2013

Sacrificial Lambs: Compensating First Subscribers to FDA-approved Medications for Postmarketing Injuries Resulting from Unlabeled Adverse Events

Rodney K. Miller

Follow this and additional works at: http://scholarship.law.edu/lawreview

Part of the Consumer Protection Law Commons, Health Law Commons, Litigation Commons, and the Torts Commons

Recommended Citation
Available at: http://scholarship.law.edu/lawreview/vol62/iss2/4

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Catholic University Law Review by an authorized administrator of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.
Sacrificial Lambs: Compensating First Subscribers to FDA-approved Medications for Postmarketing Injuries Resulting from Unlabeled Adverse Events

**Cover Page Footnote**
Assistant Professor of Law, Atlanta's John Marshall Law School; J.D., magna cum laude, and Order of the Coif, University of Pittsburgh School of Law, 2005; A.B., University of Michigan, 1995. This Article is dedicated with all of my love to my daughters Zoë Solène and Ainslie Jane Miller, in whose beautiful, wondrous, and constantly searching eyes I have found favor, and from whom I know all things are possible.

This article is available in Catholic University Law Review: http://scholarship.law.edu/lawreview/vol62/iss2/4
SACRIFICIAL LAMBS: COMPENSATING FIRST SUBSCRIBERS TO FDA-APPROVED MEDICATIONS FOR POSTMARKETING INJURIES RESULTING FROM UNLABELED ADVERSE EVENTS

Rodney K. Miller

I. IDENTIFYING UNKNOWN ADVERSE DRUG REACTIONS IN THE POSTMARKETING PERIOD ............................................. 437
   A. The FDA’s Pharmacovigilance Program Before 2007 .......................................................... 438
   B. Improved Detection Through the FDAAA and Sentinel System ........................................... 445
   C. Cracks in the Façade: The FDAAA’s 10,000-Patient Donut Hole ........................................... 447
      1. Protections Afforded Clinical Trial Participants ................................................................. 448
      2. Protections Denied First Subscribers Post-FDAAA ............................................................ 450

II. AN ARGUMENT AGAINST EITHER TORT LITIGATION OR THE INSURANCE INDUSTRY PROVIDING RELIEF FOLLOWING UNLABELED POSTMARKETING INJURIES .......................................................... 452
   A. The Inherent Inequality of Recovery from Litigation ........................................................... 453
   B. The Undisclosed Burden on Public and Private Insurance—Shifting Costs to Responsible Parties ......................................................................................................................... 458

III. PROPOSING A NO-FAULT ALTERNATIVE ................................................................. 460
   A. The Rationale for Adopting an Administrative Claims Fund .................................................. 462
   B. Considerations in Adopting a No-Fault System ................................................................. 463
      1. Eligibility .................................................................................................................. 464
      2. Administration and Funding ...................................................................................... 468
      3. Limitations on Recovery .......................................................................................... 470

* Assistant Professor of Law, Atlanta’s John Marshall Law School; J.D., magna cum laude, and Order of the Coif, University of Pittsburgh School of Law, 2005; A.B., University of Michigan, 1995. This Article is dedicated with all of my love to my daughters Zoë Solene and Ainslie Jane Miller, in whose beautiful, wondrous, and constantly searching eyes I have found favor, and from whom I know all things are possible.
IV. CONCLUSION

In recent years, the U.S. Food and Drug Administration (FDA) and the pharmaceutical industry have become easy targets for society’s growing distrust of the federal government’s ability to protect its citizens from serious health risks. Whether because of reports of the FDA’s repeated failures to identify serious adverse effects associated with prescription medications or because of stories of pharmaceutical manufacturers withholding safety data and falsifying trial results to gain marketing approval, the public’s confidence in the industry and its regulators has dissipated. Perhaps the public is correct.

The majority of Americans believe that an FDA approval equates to “the Good Housekeeping seal of approval.” In reality, however, at the time of approval and introduction into the open market, prescription medications carry significant, unknown health risks. When these adverse effects are ultimately discovered, the results can be catastrophic. For example, in 2007, eight years after receiving marketing approval from the FDA, the diabetes drug Avandia was found to increase the risk of heart attacks in patients taking the medication. In 2006, thirteen years after FDA approval, the medication Trasylol—used to reduce bleeding during surgery—was found to increase the risks of kidney failure, heart attack, and stroke. In 2004 and 2005, four and five years after their initial approvals, respectively, Cox-2 inhibitors Bextra and Vioxx were withdrawn from the market after it was discovered that they

4. See infra notes 6–10 and accompanying text (providing examples of cases in which drugs with unknown side effects were approved).
5. See Evans, supra note 1, at 429–30 (explaining the negative consequences for patients taking drugs with unknown harmful effects).
7. Dennis T. Mangano et al., The Risk Associated with Aprotinin in Cardiac Surgery, 354 NEW ENG. J. MED. 353, 361 (2006); Kris Hundley, Researcher Beat Pfizer, Then Lost to It, ST. PETERSBURG TIMES, Sept. 26, 2009, at 1A.
increased the risks of heart attack and stroke. In total, millions of patients were potentially exposed to risks that they might otherwise have avoided if the serious side effects were discovered earlier.

Unfortunately, these examples cannot be dismissed as isolated incidents. Postmarketing discovery of adverse effects is common and continues today. Moreover, the significance of these later-discovered side effects might be marginalized were it not for the enormity of the patient population impacted. In some cases, a single drug will have been prescribed to millions of patients for years before a serious, previously unknown adverse effect is discovered. If one was able to pinpoint the cause of the FDA’s inability to detect these health risks before approval, the problem of postmarketing discovery of adverse effects might be eliminated altogether. Instead, to borrow from the medical lexicon, a constellation of factors ultimately contributes to the present reality that as many as half of all approved drugs have an unknown side effect when released.

Critics have accused the FDA of an inability—be it through underfunding, understaffing, general incompetence, or collusion with manufacturers—to
require sufficient pre-approval clinical testing of medications to monitor sufficiently manufacturers’ compliance with those tests or to monitor adequately the safety of approved medications once on the open market.22

Given the FDA’s conflicting mandate: “[to get] new[,] safe[,] and effective drugs to market quickly and efficiently,” the drug approval process vis-à-vis safety assessment lends itself to second-guessing.23 In light of the failures of adverse event detection, this mandate could suggest that the FDA has made a conscious decision to emphasize expediency at the expense of safety.24 Like materials for information on accuracy, safety, and efficacy); 153 Cong. Rec. 25,038 (2007) (statement of Sen. Edward Kennedy) (noting that the 2006 revenues for a single prescription drug were more than two hundred times the entire FDA budget dedicated to postmarketing surveillance for the same time period).

19. Should FDA Drug and Medical Device Regulation Bar State Liability Claims?: Hearing Before the H. Comm. on Oversight & Gov’t Reform, 110th Cong. 7 (2008) (statement of Rep. Tom Davis, Member, H. Comm. on Oversight & Gov’t Reform); see also Tom Costello, 100 Days Later, Nation Waits for FDA Overhaul, NBCNEWS.COM (April 26, 2009, 12:33:50 AM), www.nbcnews.com/id/30388073/#.UTpDZfJBA78 (suggesting that the FDA can only inspect one percent of imported foods because of a lack of personnel).

20. Adequacy of FDA Hearings, supra note 14, at 60 (testimony of David J. Graham, Associate Director, Science and Medicine, FDA Office of Surveillance and Epidemiology) (claiming that the FDA’s failure to protect the public health was rooted in its institutional decision-making process).

21. Id. (arguing that the FDA improperly regards the pharmaceutical industry as a client).

22. Efthimios Parasidis, Patients over Politics: Addressing Legislative Failure in the Regulation of Medical Products, 2011 Wis. L. Rev. 929, 932 (“FDA epitomizes ‘the hollow government syndrome—an agency with expanded responsibilities, stagnant resources, and the consequent inability to implement or enforce its statutory mandates.’”) (quoting Peter Barton Hutt, The State of Science at the Food and Drug Administration, 60 Admin. L. Rev. 431, 432 (2008))).


24. As further proof of the FDA’s commitment to expediency, Congress enacted the Food and Drug Administration Modernization Act (FDAMA) in 1997, which codified the FDA’s longstanding practice of fast-tracking approval of a drug that has the potential to address unmet needs for a serious or life-threatening condition. Food and Drug Administration Modernization Act of 1997, Pub. L. No. 105-115, § 112, 111 Stat. 2996, 2309–10 (codified at 21 U.S.C. § 356 (2006)); see also Charles Steenburg, The Food and Drug Administration’s Use of Postmarketing (Phase IV) Study Requirements: Exception to the Rule?, 61 Food & Drug L.J. 295, 330 & n.360 (2006) (citing S. Rep. No. 105-43, at 43 (1997)). By definition, drugs approved on a fast-track basis have been proven neither safe nor effective, but rather are approved based on a “predict[ed] clinical benefit.” 21 U.S.C. § 356(b)(1); see also id. § 356(b)(2) (authorizing the FDA to condition approval on postmarketing studies that confirm a clinical benefit); id. § 356(b)(3)(B)–(C) (authorizing the FDA to withdraw approval if postmarketing data shows no clinical benefit or finds the product unsafe or ineffective).

Those who would take issue with the expedited approval process must also note that the fast-track approval guidelines themselves were the direct result of criticism of Congress’s
their counterpart in the drug approval process, manufacturers have done little
to engender support from the public, routinely withholding safety data from the
FDA.25

In the case of Avandia, both the FDA and GlaxoSmithKline (GSK), the
drug’s manufacturer, overlooked clinical trial data that supported a link
between the medication and heart attacks, leaving a third party to discover the
risk when it analyzed the publicly available data.26 Evidence further suggested
that GSK conducted an earlier safety study that identified the cardiac risks at
issue, but suppressed the data and did not submit it to the FDA.27 Similarly,
Bayer, Trasylol’s manufacturer, was found to have withheld information from
the FDA study that suggested a link between its medication and the increased
risks of heart attack and stroke.28 Likewise, in the case of Cox-2 inhibitors, not
only have critics suggested data withholding by the manufacturers,29 but they
have further alleged that the FDA was complicit in the data suppression,
asserting that it was aware of the data’s absence yet did nothing to expose
publicly the drug’s risks.30

The purpose of this Article is not to disparage the FDA or the
pharmaceutical industry. Rhetoric and animus do not improve public health

mid-twentieth century strengthening of FDA regulations to require “proof of safety and efficacy
for all new drugs,” which critics viewed as preventing patients suffering from life-threatening
illnesses from timely receiving treatment. See, e.g., Parasidis, supra note 22, at 942–44;
Steenburg, supra note 24, at 319 (“In the case of HIV and cancer treatments that conceivably
could extend the lives of patients without any other options, withholding approval potentially
consigned patients to a premature grave. The corresponding risk of subjecting patients to the side
effects of drugs that failed to live up to their original billing struck many people—particularly
patients themselves—as comparatively trivial.”).

25. See Gardiner Harris, Drug Maker Hid Test Data, Files Indicate, N.Y. TIMES, July 13,

26. Id. (“The heart risks from Avandia first became public in May 2007, with a study from a
cardiologist at the Cleveland Clinic who used data the company was forced by a lawsuit to post
on its own Web site.”).

27. Id.

28. Building a 21st Century FDA: Proposals to Improve Drug Safety and Innovation:
(statement of Jim Guest, President and Chief Executive Officer, Consumers Union) (noting that
Trasylol’s manufacturer, Bayer, withheld from the FDA news of a study that showed an increased
risk of “death, serious kidney damage, congestive heart failure and stroke”).

29. Paid toPrescribe? Exploring the Relationship Between Doctors and the Drug Industry:
S. Hearing Before the Special Comm. on Aging, 110th Cong. 50 (2007) [hereinafter Paid to
Prescribe Hearing] (testimony of Peter Lurie, Deputy Director, Public Citizen’s Health Research
Group, Washington, D.C.) (noting Pfizer’s publication of incomplete trial data on its drug,
Celebrex, because Pfizer knew the full data set was not persuasive in demonstrating the drug’s
benefit).

30. Id.; see also Adequacy of FDA Hearings, supra note 14, at 75–76 (testimony of David J.
Graham, Associate Director, Science and Medicine, FDA Office of Surveillance and
Epidemiology) (discussing data suppression).
any more than they serve as a deterrent to those who would undermine it.\textsuperscript{31} Rather, to better serve the public welfare as it relates to FDA-approved medications, focus must be on rapid identification of all serious health risks associated with marketed pharmaceuticals, thereby reducing unexpected injuries and compensating those injured by the formerly unknown risks.\textsuperscript{32} To this end, Congress and the FDA took a significant step forward in achieving rapid detection of unknown, serious health risks in marketed medications in 2007.\textsuperscript{33} The Food and Drug Administration Amendments Act of 2007 (FDAAA)\textsuperscript{34} marked a change in the agency’s supervision of pharmaceutical manufacturers and, particularly, its regulation and enforcement of postmarketing surveillance of FDA-approved medications.\textsuperscript{35}

Before 2007, the FDA was limited in its ability to monitor a medication’s safety after granting marketing approval.\textsuperscript{36} Although the FDA served as a repository for postmarketing adverse-event data reported by manufacturers, physicians, and patients through its Adverse Event Reporting System (AERS) database,\textsuperscript{37} before 2007 the FDA did not routinely monitor the database for evidence of a drug’s previously unknown side effects.\textsuperscript{38} Further, the AERS database was limited in its information pool.\textsuperscript{39} To make matters worse, when a possible unlabeled side effect was identified, the FDA lacked authority to require the manufacturer to conduct postmarketing trials to determine

\textsuperscript{31} Cf. Robert H. Eckel & Ronald M. Krauss, American Heart Association Call to Action: Obesity as a Major Risk Factor for Coronary Heart Disease, 97 CIRCULATION 2099, 2099–100 (1998) (urging action on the part of healthcare providers, legislators, insurers, and the public so that effective treatments could be formed).

\textsuperscript{32} Robert G. Hauser, Here We Go Again—Another Failure of Postmarketing Device Surveillance, 366 NEW ENG. J. MED. 873, 874 (2012).


\textsuperscript{34} Id.

\textsuperscript{35} See id. § 905, 121 Stat. at 944–45.

\textsuperscript{36} In actuality, postmarketing surveillance was entrusted almost exclusively to the manufacturers. See, e.g., Laura B. Faden & Christopher-Paul Milne, Pharmacovigilance Activities in the United States, European Union and Japan: Harmonic Convergence or Convergent Evolution?, 63 FOOD & DRUG L.J. 683, 686 (2008) (stating that, under previous law, the industry was responsible for any surveillance activities).


\textsuperscript{38} See, e.g., Struve, supra note 23, at 601 (citing a 2002 internal FDA survey, which found that respondents were not confident in the monitoring process once drugs were approved and that the FDA was incapable of monitoring or acting on gathered information).

\textsuperscript{39} See discussion infra Part I.A. Specifically, the database was not linked to other patient information sources (such as Medicare and insurance company databases) across which searches could identify entire patient populations that were prescribed a suspected drug. See, e.g., 153 CONG. REC. 25,163 (2007) (statement of Sen. Judd Gregg).
The FDA also lacked the ability to require the manufacturer to change the drug’s label to warn consumers of newly discovered risks.\(^{41}\)

Through passage of the FDAAA, Congress required the FDA to “conduct regular, bi-weekly screening[s] of the [AERS] database, and post quarterly reports on the AERS website of any new safety information or potential signal of serious risk identified within the last quarter.”\(^{42}\) Congress ordered the FDA to develop and implement a single, comprehensive data network of patient healthcare information, including all serious adverse drug experiences,\(^ {43}\) which would become known as the Sentinel System and would contain at least 100 million patients’ data by July 1, 2012.\(^ {44}\) Congress authorized the FDA to require that manufacturers conduct postmarketing clinical trials when a previously unknown safety risk is identified and to make the suspect drug’s continued marketing contingent upon completion of the required analysis.\(^ {45}\) Further, Congress empowered the FDA to require drug manufacturers to change their labels.\(^ {46}\)

Despite the number and significance of the changes to the FDA’s regulatory authority, the FDAAA forsakes or, at best, ignores those patients first exposed to FDA-approved medications—patients whose reactions to the medications make the FDAAA’s amplified postmarketing surveillance system relevant and effective.\(^ {47}\) Even with the FDAAA’s increased focus on postmarketing surveillance, the FDA will not be able to eliminate unknown adverse effects before a percentage of patients has experienced the side effects after the drug has been approved for marketing.\(^ {48}\) In fact, the Sentinel System is specifically designed to discover previously unknown adverse events post-marketing.\(^ {49}\)

---

41. See id. at 25,163–64 (statement of Sen. Judd Gregg) (finding that the FDA now has express authority to accomplish this).
43. A “serious adverse drug experience” is defined as any adverse event associated with a drug that results in death, immediate risk of death, hospitalization, incapacity, birth defect, etc. 21 U.S.C. § 355-1(b)(1), (4) (Supp. IV 2011).
44. Id. § 355(k)(3); see also Parasidis, supra note 22, at 951–52 (describing the FDAAA’s requirement to track postmarket safety concerns). In response, the Sentinel Initiative was created, which “aims to create a nationwide electronic reporting system for monitoring medical product safety.” Id.
46. Id. § 355(o)(4)(E).
47. See, e.g., 153 CONG. REC. 25,162–63 (2007) (statement of Sen. Michael Enzi) (giving several examples of how the bill expands the FDA’s ability to handle safety problems occurring post-approval, including requiring label changes).
48. Hauser, supra note 32, at 874 (describing the current surveillance system as “passive”).
49. See id. (characterizing the Sentinel Initiative as “active,” and detailing the real-time network’s intent to identify safety concerns in a timely manner).
Discovery of these effects will always lag behind the injuries that make their detection possible. Thus, a drug’s first subscribers unwittingly serve as participants in the drug’s extended “clinical trial,” but without the disclosures and protections normally afforded to such participants. When new side effects are identified postmarketing, these first subscribers are left without recourse for their injuries.

Rather than relying on the lengthy and fickle litigation process for compensation or further burdening an insurance network at its breaking point, an alternative compensation scheme must be implemented to compensate for injuries caused by a drug’s unknown side effects. Accordingly, this Article proposes the creation of an FDA-administered fund from which injury claims attributable to unlabeled adverse effects of FDA-medications would be paid. Not unlike state and federal workers’ compensation plans, the fund would insure people who suffer injury from an unlabeled side effect after taking an FDA-approved medication. This compensation system would be funded entirely by pharmaceutical manufacturers, with contribution to the fund a prerequisite of drug approval.

This Article proceeds as follows. Part I of this Article details the FDA’s postmarketing surveillance authority pre-FDAAA and the significant changes that the Act and its incorporated Sentinel System provided to the FDA’s ability to monitor medications on the open market. Part II explains why the legal system fails to sufficiently compensate those injured by prescription medications, regardless of the manufacturer’s level of fault. Part II further explores the stress placed on public and private insurance plans to budget for and compensate parties following injuries from unknown risks. Part III proposes the adoption of a no-fault compensation system that would replace

51. See infra Part I.C.
52. See infra Part II (finding that neither tort nor insurance claims sufficiently protect first subscribers to newly approved medications).
53. This Article proposes that the alternative compensation scheme articulated herein should apply only to those expenses incurred by consumers in the open market following injury from an unlabeled adverse event occurring in the postmarketing period. When known side effects of a marketed drug are disclosed in a product’s labeling, a physician can make an informed decision as to whether or not to prescribe the drug to a patient and warn the patient about the possible side effects; insurers can plan for labeled risks and fund accordingly. See, e.g., Parasidis, supra note 22, at 932 (“If marketed products contain unreliable risk-benefit disclosures, providers are unable to evaluate treatment options accurately and the ability of patients to provide informed consent is compromised.”). Conversely, clinical trial participants knowingly consent to experimental treatment on the understanding that their participation will help discover unknown health risks, which the FDA will use to warn physicians and patients following marketing approval. This Article addresses those patients who bridge the gap between these two groups—that is, those who do not consent to experimental therapy but are also without complete knowledge of all potential risks associated with a drug at the time of prescription.
54. See infra Part III.A.
55. See infra Part III.B.2.
litigation and insurance as the primary source of recompense for unlabeled drug-related injury and addresses several key considerations in implementing such a plan.

I. IDENTIFYING UNKNOWN ADVERSE DRUG REACTIONS IN THE POSTMARKETING PERIOD

“Despite [the FDA’s] vigilant premarket review, . . . all possible side effects of a drug can’t be anticipated based on preapproval studies involving only several hundred to several thousand patients . . . .”56 Stated more bluntly, virtually every drug approved by the FDA for marketing in the United States contains undiscovered health risks that will only become known after the drug is exposed to a larger patient population.57 For this reason, “[a] vital part of [the FDA’s] mission is to monitor the safety and effectiveness of drugs that are currently available to the American people.”58 Until 2007, however, the FDA’s ability to conduct postmarketing surveillance was hampered by a lack of complete access to healthcare data.59 Contrary to its common meaning, the FDA’s postmarketing surveillance was reactionary and dependent upon others to notify it of potential adverse health effects.60 As a result, although the FDA could monitor the safety of approved drugs retroactively, it could not protect initial consumers of newly approved medications by detecting latent risks; it could only notify the public of newly discovered risks after unknown side effects were reported.61

56. Postmarketing Surveillance Programs, U.S. Food & Drug Admin., http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/ucm090385.htm (last updated Aug. 19, 2009); see also Evans, supra note 1, at 456 (discussing the delicate ethical balance between the necessity of testing drugs before approval and the need to quickly introduce new drugs to the market).

57. Struve, supra note 23, at 598–99 (stating that premarket studies are not foolproof and inevitably miss a side effect or complication).


60. “Surveillance” is defined as to “watch” or to “guard” against. Oxford English Dictionary 309 (2d ed. 1989). Before 2007, the FDA’s postmarketing surveillance system was a wholly passive one. See Sentinel 2010 Report, supra note 59, at 1–2, 4 (describing adverse-event surveillance systems as passive because, for the FDA to be aware of a drug’s adverse effects, it relies on and require recognition and reports of safety concerns); see also, e.g., Anna B. Laakmann, Collapsing the Distinction Between Experimentation and Treatment in the Regulation of New Drugs, 62 Ala. L. Rev. 305, 337 (2011) (arguing that the FDA’s surveillance program is reactive and lacks the FDA’s “systematic rigor” characteristic of its approval process); Parasidis, supra note 22, at 950 (stating that the FDA has consistently relied on passive surveillance methods).

61. Parasidis, supra note 22, at 948 (outlining the enactment of the FDAAA).
A. The FDA’s Pharmacovigilance Program Before 2007

Until 2007, the FDA’s postmarketing surveillance of approved drugs consisted almost exclusively of its Adverse Event Reporting System (AERS). The AERS database comprises information received both from manufacturers, who must report to the FDA, and from healthcare professionals, consumers, and patients that report information voluntarily. Federal regulations require pharmaceutical manufacturers to report to the FDA all adverse experiences “associated with the use of a drug in humans.” Specifically, a manufacturer’s postmarketing surveillance obligations include, but are not limited to:

- Prompt review of “all adverse drug experience information obtained or otherwise received by the [manufacturer] from any source . . . .”
- Development of “written procedures for the surveillance, receipt, evaluation, and reporting of postmarketing adverse drug experiences to [the] FDA.”

62. See Prescription Drug User Fee Act (PDUFA): Adding Resources and Improving Performance in FDA Review of New Drug Applications, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/ForIndustry/UserFees/PrescriptionDrugUserFee/ucm119253.htm (last updated May 3, 2010) [hereinafter PDUFA White Paper] (stating that the AERS database provided the FDA with most of its postmarketing safety data before the FDAAA was passed); see also Parasidis, supra note 22, at 950 (characterizing the AERS database as the FDA’s “primary source” for postmarketing safety data).

63. FDA Adverse Event Reporting System, supra note 37; see also Laakmann, supra note 60, at 337 (“FDA postmarketing monitoring involves a system of mandatory reporting of adverse drug reactions (ADRs) by manufacturers and voluntary ADR reporting by health professionals and patients.”). However, no affirmative duty to search for adverse events exists. Parasidis, supra note 22, at 950; see also Laakmann, supra note 60, at 337 (stating that firms must only disclose those adverse effects reported by physicians and consumers). Consequently, some commentators criticize the FDA’s postmarketing surveillance program as encouraging drug manufacturers to sit on their hands rather than actively pursue safety information on their products. See, e.g., Struve, supra note 23, at 602 (declaring that drug manufacturers are disincentivized from identifying adverse drug effects because disclosing such information may harm the business).

64. 21 C.F.R. § 314.80(a), (c) (2012). Federal regulations require that manufacturers submit all adverse event reports to the FDA on Form FDA 3500A or a comparable form or electronic format. Id. § 314.80(f). This form requires manufacturers to report: (1) patient identifying information, including age, sex, and weight at the time of the event; (2) the adverse event experienced and subsequent outcome (e.g., death); (3) the date of the event; (4) a description of the event; (5) relevant patient laboratory data; (6) other relevant patient medical history; (7) the suspect drug, including dose, frequency of use, administration method, therapy dates, and reason(s) for use; and (8) whether the event ceased after discontinuation of the drug and/or reappeared after reintroduction of the drug. See U.S. FOOD & DRUG ADMIN., FORM FDA 3500A, at 1, http://www.fda.gov/downloads/Safety/MedWatch/HowToReport/DownloadForms/ucm082728.pdf [hereinafter FORM FDA 3500A]. Although adverse event reports submitted voluntarily are not governed by similar federal regulation, the FDA established the MedWatch program in 1993 that allows physicians to submit adverse drug events electronically. Laakmann, supra note 60, at 337.

65. 21 C.F.R. § 314.80(b).
Disclosure of “each adverse drug experience that is both serious and unexpected” no later than fifteen days after receipt of the information.  
Disclosure of all other adverse drug experiences (i.e., either not serious, or expected, or both) “at quarterly intervals, for [three] years from the date of approval of the application, and then at annual intervals.”

Although seemingly comprehensive in the data captured, solely relying on AERS as a postmarketing risk-detection tool proves the inability to detect unknown health risks, undermining the AERS database’s effectiveness.

Postmarketing surveillance exists to ensure that accurate and comprehensive warnings regarding a product’s safety are disseminated upon the detection of a health risk. As required by federal regulation, a drug’s label must be updated to disclose clinically significant adverse reactions and other potential safety hazards when a causal connection has been established with the drug, though such causation does not have to be definitive. Problematically, however, adverse event reports by themselves cannot be used to establish a causal link between the medication and injury.

Before 2007, the FDA’s pharmacovigilance program “principally involve[d] the identification and evaluation of safety signals,” which are defined as “an excess of adverse events compared to what would be expected to be associated with a product’s use.” A signal’s identification is derived from analysis of

66. Id.
67. Id. § 314.80(c)(1)(i). The regulations define “serious adverse drug experience” as one that results in death, life-threatening injury, inpatient hospitalization, disability, or birth defect. Id. § 314.80(a). An “unexpected” experience is one not already listed in the labeling for the medication. Id.
68. Id. § 314.80(b)–(c).
69. See, e.g., Laakmann, supra note 60, at 338–39; Parasidis, supra note 22, at 951 (criticizing the FDA’s current postmarketing framework); Struve, supra note 23, at 603–05.
70. See Postmarketing Surveillance Programs, supra note 56.
72. FDA Adverse Event Reporting System, supra note 37 (describing the FAERS’s shortcomings and reasons why it cannot be used in calculating the incidence of an adverse medical error in the U.S. population); see also Struve, supra note 23, at 604 (arguing that a substantial number of adverse event reports received may not involve a causal link between the drug and the injury). These flaws are significant because, without proof of a causal relationship, a manufacturer is not required to warn of a health risk identified postmarketing. 21 C.F.R. § 201.57(c)(6)(i).
73. U.S. FOOD & DRUG ADMIN., GUIDANCE FOR INDUSTRY: GOOD PHARMACOVIGILANCE PRACTICES AND PHARMACOEPIDEMIOLOGIC ASSESSMENT 4 (2005) [hereinafter GOOD
adverse events (or “case reports”) submitted to the FDA by pharmaceutical manufacturers, healthcare professionals, or consumers and is stored in the FDA’s AERS database. 74 Yet, as previously mentioned, federal regulations only mandate that manufacturers75 report adverse events, 76 whereas healthcare providers and patients only report these events voluntarily. 77 Moreover, there is no control over duplication in AERS reporting. 78 As a result—and as the FDA readily admits—case reports are both under- and over-reported.79 Because the total number of adverse events is unknown and the total number of prescriptions can only be estimated, 80 a true incidence rate cannot be determined.81

PHARMACOVIGILANCE PRACTICES], available at http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM126834.pdf. The FDA defines pharmacovigilance “to mean all scientific and data gathering activities relating to the detection, assessment, and understanding of adverse events.” Id.

74. See FDA Adverse Event Reporting System, supra note 37.

75. 21 C.F.R. § 314.80(c)(1)(iii) (2012) (mandating that the section applies to those in the chain of supply, such as packers and distributors).

76. Id. § 314.80(c); see also FDA Adverse Event Reporting System, supra note 37 (“Reporting of adverse events from the point of care is voluntary in the United States.”).

77. FDA Adverse Event Reporting System, supra note 37. Because adverse event data reported from the point of care is voluntary, the data submitted to the FDA is woefully inadequate. See, e.g., Laakmann, supra note 60, at 338 (noting that physicians under-report adverse events to the FDA’s system and that such reports are only the “‘proverbial tip of the iceberg of drug reactions and interactions’” (quoting Barbara A. Noah, Adverse Drug Reactions: Harnessing Experiential Data to Promote Patient Welfare, 49 CATH. U. L. REV. 449, 469 (2000))); Parasidis, supra note 22, at 950–51 (noting that adverse event data reported voluntarily “account[s] for less than five percent of all reported adverse events”).

78. See Manfred Hauben et al., ‘Extreme Duplication’ in the US FDA Adverse Events Reporting System Database, 30 DRUG SAFETY 551, 551–54 (2007) (describing how a scientific study found that the data in the FDA’s AERS database is highly duplicated and identifying some explanations for such duplication).

79. See Lanh Green, Office of Surveillance and Epidemiology, Presentation to the 42nd Annual Meeting of the Drug Information Association: Postmarketing Pharmacovigilance Practice at FDA (June 21, 2006), available at http://www.fda.gov/downloads/AboutFDA/CentersOffices/CDER/ucm119101.pdf (citing both the failure to report adverse events and the duplication in reporting by multiple sources—e.g., manufacturers and healthcare professionals—as skewing the true number of adverse events associated with a medication).

80. See, e.g., Parasidis, supra note 22, at 951 (“[F]rom an epidemiological standpoint, ‘the FDA does not know how many people are using the drug’ and does not have adequate information about those who are.” (quoting David A. Kessler & David C. Vladeck, A Critical Examination of the FDA’s Efforts to Preempt Failure-to-Warn Claims, 96 GEO. L.J. 461, 490 (2008))).

81. See Adequacy of FDA Hearings, supra note 14, at 60 (statement of Steven E. Nissen, Chairman, Department of Cardiovascular Medicine, Cleveland Clinic Foundation) (“The post-marketing surveillance system for drugs and devices functions poorly. Adverse event reporting is voluntary and studies show that only 1 to 10 percent of serious adverse events are ever reported to the agency. Accordingly, the actual incidence of serious or life-threatening complications cannot be calculated accurately.”); see also FDA Adverse Event Reporting System, supra note 37 (“[T]he FDA does not receive reports for every adverse event or medical error that
Further complicating matters, adverse-event data does not account for confounding factors such as concomitant medications being taken by the patient and the attendant risks associated with those drugs.\textsuperscript{82} Additionally, the data neither provides for the overall health profile of the patient\textsuperscript{83} nor serves as proof that the patient actually suffered the reported injury.\textsuperscript{84} Therefore, occurs with a product. Many factors can influence whether or not an event will be reported, such as the time a product has been marketed and publicity about an event. Therefore, FAERS data cannot be used to calculate the incidence of an adverse event . . . in the U.S. population."). Moreover, even when adverse events are timely reported to the FDA, additional problems with assessment of the data can arise because the FDA does not require electronic submission of adverse event reports. See Adverse Events Reporting System (FAERS) Electronic Submissions, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Surveillance/AdverseDrugEffects/ucm115894.htm (last updated Sept. 10, 2012) (noting that electronic submissions of adverse effect reports are encouraged for their efficiency and cost-effectiveness). For those reports submitted on paper forms, data is manually coded into the AERS database, creating the potential for human error that an adverse event will be misclassified. See Postmarketing Safety Reports for Human Drug and Biological Products; Electronic Submission Requirements, 74 Fed. Reg. 42,184, 42,188 (proposed Aug. 21, 2009) (finding that conversion of paper-submitted reports to an electronic form is time consuming, expensive, and open to error); see also PDUFA White Paper, supra note 62 (stating that over 100,000 manufacturers’ reports must be converted to the FDA’s electronic database).

“The FDA’s inability to calculate ‘the true frequency of adverse events in the population,’ . . . ‘makes it hard to establish the magnitude of a safety problem, and it makes comparisons of risks across similar drugs difficult.’” Laakmann, supra note 60, at 338 (quoting U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-06-402, DRUG SAFETY: IMPROVEMENT NEEDED IN FDA’S POSTMARKET DECISION-MAKING AND OVERSIGHT PROCESSES 24–25 (2006)). As the FDA itself stated in discussing the evaluation of safety signals: “Like the proverbial search for a needle in a haystack, the number and variety of reports, together with the number and variety of products and the lack of reliable usage information, make it difficult to distinguish variability and noise from a real concern.” FOOD & DRUG ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., MANAGING THE RISK FROM MEDICAL PRODUCT USE: CREATING A RISK MANAGEMENT FRAMEWORK 67 (1999), available at http://www.fda.gov/downloads/safety/safetyofspecificproducts/ucm180520.pdf.

82. Although Form FDA 3500A asks the manufacturer to list all concomitant medications being used by the patient at the time of the adverse event, the report and the FDA analyst reviewing it are unable to distinguish which drug, if any, actually caused the event. Form FDA 3500A, supra note 64, at 1, 9.


84. For example, unverified claims of adverse drug experiences on which a lawsuit against a prescription drug manufacturer is premised nonetheless create an obligation on the part of the manufacturer to report those claimed events to the FDA. See 21 C.F.R. § 314.80(b)–(c) (2012) (obligating manufacturers to review and report “all adverse drug experience information obtained or otherwise received by the applicant from any source, foreign or domestic” (emphasis added)); see also, e.g., DRAFT POSTMARKETING SAFETY REPORTING, supra note 83, at 8 (requiring only
alternative causation theories cannot be dismissed. Accordingly, case reports do not provide sufficient information to determine a causal association between medication and adverse event.

Before 2007, the FDA’s principal postmarketing surveillance method could not reasonably demonstrate that an identified risk in fact bore any association to the medication at issue. Even when the FDA identified a potential health risk through the AERS database, it could not require or suggest a labeling change to the manufacturer on that basis alone. Pursuant to agency guidance documents, the FDA could only ask manufacturers to “evaluate individual case reports for clinical content and completeness . . . [and] look for features that may suggest a causal relationship between the use of a product and the adverse knowledge of an identifiable patient, reporter, suspect drug, and adverse outcome to trigger a reporting obligation on the part of the manufacturer).

85. Some critics of the FDA’s adverse-event reporting system suggest that voluntary reports issued from the point of care will be written to shift blame from the provider to the manufacturer, which can result in an erroneous perception of an increased number of adverse events attributable to the product itself, rather than to user error. See e.g., James T. O’Reilly, Pin the Tail on the Other Donkey: Allocating and Avoiding Injury Losses After Drug or Device Approval, 62 FOOD & DRUG L.J. 559, 562 (2007) (“The Medwatch form [3500A] sets the choice: ‘Product Problem’ or ‘Product Use Error;’ the device or drug’s failed result in the clinical setting is more likely to be attributed by the hospital risk manager to a ‘failed’ product.” (citation omitted)). But conversely, with consumers increasingly able to obtain prescription drugs over the Internet, the possibility that many adverse drug experiences will go unreported, due to the lack of physician involvement, increases exponentially. See Bryan A. Liang & Tim Mackey, Searching for Safety: Addressing Search Engine, Website, and Provider Accountability for Illicit Online Drug Sales, 35 AM. J.L. & MED. 125, 128–31 (2009).

86. Compare 21 C.F.R. § 314.80(a) (defining “adverse drug experience” as “[a]ny adverse event associated with the use of a drug in humans, whether or not considered drug related”) (emphasis added), with GOOD PHARMACOVIGILANCE PRACTICES, supra note 73, at 4 (stating that the “actual risk to patients cannot be known from [adverse event] data because it is not possible to characterize all events definitively and because there is invariably under-reporting of some extent and incomplete information about duration of therapy, numbers treated, etc.”). See also Rider v. Sandoz Pharm. Corp., 295 F.3d 1194, 1199 (11th Cir. 2002) (finding that case reports are only reported data and not based on any scientific methodology); Hall v. Baxter Healthcare Corp., 947 F. Supp. 1387, 1411 (D. Or. 1996) (stating that the lack of controls in case reports makes them unreliable as scientific means of establishing causation); Haggerty v. Upjohn Co., 950 F. Supp. 1160, 1165 (S.D. Fla. 1996) (noting that case reports cannot replace scientific studies); Casey v. Ohio Med. Prods., 877 F. Supp. 1380, 1385 (N.D. Cal. 1995) (finding that case reports do not provide reliable scientific evidence of causation).

87. See 153 CONG. REC. 25,162–63 (2007) (statement of Sen. Michael Enzi) (stating that the FDA has no active surveillance system in place to monitor adverse events and that its ability to monitor a drug is curbed after it has entered the market).

88. See 21 C.F.R. § 201.57(c)(6)(i) (2012) (requiring reasonable evidence of a causal association); see also GOOD PHARMACOVIGILANCE PRACTICES, supra note 73, at 8 (“Data mining is not a tool for establishing causal attributions between products and adverse events.”).
event. “The guidance documents, however, did not create legal obligations and manufacturers were free to decline the FDA’s suggestions.”

Although binding, federal regulations governing AERS proved similarly ill-equipped to direct an investigation into the reported event’s cause. Until 2007, federal regulations did not affirmatively empower the FDA to require manufacturers to conduct postmarketing clinical trials following identification of potential health risks from AERS data. Although 21 C.F.R. § 314.80 requires that manufacturers promptly investigate serious and unexpected adverse events, it does not require a manufacturer to determine the event’s causation. Thus, as with FDA guidance documents, the FDA lacked the power to force manufacturers to discover the causal association in order to effect labeling changes.

Moreover, depending on the adverse effect’s severity and whether it was already listed on the product’s label, a manufacturer may not report the event for months or years. Consequently, the FDA could operate for a significant
period of time under the assumption that a potential risk did not exist when, in fact, the drug manufacturer possessed contradictory data.\textsuperscript{97}

Even if sufficient postmarketing data existed to prove a causal association between a drug and a side effect,\textsuperscript{98} before 2007 the FDA lacked the power to force a labeling change.\textsuperscript{99} Rather, the FDA could only suggest modifications, which typically resulted in protracted negotiations with the manufacturer,\textsuperscript{100} which delayed, or even prevented, the dissemination of updated warnings to physicians and the public.\textsuperscript{101} Although the FDA could withdraw a medication’s marketing approval if the manufacturer refused labeling

\begin{itemize}
\item \textsuperscript{97} See, e.g., Letter from Pub. Health Serv., U.S. Food & Drug Admin., to Gregory Irace, President and Chief Exec. Officer, Sanofi-Aventis (Jan. 28, 2011), available at http://www.fda.gov/ICECI/ENforcementActions/WarningLetters/ucm243585.htm (issuing a warning letter to Sanofi-Aventis after discovering that the pharmaceutical company was potentially 896 days late in reporting a drug’s adverse effects to the FDA). Reports of serious risks need not be reported to the FDA in the fifteen-day window if that risk is already reflected in the labeling. 21 C.F.R. § 314.80(c).
\item \textsuperscript{98} This information would have to come from sources other than AERS data, such as data from clinical trials.
\item \textsuperscript{99} In testimony before the House Committee on Government Reform, the acting director of the FDA’s Center for Drug Evaluation and Research admitted the FDA’s lack of authority to require Merck to modify its labeling for Vioxx:

\begin{quote}
Mr. WAXMAN. I want to go back to that give and take of the FDA negotiating changes in the label with the company. It seems like you had what you thought ought to be disclosed and the company did not quite agree with it, and you are not in a position legally to order it, even though you thought the public and the doctors ought to have this, particularly the doctors ought to have this warning information in light of the new studies.

Dr. GALSON. Right.
\end{quote}

Risk and Responsibility Hearing, supra note 3, at 64 (exchange between Rep. Henry A. Waxman, Member, H. Comm. on Gov’t Reform and Steven Galson, Acting Director, Center for Drug Evaluation & Research, U.S. Food & Drug Administration); see also id. at 40 (statement of Steven Galson, Acting Director, Center for Drug Evaluation & Research, U.S. Food & Drug Administration) (noting, in response to the question why the FDA could not dictate labeling changes to Merck for its medication Vioxx, that “[t]he label by law belongs to the product, which belongs to the company [and] we can work together with [the manufacturer and] . . . most of the time we are very, very successful in getting what we want”).
\item \textsuperscript{101} See, e.g., Gardiner Harris, F.D.A. Official Admits ‘Lapses’ on Vioxx, N.Y. TIMES, Mar. 2, 2005, at A15 (citing the FDA’s Deputy Director of the Office of New Drugs as stating that the FDA took too long to obtain information about health risks onto its Vioxx label and blaming the manufacturer for the delay).
\end{itemize}
recommendations, the agency admitted that it would rarely exercise such authority when there were patients benefitting from the drug.\textsuperscript{102}

\textbf{B. Improved Detection Through the FDAAA and Sentinel System}

The changes made in the drug safety components of [the FDAAA] are critical to restoring peace of mind to Americans who want to be assured that the drugs they take to treat illnesses and chronic medical conditions can be relied upon and trusted.

—Sen. Michael Enzi, R-Wyo.\textsuperscript{103}

We cannot wait another month, another week—or even another day. We must take action here and take action now to send [the FDAAA] to the President.

—Sen. Edward Kennedy, D-Mass.\textsuperscript{104}

In 2007, Congress took action to rectify the shortcomings of the FDA’s postmarketing surveillance of pharmaceutical products, overwhelmingly voting in favor of the Food and Drug Administration Amendments Act of 2007.\textsuperscript{105} The FDAAA authorized the FDA to require drug manufacturers to conduct postmarketing clinical studies and trials to assess a medication’s known and potential risks and identify additional, serious risks.\textsuperscript{106} In direct response to the limitations of the AERS database, the FDAAA ordered the creation of a national healthcare data network—the Sentinel System—that was to comprise, by July 1, 2012, data from no less than 100 million patients.\textsuperscript{107} Further, the FDAAA granted the FDA the authority to order labeling changes upon the discovery of “new safety information,” and it created civil penalties for

\begin{thebibliography}{99}
\bibitem{102} GUIDANCE FOR INDUSTRY: SAFETY LABELING CHANGES, \textit{supra} note 100, at 2; see also Evans, \textit{supra} note 1, at 504; Barbara J. Evans, \textit{Congress’ New Infrastructural Model of Medical Privacy}, \textit{84 Notre Dame L. Rev.} 585, 632–33 (2009).
\bibitem{105} The FDAAA passed through the House of Representatives by a vote of 405 to 7 and was approved unanimously in the Senate. \textit{See} 153 CONG. REC. 24,773 (2007); \textit{see also} 153 CONG. REC. 25,048 (2007). The bill was signed into law on September 27, 2007. \textit{Press Release, The White House Office of Commc’ns, President Bush Signs H.R. 2669 and H.R. 3580 into Law} (Sept. 27, 2007).
\bibitem{106} 21 U.S.C. § 355(o)(3) (Supp. IV 2011). The FDAAA authorizes the FDA to require manufacturers to conduct postmarketing studies “[t]o assess a known serious risk related to the use of the drug involved”; “[t]o assess signals of serious risk related to the use of the drug”; and “[t]o identify an unexpected serious risk when available data indicates the potential for a serious risk.” \textit{Id.} § 355(o)(3)(B); \textit{see also} Faden & Milne, \textit{supra} note 36, at 688. Importantly, the FDAAA further empowers the FDA with authority to levy monetary sanctions against manufacturers that refuse to conduct such postmarketing studies and trials. 21 U.S.C. § 333(f)(4)(A) (Supp. IV 2011) (providing civil monetary penalties of up to $250,000 for single violations limited to $1 million per proceeding, with an increase of up to $10 million when the responsible party continues the violation after receiving notice from the Secretary).
\end{thebibliography}
violations of such orders. The Act was the largest reform in half a century.

The FDAAA rejects the concept that preclinical trials could identify all of a medication’s potential side effects, thereby shifting the FDA’s regulatory focus to identifying risks after marketing approval. As noted by one scholar, the FDA’s role as the market’s gatekeeper acknowledges the reality that some products will enter the market with latent risks. The FDAAA is relevant because it “adds [the] capability to detect and manage risks after products pass through the gate.”

Working in conjunction with the AERS database, the Sentinel System allows the FDA to query patient healthcare data when a drug’s safety is in question. In order to rule out alternative causation theories, the FDA can now use the Sentinel System to pursue the question of causation by searching 100 million patients’ healthcare data to determine a drug’s users, the users’ overall health profiles (including concomitant medications), and the side effects experienced. The benefits of this system are exponential:

With claims data for 100 million people, the [Vioxx] problem could have been spotted in fewer than 3 months. If [the] FDA had had the necessary data networks in place to do large-scale observational studies in 1999, all of the people killed or injured by Cox-2 painkillers after August 1999 (i.e., three months after Vioxx went on sale) might have been spared.

108. Id. § 355(o)(4)(E).
109. See Evans, supra note 1, at 422–23 (quoting Mark McClellan, Drug Safety Reform at the FDA—Pendulum Swing or Systematic Improvement?, 356 NEW ENG. J. MED. 1700, 1700 (2007)).
110. See id. at 457–58 (stating that the FDA’s pre-1962 evidentiary paradigm, with its reliance on premarketing trials for determining adverse effects, was “beyond repair”).
111. Id. at 477 (arguing that safety is not compromised by reacting to postmarketing reports).
112. Id. (“The gate is intrinsically porous, . . . key constituencies such as the medical profession and academics overestimated the power of premarket testing and consequently showed ‘little, if any, leadership’ in developing and using postmarket risk-benefit data. In [the] FDAAA, Congress has supplied the missing leadership.” (quoting Kenneth L. Melmon, Attitudinal Factors that Influence the Utilization of Modern Evaluative Methods, in INST. OF MED., MODERN METHODS OF CLINICAL INVESTIGATION 135, 144 (Annetine C. Gelijns ed., 1990))).
113. SENTINEL 2010 REPORT, supra note 59, at 2 (asserting that the Sentinel System will augment the FDA’s current postmarket surveillance systems).
114. Id. at 3 (calling this monitoring “active surveillance”).
115. See Evans, supra note 102, at 588–89 (noting that the Sentinel System will provide the ability to examine a patient’s entire medical record to conclusively determine whether a drug’s ingestion caused an adverse effect). But cf. supra notes 73–86 and accompanying text (noting the FDA’s inability to determine the true incidence rate of a newly identified side effect based solely on adverse event reports).
116. Evans, supra note 1, at 456 (emphasis added) (footnote omitted).
This statement assumes, however, that review of the Vioxx patients’ claims data would have been focused on the adverse health effect at issue.\(^{117}\) Ultimately, although the Sentinel System’s use of active postmarketing surveillance will discover postmarketing health effects faster, the possibility of eliminating those effects entirely is not feasible.\(^{118}\)

C. Cracks in the Façade: The FDAAA’s 10,000-Patient Donut Hole

Despite the FDAAA’s significant leap forward in postmarketing surveillance, the Sentinel System has value only if some percentage of patients experience a previously undetected adverse event during the postmarketing period.\(^{119}\) Even post-FDAAA, some lag time between marketing and health risk detection will persist.\(^{120}\) To Congress’s credit, it did not shy away from these facts in drafting the Act; it embraced them.\(^{121}\)

The FDAAA directs the FDA to conduct routine surveillance of newly approved drugs\(^{122}\) and the AERS database,\(^{123}\) and then report its findings to the public.\(^{124}\) For all newly approved medications, the FDA must publicly report, “by 18 months after approval of a drug or after use of the drug by 10,000 individuals, whichever is later, . . . any new risks not previously identified, C. Cracks in the Façade: The FDAAA’s 10,000-Patient Donut Hole

Despite the FDAAA’s significant leap forward in postmarketing surveillance, the Sentinel System has value only if some percentage of patients experience a previously undetected adverse event during the postmarketing period.\(^{119}\) Even post-FDAAA, some lag time between marketing and health risk detection will persist.\(^{120}\) To Congress’s credit, it did not shy away from these facts in drafting the Act; it embraced them.\(^{121}\)

The FDAAA directs the FDA to conduct routine surveillance of newly approved drugs\(^{122}\) and the AERS database,\(^{123}\) and then report its findings to the public.\(^{124}\) For all newly approved medications, the FDA must publicly report, “by 18 months after approval of a drug or after use of the drug by 10,000 individuals, whichever is later, . . . any new risks not previously identified,
potential new risks, or known risks reported in unusual number." 125 Implicit in these requirements, however, is that the new data comes at the expense of a drug’s first subscribers who suffer the unknown adverse effects. 126

Mandated surveillance and public disclosure of postmarketing safety data are critical to reassure the public about an approved drug’s safety and to expedite updated warnings to both consumers and healthcare professionals. 127 Further, surveillance and disclosure complement the FDA’s newly prescribed authority to require updated labeling of pharmaceutical products by creating a framework through which “new safety information” 128 will be promptly identified. 129 More subtly and controversially, however, the FDAAA provides a de facto post-approval clinical trial for all new drugs, involving no fewer than 10,000 participants and conducted during the first eighteen months after market approval. 130

1. Protections Afforded Clinical Trial Participants

Clinical trials are an essential pillar of the drug approval process. 131 Before a new drug can be marketed in the United States, the FDA must first find that the drug is both safe and effective 132 and that its benefits outweigh its risks. 133 These criteria are proved through the mandatory human clinical trials that are typically conducted in three phases. 134 Phase I trials assess side effects associated with the drug and how the drug is metabolized in the human body. 135 Less than 100 individuals participate in these trials. 136 Conversely,

125. Id. § 355(r)(2)(D).
126. See supra notes 5–10 and accompanying text.
129. Id.
130. Id. § 355(r)(2)(D).
131. See Anna B. Laakmann, Collapsing the Distinction Between Experimentation and Treatment in the Regulation of New Drugs, 62 ALA. L. REV. 305, 315 (2011).
133. Id. §§ 314.2, 314.105, 314.125 (2012); see also Rebecca S. Yoshitani & Ellen S. Cooper, Pharmaceutical Reformulation: The Growth of Life Cycle Management, 7 H OUS. J. HEALTH L. & POL’Y 379, 382 (2007) (stating that, in order to receive FDA approval, clinical studies must prove a drug’s safety and effectiveness and must show that the risks in its consumption are less than the benefits gained).
134. 21 C.F.R. § 312.21 (2011); see also W. Christopher Matton & F. Scott Thomas, The Continuing Balance: Federal Regulation of Biotechnology, 44 JURIMETRICS 283, 297–98 (2004) (concluding that each phase increases the number of participants and, therefore, the quality of data).
135. 21 C.F.R. § 312.21(a).
136. Id. (finding the number generally to be between twenty and eighty participants).
Phase II trials are concerned with the drug’s effectiveness for its specified use.\textsuperscript{137} Phase II trials are relatively small but larger than Phase I, involving less than 1,000 patients.\textsuperscript{138} Phase III trials gather additional information on the drug’s safety and effectiveness so that the drug’s benefit/risk relationship can be assessed.\textsuperscript{139} Phase III trials are the largest, comprising several hundred or several thousand participants.\textsuperscript{140}

Since 1970, manufacturers have conducted postmarketing (Phase IV) clinical trials on FDA-approved medications.\textsuperscript{141} Phase IV trials assess the drug’s efficacy and safety over long-term administration and also examine the benefits of alternative dosages, including “use of the drug in other patient populations or other stages of the disease.”\textsuperscript{142} Although some suggest that the FDA ostensibly mandated early Phase IV trials as a condition of a drug’s approval,\textsuperscript{143} the authority to order such studies was premised on an unstable regulatory foundation until passage of the FDAAA\textsuperscript{144} and was seldom invoked.\textsuperscript{145} With the passage of the FDAAA, however, the FDA can now require a drug manufacturer to conduct postmarketing clinical trials upon identification of “new safety information” obtained in the post-approval period.\textsuperscript{146}

All clinical research is governed by federal regulations,\textsuperscript{147} which provide significant protections to clinical trial participants.\textsuperscript{148} Pursuant to regulations

\textsuperscript{137} Id. § 312.21(b).
\textsuperscript{138} Id. (finding the number to be no more than several hundred participants).
\textsuperscript{139} Id. § 312.21(c).
\textsuperscript{140} Id.
\textsuperscript{141} Steenburg, supra note 24, at 300.
\textsuperscript{142} See, e.g., 21 C.F.R. § 312.85 (2011) (stating that it took seven years after passing the Kefauver-Harris Amendments for the FDA to require a Phase IV study).
\textsuperscript{143} Steenburg, supra note 24, at 300 (noting approval of Parkinson’s drug Levodopa on the condition that certain long-term studies continue after approval).
\textsuperscript{144} See id. at 301 (noting that the FDA worked to codify Phase IV studies by promulgating a rule); see also Evans, supra note 1, at 477–79 (stating that the FDA claimed it had those extended powers before the FDAAA but had exercised them with caution because they were not expressly granted).
\textsuperscript{146} 21 U.S.C. § 355(o)(3)(C) (Supp. IV 2011). The FDAAA defines new safety information to include: “information derived from a clinical trial, an adverse event report, a postapproval study . . . ; data derived from the postmarket risk identification and analysis [Sentinel] system”; or “other scientific data deemed appropriate” by the FDA about a serious risk “that [FDA] has become aware of . . . since the drug was approved.” 21 U.S.C. § 355-1(b)(3) (Supp. IV 2011).
\textsuperscript{147} 21 C.F.R. § 50.1 (2011); 45 C.F.R. §§ 46.101(a)(2), 46.102(e) (2011); Matton & Thomas, supra note 134, at 316 (concerning “protection of human subjects”).
\textsuperscript{148} See infra notes 149–55 and accompanying text.
promulgated by the FDA149 and the U.S. Department of Health and Human Services (HHS),150 a new drug’s clinical trial research conducted in support of market approval must minimize all potential risks “[b]y using procedures [that] . . . do not unnecessarily expose subjects to risk,” and which “[r]isks . . . are reasonable in relation to anticipated benefits.”151 Moreover, trial sponsors must obtain participants’ informed consent before conducting the trial.152 This consent must include a statement to the participant that contains “[a] description of any reasonably foreseeable risks or discomforts to the subject”; “[a] disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject”; and, when appropriate, “[a] statement that the particular treatment or procedure may involve risks to the subject . . . which are currently unforeseeable.”153 If the trial involves more than minimal risk, the sponsor must disclose information regarding compensation and medical treatments that may be required should injury result.154 Beyond regulatory protections, trial sponsors can also obtain insurance policies to compensate trial participants for injuries incurred during the trial.155

2. Protections Denied First Subscribers Post-FDAAA

As previously mentioned, one significant component of the FDAAA’s new postmarketing surveillance regime is its requirement that the FDA publicly report an analysis of those reports identifying a new drug’s adverse reactions received after the drug’s marketing approval.156 In compiling and assessing information for the new drug’s initial summary analyses, the FDA will use both its old, passive AERS system and the new, active Sentinel System.157 Moreover, the FDA intends to prioritize its active surveillance using data obtained through postmarketing surveillance sources such as adverse event

153. 45 C.F.R. § 46.116(a)(2), (4); § 46.116(b)(1) (emphasis added); see also 21 C.F.R. § 50.25(a)-(b) (2011).
154. 45 C.F.R. § 46.116(a)(6); 21 C.F.R. § 50.25(a)(6). As defined in the regulations, “[m]inimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.” 21 C.F.R. § 56.102(i) (2011) (emphasis added); 45 C.F.R. § 46.102(i) (2011) (emphasis added).
155. But see William M. Sage, Some Principles Require Principals: Why Banning “Conflicts of Interest” Won’t Solve Incentive Problems in Biomedical Research, 85 TEX. L. REV. 1413, 1453 (2007) (noting that, “unlike other countries, the United States does not require research institutions to have clinical trials insurance, and compensation policies for research injuries are erratic and incomplete”).
157. See, e.g., id. § 355(r)(2)(C)-(D); SENTINEL 2010 REPORT, supra note 59, at 2 (stating that this creates a more comprehensive system).
In outlining what would become the Sentinel System, the FDAAA required the FDA to establish procedures to identify and report trends in the data to the Secretary of HHS. Consequently, the FDA must conduct observational studies by querying the Sentinel System for adverse drug reaction reports on a drug’s first subscribers. Whether this activity rises to the level of a clinical trial is debatable, but the distinction may be irrelevant. There is no dispute that the FDA’s conduct in querying the Sentinel System based on adverse reaction reports observes individuals taking a specified medication and measures outcomes. Conversely, whether or not the FDA’s data can be viewed as observational clinical trials, the queries are necessarily systematic investigations involving human subjects “designed to develop or contribute to generalizable knowledge” about a drug.

Because the queries into the Sentinel System data contribute to the FDA’s understanding of a drug’s risks, the question remains whether these first subscribers should receive the same protections as those of postmarketing clinical trial participants. Unlike trial participants, early subscribers to an FDA-approved drug are not required to receive information regarding

158. SENTINEL 2010 REPORT, supra note 59, at 3 (“[The] FDA will prioritize safety questions that have emerged from premarket or postmarket safety data sources (e.g., clinical trial data, spontaneous adverse event reports) and submit them to a Coordinating Center for evaluation by data partners that are part of Sentinel’s ‘distributed system.’”).


160. Id. § 355(k)(3)(C)(i)(IV)-(V). The procedures used would assure data dissemination in a timely manner, all while considering its comprehensiveness and standardization. Id. § 355(k)(3)(C)(ii).

161. See Evans, supra note 1, at 507; see also Surveillance: Post Drug-Approval Activities, supra note 58.


163. See supra notes 147–48, 156 and accompanying text.

164. See SENTINEL 2010 REPORT, supra note 59, at 3 (discussing methods employed by the Sentinel System).

165. 45 C.F.R. § 46.102(d) (2011). Some may argue that the FDA’s Sentinel System queries are exempt from HHS guidelines because they involve “the collection or study of existing data, documents, records,” and, therefore, are exempt from HHS policies on the protection of human research subjects. 45 C.F.R. § 46.101(b)(4) (2011). Although the argument appears plausible, it misses the point. Without those early subscribers to the medication, whose injuries make the FDA’s queries possible, the FDA would not have a basis to conduct the search. The information exists only because patients were allowed to take a newly approved medication without first receiving the protections afforded trial participants. But see Evans, supra note 102, at 626–27 (arguing that neither FDA nor HHS regulations apply to patient data “that are fully identified, identifiable by researchers, coded, or de-identified/anonymized”).

166. Evans, supra note 1, at 436 (noting that relying on postmarket drug studies to detect risks poses ethical problems because the participants may become ill).
alternative treatments or disclosures of potentially unknown risks.\textsuperscript{167} Likewise, because subscription to a newly approved medication can pose potentially significant risks, early subscribers would not receive the same compensation or medical treatment that clinical trial participants would receive should injury occur.\textsuperscript{168}

The rationale behind the FDAAA’s passage lies in the inevitability of postmarketing discovery of adverse health risks that could not have been identified during the pre-approval clinical trial phases.\textsuperscript{169} As scholars and members of Congress have correctly noted, a compromise between expediency and safety must be reached in the drug approval process.\textsuperscript{170} The FDAAA acknowledges that previously unknown side effects will be discovered postmarketing.\textsuperscript{171} Therefore, the question arises as to how first subscribers injured during the postmarketing period should be compensated.\textsuperscript{172}

II. AN ARGUMENT AGAINST EITHER TORT LITIGATION OR THE INSURANCE INDUSTRY PROVIDING RELIEF FOLLOWING UNLABELED POSTMARKETING INJURIES

By expanding the FDA’s postmarketing surveillance authority, the FDAAA has created a void filled with unprotected patients.\textsuperscript{173} First subscribers do not receive the disclosures, possible compensation, or healthcare provided to trial participants.\textsuperscript{174} Nor do they benefit from long-term study of a drug that identifies the medication’s health risks.\textsuperscript{175} These first subscribers, constituting the first 10,000+ FDAAA-designated users, do not willingly agree to exploratory treatment.\textsuperscript{176} Moreover, their physicians are not sufficiently informed of all the medication’s risks because they are still being discovered at

\textsuperscript{167} The warnings afforded participants in clinical trials pursuant to federal regulations do not apply to postmarket studies because the drug has already been approved. \textit{See} 45 C.F.R § 45.116(a) (2011).

\textsuperscript{168} \textit{See} \textsc{Inst. of Med., Ethical and Scientific Issues in Studying the Safety of Approved Drugs} \textit{172} (2012) (discussing the ethical issues associated with postmarket drug studies because risks and benefits associated with taking certain FDA-approved drugs need not be weighed evenly).\textsuperscript{169} Evans, supra note 1, at 425 (noting that the pretrial evidentiary data’s weight is being reassessed).

\textsuperscript{170} \textit{See}, \textit{e.g.}, \textit{id.} at 456 (asking whether it is ethical to expose patients to drugs for which some side effects may be unknown); \textit{see also} \textsc{153 Cong. Rec. 25,037} (2007) (statement of Sen. Edward Kennedy).

\textsuperscript{171} \textit{See} Evans, supra note 1, at 443 (noting the inherent shortcomings of premarket drug clinical studies to detect all side effects).

\textsuperscript{172} \textit{Cf. id.} at 456 (stating that reliance on postmarket drug studies to detect risks poses ethical problems).

\textsuperscript{173} \textit{See supra} note 125 and accompanying text.

\textsuperscript{174} \textit{See supra} note 167.

\textsuperscript{175} \textit{See} Evans, supra note 1, at 477.

\textsuperscript{176} \textit{See id.} at 456.
their patients’ expense. Thus, these first subscribers and their physicians cannot weigh the treatment’s risks and benefits when some of those risks are unknown. When injuries occur, first subscribers are left with two equally insufficient and unappealing options: tort litigation and health insurance claims. For the following reasons, neither of these options is sufficient.

A. The Inherent Inequality of Recovery from Litigation

Recovery under tort law requires the injured party to prove both causation and the manufacturer’s liability for the injury. Unfortunately, in the context of adverse health effects first discovered during the postmarketing period, finding proof of causation can be problematic and establishing liability exceedingly difficult. As a result, using tort law remedies to provide relief from newly discovered adverse health effects is, at the individual level, limited at best. Moreover, when this type of relief is expanded to society as a whole (e.g., in cases where similar adverse health effects are experienced by multiple users), additional concerns regarding unequal treatment of similarly situated parties arise, further diluting tort law’s overall effectiveness at compensating injuries.

Generally, under products liability laws, a business that sells or distributes a defective product is subject to liability for harm that the product causes. Traditionally, the bases for a products liability cause of action include a claim that the product was defectively manufactured, defectively designed, or not accompanied by proper instructions and warnings. In drug litigation,
failure-to-warn claims largely predominate. Although an injured party may choose to pursue warning claims under strict liability, negligence, or breach of warranty theories of liability, courts typically apply a negligence standard in assessing the warning’s validity by relying on the concept of foreseeability. Foreseeability requires the plaintiff to prove that the manufacturer was aware, or should have been aware, of the risk of the injury sustained and failed to warn of it.

Because an adverse health effect that is discovered after marketing approval is, by definition, previously unknown to the manufacturer, the patient sustaining the injury almost certainly will be unable to recover under any applicable tort theory. State products liability laws are virtually uniform in

187. See Owen, supra note 183, at 751 (detailing several warning issues that tend to arise in drug cases); see also Rosati, supra note 120, at 231 (characterizing improperly labeled drugs as “defective”).
188. RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 2 cmt. n; Owen, supra note 183, at 752.
189. Owen, supra note 183, at 752–53 & n.77 (citing cases in which courts have applied a negligence standard).
190. See, e.g., RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 2 cmt. m(2) (1998) (stating that most jurisdictions find a duty to warn of risks where those risks were known or should have been known to a reasonable person).
191. See, e.g., Opera v. Hyva, Inc., 450 N.Y.S.2d 615, 618 (N.Y. App. Div. 1982) (“Where the theory of liability is failure to warn or adequately instruct, negligence and strict products liability are equivalent causes of action.”); RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 2 cmt. m(2) (proposing that there is little substantive difference between the terms “reasonableness” and negligence with respect to strict liability claims). Because failure to warn claims generally include some element of foreseeability, a breach of warranty theory is similar to its strict liability and negligence counterparts because all three require some type of actual or constructive knowledge of the risk imputed to the manufacturer. RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 2 cmt. n. Moreover, those states that do not require proof of actual or constructive knowledge of the risk nevertheless require the plaintiff to prove that knowledge of the risk was known by or available to others. See, e.g., Livingston v. Isuzu Motors, LTD., 910 F. Supp. 1473, 1497 (D. Mont. 1995).
192. Because this Article focuses on the FDA’s improved efforts to detect previously unknown health risks during the postmarketing period, for purposes of this section, this Article assumes that the discovery during the postmarketing period of the adverse effect is legitimate and not the result of deliberate obfuscation by the manufacturer or lack of diligence in researching the risks of the product at issue. In such cases, an injured party would potentially be more likely to succeed in tort in obtaining relief from the manufacturer. See, e.g., McNeil v. Wyeth, 462 F.3d 364, 369–70 (5th Cir. 2006) (finding that a genuine issue of material fact existed as to whether the manufacturer had sufficient evidence of a potential risk such that its failure to supplement the warnings for its drug misled physicians).
193. See LaMontagne v. E.I. Du Pont De Nemours & Co., 41 F.3d 846, 859 (2d Cir. 1994) (affirming a lower court’s finding that the defendant was not required to warn of the risks associated with its product because the Connecticut products liability law for failure to warn is grounded in “the fundamental principle that a seller’s duty to warn is premised on the existence of its knowledge or its reason to know of the hazards is evident”); see also Coburn v. Smithkline Beecham Corp., 174 F. Supp. 2d 1235, 1240–41 (D. Utah 2001) (noting that, because the duty to warn depends on the manufacturer’s level of knowledge at the time of the drug’s release,
their requirement that plaintiffs pursuing failure-to-warn claims prove that the manufacturer knew or should have known about the defect.\footnote{194} Even if a court were to find that the manufacturer knew of the relevant risk, the injured patient must still prove that the drug caused the injury.\footnote{195} As discussed previously, proof of causation on the basis of adverse reaction reports alone will not suffice.\footnote{196} Thus, although proof of causation is scientifically possible, the injured party will incur significant expense during litigation to prove that the drug caused the injury.\footnote{197} Consequently, the enormous costs of litigation diminish the amount of compensation received by the victim.\footnote{198} Further, relief ultimately comes after a significant delay from the time of injury\footnote{199} and, in cases where causation cannot be proven, recovery may be denied altogether.\footnote{200}

When extrapolated to the larger population of drug users, additional criticisms regarding the tort system’s ability to effect prompt and equal relief become apparent.\footnote{201} As a preliminary matter, scholars agree that the tort knowledge attributable to the manufacturer can change in the case of a patient prescribed a medication at various points in time); John G. Fleming, Drug Injury Compensation Plans, 30 AM. J. COMP. L. 297, 308 (1982) (“[Negligence] does not cover ‘development risks’, i.e., risks which the manufacturer neither knew nor should have known at the time of marketing in the light of existing scientific knowledge.”); Stephen Guest, Compensation for Subjects of Medical Research: The Moral Rights of Patients and the Power of Research Ethics Committees, 23 J. MED. ETHICS 181, 182 (1997) (noting, in the context of a clinical trial, that “an injured subject cannot easily claim that a risk was ‘reasonably foreseeable in the ordinary course of events,’ because the nature of experiment is such that a. unforeseeable events are to be expected and b. there is an inherent difficulty in establishing what the ‘ordinary course of events’ actually is”).

\footnote{194} See, e.g., MISS. CODE ANN. § 11-1-63(c)(i) (Supp. 2011); LaMontagne, 41 F.3d at 859 (noting the applicability of a similar rule in Connecticut); Smith v. Eli Lilly & Co., 560 N.E.2d 324, 344 (Ill. 1990) (noting the applicability of similar rule in Illinois); Davis v. Wyeth Laboratories, Inc., 499 F.2d 121, 129 (9th Cir. 1968) (noting the applicability of a similar rule in Idaho). Moreover, even in states that define prescription drugs as “unreasonably dangerous” or “unavoidably unsafe” products—juries from which would otherwise subject the drugs’ manufacturers to strict liability—the manufacturer nonetheless is absolved from liability when the drug is accompanied by proper warnings. See, e.g., Wagner v. Roche Labs., 671 N.E.2d 252, 256 (Ohio 1996); RESTATEMENT (SECOND) OF TORTS § 402A cmt. k (1998).

\footnote{195} See O’Reilly, supra note 85, at 560.

\footnote{196} See id.

\footnote{197} Id. (describing how a plaintiff must show, by a preponderance of the evidence, that a drug was the cause of harm, regardless of whether there are other plausible causes of the injury).

\footnote{198} See, e.g., Fleming, supra note 193, at 315 (suggesting that high litigation costs prevent plaintiffs from bringing claims).


\footnote{200} See, e.g., Richardson v. Richardson-Merrell, Inc., 857 F.2d 823, 825 (D.C. Cir. 1988) (upholding the judgment notwithstanding the verdict in a drug manufacturing case in which the plaintiff was unable to establish causation).

\footnote{201} See James R. Copland, Administrative Compensation for Pharmaceutical- and Vaccine-Related Injuries, 8 IND. HEALTH L. REV. 275, 282–84 (2011) (describing flaws in the tort system which compound as more litigants are involved).
system results in unequal treatment of similarly situated parties.\footnote{202} Two or more similarly situated plaintiffs litigating identical products liability suits against the same defendant, but in different jurisdictions, could have starkly different results.\footnote{203} One plaintiff may recover; the other may not. Alternatively, both may recover, but receive dramatically different compensation.\footnote{204}

Moreover, in pharmaceutical mass tort litigation, the ability to obtain uniformity in relief is further hamstrung by procedural rules and legal wrangling among the parties, precluding equality of treatment.\footnote{205} Because individual questions of causation and liability predominate in drug cases,
class-action-type relief is often unavailable.\footnote{206} In addition, because of 
pharmaceutical manufacturers’ claims of the proprietary nature of internal 
documents, protective orders entered in individual actions prohibit or delay 
relevant information from becoming public, precluding those in other 
jurisdictions from obtaining and using that same material in their suits.\footnote{207}

Despite concerns over treatment inequalities, some commentators continue 
to support the tort system because it deters bad actors.\footnote{208} For the same reason, civil and criminal liability statutes are lauded as benefitting the marketplace by encouraging compliance with the FDA’s manufacturing and marketing standards while simultaneously imposing significant financial penalties when manufacturers fail to comply.\footnote{209} In response, however, the pharmaceutical manufacturers’ conduct over time has disproved the deterrent effect of litigation.\footnote{210} Additionally, despite the massive fines imposed on prescription drug manufacturers for federal law violations,\footnote{211} none of that money benefits

\footnote{206. See, e.g., Zehel-Miller v. AstraZenaca Pharms., LP, 223 F.R.D. 659, 664 (M.D. Fla. 2004) (denying class certification in pharmaceutical products liability litigation because “individual questions concerning patient characteristics and medical history, physician involvement, dosage, causation and comparative or contributory negligence, eviscerate any notion that common issues predominate”).


208. Parasidis, \textit{supra} note 22, at 991–92 (suggesting that state tort claims encourage companies to disclose information as quickly as it is available).


211. See, e.g., Press Release, U.S. Dep’t of Justice, GlaxoSmithKline to Plead Guilty and Pay $3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data (July 2, 2012), http://www.justice.gov/opa/pr/2012/July/12-civ-842.html (noting GSK’s agreement “to plead guilty and to pay $3 billion to resolve its criminal and civil liability arising from [its] unlawful promotion of certain prescription drugs, its failure to report certain safety data, and its civil liability for alleged false price reporting practices,” making it “the largest health care fraud settlement in U.S. history and the largest payment ever by a drug company”); see also Press
those actually injured. Thus, litigation has proven ineffective at providing comprehensive, equal relief to injured parties and is incapable of effecting improved conduct of manufacturers in the marketplace.

B. The Undisclosed Burden on Public and Private Insurance—Shifting Costs to Responsible Parties

Absent a finding of fault on the pharmaceutical manufacturer, persons injured by a medication in the postmarketing period are forced to rely on insurance for relief. Although the Patient Protection and Affordable Care Act (PPACA) significantly increased the availability of insurance coverage to the vast majority of Americans in 2010, some of those increases will not occur for several years. Moreover, the public and private costs to fund insurance programs are significant, particularly when the risks covered are unknown. Using insurance to compensate postmarketing injury fails to...
provide complete relief because it accounts only for healthcare costs. Insurance does not provide coverage for tangential losses such as lost wages or income. Ultimately, reliance on insurance as a comprehensive means of providing economic relief following an adverse drug experience is misplaced.

Although estimates vary, various scholars suggest that the average cost to treat adverse drug experiences will soon eclipse $100 billion annually. Moreover, because adverse drug experiences are routinely under-reported, and because increased access to healthcare programs is forthcoming, these estimates are likely conservative. Ultimately, the question becomes whether injuries from unlabeled adverse drug experiences sustained in the postmarketing period are even the type of injury that insurance, or even tort litigation, is intended to compensate. To the contrary, because the pharmaceutical industry benefits from these injuries (allowing companies to improve their products’ labeling, expand marketing, and avoid liability in the future), are the pharmaceutical manufacturers not the parties who should pay

---

218. For example, although the PPACA outlawed high-deductible insurance plans, even under the new regime, certain deductibles persist. See, e.g., Abigail R. Moncrieff, The Freedom of Health, 159 U. PA. L. REV. 2209, 2248 (2011). But see 42 U.S.C. § 18022(c)(2)(A) (Supp. IV 2011) (authorizing small group market plans to impose annual deductibles up to $2,000 for individual plans and $4,000 for all other plans).


221. See supra note 77 and accompanying text.

222. See Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012) (finding that the PPACA requires expansion of Medicaid programs by 2014 to individuals under 65 who meet certain economic criteria). This expansion potentially would have extended Medicaid coverage to an additional 17 million individuals presently excluded from their state plans. See, e.g., Abby Goodnough, Lines Are Drawn over Opting out of Medicaid Plan, N.Y. TIMES, July 13, 2012, at A1. It would also have provided those individuals with “access to the full apparatus of Medicaid-funded services for their primary conditions, while their providers [would have gained] access to more generous and secure funding,” which would have given them “coverage to treat the physical and psychiatric co-morbidities that now often go unaddressed.” Harold Pollack, Health Reform and Public Health: Will Good Policies but Bad Politics Combine to Produce Bad Policy?, 159 U. PA. L. REV. 2061, 2067 (2011). Nonetheless, following the Supreme Court’s decision in Sebelius, a handful of state governors have suggested that, for budgetary reasons, they will consider opting out of the additional Medicaid coverage. See Sebelius, 132 S. Ct. at 2607–09 (holding that states are not required to expand Medicaid); see also Goodnough, supra, at A1.

223. Because these risks are unknown by definition, insurers are unable to properly estimate and apply them to insurance premiums. They are also not the type that make recovery under tort theories of law possible.
for that benefit by compensating the injured parties? 224 Although the PPACA currently requires pharmaceutical manufacturers to fund a portion of the new healthcare regime, that contribution does not cover the annual losses attributable to adverse drug experiences. 225 Further, the law does not require that the fees collected from the manufacturers go to the victims of drug injuries. 226

Requiring the pharmaceutical industry to fully compensate those injured from unlabeled postmarketing adverse events will not cure any expected healthcare shortfall. 227 The fact remains, however, that neither the government nor the public should be responsible for compensating this group of individuals. 228 It is, instead, the group with the most vested interest in the issue, the pharmaceutical manufacturers, that should provide the just compensation to these injured parties. 229

III. PROPOSING A NO-FAULT ALTERNATIVE

Neither the tort system nor the insurance system can fully and equally compensate early subscribers to prescription drugs who experience an unlabeled adverse event in the postmarketing period. 230 Relief in tort is often a quixotic pursuit, with very few able to prove liability for an injury, 231 and health insurance is expensive and often inadequate. 232 The 10,000-patient


226. Pollack, supra note 222, at 2072 (finding a flaw in the ability of a congressional majority to cut or eliminate the appropriation on which the fund rests).


228. See Fleming, supra note 193, at 308 (suggesting that, because the victims of adverse events deserve compensation, they are essentially medical research volunteers); see also infra notes 301–03 and accompanying text.

229. See Resnik, supra note 224, at 266 (arguing that medication researchers are bound to minimize the harms that a participant receives).

230. See discussion supra Parts II.A–B.

231. See supra notes 192–93 and accompanying text.

232. See supra notes 214–18 and accompanying text.
donut hole created by the FDAAA requires more reliable protections for injuries sustained.\textsuperscript{233}

Over the last century, numerous compensation schemes tailored to specific sources of harm have been imposed both legislatively and otherwise\textsuperscript{234} to provide more efficient and uniform relief to injured parties.\textsuperscript{235} In direct response to the tort system’s vagaries, these plans attempt to rectify the perceived “lottery aspects” attributable to tort recovery while simultaneously reducing litigation costs.\textsuperscript{236} Most significantly, for purposes of this Article, these alternative compensation schemes significantly relax the claimant’s burden of proving causation and fault to qualify.\textsuperscript{237}

Following in the footsteps of these existing plans, a similar compensation scheme should be adopted for patients exposed to a prescription drug in the drug’s initial marketing months.\textsuperscript{238} Although this Article does not advocate for

\begin{itemize}
  \item \textsuperscript{233} See \textit{supra} note 127 and accompanying text.
  \item \textsuperscript{235} See, e.g., Light, \textit{supra} note 234, at 11,124, 11,127 (describing a study group’s suggestions for remediying the compensation plans).
  \item \textsuperscript{236} See Fleming, \textit{supra} note 193, at 306; see also Peter H. Schuck, \textit{Tort Reform, Kiwi-Style}, 27 YALE L. & POL’Y REV. 187, 188–89 (2008) (noting criticism of a fault-based tort system as evincing “false morality” and resulting in “unpredictable damage awards, and high transaction costs”).
  \item \textsuperscript{237} See Lawrence M. Solan & John M. Darley, \textit{Causation, Contribution, and Legal Liability: An Empirical Study}, 64 LAW & CONTEMP. PROBS. 265, 269 (2001) (arguing that the standard of proof for plaintiffs in proving causation should be relaxed).
  \item \textsuperscript{238} See \textit{infra} Part III.A.
\end{itemize}
an across-the-board no-fault compensation scheme for drug-related injuries,\textsuperscript{239} it does propose a specialized plan designed to address injuries caught in the gap between premarketing clinical study and widespread exposure following initial marketing.\textsuperscript{240}

\textit{A. The Rationale for Adopting an Administrative Claims Fund}

The FDAAA’s regulation of postmarketing surveillance of prescription medications should be amended legislatively to include provisions that establish a no-fault compensation scheme to care for patients injured by an unlabeled adverse drug experience within the first eighteen months of marketing.\textsuperscript{241} Pharmaceutical manufacturers would exclusively fund this compensation scheme, with contribution being a prerequisite to all new drug applications.\textsuperscript{242} Moving away from tort liability in this context is warranted because a no-fault compensation system covering all injuries associated with unlabeled events will be more equitable.\textsuperscript{243} Further, requiring contributions from the private industry will reduce the government’s obligations and reduce the attendant tax liability imposed on the public to support the insurance system.\textsuperscript{244} To maintain the role of litigation, however, the FDAAA’s proposed amendments should include an opt-out provision that would allow individuals to exempt themselves from the compensation plan in order to pursue a tort claim.\textsuperscript{245}

Modifying the FDAAA to guarantee relief to this discrete patient group is in line with the Act’s policy goals.\textsuperscript{246} Requiring pharmaceutical manufacturers to compensate early subscribers to a new medication serves as a logical trade-off to both Congress’s and the industry’s desires to expedite the approval of newly developed medications.\textsuperscript{247} Early participants to a newly marketed drug provide

\begin{itemize}
\item \textsuperscript{239} Cf. Smirniotopoulos, supra note 219, at 834–35 (proposing a no-fault compensation scheme covering all drug and medical device injuries).
\item \textsuperscript{240} See infra Part III.A.
\item \textsuperscript{241} See 21 U.S.C. § 355(r)(2)(D) (Supp. IV. 2011); see also supra note 125.
\item \textsuperscript{242} Cf. Lytton et al., supra note 202, at 269 (explaining that no-fault accident compensation would be funded by direct payments into a fund financed by risk creators).
\item \textsuperscript{243} See id. at 279 (arguing that a no-fault compensation scheme would compensate more injured plaintiffs while also reducing administrative costs).
\item \textsuperscript{244} See supra note 217 and accompanying text (stating that Congress seems to want to reduce publicly funded healthcare options).
\item \textsuperscript{245} See infra Part III.B.3.
\item \textsuperscript{246} See 153 CONG. REC. 25,162–63 (2007) (statement of Sen. Michael Enzi) (describing a goal of offering a drug to the public while protecting those harmed by its adverse effects).
\item \textsuperscript{247} See, e.g., id. at 25,037 (statement of Sen. Edward Kennedy) (noting that the FDAAA will provide “new research tools and better ways to evaluate the safety and effectiveness of drugs,” while simultaneously expediting drug development and reducing development costs); see also Evans, supra note 1, at 444–50, 457–58 (noting that preapproval trials cannot eliminate the potential for risk in the postmarketing period).
\end{itemize}
value to the pharmaceutical industry by allowing expedited marketing approval, early signal detection, and expedited labeling changes.248

Pharmaceutical manufacturers receive significant financial benefits from a new drug’s initial postmarketing evaluation.249 From a financial transaction perspective, these “trial participants” should be compensated for the value added to a drug’s worth as a result of the trial tests.250 But, beyond compensation at the individual level, for Congress’s policy initiatives to succeed and for the FDAAA to have value, society needs early subscribers to expedite detection of latent adverse effects.251 Providing no-fault compensation to a newly approved medication’s early subscribers will incentivize participation on the part of new patients and encourage physicians to prescribe new drugs.252

**B. Considerations in Adopting a No-Fault System**

Although a no-fault compensation system would improve horizontal equity in the type of relief provided to injured parties, it is not a cure-all.253 Three principal and intertwined considerations must be addressed before adopting any no-fault plan: (1) eligibility; (2) administration and funding; and (3) limitations on recovery.254

---

248. Cf. Light, supra note 234, at 11124 (relating, from the environmental context, supporters’ arguments in favor of a compensation scheme alternative to tort litigation as “a useful method of cost allocation and sharing, and a socially responsible method of internalizing the emerging costs of industrial and technological development”).

249. [In the FDAAA, Congress] gave [the FDA] a toolbox, a whole bunch of different things that they can now do so that drugs will be approved faster, and then when that clinical trial that we call the whole population of the United States kicks in, there is a mechanism for following all of those and finding small samples of problems, solutions to those small samples of problems, and the drug that is working for people across this Nation doesn’t have to be pulled off the market. It can still work for the people who aren’t affected by an adverse reaction. That is a major change we have been able to make.


250. See Resnik, supra note 224, at 266 (arguing that a subject is entitled to compensation or care for harms received during research).

251. Evans, supra note 1, at 455–56 (preferring postmarketing studies to premarketing observational clinical trials for purposes of identifying adverse effects).


253. See supra note 243 and accompanying text.

254. See infra Part III.B.1–3.
1. Eligibility

Every tort claim requires that the injured party prove that the defendant caused the injury.255 This causation requirement takes on added significance in the prescription drug context.256 Because prescription drug users are typically sick, often suffering from a myriad of physical maladies,257 causation must be based on the outcome rather than the process.258 Accordingly, even in a no-fault compensation system, the question of whether, and to what extent, causation can be proved must be answered to gain access to any relief.259

Specifically, because proof of causation places an onerous burden on injured parties,260 no-fault compensation systems often invoke a relaxed standard of causation.261 For example, under the National Vaccine Injury Compensation Program (NVICP),262 which established a no-fault compensation fund to provide relief for harms resulting from vaccinations, so long as the sustained injury appears on the legislatively created Vaccine Injury Table, the injured party need only show that the vaccination was received and that the injury followed within the statutorily prescribed time period.263 Moreover, although the NVICP requires proof of off-table claims by a preponderance of the evidence,264 courts deciding the validity of off-table vaccine injury claims have

---

255. Solan & Darley, supra note 237, at 267 (“It is a legal maxim that people should be held liable for only harms that they have actually caused.”).

256. See infra note 257 and accompanying text.


258. Schuck, supra note 236, at 199 (stating that causation is more often linked to pre-existing conditions, which the public does not desire to compensate for, rather than to the medication itself).

259. See id.

260. See supra notes 82–85, 197 and accompanying text (noting the potential for multiple co-factors contributing to adverse drug experiences, which poses a challenge for plaintiffs trying to prove actual causation).


263. Derry Ridgway, No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Programs, 24 J. Health Pol. Pol’y & L. 59, 63 (1999); see also 42 U.S.C. § 300aa-14 (establishing time periods within which specified injuries must have occurred to merit a claim).

incorporated the relaxed standard of causation for table claims when deciding off-table claims as well.265

This emphasis on temporal proximity between exposure to the drug and injury as evidence of causation has been adopted by at least one foreign country in implementing its own no-fault drug-injury compensation scheme.266 In 1978, Sweden adopted a national pharmaceutical insurance system to compensate drug-related injuries.267 To establish a causal connection between drug and injury, the claimant only needs to “prove that there is a preponderate probability that the injury was caused by the drug,” which can be demonstrated by showing “a chronological connection” between ingestion and harm.268

Outside of the drug context, analogous domestic and foreign administrative compensation schemes likewise relax causation requirements to expedite relief to injured parties.269 For example, workers’ compensation plans replace proof of actual causation with proof that the injury was sustained during employment.270 In essence, workers’ compensation plans substitute proof of causation with proof of temporality.271 The rationale behind this construct of workers’ compensation plans turns on the questions of probability and who was most likely responsible.272 New Zealand famously abolished tort law

265. Betsy J. Grey, The Plague of Causation in the National Childhood Vaccine Injury Act, 48 HARV. J. ON LEGIS. 343, 394 (2011) (arguing that the Federal Circuit requires a lower level of proof in vaccine cases to prove causation because the expert opinion of the physician and the patient’s medical records can be sufficient).

266. See infra notes 267–68 and accompanying text.


268. Id. at 448. (describing the pharmaceutical insurance system’s unique rule for establishing causation).


270. Schuck, supra note 236, at 199 (generalizing workers’ compensation plans as requiring proof only that the injury occurred on the job).

271. See Gifford, supra note 261, at 965 (providing examples of workers’ compensation liability coverage for injuries that occurred while performing job-related functions or that were caused by the employers’ conduct).

272. The inquiry under the compensation statutes was . . . not who in any individual work-accident case had caused the injury in question, but rather who—employers or employees—was best described as responsible for the aggregate toll of casualties in a given industry. . . . Causation would, in a sense, be determined by legislative fiat for compensation cases as a whole on the theory that employers were best described as the cause of the injury in the majority of the cases; the individualized causation inquiry of tort law would be replaced by an inquiry into
remedies for all personal injury claims in favor of a no-fault compensation scheme in 1974 and exemplifies this rationale in its continued reliance on temporality and probability in assessing causation.

More recent federal legislation and executive action in the United States perpetuate the themes of temporality and probability in providing no-fault compensation schemes for injuries sustained in specific contexts. For example, following the 9/11 terrorist attacks, Congress enacted the September 11th Victim Compensation Fund of 2001, a no-fault compensation system covering all persons who were immediately affected by the attack and suffered physical harm. Similarly, the Gulf Coast Claims Facility, the administrative fund developed to compensate injuries resulting from the 2010 Deepwater Horizon oil rig explosion, “presumes” compensability based on “proximity to the coast, or from direct dependence on natural resources such as beaches and fish.”

Despite a reduced burden of proof, to make a prima facie case under a no-fault compensation scheme, the claimant must also meet a threshold burden-of-production requirement to establish eligibility. Taking elements from the various alternative compensation arrangements discussed above, a workable proposal for claims assessment can be outlined.

Under the NVICP, for example, the claimant must produce an affidavit and supporting documentation demonstrating that he or she received the vaccination at issue, sustained an injury listed in the Vaccine Injury Table or other injury caused by the vaccine, that the injury was sustained in the relevant time period outlined in the Act, and that the claimant has not previously been compensated for his or her injuries.

the status of the parties accompanied by an unrebuttable presumption of employer causation based on statistical tendencies.


273. See Schuck, supra note 236, at 188–89 (further explaining that this reform was not demanded by the public but was the result of a small dedicated group working with judges).


275. See infra notes 276–77 and accompanying text.


277. See, e.g., Light, supra note 234, at 11126 (discussing the Gulf Coast Claims Facility and the facility administrator’s thoughts on determining compensability for certain classes of individuals).

278. See infra notes 280–81 and accompanying text.

279. See infra notes 290–91 and accompanying text.

wrongful death claimants must produce, inter alia, medical records demonstrating the injury or death, medical records reflecting diagnosis by a physician, records showing expenditures for care, information showing location of injury, and information regarding other means of compensation available to the claimant. Other administrative compensation programs largely follow suit, requiring proof of temporality or proximity, and at least some suggestion by a physician of a causal association.

Once the burdens of production and proof are met, many alternative compensation schemes entitle the body administering the claims to challenge causation. For example, the NVICP allows HHS to deny relief when alternative causation is found. In such a case, however, the burden of proof shifts to the agency. Moreover, evidence showing alternative causation does not overcome the legal presumption created by the Vaccine Injury Table.

In the context of the FDAAA, requiring the injured party to prove actual causation unduly burdens the injured party and can preclude recovery. Also, attempting to create a table of compensable injuries akin to the NVICP would prove unworkable because the injuries are unknown. Instead, as workers’ compensation schemes and recent federal legislation have demonstrated,


282. See, e.g., 20 C.F.R. §§ 718.101–.107 (2011) (requiring, for purposes of a claim under the federal Black Lung Program, proof of injury as demonstrated by medical evidence); U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-060-230, FEDERAL COMPENSATION PROGRAMS: PERSPECTIVE ON FOUR PROGRAMS 37 (2005) [hereinafter FEDERAL COMPENSATION PROGRAMS], available at http://www.gao.gov/assets/250/248586.pdf (noting the requirement under the Black Lung Program that proof of a claim must be supported by a statement from a pulmonary specialist); see also New Zealand Compensation Act, supra note 274, at pt. 3, § 55(1)(a) (requiring the claimant to supplement his or her claim with a “certificate by a registered health professional”).

283. See, e.g., Benshoof, supra note 261, at 424–25 (noting that, under the NCVIA, the Virginia Birth Injury Act, and the Longshore Act, once the claimant demonstrates an injury, the defendant can rebut it by showing a lack of causal connection); Ridgway, supra note 263, at 63 (noting that HHS may dispute causation for injuries on the Vaccine Table by showing an alternative cause).

284. 42 U.S.C. § 300aa-13(a)(1) (2006) (stating that compensation will not be granted if a preponderance of the evidence indicates that the vaccine did not cause the injury).

285. Ridgway, supra note 263, at 63 (indicating that HHS must prove alternative causation).

286. Id.

287. See supra notes 82–85, 197 and accompanying text.

288. See supra note 17 and accompanying text (noting the potential for unknown side effects with prescription drugs); cf. 42 U.S.C. § 300aa-14(a) (2006) (limiting the presumption of causation to a predefined list of injuries).
temporality is the touchstone of an effective no-fault compensation plan. Accordingly, compensation under any proposed FDAAA modification must be based on the temporality between drug ingestion and the incidence of adverse symptoms. Specifically, this Article proposes that proof of causation for postmarketing unlabeled events should be deemed satisfied by a showing that the patient ingested the medication and was injured thereafter. In compensating injuries from unlabeled adverse events, the FDAAA should require claimants to submit documentation proving: (1) receipt of the drug; (2) diagnosis of injury; and (3) suggestion of causation by or association to ingestion of the medication. As with the NVICP, the administrative board charged with adjudicating claims shall be allowed the opportunity to disprove causation, but must do so by showing an alternative cause.

2. Administration and Funding

Because of the federal government’s exclusive regulatory control over the pharmaceutical industry, and the aforementioned benefits provided to that industry by first subscribers to new drugs, this Article proposes that the no-fault compensation scheme for first subscribers be administered by a federal agency and funded entirely by the industry. Although the proposal of a precise administrative structure for claims made by first subscribers to a newly approved drug is beyond the scope of this Article, because of the large patient population impacted by the no-fault compensation fund and its geographic scope, the administration of the fund sensibly should reside within

289. See supra notes 270–72, 275–77 and accompanying text (discussing the temporality standard applied in workers’ compensation plans, the September 11th Victims Fund, and the Gulf Coast Claims Facility).

290. See infra note 291 and accompanying text. In fact, FDA regulations already provide a framework for labeling changes that rely on temporal proximity between ingestion and injury. See, e.g., 21 C.F.R. § 201.57(c)(6) (2012) (stating that drug “labeling must be revised to include a warning about a clinically significant hazard as soon as there is reasonable evidence of a causal association with a drug”). Some scholars have suggested a temporal relationship between exposure to the drug and observed adverse effect may be the basis. See supra note 71 and accompanying text.

291. Cf. Ridgway, supra note 263, at 63 (noting, in the context of the NVICP, that “[i]f the first manifestation of a named injury occurs within the stated time period following vaccination (for example, the first seizure as a manifestation of a seizure disorder), the injury is presumed to have been caused by the vaccine” (emphasis added)).

292. See supra notes 280–82 and accompanying text (showing what the plaintiffs must produce in similar no-fault plans).

293. See supra notes 283–86 and accompanying text.

294. See supra Part III.A.

the federal government, whose institutional knowledge in administering similar funds would benefit those developing this new plan. As other scholars have proposed, one logical place to situate the fund’s management would be HHS, one division of which already administers the NVICP. From an administrative standpoint, asking HHS to govern a fund that would bear many of the same characteristics as the NVICP is intuitive. Moreover, as others have noted, separating fund administration from the FDA’s governance over drug approval avoids the problem of agency capture. Conversely, by keeping review within HHS, safety information could be disseminated to the FDA for its use in drug safety assessment.

Similarly, asking members of the pharmaceutical industry to finance this proposed compensation structure offers the most logical option with respect to funding the plan. For obvious reasons (i.e., because the manufacturers’ products caused the injuries at issue), similar no-fault compensation programs are funded by industry, including vaccine injury programs in Norway, Sweden, Taiwan, and the United States. Further, the infrastructure designed to collect revenue is already in place and requires only an increase in the amounts to be collected to fund this new administrative fund. Both the FDAAA and the PPACA impose annual fees on prescription drug manufacturers in order to fund, respectively, a rejuvenated FDA drug safety

296. See supra notes 263–65 and accompanying text for a discussion of a similar federal fund.
297. See, e.g., Smirniotopoulos, supra note 219, at 848–49.
298. Under the NVICP, following a claimant’s application to HHS, special masters appointed by the U.S. Court of Federal Claims determine the claimant’s eligibility. See, e.g., Ridgway, supra note 263, at 63. These decisions are then subject to approval by the Court of Federal Claims and are appealable to the U.S. Court of Appeals for the Federal Circuit. Id. This same structure could be expanded and applied with only slight modification to handle claims made by the first 10,000 drug users to a newly marketed drug for unlabeled adverse effects.
299. See, e.g., Smirniotopoulos, supra note 219, at 849 (arguing for separation of the drug compensation fund from the FDA so as to insulate it from undue influence, an issue experienced in the past); cf. Mullenix, supra note 234, at 823 (criticizing the administrator of the Gulf Coast Claims Facility as “a heroic ‘special master’ with limitless unreviewable discretion, who also is in the employ of the malefactor”).
300. See supra Part I.B.
301. See Fleming, supra note 193, at 306 (articulating the common refrain in support of alternative compensation plans as providing for more efficient allocation of resources, which, in this case, would be to ask pharmaceutical manufacturers to fund a plan from which they would benefit); see also supra note 251 and accompanying text.
302. The Black Lung Program is funded by an excise tax on coal mined and sold in the United States. FEDERAL COMPENSATION PROGRAMS, supra note 282, at 15. The Price-Anderson Act, which was designed to compensate victims of nuclear accident, is funded by nuclear licensees. Mullenix & Stewart, supra note 234, at 138–40.
304. See infra notes 305–07 and accompanying text.
regime and healthcare reform.\textsuperscript{305} Imposing an additional fee on prescription drug makers, which could be incorporated into the FDAAA’s existing fee structure, would establish private liability insurance for injuries sustained in the relevant period.\textsuperscript{306} This insurance structure would be no different from those employed by other no-fault compensation schemes.\textsuperscript{307}

3. Limitations on Recovery

In order to avoid an endless stream of claims directed to the fund for newly discovered adverse drug effects, limitations on recovery must be imposed.\textsuperscript{308} This Article suggests the following restrictions on access to the fund: (1) time limitations for asserting claims; (2) limitations on specified damages amounts for all injuries and aggregate caps on recovery; and (3) availability of relief pursuant to tort causes of action only after the exhaustion of remedies under the administrative system.\textsuperscript{309}

Imposing a time bar on access to the fund is no different from statutes of limitations barring state-law tort claims, and it parallels existing no-fault compensation funds.\textsuperscript{310} As this Article has already proposed, claims to be covered by the fund would be limited to those sustained during the first eighteen months after marketing approval, parallel to the time period established by the FDAAA for initial review and assessment of newly approved drugs.\textsuperscript{311} For purposes of filing a claim, this Article proposes extending the time to assert a claim to one year after the close of the FDA’s initial eighteen-month review, equaling thirty months after receipt of FDA marketing approval.

This extension avoids fraud and allows for time to identify latent or unrecognized diseases or symptoms.\textsuperscript{312} Further, this extension takes advantage of the FDA’s existing obligation under the FDAAA to “prepar[e], by 18


\textsuperscript{306} See supra Part III.A.

\textsuperscript{307} See supra notes 234–38 and accompanying text.

\textsuperscript{308} Similar no-fault compensation funds have also imposed certain limitations. For example, a fund established to compensate victims of 9/11 prevents claims from being filed more than two years after the fund’s creation. Air Transportation Safety and System Stabilization Act, Pub. L. No. 107-42, § 405(a)(3), 115 Stat. 230, 238 (2001).

\textsuperscript{309} See infra notes 310–27 and accompanying text.

\textsuperscript{310} See, e.g., Air Transportation Safety and Stabilization Act, § 405(a)(3) (barring claims filed more than two years after the fund’s establishment).

\textsuperscript{311} See supra Part I.C.

\textsuperscript{312} See, e.g., RESTATEMENT (SECOND) OF TORTS § 899 cmt. e (1979).
months after approval of a drug or after use of the drug by 10,000 individuals, whichever is later, a summary analysis of the adverse drug reaction reports received for the drug, including identification of any new risks not previously identified.313 A filing extension beyond the eighteen-month assessment window provides early subscribers an opportunity to review the FDA’s postmarketing report on a drug and determine whether symptoms observed or injuries sustained could potentially be attributable to the drug.314 A one-year extension for filing claims will ensure that new subscribers are not unnecessarily barred from recovery for legitimate harms.315

Beyond time limitations on recovery, this Article further proposes the imposition of maximums on recovery by a patient and on the manufacturer’s total monetary liability for any one drug.316 Regarding individual recovery, patients’ recovery must be limited to calculable, economic loss,317 and then only to predetermined amounts as set by the fund’s administrative review board.318 For purposes of determining baseline claims amounts, fund administrators could rely on claims tables from workers’ compensation statutes, analogous statutory funds like the NVICP319 and commonly used actuarial models.320 In order to estimate fee amounts to be imposed on manufacturers to finance this fund, it is equally necessary to cap total liability per drug.321 Once damages tables are developed for individual claims, the amount of liability for each drug is arguably finite. Those individual claims amounts can be used to determine the total potential monetary exposure

314. See infra note 315 and accompanying text.
315. Conversely, the administrative review board could potentially use reliance on the FDA’s eighteen-month new drug assessment to deny a claim that does not appear on the report. The board could argue that sufficient postmarketing testing has not revealed a link to the claimed injury.
316. In addition, this proposal would account for relief obtained through other means (e.g., life insurance) and use those amounts received to offset recovery under the plan. See, e.g., Mullenix, supra note 234, at 859 (noting the use of the collateral source rule in administration of both the September 11th Victim Compensation Fund of 2001 and the Gulf Coast Claims Facility).
318. See infra notes 319–20 and accompanying text.
320. Mullenix, supra note 234, at 854.
321. See infra note 322 and accompanying text.
attributable to each newly approved drug and establish a cap on the amounts recoverable for injuries claimed attributable to that medicine.322

Lastly, this Article proposes that any adopted plan provide an opt-out opportunity to claimants who wish to pursue relief through tort litigation.323 Retaining the possibility of tort litigation incentivizes manufacturers to work to prevent harm through continued study and observation of their product in the postmarketing period.324 Historically, no-fault plans that have not included an opt-out provision have been criticized as intending to serve only industry manufacturers.325 Conversely, to discourage claimants from forgoing administrative relief in favor of litigation, the proposal would require that claimants first exhaust all available administrative relief before pursuing any possible legal claim.326 Ultimately, to ensure finality to all claims administered pursuant to the fund, claimants to the fund would be required to waive all legal claims arising from the injuries sustained.327

IV. CONCLUSION

This Article has proposed amending the FDAAA to establish a no-fault compensation scheme designed to provide administrative relief to those injured by newly approved prescription drugs during the first eighteen months of the drug’s marketing. The FDAAA, in its laudable efforts to improve postmarketing detection of adverse drug experiences attributable to newly approved drugs, has extended observational study of new medications to their first subscribers.

322. At least one other no-fault compensation fund has instituted a similar cap on liability. See, e.g., Mullix & Stewart, supra note 234, at 140–41 & nn. 86 & 92 (noting the Price-Anderson Act’s de facto cap on liability in light of its funding requirements, and the Supreme Court’s upholding of the cap in the face of a challenge under the Due Process Clause). But see id. at 140 n.86 (noting criticism of the Price-Anderson Act “for setting a limit on liability, in light of the possibility that [funds collected from industry] may not be enough to compensate claimants adequately in the event of an extraordinary nuclear occurrence”).


324. See Benshoof, supra note 261, at 414 (1997). Examples of bad actors within the pharmaceutical industry persist. See supra notes 26–30 and accompanying text. However, a compensation plan should be able to separate those greedy and dishonest manufacturers from those acting in good faith. Benshoof, supra note 261, at 412.

325. Benshoof, supra note 261, at 416–17 (finding that such no-fault plans eliminated many economic safety incentives for manufacturers).

326. Cf. id. at 414 (noting a claimant’s ability to waive a damages award under NVICP to pursue a civil claim against a manufacturer only after having “[fully adjudicate[d] [his or her] claims through the compensation program” (citing 42 U.S.C. §§ 300aa-11(a)(2)(A), 21(a) (2006))).

327. Cf. Mullix & Stewart, supra note 234, at 130 (noting that “[t]he centerpiece concept” of the September 11th Victim Compensation Fund of 2001 “is that claimants give up their rights and ability to resolve their claims through the tort litigation system”).
An administrative fund serving this patient group is warranted here precisely because traditional tort remedies are practically unavailable to this patient population. Moreover, an administrative fund, financed by the pharmaceutical industry, is intuitive because the information gleaned from this type of postmarketing study inures to the benefit of the industry itself. The FDA’s eighteen-month postmarketing surveillance improves manufacturers’ abilities to provide comprehensive warnings associated with their products to the public, increasing their products’ marketability, while simultaneously reducing manufacturers’ exposure to tort claims for failure to identify and warn of these same risks. With the enactment of the FDAAA, the continued viability of newly approved prescription drugs rests on the backs of these first subscribers. This Article asks only that prescription drug manufacturers do the right thing by compensating those who make the continued marketing of their products possible.