanford has not indicated it would demand higher reimbursements from BCBSND if the proposed transaction is consummated. (Tr-1, p. 273).

118. In forming his opinions about the proposed transaction, Dr. Sacher considered BCBSND's share of the commercial health insurance market, but that did not "assuage[] [his] competitive concerns." (Tr-2, p. 103). In Dr. Sacher's opinion, because there would be no good alternatives to a post-merger Sanford in the Bismarck-Mandan area, BCBSND would have no choice but to negotiate higher prices and "other unfavorable terms" with Sanford. Id. at 104.

119. The defendants' economic expert, Dr. Town, opines that, in North Dakota, there is no relationship between provider concentration and BCBSND reimbursement rates. Dr. Town analyzed statewide BCBSND claims data and found "no statistically significant positive relationship between market concentration and BCBS-ND's rates." (DX 6000, p. 32). Dr. Town also opines that there is no relationship between bargaining leverage—or WTP—and BCBSND reimbursement rates in North Dakota. Id.

120. Dr. Town's analysis focused on data from two other areas of North Dakota—Minot and Grand Forks—where there is one dominant—near monopoly—healthcare provider in each area. Dr. Town considered the Minot and Grand Forks areas as "natural experiment[s]," opining that, [redacted],

post-merger Sanford would result in higher costs to Medica and in consequent higher costs to its employer groups. Id. at 185.

124. Because Medica cannot construct a marketable provider network in the Bismarck-Mandan area without the current Sanford system, Medica could not now

. Id. at 190.

129. Lenz testified that the agreement [redacted]. Id. One of the plaintiffs' experts, Dr. Ashish Jha, testified that physician concentration leads to more referrals for invasive and costlier procedures. (Tr-4, p. 238).

130. There is no evidence that, post-merger, any MDC physician or any Sanford

133. The defendants contend that, after the agreement ends in [redacted], Medica's relatively small share of the Bismarck-Mandan commercial health insurance market would preclude Sanford from obtaining higher reimbursement rates from Medica. Leclerc testified that Sanford [redacted] [redacted] [redacted] Id. at 149-51.

134. Dr. Town's analysis estimated an [redacted] increase in Medica's spending in the Bismarck-Mandan area after the current agreement ends. (DX 6001, pp. 63-64).

135. The Sanford/Medica [redacted] agreement does not protect against post-merger rate increases after [redacted].

136. The plaintiffs also presented testimony of Kari Reichert, vice president of people services at National Information Solutions Cooperative (NISC). NISC is a member-owned technology provider with approximately 1200 employees, 475 of whom are located in Mandan. NISC provides a self-insured health plan to its employees, contracted through United Healthcare. United Healthcare, in turn, contracts with Medica, so NISC employees have access to providers in Medica's provider network.

137. [redacted]

Mandan area. Id. at 42-43. Krabbenhoft opined that the CHI organization would be capable of recruiting and realigning physicians to timely increase its presence in the Bismarck-Mandan area. Id. at 30.

142. Data presented at the hearing described recent physician recruitment of Sanford, MDC, and CHI in the Bismarck-Mandan area. Challenges to physician recruitment include the area's geographic location, its perceived adverse weather conditions, and lack of OB/GYN and pediatrics residency programs in North Dakota. (JX 0022, pp. 37-38). It is more difficult to recruit physicians who do not have prior connections to the area. (Tr-1, pp. 106-07). Because of call coverage requirements for OB/GYN physicians, pediatricians, and general surgeons, it is difficult to recruit to groups of fewer than four physicians in each of those specialties. (JX 0028, pp. 54-55; Tr-2, pp. 24-25).

143. At the hearing, Schley estimated that it would take [redacted] for CHI St. Alexius to recruit enough adult PCPs to replace those who would be lost to a Sanford/MDC merger and that it might take up to [redacted] to establish the recruited adult PCPs' reputations, to open sufficient clinic space, and to establish a patient base large enough to replace the adult PCP services currently provided at CHI St. Alexius by MDC physicians. (Tr-1, p. 108). As to pediatrician services, Schley estimated a similar timeframe to recruit and establish a practice sufficient to compete with a post-merger Sanford. Id. at 114-16, 148. Further, a general surgery practice is dependent on a referral base of adult PCPs, making it difficult for an independent general surgeon to establish a practice in the Bismarck-Mandan area. (JX 0011, p. 39; JX 0027, pp. 23, 49).

144. As to OB/GYN services, Schley testified about Dr. Bury possibly joining CHI St. Alexius, though that is not a definite plan. CHI St. Alexius has provided a stipend to Dr.

Bury's daughter for completion of her medical education, and Dr. Bury testified that she would love to have her daughter join her in practice at CHI St. Alexius. Both Schley and Dr. Bury testified about the difficulty of recruiting an OB/GYN physician to a group of fewer that four physicians because of ca

[redacted]

149. Post-merger, physicians currently practicing at MDC would likely refer more patients to Sanford rather than to CHI St. Alexius. The anticipated decline in referrals to CHI St. Alexius would indeed incentivize and motivate CHI to add physicians in the four service areas. But, 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.

150. Hearing evidence does not demonstrate that CHI would be able to recruit enough physicians to replace the MDC physicians currently referring to CHI St. Alexius. CHI's potential expansion therefore cannot be considered timely, likely, or sufficient to counter the anticompetitive effects of the proposed transaction.

151. To establish a new independent practice in any of the four physician service lines in the Bismarck-Mandan area would require large start-up expenditures. And, significant time would be required to build a patient base large enough to be competitive with a post-merger Sanford. No evidence suggests that any new provider has the ability or resources to enter the Bismarck-Mandan area market in any of the four relevant physician service lines. (PX 3018, p. 7; PX 3006, pp. 9-10).

152. The defendants have not established that any new entry or expansion would be timely, likely, or sufficient to counteract the near-monopoly that would result from the proposed transaction.

XIII. MDC's Viability

153. MDC asserts that sale of its practice, so as to align itself with an integrated healthcare system, is necessary to maintain financial viability. Although its recent financial performance has been strong, MDC's strategic review has projected declining revenues, specifically in ancillary services. Ancillary services are those not provided by physicians, including things such as MDC's ambulatory surgery center and laboratory. MDC's ancillary service revenue dropped 7% from 2014 to 2016, and MDC projects another 20% decline by 2020. (JX 0011, p. 18; Tr-4, pp. 164, 166-67). MDC has experienced a decrease in physician productivity, which its president attributes to some more experienced physicians nearing retirement and newer physicians preferring fewer work hours. But, MDC's president testified that there are "plenty of patients" for MDC physicians who desire to increase their productivity. (Tr-4, pp. 165-66, 200-02).

154. In connection with its attempts to sell, MDC engaged two consultants—HDH Advisors and Wipfli. Wipfli provided a valuation opinion of MDC's facilities, and HDH Advisors assessed the value of MDC's goodwill. Sanford and MDC used the HDH and Wipfli opinions in determining the financial terms of the proposed transaction. HDH and Wipfli both projected a positive future for MDC with an increasing demand for its services and an outlook for better reimbursements. (PX 5244, p. 17; JX 0045, p. 28; Tr-3, pp. 55-60; Tr-4, pp. 168-69, 189-90).

155. MDC's revenues increased during each of the last three years, and its 2016 financial performance showed increases in billed and collected revenues over the prior year. MDC physicians have historically earned more than the national average; in 2016, their compensation was about [redacted]. (JX 0012, p.

apparent in the National Tea case on which the defendants rely. See 603 F.2d at 701.

161.

tampering that should be considered an admission of weakness of defendants' case. denies any attempt to influence testimony, and the defendants suggest it may be that both

(Doc. #132, p. 20).

165. The court finds description of the conversation more credible than . account of the conversation is confirmed by his contemporaneously written notes and by the email that he sent to counsel and his superiors later the same day. And, the statements which attributes to are consistent with what others

having consented to jurisdiction of a magistrate judge, this court has jurisdiction to issue a preliminary injunction under 15 U.S.C. § 53(b).

II. Preliminary Injunction Standard

3. The plaintiffs allege violation of the Clayton Act, Section 7, which provides:

> No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

15 U.S.C. § 18 (emphasis added). Determination of a Section 7 violation is an adjudicatory function vested in the FTC. But, Section 13(b) of the FTC Act authorizes a district court to grant a preliminary injunction if, "weighing the equities and considering the Commission's likelihood of ultimate success," an injunction would be in the public interest. 15 U.S.C. § 53(b). The only question addressed to this court is whether the status quo is to be preserved until the FTC completes its adjudicatory function. FTC v. Food Town Stores, Inc., 539 F.2d 1339, 1342 (4th Cir. 1976). It is not the function of this court to determine whether the antitrust laws are "about to be violated." FTC v. Whole Foods Mkt., Inc. 548 F.3d 1028, 1035 (D.C. Cir. 2008) (quoting Food Town Stores, 539 F.2d at 1342). That determination is left to the FTC. Id.

4. Section 13(b) sets forth two factors to determine whether a preliminary injunction should be issued: (1) the likelihood that the FTC will ultimately succeed on the merits and (2) a balance of the equities. ProMedica, 2011 WL 1219281, at *53.

5. In considering the likelihood that the FTC will succeed on the merits, a court

concentration in the relevant product and geographic markets. If the plaintiffs make that prima facie showing, the transaction is presumed illegal and the burden then shifts to the defendants to show that the prima facie case "inaccurately predicts the relevant transaction's probable effect on future competition." United States v. Baker Hughes Inc., 908 F.2d 981, 991 (D.C. Cir. 1990). If the defendants sufficiently rebut the presumption of illegality, the burden of producing additional evidence of anticompetitive effects shifts back to the FTC. H & R Block, 833 F. Supp. 2d at 72. The FTC has the burden of persuasion at all times.

8. In weighing the equities under Section 13(b), the court considers whether a preliminary injunction is in the public interest. "The principal public equity weighing in favor of issuance of preliminary injunctive relief is the public interest in effective enforcement of the antitrust laws." FTC v. H.J. Heinz Co., 246 F.3d 708, 726 (D.C. Cir. 2001) (citation omitted). Courts recognize that, if the FTC shows a likelihood of success on the merits, the equities favor issuance of a preliminary injunction. If a merger proceeds and the FTC later finds it to be unlawful, it is difficult to restore competition to its pre-merger state. FTC v. Weyerhaeuser Co., 665 F.2d 1072, 1085-86 and n.31 (D.C. Cir. 1981). As to private equities, they "do not outweigh effective enforcement of the antitrust laws. When the [FTC] demonstrates a likelihood of ultimate success, a counter showing of private equities alone would not suffice to justify denial of a preliminary injunction barring the merger." Id. at 1083.

III. Definition of Relevant Market

9. The parties' principal dispute is the proper definition of a relevant market, specifically whether the dominance of BCBSND should be considered in defining that

market or whether BCBSND's dominance should instead be considered only as a defense.

10. The defendants have not propounded an alternative relevant market definition and have no obligation to do so. Rather, the defendants contend that the plaintiffs' proposed market definition is erroneous in not accounting for BCBSND having "all the bargaining power" by virtue of its dominance in the commercial insurance market and its practice of using statewide reimbursement rates. In the plaintiffs' view, the dominance of BCBSND should be considered only after the plaintiffs have established that the proposed transaction is presumptively illegal.

11. The plaintiffs' proposed relevant market definition is derived from application of the HMT. The defendants contend the plaintiffs' model is inadequate for this case and propound a "merger simulation model," asserting it more appropriately accounts for the dominance of BCBSND in the commercial insurance market in North Dakota.

12. As described above,[7] the HMT is an iterative process that courts often use in defining relevant markets for purposes of antitrust analysis, and the Horizontal Merger Guidelines endorse its use. See H & R Block, 833 F. Supp. 2d at 51; Horizontal Merger Guidelines §§ 4.1.1-4.1.3.

13. The merger simulation model, as described by the defendants, involves two steps. The first step is to "determine if a measure for bargaining leverage (willingness to pay) has any relationship to price in the market." (Doc. #132, p. 26). The second step is to "calculate how much the merger will increase bargaining leverage and then use the

[7] See supra, Findings of Fact, Section VI, Definition of Relevant Market.

relationship calculated in the first step to simulate how much price will increase post transaction." Id. at 27. According to Dr. Town, if there is a relationship between bargaining leverage and price, the merger simulation model will predict a price increase. (Tr-4, pp. 74-76). The defendants assert that framework has been widely adopted, including its use in ProMedica, 2011 WL 1219281, at *24, in which Dr. Town—the defendants' expert in this case—served as an expert for the FTC.

14. The defendants contend the plaintiffs' model does not adequately consider realities of North Dakota's health insurance market and that the plaintiffs' position elevates theory over reality. In support of their position, the defendants quote the FTC's acting chair, Maureen Ohlhausen, who at a recent symposium stated, "We frequently need to go beyond market shares and structural presumptions and really understand the dynamics of the markets we're evaluating." (Tr-1, p. 44). But, as the plaintiffs counter, Chair Ohlhausen supported the FTC's initiation of an enforcement action in this case. (Tr-4, pp. 259-60).

15. There exists no universal method for defining a relevant market. Rather, the defined market must be "relevant to the particular legal issue at hand." H & R Block, 833 F. Supp. 2d at 51 n.8. In a merger case, a relevant product market is the line of commerce in which competition may be substantially lessened because of the merger. Phila. Nat'l Bank, 374 U.S. at 355-56; Brown Shoe, 370 U.S. at 324-25. Interchangeability between a product—or service—and possible substitutes for it determine the outer boundaries of a relevant market. "Determining the limits of a relevant product market requires identifying the choices available to customers." Se. Mo. Hosp. v. C.R. Bard, Inc., 642 F.3d 608, 613 (8th Cir. 2011).

16. The defendants cite language of the FTC's decision in In re ProMedica Health System, Inc., No. 9346, 2012 WL 1155392, at *13 (FTC Mar. 28, 2012), where the Commission stated that "evidence of competitive effects can often inform market definition." The quoted language followed the FTC's discussion of the traditional burden-shifting framework and recognized burden-shifting as "a flexible analytical framework rather than an airtight rule." Id. In the end, however, the FTC used the traditional burden-shifting framework in that case and found a Section 7 violation. The defendants also cite Little Rock Cardiology Clinic PA v. Baptist Health, 591 F.3d 591, 596-98 (8th Cir. 2009) and describe that case as having rejected a market narrowed to commercial payers for hospital services. (Doc. #83-2, p. 15). But, Little Rock Cardiology was not a Section 7 enforcement matter; it was a restraint-of-trade claim brought by a "shut-out supplier" under the Sherman Act, and the court specifically distinguished it from prior cases involving Section 7 claims. Id. at 598.

17. In support of their argument that BCBSND's dominance should be considered when defining the relevant market, the defendants cite an FTC decision which adjudicated a consummated merger to be in violation of Section 7. In re Evanston Nw. Healthcare Corp., No. 9315, 2007 WL 2286195 (FTC Aug. 6, 2007). Specifically, they note the FTC's language regarding a "fundamental relationship between market definition and competitive effects analysis in unilateral effects cases involving differentiated product markets." Id. at *49. The defendants argue that the Commission's Evanston decision shows that actual price impact on commercial payers is pertinent to market definition.

18. In his "initial decision," the Evanston administrative law judge discussed the

consummated merger's impact on an insurer which had a significant market share and a "very strong bargaining position." In re Evanston Nw. Healthcare Corp., No. 9315, 2005 WL 2845790, at *138 (FTC Oct. 20, 2005), vacated in part, 2007 WL 2286196. The ALJ considered post-merger evidence that price increases had not been imposed on that insurer but nonetheless found that the merged entity had "gained market power though the merger." Id. The Commission's decision characterized the insurer's market power as a possible reason that there had not been post-merger price increases. Evanston, 2007 WL 2286195, at *52. Since Evanston involved a consummated merger and did not consider a powerful buyer's market share at the market definition stage, it does not lead the court to conclude that BCBSND's dominance should be considered in defining a relevant market.

19. In the absence of case law supporting the defendants' position that BCBSND's dominance should be considered in defining a relevant market, application of a traditional burden-shifting framework—considering BCBSND's dominance as a defense rather than as part of the market definition process—is appropriate. See Chi. Bridge & Iron Co. N.V. v. FTC, 534 F.3d 410, 423-24, 439-40 (5th Cir. 2008); Cardinal Health, 12

reimbursement rates and that there is, therefore, no logical basis for excluding government payers from the definition of the relevant market. (Doc. #83-2, p. 15 n.5).

21. The plaintiffs cite to several cases in which the relevant market focused on commercial health insurers to the exclusion of government payers. FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1075 (N.D. Ill 2012); Advocate Health, 841 F.3d

defendants face competition." OSF Healthcare, 852 F. Supp. 2d at 1076 (quoting Tenet Health, 186 F.3d at 1052). The Bismarck-Mandan area satisfies the HMT and constitutes a relevant geographic market for each of the four physician service lines.

V. Market Shares and Market Concentration

25. A merger that significantly increases market shares and market concentration is presumed to be unlawful under Section 7. Phila. Nat'l Bank, 374 U.S. at 363.

26. In each of the four physician service lines, as measured by the HHI, existing services in the Bismarck-Mandan area are currently highly concentrated and would be even more highly concentrated if the merger were consummated. The changes in HHI in each of the four physician service lines are well above the Merger Guidelines' threshold for presumption that the proposed transaction is likely to enhance market power.

27. Based on the HHI evidence of market concentration, the proposed transaction is presumptively unlawful in each of the four physician service lines. See Penn State Hershey, 838 F.3d at 346-47; ProMedica, 749 F.3d at 568.

VI. Competitive Effects

28. Transactions that eliminate direct competi

competition in each of those distinct service markets. See Whole Foods, 548 F.3d at 1043.

VII. Rebutting the Presumption of Illegality

30. Since the plaintiffs have established that the proposed transaction is presumptively illegal, the burden shifts to the defendants to produce evidence that clearly shows that no anticompetitive effects are likely in order to overcome the plaintiffs' prima facie case. See Phila. Nat'l Bank, 374 U.S. at 363.

A. Efficiencies and Synergies

31. In analyzing a proposed transaction under Section 7, the Eighth Circuit has directed that evidence of enhanced efficiency be considered in the context of the competitive effects of the merger. Tenet Health, 186 F.3d at 1054-55. Efficiencies resulting from a merger can rebut a presumption of illegality if they are demonstrated to be merger-specific and are independently verifiable. Sysco, 113 F. Supp. 3d at 82. The Merger Guidelines consider "whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm customers." Horizontal Merger Guidelines § 10. Additionally, claimed efficiencies must be passed through to consumers. Saint Alphunsus, 778 F.3d at 790; FTC v. Univ. Health, Inc., 938 F.2d 1206, 1223 (11th Cir. 1991).

32. In support of their assertion that 340B savings should not be considered because cancer care services are not within the relevant market, the plaintiffs cite to the Merger Guidelines statement that efficiencies justifying a transaction must be "of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market." Horizontal Merger Guidelines § 10 (emphasis added). In Tenet Health, the

Eighth Circuit found the government had not sufficiently established a well-defined market but also stated that the district court may have properly rejected the efficiencies defense but should "nonetheless have considered evidence of enhanced efficiency in the context of the competitive effects of the merger." 186 F.3d at 1054. Tenet Health did not, however, involve a challenge to alleged efficiencies as being outside the defined relevant market.

33. The defendants counter that to apply a market specificity requirement "makes no sense in a merger involving an integrated healthcare system acquiring a multi-specialty clinic, both of which enable patients to obtain services in multiple areas based on their needs." (Doc. #83-2, p. 45). They assert any 340B savings should be considered fungible benefits to the patient population as a whole.

34. The Supreme Court has not specifically recognized an efficiencies defense in a Section 7 case. Recent opinions of other circuit courts appear to limit that defense, including by closely analyzing the relationship between the claimed efficiencies and the relevant market. "It is not enough to show that the merger would allow [the merged entity] to better serve patients. [Section 7] focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate." Saint Alphonsus, 778 F.3d at 791 (citing Univ. Health, 938 F.2d at 1222). See also Miss. River Corp. v. FTC, 454 F.2d 1083, 1089 (8th Cir. 1972).

35. When an efficiencies defense is recognized, a defendant has the burden to show that the claimed efficiencies are merger-specific and to demonstrate that they are independently verifiable. H.J. Heinz, 246 F.3d at 721-22.

> powerful buyers could protect themselves, the Agencies also consider whether market power can be exercised against other buyers.

Horizontal Merger Guidelines § 8.

39. The defendants have not met either of the common applications of a "powerful buyer defense"—(1) a buyer's ability to use its leverage to sponsor entry or vertically integrate or (2) where there are alternative suppliers post-merger, a buyer is able to obtain lower prices from suppliers. See id.

40. Although Sanford advances its ethical precept of "promises made, promises kept," the defendants cite no case in which similar statements were considered as part of an antitrust analysis. To the extent the defendants urge that principle shows that Sanford does not intend to demand higher reimbursement rates from BCBSND if the proposed transaction is consummated, the court notes that the plaintiffs are not required to prove an intent to do so. See United States v. Bazaarvoice, Inc., No. 13-CV-00133, 2014 WL 203966, at *11 (N.D. Cal. Jan. 8, 2014) (stating that "intent is not an element of a Section 7 violation"); Cardinal Health, 12 F. Supp. 2d at 67 (pledge to maintain current prices for three years could not rebut likelihood of anticompetitive effects).

41. In light of BCBSND testimony that it would be forced to agree to increase reimbursements to a post-merger Sanford and evidence that BCBSND has agreed to modify contract terms [redacted], the powerful buyer defense is insufficient to overcome the plaintiffs' prima facie case.

C. Impact on Medica

42. Private agreements, such as the [redacted] contract between Sanford and Medica,

are rarely considered in antitrust analysis. In Penn State Hershey, the appellate court rejected use of a private contract to define the geographic market, noting that such private agreements could hamper effective enforcement of antitrust laws. 838 F.3d at 343-44. Commonwealth v. Partners Healthcare System, Inc. held that a time limited price cap was inadequate in the context of a consent judgment because it did not directly address loss of competition. No. SUCV2014-02033-BLS2, 2015 WL 500995, at *22-24 (Mass. Super. Ct. Jan. 30, 2015). The Sanford/Medica agreement is insufficient to ameliorate the competitive competition. No. SUCV.glompult from compproposadequate

46. The defendants have not established that any new entry or expansion is timely, likely, or sufficient to counteract anticompetitive effects of the proposed transaction.

E. MDC Viability and Alleged Admission of Weakness

47. Courts have, in rare cases, recognized a "weakened competitor" defense to a merger challenge, but the defendants have not made sufficient showing to consider it here. See ProMedica, 749 F.3d at 572; Nat'l Tea Co., 603 F.2d 694, 700 (8th Cir. 1979). MDC's current financial status is strong. There is no evidence that it would "imminently depart" from the market if the merger were not consummated as was apparent in the National Tea case on which the defendants rely. See 903 F.2d at 701.

48. The plaintiffs argue that [redacted] July 5, 2017 statements should be considered an admission by MDC of the weakness of its case. In support of their position, the plaintiffs cite Great American Insurance Co. v. Horab, 309 F.2d 262 (8th Cir. 1962). Great American Insurance, a case tried to a jury, presented a question of admission of evidence that a party had attempted to interfere with service of process. The plaintiff argued that the attempted interference was an admission of the "false and fraudulent nature" of the defendant's insurance claims. Id. at 264. The trial court excluded the evidence, and the appellate court found that exclusion was not an abuse of discretion. Though affirming exclusion of the evidence, the Eighth Circuit stated that generally, in a civil case, "evidence that a litigant, or [the litigant's] agent, has attempted to influence or suppress a witness is receivable as an admission or as an indication of the litigant's consciousness that [the litigant's] case is weak or unfounded." Id. Great American Insurance appears to be the only Eighth Circuit decision addressing evidence of alleged witness tampering in a civil case. Catipovic v. Turley, a recent opinion of a district court

in this circuit, discussed the issue extensively, though in the context of a pretrial motion seeking to keep the evidence from the jury. 68 F. Supp. 3d 983, 1003-08 (N.D. Iowa 2014).

49. While [redacted] statements can be seen as an admission of his perception that the defendants' case was weak, that admission adds little to the court's analysis. There is no suggestion that [redacted] statements were prompted by the MDC board or by any Sanford representative. The court instead considers [redacted] denial of the statements as impacting credibility of his testimony.

VIII. Equities

50. The defendants argue that public equities weigh against an injunction because, if an injunction is granted and upheld on appeal, the defendants intend to abandon the proposed transaction. Thus, from the defendants' perspective, an injunction would "permanently deprive the public of the benefits of the transaction." (Doc. #83-2, p. 55). The defendants further argue that, even assuming harm from consummation of the transaction, no harm could "realistically materialize prior to the administrative resolution of this case." Id. at 56.[8]

51. Where the FTC has demonstrated a likelihood of success on the merits, no court has denied a Section 13(b) motion for a preliminary injunction based on weight of the equities. There is a strong public interest in effective enforcement of the antitrust laws and in the FTC having the ability to order effective relief if it succeeds in an

[8] Though not addressed at the hearing, in their proposed conclusions of law, the defendants describe their intent that Sanford and MDC maintain their own facilities, with MDC remaining a separate corporate subsidiary of Sanford. Id.

administrative proceeding. See H.J. Heinz, 246 F.3d at 726-27; Sysco, 113 F. Supp. 3d at 86; ProMedica, 2011 WL 1219281, at *60. The court cannot conclude that what the defendants describe as public benefits are sufficient reason to deny the motion.

Conclusion

The court has fully considered the hearing testimony and those portions of exhibits referenced during the hearing or in the parties' proposed findings of fact and conclusions of law. Though mindful that it is not this court's task to determine the merits of the matter, the court concludes there are questions going to the merits that are so serious, substantial, difficult, and doubtful as to make them fair ground for thorough investigation and determination by the FTC.

The court concludes that the FTC is likely to succeed in proving that the proposed transaction may substantially lessen competition in each of the four relevant physician service lines sold to commercial insurers in the Bismarck-Mandan area. Additionally, the public equities favor preliminarily enjoining the proposed transaction. The plaintiffs' motion for a preliminary injunction is therefore **GRANTED**.

JUDGMENT SHALL BE ENTERED ACCORDINGLY.

Dated this 1th day of December, 2017.

/s/ Alice R. Senechal
Alice R. Senechal
United States Magistrate Judge