

Strategic Submissions: A Cross-Country Analysis of Supplemental Drug Approvals

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Abstract

Off-label use regulation has the potential to change pharmaceutical firms' behavior and—consequently—affect patient welfare. We investigate the impact of changes in off-label regulation on pharmaceutical firms' behavior in seeking formal marketing approval for supplementary uses. In 2012, a US court decision protected truthful off-label promotion, providing pharmaceutical companies more leeway to promote off-label uses of their drug. Using a unique data set of pharmaceutical firms' research and development projects, we exploit this regulatory change to understand how firms react to government policies. Results demonstrate that firms responded to the US policy which lowered incentives to submit supplemental uses for formal approval. These results have implications not only for innovation policy but for the creation of high-quality data for certain indications.

Keywords: Pharmaceutical Firm Behavior, Prescription Drugs, Drug Efficacy, Off-Label Drugs.

JEL Codes: I10, D22, L20, I18

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1 Introduction

All developed countries require drugs to be approved for at least one use before the drug is marketed. Drug approval is not substance-specific: instead, regulatory agencies approve drugs only for the specific diseases (or “indications”)¹ requested by pharmaceutical companies. This sequential process of innovation and regulatory approval creates opportunities for firms to strategically exploit differences in policy to maximize sales and minimize regulatory costs. This paper examines an exogenous shock to regulatory benefits of formal supplemental approval to measure the effect on firms’ willingness to submit additional drug uses for formal supplemental approval, rather than leave the use “off-label.” It finds evidence consistent with firms strategically timing supplemental approval of additional uses of drugs to exploit the newfound ability to promote off-label uses and to maximize market exclusivity.

A company’s decision to submit a drug use for formal approval considers common factors: the relevant costs of approval (e.g., cost of scientific studies (Wong et al. (2014)), administrative procedure, and government incentives to innovate (Yin (2009); Chandra et al. (2024))) and benefits of approval (e.g., expected market size (Acemoglu and Linn (2004); Dubois et al. (2015)), competition (Khmelnitskaya (2023); Aghion et al. (2005), and price (Cockburn et al. (2016))). The types of costs and benefits, however, differ based on whether the use is the first approval for the drug (an “original” use) or an additional use (a “supplemental” use).

For an original use, formal approval grants access to the market for the drug substance, as unlicensed use of a drug is uniformly illegal. Once a drug has been approved for one indication, however, its prescription and consumption for a disease for which it was *not* approved is considered legal by most countries, a phenomenon known as “off-label” use. Physicians are not constrained to prescribe on-label but instead are generally free to prescribe drugs for off-label uses. The continued access to the market constitutes a significant difference

¹Off-label prescription can refer to the prescription of a drug for a different population, in a different dose, or for a different disease (hereinafter “indication”) than that for which it was formally approved. This paper will concentrate on the prescription of drugs for different indications.

for supplemental uses.

Countries’ willingness to allow off-label prescription reflects the tension between two interests: 1) access to innovative treatments and 2) the creation of new scientific information. Given the expense and delay associated with formal approval,² waiting for potential treatments to receive approval can unnecessarily limit physician practice of medicine: physicians seeking alternative cures for patients for whom approved treatments have failed—or for whom approved treatments are not well-tolerated—may demand medical alternatives, which off-label uses supply. Indeed, off-label use is very common ((Radley et al., 2006; Tuncel, 2024; Berger et al., 2021)). The most comprehensive study on off-label prescriptions, using nationally representative data, found that among the 160 most commonly prescribed drugs in the U.S., off-label prescriptions account for approximately 21% of overall use (Radley et al., 2006). It reports that off-label uses comprise 46% of cardiac therapies, 46% of anti-convulsants, 42% of antiasthmatics, 34% of allergy therapies, and 31% of psychiatric therapies. This high prevalence reflects the potential benefits associated with allowing physicians greater freedom in their prescription decisions. Tuncel (2024) shows that among French general practitioners, 21% of drugs prescribed for depression treatment are off-label drugs and that, in terms of health outcomes, such uses are not worse than approved alternatives.

On the other hand, rigorous scientific study is often only undertaken in order to receive regulatory approval. Not all scientific data are created equal: robust evidence of efficacy and safety is best created by double-blind, randomized controlled studies. Moreover, large-scale studies have better chances of identifying rarer safety risks. Such expensive studies are most likely to be undertaken by pharmaceutical companies in pursuit of formal approval. Given that pharmaceutical companies are not required to present results to justify off-label uses of their drug, rigorous evidence regarding the safety and efficacy for off-label uses is scarce. Radley et al. (2006) report that only 27% of off-label uses were supported by strong scientific evidence. Other off-label prescriptions could result from physicians relying on inferences from

²Notably, the US government has attempted to create incentives to do so by subsidizing applications for drugs targeted to rare diseases Yin (2009).

formal approval of a drug in a similar class or reports of documented side effects of the drug. Physicians may also rely on small-scale studies or anecdotes from colleagues to attempt a novel treatment. This neither supports a treatment decision in the most robust way nor incentivizes creation of better public scientific information about a drug use.

While off-label prescription is generally legal, most countries have placed restrictions on the ability of pharmaceutical companies to advertise off-label uses to physicians through a process called “detailing” or “promotion.” While most countries allow pharmaceutical companies to promote on-label uses, most restrict promotion of off-label uses to providers,³ under the rationale that pharmaceutical companies have too great an incentive to falsely represent off-label uses of their drug for economic purposes.⁴

Against this backdrop, this paper focuses on a recent change in off-label drug use policy. The United States recently relaxed its restrictions on off-label promotion based on the theory that such promotion is protected by the First Amendment. After a circuit ruling which extended this protection to off-label promotion, increasing the relative benefits associated with keeping a use off-label, we expect that firms are subsequently less likely to apply for formal approval for supplemental uses. An additional analysis, located in the Appendix, focuses on a nominally more drastic change in off-label regulation in France.⁵

Using a unique data set listing the research and development projects for pharmaceutical firms, this paper exploits these regulatory changes to understand the effect of government incentives on firms’ decisions to submit uses for formal approval. We find that the expectation of more relaxed off-label promotion regulations led to a lower hazard of formal supplemental approval in the US. These results are robust to a variety of specifications and to within and across country comparisons.

This paper contributes to the considerable literature on incentives to innovate (Chandra et al. (2024); Grennan and Town (2020); Garthwaite et al. (2021); Gupta and Kao (2024)). It

³This paper will not focus on direct-to-consumer advertising, but it is worth noting that most countries prohibit direct-to-consumer advertising in general, with the United States being a notable exception.

⁴Countries also often restrict reimbursement of off-label uses.

⁵Description of the regulatory change, methodology, and results are left to Appendix B.

is well-documented that firms strategically respond to government incentives to bring products to market. Cockburn et al. (2016) analyze this issue in the context of drug launches across countries. Focusing on the effects of price regulation of pharmaceuticals and corresponding patent protection, Cockburn et al. (2016) find that the former delays launch while the latter accelerates it. Chandra et al. (2024) examine the effect of new approval pathways on the efficiency of the approval process and safety of the resulting approvals. They find that the Breakthrough Therapy Designation was able to shorten clinical development time while not increasing adverse events associated with the approved drugs. Similarly, Yin (2009) considers government in the context of the Orphan Drug Act (“ODA”), which provided monetary incentives to pharmaceutical companies to develop drugs for sufficiently rare indications. Yin documents that pharmaceutical companies responded perversely to this incentive by developing drugs for “rare,” ODA-qualifying subdivisions of non-rare diseases. Such perverse reactions to new government regulation are also documented in Gentry and McMichael (2020), which examines the response of device manufacturers to newly immunized products liability in response to a Supreme Court decision. Gentry and McMichael (2020) present evidence consistent with manufacturers bringing more high-risk products to market after the Supreme Court decision, seemingly in response to the change in liability regime. Against this backdrop, this paper explores the effect of changes in off-label regulation on firm incentives to submit pharmaceuticals for formal approval.

The paper proceeds as follows: Section 2 discusses our conceptual model, the regulatory background surrounding off-label use, and our empirical strategy. In particular, the section describes the policy changes enacted during the study period, and the consequent effect only on supplemental uses, to identify the effect of such policy changes on firm incentives. Section 3 describes the data, and Section 4 presents evidence consistent with firms strategically responding to such policy incentives. Section 5 concludes.

2 Background and Conceptual Model

2.1 Conceptual Model

When deciding whether to submit a use for formal approval, a firm weighs the expected costs of approval against the comparable benefits. For the first approval of a drug, the “original” approval, the benefits are extensive. Since no developed country allows for prescription of unapproved drugs, initial approval represents access to the market. If the expected sales exceed the costs of approval, a firm should file for formal approval.

After an initial submission, however, the calculus shifts. Given that most developed countries do not restrict the prescription of drugs for off-label purposes, firms can still make money off off-label uses. Rather than deciding whether to file for approval or not sell a drug, firms decide between filing for approval or leaving the use off-label (while still selling the drug). In order to continue making money on off-label uses, however, pharmaceutical companies must persuade physicians to prescribe their drug for off-label uses. To do this, firms generally engage in direct-to-physician promotion.⁶ In countries where such promotion is illegal, companies risk large penalties for engaging in such conduct. Accordingly, such behavior is costly and reduces expected benefits of sales.

Once direct-to-physician promotion is protected, however, the cost of keeping drugs off-label declines. Accordingly, drug uses for which the benefits of approval only marginally justified the costs may no longer be submitted, as costs of approval remain the same but the expected benefits drop. This should result in a marginally lower likelihood of submitting supplemental uses for formal approval.

We exploit the general regulatory approval process in order to isolate the marginal effect of the policy changes in the US and France on pharmaceutical companies’ strategic decisions.

⁶Additionally, in countries where direct to consumer promotion is legal for approved uses, pharmaceutical companies may face larger incentives to file for formal approval.

A drug typically completes 4 stages before approval:⁷ The preclinical stage generally involves animal testing. Phase I includes small samples, generally testing for issues of safety. The study focuses on frequent side effects and understanding how the drug is metabolized. Phase II expands the scope to a larger group of individuals, focusing on efficacy. Comparisons between the developing drug and either a placebo or other drugs provide the basis for these controlled trials. Phase III is conducted over the largest sample, generally several hundreds to several thousands, and is generally costlier than prior phases (Wong et al., 2014). During this stage, more information on safety and effectiveness is collected, along with information on dosages and interactions with other drugs. After completing Phase III, the pharmaceutical company will formally ask for approval.

Because we are interested in understanding a pharmaceutical company’s decision to file for approval once it believes a use is viable, we use a hazard model to capture the temporal relationship between changing benefits of approval and the hazard of approval. In doing so, we want to compare the hazard of failure (approval) for original and supplemental uses during periods in which the temporal relationship to failure should be comparable prior to the regulatory change. Because Preclinical and Phase I involves collecting initial evidence of safety—and because the safety data from original uses can transfer to supplemental use—we wait until the use completes these stages. Phase II provides some evidence of efficacy, which creates materials that pharmaceutical representatives could use to promote the drug use off-label. Because of this, we treat Phase III as the period when a drug indication becomes “at risk.” Given this established approval process, we condition on the date associated with Phase III status and estimate the hazard that the use is approved. By constructing the hazard model this way, we can assess the marginal impact of the policy changes concerning off-label use/promotion on the hazard rate of supplemental approvals.

Three important assumptions underlie our analysis. First, we cannot reliably observe when drugs in our research and development sample are submitted for approval, only when

⁷<https://www.fda.gov/media/82381/download>

they receive approval. We cannot supplement this research and development data with external data to obtain submission dates because the FDA has a policy of not acknowledging or disclosing data on submitted-but-not-approved drug applications. To accommodate this limitation, we use approval as our “failure”; our results are informative of submission behavior as long as the difference over time in the number of submitted but not approved applications is equal for original and supplemental applications. We think this is a reasonable assumption given that pharmaceutical companies are repeat players and have reasonable beliefs about the approval standards.

Our second assumption is as follows: while the pre-approval process can vary across countries (i.e., pharmaceutical companies may reach different stages in different countries at different times), we treat this process as unitary. We are only interested in the difference in approval by country, not in any of the preceding steps. We do this because we are predominantly interested in the current information a company has regarding the efficacy of the drug. If they know that it is Phase III ready in one country, this is constructive knowledge applicable to its process in other countries.

Finally, our identifying assumption is that the aforementioned changes in off-label regulation only affect the decision to file for supplemental approval, not the decision to file an original approval. We think this is reasonable because the restrictions on unapproved substances do not change during this period; in order for a drug to reach the market, it must receive an original approval. We use this fact to perform a simple differences-in-differences analysis, focusing on the change in US and French policy.

One potential effect of off-label regime changes, however, is that it increases the potential profits of a drug by eliminating approval costs for the supplemental use and allowing for some additional revenues from promoting the use to physicians. Insofar as this transforms a previously-unprofitable original use into a profitable one, original uses may be more likely to be submitted for approval, violating our third assumption. While this is theoretically possible, it seems empirically rare for our study. In such a case, the original use must

itself be unprofitable, prior to the regulatory change. Given that the original use is more likely to receive patent protection and market exclusivity, this seems unlikely. Moreover, since off-label prescription is allowed pre-*Caronia*, the original use must be so unprofitable, that its expected on-label prescriptions plus pre-*Caronia* off-label prescriptions must be also unprofitable. Moreover, since none of the supplemental uses would have been submitted as original uses, each supplemental use must have been individually unprofitable. Essentially, this requires that the increase in revenues from physician promotion to be sufficiently large to subsidize prior unprofitable uses (both with and without off-label prescription). This is most easily satisfied for drugs for which original plus off-label use profits were just barely negative. Since our analysis condition on reaching Phase III, the relevant changes should happen at Phase III. For supplemental uses, this is the optimal stage for this strategic decision: armed with clinical information about the supplemental use, a firm simply decides to forego filing for approval. For an original use, however, this is a late stage for a drug with otherwise-unprofitable uses to reach. While the general increase in profits may manifest into marginal movement for previously unprofitable drugs, we expect most of this movement to occur earlier in drug development. The hazard of filing conditional on reaching Phase III should not be empirically changed.

Insofar as this is not true,⁸ however, this would suggest that the original approvals would not function well as a control group. To address this, we move to a triple differences model, and we capture the total increase in original approvals/decrease in supplemental approvals implied by the regulatory change.

2.1.1 Changes in United States Policy

The exogenous change examined in this paper is the change in off-label regulation. Previously, the United States allowed off-label prescription but prohibited direct-to-physician

⁸Notably, the violation of this assumption would be further evidence of the hypothesized sensitivity to reduced liability, and the effect captured would constitute the total effect of the change on original and supplemental uses.

promotion of off-label use by pharmaceutical companies. In the United States, off-label promotion was presumptively illegal under the Food, Drug, and Cosmetic Act (FDCA).⁹ The Food and Drug Administration (“FDA”) considered a pharmaceutical company promoting a drug for any purpose other than that for which it received approval as a type of “misbranding,” punishable by civil and criminal penalties. This interpretation continued, though years of First Amendment jurisprudence slowly chipped away at the foundations.¹⁰ In 2012, however, a major court decision changed the expectations of liability for off-label promotion. In *United States v. Caronia*,¹¹ the Second Circuit Court of Appeals created a schism from prior jurisprudence, holding that truthful off-label promotion, even by pharmaceutical companies, is protected under the First Amendment. While false or inherently misleading promotion would not fall under this protection, the government did not allege that the promotion in question was either false or misleading, though there may have been room to do so (Philip, 2014; Robertson, 2014).¹²

While the Second Circuit’s decision was not formally binding on the entire country,¹³ it did provide a credible signal to pharmaceutical companies nationwide. Following the holding, the FDA chose not to appeal the decision, signaling that it did not expect to win at

⁹Title 21 United States Code §352.

¹⁰Insofar as pharmaceutical companies updated their beliefs of expected liability through related litigation, we may underestimate the cumulative effect of the change in misbranding liability for off-label promotion overall.

¹¹Decision of United States Court of Appeal, Second Circuit, Volume 703 Federal Reporter 3d 149 (2012).

¹²Note that misbranding is not the only form of liability potentially imposed on firms related to off-label promotion. The government sometimes brings suit against pharmaceutical companies under the False Claims Act (FCA), a fraud statute that prohibits people from submitting claims that are false or fraudulent for reimbursement to the government. For off-label promotion, FCA claims allege that pharmaceutical companies fraudulently cause a claim for reimbursement to falsely be presented to the government. The specifics of these claims are unclear because most companies settle with the US government rather than take the case to trial. While there have been some changes to the interpretation and execution of FCA claims during this time, these are not targeted to off-label promotion.

If off-label liability under the FCA is otherwise unchanged during this time, our results measure the marginal effect of the change in misbranding liability for off-label promotion against the backdrop of other potential liability. If FCA liability gets more stringent, our results would be understated. If instead FCA liability for off-label promotion became more limited after *Caronia*, this most likely would be *because of Caronia* (i.e., courts may no longer allow off-label promotion to serve as a basis for the FCA claim because it is no longer considered misbranding under *Caronia*). Insofar as this is the case, this would be an indirect effect of the change in misbranding liability, which we correctly capture.

¹³Circuit opinions are only binding within the Circuit.

the Supreme Court level. Moreover, a similar case was brought with the same holdings, further supporting the jurisprudence.¹⁴ A recent analysis of jurisprudence following *Caronia* found that of 42 cases discussing *Caronia* in connection with off-label promotion, 22 adopted *Caronia* and 11 distinguished the case on the facts (Liu et al., 2021).¹⁵ Accordingly, despite *Caronia* being a Circuit Court decision, the FDA’s actions, and subsequent litigation, indicates that pharmaceutical companies should feel marginally more able to market off-label uses of their drugs as long as the information conveyed falls into the ambiguous category of “truthful.” Insofar as marketing increases the expected market size of a given drug, *Caronia* allowed pharmaceutical companies to gain market size without incurring either approval costs or legal liability.

While there are small developments in FDA law during this period, they either affect both original and supplemental approvals or bias against our results. In 2012, the Food and Drug Administration Safety and Innovation Act (FDASIA) added another track for priority review: breakthrough therapy designation. However, this status applied to both original and supplemental approvals.¹⁶ In 2016, Congress passed The Medical Cures Act, which broadened the type of evidence that could be submitted as part of a drug application.¹⁷ According to the FDA “real world evidence can be generated by different study designs or analyses, including but not limited to, randomized trials, including large simple trials, pragmatic trials, and observational studies (prospective and/or retrospective).”¹⁸ Insofar as

¹⁴Amarin Pharma, Inc. v. U.S. Food & Drug Admin., 119 F. Supp. 3d 196, 226 (S.D.N.Y. 2015)

¹⁵These distinctions followed 2 major approaches: distinguishing the procedural posture (state tort claim for compensation by injured individuals) from that of *Caronia*’s (criminal conviction under the FDCA) or distinguishing the truthfulness of the speech (actual falsity categorically not protected by the First Amendment) from the speech at issue in *Caronia* (truthful speech). Of the 9 cases not following *Caronia*, 4 adhered to their jurisdiction’s prior holding (Liu et al., 2021).

¹⁶In 2019, 26 uses were approved through the breakthrough therapy designation, 12 of which were supplemental uses. [fda.gov/media/95302/download](https://www.fda.gov/media/95302/download).

¹⁷The statute provides that “The Secretary shall establish a program to evaluate the potential use of real world evidence— “(1) to help to support the approval of a new indication for a drug approved under section 505(c); and “(2) to help to support or satisfy postapproval study requirements” 21 U.S.C. 355g. The section allows for real world evidence to be used in other contexts as well, at the Secretary’s discretion and notes that this should not be construed as changing the standards of period for consideration or grounds for refusing or approving an application.

¹⁸<https://www.fda.gov/science-research/science-and-research-special-topics/real-world-evidence>

real-world evidence reduces the cost of approval, this could make filing for formal approval marginally more attractive after 2016. Theoretically, real-world evidence may be more likely to be used to support supplemental uses because it would be easier to collect real-world evidence after an initial approval. Insofar as this decline in cost is bigger for supplemental uses, this should only bias against our hypothesized effect of fewer supplemental submissions after *Caronia*.

With this newfound ability to market uses that remain off-label, a major concern emerges as to why pharmaceutical companies should try to submit supplemental uses for formal approval. When off-label promotion was illegal, the ability to openly and freely disperse information remained a major reason to undertake this cost. With this distinction eroding, pharmaceutical companies may be marginally less likely to incur the cost of supplemental approval and leave new uses off-label.

2.2 Empirical Strategy

The paper uses survival analysis to estimate the differential effect of off-label regulation on the hazard of drug approval for a given indication. The hazard function estimates the likelihood of survival (remaining unapproved) at time t , conditional on an observation reaching time t without approval. It essentially allows for differences in the relationship between time and failure based on treatment, conditional on other control variables. The analysis allows for an observation-specific origin point—the Phase III date—at which point the observation becomes “at risk.” Drug indications are observed until either formal approval or until the end of the sample period (censored). Failure in this model is indicated when the observation is approved. The indication-specific origin ensures that the outcomes are not conflated with observation period (i.e., later observations are not incorrectly seen as having a lower hazard of approval). Instead, the hazard function at any given t *from the origin* is compared across observations, and time-varying covariates are allowed to change the hazard function. This captures our metric of interest much more specifically than simply estimating the likelihood

of approval by treatment status.

Our model requires time-varying treatment, which we obtain by splitting the data in two ways. The first split occurs at the first failure (approval) for a drug substance. Prior to the first approval, any extant use could be considered the “original” use and none could be used off-label. Once a use receives approval, all subsequent uses (extant or future) are considered supplemental. Accordingly, supplemental status is a dynamic concept linked directly to the ability to legally sell the drug for some purpose after the original approval. This definition of supplemental does not require perfect prediction of the first approval (i.e., the original use). All uses are constrained to have the same hazard ratio until the first approval, after which a separate ratio is estimated for supplemental uses.

The second time-varying treatment is by year. We split the survival time into year-long intervals, allowing covariates—such as competition, patent duration, etc.—to vary by year. This allows us to estimate a different proportional hazard ratio for each subperiod. These splits also allow us to designate *Caronia* as years 2013 onward.¹⁹

Our main specification is a difference-in-difference hazard rate model of approval.

$$h(t)_{id} = h_0(t) \exp(X' \beta) \quad (1)$$

where the event is defined as approval of drug d for indication i . $h(t)_{id}$ is the hazard that drug d is approved for indication i at time t conditional on having Phase III trial before time t . Any approval date that was subsequent to the end of the sample period was treated as not having been approved by the end of observation.

$$\begin{aligned} X' \beta = & \delta_i + \alpha_t + \beta_0 X_t^i + \beta_1 X_t^d \\ & + \beta_2 \text{Supplemental}_{idt} + \beta_3 \text{OLDU}_t + \beta_4 \text{Supplemental}_{idt} \times \text{OLDU}_t \end{aligned} \quad (2)$$

¹⁹The holding of *Caronia* was issued in December 2012.

where $Supplemental_{idt}$ is an indicator variable for whether the use of drug d for indication i in year t is considered supplemental. As noted above, $Supplemental$ is time-varying at the drug-indication level such that until the original approval of the drug for any indication, $Supplemental$ is 0 for all indications of that drug. After the original approval, all other indications for drug d are candidates for supplemental approval ($Supplemental=1$). $OLDU$ is a generalization of the Off-Label Drug Use (OLDU) regulatory change, which represents *Caronia* in the US.²⁰ $Caronia_t$, reported in the results section below, is an indicator for whether t is after the *Caronia* holding. Because these specifications only consider changes within a country, no country interactions are necessary. With X_t^i we control for disease indication-time specific variables such as the prevalence of disease i in year t in the country or the competition level in the market of disease i in year t . Prevalence of disease i controls for the potential market size of such indication in the country, which is likely to positively affect approval. X_t^d stands for drug-time specific variation such as patent life of drug substance d . We also include indicator variables for year t , and ICD classification of the indication i .²¹ The coefficient of the interaction of the indicator variable $Supplemental_{idt}$ with the dummy variable of the regulatory change should identify the relative impact of the policy change on the hazard of approval of supplemental indications.

2.3 Choice of Origin Point

In modeling the decision to submit a drug for formal approval, we have to choose an origin point, i.e. a phase at which the observation becomes “at risk” of failure. We choose the beginning of Phase III as an origin point, such that companies have completed Phase I and Phase II and accordingly have general evidence of safety and effectiveness from those prior phases. This choice is ideal for two reasons.

²⁰ $OLDU$ represents TRU in France. See the appendix for details on the regulatory change in France and the results on this change. TRU_t in the appendix is an indicator for whether t falls after the TRU regime was passed.

²¹Each observation is associated with a specific indication; however, for the sake of estimating fewer fixed effects, we aggregate these indications into broader ICD codes.

First, at the beginning of Phase III, a company has some evidence of both safety and effectiveness that it can use to promote the drug off-label. Phase I provides evidence of drug safety and Phase II provides some evidence of efficacy (albeit in small samples). Only conditioning on initiating Phase I and II will include observations in which the company may not have results to promote even without approval. Phase III is a more expensive phase, so a company may rationally decide not to complete it and leave the use off-label using the data from prior phases as promotional material. Insofar as a company decides to not even begin a Phase III trial and instead market the use off-label, our model estimates would provide a lower bound of the effect of legal reform.

Second—and most importantly—the primary assumption of a difference-in-differences analysis is that the treated and untreated groups’s trends would be comparable absent treatment. Since an original use is often the first to go through Phase I, there may be different factors affecting its hazard of completing that stage (which in turn, affects its hazard of formal approval). Similarly, insofar as less information is available for original uses than for supplemental uses (because supplemental uses have already had the drug approved for another use), this difference declines as phases progress. Put simply, the hazard approval seem most comparable for original and supplemental uses after Phase I and Phase II due to extant evidence on safety and initial efficacy.

In addition to the reasons noted above for why conditioning on Phase III best captures the decision between formal approval and off-label use, using the Phase III date as the origin point does not create selection effects. The difference-in-differences model captures the change in hazard of approval after *Caronia*. If companies already know whether they will keep a use off-label by the origin point (the beginning of Phase III), and their decision is not influenced by the new legal freedoms afforded by *Caronia*, our coefficient of interest will be insignificant. For this reason, using the Phase III date best isolates candidates for pharmaceutical choice while isolating any change in such choice created by the legal change.

2.4 Triple Difference Analysis and Choice of Country Comparator

Insofar as our assumptions about *Caronia* not affecting the choice to submit original approvals is unfounded, a triple difference model identifies the total effect of *Caronia* (on both original and supplemental uses) by comparing the change in the difference in original and supplemental approvals across countries, as specified in equation (3).

Choosing the correct country, however, is important. For the US, we choose Australia because of its similarity to the US in terms of regulatory authority and culture. The United States' experience with health delivery and drug prescription is more reliant on private systems and individual payments than most developed countries. While Australia does have a national health insurance, called Medicare, it is different from Canada in that Australia has a system of deductible and co-payment in purchasing prescription medications (Marchildon, 2005).²² It also embraces a more even mix of public and private hospitals than Canada. Indeed, the out of pocket payments per capita for Australia track the US's more than any comparator country (Appendix Figure A1).²³

In terms of population demographics, Australia is the closest to the US in obesity and hypertension prevalence. While all countries seem relatively similar in level and path of obesity (Figure A2), their experiences with hypertension differ. While Canada and the Great Britain have declining for hypertension, the US and Australia hold steady (Figure A3).

Accordingly, we present triple difference results using Australia as the comparator country for the United States.

In contexts considering comparisons across countries, c , we move to a triple difference

²²In contrast, cost-sharing is illegal in Canada.

²³This is based on statistics reported by Health Nutrition and Population Statistics for the United States, Canada, Great Britain, and Australia for years 2000-2016 and reproduced in Appendix Figures A1-A3.

model:

$$\begin{aligned}
X'\beta = & \delta_i + \gamma_c + \alpha_t + \beta_0 X_{ct}^i + \beta_1 X_t^d + \\
& \beta_2 \text{Supplemental}_{idct} + \beta_3 \text{OLDU}_t + \beta_4 \text{Supplemental}_{idct} \times \text{OLDU}_t + \\
& \beta_5 \text{Supplemental}_{idct} \times \text{ChangeCountry} + \beta_6 \text{OLDU}_t \times \text{ChangeCountry} + \\
& \beta_7 \text{Supplemental}_{idct} \times \text{OLDU}_t \times \text{ChangeCountry}
\end{aligned} \tag{3}$$

where OLDU_t again refers the period of time corresponding to the policy change and ChangeCountry is an indicator for the country of the policy change, either US or France. Note that Caronia_t and TRU_t (in the appendix) are constructed as in equation (2) and are interacted with the relevant country of change. γ_c is a country-specific fixed effect. X_{ct}^i represents indication-country-time specific variables such as the prevalence of disease i in country c and year t . The parameter β_7 signifies the relative change between original and supplemental approvals in US(France) after Caronia (TRU) relative to the comparable change in the difference between original and supplemental approvals in other countries.

3 Data and Descriptive Statistics

3.1 Research and Development Data

The main source of data is from Citeline, Informa Pharma Intelligence.²⁴ This data lists the unique drug products for companies engaging in research and development. For each drug substance, we observe the diseases (“indications”) for which it is being developed, the status of each disease worldwide, and key events in the development process. Using a string-processing algorithm, we use the data to determine the dates of approval for each disease for a sample of countries.²⁵

²⁴This data was downloaded in February 2019.

²⁵A full description of the data fields provided by Citeline, and the specific process by which we use these to produce indication-country specific dates, is available in the replication package.

Using this data and algorithm, we construct a dataset in which a single observation is a unique drug-indication-country entry. Only observations with non-missing Phase III dates are retained. We limit observations to those with Phase III dates between 2000 and the date of download (February 2019). For countries who are members of the EU, we impute EU dates if they precede the national dates of approval.²⁶

The indications in the Citeline data, while detailed, require standardization. In order to operationalize this rich data, we crosswalk the indications listed in Citeline to ICD-10 codes.²⁷ In order to do so, we use a mixture of automated string matching and manual matching to match indications to ICD codes of varying specificity. We then group ICD-10 codes into 87 broader disease categories. This allows us to control for differences in hazard of approval by broad disease categories.

3.2 Drug Classification

In order to account for differences in hazard of approval by drug characteristics, we use 3 strategies. First, we create “generic group indicators” by grouping drugs based on generic names using the International Nonproprietary Names (INN) stems and prefixes established by the World Health Organization. While a nonproprietary name could belong to more than one category, based on prefixes and stems, we only place it in one category. Where no generic name was available²⁸ we crosswalk based on listed mechanism of action to generic stems.

The second and third approaches involve principal factor analysis to reduce a set of nonexclusive indicator variables into a smaller number of factors using therapeutic class and mechanism of action, respectively. Therapeutic class categorizes the type of pathologies each drug is meant to treat, and a drug substance can be associated with multiple therapeutic classes. For mechanism of action, we simplify the listed mechanism of actions into groups

²⁶This data also provides information on whether a drug obtained an expedited review designation or orphan drug status. We consider these designations granted if the date associated with them is not missing.

²⁷Some of the interactions could not be matched to a broad ICD code. These are retained in the following analysis, under an “Unassigned” ICD category.

²⁸Sometimes a drug is too preliminary to have a name or only has an alphanumeric name.

corresponding to the type of enzyme targeted by the compound as well as information about the systems it affects.²⁹ This still leaves us with a large number of indicator variables.³⁰ Using these indicator variables, we perform a principal component analysis to condense the variation in therapeutic class and the mechanism of action indicators into 30 and 40 factors, respectively. The following analysis uses each of these approaches to control for differences in drug substance.

3.3 Competition Data

To control for potential competitors in a given indication, we use the Citeline data itself. Our measure of competition is the number of substances getting approval in the same ICD category and country 5 years prior. This is a much more detailed measure of competition than can be found outside of the data, as we observe development of specific ICD codes (rather than therapeutic classes, which do not always line up with indication). The country-specific measure seeks to capture the fact that certain markets might be saturated with recently-approved substances at different times. The 5 year lag allows for a forward-looking firm to anticipate waning exclusivity. In addition to the lag, we normalize the competition measure by subtracting the mean number of approved substances country and ICD category over the period studied. What remains is a measure of deviation from the mean number of competitors, such that we can interpret this measure as a reaction to relatively high levels of competition.³¹ This data is merged into the Citeline data by year, country, and ICD group.³²

²⁹We group mechanism of actions into the type of enzyme targeted (without considering whether it is an antagonist or agonist).

³⁰We do not include mechanism of action categories that apply to five or less drug entities to preserve degrees of freedom.

³¹This construction solves the ambiguous nature of competition noted in by removing the market size component of competition.

³²Previous versions of the analysis had used competition data from earlier stages of development. Namely, competition was measured by the number of substances each year that reaches Phase III in a given ICD category. Notably, this measure cannot be country-specific, glossing over different competitive pressures felt in each market. By only looking at indications reaching Phase III, we cull some noise of experimentation. This measure of competition necessarily assumes that firms are aware of projects that competitors have in the pipelines. Given the level of repeated play between pharmaceutical companies and that they usually have access to Citeline data, we think this is a reasonable assumption. The results using this measure were

3.4 Disease Prevalence

The decision to file for formal approval depends on the expected market size for a drug (Acemoglu and Linn, 2004; Dubois et al., 2015; Berger et al., 2021). For a sufficiently large market, it may make more sense to incur the costs of formal approval, all else being equal. To capture a measure of the prevalence of the disease targeted, we incorporate data from the Institute for Health Metrics and Evaluation at the University of Washington. We use their Global Health Data Exchange³³ tool to collect information on disease prevalence. We then use string and manual matching to associate this information with the indications in the Citeline data. Since the GHD data is less detailed than the indications in the Citeline data, we classify each indication as falling within broader GHD disease categories.³⁴ While we would ideally prefer a more detailed measure of prevalence, the broad categories provide a measure of potential use, while ensuring that all indications are on the same playing field.

For our prevalence measure, we use nominal prevalence data, defined as the total number of cases in the population.³⁵ We chose this measure because it not only gives the relative importance of the disease within the country but also provides a sense of the cross-country relative size of affected population. If a country has a small population but a large incidence of the disease, pharmaceutical companies may value the country’s regulations less strongly. Conversely, if a country is relatively large, even if it has a small affected population, a pharmaceutical company may choose to file for formal approval, given country regulations.

In addition to the GHD data, we also incorporate data on mortalities from the World Health Organization (WHO). As number of mortalities captures the most severe impact of a given indication, this should supplement the prevalence data. The data uses deaths from national vital registration systems and lists the causes of deaths for various age groups and

largely insignificant.

³³This data was downloaded on March 2021 from <http://ghdx.healthdata.org/gbd-results-tool>. The data is available from 1990 to 2019.

³⁴Specifically, we group indications as falling within the level 2 classification of causes in the GHD data.

³⁵We represent this value in billions for ease of coefficient interpretation.

sex. We use the death count for all ages and sexes for a country in a given year.³⁶ For some countries, some years of data are missing. In order to account for this, we impute the prevalence of the most recent preceding year. The availability of this data varies by year, country, and level of ICD detail. Using our indication-ICD code crosswalk, we crosswalk indications to any 3-digit ICD code associated with it. Our program aggregates deaths across the range of ICD codes associated with each indication.

3.5 Patent Expiration

The remaining time on a given patent can affect a firm’s decision process. If the firm feels that the supplemental use can create additional patent rights, a shortened time to expiration may spur a company to file for supplemental approval. Conversely, when more time remains on the patent, supplemental approval may not be necessary to maintain exclusivity. We use data from the PAIR database (Public Patent Application Information Retrieval of US Patent and Trademark Office) and match it to US patents listed in Citeline. Taking the latest filing date as the relevant filing date, we approximate the expiration date as twenty years after. For any given date interval in our data, we subtract the date from the expiration date, creating a “Remaining Patent Days” measure. We represent this value in terms of thousands for ease of coefficient interpretation. Once the patent expiration occurs, this value becomes zero (as does any observation with no patent associated with it).

While we would like to use data from Orange Book on other types of exclusivity, many of our observations never reach approval. Accordingly, data on patent rights for approved drugs (such as the Orange Book) would force us to exclude unapproved drugs. Data from the PAIR database allows us to keep not-yet-approved drugs.

³⁶We represent this value in hundreds of thousands for ease of coefficient interpretation.

3.6 Descriptive Statistics

Table 1 presents some basic descriptive statistics regarding approved drugs across countries and years, breaking out these averages by time periods, 2000-2012 and 2013-2018. Total number of approvals are the highest in the US, and the fewest number of approvals and drugs are in Australia. Comparing the average supplemental approvals per drug across columns shows a drop in supplemental approvals for the United States and France, but not for Australia. These data are simply suggestive, however. The following section displays results for the full models.

Table 1: Descriptive Statistics (2000-2012, 2013-2018)

	United States		France		Australia	
	2000-2012	2013-2018	2000-2012	2013-2018	2000-2012	2013-2018
Total approvals	1014	898	873	706	468	439
Original approvals	765	660	762	618	399	349
Supplemental approvals	249	238	111	88	69	90
Supp. approvals per drug (ave.)	.49	.47	.27	.24	.31	.42

Notes: The table lists approvals by type and country. Because sometimes an original application contains multiple indications, original approvals can be bigger than approved drugs.

4 Results

In this section, we present the results of a proportional hazard model. Results of a weibull parametric model are displayed in the main text, and results from a cox proportional model are displayed in Appendix A. Each model imposes a different assumption on the baseline hazard function, so the results are interesting to compare. This analysis models the hazard of failure, which in this context is formal approval. The coefficients reported are hazard ratios. A hazard ratio greater than one indicates that the variable is associated with a higher rate of failure (formal approval), while a ratio less than one is associated with a lower rate of failure.³⁷

The difference-in-difference model follows equation (2). As noted above, we split the survival time into year-long intervals, allowing covariates—such as competition, patent duration, etc.—to vary by year. This allows us to estimate a different proportional hazard ratio for each subperiod. These splits also allow us to designate *Caronia* as years 2013 onward. Because we include a full set of year indicator variables, however, we do not report the main effects for *Caronia* in the following results, as it is not meaningful. Given that we split our units of observations, we can have multiple intervals of time for each drug-indication-country unit.³⁸

4.1 US Within-Country Analysis

The simplest comparison is within a single country. By looking at the change in the relative hazard rate between original and supplemental approvals, we start by looking only within the US. Here, the variable of interest is $Caronia \times Supplemental$, which we expect

³⁷The standard errors are calculated using the delta method, but the p-values are calculated from the natural regression coefficients (i.e., if a coefficient is significantly different than zero). While tests based on the hazard ratio would be asymptotically equivalent to one based on the underlying coefficient, the hazard ratio has a more skewed distribution in real samples.

³⁸For this reason, the observations reported are the number of split intervals, not indication-drug-country units.

Table 2: Weibull Proportional Hazard Model for Approval: Caronia, Within-Country

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	5.607*** (1.056)	5.939*** (1.074)	6.172*** (1.216)	5.784*** (1.059)	6.685*** (1.312)
Supplemental x Caronia	0.807 (0.144)	0.665** (0.106)	0.759 (0.141)	0.758 (0.137)	0.707* (0.132)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year and icd group. Standard errors clustered by icd group. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

will be associated with a lower proportional hazard of approval. For the survival analysis, this means that the hazard ratio to failure (approval) should be significantly less than one. The results are listed in Table 2. The columns vary by the method by which we control for drug substance characteristics, indicated by the fourth, fifth, and sixth rows.

Caronia \times *Supplemental* is associated with a hazard ratio less than one, multiplicatively lowering the hazard rate of formal approval for supplemental uses after *Caronia*, relative to the comparable effect on original uses. This sparse specification produces estimates that are only statistically significant at conventional levels when including generic group indicator variables or both mechanism of action and therapeutic class factors. The magnitude of this effect ranges from 0.665 in column (2) to 0.807 in column (1).

Table 3 presents the same models as Table 2, including other control variables such as patent protection, competition, and prevalence. For the main variables of interest, *Supplemental* \times *Caronia*, the coefficients are uniformly significantly less than 1, indicating that the hazard rate of formal approval declines post-Caronia relative to the rate for original uses.

The other control variables are similarly interesting. We allow for the impact of competition with *Adjusted Competition* which is significantly less than 1 at the 10% level across

Table 3: Weibull Proportional Hazard Model for Approval: Caronia, Within-Country

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	9.091*** (2.176)	9.453*** (2.410)	10.509*** (2.749)	9.428*** (2.280)	11.573*** (3.127)
Supplemental x Caronia	0.590*** (0.114)	0.472*** (0.098)	0.551*** (0.113)	0.547*** (0.116)	0.502*** (0.115)
Adjusted Competition	0.972* (0.016)	0.971* (0.016)	0.971* (0.016)	0.972* (0.016)	0.972* (0.016)
Mortality/100k	1.148 (0.293)	1.020 (0.214)	1.103 (0.237)	1.099 (0.260)	1.101 (0.246)
Supplemental x Mortality/100k	1.268*** (0.089)	1.303** (0.134)	1.258*** (0.091)	1.254*** (0.096)	1.258*** (0.092)
Remaining Patent Days/1000	1.171*** (0.017)	1.179*** (0.019)	1.189*** (0.017)	1.178*** (0.018)	1.194*** (0.019)
Suppl. x Remaining Patent Days/1000	0.808*** (0.036)	0.825*** (0.047)	0.801*** (0.037)	0.807*** (0.039)	0.796*** (0.040)
Expedited Review Designation	2.439*** (0.292)	2.202*** (0.290)	2.391*** (0.275)	2.500*** (0.286)	2.336*** (0.260)
Orphan Drug Act Status	1.222 (0.180)	1.039 (0.154)	1.259 (0.196)	1.195 (0.183)	1.232 (0.193)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year, icd group, and missing mortality data (with interactions). Standard errors clustered by icd group. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

all specifications. This is consistent with firms strategically using formal approval when competition is expected to be lower across all specifications.

We also include indicator variables for whether a drug has received an expedited review or orphan drug designation. *Expedited Review Designation* is uniformly significantly greater than 1, consistent with theory. *Orphan Drug Act* is more noisy and less precise.

Finally, our measure of market size is *Mortality* and *Supplemental* \times *Mortality*, which represents the prevalence of the most severe consequences of a disease in a given country and year. While *Mortality* is indistinguishable from one, *Supplemental* \times *Mortality* is significantly greater than one, indicating that the relationship of market size to approval may depend on severity of the disease consequences, particularly for supplemental uses.

Remaining Patent Days is significantly greater than one, suggesting a higher hazard of approval corresponding to more days remaining on-patent.³⁹ *Remaining Patent Days* \times *Supplemental* is significantly less than one, suggesting that relative to original uses, remaining time reduces the proportional hazard of supplemental approval (or more intuitively, less time increases the proportional hazard of supplemental approval). This is consistent with firms strategically using supplemental formal approvals to retain some level of exclusivity. To further unpack this effect, Table 4 transforms *Remaining Patent Days* into 4 categorical variables: *No Remaining Patent Days*, *Remaining Patent (0–5Years)*, *Remaining Patent (5–10Years)*, and *Remaining Patent (> 10Years)* (omitted category). By estimating the effect of these categories and their interaction with *Supplemental* status, the story becomes clear. Relative to greater than ten years of patent protection (the omitted category), the hazard of approval for original uses declines for all shorter protection categories. This is consistent with firms filing for approval early in the patent life of a drug. Relative to this, however, supplemental status increases the hazard of filing for approval as remaining days get smaller. *No Remaining Patent Days* \times *Supplemental* is significantly greater than one indicating that when patent life expires, the hazard of approval for sup-

³⁹Notably, given that the measure is in thousands of days, however, this is a very small effect.

Table 4: Weibull Proportional Hazard Model for Approval: Caronia, Within-Country Dis-aggregated Patent

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	2.684*** (0.522)	2.925*** (0.602)	2.864*** (0.580)	2.695*** (0.508)	2.951*** (0.591)
Supplemental x Caronia	0.593*** (0.120)	0.474*** (0.096)	0.548*** (0.119)	0.547*** (0.118)	0.496*** (0.117)
Adjusted Competition	0.970* (0.016)	0.970* (0.017)	0.969* (0.016)	0.969* (0.016)	0.970* (0.016)
Mortality/100k	1.105 (0.263)	0.991 (0.201)	1.055 (0.221)	1.065 (0.233)	1.056 (0.228)
Supplemental x Mortality/100k	1.259*** (0.101)	1.285** (0.146)	1.236** (0.102)	1.248*** (0.107)	1.243*** (0.104)
No Remain. Pat. Days	0.349*** (0.033)	0.337*** (0.034)	0.319*** (0.031)	0.335*** (0.031)	0.309*** (0.032)
No Remain. Pat. Days x Suppl.	4.279*** (0.966)	4.056*** (1.159)	4.817*** (1.122)	4.601*** (1.091)	5.278*** (1.308)
Remain. Pat. Days (0-5 Years)	0.268*** (0.091)	0.289*** (0.107)	0.272*** (0.095)	0.272*** (0.095)	0.288*** (0.104)
Remain. Pat. Days (0-5 Years) x Suppl.	1.798 (0.793)	1.878 (0.969)	1.894 (0.866)	1.766 (0.784)	1.863 (0.839)
Remain. Pat. Days (5-10 Years)	0.470*** (0.097)	0.490*** (0.122)	0.480*** (0.097)	0.487*** (0.105)	0.499*** (0.106)
Remain. Pat. Days (5-10 Years) x Suppl.	0.877 (0.279)	0.797 (0.271)	0.861 (0.263)	0.839 (0.264)	0.852 (0.258)
Expedited Review Designation	2.371*** (0.295)	2.148*** (0.290)	2.362*** (0.281)	2.411*** (0.291)	2.285*** (0.268)
Orphan Drug Act Status	1.185 (0.180)	1.026 (0.158)	1.220 (0.198)	1.174 (0.184)	1.204 (0.195)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. The omitted category is remaining patent days exceeding 10 years. Other variables included but not reported are indicator variables for year, icd group, and missing mortality data (with interactions). Standard errors clustered by icd group. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

Table 5: Weibull Proportional Hazard Model for Approval: Caronia, Within-Country

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	10.665*** (3.628)	11.420*** (4.130)	12.428*** (4.498)	10.522*** (3.552)	12.913*** (4.678)
Supplemental x Caronia	0.605*** (0.114)	0.485*** (0.100)	0.562*** (0.112)	0.553*** (0.114)	0.505*** (0.112)
Adjusted Competition	0.972* (0.016)	0.970* (0.016)	0.971* (0.016)	0.972* (0.016)	0.972* (0.016)
Prevalence (Billions)	3.893 (3.889)	2.515 (3.747)	5.495 (7.702)	7.880** (7.580)	8.857 (11.978)
Supplemental x Prevalence	0.095 (0.195)	0.061 (0.157)	0.067 (0.156)	0.200 (0.367)	0.160 (0.326)
Remaining Patent Days/1000	1.171*** (0.017)	1.177*** (0.019)	1.188*** (0.017)	1.178*** (0.018)	1.193*** (0.019)
Suppl. x Remaining Patent Days/1000	0.807*** (0.035)	0.819*** (0.046)	0.802*** (0.037)	0.806*** (0.039)	0.796*** (0.040)
Expedited Review Designation	2.499*** (0.294)	2.266*** (0.285)	2.447*** (0.270)	2.561*** (0.287)	2.393*** (0.255)
Orphan Drug Act Status	1.191 (0.179)	1.005 (0.150)	1.234 (0.197)	1.175 (0.186)	1.217 (0.198)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year, icd group, and missing prevalence data (with interactions). Standard errors clustered by icd group. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

plemental uses multiplicatively significantly increases relative to original uses, consistent with using supplemental approval to extend exclusivity. *Remaining Patent* ($0 - 5\text{yrs}$) \times *Supplemental* is greater than one, though never statistically significant.

Table 5 performs the same analysis as Table 3, except that it substitutes *Prevalence*, the nominal prevalence of a disease in a given country and year, for the number of deaths. This variable is largely insignificant, as is its interaction with *Supplemental* status. This insignificance is likely due to the very crude disease classifications available in the data. All the rest of the coefficients follow similar patterns as in Table 3.

Finally, in order to test the parallel trends assumption for the difference-in-differences specification, we perform an event study. *Caronia* is decomposed into a series of time

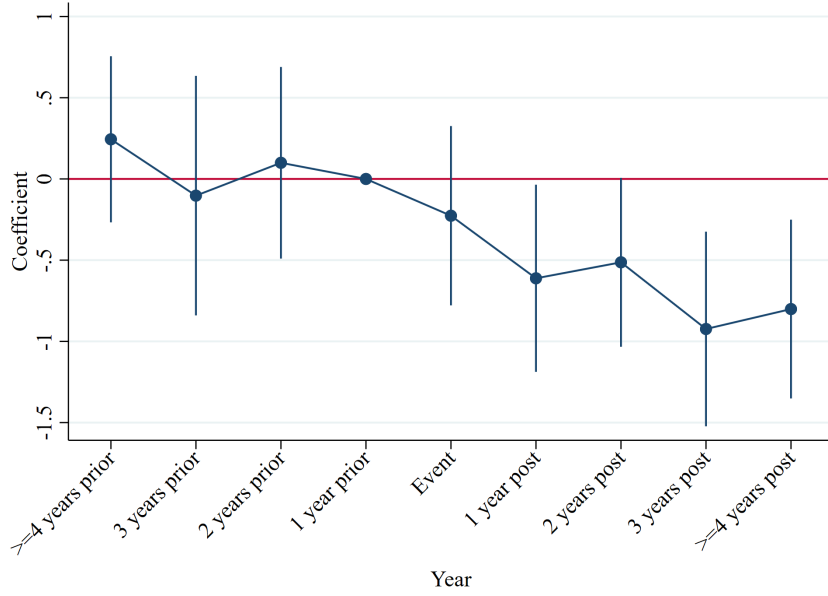


Figure 1: Event Study: Caronia

Notes: The coefficients plotted in the figure follow the specification in Table 3, column (2), with period indicator variables replacing *Caronia*. The interactions of *Caronia* and period indicators are plotted in the figure, with a 95% confidence interval. Standard errors are clustered by icd group. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

indicator variables, with year 2013 designated as the “event year” and the year prior as the baseline period. Figure 1 plots the coefficients⁴⁰ for the interaction effects for these periods, representing the change relative to the baseline period. The interaction effects leading up to *Caronia* have coefficients close to zero and statistically insignificant. As we would expect with an exogenous shock, the effects for the event and subsequent periods are negative and significant.

4.2 US Cross-Country Comparisons

The prior analyses have only considered changes within the US, relying on the fact that the regulatory changes only affect supplemental uses, not original uses. Insofar as *Caronia* affects original uses, a cross-country comparison addresses this. As mentioned in Section 2.4, the choice of country comparators is important and challenging. A comparator that is not

⁴⁰The plotted effects are coefficients, not hazard ratios, so the baseline is zero. Hazard ratios can be obtained by the exponent of the coefficient.

Table 6: Weibull Proportional Hazard Model for Approval: Caronia, Cross-Country Comparison with Australia

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	4.061*** (0.810)	4.399*** (0.882)	4.145*** (0.821)	4.167*** (0.837)	4.317*** (0.891)
Supplemental x Caronia x US	0.577** (0.161)	0.591* (0.159)	0.557** (0.152)	0.612* (0.173)	0.589* (0.161)
Observations	113,919	113,919	113,919	113,919	113,919
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. The full permutation of double interactions (and the main effects for Caronia and U.S.) are included but not reported for the sake of space. Other variables included but not reported are indicator variables for year and icd group. Standard errors clustered by country-icd group pairs. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

otherwise expected to follow a parallel trend absent treatment would introduce additional error. Given the United States’ unique position in public health, we detail the decision to choose Australia as a comparator in Section 2.4.

Table 6 displays the results of the triple difference for *Caronia*, and Table 7 displays the results controlling for competition, patent protection, and market size. The full permutation of double interactions (and the main effects for *Caronia* and *U.S.*) are included but not reported for the sake of space. The parameter of interest is the coefficient on $US \times Caronia \times Supplemental$, which is consistently around 0.5 - 0.6 in both tables. This estimate is statistically significant in Table 6, and as control variables are added in Table 7. Not only is the treatment effect as expected, but the control variables also present intuitive effects consistent with prior tables. The effect of *AdjustedCompetition*, *RemainingPatentDays* is the same as in prior tables, as is the effect of *Mortality*.

Results are consistent with firm sensitivity to changes in costs of off-label regulation characterized by *Caronia*. The lower cost associated with promoting off-label uses lowers the hazard of supplemental approval, relative to original approvals—across a variety of specifications. Further, insofar as original uses do not provide a good control group, our

Table 7: Weibull Proportional Hazard Model for Approval: Caronia, Cross-Country Comparison with Australia

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	6.099*** (1.292)	6.440*** (1.448)	6.556*** (1.414)	6.234*** (1.343)	6.708*** (1.521)
Supplemental x Caronia x US	0.565** (0.161)	0.561** (0.157)	0.552** (0.155)	0.583* (0.170)	0.572** (0.161)
Adjusted Competition	0.966** (0.015)	0.966** (0.016)	0.965** (0.015)	0.966** (0.015)	0.966** (0.015)
Mortality/100k	1.047 (0.091)	1.005 (0.063)	1.028 (0.070)	1.042 (0.083)	1.031 (0.069)
Supplemental x Mortality/100k	1.266*** (0.084)	1.256** (0.124)	1.267*** (0.089)	1.225*** (0.091)	1.251*** (0.091)
Remaining Patent Days/1000	1.152*** (0.014)	1.157*** (0.014)	1.169*** (0.014)	1.155*** (0.014)	1.170*** (0.015)
Suppl. x Remaining Patent Days/1000	0.835*** (0.032)	0.847*** (0.044)	0.832*** (0.032)	0.830*** (0.034)	0.829*** (0.035)
Expedited Review Designation	2.417*** (0.295)	2.144*** (0.307)	2.390*** (0.275)	2.461*** (0.286)	2.366*** (0.268)
Orphan Drug Act Status	1.389** (0.200)	1.129 (0.166)	1.377** (0.195)	1.385** (0.204)	1.367** (0.197)
Observations	113,919	113,919	113,919	113,919	113,919
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. The full permutation of double interactions (and the main effects for Caronia and U.S.) are included but not reported for the sake of space. Other variables included but not reported are indicator variables for year, icd group, and missing mortality data (with interactions). Standard errors clustered by country-icd group pairs. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

cross-country analysis shows that the difference in hazard between supplemental and original uses is significantly different in the US relative to the comparable difference in Australia over this period.

4.3 Discussion

The results in Section 4 are broadly consistent with firms responding to government incentives to submit uses for formal approval.

The consistent pattern reflected in these results is interesting in light of the difference in the nature of these policy changes. When weighing the relative merits of undergoing formal approval for an additional use of a drug, the ability to promote off-label uses of drugs is a significant benefit. In the United States, the policy change was limited to that of promotion. Where previously firms were not confident about marketing off-label uses of their drugs to physicians, *Caronia* changed this and increased the benefits of leaving a use off-label. Without the threat of criminal liability for promoting off-label uses, pharmaceutical companies have fewer costs associated with leaving uses off-label while still retaining the benefits of off-label sales. Consistent with this effect, we see evidence that the hazard of approval for supplemental uses, relative to original uses, in the US declined after *Caronia*. These effects are both statistically and practically significant across a variety of samples and specifications.

These results are consistent with firms prioritizing uses of their drugs to submit for formal approval in response to the restrictions (or freedoms) a country enacts toward off-label promotion and prescription. Liberalization of promotion—particularly in a large market—seems to be very influential, while weak enforcement of even stringent regulations may fall short.

While these results have economically interesting implications about the type of regulations that may influence firm behavior, the significance of these results are also incredibly practical. While off-label use need not present a threat to the practice of medicine, formal

approval serves an important function. Not only does its signal value decline if firms opt to keep more uses off-label for reasons unrelated to efficacy, but formal approval was a chief incentive for conducting costly—but extremely probative—scientific studies. If the incentive declines—particularly if it declines for specific indications—the informational landscape may significantly change in a way that would threaten patient care.

5 Conclusion

Off-label regulation has important ramifications for companies, physicians, and patients. Not only do off-label regulations affect the way that pharmaceutical companies strategically manage their research pipelines, but their behavior has important consequences for the amount of scientific information available to the public. The paper articulates a conceptual model of firm strategy and presents results consistent with firms strategically responding to new regulatory changes. This paper sought to analyze periods in which countries undertook unprecedented off-label regulation. The United States liberalized its regulatory regime by reducing the legal cost associated with off-label promotion. With this newfound ability to promote off-label uses, firms should be marginally more likely to leave a drug use off-label rather than file for formal approval. Using data from firms' research and development pipelines, this paper finds that the hazard of formal approval declines for supplemental uses relative to original uses, consistent with firms leaving uses off-label to minimize costs. This result is robust to a number of specifications, inclusion of many control variables, and to within- and across-country analyses.

While the results focus on firm behavior, their importance extends to the availability of quality data on drug efficacy. The perverse effects of the liberalization of off-label promotion can result in the decline of rigorous studies on new drug indications. In considering such a policy change, governments should consider the potential effects on patient welfare caused by the different informational landscape and the diluted signal value of formal approval.

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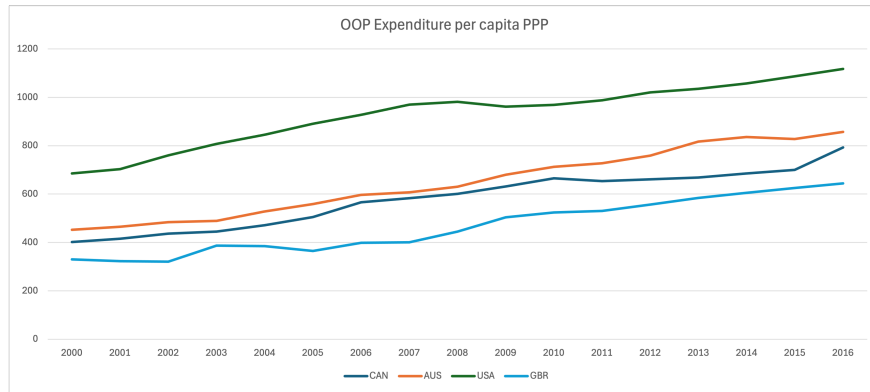


Figure A1

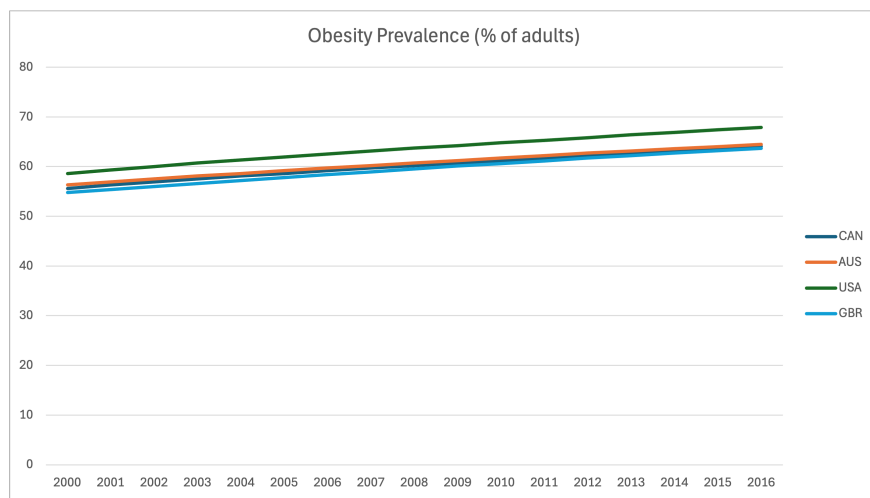


Figure A2

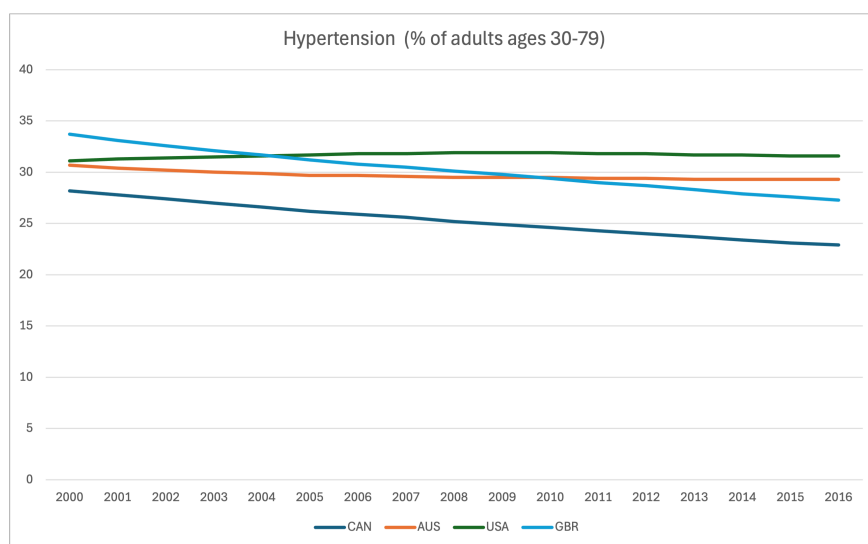


Figure A3

A Appendix: Additional Tables

Table A1: Cox Proportional Hazard Model for Approval: Caronia, Within-Country

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	5.351*** (1.000)	5.543*** (1.042)	5.923*** (1.160)	5.451*** (1.004)	6.297*** (1.242)
Supplemental x Caronia	0.894 (0.169)	0.714* (0.127)	0.831 (0.161)	0.840 (0.165)	0.767 (0.154)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year and icd group. Standard errors clustered by icd group. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A2: Cox Proportional Hazard Model for Approval: Caronia, Within-Country

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	8.332*** (1.935)	8.823*** (2.210)	9.665*** (2.431)	8.684*** (2.021)	10.603*** (2.754)
Supplemental x Caronia	0.663** (0.135)	0.507*** (0.111)	0.612** (0.130)	0.609** (0.134)	0.549** (0.130)
Adjusted Competition	0.970* (0.017)	0.971* (0.017)	0.970* (0.016)	0.971* (0.017)	0.971* (0.017)
Mortality/100k	1.101 (0.215)	0.984 (0.167)	1.060 (0.188)	1.061 (0.198)	1.055 (0.198)
Supplemental x Mortality/100k	1.339*** (0.109)	1.344*** (0.140)	1.316*** (0.112)	1.331*** (0.119)	1.321*** (0.116)
Remaining Patent Days/1000	1.163*** (0.016)	1.173*** (0.019)	1.180*** (0.017)	1.170*** (0.018)	1.186*** (0.019)
Suppl. x Remaining Patent Days/1000	0.821*** (0.033)	0.825*** (0.045)	0.813*** (0.034)	0.816*** (0.036)	0.805*** (0.038)
Expedited Review Designation	2.119*** (0.247)	1.930*** (0.253)	2.083*** (0.235)	2.186*** (0.248)	2.057*** (0.228)
Orphan Drug Act Status	1.162 (0.169)	0.996 (0.150)	1.213 (0.188)	1.130 (0.172)	1.182 (0.182)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year, icd group, and missing mortality data (with interactions). Standard errors clustered by icd group. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

Table A3: Cox Proportional Hazard Model for Approval: Caronia, Within-Country

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	9.735*** (3.186)	10.457*** (3.661)	11.166*** (3.890)	9.633*** (3.104)	11.579*** (4.020)
Supplemental x Caronia	0.689* (0.137)	0.528*** (0.115)	0.630** (0.131)	0.623** (0.133)	0.556** (0.127)
Adjusted Competition	0.970* (0.017)	0.971* (0.017)	0.970* (0.016)	0.971* (0.017)	0.971* (0.017)
Prevalence (Billions)	3.432 (3.219)	2.105 (2.868)	3.914 (5.329)	6.701** (6.050)	6.392 (8.314)
Supplemental x Prevalence	0.095 (0.195)	0.075 (0.185)	0.091 (0.216)	0.211 (0.387)	0.216 (0.447)
Remaining Patent Days/1000	1.162*** (0.017)	1.172*** (0.019)	1.179*** (0.017)	1.170*** (0.018)	1.185*** (0.019)
Suppl. x Remaining Patent Days/1000	0.821*** (0.032)	0.822*** (0.044)	0.816*** (0.034)	0.816*** (0.035)	0.807*** (0.038)
Expedited Review Designation	2.162*** (0.251)	1.983*** (0.252)	2.127*** (0.234)	2.232*** (0.252)	2.103*** (0.227)
Orphan Drug Act Status	1.135 (0.168)	0.966 (0.146)	1.191 (0.188)	1.112 (0.174)	1.169 (0.186)
Observations	53,612	53,612	53,612	53,612	53,612
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year, icd group, and missing prevalence data (with interactions). Standard errors clustered by icd group. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

Table A4: Cox Proportional Hazard Model for Approval: Caronia, Cross-Country Comparison with Australia

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	3.820*** (0.773)	4.208*** (0.869)	3.928*** (0.788)	3.848*** (0.786)	4.010*** (0.839)
Supplemental x Caronia x US	0.565* (0.166)	0.583* (0.170)	0.544** (0.156)	0.600* (0.182)	0.576* (0.168)
Observations	113,919	113,919	113,919	113,919	113,919
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year and icd group. Standard errors clustered by country-icd group pairs. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

Table A5: Cox Proportional Hazard Model for Approval: Caronia, Cross-Country Comparison with Australia

Variables	(1)	(2)	(3)	(4)	(5)
Supplemental	5.623*** (1.190)	6.188*** (1.398)	6.078*** (1.304)	5.702*** (1.229)	6.160*** (1.392)
Supplemental x Caronia x US	0.554* (0.167)	0.559* (0.169)	0.543** (0.161)	0.573* (0.178)	0.561* (0.169)
Adjusted Competition	0.965** (0.015)	0.966** (0.016)	0.964** (0.015)	0.966** (0.016)	0.966** (0.016)
Mortality/100k	1.037 (0.078)	1.000 (0.056)	1.019 (0.062)	1.030 (0.074)	1.019 (0.063)
Supplemental x Mortality/100k	1.329*** (0.103)	1.302** (0.135)	1.319*** (0.109)	1.286*** (0.111)	1.303*** (0.113)
Remaining Patent Days/1000	1.146*** (0.013)	1.154*** (0.014)	1.163*** (0.014)	1.150*** (0.014)	1.164*** (0.015)
Suppl. x Remaining Patent Days/1000	0.844*** (0.030)	0.847*** (0.042)	0.840*** (0.030)	0.837*** (0.032)	0.835*** (0.033)
Expedited Review Designation	2.144*** (0.255)	1.931*** (0.275)	2.130*** (0.242)	2.206*** (0.256)	2.136*** (0.241)
Orphan Drug Act Status	1.329** (0.191)	1.096 (0.162)	1.341** (0.191)	1.323* (0.196)	1.330** (0.191)
Observations	113,919	113,919	113,919	113,919	113,919
Generic Group Indicators		x			
Therapeutic Class Factors			x		x
Mechanism of Action Factors				x	x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year, icd group, and missing mortality data (with interactions). Standard errors clustered by country-icd group pairs. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

B Appendix: French Policy

B.1 Changes in French Policy

During recent years, France has experienced its own change in policy regarding off-label prescription. Prompted by the Mediator scandal, in which a diabetes drug caused sometimes-fatal valvular heart disease, France passed a law in December 2011 aimed at strengthening the safety of medicines and health care products. Together with a related decree regarding “Temporary Recommendations for Use” (TRUs), the law aims to provide a regulatory process for temporarily supervising the prescribing of drugs for indications for which they are not yet approved (Emmerich et al., 2012).

The “Temporary Recommendations for Use” (“TRUs”) decree established a process for limiting off-label use and temporarily supervising prescriptions for off-label indications. The objective of the process was to open an observation window (maximum of three years) in order to assess the benefits and risks of marketed drugs for off-label indications and to collect scientific information to ensure their safe use. Pharmaceutical companies bore the responsibility to track prescriptions of their drugs with a TRU and report any unusual prescriptions to the National Agency of Medicine and Health Product Safety (Agence Nationale de Sécurité du Médicament et des Produits de Santé [ANSM]) and take all appropriate measures to inform health care professionals and prevent off-label use (Emmerich et al., 2012).

The issuance of a TRU depended on the inherent safety of the drug, quality of existing scientific information, and the severity of the illness. The ANSM authorized a TRU if there were no other appropriate medications available (Emmerich et al., 2012). After the French government realized that being too restrictive on regulation of off-label prescriptions creates financial cost, France amended the policy in 2014 to allow a TRU to be issued even if a therapeutic alternative is available, as long as the alternative does not share the active substance, dosage, and form. Similarly, the ability to prescribe was broadened slightly.

While the proposed regulation was theoretically restrictive, the institution of the TRU regime had ambiguous effects on off-label prescriptions. The regime still acknowledged a physician’s ability to prescribe off-label for specific patients, though it aimed to limit such prescriptions (Emmerich et al., 2012). Anticipated effects were mixed: one scholar opines that the TRU worked to liberalize off-label policy (Degrassat-Théas et al., 2015) while another scholar anticipated that off-label use would be restricted because “the off-label prescription rules will be binding for physicians and could restrict access to off-label drugs by patients as their reimbursement will be restricted” (Rémuzat et al., 2013).

Empirical evidence on this policy has suggested that prescribers largely ignored TRUs in their prescription patterns. While very few drugs have actually received TRUs (Degrassat-Théas et al., 2015),⁴¹ off-label prescription has not seemed to drop considerably. A survey of twenty-three general practitioner offices in France in 2015-2016 found that 18.5% of drug prescriptions were for off-label purposes (Drogou et al., 2019). The study noted that the TRUs were “intended for specific groups of patients and rare diseases, and does not really concern [general practitioners].” Similarly, a 2015 survey studied pharmacists’ understanding of the prescription of baclofen for alcohol dependence, the first TRU to be issued (in 2014) (Auffret et al., 2018). The survey found that despite 81% of the pharmacists knowing that the TRU had been issued for baclofen, 65.7% of responding pharmacists had never seen “TRU” written on the prescription. Despite this, the pharmacists continued to dispense the drug. The same study noted that including patients in a TRU is often burdensome for practitioners, who continue to prescribe the off-label use without monitoring the patients.

If physicians largely did not change prescription habits in response to TRUs, pharmaceutical companies may rationally leave their submission strategy unchanged. Indeed, insofar as the TRU allows an additional three-year observation window, pharmaceutical companies may choose to postpone formal approval (Degrassat-Théas et al., 2015). This effect, however, will be more difficult to isolate, given France’s relatively small impact on global pharmaceu-

⁴¹Indeed, only 3 drugs received TRUs by the end of 2014 (Covington and Burling, 2015).

Table B1: Cox Proportional Hazard Model for Approval: TRU, Within-Country

Variables	(1)	(2)	(3)	(4)
Supplemental	2.620*** (0.543)	2.588*** (0.563)	2.599*** (0.527)	2.697*** (0.574)
Supplemental x TRU	1.114 (0.225)	0.742 (0.177)	0.979 (0.206)	0.999 (0.224)
Observations	55,364	55,364	55,364	55,364
Generic Group Indicators		x		
Therapeutic Class Factors			x	
Mechanism of Action Factors				x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year and icd group. Standard errors clustered by icd group. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

tical sales. This exercise presents a first pass at estimating sensitivities over the full sample of drugs.

B.2 Results

Turning to France’s TRU process, we perform the same difference-in-differences analysis. The construction of the data for the survival models is described above.⁴² As noted above, while the regulation was intended to restrict off-label prescription—and accordingly, increase the benefits of formal approval—it was largely ignored by physicians. Weak enforcement could either lead to no response from pharmaceutical companies or to even extending time until approval, as the delay is essentially sanctioned by the French government.

Tables B1-B2 only examine behavior within France. Table B1 incorporates the most parsimonious specification. The parameter of interest, $Supplemental \times TRU$, is statistically insignificant, finding no effect of the TRU on supplemental drug approval.

⁴²This section only presents Cox proportional models, as the Weibull parametric models had highly singular or nonsymmetric variance matrices.

Table B2: Cox Proportional Hazard Model for Approval: TRU, Within-Country

Variables_x	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Supplemental	2.664*** (0.533)	2.439*** (0.485)	2.584*** (0.546)	2.672*** (0.561)	2.625*** (0.650)	2.210*** (0.502)	2.586*** (0.592)	2.564*** (0.649)
Supplemental x TRU	1.074 (0.209)	0.761 (0.174)	0.977 (0.194)	0.977 (0.212)	1.064 (0.209)	0.731 (0.169)	0.962 (0.196)	0.957 (0.208)
Adjusted Competition	0.939** (0.024)	0.940** (0.023)	0.938** (0.024)	0.938** (0.024)	0.939** (0.024)	0.940** (0.024)	0.938** (0.024)	0.938** (0.024)
Mortality/100k	0.843 (0.700)	0.643 (0.569)	0.720 (0.533)	0.845 (0.694)				
Supplemental x Mortality/100	4.432*** (1.494)	3.717*** (0.947)	5.133*** (1.550)	3.813*** (1.148)				
Prevalence (Billions)					0.173 (0.871)	64.068 (299.652)	0.461 (2.518)	2.743 (13.215)
Supplemental x Prevalence					147.521 (1,220.999)	152,358.769*110.383 (978,404.122)(826.591)		804.027 (6,111.205)
Remaining Patent Days/1000	1.064*** (0.014)	1.067*** (0.015)	1.072*** (0.017)	1.079*** (0.015)	1.065*** (0.014)	1.067*** (0.015)	1.072*** (0.017)	1.080*** (0.015)
Suppl. x Remaining Patent Days/1000	0.957 (0.045)	0.978 (0.055)	0.965 (0.050)	0.964 (0.052)	0.955 (0.046)	0.978 (0.054)	0.963 (0.051)	0.963 (0.053)
Observations	55,364	55,364	55,364	55,364	55,364	55,364	55,364	55,364
Generic Group Indicators		x				x		
Therapeutic Class Factors			x				x	
Mechanism of Action Factors				x				x

Notes: Reported effects are hazard ratios. Other variables included but not reported are indicator variables for year, icd group, and missing prevalence/mortality data (with interactions). Standard errors clustered by icd group. Significance levels: *** p<0.01, ** p<0.05, * p<0.1.

After including additional control variables, Table B2 displays similar results as Table B1: the interaction effect *Supplemental* \times *TRU* is not significantly different from one. The results for the control variables are similar to those in Table 5. Remaining days on patent has similar effects as previously: days remaining increases the hazard of approval for original uses. Relative to this effect, however, days remaining decreases the hazard of approval for supplemental uses, consistent with using supplemental approval as a way to maintain some exclusivity. This latter effect, however, is insignificant for France. The effect of *Prevalence* and *Mortality* and their interactions with supplemental status are similar as the US's analysis, suggesting that similar determinants were significant for the hazard of approval. The effect of the TRU, however, is never statistically significant.

B.3 Discussion

The results for France suggest no significant effect for the imposition of the TRU. As noted above, however, finding a true effect for France is complicated by the fact that it is a relatively small player in the global market. Moreover, with some approvals going through the European Union, changes in French policy may not create a large effect.

The TRU regulation is a more complicated change. While physicians were supposed to enroll their patients into TRU monitoring programs upon prescription, prior evidence suggests that this was not the case in practice. And while pharmaceutical companies were intended to be encouraged to apply for formal approval, the existence of the TRU period of monitoring could actually extend the time between Phase III and approval (rather than file for formal approval immediately, a firm may delay for the state-sanctioned three-year monitoring period). Accordingly, pharmaceutical companies could rationally expect unchanged or even increased benefits of leaving uses off-label under the TRU. In line with this strategic behavior, we are unable to detect a change in hazard of approval for supplemental uses in France after TRU implementation.

Of course, in terms of pure market size, France is a much smaller player than the United

States. Indeed, France is a small player even within the context of the EU. Given the increasingly uniform approval process at the EU level, rather than at the nationwide level, the effect of French policy is more likely to be muted. However, even in drug classes for which France should be a bigger global player, the effects are statistically insignificant.⁴³

France took a more stringent policy stance—nominally restricting the prescription of off-label uses—but neglected to enforce it. Our analysis could find no significant effect of this regulatory change. While France is a smaller global player, which may account for some of the insensitivity, no significant effect is discernible even for drug classes that are particularly important in France. This result highlights the necessity of proper enforcement of even the most restrictive regulations.

⁴³In analyses available upon request, we look at only observations associated with ICD codes corresponding to cancer or depression, as these are significant areas of treatment in France. Using these subsamples—and clustering errors by drug rather than ICD group due to the few included ICD groups—we still find no significant result.