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

FEDERAL TRADE COMMISSION,

and

TABLE OF CONTENTS

Statutes

Other Authorities

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

Mar. 28, 2012); *Saint Alphonsus Med. Ctr. – Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 783 (9th Cir. 2015) ("*St. Luke's*"); *Chi. Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008). Under this framework, a plaintiff may establish a *prima facie* case by defining a relevant product and geographic market and showing that the transaction will lead to undue concentration in that market. *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990).

Because a merger to near-monopoly, as here, is presumptively illegal, *see United States v. Phila. Nat'l Bank*, 374 U.S. 321, 364 (1963), under the burden-shifting framework defendants "seeking to rebut a presumption of antic

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

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

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

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

i. The Relevant Service Markets Are Four Distinct Physician Services

The "reasonable interchangeability, or cross-elasticity of demand, between the product itself and possible substitutes for it" determine the boundaries of a relevant product or service market. *Se. Mo. Hosp. v. C.R. Bard, Inc.*, 642 F.3d 608, 613 (8th Cir. 2011) (citing *Brown Shoe*, 370 U.S. at 325). That is, courts look at whether "consumers will shift from one product to the other in response to changes in their relative costs." *SuperTurf, Inc. v. Monsanto Co.*, 660 F.2d 1275, 1278 (8th Cir. 1981) (citation omitted); *see also ProMedica*, 749 F.3d at 565 (discussing customer substitution as a step in defining relevant product markets). In the healthcare context, this means looking at whether health insurers—again, the ones who will feel the initial impact of any price increase—cout327agai

Defendants compete in the following service lines: (1) adult primary care physician services, (2) pediatrician services, (3) OB/GYN services, and (4) general surgeon services.[8] Each of these four services meets the hypothetical monopolist test, and therefore is a relevant market in which to analyze the transaction's competitive effects. For each of these four services, customers—in this case, health insurers—would not switch away from that service because they could not market a product that omitted it entirely, which they would be forced to do should they not agree to the hypothetical monopolist's SSNIP.[9] Given the distinct characteristics of each service line, including both the physicians' specialized training and qualifications and the unique services provided by each of these four physician types, patients demand in-network access to each of these types of providers. Therefore, a hypothetical monopolist of each service could profitably negotiate a SSNIP. Federal court decisions embrace physician services markets consistent with those identified here. *See St. Luke's*, 778 F.3d at 784 (adult PCPs); *Sidibe v. Sutter Health*, 4 F. Supp. 3d 1160, 1168 (N.D. Cal. 2013) (OB/GYN, general surgery); *Woman's Clinic, Inc. v. St. John's Health Sys., Inc.*, 252 F. Supp. 2d 857, 867 (W.D. Mo. 2002) (OB/GYN); *HTI Health Servs., Inc. v. Quorum Health Grp., Inc.*, 960 F. Supp. 1104, 1115-16

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

Geographic market definition is a prospective exercise. Similar to evaluating whether consumer behavior regarding a product would change in the face of a SSNIP, geographic market definition predicts consumers' willingness to travel in response to a hypothetical price increase. *St. Luke's*, 778 F.3d at 785; *Tenet*, 186 F.3d at 1053-54. A properly defined geographic market must reflect "the commercial realities of the industry." *Advocate*, 841 F.3d at 468 (citing *Brown Shoe*, 370 U.S. at 336) (internal quotation marks and citations omitted); *see also Penn State Hershey*, 838 F.3d at 338. In the healthcare industry, insurance companies effectively channel consumer preferences and thus are the appropriate subject of the hypothetical monopolist test. *See Penn State Hershey*, 838 F.3d at 342 ("Patients are relevant to the analysis, especially to the extent that their behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates. But patients, in large part, do not feel the impact of price increases. Insurers do.") (footnote omitted); *Advocate*, 841 F.3d at 471; *St. Luke's*, 778 F.3d at 784 ("[T]he district court correctly focused on the 'likely response of *insurers* to a hypothetical demand by all the [primary care physicians] in a particular market for a [SSNIP].'") (emphasis added).

10

The geographic market question essentially

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

iii. Market Concentration Levels Easily Trigger a Presumption of Illegality

Market concentration levels in *each* of the four relevant

also Heinz, 246 F.3d at 715-16; *Baker Hughes*, 908 F.2d at 982-83 & n.3. Plaintiffs "can establish a prima facie case by showing a high market concentration based on HHI numbers." *Penn State Hershey*, 838 F.3d at 347; *see also St. Luke's*, 778 F.3d at 788-89; *Heinz*, 246 F.3d at 715-16.

In this case, each of the four relevant markets is *already* highly concentrated, and post-merger concentration levels and HHI increases fa

					_____
					_____
					_____
					_____
					_____

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

iv. Additional Evidence Bolsters Strong Presumption of Harm and Illegality

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

a. The Merger Eliminates Close Competition Between Sanford and MDC

The "extent of direct competition" between the merging parties is a "central" part of evaluating the unilateral competitive effects from an acquisition. *ProMedica*, 749 F.3d at 569 (quoting Merger Guidelines § 6.1). "A merger is likely to have unilateral anticompetitive effect if the acquiring firm will have the incentive to raise prices or reduce quality after the acquisition, independent of competitive responses from other firms." *United States v. H&R Block*, 833 F. Supp. 2d 36, 81 (D.D.C. 2011); *see St. Luke's*

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

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

Sanford and MDC also respond to each other's marketing campaigns, monitor each

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

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

continue to offer a viable

[redacted]

[redacted][40]

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

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

In addition to the documentary and testimonial evidence above, Dr. Sacher has performed a "willingness to pay" (or "WTP") analy d

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

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

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

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

The sophistication and market power of one large buyer alone are not sufficient conditions to make out the "powerful buyer" defense. There are two ways in which the powerful buyer defense could apply, but neither is met here. First, a powerful buyer may be characterized by the ability to leverage its size or sophistication to sponsor entry or vertically integrate. Merger Guidelines § 8;[56]

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

H&R Block, 833 F. Supp. 2d at 82; *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1285 (N.D. Ill. 1989). The reduction in competition on non-price terms that will result from this merger occurs independent of the contracts nego

be "timely, likely, and sufficient in its magnitude, character and scope to deter or counteract the competitive effects" of the proposed transaction. Merger Guidelines § 9; *see FTC v. Procter & Gamble, Co.*, 386 U.S. 568, 579 (1967). A finding of "high entry barriers 'eliminates the possibility that the reduced competition caused by the merger will be ameliorated by new competition from outsiders and further strengthens the FTC's case.'" *St. Luke's*, 778 F.3d at 788 (citing *Heinz*, 246 F.3d at 717).

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

Further, certain practice types require call coverage or referral sources, making independent entry even less likely. OB/GYNs and general surgeons, for example, must participate in or provide for call coverage of hospitalized patients. A reasonable call rotation requires at least four to five physicians; otherwise the practice is not attractive to new recruits.[72] General surgeons also require referral sources, and independent or newly recruited general surgeons in the Bismarck-Mandan area would lack the necessary source of referrals, as Sanford would employ almost all primary care physicians in the area. Given the size and breadth of

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

Defendants' flawed argument that the proposed merger will benefit healthcare consumers through cost savings and quality improvements also cannot save this presumptively unlawful transaction. Far from the proof of "extraordinary efficiencies" required under the case law where

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

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

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

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

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

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

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

Today, MDC successfully meets quality and financial targets, and compensates its

[87] In fact, a third-party valuation firm, in an independent valuation of MDC, projected a stable and healthy financial outlook for MDC for the

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

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

> It is generally held that, in a civil case, evidence that a litigant, or his agent, has attempted to influence or suppress a witness is receivable as an admission or as an indication of the litigant's consciousness that his case is weak or unfounded or that his claim is false or fraudulent. SpthanoTJ/ tim-1.92ion as anst the

relief include "(i) the public interest in effectively enforcing antitrust laws and (ii) the public interest in ensuring that the FTC has the ability to order effective relief if it succeeds at the merits trial." *Sysco*, 113 F. Supp. 3d at 86; *see also Heinz*, 246 F.3d at 726;

CONCLUSION

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