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

Federal Trade Commission and State of North Dakota, Plaintiffs, vs. Sanford Health, Sanford Bismarck, and Mid Dakota Clinic, P.C., Defendants.	)	Case No. 1:17-cv-133 **MEMORANDUM OF DECISION, FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER**

INTRODUCTION

Alleging that a proposed transaction between two healthcare providers—Sanford Health/Sanford Bismarck and Mid Dakota Clinic, P.C.—would substantially lessen competition and cause significant harm to consumers, the Federal Trade Commission and the State of North Dakota brought this action to preliminarily enjoin consummation of the proposed transaction pending an FTC administrative hearing. The administrative hearing is currently scheduled to begin on January 17, 2018.[1]

The parties stipulated to entry of a temporary restraining order, under which the proposed transaction cannot be closed until five business days after the court rules on the plaintiffs' motion for a preliminary injunction. (See Doc. #7).

Pursuant to 28 U.S.C. § 636(c), all parties consented to jurisdiction of a magistrate judge. (Doc. #39). Beginning on October 30, 2017, the undersigned magistrate judge held a four-day evidentiary hearing on the motion for a preliminary

[1] At the time of the preliminary injunction hearing, the administrative hearing was scheduled to begin on November 28, 2017, within the five-month period provided by 16 C.F.R. § 3.11(b)(4). The administrative law judge has since granted an extension to January 17, 2018.

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. Following conclusion of the hearing, the parties submitted proposed findings of fact and conclusions of law. The court's review of documents received into evidence has been limited to those portions of the documents addressed during hearing testimony or cited in the parties' proposed findings of facts and conclusions of law.

The plaintiffs contend that the pending transaction would unlawfully lessen competition among four physician service lines—adult primary care physician (PCP) services, pediatrician services, obstetrician/gynecologist (OB/GYN) physician services, and general surgeon services—in the Bismarck-Mandan, North Dakota, Metropolitan Statistical Area (Bismarck-Mandan area), which includes the counties of Burleigh, Morton, Oliver, and Sioux. The defendants argue that the plaintiffs' position does not adequately consider the impact of a powerful buyer—Blue Cross Blue Shield of North Dakota (BCBSND). The defendants assert that the presence of that powerful buyer would preclude any anticompetitive effects that might otherwise result from the proposed transaction and that the proposed transaction would benefit consumers in the Bismarck-Mandan area.

Having fully considered the hearing testimony, the exhibits as described above, and the briefs of the parties, the court makes the following findings of fact and

[2] Because some of the testimony concerned sensitive and confidential business information of the defendants and of third parties, portions of the hearing were not open to the public. For the same reason, certain of the exhibits have been sealed and are not available to the public. Portions of this decision have been redacted to preserve that confidentiality.

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 [redacted] covered through individual plans or Medicare supplement plans. In the Bismarck-Mandan area, approximately [redacted] 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,

[redacted]. (JX 0083; Tr-1, pp. 190-91).

III. Proposed Transaction

16. In 2015, MDC offered itself for sale by requesting purchase proposals from two entities—CHI and Sanford. Both CHI and Sanford submitted proposals, and MDC's shareholders initially voted to accept CHI's proposal. In February 2016, MDC and CHI signed a Letter of Intent (LOI) for CHI's purchase of MDC. (DX 4008). But, on March 28, 2016—three days before the LOI's deadline for doing so—CHI gave written notice of its termination of the LOI and discontinued negotiations for purchase of MDC. The decision to terminate the LOI was made at CHI's corporate level, not by local administrators. (JX 0016, p. 114).[4] In terminating the LOI, CHI stated it did so because of [redacted]. (DX 4079).

17. After CHI terminated the LOI, MDC reinitiated discussions with Sanford. On August 22, 2016, Sanford and MDC signed a term sheet for Sanford's purchase of MDC. The term sheet provides for Sanford's purchase of all MDC practice assets, MDC's real estate and other tangible assets, and retention loans for MDC physicians who join Sanford after consummation of the transaction. It also provides for Sanford's acquisition of real estate and other assets owned by Mid Dakota Medical Building Partnership, an entity which leases a building to MDC. On approximately June 19, 2017, Sanford and MDC signed a stock purchase agreement. The total value of the proposed

[4] JX 0016, p. 114 refers to the conventionally filed exhibit; the document also appears in the electronic docket as JX 0016, p. 30. (See Doc. #131-7).

Sanford/MDC transaction is approximately [redacted]. (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 initiated an administrative proceeding on the antitrust merits. (Doc. #11, p. 10).

19. Subsequent to Sanford and MDC signing their term sheet in August 2016, there were discussions between MDC and CHI St. Alexius [redacted]. After the FTC announced its challenge to the transaction, Schley sent an email to CHI St. Alexius staff members. That email—authored at least in part at CHI's corporate headquarters—expressed CHI's support of the FTC's action and referred to the proposed transaction as harming the community by increasing physician fees, reducing quality, and eliminating choice. (DX 3010).

20. MDC physicians were angered and offended by Schley's email. [redacted] testified that, during a July 5, 2017 meeting with [redacted], [redacted] told him that the [redacted]. [redacted] testified that he responded that he would testify truthfully. [redacted] denied telling [redacted] that [redacted], and [redacted] considers it to be [redacted]. Handwritten notes which [redacted] made during the July 5th meeting were received into evidence, as was an email he sent to his superiors at [redacted] and to [redacted] counsel later that day. The email summarizes [redacted] perspectives on the

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

plan depends largely on the insureds' ability to access a variety of quality in-network healthcare services that are geographically convenient. All else being equal, the more geographically convenient and high quality providers included in a health insurance plan, the more marketable that plan is to potential purchasers. (Tr-1, pp. 169-70, 230-31; PX 3014, p. 3). Currently, a network including either Sanford or MDC physicians in the four physician service lines at issue can support a marketable health insurance product in the Bismarck-Mandan area. (See JX 0009, p. 26; JX 0003, p. 12). BCBSND considers Sanford and MDC as alternatives to each other for insurance plan networks in the Bismarck-Mandan area for each of the four physician service lines at issue. (Tr-1, p. 243). Consequently, during contract negotiations, a commercial insurer can currently credibly threaten to exclude either Sanford or MDC from its Bismarck-Mandan provider network. (PX 3014, p. 7; PX 3016, p. 3).

31. One factor influencing a commercial insurer's bargaining leverage is the number of alternative healthcare providers in a geographic area. The fewer the number of alternative providers in the area, the greater the bargaining leverage of a large provider over a commercial insurer. If a large provider is no longer included in a commercial insurer's network in a geographic area with few alternatives, subscribers may choose to purchase insurance from another insurer. (Tr-1, pp. 174-77, 255-56; Tr-3, p. 173; PX 3014, pp. 5-6).

B. Second-Stage Competition

32. In the second stage of healthcare competition, in-network providers compete with each other to attract patients. Within a health insurance plan, there is little variance in out-of-pocket costs to patients receiving care from in-network providers, i.e.,

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. (JX 0004, p. 34; Tr-1, pp. 86-87; JX 0014, p. 9).

36. While APPs provide some of the same services as adult PCPs, a health insurance plan that included APPs but excluded adult PCPs would not be marketable in the Bismarck-Mandan area. APPs are not trained to provide all of the services that adult PCPs provide. Though patients in more rural areas might accept APPs as their primary providers, Bismarck-Mandan residents often prefer an adult PCP over an APP for their primary care. (Tr-1, pp. 85, 181-82, 235-36).

37. Plaintiffs' expert economist, Dr. Sacher, analyzed the percentage of spending for "evaluation and management" visits in the Bismarck-Mandan area. His analysis demonstrates that approximately 74% of spending for adult PCP services, but only 26% of spending for specialists, falls into that category. Dr. Sacher also analyzed data which shows that approximately 6% of patients in the Bismarck-Mandan area received primary

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

14 and under in the Bismarck-Mandan area are performed by pediatricians. That data confirms a strong consumer preference for in-network access to services of pediatricians. (PX 6000, pp. 41, 216).

41. In constructing a marketable health insurance plan network, pediatric hospitalists could not be substituted for pediatricians since pediatric hospitalists do not treat patients in a clinic setting. There was no evidence that physicians in any other service line could be substituted for pediatricians in constructing a marketable health insurance plan network in the Bismarck-Mandan area. (Tr-1, pp. 89-90).

42. Representatives of each of the three primary commercial insurers—BCBSND, SHP, and Medica—all agreed that an insurance plan's network must include pediatricians in order to be marketable in the Bismarck-Mandan area. (Tr-1, pp. 179-80, 234; JX 0028, p. 50). Hearing testimony confirmed that an employer purchasing health insurance coverage for its employees in the Bismarck-Mandan area expects a plan's network to include pediatricians. (Tr-2, p. 163).

43. Currently, both Sanford and MDC offer pediatrician services in the Bismarck-Mandan area, with respective market shares of 34% and 64.6%. Post-merger, Sanford would provide 98.6% of the pediatrician services in the Bismarck-Mandan area. The only other provider of pediatrician services, UND-CFM, would have the remaining market share. (PX 6000, p. 170).

44. OB/GYN physicians provide services focused on prenatal care, management of labor and delivery, well-woman visits, contraception, management of menopause, diagnosis of gynecological cancers, and evaluation and treatment of various other diseases of female patients. Although adult PCPs and APPs provide some of the same

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.

46. Representatives of each of the three primary commercial insurers—BCBSND, SHP, and Medica—all agreed that an insurance plan's network must include OB/GYN physicians in order to be marketable in the Bismarck-Mandan area. (Tr-1, pp. 180-81, 234-35; JX 0028, p. 51). Hearing testimony confirmed that an employer purchasing health insurance coverage for its employees in the Bismarck-Mandan area expects that a plan's network would include OB/GYN physicians. (Tr-2, p. 163). Female employees—and female family members of employees—who are of child-bearing age expect in-network access to OB/GYN physicians.

47. Dr. Sacher's analysis compared claims for services of adult PCPs in the Bismarck-Mandan area to those of OB/GYN physicians and demonstrated that OB/GYN physicians perform significantly more surgeries than adult PCPs and that OB/GYN physicians perform almost 98% of gynecological surgeries.

48. Currently, both Sanford and MDC offer OB/GYN physician services. Their respective market shares are 23.9% and 75.1%. The only other OB/GYN physician

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).

51. Representatives of each of the three primary commercial insurers—BCBSND, SHP, and Medica—all agreed that an insurance plan's network must include general surgeons in order to be marketable in the Bismarck-Mandan area. (Tr-1, pp. 180-81, 236; JX 0028, p. 51). Hearing evidence confirmed that an employer purchasing health insurance coverage for its employees in the Bismarck-Mandan area would consider in-network general surgeons an important component of a health insurance plan. (PX 3008, p. 6).

52. Of the general surgeon services in the Bismarck-Mandan area, Sanford currently provides 36.1% and MDC provides 63.7%. Post-merger, Sanford would be the only entity providing general surgeon services in the Bismarck-Mandan area. (PX 6000, p. 175).

VI. Definition of Relevant Market

53. In antitrust analysis, a relevant market identifies a set of products or services and a geographic area of competition in which to analyze the potential effects of a proposed transaction. The purpose of market definition is to identify options available to consumers.

54. The parties' principal dispute is the proper definition of a relevant market, specifically whether BCBSND's dominance should be considered in defining that market or whether it should instead be considered only as a defense.

55. For reasons discussed below,[5] this court finds it appropriate to consider BCBSND's dominance as a defense rather than as part of the market definition process.

56. The plaintiffs' proposed relevant market definition is derived from application of

[5] See infra, Conclusions of Law, Section III, Definition of Relevant Market.

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. United States v. H & R Block, Inc., 833 F. Supp. 2d 36, 51 (D.D.C. 2011). The Merger Guidelines issued by the FTC and the United States Department of Justice endorse use of the HMT. U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines §§ 4.1.1-4.1.3 (2010).

58. It is appropriate to use the HMT to define the relevant market in this case.

59. In healthcare merger cases, other courts have defined relevant markets in terms of specific types of physician services. See Saint Alphonsus Med. Cent.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 784 (9th Cir. 2015); Woman's Clinic, Inc. v. St. John's Health Sys., Inc., 252 F. Supp. 2d 857, 867 (W.D. Mo. 2002). That approach is appropriate for this case.

60. A relevant product market definition may be based on a distinct category of

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 immediate purchasers of physician services, it is logical to consider the process by which commercial insurers build provider networks.

62. Since commercial insurers market their products to health insurance plan purchasers, the insurers must consider the needs and preferences of their insureds—employers, employees, and employees' families. (PX 6000, pp. 25-26; Tr-2, pp. 60-61; Tr-4, p. 112). When the HMT is employed in analyzing a healthcare merger, the inquiry is whether a hypothetical monopolist of a candidate physician services

market (or a candidate geographic market) could negotiate a SSNIP from commercial insurers. (Tr-2, pp. 61-62; PX 6000, p. 31).

63. The geographic market definition considers "where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate." United States v. Phila. Nat'l Bank, 374 U.S. 321, 357 (1963).

64. The Merger Guidelines support use of the HMT to define a geographic market, and other courts have endorsed that approach. See Horizontal Merger Guidelines § 4.2; Advocate Health, 841 F.3d at 468-73. Dr. Town agreed that, if one were going to define a geographic market in this situation, use of the HMT—or SSNIP—test would be an appropriate method for doing so. (Tr-4, p. 112). It is appropriate to use the HMT to define the geographic market for this case.

65. The Bismarck-Mandan area includes the cities of Bismarck and Mandan and smaller communities within the surrounding 40 to 50 mile radius. The population of the Bismarck-Mandan area is approximately 130,000, with approximately 93,000 of those people living within either Bismarck or Mandan. The cities closest to Bismarck and Mandan (Minot, Dickinson, and Jamestown) are each between 90 and 110 miles away. Clinics within the Bismarck-Mandan area are almost all within an eight-mile radius of central Bismarck. (PX 3002, p. 2; PX 6000, pp. 55, 235).

66. Both MDC and Sanford Bismarck consider their primary geographic market to be the area encompassing the four counties that the plaintiffs include in their proposed definition of the relevant market. (JX 0012, pp. 202-03; JX 0007, p. 31). Dr. Sacher's quantitative analysis confirms that patients residing within the Bismarck-Mandan area prefer to receive healthcare services within that area, (PX 6000, pp. 62, 64, 70, 155), and

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 HHI (defined as twice the product of the market shares of the merging firms) which results from the merger. Under the Guidelines, an HHI above 2500 demonstrates a

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" or UPP, and "willingness to pay" or WTP.

74. Both qualitative and quantitative analyses demonstrate that Sanford and MDC are close competitors in the Bismarck-Mandan area. Hearing testimony and exhibits show that each of the two entities views the other as its primary competitor. (See PX 4150, p. 4; Tr-2, p. 21; Tr-3, p. 81; PX 5174, p. 2; PX 5162, pp. 6-7; PX 5238, p.1). Sanford and MDC follow each other's changes in patient services, such as clinic locations, weight loss programming, and sports physicals. (JX 0011, p. 37; PX 4084, p. 23; PX 5157).Further, Sanford and MDC track each other's marketing and advertising and have responded to each other's advertising with advertising of their own. (PX 5168, p. 2; PX 4020, pp. 3-4; PX 5145, p. 1; PX 4099, p. 3; PX 5177, p. 3).

75. The plaintiffs' expert performed quantitative analyses which confirmed that Sanford and MDC are close competitors in the Bismarck-Mandan area in each of the four relevant physician service lines. He analyzed "interfirm diversion ratios" between the two entities—the percentage of a provider's patients that, if their provider were no longer available, would switch to the other provider. Dr. Sacher's interfirm diversion ratio analysis confirmed that Sanford patients in the Bismarck-Mandan area regard

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 Saint Alphonsus, 778 F.3d 775.

76. Dr. Sacher also considered UPP. His UPP analysis assessed the incentive of a post-merger Sanford to increase prices due to "internalization of substitution." (Tr-2, p. 94). Currently, if an MDC patient switches to Sanford because MDC is no longer in the network of the patient's health insurance plan, MDC would lose the profits it would otherwise have derived from serving that patient. Post-merger, if a patient switches from a former MDC physician to a Sanford physician, there would be no lost profits because the substitution would have been "internalized." The greater the value of the internalized substitution, the greater the incentive to increase price. (Tr-2, pp. 93-96).

77. Dr. Sacher's UPP analysis considered the interfirm diversion ratios between Sanford and MDC together with their incremental profit margins. He used financial information provided by Sanford and MDC to determine their incremental profit margins, together with his estimates of interfirm diversion ratios, and concluded that the proposed transaction is likely to result in a UPP of 6% to 22%. Those percentages equate to $16 million to $27 million annually. (PX 6000, p. 91; Tr-2, pp. 93-97).

78. Dr. Sacher also employed a WTP analysis, which measures the value patients place on having a particular provider in their insurer's network. He concluded that the

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.

IX. Efficiencies and Synergies

82. The defendants contend that the proposed transaction will generate efficiencies and synergies which will improve services to consumers in the Bismarck-Mandan area and that those efficiencies and synergies will counteract any anticompetitive effects of the proposed transaction.

83. In late 2016 and early 2017, the defendants prepared a document titled "Stronger Together: Synergy," which they describe as "a summary of merger-specific synergies identified through a collaborative process between Sanford and MDC clinical and administrative personnel." (Doc. #132, p. 69; Tr-3, pp. 218-219, 232; DX 2061). A group of Sanford and MDC employees participated in the collaborative process, but "Stronger Together" was written primarily by counsel. (Tr-3, p. 231).

84. The plaintiffs characterize "Stronger Together" as a "high-level discussion of theoretical gains . . . created after the parties decided to merge." (Doc. #131, p. 68). They argue that Sanford and MDC have not presented verifiable, merger-specific efficiencies.

85. Sanford witnesses described the organization's ethical philosophy of "promises made, promises kept." (Tr-3, pp. 16, 84). Following its acquisitions of healthcare facilities in Bismarck, Fargo, and other communities, Sanford made significant financial investments in those facilities, as it had said it would when the acquisitions were finalized. Sanford advances its "proven track record of achieving efficiencies." (Doc. #132, p. 8).

86. Sanford's counsel engaged Deloitte to analyze and quantify the efficiencies and synergies identified in "Stronger Together," and Deloitte presented its work in a document titled "Efficiency Summary." (DX 4018). In performing its analysis, Deloitte

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 [redacted] 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 calculations. On rebuttal, a plaintiffs' expert testified that Leclerc's calculations had not described the DSH calculation formula correctly. (Tr-4, pp. 234-37; see also PDX 005-001). In response, the defendants cite the DSH formula that is available from the Centers for Medicare and Medicaid Services (CMS) website. (Doc. #132, p. 72). The formula set out on the CMS website appears consistent with testimony of the plaintiffs' expert witness. Given the lack of confirming documentation and the disputed application of the CMS formula, Sanford's calculations regarding potential for loss of its DSH status are not persuasive.

92. The expert whom plaintiffs retained to analyze the defendants' claimed efficiencies, Dr. Thomas Respess, testified about a change in a federal rule governing 340B reimbursements. Respess testified that the change, which became effective November 1, 2017, reduced reimbursements to 340B providers. (PX 6001, pp. 19-20; Tr-2, p. 202). Deloitte's analysis did not consider the rule change. The Deloitte consultant testified she had not done so because the rule change is not related to pricing of the purchasing of oncology drugs. (Tr-4, p. 34). The rule change affects the reimbursements for 340B drugs that hospitals receive, not the purchase price of those drugs. The Deloitte Report analyzed only the savings from drug purchasing, but did not analyze reduced reimbursements. Id. at 32-34. Hearing evidence does not establish whether the rule change would impact net 340B savings to a post-merger Sanford.

93. The defendants assert the recent 340B rule change will facilitate pass-through of 340B discounts to Medicare and to Medicare beneficiaries. Medicare and its beneficiaries are not within the relevant market.

94. Because any 340B savings resulting from the proposed transaction would not arise in any of the physician service lines at issue, because the impact of the recent rule modification is not well defined, because Deloitte did not consider possible impact of the merger on Sanford's 340B status, and because they have not sufficiently shown that any 340B savings would be passed through to healthcare consumers, the defendants have not met their burden as to the claimed 340B efficiencies.

95. Deloitte's projected net savings also included approximately [redacted] in laboratory costs. But, that projection did not consider that MDC recently entered into a contract for reference laboratory services with a third party or that MDC had estimated

approximately [redacted] in annual savings as a result of that contract. (PX 5263, p. 1; DX 4018, p. 18; PX 5276, p. 2; Tr-4, pp. 28-29, 36). Deloitte's consultant testified at the hearing that, after learning of that contract, Deloitte "prepared an analysis that overlays those new prices on top of what we had calculated, and the figures would be reduced by about [redacted]," (Tr-4, p. 37), but did not explain why savings would be less than MDC had estimated.

96. In the non-clinical areas, Deloitte projected the proposed transaction would lead to costs savings related to physician recruiting, revenue cycle services, information technology, electronic medical records, and infrastructure. But, the magnitude of those projections is small in relation to the defendants' estimated 340B savings, and implementation of any savings in those non-clinical areas would require significant expenditures. Deloitte's projections in these areas are based only on defendants' estimates—Deloitte did not independently verify those estimates. (JX 0007, p. 2; JX 0069, p. 2; JX 0070, p. 2; JX 0013, pp. 73-74; DX 4018, pp. 5, 22-34).

97. The defendants have not demonstrated monetary efficiencies in non-clinical areas sufficient to overcome the anticompetitive effects of the proposed transaction.

98. Even if all of the claimed monetary efficiencies were considered merger-specific and verifiable, they would be insufficient to offset the price increase predicted by Dr. Sacher's UPP analysis. (PX 6000, pp. 96-98; Tr-2, pp. 112-114).

99. In addition to the 340B program, Sanford and MDC asserted a number of quality efficiencies. Their asserted quality efficiencies include (1) Imagenetics, a program integrating genetic medicine into primary care; (2) embedding behavioral health therapists into primary care clinics; (3) cancer care trials and cancer care outreach to

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.

101. This court finds the claimed quality efficiency in the Imagenetics program to be merger-specific, but the defendants have not demonstrated that the other claimed quality efficiencies are merger specific.

102. The claimed quality efficiencies must be considered in light of the Merger Guidelines and case law interpreting those guidelines. Under the guidelines, the lesser the adverse competitive effects, the greater the weight ascribed to efficiencies. "Efficiencies almost never justify a merger to monopoly or near-monopoly." Horizontal Merger Guidelines § 10; see also Saint Alphonsus, 778 F.3d at 790; FTC v. ProMedica Health Sys., Inc., No. 3:11-cv-47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011). Given that the proposed transaction would result in near-monopoly, the claimed quality efficiencies are insufficient to overcome the presumption of illegality.

X. BCBSND as a Powerful Buyer

103. There is no question that BCBSND is a powerful buyer in the Bismarck-Mandan area and throughout the state. Various documents in the record show its statewide share

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.

contracts. BCBSND has deviated from the statewide fee schedule in response to "provider-specific" requests and providers' demonstrated need. [redacted] (Tr-1, p. 287).

107. Chelsey Matter, BCBSND's Director of Provider Partnerships and Analytics, testified about the process BCBSND uses for contracting with network providers. BCBSND endeavors to set reimbursement rates adequate to "make sure the providers can continue to offer services in North Dakota." Id. at 255, 280. [redacted] Id. at 262-65, 256, 281, 292.

108. In its interactions with providers, BCBSND [redacted] Id. at 291. But, a provider offering "a whole lot of services to a lot of [BCBSND] members" or a provider offering the only "super specialist that many [BCBSND] members need" has greater leverage in establishment of the fee schedule. Id. at 255-56.

109. With Sanford as the largest provider in the state, BCBSND consults with Sanford

"on a very regular basis." (Tr-3, p. 178). Sanford is [redacted]. (See Tr-1, p. 256).

110. Though the defendants contend that BCBSND does not truly negotiate with providers, in various documents in the record, defendants have characterized their interactions with BCBSND as "negotiation." Those documents demonstrate several recent instances in which BCBSND [redacted]. (See PX 4081, pp. 1, 3, 5; PX 4075, pp. 1-2; PX 4156, p. 1; PX 4080, p. 1). When BCBSND moved to a different methodology for inpatient reimbursement, there was [redacted] which resulted in BCBSND making adjustments to create a "buffer to transition into the new methodology." (Tr-1, pp. 256-57). In May 2016—after CHI terminated the LOI and before Sanford and MDC signed the term sheet—Leclerc sent an email discussing Sanford's acquisition of Great Plains Clinic in Dickinson, North Dakota, which had been a part of PrimeCare. The email referenced the clinic's transition from PrimeCare and stated, [redacted] (PX 4227, p. 1).

111. When contracting for its provider networks in the Bismarck-Mandan area, BCBSND does not consider CHI a viable alternative to either Sanford or MDC since CHI does not offer services sufficient to meet the needs of BCBSND's insureds in that area. BCBSND could not construct a marketable health plan in the Bismarck-Mandan area if it did not include a post-merger Sanford. (Tr-1, pp. 244, 246-47).

112. BCBSND is concerned about the proposed transaction because a post-merger

Sanford would control a large portion of the four physician service lines in the Bismarck-Mandan area so that Sanford "could really present [BCBSND] with an ultimatum" if it chose to. Id. at 261. Matter testified that, if Sanford were to request a rate increase and threaten to terminate its network agreement with BCBSND if the increase were not granted, BCBSND would have to choose between agreeing to the increase or no longer offering health plans in the Bismarck-Mandan area.

113. BCBSND expects an immediate increase in Sanford's bargaining leverage if the proposed transaction is consummated, including leverage to seek favorable terms in its value plan agreement with BCBSND. Id. at 260-62, 274.

114. If BCBSND were to agree to a rate increase in response to a post-merger demand from Sanford, that would result in increased premiums for BCBSND customers. An increase in Sanford's reimbursement rates would also [redacted]. Self-insured employer groups would see an immediate increase in their costs if BCBSND acceded to a post-merger Sanford demand for a reimbursement rate increase. Id. at 261-63, 299.

115. Additionally, BCBSND is concerned that, if Sanford were to terminate its network agreement with BCBSND, patients in the Bismarck-Mandan area would have an option of coverage under SHP, and if BCBSND increased reimbursements to Sanford in response to an ultimatum, SHP could offer lower premiums than BCBSND. Id. at 263.

116. Leclerc testified that Sanford would not present an ultimatum to BCBSND because Sanford cannot afford to terminate its statewide agreement with BCBSND, which accounts for a large percentage of Sanford's revenue in North Dakota and is the largest payer to the Sanford system as a whole. As Leclerc described, BCBSND is

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],

there is no reason to believe that the proposed transaction would result in BCBSND increasing reimbursement rates to a post-merger Sanford in the Bismarck-Mandan area. (Tr-4, pp. 92-98).

121. Altru has a near monopoly on healthcare services in the Grand Forks area. [redacted]

122. BCBSND's response [redacted] shows that a near-monopoly provider has leverage in negotiations with BCBSND.

XI. Proposed Transaction's Impact on Medica and Self-Insured Employer

123. Michael Lenz, who until August 2017 was Medica's vice president of strategic initiatives, testified that the proposed transaction "would substantially increase Sanford's leverage" in negotiations with Medica, likely resulting in Sanford's post-merger ability to demand more favorable reimbursement rates and reimbursement terms. (Tr-1, p. 223). Medica has a system-wide contract with Sanford, covering all of Sanford's providers in each of the states in which Medica offers commercial health insurance plans. Id. at 174. Lenz testified that increased reimbursement rates paid to a

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 credibly threaten to walk away from negotiations with Sanford. See id. at 183-84.

125. If the proposed transaction is consummated, Medica would not be able to offer a marketable health insurance plan in the Bismarck-Mandan area that did not include a post-merger Sanford. See id. at 178. Lenz testified that, because of its additional leverage in the Bismarck-Mandan area, a post-merger Sanford would be able to secure higher reimbursement rates from Medica "for the broader agreement." Id. at 184.

126. Lenz testified about impacts of healthcare facility mergers he had observed in other markets and that he had seen changes in referral patterns resulting from those mergers. In his experience with healthcare facility mergers in other locations, Lenz has never seen any cost savings passed along to consumers through lower reimbursement rates. Id. at 187.

127. The defendants contend that the proposed transaction would cause no adverse effects to Medica during the [redacted] of the Sanford/Medica agreement and that impacts on Medica after [redacted] will be negligible and offset by efficiencies and by CHI's expansion in the Bismarck-Mandan area.

128. Lenz testified about the [redacted] rate agreement between Sanford and Medica, which sets parameters of reimbursement rates. He testified that the agreement [redacted]

[redacted]. 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 physician would make decisions about patient referrals based on a patient's insurance coverage.

131. A Medica document captioned [redacted] The defendants contend that document demonstrates that Medica's costs would decrease as a result of the proposed transaction. (Doc. #132, p. 42). Because that document did not account for post-merger practice pattern changes or differences in the charge master, and given the small number of Medica's insureds in the Bismarck-Mandan area and limited time period analyzed, the document is not useful in analyzing impacts of the proposed transaction. (See Tr-1, pp. 202, 220).

132. Leclerc, who was involved in negotiating the [redacted] rate agreement, testified that the agreement's [redacted]

[redacted]

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] 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]

[redacted] (See Tr-2, pp. 166-67).

138. NISC is concerned that [redacted]. Further, NISC is concerned that [redacted]. Id. at 158-59, 169-70, 172, 182-84.

XII. New Entry or Expansion

139. Entry or expansion of competitors into a market may be sufficient to counteract anticompetitive effects of a proposed merger. Horizontal Merger Guidelines § 9; FTC v. Cardinal Health, Inc., 12 F. Supp. 2d 34, 54-58 (D.D.C. 1998). But, to ameliorate the lost competition, entry or expansion must be timely, likely, and sufficient.

140. The defendants contend that, if the merger is consummated, there would nonetheless be strong healthcare competition in the Bismarck-Mandan area. They assert that CHI St. Alexius has the "incentive, ability, and intent" to compete with a post-merger Sanford in each of the four physician service lines at issue. (Doc. #83-2, p. 38). Further, the defendants assert that CHI, as the fourth-largest healthcare system nationwide, will be a "much stronger competitor" to Sanford than MDC is currently. Id. The plaintiffs respond that CHI St. Alexius's expansion would not be timely, likely, or sufficient to counter competitive harm.

141. At the hearing, Krabbenhoft testified that, in a community the size of Bismarck-Mandan, a healthcare monopoly would be "a bad thing." (Tr-3, p. 38). He acknowledged that, if CHI St. Alexius did not have physicians in each of the four service lines at issue, there would be no real viable competition for a post-merger Sanford in the Bismarck-

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 call coverage concerns, and both estimated it would take at [redacted] years to recruit enough OB/GYN physicians and another [redacted] to build a patient base sufficient to compete with a post-merger Sanford. (Tr-1, pp. 116-118; Tr-2, pp. 23-25, 35-36, 40; JX 0014, pp. 31-33, 39).

145. Schley testified that [redacted]. (Tr-1, pp. 109-110; JX 0027, pp. 26, 42).

146. Other than adult PCPs, CHI St. Alexius would need to establish new physician service groups to compete with a post-merger Sanford in the physician service lines at issue, making it difficult to recruit physicians for those services. (JX 0027, pp. 41-42; JX 0030, pp. 32-33).

147. Because of the differences in their training and practice, the hospitalists currently employed by CHI St. Alexius [redacted]. (See Tr-1, pp. 109-11). Further, locum tenens physicians are not good substitutes for employed physicians because of their cost and because patients prefer employed physicians with a local reputation. See id. at 120-21.

148. [redacted]

[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.

16; PX 4192, p. 29; Tr-4, p. 164).

156. Various quality metrics show that MDC provides high quality patient care. (Tr-4, pp. 243-45; PX 6002, pp. 35-42; Tr-1, pp. 301-02).

157. MDC has strategies for moving forward if the proposed transaction is not consummated. (PX 5167).

158. The record includes statements of MDC shareholders demonstrating a desire to sell motivated by current high share value rather than because of concerns over MDC's viability. (PX 5224, p. 1; PX 5284, p. 1; JX 0029, pp. 33-35; JX 0012, p. 47).

159. Dr. Seifert testified that MDC has a limited physician recruitment budget and that MDC anticipates difficulty recruiting physicians to replace those nearing retirement. (Tr-4, pp. 165-66). The plaintiffs countered with evidence that MDC hired eighteen physicians over 5 ½ years to replace seventeen physicians who left MDC, recruited three physicians in 2017, recently signed a general surgeon to an employment contract, and hired three physicians away from Sanford in the last four years. (JX 0024, pp. 48-49; JX 0010 pp. 30-31, 33-34, 37). The Deloitte consultant assumed, based on MDC's history, that it would recruit seven physicians per year absent the proposed transaction. (Tr-4, p. 38). The defendants did not establish that MDC's viability is endangered by physician recruitment difficulties.

160. 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; FTC v. 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 603 F.2d at 701.

161. Evidence questioning MDC's long term viability is not sufficient to counteract anticompetitive effects of the proposed transaction.

XIV. Defendants' Acknowledgment of Antitrust Risk and Alleged Admission of Weakness

162. Various MDC personnel expressed concern that the proposed transaction would be bad for the community because of elimination of competition and patient choice. Physicians formerly associated with Sanford and MDC made similar statements. Statements of [redacted] questioned whether a sale to Sanford would violate antitrust laws, more so than a sale to CHI. (PX 5180; PX 5179; PX 5183, p. 2; PX 5205; PX 5221, p. 2; JX 0029, p. 41; JX 0014, p. 30; PX 5119, p. 6; JX 0030, p. 27; PX 3019, pp. 1-2; PX 3017, pp. 2-3). In its proposed term sheet to Sanford, MDC [redacted]. (DX 2013, p. 5).

163. The statements by MDC personnel referenced above show that some MDC personnel recognized that the proposed transaction would have anticompetitive effects. Further, the defendants entered into the proposed transaction knowing that it raised significant concerns under antitrust laws. See ProMedica, 2011 WL 1219281, at *50 (finding that defendants entered into that transaction "with full knowledge of the applicable antitrust laws").

164. The plaintiffs contend that [redacted] July 5, 2017 statements to [redacted]—[redacted]—constitutes witness

tampering that should be considered an admission of weakness of defendants' case. [redacted] denies any attempt to influence [redacted] testimony, and the defendants suggest it may be that both [redacted] (Doc. #132, p. 20).

165. The court finds [redacted] description of the conversation more credible than [redacted]. [redacted] 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 [redacted] attributes to [redacted] are consistent with what others described about [redacted] communication style. (PX 5315, p. 1; PX 5318, p. 4; PX 5219, p. 2; PX 5307, p. 1; Tr-2, pp. 31-34).

CONCLUSIONS OF LAW

I. Jurisdiction and Venue

1. The FTC is authorized by law to bring this action. 15 U.S.C. § 18. The Attorney General of North Dakota has authority to bring this action on behalf of the State of North Dakota. 15 U.S.C. § 26; N.D. Cent. Code §§ 32-06-02, 51-08.1-07 to -08, and 51-15-07. This court has subject matter jurisdiction under 15 U.S.C. §§ 53(b) and 26; 28 U.S.C. §§ 1331, 1337, and 1345.

2. The defendants are engaged in—and at all relevant times have been engaged in—activities in or affecting commerce as that term is defined by 15 U.S.C. §§ 12 and 44. Defendants transact business in this district and are subject to personal jurisdiction in this district. Venue is proper. 28 U.S.C. § 1391(b)-(c); 15 U.S.C. § 53(b). The parties

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

weighs the probability that the FTC will prove that the effect of the proposed transaction may be to substantially lessen competition. The Eighth Circuit has stated that, to prevail on a motion for a preliminary injunction, the FTC "must raise questions going to the merits so serious, substantial, difficult and doubtful as to make them fair ground for thorough investigation, study, deliberation, and determination by the FTC in the first instance and ultimately by the Court of Appeals." FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1051 (8th Cir. 1999). A showing of "fair or tenable chance of success on the merits" is not sufficient. Id.

6. Section 7's inclusion of the phrase "may be substantially to lessen competition" demonstrates a legislative concern with probabilities rather than certainties. Brown Shoe Co. v. United States, 370 U.S. 294, 323 (1962). To establish a Section 7 violation, a plaintiff need not demonstrate actual anticompetitive practices, though it must show more than "ephemeral possibilities." ProMedica, 2011 WL 1219281, at *52 (quoting United States v. Marine Bancorporation, Inc., 418 U.S. 602, 623 (1974)). It is the FTC's burden to show that loss of competition is a "sufficiently probable and imminent result of a merger or acquisition," but the FTC is not required to show that the challenged transaction will lessen competition. FTC v. CCC Holdings, Inc., 605 F. Supp. 2d 26, 35 (D.D.C. 2009) (internal quotation marks and citation omitted). Section 7 is intended to prevent anticompetitive mergers before they create anticompetitive harm. Phila. Nat'l Bank, 374 U.S. at 362.

7. Courts commonly employ a burden-shifting analysis in evaluating the FTC's likelihood of success on the merits. The first step is to determine whether the plaintiffs have made a prima facie showing that the transaction would lead to undue

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 F. Supp. 2d at 52-61. This is consistent with a powerful buyer's position being analyzed in rebuttal of the government's prima facie case since market definition is an element of a prima facie case.

IV. Application of HMT

20. The plaintiffs base an exclusion of government payers from the market definition on government payers not negotiating reimbursement rates with providers. (Doc. #71-2, p. 12, n.8). The defendants contend that BCBSND does not truly negotiate

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 at 468; ProMedica, 2011 WL 1219281, at *8-9. It does not appear exclusion of government payers was disputed in any of those cases, and the defendants have not cited any healthcare merger cases in which government payers were included in the relevant market. Commercial health insurance plans effectively channel consumer preferences and are therefore an appropriate subject of the HMT. See Penn State Hershey, 838 F.3d at 342. This court concludes it is appropriate to consider a relevant market limited to a distinct category of customers—commercial health insurance plans.

22. The relevant service markets in which to analyze competitive effects of the proposed transaction are adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services which are sold or provided to commercial insurers and their members in the Bismarck-Mandan area.

23. 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 physicians providing adult PCP services, pediatrician services, OB/GYN services, and general surgeon services.

24. The relevant geographic market is "the area in which consumers can practically turn for alternative sources of the product [or service] and in which the antitrust

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 competition between two entities are likely to result in anticompetitive effects. FTC v. Sysco Corp., 113 F. Supp. 3d 1, 61 (D.D.C. 2015); Horizontal Merger Guidelines § 6. If a merger "eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage," the merger is likely to cause competitive harm. Horizontal Merger Guidelines § 8.

29. The proposed transaction will eliminate current competition between Sanford and MDC for adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services in the Bismarck-Mandan area and, so, is likely to harm

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.

36. Under the guidelines, the lesser the adverse competitive effects, the greater the weight ascribed to efficiencies. "Efficiencies almost never justify a merger to monopoly or near-monopoly." Horizontal Merger Guidelines § 10; see also Saint Alphonsus, 778 F.3d at 790; ProMedica, 2011 WL 1219281, at *57. Given that the proposed transaction would result in near-monopoly, the claimed monetary and quality efficiencies are insufficient to overcome the presumption of illegality.

B. Powerful Buyer Defense

37. Evidence of BCBSND's bargaining leverage is properly considered when analyzing competitive effects and not as part of the definition of a relevant market. See Chi. Bridge & Iron, 534 F.3d at 423-24; Cardinal Health, 12 F. Supp. 2d at 1409-13, 1416-19.

38. Sanford and MDC contend that BCBSND is such a powerful buyer that a post-merger Sanford could not negotiate higher reimbursement rates from BCBSND. The plaintiffs assert that a "powerful buyer defense" is limited to two situations not present here—(1) where a buyer is able to use its leverage to sponsor entry or vertically integrate and (2) where there are alternative suppliers post-merger, and a buyer is able to obtain lower prices from suppliers. (Doc. # 71-2, p. 26). The agency guidelines address powerful buyers:

> The Agencies consider the possibility that powerful buyers may constrain the ability of the merging parties to raise prices. . . . However, the Agencies do not presume that the presence of powerful buyers alone forestalls adverse competitive effects flowing from the merger. Even buyers that can negotiate favorable terms may be harmed by an increase in market power. The Agencies examine the choices available to powerful buyers and how those choices likely would change due to the merger. Normally, a merger that eliminates a supplier whose presence contributed significantly to a buyer's negotiating leverage will harm that buyer. . . . Furthermore, even if some

> 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 [redacted] agreement is insufficient to ameliorate the competitive harm that would result from the proposed transaction.

43. The defendants acknowledge that, after the [redacted] contract expires, Medica's spending in the Bismarck-Mandan area would increase as a result of the proposed transaction. Antitrust law does not recognize a de minimus exception.

D. Entry or Expansion into the Market

44. Entry or expansion of competitors into a market may ameliorate anticompetitive effects of a proposed merger if entry or expansion is timely, likely, and sufficient. Horizontal Merger Guidelines § 9; Cardinal Health, 12 F. Supp. 2d at 54-58.

45. Hearing evidence does not demonstrate that CHI would be able to recruit enough physicians to timely replace the MDC physicians currently referring to CHI St Alexius. Physician recruitment challenges constitute a high entry barrier, reducing the possibility that market expansion would ameliorate the reduced competition resulting from the proposed transaction. Saint Alphonsus, 778 F.3d at 788. CHI's potential expansion therefore cannot be considered timely, likely, or sufficient to counter the anticompetitive effects of the proposed transaction.

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 15th day of December, 2017.

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