No. 17-3783

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

FEDERAL TRADE COMMISSION and
STATE OF NORTH DAKOTA,
Plaintiffs-Appellees,

v.

SANFORD HEALTH, SANFORD BISMARCK,
and MID DAKOTA CLINIC, P.C.,
Defendants-Appellants.

On Appeal from the United States District Court
for the District of North Dakota
No. 1:17-cv-133-ARS

ANSWERING BRIEF FOR PLAINTIFFS-APPELLEES THE FEDERAL TRADE COMMISSION AND STATE OF NORTH DAKOTA

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SUMMARY OF THE CASE

The district court held that the merger of the two appellants likely violates Section 7 of the Clayton Act, 15 U.S.C. §18, and it preliminarily enjoined the merger pending an administrative adjudication before the FTC. The question presented is whether the court properly granted that relief in the face of a merger to monopoly in one relevant antitrust market and to near-monopoly in three others. In appellees' view, the appeal mostly presents only factual disputes, not legal issues.

Appellees believe that the merits of a Clayton Act challenge to a merger to total monopoly are sufficiently apparent that this Court can decide the appeal without argument. If the Court decides to hear argument, we believe that 15 minutes per side will be adequate.

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JURISDICTION

Appellees agree with appellants' jurisdictional statement. The Court also has jurisdiction under 28 U.S.C. § 1291.

QUESTION PRESENTED

Sanford, the largest healthcare system in the Bismarck-Mandan area of North Dakota, seeks to acquire Mid Dakota Clinic, the largest independent multispecialty physician practice in the area. They are one another's only meaningful rival in four critical physician service lines and together would control 100 percent of one of them, 99 percent of another, and 85+ percent of the remaining two.

The Clayton Act makes unlawful any acquisition where "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. §18. The district court granted a preliminary injunction to preserve the status quo pending an administrative trial to determine whether the acquisition violates that statute. The questions presented are:

1. Whether, after finding that the Government had shown a prima facie case that the merger is unlawful, the district court properly evaluated defendants' rebuttal arguments and the Government's additional evidence of anticompetitive effects.

- *ProMedica Health Sys., Inc. v. FTC,* 749 F.3d 559 (6th Cir. 2014)

- *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015) ("*St. Luke's*")
- *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016)
- *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410 (5th Cir. 2008)

2. Whether the district court properly defined the relevant markets.

- *Brown Shoe Co., Inc. v. United States*, 370 U.S. 294 (1962)
- *SuperTurf, Inc. v. Monsanto Co.*, 660 F.2d 1275 (8th Cir. 1981)
- *Community Publishers, Inc. v. DR Partners*, 139 F.3d 1180 (8th Cir. 1998)

STATEMENT OF THE CASE

Mid Dakota Clinic ("MDC") and Sanford Health and Sanford Bismarck (together, "Sanford") ask the Court to permit them to merge and form a monopoly in one market and near-monopolies in three others. In a comprehensive opinion, the district court determined that the merger likely violates antitrust law. Sanford and MDC ("defendants") do not deny the extreme market concentration that would result from their combination. Their primary defenses below were that a large insurer would prevent the monopoly from raising its prices and that another hospital in Bismarck would soon expand to replace the lost competition. Testimony from the insurer and the hospital directly refuted those claims. On appeal, their case fails again.

Defendants are by far the two largest providers of adult primary care physician ("PCP"), pediatrician, OB/GYN physician, and general surgeon services in the Bismarck-Mandan metropolitan statistical area. They are each other's closest rivals, competing for inclusion in insurance company physician networks. They now wish to stop competing and combine their practices into a single entity that holds an absolute or near-monopoly in all four practices, controlling between 85 and 100 percent of each service. Following the merger, there would be no competition at all in general surgery and almost none in the other three areas. MDC acknowledged the problem in contemporaneous documents, noting that the merger would create "a monopoly in Bismarck," and "would give Sanford control of virtually 100% of the physician practices" there. PX05178-002 (SA173); PX05205-001(SA162). An MDC doctor/shareholder asked whether merging with Sanford was "not an option because of ND monopoly law stuff?" PX05179-001 (SA167).[1]

After an evidentiary hearing, the district court preliminarily enjoined the merger pending further inquiry by the FTC. The court found that the acquisition likely would enable the combined practices to exploit increased market power to

[1] We use the following abbreviations: "FOF": findings of fact; "COL": conclusions of law; "A": appellants' appendix; "SA": appellees' supplemental appendix; "PX": plaintiffs' exhibit; "JX" parties' joint exhibit; "DX": defendants' exhibit; "Tr-[vol. #]": hearing transcript.

obtain substantially higher reimbursement rates from insurers than either practice could bargain for if they remained competitors. The court also found that the acquisition would eliminate significant non-price competition between Sanford and MDC and deprive local patients of the corresponding benefits.

The court considered and rejected the claims that (1) a large insurer's buyer power and another insurer's temporary rate agreement would prevent prices from rising anticompetitively; (2) entry or expansion by Bismarck's other healthcare system would counteract the transaction's anticompetitive effects; (3) efficiencies from the combination would outweigh its anticompetitive harms; and (4) MDC's purported concerns about its future profitability justified the loss of competition. The district court thus held that the FTC is likely to succeed in proving in the administrative trial that the acquisition violates the Clayton Act.

1. The Proposed Acquisition.

Sanford is an integrated healthcare system that operates a general acute care hospital in Bismarck and a number of local clinics. FOF1 (A0025). Sanford's Bismarck division employs 37 adult primary care physicians (whose services account for a 34.4% share of the Bismarck-Mandan area market), 5 pediatricians (34% market share), 8 OB/GYNs (23.9% market share), and 4 general surgeons (36.1% market share). FOF2, 39, 43, 48, 52 (A0025-26, 39-43). Sanford also operates a health insurance plan (Sanford Health Plan), which is the second-largest

commercial health insurer in North Dakota. FOF12 (A0029).

MDC is a multispecialty medical practice in Bismarck, where it operates numerous clinics and an ambulatory surgery center. FOF3 (A0026). It employs 23 adult primary care physicians (whose services account for a 51.3% market share), 6 pediatricians (64.6% market share), 8 OB/GYNs (75.1% market share), and 6 general surgeons (63.7% market share). FOF3, 39, 43, 48, 52 (A0026, 39-43).

Other than the Sanford and MDC doctors, there are no general surgeons in the Bismarck-Mandan area, only one OB/GYN physician, and one other pediatrician. FOF6 (A0027). The area's other healthcare system is Catholic Health Initiatives ("CHI"). CHI operates St. Alexius, a general acute care hospital in Bismarck, and a clinic in Mandan. It employs five adult primary care doctors but no general surgeons, OB/GYNs, or pediatricians. FOF4 (A0026-27). Bismarck is about 200 miles west of Fargo, the nearest large city, and 90 miles from the nearest city of any size. FOF65 (A0046).

MDC is the largest source of referrals for inpatient admissions for CHI, and MDC doctors treat patients at St. Alexius for services not available from CHI's own physicians. FOF5 (A0027). CHI and MDC co-own PrimeCare, which negotiates contracts with health insurance plans on behalf of its members, including CHI's and MDC's physicians. *Id*.

In 2015, MDC began considering whether to sell itself to either CHI or

Sanford. FOF16 (A0031). It first struck a deal with CHI, but when that fell through, MDC resumed talks with Sanford, and in August 2016 they reached agreement. FOF17 (A0031). If the merger goes through, Sanford would have market shares in the Bismarck-Mandan area of 100 percent of general surgeon services,[2] 99 percent of pediatrician services, 86 percent of adult primary care physician services, and 85 percent of OB/GYN physician services.[3] FOF39, 43, 48, 52 (A0039-43).

2. The Healthcare Market.

a. Commercial healthcare markets have three sets of participants: (1) consumers—patients with health insurance (whom the district court called "members") and their employers, who select the policies offered to the employees; (2) sellers—healthcare providers such as Sanford and MDC; and (3) payers—insurance companies such as Blue Cross Blue Shield of North Dakota ("Blue Cross" or "BCBSND") and the Sanford Health Plan. Patients ordinarily pay directly for only a portion of the cost through co-payments and deductibles. Insurers pay the bulk of the bills and, as described below, negotiate prices—

[2] Market shares calculated using insurer claims data show a 99.8% combined market share for general surgeon services. PX06000-175 (SA431). There would be no remaining competition, however, because Sanford and MDC employ every general surgeon in the Bismarck-Mandan area. FOF4, 6 (A0026-27).

[3] Defendants currently have a 99% combined market share for OB/GYN physician services. The 85% post-merger market share calculation assumes that one of MDC's doctors would switch to CHI post-merger. FOF48 (A0042).

reimbursement rates—with providers. FOF22 (A0033); Tr-2 at 50-51, 60-61 (SA059-60, 69-70).

Insurers must make their policies commercially attractive to sell them to members and their employers. A policy's marketability depends in large part on the selection of doctors in that insurer's "network," including their location and quality. Tr-2 at 51 (SA060). PX06000 ¶49 (SA310). A network is the group of healthcare providers who have agreed to treat the insurer's members at rates negotiated between the provider and the insurer. These negotiated rates are lower than those charged by out-of-network providers. Tr-1 at 170-172 (SA013-15).

Competition among healthcare providers, including groups of physicians, for commercially insured patients occurs in two distinct but interrelated stages. FOF23 (A0033-34); *see FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016); *Penn State Hershey*, 838 F.3d at 342; *St. Luke's*, 778 F.3d at 784 n.10 (calling the two-stage model the "accepted model" for analyzing the competitive effects of healthcare-provider mergers). First, providers compete with each other for inclusion in a network. The network is an important source of patients, who prefer in-network doctors because they cost the patients less. Tr-1 at 170-172 (SA013-15); Tr-2 at 52 (SA061). When doctors compete for inclusion, insurers can negotiate lower reimbursement rates (as described immediately below), which in turn lead to lower costs for members and employers. Conversely, less competition

allows providers to negotiate higher rates, which lead to increased consumer costs. *See* Katherine Ho, *Insurer-Provider Networks in the Medical Care Market*, 99 Am. Econ. Rev. 393, 396 (2009); Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 Antitrust L. J. 671, 674-675 (2000).

Once providers are in an insurance company's network, they compete with other in-network providers to attract patients based on non-price factors such as quality of service and convenience. FOF32 (A0036-37); Tr-2 at 58-59 (SA067-68); Tr-3 at 80-83 (SA130-133); *see also Advocate*, 841 F.3d at 465. Less competition means less incentive to improve quality. Tr-2 at 106 (SA108); Tr-3 at 37-38 (SA128-129).

b. The price of a given service—the amount an insurer reimburses an in-network provider for that service—is established in a contract negotiation. Tr-2 at 52 (SA061). Like any business transaction, both sides have some amount of bargaining leverage, and the agreement reached depends on the relative strengths of that leverage. Tr-1 at 172-73 (SA015-16); Tr-2 at 53-55 (SA062-64). Providers need inclusion in networks to attract patients; insurers need providers to participate in a network to make their policies marketable. Whichever side has the stronger bargaining position achieves more favorable rates. *See ProMedica*, 749 F.3d at 562; *St. Luke's*, 778 F.3d at 784-785.

Bargaining leverage consists largely of the ability to "walk away" from the

negotiating table. FOF27-29 (A0035); Tr-2 at 53-54 (SA062-63); Tr-4 at 110-111 (SA141-142). If multiple alternative providers are competing for inclusion in the network, an insurer facing an unacceptably high demand by one provider can walk away from the negotiation and turn to other providers to form a commercially attractive network. If, however, there are few (or no) alternative providers in a geographic area, an important provider can walk away and turn to another insurer who will meet its rate demand. Its greater bargaining leverage allows it to negotiate higher rates and other favorable contract terms. Tr-1 at 173-176, 255-256 (SA014-19, 46-47); Tr-3 at 174-176 (SA134-136); JX00009 at 137-138 (SA197); *see also ProMedica*, 749 F.3d at 562. An insurer that refuses that provider's demands risks losing members to other insurers who will meet the demand and have the provider in their networks, thus making their policies more commercially attractive. FOF31 (A0036); PX03014 ¶15 (SA220). The more important a provider is to the formation of a marketable network, the stronger its bargaining position will be, and the higher the rates it may successfully demand. PX06000 ¶¶54-59 (SA311). Higher rates are borne by employers and members via increased premiums, co-pays, deductibles, and other out-of-pocket costs. Tr-1 at 299 (SA053); Tr-2 at 57-58, 97-98, 156-157 (SA066-67, 99-100); PX03014 ¶16 (SA220); PX06000 ¶60 (SA313-314).

c. At present, Sanford and MDC compete against each other for inclusion in insurer networks. They are the only providers of general surgeon services, the only meaningful providers of pediatrician and OB/GYN physician services, and the key providers of adult PCP services in the Bismarck-Mandan area. From patients' and insurers' perspectives, MDC and Sanford are each other's closest substitutes for each of these services. Patients unable to use one practice will more likely switch to the other practice than to any third alternative; for general surgeon services there is no alternative. FOF75 (A0049-50); Tr-2 at 90-93 (SA092-95).

In the current competitive environment, if Sanford demanded excessive rates in a price negotiation, an insurer could turn to MDC to form a viable, attractive network. Conversely, if MDC demanded excessive rates, an insurer could turn to Sanford. PX03014 ¶24 (SA222); PX03016 ¶13 (SA231). Indeed, that very thing has happened. When Sanford Health Plan was developing a provider network for a large group contract bid, it threatened to exclude MDC (and other PrimeCare providers) from the network if they did not agree to a 5% rate reduction. JX00009 at 131-132 (SA195); PX04000-001 (SA168). Sanford Health Plan could credibly threaten to exclude PrimeCare because it had close substitutes—*i.e.*, Sanford's own doctors—available for its network. JX00009 at 137-138 (SA197).

After the proposed acquisition, however, the combined practice would have a total monopoly in general surgeons and a near-monopoly in three other "critical

components of a marketable health plan." PX03014 ¶42 (SA226-227). Insurers would have no "viable alternative" as a fallback in negotiation. Tr-1 at 244-247 (SA039-42). The acquisition thus would significantly increase Sanford's bargaining leverage and thereby enhance its ability to negotiate higher reimbursement and other favorable contract terms. Tr-1 at 184-185, 260-262 (SA025-26, 49-51).

Not only would consumers suffer from higher prices, they also would face the prospect of doctors with less competitive incentive to provide better services. Tr-2 at 21-23, 104-106 (SA056-58, 106-108). As competitors, Sanford and MDC have spurred each other to compete for patients by acquiring new technology, expanding services, and improving access. PX06000 ¶¶ 236-246 (SA393-399). For example, MDC invested significant money in 3D mammography "[b]ecause [patients] were walking over to Sanford." JX00002 at 221 (SA180). To better compete with MDC, Sanford invested in technology that allows some gynecological procedures to be performed in the doctor's office rather than the hospital. JX00004 at 241-42 (SA184). And MDC opened a walk-in clinic specifically "to answer [Sanford]'s walk ins; to increase our market share and to provide [patient] access" to doctors. PX05181-001 (SA159); *see also* JX00011 at 135-137 (SA199-200).

3. The District Court's Decision.

After discovery and a 4-day hearing that included 16 witnesses and over 1,600 exhibits, the district court preliminarily enjoined the merger pending the FTC's administrative adjudication to determine whether the transaction violates the Clayton Act.

a. Product and Geographic Market Definitions.

The court determined that the relevant markets for assessing the transaction's competitive effects are adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services sold to commercial insurers or their members in the Bismarck-Mandan area. FOF68 (A0047).

The Court reached those determinations using a standard economic tool of market definition: the "hypothetical monopolist" test set forth in the *Horizontal Merger Guidelines* issued by the Department of Justice and the FTC. *See* U.S. Dep't of Justice & Federal Trade Comm'n, *Horizontal Merger Guidelines* §4 (2010) ("*Merger Guidelines*"); FOF56-58 (A0043-44). This test analyzes whether a proposed market is an antitrust market by determining whether a hypothetical profit-maximizing firm controlling all sellers in a candidate market could profitably impose a "small but significant and non-transitory increase in price" ("SSNIP")—typically a 5% price increase. If so, that means other goods or services (for product markets) or sellers outside the proposed market (for

geographic market) are not meaningful substitutes, and the proposed market is a relevant antitrust market. *Merger Guidelines* §§4.1, 4.2; *Penn State Hershey*, 838 F.3d at 338; Tr-2 at 61-65 (SA070-74).

The parties did not dispute the four product markets proposed by the Government. The district court analyzed them anyway and found each was a proper antitrust market. The relevant consumers are the commercial insurance companies that directly pay for services and bargain with providers over their price. FOF60-62 (A0045). The court then assessed whether insurers would switch away from a hypothetical monopolist in each service line that sought to negotiate a SSNIP. For each service, the answer was no, because no other provider would be a viable substitute in a marketable insurer network. FOF34-52 (A0037-43); Tr-2 at 65-82 (SA074-91).

The court also found the Bismarck-Mandan area (which includes smaller surrounding communities within a 40-to-50-mile radius) to be a relevant geographic market. The area has a population of approximately 130,000—about 93,000 of whom live within the cities of Bismarck and Mandan. FOF65 (A0046). The next closest population centers "are each between 90 and 110 miles away." *Id.* Evidence showed, without dispute, that patients who live in the Bismarck-Mandan area strongly "prefer to receive healthcare services within that area." FOF66 (A0046-47); *see* Tr-2 at 77 (SA086); PX06000 ¶127 & Table 6 (SA346-347, 430)

(95 to 99 percent of Bismarck-Mandan area patients receive relevant physician services locally). Because consumers insist on local care, a health insurance plan without local providers "would not be marketable in the Bismarck-Mandan area." FOF66 (A0047). A provider monopolist in the area would be able to successfully negotiate a price increase, and the Bismarck-Mandan area thus is a relevant geographic market.

b. Clayton Act Analysis.

The court applied a three-part burden-shifting regime well established under the Clayton Act. First, the Government had to prove a prima facie case that the merger would violate the Act by showing significantly increased market shares and "undue concentration in the relevant product and geographic markets." COL7 (A0076-77). Sufficiently high market concentration can establish a presumption that the merger will substantially lessen competition. FOF69 (A0047).

In response to a prima facie case, defendants could rebut the presumption by producing evidence showing that "the prima facie case inaccurately predicts the relevant transaction's probable effect on future competition." COL7 (A0077) (internal quotation marks omitted), citing *United States v. Baker Hughes Inc.*, 908 F.2d 981, 991 (D.C. Cir. 1990).

Finally, "[i]f the defendants sufficiently rebut the presumption of illegality, the burden of producing additional evidence of anticompetitive effects shifts back

to the FTC." *Id.* The Government, the court specified, "has the burden of persuasion at all times." *Id*.

i. *Presumption of illegality.*

The district court found that the Government had shown the acquisition presumptively anticompetitive. The court measured market concentration using the Herfindahl-Hirschman Index ("HHI"), a standard economic tool. *See St. Luke's*, 778 F.3d at 786; *ProMedica*, 749 F.3d at 568. The HHI is calculated by summing the squares of the market shares for all participants in the market. "[A]n 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." FOF69 (A0047-48); *see Merger Guidelines* §5.3.

The HHIs for the Sanford/MDC transaction were off the charts. FOF70-71 (A0048).

Service	Post-Merger HHI	Increase
General Surgeon	9,964	4,602
Pediatrician	9,726	4,393
Adult PCP	7,422	3,531
OB/GYN	7,363	1,152

Those figures by themselves raised a strong presumption that Sanford's acquisition of MDC "is likely to enhance [its] market power" and "is unlawful in

each of the four physician service lines." FOF71-72 (A0048); *see St. Luke's*, 778 F.3d at 786 (merger with an HHI of 6,219 and increase of 1,607 presumed anticompetitive); *ProMedica*, 749 F.3d at 568 (merger with an HHI of 4,391 and increase of 1,078 "blew through [the HHI] barriers in spectacular fashion").

ii. *Likely Competitive Effects.*

The Government presented additional evidence that strongly bolstered the presumption of competitive harm. The defendants' own documents and testimony showed that "each of the two entities views the other as its primary competitor." FOF74 (A0049). An empirical analysis (calculating "interfirm diversion ratios") by the FTC's expert economist, Dr. Sacher, confirmed that Sanford and MDC are each other's closest competitor in each of the relevant services and their *only* competitor in one service. FOF75 (A0049-50).

The district court also found convincing Dr. Sacher's "upward pricing pressure" analysis, which measured the changes in Sanford and MDC pricing incentives when they stopped competing. FOF76 (A0050). The analysis showed that the proposed acquisition is likely to cause price increases of 6 to 22 percent—up to $27 million annually. FOF 77 (A0050); Tr-2 at 93-97 (SA095-99); PX06000 ¶¶206, 212 (SA380, 382). And the court found that a "willingness to pay" analysis by Dr. Sacher further confirmed that the acquisition would "significantly increase"

Sanford's leverage with insurers, the root cause of price increases. FOF78 (A0050-51); *see* Tr-2 at 98-103 (SA100-105).

The district court also found that the acquisition would "eliminate the second-stage competition that currently exists between Sanford and MDC," FOF81 (A0051), thereby reducing incentives to improve quality and service

c. Rejection of Rebuttal Arguments.

i. *Defendants' claim that Blue Cross could resist a rate increase.*

Defendants attempted to rebut the prima facie case on the principal ground that Blue Cross's large share of the insurance market and the importance of its members to defendants would prevent post-merger Sanford from exercising its increased bargaining leverage to obtain higher reimbursement rates. The court found that the evidence did not support this proposition.

Although Blue Cross is certainly a "powerful buyer," "its market share has declined" in recent years. FOF103-104 (A0057-58). In particular, Blue Cross has lost market share to Sanford Health Plan—the insurer owned by Sanford itself. FOF104 (A0058). Thus, at the negotiating table, Sanford/MDC would have a fallback option, but Blue Cross would not.

Defendants contended that Blue Cross's use of a uniform statewide rate schedule, even for providers with large market shares, proved that it has overwhelming bargaining power. The court found, however, that the causation

worked the other way around: it is not that Blue Cross forces uniform fees on all providers, but that powerful providers can cause increases in Blue Cross's statewide rates. "[A] provider offering 'a whole lot of services to a lot of [BCBSND] members' or … offering the only 'super specialist that many [BCBSND] members need' has greater leverage in establishment of the fee schedule." FOF107-108 (A0059); Tr-1 248-249, 255-256 (SA043-44, 46-47). Indeed, as the largest provider in the state, Sanford already has "leverage sufficient to influence adjustments" in the rate schedules. FOF109 (A0060).

The court credited the testimony of Blue Cross's representative that, post-merger, Sanford "could really present [the insurer] with an ultimatum." Tr-1 at 261 (SA050). In that event, Blue Cross "would have to choose between agreeing to the increase or no longer offering health plans in the Bismarck-Mandan area." FOF112 (A0061). The threat was real, because if Blue Cross refused a rate increase and Sanford left the network, patients in the Bismarck-Mandan area could switch to the Sanford Health Plan. FOF115 (A0061). On that record, Dr. Sacher opined in testimony credited by the court that "despite Blue Cross' size, it's going to have no choice but to negotiate higher prices and accept other unfavorable terms from the merged parties." Tr-2 at 104 (SA106); FOF118 (A0062).

ii. *Defendants' claim that Medica is protected against rate increases.*

Defendants also argued that the acquisition would not immediately harm another insurer, Medica, whose contract with Sanford controls reimbursement rates through [redacted]. Defendants claimed that after the rate agreement expires, any adverse effects on Medica will be negligible and offset by efficiencies and entry by CHI.

The court found the agreement "insufficient to ameliorate the competitive harm that would result from the proposed transaction." COL42 (A0088). Medica's representative testified that the contract does not fully protect Medica against all rate increases. FOF128 (A0064-65); Tr-1 at 189-190 (SA030-31). Evidence also showed that Medica could face increased costs due to changes in referral patterns resulting from the transaction. FOF129 (A0025); Tr-1 at 184-185 (SA025-26); Tr-4 at 238 (SA155).

Moreover, once the temporary agreement expires, post-merger Sanford's "additional leverage" will enable it "to secure higher reimbursement rates from Medica." FOF125 (A0066); COL43 (A0088). Defendants' own expert "estimated an [redacted]." FOF134 (A0066); DX6001-064 (A1375) (assuming no entry by CHI).

iii. *Entry by CHI.*

The district court rejected defendants' argument that CHI would replace the competition eliminated by the acquisition. The entry of a competitor can counteract the anticompetitive effect of a proposed merger only if it is "timely, likely, and sufficient." FOF44 (A0088), citing *Merger Guidelines* §9.

The court determined that it would take years for CHI to recruit enough doctors in each service—and more years after that to build a patient base sufficient to compete with a post-merger Sanford. The president of St. Alexius, Kurt Schley, estimated that recruiting adult PCPs and pediatricians would take [redacted] and building a patient base to replace the MDC doctors would take [redacted] FOF143 (A0068). For OB/GYN, recruitment would take "at least [redacted] and building the patient base "another [redacted] FOF144 (A0069). Replacing general surgeons is even more difficult because "a general surgery practice is dependent on a referral base of adult PCPs." FOF143 (A0068). And even if CHI could recruit all the necessary doctors, the population of the Bismarck-Mandan area may not be "[redacted]," FOF149 (A0070), because the area "[redacted]" FOF145 (A0069).

The court concluded that CHI's potential expansion "cannot be considered timely, likely, or sufficient." FOF150 (A0070). No evidence suggested that another provider could enter the markets. FOF151 (A0070).

iv. *Efficiencies Claims.*

Defendants further argued that they had overcome the presumptive harm to competition because the merger would generate efficiencies and improve the quality of defendants' services. Such an efficiencies defense, the court held, required defendants to demonstrate "merger-specific" benefits that are "independently verifiable." COL35 (A0085), citing *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 721-22 (D.C. Cir. 2001). The court found that defendants did not meet that burden.

The claimed cost savings were riddled with analytical errors and were not verifiable. FOF87-97 (A0053-56). Even a more rigorous analysis "would be insufficient to offset the price increase predicted by Dr. Sacher's [pricing] analysis." FOF98 (A0056). Defendants have now abandoned their monetary efficiencies defense.

The court also rejected defendants' asserted quality efficiencies. It found that only one of these claimed efficiencies—Imagenetics, "a program integrating genetic medicine into primary care"—was merger-specific; the rest were not. FOF99, 101 (A0056-57). That one small improvement was "insufficient to

overcome the presumption of illegality" of a "transaction that would result in near monopoly." FOF102 (A0057).

v. *MDC's Financial Viability.*

Lastly, defendants argued that MDC would be financially unviable without the merger. The district court determined that the record did not support that gloomy forecast.

Two independent consultants retained by defendants "projected a positive future for MDC with an increasing demand for its services and an outlook for better reimbursements." FOF154 (A0071). Indeed, the evidence showed that "MDC's revenues increased during each of the last three years." FOF155 (A0071). In 2016, MDC doctors' "compensation was about 32% above the national industry benchmark." *Id.* The court found that MDC wanted to sell not "because of concerns over MDC's viability" but because of "current high share value"—*i.e.*, the desire to cash in at an opportune moment. FOF158 (A0072).

SUMMARY OF ARGUMENT

The Clayton Act prohibits acquisitions that may "substantially … lessen competition, or … tend to create a monopoly." 15 U.S.C. §18. Sanford's merger with MDC violates both parts of the statute. It does not just "tend to" create a monopoly—it does create a monopoly, giving Sanford 100 percent of the market for general surgeons in the Bismarck-Mandan area. And it gives Sanford a near-

monopoly in three other physician services, threatening to substantially lessen competition in those markets as well. The astronomical level of market concentration by itself would warrant careful scrutiny by the FTC in administrative adjudication and a concomitant preliminary injunction. But the FTC also presented considerable evidence that beyond just the numbers, the deal would also have significant anticompetitive effects. The district court properly enjoined the merger pending further inquiry by the FTC into whether it violates the Clayton Act.

Defendants' principal gambit on appeal is an attempt to cloak the district court's resolution of factual disputes in the garb of legal error. But there was no legal error here. The court heard two sides of the story, in large part from expert witnesses and industry participants, and it resolved the facts in favor of the Government. Given the total absence of competition in one market and the near-total absence in three others, the outcome is hardly a surprise, especially when doubts must be resolved against allowing a merger to go forward.

1. The district court properly placed on the Government the burden of persuasion throughout the case. Defendants claim that the district court improperly shifted the burden to them. As evidence, they point to the court's citation of the Supreme Court's decision in *Philadelphia National Bank*, which stated that Clayton Act defendants must make "clear showing" to rebut the Government's prima facie case. They claim that the correct standard under the D.C. Circuit's

decision in *Baker Hughes* is simply a "showing." But the district court cited and applied *Baker Hughes* along with other judicial decisions that relied on it. Nothing in the court's decision indicates that it actually placed the burden of persuasion on defendants; the court explicitly stated otherwise. Moreover, even if the subtle distinction between "showing" and "clear showing" could matter in some case, it would not have here. The Government's prima facie case presented both overwhelming statistical evidence and voluminous additional evidence showing the transaction's anticompetitive effects. *Baker Hughes* recognized that a compelling prima facie case calls for significant evidence in rebuttal.

2. The district court properly resolved a series of ordinary factual disputes to find that defendants failed to rebut the Government's prima facie case. The court did not "ignore" the testimony of defendants' expert that market concentration is not correlated with higher reimbursement rates in North Dakota. The court directly acknowledged that testimony and resolved the matter in favor of the Government's expert, who explained that the lack of variation was due to Blue Cross's statewide rate schedule. But the use of a statewide schedule did not negate anticompetitive effects. The evidence showed that Blue Cross would raise the schedule in response to the demands of local powerful providers. In particular, a Blue Cross witness confirmed that a combined Sanford/MDC could force a price increase because

Blue Cross would have no viable alternatives in the Bismarck-Mandan area for the four relevant physician services.

The same evidence refuted defendants' claim that Blue Cross's size alone would immunize it from anticompetitive effects. The witness testimony meshed seamlessly with the economics of price negotiations. At the bargaining table, Blue Cross could not easily walk away from the monopoly provider in four critical service lines in Bismarck; any rational insurer would agree to a price increase instead. Sanford/MDC, on the other hand, would have a viable alternative to Blue Cross and could leave the table.

Defendants's [redacted] rate agreement with Medica also did not salvage the merger. Their own expert estimated price increases of [redacted] after expiration. And price restrictions do nothing to address the Government's showing that the acquisition would eliminate non-price competition.

3. The district court properly found that CHI was unlikely to expand its operations timely enough or sufficiently enough to offset the merger's anticompetitive effects. The president of St. Alexius estimated a [redacted] timeline to recruit enough doctors to replace MDC and build the patient base that would make CHI a viable fallback option for insurers negotiating with a combined Sanford/MDC. Even that might be overoptimistic, because the population of the Bismarck-Mandan area may not support more adult PCPs or general surgeons.

4. The district court properly rejected defendants' efficiencies defense. Courts look skeptically on such defenses in the first place, and those asserted to justify mergers-to-monopoly deserve particularly exacting scrutiny—no court has ever approved such an anticompetitive merger due to efficiencies. Defendants cannot claim that enhanced efficiency will allow them compete more vigorously; there will be no one left to compete against. And defendants did not satisfy the stringent requirements that they substantiate the efficiencies and show that merger is necessary to achieve them.

5. The district court correctly found that MDC was viable as an independent practice, so the merger could not be saved on a "weakened competitor" defense. That defense, which has been called a "hail-Mary pass," lacks any basis in the record. The evidence showed that MDC's finances are healthy, its future prospects are good, and its principal motivation for selling to Sanford was simply cashing out at a favorable time.

6. Finally, the district court properly defined the product and geographic markets. The evidence showed that doctors in the four services have unique characteristics that make them unsuitable for substitution and that insurer networks are not commercially viable if they do not include these types of doctors. Insurers therefore would accept a hypothetical monopolist's demanded price increase.

Defendants waived their claim that the Government was required to present a "cross-price elasticity" study, but the law does not demand such evidence.

With respect to the geographic market, the evidence showed that 95+ percent of Bismarck-Mandan area residents receive the relevant services locally. An insurance policy that required driving 100 miles to visit a doctor therefore would be unmarketable, and an insurer would accept a hypothetical monopolist's demanded price increase.

STANDARD OF REVIEW

This Court reviews the grant of a preliminary injunction for abuse of discretion, giving "deference" to the district court. *Doe v. S. Iron R-1 Sch. Dist.*, 498 F.3d 878, 880 (8th Cir. 2007). The Court does not "pass final judgment on the underlying issues," but ensures only that the injunction was not issued "on the basis of any clearly erroneous findings of fact or any clear error on an issue of law." *Olin Water Servs. v. Midland Research Labs., Inc.*, 774 F.2d 303, 307 (8th Cir.1985). Under clear error review, the Court will affirm unless it has a "definite and firm conviction" of error. *Am. Boat Co. v. Unknown Sunken Barge*, 567 F.3d 348, 352 (8th Cir. 2009). The district court's decision may be affirmed on any ground supported by the record. *Khaalid v. Bowersox*, 259 F.3d 975, 978 (8th Cir. 2001).

ARGUMENT

Section 7 of the Clayton Act prohibits an acquisition that "may" substantially lessen competition or "tend" to create a monopoly. 15 U.S.C. §18. Congress used the words "may" and "tend" deliberately, for its "concern was with probabilities, not certainties." *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 658 (1964); *accord Brown Shoe*, 370 U.S. at 323. The Clayton Act thus creates an "expansive definition of antitrust liability." *California v. Am. Stores Co.*, 495 U.S. 271, 284 (1990). "[A]ny 'doubts are to be resolved against the transaction.'" *Penn State Hershey*, 838 F.3d at 337, quoting *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989).

Congress vested principal responsibility for enforcement of Section 7 with the FTC through administrative adjudication. *See Heinz*, 246 F.3d at 714. Congress also provided a mechanism to maintain the status quo pending the administrative process, thereby preventing interim harm to competition and preserving the Commission's ability to fashion effective relief. Specifically, Section 13(b) of the FTC Act authorizes a federal district court to grant a preliminary injunction "[u]pon a proper showing that, weighing the equities and considering the Commission's likelihood of ultimate success, such action would be in the public interest." 15 U.S.C. § 53(b)(2); *see FTC v. Nat'l Tea Co.*, 603 F.2d 694, 696 (8th Cir. 1979).

To merit a preliminary injunction, the Government need not "*establish* that the proposed merger would in fact violate Section 7." *Heinz*, 246 F.3d at 714 (emphasis in original). Rather, Section 13(b) requires only that the Government show a *likelihood* that the merger ultimately will be found unlawful. The Government satisfies this burden if it raises "'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 ….'" *Nat'l Tea*, 603 F.2d at 698, quoting *FTC v. Beatrice Foods Co.*, 587 F.2d 1225, 1229 (D.C. Cir. 1978) (rejecting the "more stringent standard" of a "strong likelihood" of success on the merits).

I. THE DISTRICT COURT PROPERLY DETERMINED THAT THE FTC IS LIKELY TO SUCCEED ON THE MERITS.

The staggering HHI statistics here, *see* pp. 15-16, *supra*, by themselves created a strong presumption that a merger of Sanford and MDC will substantially lessen competition. *See ProMedica*, 749 F.3d at 568. But the court did not rest on those figures alone. It also relied on considerable evidence showing that the acquisition would remove competition between the two largest and most closely competing providers of four critical physician services in the Bismarck-Mandan area. The reduction in competition would enhance the combined practice's ability to demand higher prices for these services and reduce their incentive to improve quality. FOF73-81 (A0049-51). And the court found that defendants' rebuttal

evidence—which the Government refuted—did not undermine the Government's prima facie case. FOF82-161 (A0052-73); COL31-47 (A0084-89). The district court further properly determined that the public equities warrant a preliminary injunction. COL51 (A0090). Nothing in defendants' brief shows otherwise.

Indeed, the Clayton Act prohibits not only mergers that may "substantially lessen competition," but also those that "tend to create a monopoly." 15 U.S.C. §18. This merger does not merely "tend to" create a monopoly—it *does* create a monopoly, giving Sanford 100 percent of the market for general surgeons in the Bismarck-Mandan area. At the very least, a merger to total monopoly presents a "likelihood" that the FTC will ultimately succeed in blocking the merger and a question on the merits that is "serious" and "substantial." That is all Section 13(b) requires to warrant a preliminary injunction.

Defendants fail to show that the district court erred in its assessment of the evidence. Though they cloak their criticisms as legal arguments, their claims boil down to nothing more than routine challenges to the court's factual findings. Those findings are not erroneous at all, let alone clearly erroneous, and the court's legal analysis flows directly from them.

A. The District Court Properly Applied The Burdens Of Production And Persuasion.

Defendants concede that the acquisition "will significantly increase concentration" in four "relevant" service lines: "adult primary care, OB/GYN,

pediatrics, and general surgery." Br. 1.[4] But, they argue, "[e]ven assuming the Government established a market and prima facie case of illegality," the district court "erred as a matter of law" in concluding that they failed to rebut the presumption of illegality and "thus in not requiring the Government to meet its ultimate burden of persuasion." Br. 9. In other words, they claim that when the district court found inadequate defendants' attempt to rebut the Government's prima facie case, it improperly shifted onto them the burden of persuasion.

That claim is meritless. Defendants seize upon (Br. 14-15) the district court's statement in COL30 that, to overcome the Government's prima facie case, defendants had to produce evidence that "clearly shows" anticompetitive effects are unlikely. COL30 (A0084), citing *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363 (1963). Defendants argue, citing *Baker Hughes*, that modern cases require a simple "showing." The district court, however, obviously followed *Baker Hughes*. It identified *Baker Hughes* as presenting the appropriate analytical framework and, in addressing defendants' rebuttal arguments, relied extensively on court decisions applying that framework. COL7, 31-37, 44-45 (A0076, 84-86, 88). In particular, the court made clear that "[t]he FTC has the burden of persuasion at

[4] Defendants nonetheless contend that the district court erred in defining the relevant market. Br. 54-56. We address that argument at pages 54-60 below.

all times," COL7 (A0077), and it is obvious from the court's decision that the FTC amply met that burden.

Moreover, the distinction between "clear showing" and "showing" is not particularly meaningful in this case. *Baker Hughes* addressed the defendant's burden to rebut a case that rested entirely on HHI figures; the government presented no additional evidence of anticompetitive effects. *Baker Hughes*, 908 F.2d at 983, 992. In contrast, here the Government presented not just astronomical concentration statistics, but also considerable additional evidence demonstrating a high likelihood of anticompetitive effects. The district court was correct to require rebuttal evidence that would counter this strong showing. As the court in *Baker Hughes* recognized, "[t]he more compelling the prima facie case, the more evidence the defendant must present to rebut it successfully." *Id.* at 991.

Furthermore, the *Baker Hughes* framework is "flexible." *Chicago Bridge*, 534 F.3d at 424. Typically, the Government puts in all of its evidence at once: its statistical case, additional evidence of anticompetitive effects, and evidence countering the defendant's rebuttal arguments. Thus, a court "can conclude [the defendant's] burden of production on rebuttal is not satisfied without having to formally switch the burden of production back to the Government." *Id.* at 424. A court properly "preserve[s] the *prima facie* presumption if the [defendant] fails to satisfy the burden of production in light of contrary evidence in the *prima facie*

case." *Id.* at 425. As mentioned above, a compelling prima facie case calls for substantial rebuttal evidence. *Baker Hughes*, 908 F.2d at 991.

The court not only articulated the correct standard, but properly applied it. The Government first presented evidence that both established its prima facie case of anticompetitive effects and refuted the defendants' expected arguments. After the defendants' case, the Government then presented additional evidence that contravened each of their arguments. The district court assessed the totality of that evidence and reasonably found that defendants had not overcome the Government's prima facie case. The court's resolution of these *factual disputes* does not show *legal error* in its application of the *Baker Hughes* framework for production of evidence and persuasion. If defendants could convert a factual dispute into legal error that easily, it would upend the burden-shifting regime and unmoor appellate review from its traditional functions. The Court should reject their invitation to change the standard of review for purely factual determinations.

B. The District Court Properly Found That Defendants Failed to Rebut the Government's Prima Facie Case.

1. Defendants Failed To Rebut The Government's Showing That The Acquisition Is Presumptively Anticompetitive And Would Lead To Price Increases.

a. The district court properly resolved the "battle of the experts."

Defendants contend that the district court erred by "ignoring" evidence that "negates the predictive value" of market concentration alone. Br. 18, 20. They

claim specifically that the court overlooked a study by their economic expert, Dr. Town, that found no significant relationship between provider concentration and insurance company reimbursement rates in North Dakota. In fact, the district court credited the Government's expert's testimony over Dr. Town's, an ordinary resolution of a battle-of-the-experts, well supported in the record.

The court expressly considered Dr. Town's study, FOF119 (A0062), and properly determined that his analysis did not rebut the presumption of illegality. A substantial amount of other evidence demonstrated that dominant providers can exert leverage in negotiations with insurers to obtain higher prices. FOF107-11, 118, 121-122 (A0059-63). The record bears out the court's conclusion, which reflects no error at all, let alone clear error.

To begin with, Dr. Town's analysis did not demonstrate that high provider concentration does not affect price competition in North Dakota as a general proposition. The analysis purported to show only that *Blue Cross*, the state's largest insurer, is uniquely capable of resisting provider leverage. But Blue Cross is not the only insurer with interests at stake; the acquisition also harms other, smaller insurers (and employers and individuals) in the market with less bargaining leverage—specifically, Medica. *See* pp. 39-41, *infra*. Notably, Dr. Town found that, for Medica, there is a "positive relationship between [provider] bargaining leverage and reimbursement rates." A0382.

Even as to Blue Cross, Dr. Town's analysis failed to undermine the Government's case. As the Government's expert economist, Dr. Sacher, explained, Dr. Town's finding that concentration was not related to rates was "simply an artifact of BCBS-ND's statewide pricing policy." PX06003 ¶46 (SA497). In other words, because Blue Cross uses a uniform statewide schedule, more concentrated markets typically will not have higher rates than less concentrated ones—all markets have the same rate. But that means only that market power exercised in one area can affect the entire state; it does not mean that Blue Cross is immune from market forces. As Dr. Sacher put it, "statewide pricing is not evidence that an insurer has 'all the bargaining power'" and thus may overcome the bargaining leverage of large providers. *Id.* ¶47 (SA497).

Moreover, as Dr. Sacher explained, Dr. Town's analysis simply looked at Blue Cross's reimbursements at a single point in time and thus failed to address the inquiry pertinent to this merger: what effect *changes* in provider concentration may have on rates. *Id*. ¶50 (SA498). Existing rates reflect the current competitive environment, where Sanford and MDC can discipline each other's prices. In the absence of that price discipline—that is, in the face of a substantial increase in bargaining leverage—prices are likely to increase. Tr-2 at 103-104 (SA105-106)

b. Statewide reimbursement schedules do not negate anticompetitive effects.

Defendants also wrongly contend that Blue Cross's use of a statewide reimbursement schedule demonstrates "the absence of anticompetitive effects" and that no provider has ever used bargaining leverage to negotiate higher rates. Br. 22, 25. In fact, the record showed that Blue Cross will adjust its reimbursement schedule in response to the demands of large providers. Tr-1 at 248-249, 255-56 (SA043-44, 46-47). Blue Cross's Chelsey Matter testified that Sanford is one of the handful of providers in North Dakota that already "ha[s] the leverage to influence the adjustments" that Blue Cross makes to its reimbursement schedule. Tr-1 at 256 (SA047). The acquisition of MDC would augment Sanford's leverage and diminish Blue Cross's bargaining position against it. This would give the combined practices even greater ability to negotiate higher prices. Tr-4 at 212-214 (SA151-153). And given Blue Cross's statewide schedule, a single large provider's exercise of market power to demand a higher rate can translate into a statewide rate increase for all providers, to the detriment of every Blue Cross member in North Dakota.

The record contained a vivid example of a powerful provider using its leverage to force Blue Cross to accede to demands for higher rates. In 2012, Altru, a near-monopolist provider of healthcare services in Grand Forks, demanded a higher adjustment to Blue Cross's base fee schedule or else Altru would terminate

its contract. Tr-1 at 249-250, 304 (SA044-45, 54). Blue Cross acceded to this demand because it "couldn't afford to have Altru out of network" and still offer a commercially viable health plan. Tr-1 at 250 (SA045); PX07096 -002 (A0429). The district court properly recognized that the Altru episode shows that a provider with sufficient market power can obtain higher reimbursement rates from Blue Cross in North Dakota. FOF122 (A0063).

c. Blue Cross's size does not insulate it from price demands.

Defendants argue that Blue Cross's size neutralizes any anticompetitive increase in market power from the transaction. Br. 26. Courts routinely reject the "power buyer" argument because if there are no competitive alternatives, companies controlling essential inputs (here, the four services in which defendants would have a monopoly or near-monopoly) can often force larger companies to accept price increases. *See ProMedica*, 749 F.3d at 562; *Chicago Bridge*, 534 F.3d at 440. As the Fifth Circuit pointed out, "the economic argument for … rebutting a presumptive case, because a market is dominated by large buyers, is weak." 534 F.3d at 440; *see also FTC v. OSF Healthcare Sys.*, 852 F.Supp.2d 1069, 1083-1084 (N.D. Ill. 2012); *Merger Guidelines* §8 ("Even [powerful] buyers that can negotiate favorable terms may be harmed by an increase in market power."). The Clayton Act prohibits *all* anticompetitive combinations, not just ones with smaller buyers on the other side of the negotiating table.

Theory aside, the record in this case leaves little doubt that *this* combined company could exploit its enhanced bargaining leverage to force price increases even on Blue Cross. Ms. Matter testified that if Sanford were to acquire MDC, it—like Altru before it—"could really present [Blue Cross] with an ultimatum" to obtain higher rates. Tr-1 at 261 (SA049).[5] The acquisition would give Sanford "the potential to punch a real hole in Blue Cross's network in a way that didn't exist before," Tr-4 at 214 (SA153), because Blue Cross would no longer have a fallback option if it failed to contract with Sanford/MDC. There simply would be no viable alternatives in the Bismarck-Mandan area for the four relevant physician services. Tr-1 at 243-247 (SA038-42). At the same time, the combined Sanford/MDC would have fallback options for insurers, such as Medica or Sanford's own captive insurance company. Sanford's in-house insurer, which has been gaining market share against Blue Cross, proves that Blue Cross is not immune from competition, as a provider monopoly would be. FOF104 (A0058).

Faced with a demand for rate increases from the combined practice, Blue Cross would have two options: it could either walk away from the table and try to sell policies that offer little to no services in four critical areas in the second-largest

[5] That Blue Cross's business is important to defendants will not, as they contend (Br. 23), prevent anticompetitive effects. As Dr. Town acknowledged, Blue Cross's business presumably also was very important to Altru, Tr-4 at 155 (SA145), but Altru still obtained higher rates. *See* pp. 36-37, *supra*.

metropolitan area in the state; or it could give in to a price demand. Tr-1 at 261-263 (SA050-52). Any rational insurer, however large, would choose the latter option.

Defendants try unsuccessfully to dress up the factual dispute over their power buyer argument as a claim of legal error. They argue that the district court improperly "cabin[ed] the evidence," failed to consider Blue Cross's ability to prevent price increases, and improperly placed the burden of persuasion on them to prove a "defense." Br. 27-30. That is simply untrue. The district court thoroughly assessed the evidence regarding Blue Cross's buyer power and found that as a factual matter it was insufficient to overcome the presumption that the merger is unlawful. *See* pp. 17-18, *supra*.[6]

d. A temporary private rate agreement cannot salvage an unlawful merger.

Defendants fare no better in arguing that they rebutted the presumption of competitive harm with respect to Medica because their agreement with Medica

[6] Defendants place great emphasis on Dr. Town's distinction between "bargaining power" and "bargaining leverage." Br. 26. But Dr. Town himself was hard-pressed to articulate his distinction coherently. Tr-Vol. 4 at 126-127 (SA143-144) (defining "bargaining power" as "stuff that's kind of included in the specific negotiations you're examining," which includes "stuff that's not captured in the bargaining leverage"). Dr. Sacher, whose testimony was credited by the district court, left no doubt that the merger would alter the bargaining positions of the parties substantially enough to allow the combined Sanford/MDC to negotiate higher prices than either could without their combination.

"precludes Sanford from raising rates on Medica for the next [redacted]." Br. 32-33. A private "remedy" against anticompetitive effects will not save an unlawful merger. It does not cure the changed competitive conditions resulting from the merger, does not prevent future anticompetitive effects when the agreement expires, and is susceptible to circumvention. The Third Circuit recently rejected reliance on a virtually identical rate agreement as a defense to an otherwise unlawful merger. *Penn State Hershey*, 838 F.3d at 343-344; *see also FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 65 (D.D.C. 1998) (rate guarantees "cannot cure the likely anti-competitive effects of the mergers").

Evidence showed that a combined Sanford/MDC could increase prices to Medica even while the rate agreement is in place. Michael Lenz, Medica's vice president of network management (until August 2017), testified that some reimbursements under the agreement are based on a percentage of Sanford's standard rates, so if "those charges change with the merger, [Medica's] costs will go up." Tr-1 at 190 (SA031). He also stated that the acquisition could change referral patterns, increasing costs to Medica. Tr-1 at 184-185 (SA025-26). For example, MDC doctors that previously referred patients to independent imaging centers could be required to use Sanford's imaging center, and "typically you see the unit rate go up." *Id*. at 185 (SA026). Dr. Jha, another Government expert, testified that concentration leads to more referrals and costlier procedures." Tr-4 at

238 (SA155). And even if the rate agreement actually froze all rates, it would do nothing to address the harm that Medica's members will face from lost quality competition between Sanford and MDC. *See* pp.42-43, *infra*.

Moreover, a combined Sanford/MDC could raise prices after the agreement expires (in [redacted]) due to its "additional leverage." Tr-1 at 184 (SA025). As Mr. Lenz colorfully put it, "Sanford already has a big club when it comes to negotiation. This would just make their club even bigger." *Id*. Indeed, defendants' own expert estimated that the merger would ultimately force Medica to pay [redacted] more for the relevant services. DX6001-064 (A1375).[7] Defendants argue that an [redacted] increase amounts to "only [redacted]" and is insufficiently "substantial[]" to warrant Clayton Act condemnation. This argument is specious. Section 7 contains no de minimis harm exception, but prohibits any merger that "may substantially lessen *competition*."

2. Defendants Failed To Rebut The Government's Showing That The Acquisition Would Eliminate Non-Price Competition.

The Clayton Act is concerned with both price and non-price competition. *See Philadelphia Nat'l Bank*, 374 U.S. at 368 (discussing price and non-price factors); *see also FTC v. Sysco Corp.*, 113 F. Supp. 3d 1, 65 (D.D.C. 2015) ("non-

[7] Dr. Town projected higher costs to Medica—[redacted]—even if CHI enters or expands in the relevant physician service lines. A1375.

price incentives, such as signing bonuses; service; and other value-added offerings" would be undermined by merger); *United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 82 (D.D.C. 2011) (diminution in quality is an anticompetitive effect).

The same goes in healthcare, where courts have highlighted the relationship between competition and quality. In *ProMedica*, the district court granted a preliminary injunction in part because competition had led to "increased quality of care, additional service offerings, and other non-financial benefits," which were threatened by the merger. *FTC v. ProMedica Health Sys., Inc.*, No. 3:11 CV 47, 2011 WL 1219281, at *29 (N.D. Ohio Mar. 29, 2011); *see also United States v. Aetna, Inc.*, 240 F. Supp. 3d 1, 46 (D.D.C. 2017) ("head-to-head competition" "drives improvements to plan cost and quality").

Sanford and MDC engaged in vigorous head-to-head competition for patients, which spurred each to invest in new technology, expand services, and improve access. *See* p. 11, *supra*. Kelby Krabbenhoft, Sanford's CEO, acknowledged that "competition … keeps you always . . . aspiring to provide a better product at a more competitive price." Tr-3 at 38 (SA129); *see also* Tr-2 at 21-22 (SA056-57). The district court reasonably found that the proposed acquisition would eliminate such beneficial non-price competition. FOF81 (A0051).

Defendants argue that that the court failed to consider "uncontroverted evidence" (another analysis by their economist, Dr. Town) showing "no relationship between provider concentration and quality of care." Br. 19, 21. The evidence was not uncontroverted. Both Dr. Sacher and Dr. Jha, the Government's expert on healthcare quality and efficiency, addressed Dr. Town's analysis, finding it "flawed" and "incomplete." PX06003 ¶133 (SA529-530); PX06005 ¶¶3-4, 22 (SA551-552, 560); *see* Tr-4 at 237-241 (SA154-158). Dr. Jha explained, for example, that Dr. Town "omitted … two of the most important quality metrics when you're trying to assess ambulatory quality of care"—preventable emergency room visits and preventable hospitalizations—which was "a mistake that is very common for people who … don't work in the quality field." Tr-4 at 240-241 (SA157-158). More importantly, the district court had no need to rely on theories that increased concentration would lower incentives to increase quality of service. The clear evidence showed that competition between Sanford and MDC has spurred them to improve their services. The elimination of competition between them would destroy that incentive.

3. Defendants Failed To Rebut The Government's Showing That Entry Or Expansion By CHI Would Not Be Timely Or Sufficient.

Defendants argued below that the proposed acquisition will not lessen competition because CHI has the incentive and ability to enter the markets and

compete with Sanford/MDC in the four services at issue. To prevail on this claim, defendants must show that entry (or expansion) is: (1) *timely*—it will happen soon enough to make price increases unprofitable; (2) *likely*—technically possible and economically sensible; and (3) *sufficient*—it will replace the competition that existed prior to the merger. *See Merger Guidelines* §9; *Chicago Bridge*, 534 F.3d at 429-30 (affirming that "potential entrants would not be of a sufficient scale … and thus would be unable to constrain the likely anti-competitive effects"). Evidence of entry is assessed on a sliding scale: "The more concentrated the market and the greater the threat posed by the challenged practice, the more convincing must be the evidence of likely, timely and effective entry." IIB Phillip E. Areeda, Herbert Hovenkamp & John Solow, *Antitrust Law* ¶422, at 94 (4th ed. 2014). Here, that test calls for an extraordinarily convincing showing.

The district court correctly found that defendants failed to make this showing. Evidence showed that recruiting physicians to the Bismarck area is particularly challenging, among other reasons because of its inhospitable climate and geographic isolation. JX00022 at 145 (SA208); JX00027 at 159-161 (SA210); Tr-1 at 106-107 (SA002-03).[8] Kurt Schley, president of St. Alexius, estimated that

[8] Defendants cite two cases in which courts found low barriers to entry in physician markets. Br. 36-37. Even if that were true as a general matter, neither case addressed the evidence submitted here that it is especially difficult to enter the Bismarck-Mandan area market.

it would take at least [redacted] to recruit enough adult primary care, pediatrician, and OB/GYN doctors and [redacted] to recruit enough general surgeons to replace MDC's practice. Tr-1 at 108, 114-120 (SA004, 6-12); PX03009 ¶¶46-48 (A1106).

But these numbers tell only half the story. As Mr. Schley explained, "once we have done the recruiting, we have to establish the name and reputation of those providers to a similar extent as Sanford and Mid Dakota Clinic"—which he estimated would take "up to [redacted]." Tr-1 at 108, 114-117 (SA004, 6-9). Without this patient base, CHI will not be attractive to insurers and thus cannot serve as a sufficient fallback option for insurers negotiating with Sanford/MDC. CHI therefore will be unable to prevent post-merger Sanford from using its increased bargaining leverage to negotiate higher prices. Tr-2 at 109-111 (SA109-111). And even if were possible to recruit doctors to this area, [redacted] the Bismarck area might already have enough primary care doctors and general surgeons to satisfy the total demand, so CHI could not expand under any circumstances. [redacted]

Defendants wrongly contend that the district court ignored CHI's estimates regarding entry. Br. 40-41. In fact, the court relied extensively on Mr. Schley's testimony. FOF143-148 (A0068-70). It is defendants who have ignored the record, including Mr. Schley's testimony that recruiting doctors does not by itself suffice

to establish a competitive practice and that it will take CHI [redacted] to become viable competitive alternatives to post-merger Sanford.

Defendants also argue that the district court's finding that the Bismarck area's population may not be large enough to support all these additional doctors, FOF149 (A0070), "is contrary to" the court's findings in FOF153-154 (A0071) (addressing MDC's viability) that there are "'plenty of patients' for MDC physicians" and an "increasing demand for its services." Br. 40. There is no inconsistency. An increase in demand for one provider's services does not mean that the total demand in the market is also increasing. Demand for market leader MDC does not show that there will be similar demand for newly-recruited, unknown doctors without established reputations. Here again, defendants ignore that sufficient and timely entry by CHI does not involve merely recruiting physicians (assuming that is even possible), but also concerns building practices and public comfort with them sufficient to make them a viable alternative to a combined Sanford/MDC in an insurer's network.

On this record, the district court correctly held that entry by CHI would not be "timely, likely, or sufficient" to counteract the merger's anticompetitive effects. FOF150 (A0070).

4. The District Court Properly Rejected Defendants' Efficiency Defense.

Defendants urged the court below to disregard the acquisition's anticompetitive effects on the theory that increased efficiency from the deal would reduce the cost of service and improve quality. The district court correctly rejected that defense because defendants failed both to verify the monetary efficiencies and show that the claimed quality benefits could be achieved only through the acquisition.

Defendants now abandon their cost savings claims and press only their quality claims. Their argument boils down to the claim that an anticompetitive acquisition is permissible because the merged firm will use its monopoly profits to deliver high-quality services. No authority supports such a proposition, especially where a merger would create a monopoly.

a. The Legal Standard For An Efficiency Defense.

Efficiency defenses are carefully scrutinized and viewed with skepticism. *See Penn State Hershey*, 838 F.3d at 347-48; *St. Luke's*, 778 F.3d at 789-90. "The Clayton Act focuses on competition," so claimed efficiencies "must show that the prediction of anticompetitive effects from the prima facie case is inaccurate." *St. Luke's*, 778 F.3d at 791; *accord FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999). But defendants do not even argue that their claimed quality benefits will enhance the merged practice's ability and incentive to compete—

indeed, for the most part, there would be no one to compete against. Thus, their claims of quality, even if valid, could not overcome the prediction that their creation of a monopoly harms competition.

The asserted efficiencies here deserve particularly exacting scrutiny because "[e]fficiencies almost never justify a merger to monopoly or near-monopoly." *Merger Guidelines* §10; *accord St. Luke's*, 778 F.3d at 790. It is no surprise that defendants cite no case in which a court has ever approved a merger to monopoly due to efficiencies.

Defendants' efficiency claims do not nearly meet the two-part test for an efficiency defense in an ordinary case. First, asserted efficiencies must "represent more than mere speculation and promises about post-merger behavior." *Heinz*, 246 F.3d at 721. "[I]t is incumbent upon the merging firms to substantiate efficiency claims." *Merger Guidelines* §10. An efficiency claim "based on mere possibilities" is insufficient. IVA Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law* ¶970c, at 32 (4th ed. 2016).

The test is especially demanding where there are "high market concentration levels." *Heinz*, 246 F.3d at 720. Such a case calls for "precise proof of a very high degree of efficiency." Areeda ¶970b, at 26. "Few defendants will be able to make this showing." *Id.* Ensuring they have done so is critical in an industry like

healthcare, in which promises of improved efficiency are easy to make, yet hard to fulfill.

Second, asserted efficiencies must be "merger-specific," meaning that merging parties must "explain[] why [they] could not achieve the kind of efficiencies urged without merger." *Heinz*, 246 F.3d at 722. To be merger-specific, the efficiency must be "a *unique consequence* of the merger" that "could not readily be attained by other means." Areeda ¶973a, at 61; *see Heinz*, 246 F.3d at 722; *In re Evanston Nw. Healthcare Corp.*, FTC No. 9315, 2007 WL 2286195 at *70 (Aug. 6, 2007) ("could not practicably be achieved without the proposed merger"); *Merger Guidelines* §10. If efficiencies are not merger-specific, "the merger's asserted benefits can be achieved without the concomitant loss of a competitor." *Heinz*, 246 F.3d at 722; *accord Merger Guidelines* §10.

b. Defendants Failed To Substantiate Their Quality Efficiency Claims.

Although the district court did not rule on this prong of the test, the asserted benefits are clearly speculative.

Defendants produced only one substantive document to support their claims—an advocacy piece they entitled "*Stronger Together*," which was drafted largely by counsel after the deal had been struck. Tr-3 at 230-232 (SA137-139); PX04045 at 021-036 (A0739-754). The document contains a general discussion of potential "synergies" but few details showing how to accomplish them. Tr-3 at 231

(SA138); Tr-2 at 243-244 (SA116-117); PX06002 ¶¶16-18 (SA440-442). Indeed, defendants admit that they barely analyzed these synergies. *See* JX00008 at 218-220 (SA191). Sanford Bismarck's Executive Vice President described synergy efficiencies as "conjecture." JX00004 at 124 (SA182). MDC's Chairman testified that the synergy team had done no "practical work," Tr-4 at 202-203 (SA146-147), and had not progressed beyond "conceptual plans," JX00022 at 16-17 (SA206-207).[9]

c. Defendants Failed To Show Merger-Specificity.

The district court correctly determined that, with one exception, defendants had "not demonstrated that the … claimed quality efficiencies are merger specific." FOF101 (A0057).

Government expert witness Dr. Jha, testified that the merger was unnecessary to accomplish the "synergies" identified in *Stronger Together*. Tr-2 at 267-68 (SA125-126). For example, defendants can embed behavioral health into primary care clinics without merging, as many other practices have done. Tr-2 at 262-264 (SA122-124); PX06002 ¶¶53-56 (SA457-458). A Sanford executive agreed. JX00008 at 33 (SA188). Nor do defendants need the merger to recruit the subspecialists identified in *Stronger Together*. Tr-2 at 249-252 (SA118-121);

[9] Indeed, MDC does not want to use Sanford's Electronic Medical Records system, which was one of the claimed efficiencies. Dr. Seifert testified that she prefers MDC's current system. JX00011 at 247-48 (SA201).

PX06002 ¶¶26-27 (SA445). Dr. Jha explained that patient demands for service, not the size of a practice, determine whether an area can support a subspecialist. Tr-2 at 250-251 (SA119-120); PX06002 ¶¶28-30 (SA446-447); *see* JX00008 at 185-190 (SA189-190). Indeed, defendants are currently recruiting the types of subspecialists identified in *Stronger Together*. PX06002 ¶32 (SA447-448).

Defendants contend that the asserted quality improvements must be considered merger-specific because they are "likely to be implemented if the transaction proceeds, and … unlikely to be implemented if it does not." Br. 43. That is not the correct test. Efficiencies count only if they "*cannot be achieved* by either company alone," *Heinz*, 246 F.3d at 722 (emphasis added), not merely if neither one would bother. The test is strict because "society would be better off if … efficiency gains could be realized without the anticompetitive merger." Areeda ¶973a, at 61; *see also Merger Guidelines* §10 ("competition, not internal operational efficiency," is most important under the Clayton Act); *United States v. Third Nat'l Bank in Nashville*, 390 U.S. 171, 189 (1968) (if "loss of competition could be avoided … in ways short of merger[,]" the merging parties must "demonstrate that they made reasonable efforts" to achieve efficiency outside of the merger).

Defendants' alleged merger-specific benefits are ones that Sanford already provides. The gist of defendants' argument is that the merger will allow MDC

doctors to use sophisticated technology, benefiting MDC patients. Br. 42 (listing benefits to MDC arising from participation in Sanford programs). But it was defendants' burden to show that *this* acquisition is necessary for MDC to achieve those benefits—that MDC could not do these things on its own or with another partner. Defendants failed to meet this burden. The one merger-specific benefit the district court found does not suffice to justify a merger to monopoly.

5. The District Court Properly Rejected Defendants' Claim That MDC's Long-Term Prospects Justify The Acquisition.

Defendants claimed that MDC's uncertain long-term viability as an independent practice justified its decision to combine with Sanford. The district court rejected that argument, finding MDC's finances healthy and its future prospects good. FOF153-161 (A0071-73). Yet again, defendants have shown no error, let alone clear error.

The contention rests on shaky ground to begin with. The weakened competitor defense—the argument that, due to financial or other problems, a firm's current market shares may overstate its future competitive role—"is probably the weakest ground of all for justifying a merger," and it "certainly cannot be the primary justification of a merger." *Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1339, 1341 (7th Cir. 1981). The Sixth Circuit has called the defense "the Hail-Mary pass of presumptively doomed mergers." *ProMedica*, 749 F.3d at 572; *see FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164 (9th Cir. 1984)

(financial weakness defense is disfavored because it "would expand the failing company doctrine, a defense which has strict limits"); *Nat'l Tea*, 603 F.2d at 700 ("imminent departure" from the market is relevant to likely competitive effects).

The defense has no viable basis in the record. The evidence showed that MDC is profitable today and has strong operating income and patient volumes. JX00005 at 86-87 (SA186); JX00012 at 57-58 (SA203). Recent financial reports showed "record setting collected receipt[s]" and "strong productivity." PX05158-002 (SA176). MDC's revenues have increased for each of the last three years. Tr-4 at 205-206 (SA149-150). Two independent consultants concluded that "the outlook for MDC is anticipated to be positive" and projected "increasing demand for [MDC] and better reimbursement." PX05244-017 (SA171); JX00045-028 (SA178); *see also* Tr-2 at 206-207 (SA114-115); PX06001 ¶¶110-118 (SA281-284).

Testimony and ordinary course documents demonstrated that MDC's principal motivation was not concern about long-term viability but maximizing profit from the transaction. The doctors who owned the practice simply "decided to cash in their equity" at a time when the company was especially valuable. JX00012 at 190-191 (SA204); *see* PX05224-001 (A0570) ("share value is probably at its highest possible" so deal would reap "maximum amount in short term."); *see also* JX00029 at 152-54 (SA215) (MDC would remain independent "[i]f we did not get

the valuation that we were told we were valued at"). The evidence eviscerates the future viability defense.[10]

II. THE DISTRICT COURT CORRECTLY DEFINED THE RELEVANT MARKETS.

Finally, defendants make a halfhearted argument that the district court erred in defining the markets. Assessed against standards of both antitrust law and basic common sense, their claims are plainly wrong.

A relevant product market is defined by examining the "reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it." *Brown Shoe*, 370 U.S. at 325. The inquiry is whether "consumers will shift from one product to the other in response to changes in their relative costs." *SuperTurf*, 660 F.2d at 1278 .

A relevant geographic market is the area "to which the purchaser can practicably turn for supplies." *Philadelphia Nat'l Bank*, 374 U.S. at 359 (internal quotation marks and emphasis omitted). This inquiry requires a "pragmatic, factual approach" that "correspond[s] to the commercial realities of the industry." *Brown Shoe*, 370 U.S. at 336-37 (internal quotation marks and footnote omitted).

[10] Defendants claim (Br. 53) that MDC's allegedly poor long-term prognosis means that it is unlikely to undertake the asserted "synergies" and that CHI will enter the market to replace MDC. The contentions fail because they assume MDC's future weakness—a fact the district court reasonably found could not be squared with the evidence.

The district court relied on both economic analysis and testimony of market participants to conclude that adult primary care, pediatrician, OB/GYN, and general surgery physician services are relevant product markets, because "an insurance plan's networks must include" each of type of doctor "in order to be marketable in the Bismarck-Mandan area." FOF38, 42, 46, 51 (A0039-43). Representatives of each of the three primary commercial insurers—Blue Cross, Sanford Health Plan, and Medica—testified that they could not market a health plan that did not include all these types of doctors. Tr-1 179-181 (SA020-22) (Medica); Tr-1 233-236 (SA032-35) (Blue Cross); JX00028 at 196-197 (SA212-213) (Sanford Health Plan). Empirical analysis of claims data confirmed that other specialists or non-physician providers (such as nurses) are not substitutes for adult PCPs, pediatricians, OB/GYNs, and general surgeons. Tr-2 at 69-71 (SA078-80); PX06000 ¶¶83-84, 90, 96-100 (SA326, 329, 332-334). That evidence ratified everyday understanding of medical practice and showed that doctors in these service lines have unique characteristics, including specialized training and qualifications, that make them unsuitable for substitution. *See United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990) ("If you need your hip replaced, you can't decide to have chemotherapy instead…."). Each medical specialty thus constitutes a valid product market.

The court likewise relied on both economic analysis and fact testimony to conclude that the Bismarck-Mandan area is the relevant geographic market. It found that "[a] health insurance plan that did not include Bismarck-Mandan area [doctors] would not be marketable in the Bismarck-Mandan area." FOF66 (A0046-47).

The undisputed evidence showed that consumers insist on local care. The Government's expert, Dr. Sacher, showed that 95 to 99 percent of patients living in the Bismarck-Mandan area stay there to receive the relevant services. PX06000 ¶127 (SA346-347); *see Penn State Hershey*, 838 F.3d at 341 ("a high number of patients who do not travel long distances for healthcare supports" a local geographic market). Dr. Sacher determined that Bismarck-Mandan area patients typically travel 4 miles—a 10 minute drive—to receive care. PX60000 ¶131 (SA349). Such data are hardly surprising in a vast area that contains a small number of widely spaced population centers.

Moreover, convenience is a principal factor in consumer decisions about where to seek medical care. Much more so than price, since "much of the expense of health insurance is covered by the insurer," Tr-2 at 50 (SA059), and patients pay only a small percentage out of pocket. All three insurers in the area confirmed that they could not successfully market a network in the Bismarck-Mandan area that lacked local doctors in each of the relevant services. Tr-1 at 182-183 (SA024-25)

(Medica); Tr-1 at 237-238 (SA036-37) (Blue Cross); JX00009 at 88-92 (SA193-194) (Sanford Health Plan).

Both the geographic and the product market definitions were supported by standard economic analysis. Using the evidence discussed above, the court applied the hypothetical monopolist test (*see* pp. 12-13, *supra*) to each product market and to the geographic market and concluded that "commercial insurers would accept a hypothetical monopolist's SSNIP rather than market a health plan in the Bismarck-Mandan area that did not include Bismarck-area adult PCP services, pediatrician services, OB/GYN physician services, and general surgeon services." FOF67 (A0047); *see ProMedica*, 749 F.3d at 572 (insurers "assemble networks based primarily upon patients' preferences, not their own"); *St. Luke's*, 778 F.3d at 784 (determination of relevant market focuses on the "likely response of insurers" to a price increase).

Defendants have shown no clear error in the district court's factual findings supporting its determination of the relevant markets. *See Community Publishers*, 139 F.3d at 1183-84 (product and geographic market determinations reviewed for clear error). That alone is sufficient reason to uphold the definitions. Defendants' legal claims are feeble.

With respect to the product markets, defendants concede that the consolidation of Sanford and MDC would "significantly increase concentration" in

"four relevant service areas" generally corresponding to the markets the district court defined. Br. 1. They argue, however—for the first time—that proving a relevant market requires a "cross-price elasticity" study "analyz[ing] the variability of pricing in the alleged markets." Br. 54-55. Because defendants did not make this argument below, they have waived it. *See Campbell v. Davol, Inc.*, 620 F.3d 887, 891 (8th Cir. 2010) ("issues not raised in the trial court cannot be considered … as a basis for reversal.") (citations and internal quotation marks omitted).

The argument is untenable anyway. We are aware of no case law that supports that proposition. *Brown Shoe*, for example, explains that "reasonable interchangeability" is sufficient, although cross-elasticity data also could be relevant. 370 U.S. at 325. For all the reasons described above and found by the district court (and consistent with common experience in visiting doctors), the service lines at issue here are not reasonably interchangeable.

The cases defendants cite do not mandate a cross-elasticity study. Those cases demonstrate that courts rely on a variety of evidence to determine "the practicable choices available to consumers." *FTC v. Freeman Hosp.*, 69 F.3d 260, 270 (8th Cir. 1995). The evidence could include the "testimony of market participants" if it "address[es] the practicable choices available to consumers." *Id.* Neither does *FTC v. Lundbeck, Inc.* support defendants' claim. The court did not require a specific mathematical study. It upheld the lower court's assessment of a

product market on the basis of general industry-participant testimony that buyers were not price sensistive. 650 F.3d 1236, 1240-41 (8th Cir. 2011). Nothing in the opinion suggests that specific studies were required. *Tenet* likewise imposed no specific analysis, explaining instead that the relevant inquiry was "where consumers could practicably go for inpatient hospital services." 186 F.3d at 1054.

Defendants also argue (Br. 56) that the district court's market definitions were wrong because Dr. Town showed that Blue Cross would not accept a SSNIP if demanded by a hypothetical monopolist. That showing, the argument goes, proves that the market definitions must be wrong.

This argument rests on a fundamentally mistaken understanding of the hypothetical monopolist test. The test considers whether buyers would turn to a different product or geographic area in the face of a price increase demanded by a hypothetical monopolist. The test does not ask whether an actual buyer in the market could constrain prices—that is a competitive effects, not relevant market, question. Dr. Town's analysis showed nothing about whether Blue Cross's members could substitute nurse practitioners for general surgeons (which they obviously cannot) or whether the company could successfully sell policies that forced the members to drive a hundred miles for care (which they plainly could not).

Even on its own terms, the argument fails because it rests on the faulty assumption that Blue Cross can resist a monopolist provider's demand for higher prices. The premise is baseless for the reasons addressed at pages 34-39 above, including that Blue Cross has in fact given into to rate demands by monopolists and near-monopolists, and there is no reason to suspect it would not do so again.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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I certify that this brief complies with the type-volume limitation set forth in Fed. R. App. 32 (a)(7)(B), in that it contains 12,987 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii), and complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6), because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in Times New Roman 14-point font.

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I hereby certify that on March 5, 2018, I served the foregoing brief on counsel of record by electronic mail. Service will further be accomplished by delivery of paper copies by a third-party carrier.

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March 5, 2018