

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: Maureen K. Ohlhausen, Acting Chairman
Terrell McSweeney

In the Matter of)	
)	
Sanford Health, a corporation;)	Docket No. 9376
)	
Sanford Bismarck, a corporation;)	
)	PUBLIC VERSION
and)	
)	
Mid Dakota Clinic, P.C., a corporation.)	
)	

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act (“FTC Act”), and by the virtue of the authority vested in it by the FTC Act, the Federal Trade Commission (“FTC” or “Commission”), having reason to believe that Respondents Sanford Health, Sanford Bismarck (together with Sanford Health, “Sanford”), and Mid Dakota Clinic, P.C. (“MDC”), have executed a term sheet (“Term Sheet”) in violation of Section 5 of the FTC Act, as amended, 15 U.S.C. § 45, which, if consummated would violate Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18, and Section 5 of the FTC Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint pursuant to Section 5(b) of the FTC Act, 15 U.S.C. § 45(b), and Section 11(b) of the Clayton Act, 15 U.S.C. § 21(b), stating its charges as follows:

I.

NATURE OF THE CASE

- Sanford and MDC are the two largest providers of adult primary care physician services, pediatric services, obstetrics and gynecology services, and general surgery physician services in Bismarck and Mandan, North Dakota. The proposed transaction between Respondents (“Transaction”) would create by far the largest—and, in one case, the only—group of physicians offering these services in Bismarck and Mandan.

2. The proposed Transaction will substantially lessen competition and cause significant harm to consumers. If Respondents consummate the Transaction, healthcare costs will rise, and the incentive to increase service offerings and improve the quality of healthcare will diminish.
3. Sanford and MDC are each other's closest competitor in the Bismarck-Mandan area. Sanford describes MDC as its "major competitor for primary care" and "main clinical competitor" in the Bismarck-Mandan area. MDC views Sanford as a significant competitor that threatens its market share in the Bismarck-Mandan area, describing it as "a demon to deal with competitively" and observing that "combining with them would put us in the dominant health care system for quite a while." Respondents also directly respond to one another by purchasing new equipment, updating technology, expanding services, recruiting high-quality physicians, and providing patients with convenient and accessible physician and surgical services.
4. The Transaction will substantially lessen competition in the markets for adult primary care physician services ("adult PCP services"), pediatric physician services ("pediatric services"), obstetrics and gynecology physician services ("OB/GYN services"), and general surgery physician services sold and provided to commercial payers and their insured members (together, the "relevant services"). The relevant geographic market in which to analyze the effects of the Transaction is an area no broader than the four-county Bismarck, ND Metropolitan Statistical Area (the "Bismarck-Mandan area").
5. Respondents are the two largest providers of the relevant services in the Bismarck-Mandan area. Post-Transaction, Respondents would control over 75% of the market for adult PCP services, over 80% of the market for pediatric services, over 85% of the market for OB/GYN services, and 100% of the market for general surgery physician services, by physician headcount, in the Bismarck-Mandan area. The Transaction significantly increases concentration in already highly concentrated markets, making it presumptively unlawful under the 2010 U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines ("Merger Guidelines").
6. Today, Sanford and MDC compete for inclusion in commercial payers' provider networks. Without either of these physician groups, it would be very difficult for commercial payers to market a health plan provider network to employers with employees living in the Bismarck-Mandan area. Competition between Sanford and MDC results in lower prices, higher quality, and greater services offerings.
7. By eliminating competition between Sanford and MDC, the Transaction is likely to increase Respondents' bargaining leverage with commercial payers, and enhance Respondents' ability to negotiate more favorable reimbursement terms, including reimbursement rates (i.e., prices). Faced with higher rates and other less favorable terms, commercial payers will have to pass on those higher healthcare costs to employers and their employees in the form of increased premiums and, potentially, higher co-pays, deductibles, or other out-of-pocket expenses. The merged firm will also have a diminished incentive to expand services, acquire new technology, and improve quality and access for patients in the Bismarck-Mandan area.

8. Entry or expansion by other providers into the relevant services will not likely be timely or sufficient to offset the competitive harm that will likely result from the Transaction. It will take ██████████ for CHI St. Alexius Health (“CHI St. Alexius”)—a vertically integrated healthcare provider in Bismarck and Mandan with only minimal service line overlap with MDC—to enter or reposition sufficient to offset the potential competitive harm from the Transaction. Smaller, independent physician groups cannot recruit and accommodate new physicians on a necessary scale to counteract or constrain post-Transaction price increases or quality and service decreases, and new independent physicians or large healthcare organizations from outside the Bismarck-Mandan area are unlikely to enter *de novo*.
9. Respondents’ speculative efficiency and quality-of-care claims are unsubstantiated, not merger-specific, and not cognizable. Even assuming Respondents’ purported efficiencies were cognizable, they are far outweighed by the Transaction’s potential harm and would not justify the Transaction.

II.

BACKGROUND

A.

Jurisdiction

10. Respondents, and each of their relevant operating entities and parent entities, are, and at all relevant times have been, engaged in commerce or in activities affecting “commerce” as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12.
11. The Transaction constitutes an acquisition subject to Section 7 of the Clayton Act, 15 U.S.C. § 18.

B.

Respondents

12. Respondent Sanford Bismarck is a North Dakota not-for-profit corporation and vertically integrated healthcare delivery system headquartered at 300 N. 7th Street, Bismarck, North Dakota 58501. Sanford Bismarck is a wholly-owned subsidiary of Respondent Sanford Health, a not-for-profit corporation. Together and with other controlled corporations, Sanford Bismarck and Sanford Health constitute and operate Sanford. In the cities of Bismarck and Mandan, North Dakota, Sanford operates Sanford Bismarck Medical Center, a 217-bed general acute care hospital and Level II trauma center offering inpatient and outpatient services; eight clinics that provide primary care services; and a number of specialty clinics. Sanford employs approximately 160 primary care and specialist physicians who work in Bismarck or Mandan, including 36 adult PCPs, 4 pediatricians, 8 OB/GYNs, and 4 general surgeons. Sanford also employs approximately 100 advanced practice providers (“APPs”). Sanford is the largest private employer in the

Bismarck-Mandan area and plans to recruit an additional [REDACTED] physicians over the next [REDACTED] years, including [REDACTED] to work in its clinic and facility locations in Bismarck and Mandan. Sanford Health, its Sanford Bismarck subsidiary, and other subsidiaries generated [REDACTED] in revenue for the fiscal year ending on June 30, 2016.

13. Sanford sells health insurance in four states, including North Dakota, under the operating name Sanford Health Plan. Sanford Health Plan has approximately [REDACTED] covered lives in North Dakota.
14. Respondent MDC is a for-profit, physician-owned professional corporation under North Dakota law that is headquartered at 401 N. 9th Street, Bismarck, North Dakota 58501. MDC is a multispecialty medical practice that employs 61 physicians who provide primary care and specialty practice medical services in Bismarck, including 23 adult PCPs, 6 pediatricians, 8 OB/GYNs, and 6 general surgeons. MDC also employs 19 APPs. Additionally, MDC operates six clinics, a Center for Women, and an ambulatory surgery center (“ASC”) in Bismarck. MDC is the twelfth-largest private employer in Bismarck. For the fiscal year ending on December 31, 2015, MDC generated [REDACTED] in revenue.
15. MDC’s 53 physician shareholders control Mid Dakota Medical Building Partnership, a partnership under North Dakota law that owns real estate and other assets, including two medical office buildings and a warehouse located in Bismarck. For the fiscal year ending on December 31, 2015, Mid Dakota Medical Building Partnership generated over [REDACTED] in income for its physician shareholders.
16. MDC holds a non-transferable 25% interest in PrimeCare Health Group (“PrimeCare”), a physician-hospital organization that contracts with commercial payers on behalf of MDC’s physicians. CHI St. Alexius holds the remaining 75% interest in PrimeCare.

C.

The Transaction

17. In early 2015, MDC initiated discussions with Sanford regarding a potential affiliation. MDC also discussed a potential affiliation with CHI St. Alexius in 2015 and early 2016. In spring 2016, MDC’s affiliation discussions with CHI St. Alexius terminated, and Respondents’ affiliation discussions became exclusive. On August 22, 2016, Respondents signed a Term Sheet, according to which Sanford will purchase MDC’s practice assets, including its clinics, ASC, laboratory, and diagnostic imaging equipment, as well as the real estate and other assets owned by the Mid Dakota Medical Building Partnership that are leased by MDC. Respondents have finalized a Stock Purchase Agreement for the sale of MDC’s practice assets at [REDACTED], and a Real Estate and Asset Purchase Agreement for the sale of the Mid Dakota Medical Building Partnership assets at [REDACTED]

The Transaction value includes [REDACTED]

III.

THE RELEVANT SERVICE MARKETS

18. The Transaction threatens substantial harm to competition in four relevant service markets: (1) adult PCP services; (2) pediatric services; (3) OB/GYN services; and (4) general surgery physician services. The appropriate product market in which to analyze the Transaction is the set of services for which a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price (“SSNIP”). This group of services constitutes an appropriate market when payers would accept a SSNIP rather than market a network that omitted the services of the hypothetical monopolist.

A.

Adult PCP Services Market

19. The Transaction threatens substantial competitive harm in the market for adult PCP services sold and provided to commercial payers and their insured members. This market encompasses services provided to commercially insured patients age 18 and over by physicians who are board-certified in internal medicine, family medicine, and general practice. Adult PCP services typically include routine medical services in an outpatient or office setting, such as physical exams, basic medical procedures, treatments of common illnesses and injuries, and long-term management of chronic conditions such as diabetes and hypertension.
20. The adult PCP services market excludes obstetricians and gynecologists (“OB/GYNs”) because for many health plan enrollees, including all males, services offered by OB/GYN physicians are not viable substitutes for adult PCP services. The market also excludes services provided by pediatricians because pediatricians typically only treat patients under age 18, and thus do not compete with PCPs that treat adults. A payer would accept a SSNIP rather than market a network that omits adult PCP services even if that network also includes OB/GYN services and pediatric services.

B.

Pediatric Services Market

21. The Transaction also threatens substantial competitive harm in the market for pediatric physician services sold and provided to commercial payers and their insured members. This market includes primary care services provided by pediatricians to children under the age of 18. Pediatricians receive additional training to treat medical conditions affecting pediatric patients, and physicians trained for other specialties generally do not have this required expertise and thus do not compete with pediatricians. A payer would accept a SSNIP rather than market a network that omits pediatricians.

C.

OB/GYN Services Market

22. The Transaction also threatens substantial competitive harm in the market for OB/GYN physician services sold and provided to commercial payers and their insured female members. The market for OB/GYN services includes services provided by OB/GYN physicians related to women's reproductive health, pregnancy, and childbirth. The OB/GYN services market excludes physicians who lack additional training in these services because the services provided by other types of physicians are not viable substitutes for OB/GYN services. A payer would accept a SSNIP rather than market a network that omits OB/GYN services.

D.

General Surgery Physician Services Market

23. The Transaction also threatens substantial competitive harm in the market for general surgery physician services sold and provided to commercial payers and their insured members. The general surgery physician services market encompasses services offered by physicians who are board-certified exclusively in general surgery. General surgeons typically perform basic surgical procedures including abdominal surgeries, hernia repair surgeries, gallbladder surgeries, and appendectomies. Specialty surgeons who receive additional training and certification in particular types of procedures beyond the scope of general surgery training do not perform the same set of services as surgeons who are board-certified exclusively in general surgery, and therefore are excluded from the market. A payer would accept a SSNIP rather than market a network that omits general surgery physician services.

IV.

THE RELEVANT GEOGRAPHIC MARKET

24. The relevant geographic market in which to analyze the effects of the Transaction for each relevant service market is an area no larger than the four-county Bismarck, ND Metropolitan Statistical Area, which includes Burleigh, Morton, Oliver, and Sioux counties. The Bismarck-Mandan area covers a population of more than 125,000 people and includes the cities of Bismarck and Mandan, as well as rural areas and farming communities extending 40 to 50 miles outside of the two cities in every direction.
25. The appropriate geographic market in which to analyze the Transaction is the area where a hypothetical monopolist of the relevant services could profitably impose a SSNIP. If a hypothetical monopolist could impose a SSNIP, the boundaries of that geographic area are an appropriate geographic market.
26. Bismarck-Mandan area residents strongly prefer to obtain the relevant services close to where they live. Indeed, it would be very difficult for a payer to market successfully to employers with employees living in the Bismarck-Mandan area a health plan that did not

include PCPs, pediatricians, OB/GYNs, or general surgeons located within the Bismarck-Mandan area. A hypothetical monopolist that controlled all providers of any relevant service in the Bismarck-Mandan area could profitably impose a SSNIP on payers. The Bismarck-Mandan area is therefore a properly defined geographic market.

27. The Bismarck-Mandan area is the main area of competition between Sanford and MDC in each relevant service market. It also comprises the population center from where Respondents draw a significant portion of their patients. Approximately 95% of patients living in the Bismarck-Mandan area stay within the Bismarck-Mandan area for the relevant services. Quantitative and qualitative evidence, including Respondents' own executives and ordinary course documents, confirm that the Bismarck-Mandan area is the relevant geographic market in which to analyze the effects of the Transaction.

V.

MARKET STRUCTURE AND THE TRANSACTION'S PRESUMPTIVE ILLEGALITY

28. Sanford and MDC are the two largest providers of each of the relevant services in the Bismarck-Mandan area.
29. Under relevant case law and the Horizontal Merger Guidelines, the Transaction is presumptively unlawful in all four relevant service markets. Based on physician headcount in the Bismarck-Mandan area, post-Transaction, Respondents will control 77% of the adult PCP services market, 83% of the pediatric services market, 88% of the OB/GYN services market, and 100% of the general surgery physician services market.
30. The courts and antitrust agencies commonly use the Herfindahl-Hirschman Index ("HHI") to measure market concentration. The HHI is calculated by totaling the squares of the market shares of every firm in the relevant market. Under the Merger Guidelines, a market with an HHI that exceeds 2,500 points is considered highly concentrated. A merger or acquisition is presumed likely to create or enhance market power—and is presumptively illegal—when the post-acquisition HHI exceeds 2,500 points and the merger or acquisition increases the HHI by more than 200 points. Here, the market concentration levels far exceed these thresholds. As measured by physician headcount in the Bismarck-Mandan area, each of the relevant service markets is already highly concentrated today, and the Transaction further concentrates these markets. The following tables summarize the market shares and HHI figures for each relevant service market.

ADULT PCP SERVICES			
Preliminary Market Shares by Physician Headcount for Providers Within Bismarck-Mandan Area			
Provider	Adult PCP Headcount	Market Share	
		Pre-Transaction	Post-Transaction
Sanford Bismarck	36	47%	77%
Mid Dakota Clinic	23	30%	
CHI St. Alexius Health	6	8%	8%
UND Center for Family Medicine	6	8%	8%
Independent Doctors, P.C.	3	4%	4%
Baker Family Medicine	1	1%	1%
Glen Ullin Family Clinic	1	1%	1%
Jeffrey Smith, MD	1	1%	1%
HHI		3,220	6,013
Change in HHI		2,793	

PEDIATRIC SERVICES			
Preliminary Market Shares by Physician Headcount for Providers Within Bismarck-Mandan Area			
Provider	Pediatrician Headcount	Market Share	
		Pre-Transaction	Post-Transaction
Sanford Bismarck	4	33%	83%
Mid Dakota Clinic	6	50%	
Independent Doctors, P.C.	1	8%	8%
UND Center for Family Medicine	1	8%	8%
HHI		3,750	7,083
Change in HHI		3,333	

OB/GYN SERVICES				
Preliminary Market Shares by Physician Headcount for Providers Within Bismarck-Mandan Area				
Provider	OB/GYN Headcount		Market Share	
	Pre-Transaction	Post-Transaction	Pre-Transaction	Post-Transaction
Sanford Bismarck	8	15	47%	88%
Mid Dakota Clinic	8		47%	
UND Center for Family Medicine	1	1	6%	6%
CHI St. Alexius Health*	0	1	0%	6%
HHI			4,464	7,855
Change in HHI			3,391	

GENERAL SURGERY PHYSICIAN SERVICES			
Preliminary Market Shares by Physician Headcount for Providers Within Bismarck-Mandan Area			
Provider	General Surgeon Headcount	Market Share	
		Pre-Transaction	Post-Transaction
Sanford Bismarck	4	40%	100%
Mid Dakota Clinic	6	60%	
HHI		5,200	10,000
Change in HHI		4,800	

VI.

ANTICOMPETITIVE EFFECTS

A.

Competition Among Healthcare Providers Benefits Consumers

31. Competition between healthcare providers occurs in two distinct but related stages. First, providers compete for inclusion in commercial payers' health plan provider networks. Second, in-network providers compete to attract patients, including commercial payers' health plan members.

* CHI St. Alexius's post-Transaction headcount and market share consist of Dr. Jan Bury, a current MDC OB/GYN who is moving to CHI St. Alexius post-Transaction. She is counted as an MDC physician for purposes of calculating the pre-Transaction HHI, and counted as a CHI St. Alexius physician for purposes of calculating the post-Transaction HHI.

32. In the first stage of provider competition, providers compete to be included in commercial payers' health plan provider networks. To become an in-network provider, a provider negotiates with a commercial payer and, if mutually agreeable terms can be reached, enters into a contract. The financial terms under which a provider is reimbursed for services rendered to a health plan's members are a central component of those negotiations, regardless of whether reimbursements are based on fee-for-service contracts, risk-based contracts, or other types of contracts.
33. In-network status benefits a provider by giving it preferential access to the health plan's members. Health plan members typically pay far less to access in-network providers than those out-of-network. Thus, all else being equal, an in-network provider will attract more patients from a particular health plan than an out-of-network one. This dynamic motivates providers to offer lower rates and other more favorable terms to commercial payers to win inclusion in their networks.
34. From the payers' perspective, having providers in-network is beneficial because it enables the payer to create a health plan provider network in a particular geographic area that is attractive to current and prospective members, typically local employers and their employees.
35. Under a fee-for-service payment model, a provider receives payment (i.e., reimbursement) for the services it provides to a commercial payer's health plan members. Such payment is typically on a per-service, per-diem, or discount-off-charges method. Under a full risk-based payment model, a provider is reimbursed a fixed payment for all services provided to a particular member. As a result, the provider has an incentive to reduce overall utilization of services by patients. Regardless of whether a contract's reimbursement method is based on fee-for-service terms, risk-based terms, or some combination of both, relative bargaining leverage plays a key role in negotiations between commercial payers and providers.
36. A critical determinant of the relative bargaining positions of a provider and a commercial payer during contract negotiations is whether other, nearby, comparable providers are available to the commercial payer and its health plan members as alternatives in the event of a negotiating impasse. Alternative providers limit a provider's bargaining leverage and thus constrain its ability to obtain more favorable reimbursement terms from commercial payers. The more attractive these alternative providers are to a commercial payer's health plan members in a local area, the greater the constraint on that provider's bargaining leverage. Where there are few or no meaningful alternatives, a provider will have greater bargaining leverage to demand and obtain higher reimbursement rates and other more favorable reimbursement terms.
37. A merger between providers that are close substitutes in the eyes of commercial payers and their health plan members therefore tends to increase the merged entity's bargaining leverage. Such mergers lead to higher reimbursement rates by eliminating an available alternative for commercial payers. This increase in leverage is greater when the merging providers are closer substitutes for (and competitors to) each other. This is true even where other factors, such as a payer's leverage as a result of having high market share,

may impact the pre-merger bargaining dynamic. Preexisting leverage for the payer does not eliminate the concern about an increase in the post-merger bargaining leverage of the merged entity.

38. Changes in the reimbursement terms negotiated between a provider and a commercial payer, including increases in reimbursement rates, significantly impact the commercial payer's health plan members. "Self-insured" employers rely on a commercial payer for access to its health plan provider network and negotiated rates, but these employers pay the cost of their employees' healthcare claims directly and thus bear the full and immediate burden of any rate increase in the healthcare services used by their employees. Employees may bear some portion of the cost through premiums, co-pays, and deductibles. "Fully-insured" employers pay premiums to commercial payers—and employees pay premiums, co-pays, and deductibles—in exchange for the commercial payer assuming financial responsibility for paying provider costs generated by the employees' use of provider services. When provider rates increase, commercial payers pass on these increases to their fully-insured customers in the form of higher premiums, co-pays, and deductibles.
39. In the second stage of provider competition, providers compete to attract patients to their facilities. Because health plan members often face similar out-of-pocket costs for in-network providers, providers in the same network compete to attract patients on non-price features—that is, by offering better quality of care, amenities, convenience, and patient satisfaction than their competitors. Providers also compete on these non-price dimensions to attract patients covered by Medicare and Medicaid, and other patients without commercial insurance. A merger of competing providers eliminates that non-price competition and reduces the merged entity's incentive to improve and maintain quality. Providers also compete on price terms in this second stage of competition in circumstances when patients pay the full cost of the procedure out of pocket, regardless of whether they are commercially insured.

B.

The Transaction Would Eliminate Beneficial Head-to-Head Competition and Increase Bargaining Leverage

40. Sanford and MDC are each other's closest competitor in the Bismarck-Mandan area for each of the relevant services. Sanford's ordinary course documents reflect the close competition between the Respondents. Sanford believes MDC is its "main clinical competitor" and "major competitor for primary care" in the Bismarck-Mandan area and identifies MDC as its only competitor for pediatric services in the Bismarck-Mandan area. Sanford also considers MDC's OB/GYN department to be Sanford's "top competitor" delivering babies in the Bismarck-Mandan area and describes MDC's general surgeons as Sanford's "primary competition in Bismarck" for bariatric procedures. Sanford's internal marketing and market research documents closely monitor MDC service offerings and routinely compare MDC's service offerings to its own, particularly in women's services and general surgery, in an effort to assess Sanford's "competitive advantage" over MDC.

41. Similarly, MDC considers Sanford to be a significant competitor and a threat to its market share in the relevant service markets. MDC expressed concern that Sanford “put a large target on [MDC’s] finances and market share” and emphasized a need to “work on retaining the market share” in the face of Sanford “making some inroads into OB.” Additionally, the results of a 2015 MDC strategy assessment conducted by MDC’s marketing consulting focused on Sanford as MDC’s closest clinical competitor in the Bismarck-Mandan area. MDC’s Chief Financial Officer observed that “Sanford is going to be a demon to deal with competitively. . . . Combining with them would put us in the dominant health care system for quite a while.”
42. Respondents track and respond to each other’s marketing campaigns and advertising spending, which neither Respondent does with respect to other providers. Sanford and MDC are also each other’s closest competitor to recruit adult PCPs, pediatricians, OB/GYNs, and general surgeons, and are the two practices in the Bismarck-Mandan area that graduating residents and physicians in these service lines relocating to the Bismarck-Mandan area look to for employment. Because Sanford and MDC are close substitutes for each of the relevant services, the Transaction would eliminate significant head-to-head competition between the Respondents.
43. Diversion analysis, a standard economic tool that uses data on where patients receive healthcare services to determine the extent to which providers are substitutes, confirms that Sanford and MDC are close competitors. Preliminary diversion analysis shows that if all Sanford physicians providing adult PCP services were not available to Bismarck-Mandan area patients, approximately 77% of their patients would seek care at MDC. Correspondingly, if all MDC physicians providing adult PCP services were not available to Bismarck-Mandan area patients, approximately 82% of their patients would seek care at Sanford. In other words, each is by far the next-best alternative for patients of the other. Diversions for adult PCP services and other relevant services are shown in the table below:

Service	Diversion from Sanford to MDC	Diversion from MDC to Sanford
Adult PCP	77%	82%
Pediatric	90%	94%
OB/GYN	77%	70%
General Surgery	96%	98%

44. Offering provider coverage in the Bismarck-Mandan area is essential for a commercial payer to market a health plan provider network successfully to employers with employees in the Bismarck-Mandan area. At present, Sanford and MDC serve as the key providers of the relevant services for consumers living in the Bismarck-Mandan area, and either one can support a marketable health plan provider network. For example, Sanford offers its employees a group health plan that excludes MDC physicians as in-network providers, and MDC offers its employees a group health plan that excludes Sanford physicians as in-network providers. This substitutability leads to lower prices. When developing a provider network for the North Dakota Public Employees Retirement System

(“NDPERS”), Sanford Health Plan [REDACTED]

[REDACTED] Commercial payers and employers do not view other providers in the Bismarck-Mandan area as adequate substitutes for Sanford or MDC. Consistent with that view, Bismarck-Mandan area residents strongly prefer that their health plan networks include at least one of the Respondents.

45. By combining the two largest providers of the relevant services in the Bismarck-Mandan area, the Transaction would increase Respondents’ bargaining leverage in contract negotiations with commercial payers because employers in the Bismarck-Mandan area would have little, if any, interest in a health plan network that excluded the combined system. Defendants’ increased bargaining leverage would enhance their ability to negotiate higher reimbursement rates and more favorable reimbursement terms in payer contracts. Commercial payers would have little choice but to accept the reimbursement terms demanded by the merged system or exclude the merged system and risk having their network fail.
46. Today, when constructing provider networks for Bismarck-Mandan area employers, commercial payers treat Sanford and MDC (as part of PrimeCare) as substitutes—some include Sanford while excluding MDC and PrimeCare, and others exclude Sanford while including MDC and PrimeCare. If the merger is consummated, virtually every provider network marketed to consumers in the Bismarck-Mandan area will need to include the combined entity.

C.

The Transaction Would Eliminate Vital Quality and Service Competition

47. Competition drives providers to invest in quality initiatives and new technologies to differentiate themselves from competitors. Sanford and MDC compete with one another across various non-price dimensions, which has provided patients in the Bismarck-Mandan area with higher quality care and more extensive healthcare service offerings. Sanford and MDC have substantially invested in acquiring new technology, expanding their services and facilities, and improving patient access to compete against one another. The Transaction would eliminate this competition.
48. Sanford and MDC have invested in new technology to attract patients. In 2014, Sanford acquired 3D mammography technology, a state-of-the art technology that provides breast tissue imaging superior to the existing 2D technology. Sanford’s capital expense and marketing documents explicitly noted the need to acquire the technology to compete with MDC. MDC subsequently acquired the same 3D mammography technology, and “put a million dollars into 3D [mammography technology] . . . [b]ecause [patients] were walking over to Sanford.” Since acquiring the technology, Respondents have continued to compete for 3D mammography patients along several dimensions, including price, access, and breast care services. Similarly, Sanford invested in a tower-free hysteroscopy system to transition certain gynecological procedures from an operating room to a clinical

setting. Sanford made this investment to remain competitive with MDC, which offered these procedures in an office setting. Sanford also promotes its use of the da Vinci robotic surgery system for gynecological surgeries as a differentiator between Sanford and MDC's OB/GYN departments, and MDC acknowledged that Sanford's adoption of this technology attracted patients from MDC to Sanford. Ultimately, MDC encouraged CHI St. Alexius Medical Center, the only other acute care hospital in Bismarck apart from Sanford Bismarck Medical Center, to invest in the robot technology and two MDC OB/GYN physicians trained to use the robot in order to compete with Sanford's OB/GYNs.

49. Sanford and MDC have also improved patient access and convenience options in order to attract patients. Both Respondents operate walk-in clinics to provide patients with convenient options for acute care episodes and utilize the clinics as a way to attract and retain patients. MDC opened its Today Clinic specifically "to answer [Sanford]'s walk-ins; to increase [MDC's] market share and to provide [patient] access." Both Respondents post wait times on their respective websites as a transparent display of the convenience offered by their walk-in clinics. MDC has observed that "Sanford consistently promotes their SameDay [program]" and expressed a desire to promote its own program to attract patients. Similarly, both Respondents offer sports physicals for school-aged children in their walk-in clinics as a convenient and less expensive alternative to comprehensive child wellness/preventative exams. MDC specifically monitors Sanford's sports physical offerings when developing its own sports physical policy. In June 2016, for example, MDC matched Sanford's price for sports physicals. To attract patients and gain a competitive edge over Sanford, MDC also offers services and amenities not available at Sanford, such as MDC's Center for Women, which provides women patients access to multiple services in one location, and a comprehensive breast program with the only breast fellowship-trained radiologist in North Dakota, who coordinates patient care with other specialists such as surgeons and oncologists.
50. Patients benefit from this direct competition in the quality of care and services offered to them by Respondents. Because the merged entity will control the majority of the relevant services in the Bismarck-Mandan area, it will face limited outside competition for patients seeking such services. Thus, the Transaction will dampen the merged firm's incentive to compete on quality of care and service offerings, to the detriment of all patients who use these providers, including commercially insured, Medicare, Medicaid, and self-pay patients. As one longtime MDC physician put it:

competition is good and maybe no more important place than in health care, that it keeps us all striving to be better to make the best possible scenario for the patient and not settle for mediocre when that would be easier if you weren't competing with someone. . . . [W]hen you have competition it makes you step up and try to be better and provide excellent quality without just settling for average, which you can get away with when there is no one to compete with. . . . I don't feel like I want to drop to a mediocre standard of care, after working my whole life just to build a good reputation, I don't want to be just good enough. I want to be good

and competitive. And I think that monopoly in health care is not a good thing.

VII.

ENTRY BARRIERS

51. Entry by new market participants into the relevant service markets in the Bismarck-Mandan area is unlikely to occur in a timely or sufficient manner to deter or counteract the likely anticompetitive effects of the Transaction. Repositioning or expansion by current market participants is also unlikely to offset fully the Transaction's likely harm to competition for the relevant services in the Bismarck-Mandan area.

A.

Adult PCP and Pediatric Services Entry Will Not Be Timely or Sufficient

52. Existing adult PCP and pediatric practices in the Bismarck-Mandan area are unlikely to expand sufficiently and in a timely manner to offset the anticompetitive effects of the Transaction. The Bismarck-Mandan area's geographic location, including its cold climate and distance from larger metropolitan areas, makes it difficult for an existing competitor to attract and retain physicians, including adult PCPs and pediatricians, from outside of the area. Even if an existing competitor successfully recruited adult PCPs and pediatricians, it would be challenging for it to attract the substantial number of patients in the Bismarck-Mandan area needed to be a financially viable competitor. It would take [REDACTED] for CHI St. Alexius, the only remaining market participant positioned to enter or reposition in the Bismarck-Mandan area, to hire enough physicians, open adequate clinic space, and establish a presence in the area sufficient to replace the adult PCP and pediatric services offered by MDC. The other existing adult PCP and pediatric practices in the Bismarck-Mandan area lack the resources or ability to expand to the magnitude where they could counteract or constrain the anticompetitive effects of the Transaction.
53. New entry by independent physicians into the adult PCP or pediatric services markets in the Bismarck-Mandan area is also unlikely because of the significant financial challenges and risk involved in establishing an independent adult PCP or pediatric practice in the Bismarck-Mandan area, including renting or buying office space, renting or purchasing medical and office equipment, hiring administrative staff, investing in an electronic medical records system, and purchasing malpractice insurance. A local labor shortage in the Bismarck-Mandan area makes starting an independent adult PCP or pediatric practice even more challenging. Moreover, new physicians finishing their residency programs often have substantial debt and lack the financial resources and experience to open an independent practice. After opening an office, it likely would take each adult PCP or pediatrician new to the Bismarck-Mandan area two years or longer to establish a patient base, and substantial time and money for a practice to become self-sustaining and a meaningful competitor, posing additional hurdles to new entrants.

B.

OB/GYN Services Entry Will Not Be Timely or Sufficient

54. New entry or expansion into the OB/GYN services market in the Bismarck-Mandan area will not be timely or sufficient to offset the Transaction's competitive harm. In addition to the financial and practical challenges that adult PCPs and pediatricians face in starting an independent practice, OB/GYNs need access to a hospital in order to provide the full scope of OB/GYN services, and must participate in or provide for call coverage for their patients in the hospital. A solo OB/GYN would have to be on call all the time, which, if even feasible, would likely lower the quality of care. To have a reasonable call rotation, a practice needs a minimum of four to five OB/GYNs. It would take [REDACTED] for CHI St. Alexius, the only remaining market participant positioned to enter or reposition in the Bismarck-Mandan area, to recruit five OB/GYNs to a new practice and open an OB/GYN clinic in the Bismarck-Mandan area, and up to another two years for each new OB/GYN to build a patient base.

C.

General Surgery Physician Services Entry Will Not Be Timely or Sufficient

55. Entry or expansion into the general surgery physician services market in the Bismarck-Mandan area is unlikely to be timely and sufficient to offset any competitive harm that results from the Transaction. Sanford and MDC employ the only general surgeons in the Bismarck-Mandan area. In addition to the challenges that adult PCPs, pediatricians, and OB/GYNs face starting a practice in the Bismarck-Mandan area, general surgeons need a source of patient referrals. An independent general surgeon in the Bismarck-Mandan area would be unlikely to receive referrals because PCPs and other physicians are likely to refer patients to affiliated general surgeons. As with OB/GYNs, call requirements for general surgeons make it unlikely that a general surgeon would operate a solo practice and difficult for a hospital or physician group to recruit a single general surgeon to start a general surgery group. A general surgery physician practice needs a minimum of four to five general surgeons to provide call coverage, and it would take [REDACTED] for CHI St. Alexius, the only remaining market participant positioned to enter or reposition in the Bismarck-Mandan area, to recruit a practice of five general surgeons.

VIII.

EFFICIENCIES

56. Respondents' claimed efficiencies do not outweigh the Transaction's likely harm to competition. The purported benefits would not enhance competition for the relevant services and fall far short of the cognizable efficiencies needed to outweigh the Transaction's likely significant harm to competition in the Bismarck-Mandan area.
57. Respondents have projected several categories of cost savings that will result from the Transaction, but many of these estimated cost savings are unsubstantiated and reflect speculative assumptions. Even if the claimed efficiencies were substantiated and

achievable, many are not merger-specific. MDC could achieve many of the claimed cost savings by affiliating with a suitable and interested alternative partner far less harmful to competition. In any event, Respondents' projected cost savings are not nearly of the magnitude necessary to justify the Transaction in light of its potential to harm competition.

58. Respondents' other efficiency claims, including those relating to quality improvements, are speculative and unsubstantiated. The claimed quality efficiencies are also not merger-specific because they could be accomplished absent the Transaction. Sanford and MDC already are high-quality providers and have presented no evidence demonstrating how the Transaction will improve the quality of care either Respondent provides. In fact, Sanford already has engaged in efforts to achieve some of these purported quality improvements independent of the Transaction, such as recruiting and retaining specialists and subspecialists as well as launching or expanding service lines.

IX.

VIOLATION

COUNT I – ILLEGAL AGREEMENT

59. The allegations of Paragraphs 1 through 58 above are incorporated by reference as though fully set forth herein.
60. The Term Sheet constitutes an unfair method of competition in violation of Section 5 of the FTC Act, as amended, 15 U.S.C. § 45.

COUNT II – ILLEGAL ACQUISITION

61. The allegations of Paragraphs 1 through 58 above are incorporated by reference as though fully set forth herein.
62. The Transaction, if consummated, may substantially lessen competition in the relevant markets in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18, and is an unfair method of competition in violation of Section 5 of the FTC Act, as amended, 15 U.S.C. § 45.

NOTICE

Notice is hereby given to the Respondents that the twenty-eighth day of November, 2017, at 10:00 a.m., is hereby fixed as the time, and the Federal Trade Commission offices at 600 Pennsylvania Avenue, N.W., Room 532, Washington, D.C. 20580, as the place, when and where an evidentiary hearing will be had before an Administrative Law Judge of the Federal Trade Commission, on the charges set forth in this complaint, at which time and place you will have the right under the Federal Trade Commission Act and the Clayton Act to appear and show cause why an order should not be entered requiring you to cease and desist from the violations of law charged in the complaint.

You are notified that the opportunity is afforded you to file with the Commission an answer to this complaint on or before the fourteenth (14th) day after service of it upon you. An answer in which the allegations of the complaint are contested shall contain a concise statement of the facts constituting each ground of defense; and specific admission, denial, or explanation of each fact alleged in the complaint or, if you are without knowledge thereof, a statement to that effect. Allegations of the complaint not thus answered shall be deemed to have been admitted.

If you elect not to contest the allegations of fact set forth in the complaint, the answer shall consist of a statement that you admit all of the material facts to be true. Such an answer shall constitute a waiver of hearings as to the facts alleged in the complaint and, together with the complaint, will provide a record basis on which the Commission shall issue a final decision containing appropriate findings and conclusions and a final order disposing of the proceeding. In such answer you may, however, reserve the right to submit proposed findings and conclusions under Rule 3.46 of the Commission's Rules of Practice for Adjudicative Proceedings.

Failure to file an answer within the time above provided shall be deemed to constitute a waiver of your right to appear and to contest the allegations of the complaint and shall authorize the Commission, without further notice to you, to find the facts to be as alleged in the complaint and to enter a final decision containing appropriate findings and conclusions, and a final order disposing of the proceeding.

The Administrative Law Judge shall hold a prehearing scheduling conference no later than ten (10) days after the Respondents file their answers. Unless otherwise directed by the Administrative Law Judge, the scheduling conference and further proceedings will take place at the Federal Trade Commission, 600 Pennsylvania Avenue, N.W., Room 532, Washington, D.C. 20580. Rule 3.21(a) requires a meeting of the parties' counsel as early as practicable before the pre-hearing scheduling conference (but in any event no later than five (5) days after the Respondents file their answers). Rule 3.31(b) obligates counsel for each party, within five (5) days of receiving the Respondents' answers, to make certain initial disclosures without awaiting a discovery request.

NOTICE OF CONTEMPLATED RELIEF

Should the Commission conclude from the record developed in any adjudicative proceedings in this matter that the Transaction challenged in this proceeding violates Section 5 of the Federal Trade Commission Act, as amended, and/or Section 7 of the Clayton Act, as

amended, the Commission may order such relief against Respondents as is supported by the record and is necessary and appropriate, including, but not limited to:

1. If the Transaction is consummated, divestiture or reconstitution of all associated and necessary assets, in a manner that restores two or more distinct and separate, viable and independent businesses in the relevant service and geographic markets, with the ability to offer such products and services as Sanford and MDC were offering and planning to offer prior to the Transaction.
2. A prohibition against any transaction between Sanford and MDC that combines their businesses in the relevant markets, except as may be approved by the Commission.
3. A requirement that, for a period of time, Sanford and MDC provide prior notice to the Commission of acquisitions, mergers, consolidations, or any other combinations of their businesses in the relevant markets with any other company operating in the relevant markets.
4. A requirement to file periodic compliance reports with the Commission.
5. Any other relief appropriate to correct or remedy the anticompetitive effects of the transaction or to restore MDC as a viable, independent competitor in the relevant service and geographic markets.

IN WITNESS WHEREOF, the Federal Trade Commission has caused this complaint to be signed by its Secretary and its official seal to be hereto affixed, at Washington, D.C., this twenty-first day of June, 2017.

By the Commission.

Donald S. Clark
Secretary

SEAL: