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I. INTRODUCTION

In *Lundbeck* the Eighth Circuit affirmed a district court's decision approving a merger of the only two drugs authorized to treat a rare but serious heart condition in infants.[2] When the acquisition occurred Lundbeck owned a patented drug called Indocin IV, which at the time was the only drug approved by the FDA to treat this condition. It then acquired the rights to NeoProfen, a drug that had been developed but was still awaiting FDA approval. The two drugs were not bioequivalents, and had different ingredients and side effects. When approval was granted Lundbeck introduced the new drug at a price some 1300 percent higher than the price of its older drug Indocin IV, and also raised the price of Indocin IV to about the same level.[3]

Generic alternatives to Indocin IV became available in 2010, but until that time Lundbeck owned all approved drugs for treating this condition.[4] Prior to the acquisition Merck, the former owner of Indocin IV, had charged $77.77 per treatment. After it owned both drugs Lundbeck raised the price of Indocin IV to $1614.44 and the price of NeoProfen was set at $1450 per treatment, eventually rising to $1522.50. Prior to its approval, the price of NeoProfen had been forecast at roughly $450 to $500 per treatment; however, this was in an environment in which the price of Indocin IV was under $80.[5]

II. THE *LUNDBECK* DECISION

The district court rejected the FTC's challenge to the acquisition after holding that the two drugs must be shown to be in the same product market, and that the FTC had not carried its burden on this issue.[6] The court heard testimony from hospital officials and other experts that hospitals would have been able to force price competition between the two drugs if they had been independently owned, as well as experts who disagreed.[7] The court credited the testimony of the latter, concluding that there would not have been effective price competition between the two drugs even if they had been owned by different firms.[8]

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[2] *FTC v. Lundbeck, Inc.*, 650 F.3d 1236 (8th Cir. 2011). The heart condition, called "patent ductus arteriosus (PDA)" primarily affects low birthweight babies. The recommended treatments were the drugs in question as a first line treatment, and surgery as an alternative.

[3] 650 F.3d at 1237.

[4] *Id.*

[5] *See* the district court's opinion, 2010 WL 3810015 at *8-9(D.Minn. Aug. 31, 2010).

[6] *Id.*

[7] *See Id.*, fact finding ¶95.

[8] The district court also observed:

> As of March 2009, of the hospitals in the United States that purchased either NeoProfen or Indocin IV, 51% purchased only Indocin IV; approximately 42% purchased both Indocin IV and NeoProfen; and approximately 5% purchased

The district court also listened to the testimony of several neonatologists at various hospitals and other facilities who were involved in drug use or purchase decisions. Some testified that in their view NeoProfen was safer and that they used it almost exclusively. Others testified that they believed both drugs were acceptable. Some physicians testified that the cost of a drug did not factor into their treatment decisions. Some testified that they were not even aware of drug costs when they made treatment decisions.

Finally, the district court also heard but was apparently unpersuaded by evidence that in its marketing development plans Lundbeck used a color-coded red-yellow-green system to divide customers into groups based on their perceived commitment to one or the other drug, with the yellow group in the middle deemed to be customers who were in play for both drugs.[9]

The district court appeared to assume that those testifying that drug pricing was irrelevant or unimportant to their decision were "right," while those testifying that they regarded the two drugs as competing were testifying inconsistently and thus were "wrong." But product differentiated markets do not work in that fashion. Different customers make decisions for different reasons. Some may be extremely sensitive to price, while others are not.

Further, often the fickleness of a fairly small number suffices to make a price increase unprofitable. It is quite possible, for example, that in response to Alpha product's price increase, only 20 percent of marginal customers would switch to a differentiated product Beta,[10] while the remaining 80 percent would not switch. However, the price increase could still be unprofitable if the loss from the switchers exceeded the gains from the non-switchers. This is particularly likely to be true if price/cost margins are very high, as they were in this case.[11] Eighty percent of the customers could testify that they would not switch, but the two drugs would still be competitors. In this case the dramatic price increases alone were sufficient evidence of decreased competitive pressure to justify condemning a merger that did not even arguably produce any efficiencies.

Customer testimony about product decisions is generally unreliable.[12] Such questioning seldom reveals more than snapshots of a person's immediate instincts, while pricing pressure operates over more extended time periods and forces buyers to rank other priorities. This is

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only NeoProfen. The remainder is unknown. Indocin IV accounts for approximately 60% and NeoProfen accounts for approximately 40% of the Indocin IV and NeoProfen used in the United States.

[9] *See* Brief for Plaintiffs-Appellants FTC and State of Minnesota, FTC v. Lundbeck, Inc. 2010 WL 5558180 (Dec. 27, 2010) at *37. The district court did not mention the color-coding system.

[10] The FTC noted that such marginal customers existed. *See id*. at *25, *36-37. *See id*. at 38: "Even where cross-elasticity is low, a single company owning the only two alternatives has the ability and incentive to profitably raise price, because it recaptures the revenues from sales lost by one product to the other."

[11] For example, suppose that costs are $10 and the price is $85, producing 100 sales. The firm than raises the price to $100 and loses only 20 sales, while the remaining 80 pay the higher price. Profits before the switch are $75 x 100, or $7500. Profits after the switch are $90 x 80, or $7200. By acquiring the product to which the substitutors switched, the firm would be able to recapture all or a significant part of these losses.

[12] *See* 2B PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶538b (3d ed. 2007).

particularly likely in cases involving third party payors, who might make adjustments in drug assignment and payout protocols only after a periodic review process. Nonetheless, some, and perhaps most, health insurers and other health plans use methods to steer physicians toward more cost effective drugs.[13] In this case, the price increases that followed the acquisition were market evidence far more convincing than anything that testimony could provide.

Customer testimony is particularly unreliable when products are differentiated, because different customers respond differently to relative price changes. The result is that one customer's testimony cannot be used as a surrogate for that of other customers. A small sample of customers, such as those who testified in *Lundbeck*, could truthfully testify that they would not switch. Yet a merger that eliminated a close substitute could produce a significant price increase by eliminating the choices of other customers.

The following statement in the district court's decision indicates that the court did not appreciate the difference between price setting in differentiated and undifferentiated markets:

> Were NeoProfen and Indocin IV in the same product market, Lundbeck's attempt to persuade neonatologists to switch from Indocin IV to NeoProfen would not make sense.[14]

It might well be true in the market for an undifferentiated product such as cement, persuading a customer to switch from one producer to another would not make sense. But that is hardly the case of differentiated products. For example, Mercedes and BMW are very likely in the same product market for antitrust purposes, but individual customers may have enthusiastic preferences for one of them or the other. As a result car dealers persuade vigorously for their business. The presence of even a minority of customers who are sensitive to price and prepared to switch may substantially limit the ability of one to raise prices.

In sum, all of those testifying on the issue could have been correct but the two products were still in the same market, as the pricing evidence indicates. Indeed, one might say the same thing that the district court said about Lundbeck's color-coding system. If no customers regarded the two drugs as substitutes it would not make sense for Lundbeck to monitor the vulnerability of customers to switching between the two drugs.

As the Eighth Circuit described the relationship between the acquisition and the price increase:

> According to Lundbeck's internal documents, it anticipated that a dramatic price increase of Indocin IV would draw generic competitors into the market. As a result, it ceased promoting Indocin IV, focusing instead on increasing the market share of NeoProfen—as a superior PDA treatment. The FTC argues that this business strategy—to market NeoProfen as better than Indocin IV—means that Lundbeck viewed NeoProfen as a direct competitor to Indocin IV, and thus the drugs must be in the same product market. However, Lundbeck's strategy to discontinue promoting Indocin IV in favor of NeoProfen can also be interpreted

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[13] *See*, e..g, http://www.oregon.gov/OHA/healthplan/tools_prov/pdl.shtml (describing Oregon Health Plan preferred drug list); http://www.shpnc.org/myPharmacyBenefits/default.aspx (similar, North Carolina); http://cchealth.org/health_plan/pdl.php (similar; Contra Costa Health Services Plan).

[14] *Lundbeck*, 2010 WL 3810015, fact finding ¶116.

> to mean that while Indocin IV was vulnerable to generics, NeoProfen was not, and thus the products are not interchangeable. If there are two permissible views of evidence, the factfinder's choice between them is not clearly erroneous.[15]

But the alternative strategy that the Eighth Circuit described and that the district court accepted was just as anticompetitive as the FTC's theory. Lundbeck, facing the prospect that its existing drug was susceptible to generic entry, acquired the newer drug, stopped promoting its older drug in order to induce users to switch, and began charging a much higher price for the newer drug, given the lack of price competition from the older one. That scenario makes the merger no less harmful.

In any event, if the two drugs were not in the same relevant market, then each one was very likely a monopoly, because the two were the only drugs approved for the heart condition in question. While surgery was an option, it would use radically different technologies, and in this case the drugs were clearly the preferred course of action.[16]

A monopolist's acquisition of a nascent rival is just as much a source of competitive concern as a merger of two firms currently producing in the same market.[17] To be sure, a dominant firm may sometimes require the productive assets of a nascent rival in order to improve its own technology or keep it up to date. Extreme care must be taken, however, lest such acquisitions become devices for shutting out the only viable avenues toward greater competition.

For that reason a monopolist should be permitted to acquire only a nonexclusive license to a patent within the area of its power.[18] In this case there was no claim to be made that the defendant's acquisition of the second drug was necessary for efficient production or distribution. The acquisition. plus the subsequent price increases. indicated that its only purpose was to prevent competition with a nascent rival and prolong a dominant position in the face of possibly increasing generic entry.[19]

The court also rejected the use of what it termed a "hypothetical" market in which the merger had not occurred.[20] In fact, however, *all* merger analysis involves the use of hypothetical markets that postulate alternatives in which the merger did or did not occur. The "may … substantially lessen competition" standard in §7 of the Clayton Act contemplates that the fact

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[15] *Lundbeck*, 650 F.3d at 1242, citing Anderson v. City of Bessemer City, 470 U.S. 564, 574 (1985).

[16] That is to say, one must not commit the "Cellophane" fallacy of putting the drugs and the surgery in the same market simply because they exhibited some substitution for one another, but without considering whether current prices were already well above cost. Presumptively, products using significantly different technologies belong in different markets. *See* 2B Antitrust Law ¶539. *See also* United States v. H&R Block, Inc., ___ F.Supp.2d ___, 2011 WL 5438955 (D.D.C., November 10, 2011) (computer tax preparation programs not in same market as commercial tax preparation services).

[17] *See* 4 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶912 (3d ed. 2009).

[18] *See* 3 *id.*, ¶707g (3d ed. 2008).

[19] The strategy resembles one used via tying when a dominant firm in a current technology tries to roll that position into one of dominant in a successor technology. *See* 9 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶1703d, 1729d2 (3d ed. 2011).

[20] *Lundbeck*, 650 F.3d at 1240-1241 & n.3.

finder must consider movement from the situation that currently exists to a hypothetical one that would otherwise exist. If the case involves a pre-acquisition challenge, then the hypothetical market is the one in which the merger has occurred; if it involves a post-acquisition challenge such as this one, then the hypothetical market is the one prior to the merger. That is to say, the word "lessen" implies movement, and one cannot assess movement without hypothesizing a position that is different from the current one.

Finally, the *Lundbeck* decision yields the perverse result that it makes condemnation of a merger more difficult in precisely the situations where the market is less sensitive to price increases—namely, where the decisions are made by persons who are not sensitive to pricing. Although the physicians who write prescriptions are not out of pocket, and many may be insensitive to price in the short run, eventually they will respond to the pressures imposed by insurers, other prepaid health care providers, and even state law.[21] However, their stickiness in responding calls for greater, not less, competitive scrutiny.

III. CONCLUSION

Most mergers that are subject to challenge occur in markets that exhibit some degree of product differentiation. The analytic problems of the *Lundbeck* case lie principally in an attempt to use a model of perfect competition in a setting where it does not apply. The fact that the two drugs at issue in *Lundbeck* were not identical bioequivalent competitors suggests strongly that user responses will be arrayed over time and space in a complex fashion. This is not a situation in which virtually all customers immediately drop one brand in response to the other's price cut, or where none of them does.

As soon as we know that differentiation exists it makes little sense to state categorically that two products are not in the same market until we can ascertain with some certainty that the demand for one is unresponsive—across the full range of consumers—to the price of the other. As soon as we know that some customers are on the margin, however, then it becomes necessary to determine whether they are a sufficient constraint on pricing to warrant merger concern. The post-merger price increase in this case provides a clear answer. In a situation such as *Lundbeck*, where the drug treatments in question were the only two available options and price/cost margins were very high, condemnation should have been an easy call.

[21] *See* the websites mentioned in note 13, *supra*; *and see* Robert N. Sahr, *The Biologics Price Competition and Innovation Act: Innovation Must come Before Price Competition*, 2009 B.C. INTELL. PROP. & TECH. FORUM 070201 (July 19, 2009) (summarizing state laws compelling generic substitution).