

STATE AFFRONTS TO FEDERAL PRIMACY IN THE LICENSURE OF PHARMACEUTICAL PRODUCTS

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ABSTRACT

Do individual states have the power to prohibit the sale and use of a drug that the U.S. Food and Drug Administration (FDA) has approved? Two years ago, the Commonwealth of Massachusetts tried to do so, but a federal court issued a preliminary injunction against this action. Although criticized at the time as unprecedented, the Massachusetts ban hardly represented the first time that a state had taken such an initiative, but it did provide the occasion for considering whether the U.S. Constitution would stand in the way. This Article carefully evaluates objections based on implied preemption under the Supremacy Clause, the dormant Commerce Clause doctrine, and the Due Process Clause of the Fourteenth Amendment. As it turns out, the question does not admit of a categorical answer, but at least in some circumstances a state would violate the Constitution if it tried to nullify a federal license granted to the manufacturer of a pharmaceutical product.

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INTRODUCTION

Fifteen years ago, I asked: “Could a state entirely prohibit the sale of a drug approved by the FDA?”¹ The question arose in the immediate aftermath of the controversial decision of the U.S. Food and Drug Administration (FDA) to authorize the introduction of mifepristone (Mifeprex[®]) and the prospect that some states might try to ban the use of this abortifacient.² The tentative answer that I sketched at the time turned in part on peculiar aspects of that drug and its licensing process,³ and, as it turned out, the problem remained entirely hypothetical. Subsequently, in my *Medical Technology* casebook, I posed the question somewhat more broadly: “[W]hat about other therapeutic agents that do not raise the constitutional questions in connection with procreative choices? If a state entirely prohibited sales within its borders of an FDA-approved product, . . . would the Constitution forbid such an exercise of a state’s police power?”⁴ Then, in 2014, one state tried to ban a drug that lacked any of the special baggage associated with mifepristone, thereby presenting the constitutional questions in a fairly straightforward fashion,⁵ and a federal district court found enough merit in some of these objections to preliminarily enjoin enforcement of the state’s prohibition.⁶

Part I discusses the recent effort by officials in the Commonwealth of Massachusetts to prohibit the sale of a narcotic analgesic product less than six months after the FDA approved this prescription drug. A court granted the manufacturer a preliminary injunction, though it did so on the basis of a seriously flawed preemption analysis. Part I then compares and contrasts what happened in Massachusetts with occasional attempts in other states to nullify licensing decisions by the FDA. Part II examines the

1. Lars Noah, *A Miscarriage in the Drug Approval Process?: Mifepristone Embroils the FDA in Abortion Politics*, 36 WAKE FOREST L. REV. 571, 600 (2001).

2. See *id.* at 599 & n.132. I also had considered whether the FDA (under new leadership) could have reversed course, see *id.* at 591-94, and whether Congress could have overridden the agency’s licensing decision, see *id.* at 594-99.

3. See *id.* at 601-03. For more about mifepristone, see *infra* notes 66-71 and accompanying text.

4. LARS NOAH, LAW, MEDICINE, AND MEDICAL TECHNOLOGY 144 (Foundation Press, 3d ed. 2012).

5. See *infra* Section I.A.

6. See *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 1454696, at *2 (D. Mass. Apr. 15, 2014); see also *infra* notes 23-44 and accompanying text (discussing and critiquing this decision).

primary constitutional objections to such initiatives, including a more nuanced consideration of the implied preemption arguments as well as dormant Commerce Clause and substantive due process objections not considered by the court in Massachusetts. By assessing these possible obstacles in tandem, one can better identify under exactly what circumstances states must abide by the judgments of federal regulatory officials when licensing pharmaceutical products.

I. STATE EFFORTS TO PROHIBIT WHAT THE FDA HAS ALLOWED

Although hardly unprecedented, the recent decision in Massachusetts to ban the sale of a drug shortly after FDA approval represented a stark affront to the licensing judgments of federal officials. The resulting litigation, however, left more questions than answers about the constitutionality of such efforts. Before tackling those loose ends in Part II, it helps to situate this latest case among earlier state initiatives to prohibit the sale or use of pharmaceutical products approved by the FDA.

A. Massachusetts Takes on Zohydro[®] (and Loses)

In 2013, the FDA approved a new drug application (NDA) submitted by Zogenix, Inc. for an extended-release hydrocodone product intended for patients with chronic severe pain that failed to respond to alternative treatment.⁷ A couple of years earlier, critics had questioned the wisdom of developing this opioid analgesic,⁸ and an advisory committee convened by the FDA had voted against recommending approval.⁹ Nonetheless, the agency decided to allow

7. See Matthew Perrone, *FDA Unexpectedly OK's New Hydrocodone Option*, BOS. GLOBE, Oct. 26, 2013, at B5.

8. See Chris Hawley, *Hopped-up Painkiller Has Experts Worried: Pure Version of Hydrocodone, Now Being Tested, Raises Addiction Fears*, ST. LOUIS POST-DISPATCH, Dec. 27, 2011, at A1; Gary Robbins, *San Diego Drugmaker Plays Down Concerns on Painkiller; It Says Zohydro Would Not Be Abused, as Addiction Experts Fear*, SAN DIEGO UNION-TRIB., Jan. 4, 2012, at C1.

9. See Perrone, *supra* note 7, at B5 (“The approval came as a surprise since the agency’s own panel of outside advisers gave the drug an overwhelmingly negative review last year. The panel of pain specialists voted 11 to 2 . . . against approving the drug, questioning the need for a new form of one of most widely abused prescription drugs in the United States.”); Roni Caryn Rabin, *New Painkiller Rekindles Addiction Concerns*, N.Y. TIMES, Apr. 22, 2014, at D1 (“Members of the F.D.A. committee who voted against approval acknowledged they were influenced by the drug overdoses claiming more and more lives each year. But they were also disturbed by red flags raised during the clinical trials of Zohydro.”); see also John

the California-based company to introduce its product (marketed as Zohydro ER[®]), which drew howls of protest from public health experts and law enforcement officials.¹⁰ After all, for two decades the FDA had struggled to manage widespread abuse and diversion of a similar extended-release oxycodone product (OxyContin[®]).¹¹ The agency's approval of Zohydro struck some observers as doubly perplexing insofar as it had just one day earlier recommended rescheduling combination products that included hydrocodone from Schedule III to the more restrictive Schedule II in response to escalating patterns of abuse.¹² Hydrocodone when used as the sole

Fauber, *Potent New Painkiller Open to Abuse: FDA's Approval of Easily Crushed Opioid Ignores Its Own Staff Advisers*, MILWAUKEE J. SENTINEL, Oct. 28, 2013, at A1 ("A November 2012 memo from the FDA's own staff warns that the drug will be abused more than traditional hydrocodone products.").

10. See Bradley J. Fikes, *Painful Dilemma: San Diego Company's Zohydro ER Caught in Debate over Needs of Legitimate Patients Versus Potential for Drug Abuse*, SAN DIEGO UNION-TRIB., Mar. 23, 2014, at C1 (describing "a firestorm of criticism"); Sabrina Tavernise, *Pressured on Opioids, F.D.A. Takes Steps to Toughen Stance*, N.Y. TIMES, Feb. 5, 2016, at A12 ("The F.D.A. has come under fire for continuing to approve opioids. . . . Its approval in 2013 of a drug called Zohydro brought public outcry over what critics saw as yet another opioid in a market flooded with them."); *Opioid Painkillers: Fact and Myth*, WASH. POST, Nov. 11, 2014, at E3 ("[A]ttorneys general from 28 states have asked the FDA to reconsider its decision because the drug offers no clear advantages over others already on the market and its potency makes it a target for misuse and abuse. And more than a dozen Republican and Democratic members of Congress have signed a bill that would ban Zohydro ER."); cf. Anne E. Schweighardt & Katherine M. Juba, *Extended-Release Hydrocodone: The Devil in Disguise or Just Misunderstood?*, 48 ANNALS PHARMACOTHERAPY 1362, 1363-64 (2014) (suggesting that fears of misuse have been overblown). Indeed, a whiff of scandal surrounded the process. See John Fauber & Kristina Fiore, *Senators Probe FDA-Drug Firm Meetings: Letter Alleges "Pay-to-Play" on Zohydro Approval*, MILWAUKEE J. SENTINEL, Feb. 28, 2014, at A7.

11. See Lars Noah, *Product Hopping 2.0: Getting the FDA to Yank Your Original License Beats Stacking Patents*, 19 MARQ. INTELL. PROP. L. REV. 161, 171-78 (2015).

12. See Barry Meier & Eric Lipton, *F.D.A. Shift on Painkillers Was Years in the Making*, N.Y. TIMES, Oct. 28, 2013, at A1 ("[P]ublic health advocates who had cheered the agency's [long delayed rescheduling] decision the day before were dismayed when the F.D.A. approved" Zohydro.); Editorial, *FDA Undermines Campaign Against Deadly Painkillers*, USA TODAY, Sept. 30, 2014, at 8A; see also Drug Enforcement Admin. (DEA), Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products from Schedule III to Schedule II, 79 Fed. Reg. 49,661, 49,682 (Aug. 22, 2014) (codified at 21 C.F.R. § 1308.13(e)(1) (2015)).

active ingredient had always faced Schedule II controls,¹³ which may help to explain why no company had ever before commercialized such a product.

Traditionally, hydrocodone drug products included the nonnarcotic analgesic acetaminophen (brand name Tylenol[®]), but that active ingredient came under increased scrutiny after reports of liver damage from prolonged use coupled with cases of excessive dosing because acetaminophen appears in numerous prescription (Rx) and over-the-counter (OTC) products.¹⁴ A pure hydrocodone product avoided those risks,¹⁵ though it would increase concerns about abuse and diversion, and Zohydro magnified such worries because it represented an extended-release version packing a higher dose of hydrocodone in each tablet.¹⁶ When taken as directed, the active ingredient would diffuse more slowly in the patient's body, providing longer and more even pain relief than traditional hydrocodone products with acetaminophen (e.g., Vicodin[®] and Lortab[®]); if, however, an abuser managed to circumvent the slow-release mechanism by, for instance, crushing the tablet, then the full dose would become available for immediate absorption. Moreover, and in contrast to the currently marketed versions of OxyContin, Zohydro failed to incorporate any abuse-resistant features.¹⁷

13. See David Sell, *DEA to Tighten Control of a Type of Pain Pill*, PHILA. INQUIRER, Aug. 22, 2014, at A17 (“Hydrocodone alone had been a Schedule II drug since 1970, when Congress passed the Controlled Substances Act.”).

14. See Melissa Dribben, *Suits Against Tylenol Maker Seek to Highlight Dangers*, PHILA. INQUIRER, Feb. 16, 2014, at G1; Deborah Franklin, *Poisonings from a Popular Pain Reliever Are on the Rise*, N.Y. TIMES, Nov. 29, 2005, at F5; Matthew Perrone, *Tylenol, Implicated in Liver Failure, Will Carry New Warning*, BOS. GLOBE, Aug. 30, 2013, at B7.

15. See Harry J. Gould, III & Dennis Paul, *Hydrocodone Extended-Release: Pharmacodynamics, Pharmacokinetics and Behavioral Pharmacology of a Controversy*, 91 PHARMACOLOGICAL RES. 99, 100-01 (2015); Keith Darcé, *Late-Stage Test Brings Success for Zogenix Pain Pill; Would Be First Such Drug Without Limits of Acetaminophen*, SAN DIEGO UNION-TRIB., Aug. 18, 2011, at C1.

16. See Kevin Deutsch, *It's Purer—and Potent; Experts Fear New Painkiller Will Fuel Drug Abuse; Can Be 10 Times as Strong as Current Narcotics*, NEWSDAY, Mar. 25, 2013, at A2; Bradley J. Fikes, *Consumer Reports Analysis Criticizes Overuse of Opioids; Group Also Opposes Approval of San Diego Company's Painkiller Zohydro ER*, SAN DIEGO UNION-TRIB., Aug. 1, 2014, at C1 (“[B]ecause Zohydro ER contains higher doses of hydrocodone than regular formulations, critics said it is more likely to be abused.”).

17. See Kristina Fiore & John Fauber, *Zohydro Lacks Abuse Deterrent: FDA Did Not Require Safeguard for Painkiller*, MILWAUKEE J. SENTINEL, Oct. 29, 2013, at A1; Peter Loftus, *Doctors Split on Benefits of Longer-Lasting New Painkiller*, WALL ST. J., May 27, 2014, at D1; cf. Lewis S. Nelson et al., Editorial,

The Commonwealth of Massachusetts responded aggressively to the imminent marketing of Zohydro. Although it had not encountered nearly the problems with OxyContin experienced by West Virginia and other states in the Appalachian region,¹⁸ officials in Massachusetts knew of that drug's scourge,¹⁹ and they seemed determined to prevent a replay. On March 27, 2014, Governor Deval Patrick issued an emergency declaration authorizing the Department of Public Health to prevent sales of the drug in Massachusetts until the manufacturer addressed concerns about abuse and diversion, which the Commissioner of Health did later that same day.²⁰ The FDA expressed dismay that a state would try to countermand its judgment in this fashion,²¹ and Zogenix lodged various constitutional

Addressing the Opioid Epidemic, 314 JAMA 1453, 1453 (2015) ("New opioid medications, many of them with tamper-resistant formulations, continue to be marketed despite the lack of evidence that these preparations reduce the risk of addiction."); Alan Schwarz, *Painkillers Resist Abuse, but Experts Still Worry; Inventive Addicts Thwart Safeguards*, N.Y. TIMES, June 7, 2015, at A16 (reporting some concerns about the limitations of such features). This would come later. See *infra* note 58 and accompanying text.

18. See Aron J. Hall et al., *Patterns of Abuse Among Unintentional Pharmaceutical Overdose Fatalities*, 300 JAMA 2613, 2617-19 (2008) (focusing on West Virginia); see also Bridget M. Kuehn, *CDC: Major Disparities in Opioid Prescribing Among States: Some States Crack Down on Excess Prescribing*, 312 JAMA 684, 685 (2014) ("[I]t's not clear why opioids and benzodiazepines are prescribed more in the South.").

19. See Yasmeen Abutaleb, *State Ranks Low in Prescribing of Opioids; Long-Acting Pills an Exception*, BOS. GLOBE, July 2, 2014, at A1; Tracy Jan, *Critics' Calls for Tougher Pain Pills Are Resisted; Want Drug Makers, FDA to Act to Help Stem Opiate Abuse*, BOS. GLOBE, Feb. 19, 2014, at A1; Elizabeth Mehren, *Hooks of "Hillbilly Heroin": Abuse of Prescription Painkiller OxyContin Ravages Poor Areas in the East*, L.A. TIMES, Oct. 4, 2001, at A1 ("Since April, more than 100 Boston-area pharmacies have been robbed of OxyContin. The robbers demand nothing else: not even cash . . ."); see also Brian MacQuarrie, *Governor Declares an Emergency on Opiate Abuse*, BOS. GLOBE, Mar. 28, 2014, at A1 ("Opiate overdoses in Massachusetts rose 90 percent from 2000 to 2012, the governor said.").

20. See Bradley J. Fikes, *Massachusetts Bans Painkiller Zohydro ER; Zogenix Takes Issue with Action, Which Applies to All Pure-Hydrocodone Drugs*, SAN DIEGO UNION-TRIB., Mar. 29, 2014, at C1. Other states contemplated doing so as well. See Jon Kamp, *New Painkiller Sparks Abuse Concern*, WALL ST. J., May 24, 2014, at A3 ("Lawmakers in Ohio and New York recently proposed measures that would effectively ban Zohydro by classifying it as a drug akin to heroin or LSD."); *id.* ("The manufacturer has . . . argued against legislation for state-level bans in New York and Ohio, which legal experts said could prove hard to defend because they counter a federal agency.").

21. See Fikes, *supra* note 20, at C1 ("[T]he [FDA] said state and congressional actions to unilaterally determine the legal status of various medications are 'extremely troubling.'"); see also Michael McCarthy, *FDA Chief*

objections to what commentators characterized as an unprecedented move.²²

Less than one month later, the federal district court in Massachusetts sided with Zogenix, issuing a preliminary injunction against the Commonwealth.²³ Although the court's order naturally offered only a limited discussion of the constitutional issues, Judge Rya Zobel concluded that the congressional statute governing the approval of new drugs impliedly preempted the state's action.²⁴ She ruled that a prohibition on the sale of an FDA-approved product in a particular state probably would stand as an obstacle to the accomplishment of federal purposes, which she understood as "mak[ing] drugs available to promote . . . the public health."²⁵ Judge

Defends Zohydro Approval as US States Rebel, 348 BMJ g2939 (Apr. 24, 2014), <http://dx.doi.org/10.1136/bmj.g2939> [<https://perma.cc/VNK3-7UW4>]. The FDA Commissioner later penned a commentary to this effect. See Margaret A. Hamburg, Opinion, *FDA Combats Opioid Abuse*, USA TODAY, Sept. 30, 2014, at 8A ("Zohydro is a very small fraction of the opioid marketplace. Singling out any individual opioid diverts the nation's focus from interventions that can make a real difference."). Her former deputy offered a somewhat less sanguine assessment. See Yngvild Olsen & Joshua M. Sharfstein, *Chronic Pain, Addiction, and Zohydro*, 370 NEW ENG. J. MED. 2061, 2063 (2014); see also Editorial, *Patrick's Drug Ban Shows Need for More Non-Opioid Painkillers*, BOS. GLOBE, Apr. 7, 2014, at A10 (applauding the state's action even while conceding that "[o]verruling the FDA—in effect, nullifying federal health policy—is no small matter").

22. See Travis Andersen, *Patrick Asks Ban on Drug Be Upheld: But Painkiller Zohydro Was Approved by FDA*, BOS. GLOBE, Apr. 12, 2014, at B2; Brady Dennis, *U.S. Judge Set to Rule on Drug Firm's Suit Against Massachusetts over Painkiller Ban*, WASH. POST, Apr. 14, 2014, at A4; Michael Ollove, *Fearing Abuse, States Target Painkiller: Local Limits on Zohydro Challenge the FDA on Protecting the Public*, CHI. TRIB., May 21, 2014, at N8 (calling it "perhaps the first time a state has ever tried to ban a drug approved by the FDA"); Milton J. Valencia, *State Defends Ban on New Drug; Zohydro's Maker Seeks Injunction*, BOS. GLOBE, Apr. 15, 2014, at B1 ("No other state is believed to have banned a drug that has already been approved by the" FDA.).

23. See Brady Dennis, *Judge Voids Ban on Painkiller in Mass.; State Claimed Zohydro's Pure Hydrocodone Is an Addiction Risk*, WASH. POST, Apr. 16, 2014, at A3; Milton J. Valencia, *US Judge Blocks State Ban on Opiate; Critics Say Zohydro Could Be Misused*, BOS. GLOBE, Apr. 16, 2014, at B1.

24. *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 1454696, at *2 (D. Mass. Apr. 15, 2014). At this point, Murray the muppet from *Sesame Street* might intone that "today's episode was brought to you by the letter Z."

25. *Id.* ("The FDA endorsed Zohydro ER's safety and effectiveness when it approved the drug. . . . If the Commonwealth were able to countermand the FDA's determinations and substitute its own requirements, it would undermine the FDA's ability to make drugs available to promote and protect the public health."). Notably, Judge Zobel never suggested finding implied conflict preemption premised instead on an impossibility of dual compliance.

Zobel distinguished cases that had rejected an implied preemption defense to inadequate warning claims in tort litigation:

Here, the obstruction is clearer because the drug Massachusetts wants Zogenix to adopt—Zohydro ER with an “abuse-resistant formulation”—has not been approved Zogenix would be required to return to the FDA and seek approval of a drug different from the one the FDA has already deemed safe.²⁶

Forecasting that Zogenix was likely to prevail on the merits, and finding the other factors for granting preliminary relief satisfied, Judge Zobel issued an injunction; she did not have to reach the plaintiff’s dormant Commerce Clause and other constitutional arguments.²⁷

Although Judge Zobel’s instincts seem entirely correct, it takes little effort to quibble with her characterization of the purposes underlying federal law. Congress crafted the current version of the licensing scheme for new drugs in order to *prevent* the introduction of unsafe or ineffective pharmaceutical products, and, when it did so, the legislation included language that appeared to preserve state authority:

Nothing in the amendments made by this Act to the Federal Food, Drug, and Cosmetic Act [FDCA] shall be construed as invalidating any provision of State law which would be valid in the absence of such amendments unless there is a direct and positive conflict between such amendments and such provision of State law.²⁸

The federal Controlled Substances Act (CSA) contains similar language.²⁹ In displacing state law only to the extent that “a direct

26. *Id.* (rejecting as well the defendants’ argument that “federal regulation is a floor, not a ceiling; if states wish to regulate over and above federal regulations, they may do so”).

27. *See id.* at *2 n.2; *see also infra* Section II.B (elaborating on the dormant Commerce Clause doctrine).

28. Drug Amendments of 1962, Pub. L. No. 87-781, § 202, 76 Stat. 780, 793. Even subsequently adopted express preemption provisions governing other therapeutic products regulated by the FDA provide for some flexibility. *See* 21 U.S.C. § 360k(b)(2)(A) (2012) (allowing states to seek waivers of preemption for medical devices where “required by compelling local conditions”); *id.* § 379r(b)(1) (allowing states to seek waivers for nonprescription drug products where a nonidentical requirement “protects an important public interest that would otherwise be unprotected, including the health and safety of children” and “would not unduly burden interstate commerce”).

29. *See* 21 U.S.C. § 903 (2012) (displacing state law only when “there is a positive conflict . . . so that the two cannot consistently stand together”); *see also* *City of Hartford v. Tucker*, 621 A.2d 1339, 1341 (Conn. 1993) (explaining that this section, “the antipreemption provision of the Controlled Substances Act, evidences

and positive conflict” exists, Congress expressed an intent that arguably forecloses implied preemption absent an impossibility of dual compliance—not because it can dictate how the federal courts apply the Supremacy Clause of the Constitution but by announcing a lack of any broader purpose to interfere with state authority. In contrast, the FDA’s subsequently codified—and entirely aspirational—mission statement,³⁰ which Judge Zobel had quoted,³¹ hardly supports her claim of an overriding federal purpose to promote patient access to approved drugs.

Congress has maintained the FDA’s stringent system for new drug approval in spite of frequent complaints that these requirements erect undue barriers to the prompt introduction of valuable pharmaceuticals.³² On occasion, it has lowered the threshold for licensure in order to serve significant unmet patient needs,³³ but these narrow exceptions only reinforce understanding the more general rules as designed to restrict rather than promote ready patient access. On even rarer occasions, the FDA has actively encouraged

the fact that Congress specifically considered the issue of concurrent state proceedings and decided to allow them”).

30. See Food and Drug Administration Modernization Act of 1997, Pub. L. No. 105-115, § 406(a), 111 Stat. 2296, 2369 (codified as amended at 21 U.S.C. § 393(b) (2012)).

31. See *Zogenix*, 2014 WL 1454696, at *2. Even if this purpose does not animate the FDA’s organic statute, Judge Zobel correctly considered issues of access for legitimate patients in assessing the other factors relevant to deciding whether to grant preliminary relief. See *id.* (“As to the equities, although the ban may prevent someone from misusing the drug, the ban prevents all in need of its special attributes from receiving the pain relief Zohydro ER offers. For the same reason, the injunction is in the public interest.”).

32. See Lars Noah, *Triage in the Nation’s Medicine Cabinet: The Puzzling Scarcity of Vaccines and Other Drugs*, 54 S.C. L. REV. 741, 748 (2003) (“Over the years, critics have blamed the FDA’s lengthy and demanding approval process for creating a ‘drug lag’ that delayed pharmaceutical products already approved in Europe and elsewhere from reaching the United States market.”); Scott Gottlieb, Opinion, *The FDA Is Evading the Law*, WALL ST. J., Dec. 23, 2010, at A17 (“Europeans are now approving novel drugs an average of three months more rapidly than we do.”); see also Sabrina Tavernise, *Bill to Speed Approvals for Drugs Is Cut Back*, N.Y. TIMES, May 1, 2015, at A16 (describing the latest congressional proposals to streamline the process).

33. See, e.g., 21 U.S.C.A. § 356 (West 2015) (delineating various expedited approval procedures for drugs intended to treat serious or life-threatening diseases); *id.* § 356-1 (same, for countermeasures to bioterror agents); see also Notice of Availability, Guidance for Industry on Expedited Programs for Serious Conditions—Drugs and Biologics, 79 Fed. Reg. 31,117 (May 30, 2014); Stephanie M. Lee, *FDA Speeds up Approval of Drug Breakthroughs*, S.F. CHRON., Aug. 4, 2014, at A1.

companies to seek approval for particular drugs, but generally the agency leaves those choices to the private sector.³⁴ Contrast the FDA's largely agnostic stance about the introduction of pharmaceutical products—and, even more so, the often grudging approach of the Drug Enforcement Administration (DEA) to the down-scheduling of controlled substances³⁵—with the recommendations sometimes issued by the U.S. Centers for Disease Control and Prevention (CDC) favoring, for instance, the use of certain vaccines.³⁶

34. See Noah, *supra* note 1, at 578 (“Usually, the FDA reviews whatever new drug applications happen to come in the door, but, on occasion, it actively recruits companies to seek approval for a product that the agency wants to see brought to market.”). In contrast, the National Institutes of Health (NIH) generously fund and license research into drugs that the government wants to see brought to market. See NOAH, *supra* note 4, at 1048-49; Alice Dembner, *Public Handouts Enrich Drug Makers*, BOS. GLOBE, Apr. 5, 1998, at A1 (“NIH spent at least \$1 billion on drug and vaccine development in fiscal 1996, but took in only \$27 million in royalties from all products.”).

35. See Lars Noah, *Challenges in the Federal Regulation of Pain Management Technologies*, 31 J.L. MED. & ETHICS 55, 60 (2003); *id.* at 61 (“The [DEA] also has shown less deference to medical practitioners and the regulatory prerogative of the states, instead seeming to regard them with some suspicion.”); see also *id.* at 55 (“[B]oth agencies have shown a marked resistance to making narcotics available as analgesic products, though the FDA has better appreciated the value of providing patients with a wide range of options for treating pain.”).

Traditionally, the FDA has adopted a clinical (or individualistic) mindset, leaving most of the difficult risk-benefit judgments in the hands of health care professionals and patients. . . . Conversely, the DEA's law enforcement mindset goes to the opposite extreme, giving perhaps undue weight to the negative externalities associated with access to narcotics and not trusting health care professionals. A public health perspective, [as exemplified by] the Centers for Disease Control and Prevention . . . , might help to mediate between these two potentially incompatible perspectives.

Id. at 64; see also *id.* at 60-61 (“This distribution of regulatory authority, between a traditional law enforcement agency and one that focuses on patient health, can generate incongruities.”).

36. See, e.g., Raymond A. Strikas, *Advisory Committee on Immunization Practices Recommended Immunization Schedules for Persons Aged 0 Through 18 Years—United States, 2015*, 64 MORBIDITY & MORTALITY WKLY. REP. 93 (2015). In connection with opioid drugs, however, the CDC recently sought to discourage their overuse; its new guidelines recommend, among other things, that primary care physicians first try nonopioid therapies—and then prescribe only a three- to seven-day course of opioids—when treating patients with acute pain. See Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016*, 315 JAMA (forthcoming Apr. 2016); Sabrina Tavernise, *New Standards for Painkillers Aim to Stem Overdose Deaths*, N.Y. TIMES, Mar. 16, 2016, at A1 (summarizing some of the controversy surrounding the issuance of these technically

Thus, federal drug approval requirements create a fairly stringent barrier to entry designed to guard against the marketing of worthless or unduly dangerous therapeutic agents.³⁷ Moreover, sponsors of genuinely promising investigational products can decide not to seek FDA approval,³⁸ even if they do so (and ultimately succeed), license holders generally have no obligation to commercialize their products,³⁹ to do so at an affordable price,⁴⁰ or in

nonbinding guidelines, and forecasting that they will prove to be highly influential); *id.* (“The federal government has lagged the states in its response to the opioid epidemic.”).

37. In fact, incumbent firms may take advantage of such strict licensing requirements to block rivals. See Lars Noah, *Sham Petitioning as a Threat to the Integrity of the Regulatory Process*, 74 N.C. L. REV. 1, 5-11 (1995) (illustrating different ways of manipulating the drug approval process for anticompetitive purposes); *id.* at 19-20 (explaining that “opportunities for deterring market entry [by potential competitors] may have been part of the political bargain struck between lawmakers and regulated entities”).

38. See Bruce M. Psaty & Drummond Rennie, Editorial, *Stopping Medical Research to Save Money: A Broken Pact with Researchers and Patients*, 289 JAMA 2128, 2129-30 (2003) (questioning the ethics of halting clinical trials solely for commercial reasons); Kurt M. Saunders, *Patent Nonuse and the Role of Public Interest as a Deterrent to Technology Suppression*, 15 HARV. J.L. & TECH. 389, 395-96 (2002) (suggesting that Amgen had shelved a patent on a protein binding factor that would have dramatically slowed the excretion—and therefore the dosages needed—of its blockbuster anemia drug Epogen[®]); *id.* at 411-12 (discussing antitrust claim brought against analgesic drug manufacturer after it had acquired but then restricted the sales of a competitor’s medical device used for pain relief); see also *Cacchillo v. Insmad, Inc.*, 638 F.3d 401, 406 (2d Cir. 2011) (affirming the denial of a preliminary injunction that would have ordered the sponsor of a completed (and unsuccessful) clinical trial of Iplex for muscular dystrophy to support a former subject’s application to the FDA for a compassionate use exemption to continue taking the abandoned investigational drug).

39. See William M. Janssen, *A “Duty” to Continue Selling Medicines*, 40 AM. J.L. & MED. 330, 342, 346-47, 364-66 (2014) (explaining that federal courts had summarily and correctly rejected the claim—asserted by plaintiffs in tort litigation after patients had lost access to critical drugs because of supply shortages—that FDA approval obligated license holders to continue selling their products); *id.* at 363 (“Existing law, however creatively repackaged, does not impose upon pharmaceutical manufacturers a ‘duty’ to keep selling their medicines.”); Noah, *supra* note 32, at 747 (explaining that drug manufacturers sometimes must give the FDA advance notice of supply interruptions); see also Noah, *supra* note 11, at 168-70 (identifying anticompetitive reasons why manufacturers may decide to cease marketing an older FDA-approved product).

40. See Lars Noah, *Governance by the Backdoor: Administrative Law(lessness?) at the FDA*, 93 NEB. L. REV. 89, 129 (2014) (explaining that “the FDA has no business trying to influence decisions about what prices companies charge for products subject to its jurisdiction”).

a manner that ensures easy access.⁴¹ Lastly, FDA approval does not invariably guarantee insurance coverage, even by the Centers for Medicare and Medicaid Services (CMS),⁴² an agency housed alongside the FDA in the Department of Health and Human Services (HHS). In short, approval of a new drug application represents a necessary but hardly sufficient condition for patient access.

If, in fact, these rather different purposes underlie drug approval requirements, then the argument for obstacle preemption loses much of its force. After all, many observers had misgivings about the wisdom of the FDA's risk-benefit judgment on Zohydro, and public health officials in Massachusetts had decided to take more seriously concerns about abuse and diversion, especially in light of doubts about the need for yet another powerful opioid analgesic. Then again, to the extent that Congress intended for the FDA to make definitive and nationally uniform judgments about the safety and effectiveness of pharmaceutical products,⁴³ state efforts to second-guess the agency's determinations certainly would threaten to frustrate those somewhat different purposes.⁴⁴

41. See Lars Noah, *Treat Yourself: Is Self-Medication the Prescription for What Ails American Health Care?*, 19 HARV. J.L. & TECH. 359, 360-62, 365, 383-91 (2006) (explaining that drug manufacturers generally prefer prescription status when first launching a new product, and arguing that the FDA could not switch it to nonprescription status over the license holder's objections).

42. See Lars Noah, *Coerced Participation in Clinical Trials: Conscripting Human Research Subjects*, 62 ADMIN. L. REV. 329, 333 & n.16 (2010).

43. See Peter H. Schuck, *Multi-Culturalism Redux: Science, Law, and Politics*, 11 YALE L. & POL'Y REV. 1, 39 (1993) ("For better or for worse, the FDA is the agency that the public has empowered to make authoritative judgments of this kind on its behalf."). See generally Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. (forthcoming 2017) (suggesting obstacle and even field preemption).

44. See *Ray v. Atl. Richfield Co.*, 435 U.S. 151, 165-68 (1978) (holding that a federal statute and implementing regulations promulgated by the Secretary of Transportation, which required vessels to secure certificates of inspection establishing compliance with those standards, impliedly preempted Washington's more stringent design requirements for oil tankers because they posed an obstacle to the accomplishment of Congress's goal of uniformity); *id.* at 164 ("Congress did not anticipate that a vessel found to be in compliance with the Secretary's design and construction regulations and holding a Secretary's permit, or its equivalent, to carry the relevant cargo would nevertheless be barred by state law from operating in the navigable waters of the United States on the ground that its design characteristics constitute an undue hazard."). For unanimous Supreme Court decisions holding similarly in later cases, see *United States v. Locke*, 529 U.S. 89, 108-16 (2000) (invalidating Washington's revised limits on oil tanker operation and personnel); *Barnett Bank of Marion Cty. v. Nelson*, 517 U.S. 25, 31-38 (1996) (invalidating a Florida statute that prohibited national banks from selling insurance in small towns where a federal statute had authorized such conduct); and *California v. FERC*, 495

Rather than continue litigating the case to secure a decision on the merits and possibly appeal (which might have allowed the courts to better assess these and other nuances), Massachusetts issued new rules that focused instead on the behavior of medical professionals licensed by the state: Before prescribing Zohydro, physicians would, among other things, have to check patient records for any evidence of substance abuse, and they then would have to prepare a letter of medical necessity (attesting, for instance, that other pain management treatments had failed) without which pharmacists could not dispense the drug.⁴⁵ In an amended complaint, Zogenix characterized these new rules as amounting to “a *de facto* ban,” and the federal district court found even some of these more limited restrictions problematic.⁴⁶

Judge Zobel explained that the letter of medical necessity requirement suffered from various ambiguities and could mean that, contrary to the labeling approved by the FDA, physicians should use Zohydro only as a drug of last resort.⁴⁷ Finding a probability of implied preemption because such an interpretation would frustrate the federal decision to make this product available for health professionals to use whenever they deemed it appropriate, she preliminarily enjoined enforcement of this rule pending clarification from the defendants.⁴⁸ As for the company’s challenge to a related state rule that allowed only licensed pharmacists to handle Zohydro

U.S. 490, 506-07 (1990) (“[A]llowing California to impose the challenged [minimum stream flow] requirements would be contrary to congressional intent regarding the Commission’s licensing authority and would constitute a veto of the [dam] project that was approved and licensed by FERC.”). Section II.A further elaborates on such arguments.

45. See Bradley J. Fikes, *Zogenix Fights New Restrictions; S.D. Biotech to Ask Court to Stop Mass. Rules for Painkiller Zohydro ER*, SAN DIEGO UNION-TRIB., June 10, 2014, at C2; Milton J. Valencia, *State Limits Use of Potent Painkiller; Addiction Concerns Raised on Zohydro*, BOS. GLOBE, Apr. 23, 2014, at B1; see also Ollove, *supra* note 22, at N8 (“[Gov.] Patrick responded to his loss in court by slapping other restrictions on Zohydro, beyond those mandated by the federal government. . . . Next door in Vermont, Democratic Gov. Peter Shumlin has already taken similar steps.”).

46. See *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 3339610, at *3-5 (D. Mass. July 8, 2014), *vacated in part*, 2014 WL 4273251 (D. Mass. Aug. 28, 2014).

47. See *id.* at *4.

48. See *id.* at *5. Strangely, apart from finding a probability of success on the merits, Judge Zobel said nothing about the other three prerequisites for granting preliminary relief even though her brief discussion of these factors when initially enjoining the outright prohibition would hardly apply with equal force to the prescribing restrictions.

(thereby barring pharmacy technicians or interns from doing so), Judge Zobel found insufficient evidence to justify a preliminary injunction on grounds of implied preemption.⁴⁹ She also summarily rejected an equal protection claim asserted by Zogenix, which had alleged that the defendants lacked any rational basis for singling out their drug from all of the other long-acting opioids.⁵⁰ Less than two months later, after the defendants issued revised rules clarifying what should appear in the medical necessity letter, Judge Zobel vacated her previous order: Instead of having to declare that other pain management options had “failed,” now physicians simply would have to refer to the “inadequa[cy]” of alternatives for a particular patient, which essentially mimicked the FDA-approved labeling and therefore avoided implied preemption.⁵¹

Even more so than her preemption analysis when preliminarily enjoining the outright ban, Judge Zobel offered a questionable explanation of how the prescribing and dispensing restrictions might conflict with federal law. She properly conceded that uncertainty about how state officials might interpret these rules made it difficult to discern whether they genuinely would frustrate federal purposes,⁵² but, even absent any such contingency (in short, assume that Massachusetts unmistakably had narrowed the circumstances of use

49. See *id.* (concluding that Zogenix had failed to “provide sufficient detail that pharmacies will not carry Zohydro”).

50. See *id.* at *2 n.3 (explaining that the Supreme Court has reserved so-called “class-of-one” equal protection claims for situations where clear standards exist against which to measure individual departures made by regulatory classifications rather than discretionary judgments that depend on particularized assessments). Judge Zobel also again declined to reach the plaintiff’s Contract Clause and dormant Commerce Clause objections. See *id.* (calling these “undeveloped arguments”); see also *Zogenix, Inc. v. Baker*, No. 14-11689-RWZ, 2015 WL 1206354, at *4-8 (D. Mass. Mar. 17, 2015) (declining to dismiss the plaintiff’s third amended complaint insofar as it again claimed implied preemption of the pharmacist-only handling restrictions, but granting the defendants’ motion to dismiss the equal protection, Contract Clause, and dormant Commerce Clause objections to that rule).

51. See *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 4273251, at *2-3 (D. Mass. Aug. 28, 2014). Having back-pedaled twice in response to preliminary injunctions, Massachusetts officials evidently now plan to rely on better prescription monitoring of all opioids. See Stephanie Ebbert, *New AG Seeks Tighter Prescription Monitoring: Drug Fight Is Top Healey Priority*, BOS. GLOBE, Jan. 5, 2015, at A1; cf. Christopher Rowland, *Groups Unite Against Curbing Painkillers; Industry, Doctors, Patients Lobby over Opiate Laws*, BOS. GLOBE, Dec. 29, 2014, at A1 (reporting some resistance to such initiatives).

52. See *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 3339610, at *5 (D. Mass. July 8, 2014).

or otherwise imposed conditions on prescribing above and beyond those of federal law), it would not create nearly the same conflict as had the original prohibition on use. No doubt, as Judge Zobel explained, a tradition of state regulation of the medical profession does not exclude the possibility of preemptive federal involvement in the field,⁵³ but she failed to recognize that Congress repeatedly had offered assurances that the FDA's authority to license therapeutic products would not interfere with the practice of medicine.⁵⁴

Thus, and entirely apart from doubts about Judge Zobel's view of the FDA's licensing requirements as designed to "promote" the availability of approved pharmaceuticals,⁵⁵ Congress evidently did not intend any such purpose to intrude upon the well-accepted powers of the states to regulate the activities of health care professionals. This legislative guidance seemingly renders obstacle preemption inapt,⁵⁶ unless, of course, a state rule purporting to regulate drug prescribing or dispensing in fact represented a veiled prohibition on use of an approved product.⁵⁷ In spite of its setbacks in the litigation, the Massachusetts Department of Public Health could

53. See *id.* at *4.

54. See Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. KAN. L. REV. 149, 166 n.74, 173 (2004); see also *id.* at 155 ("Congress repeatedly has announced its intention that federal officials take care not to interfere with the practice of medicine."); *id.* at 171, 175-76, 180, 191 n.179 (explaining that the FDA and the DEA defer to state decisions about who enjoys prescribing privileges). That article addressed the flipside of the problem considered here—namely, asking whether the Constitution might bar restrictive federal decisions in connection with therapeutic product licensure for posing an affront to state primacy in regulating health professionals.

55. See *supra* notes 28-42 and accompanying text. In contrast, when the Commonwealth of Massachusetts decided to boycott most companies doing business with Burma (Myanmar), it plainly threw a monkey wrench into the flexibility that Congress thought the President needed in using economic sanctions in response to human rights abuses in that country, resulting in a unanimous decision from the Supreme Court in an implied preemption case. See *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 373-88 (2000); *id.* at 388-91 (Scalia, J., concurring in the judgment) (taking issue only with the majority's repeated references to legislative history).

56. See Noah, *supra* note 54, at 166 ("[C]ourts have cited this provision [appearing in the Medicare statute] as evidence that Congress did not intend to preempt state laws related to the delivery of health care services to the elderly or the disabled."); cf. *id.* at 167-68 (conceding that the inclusion of a "savings" clause would do so more clearly).

57. Cf. *Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1398 (2013) ("A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect.").

find some solace in the fact that the FDA subsequently approved abuse-resistant versions of the pure hydrocodone product.⁵⁸

B. Previous Attempts to Bar FDA-Approved Drugs

Although the actions taken against Zohydro by officials in Massachusetts were unusual, the effort to restrict the availability of a pharmaceutical product licensed by the federal government was hardly unprecedented. On rare occasions, states have tried to ban or limit access to FDA-approved drugs ranging from contraceptives to controlled substances, and jurors applying state tort law have imposed liability on manufacturers for marketing dangerous pharmaceuticals notwithstanding the fact that expert regulatory officials had decided to license their sale. These various illustrations differ, however, from permissive state laws—such as those purporting to authorize the medical use of marijuana—in the face of federal prohibitions against the sale or possession of a drug.

One of the FDA's most prominent licensing decisions, now more than half a century ago, prompted resistance from state officials. After the agency approved the first oral contraceptive in 1960,⁵⁹ some states attempted to limit or entirely bar access by enforcing longstanding prohibitions against the use of contraceptives.⁶⁰ The United States Supreme Court invalidated these

58. See Thomas M. Burton, *Painkiller Maker Tries to Curb Abuse*, WALL ST. J., Oct. 2, 2014, at B9 (reporting that Zogenix had filed a supplemental approval application for such a formulation); Bradley J. Fikes, *Painkiller Unit Sold for \$100M Upfront; San Diego-Based Zogenix to Use Proceeds for Other Drug Trials*, SAN DIEGO UNION-TRIB., Mar. 11, 2015, at C1; see also Lisa Girion, *Powerful Painkiller Approved*, L.A. TIMES, Nov. 21, 2014, at A8 (reporting that Purdue Pharma, the manufacturer of OxyContin, had secured FDA approval for its abuse-resistant extended-release hydrocodone product Hysingla ER[®]).

59. See Melissa Bell, *On the Pill for Half a Century; Oral Contraceptives Have Had Broad Social Impact, but Some Women Now Seek Alternatives*, WASH. POST, May 11, 2010, at E1 (“It is hailed as one of the 10 greatest public-health accomplishments of the 20th century.”); Gardiner Harris, *It Started More Than One Revolution*, N.Y. TIMES, May 4, 2010, at D1 (“The pill’s role in the maturing of the F.D.A. has often been overlooked . . .”).

60. See Justin Driver, *Constitutional Outliers*, 81 U. CHI. L. REV. 929, 971 (2014) (“While Connecticut and Massachusetts were alone in prohibiting all sale and distribution of contraceptives, more than half of the states in the nation joined them with statutes forbidding advertisements for contraceptives. Nearly one-third of the states, moreover, had laws permitting only certain authorized medical professionals to distribute contraceptives.” (footnotes omitted)); Peter Smith, Comment, *The History and Future of the Legal Battle over Birth Control*, 49

restrictions.⁶¹ Decades later, after the FDA approved an emergency contraceptive product in 1999, some states balked,⁶² partly because of suspicions that it may work by blocking implantation of a fertilized egg.⁶³ Then, as federal officials grudgingly expanded nonprescription availability of this drug,⁶⁴ some states sought to restrict access to it.⁶⁵

CORNELL L.Q. 275, 278 (1964) (counting half a dozen other states with complete bans at that time).

61. See *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965) (invalidating state law as infringing marital right of privacy); see also *Carey v. Population Servs. Int'l*, 431 U.S. 678, 686-91 (1977) (invalidating New York law that allowed only pharmacists to dispense OTC contraceptives); *id.* at 691-99 (plurality opinion) (invalidating provision that barred almost all contraceptive access for individuals under sixteen years of age); *Eisenstadt v. Baird*, 405 U.S. 438, 447-55 (1972) (invalidating Massachusetts law that prohibited distribution to unmarried individuals as irrational under the Equal Protection Clause); *infra* notes 178-80 and accompanying text (elaborating on the basis for these decisions). See generally Ryan C. Williams, *The Paths to Griswold*, 89 NOTRE DAME L. REV. 2155 (2014). Although the introduction of oral contraceptives may have provided some of the impetus for challenging the old state laws, none of the cases decided by the Supreme Court focused on these powerful new hormonal agents (as opposed to older products such as condoms, diaphragms, and spermicides). Cf. *Eisenstadt*, 405 U.S. at 463-64 & n.4 (White, J., concurring in judgment) (contrasting FDA prescription requirements for the pill with state prescription requirements that would apply even to vaginal foam dispensed to a married person); *id.* at 469-71 & n.4 (Burger, C.J., dissenting) (discussing same); Mary L. Dudziak, *Just Say No: Birth Control in the Connecticut Supreme Court Before Griswold v. Connecticut*, 75 IOWA L. REV. 915, 936 (1990) (“The [New Haven] clinic served a heavy load of clients, and prescribed a variety of contraceptives, including the new birth control pills.”).

62. They did so indirectly by enacting “conscientious objector” laws that allowed pharmacists and other health care professionals to refuse to dispense or prescribe such drugs. See, e.g., MISS. CODE ANN. § 41-107-3 & -5 (2015); S.D. CODIFIED LAWS § 36-11-70 (2015); Angela K. Brown, *Lawsuit Protection Helps South Dakota Druggists Bring Beliefs to Work*, CHI. TRIB., May 14, 1998, at C2; Monica Davey & Pam Belluck, *Pharmacies Balk on After-Sex Pill and Widen Fight*, N.Y. TIMES, Apr. 19, 2005, at A1; see also Marcia D. Greenberger & Rachel Vogelstein, *Pharmacist Refusals: A Threat to Women’s Health*, 308 SCIENCE 1557, 1558 (2005) (“Since 1997, 28 states have introduced legislation that would permit pharmacists to refuse to dispense, and sometimes to refer or transfer, drugs on the basis of moral or religious grounds.”).

63. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2762-63, 2765-66 (2014); Marc Kaufman, *Plan B Battles Embroid States; Proposals Mirror Red-Blue Divide*, WASH. POST, Feb. 27, 2006, at A1; see also Pam Belluck, *No Abortion Role Seen for Morning-After Pill*, N.Y. TIMES, June 6, 2012, at A1 (reporting that concerns of an arguably abortifacient mechanism of action lack any scientific foundation).

64. See *Tummino v. Hamburg*, 936 F. Supp. 2d 198, 201 (E.D.N.Y. 2013) (declining to tolerate any further “agency filibuster”), *stay granted in part*, No. 13-

In 2000, the FDA approved the controversial abortifacient drug mifepristone (Mifeprex[®]).⁶⁶ Initially, it seemed that some states would try to forbid its sale.⁶⁷ Although outright prohibitions never materialized, several states decided to impose restrictions on use of the drug,⁶⁸ which have triggered challenges in the courts.⁶⁹ Insofar as

1690, 2013 WL 2435370 (2d Cir. June 5, 2013); *id.* at 208-09 (reiterating that the FDA's decision was tainted by political interference, and calling the government's arguments "frivolous and . . . taken for the purpose of delay"); Lisa Heinzerling, *The FDA's Plan B Fiasco: Lessons for Administrative Law*, 102 GEO. L.J. 927, 938-58 (2014); Michael D. Shear & Pam Belluck, *Obama to Drop Limit on Selling a Contraceptive*, N.Y. TIMES, June 11, 2013, at A1 ("The fight to make emergency contraceptives universally available without a prescription is more than a decade old.").

65. See Samantha Harper, Note, "*The Morning After*": *How Far Can States Go to Restrict Access to Emergency Contraception?*, 38 COLUM. HUM. RTS. L. REV. 221, 222, 235-36 (2006); John Schwartz, *Oklahoma: Birth Control Limit Halted*, N.Y. TIMES, Aug. 20, 2013, at A11 ("The Oklahoma Legislature subsequently passed a law that required purchasers to show identification and, if age 17 or under, to have a prescription.").

66. See Gina Kolata, *U.S. Approves Abortion Pill; Drug Offers More Privacy, and Could Reshape Debate*, N.Y. TIMES, Sept. 29, 2000, at A1; see also David Crary, *Abortion Pill Remains Controversial*, WASH. POST, Oct. 3, 2010, at A3 (reporting that almost 1.4 million women in the U.S. have taken mifepristone in the first decade of availability, now accounting for about 15% of all abortions); Marc Kaufman, *Abortion Foes Want RU-486 Pill Pulled; Deaths of Several Women Are Cited*, WASH. POST, May 17, 2006, at A3 (reporting that opponents have lobbied Congress and petitioned the FDA to withdraw approval).

67. See Charles Ornstein, *Abortion Pill's Foes Shift Focus—Restrictions, Ban to Be Sought in States*, DALL. MORNING NEWS, Sept. 30, 2000, at 1A; Charles Ornstein, *Lawmakers Urge Restrictions on Abortion Pill*, DALL. MORNING NEWS, Feb. 2, 2001, at 8A (reporting that a bill had been introduced in Oklahoma to ban sales); Stephanie Simon, *Abortion Rights Group Challenges Mich. Law*, L.A. TIMES, Feb. 27, 2001, at A12 ("16 states have introduced legislation to restrict the use of RU-486."). A few states still have old laws on the books making it a crime to distribute abortifacient drugs. See, e.g., LA. STAT. ANN. § 14:88 (2015); N.Y. PENAL LAW § 125.60 (McKinney 2015).

68. See Laurah J. Samuels, Note, *Mifepristone Protocol Legislation—The Anti-Choice Movement's Disingenuous Method of Attack on the Reproductive Rights of Women and How Courts Should Respond*, 26 COLUM. J. GENDER & L. 316, 325-30 (2014) (discussing statutes from Arizona, North Dakota, Ohio, Oklahoma, and Texas); see also Sandhya Somashekhar, *Abortion Pills Prescribed via Net Targeted*, WASH. POST, Dec. 31, 2010, at A2 ("State legislators in Iowa and Nebraska have announced their intention to try to ban telemedicine abortions . . .").

69. See, e.g., *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 600-05 (5th Cir. 2014) (rejecting constitutional objections to Texas statute); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 907-10, 915-18 (9th Cir.) (concluding that plaintiffs were entitled to a preliminary injunction to block Arizona's law), *cert. denied*, 135 S. Ct. 870 (2014); *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490, 513-18 (6th Cir. 2012) (affirming

these states simply mandated strict adherence to the directions for use specified in the labeling approved by the FDA, even though the agency itself does not do so,⁷⁰ they at least managed to avoid a direct confrontation with the federal licensing decision.⁷¹

Miscellaneous other drugs approved by the FDA have encountered state-imposed limitations. For instance, in 1978, Illinois moved the analgesic pentazocine (Talwin[®]) from Schedule IV to the far more restrictive Schedule II.⁷² More than a dozen states added the muscle relaxant carisoprodol (Soma[®]) to their schedules of controlled substances before the federal government decided to

summary judgment granted to Ohio officials); *Planned Parenthood Sw. Ohio Region v. DeWine*, 64 F. Supp. 3d 1060, 1069-70 (S.D. Ohio 2014) (rejecting a motion to dismiss the plaintiffs' sole remaining constitutional objection related to the lack of a health exception in Ohio's law); *see also* *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 265-69 (Iowa 2015) (invalidating rule barring telemedicine to dispense mifepristone). These challenges claimed an undue burden on the abortion decision but did not raise any preemption arguments.

70. *See* Marc Kaufman, *Death After Abortion Pill Reignites Safety Debate; Opponents Renew Drive to Ban Drug Woman Took*, WASH. POST, Nov. 3, 2003, at A3; *see also* Eric A. Schaff et al., *Vaginal Misoprostol Administered 1, 2, or 3 Days After Mifepristone for Early Medical Abortion*, 284 JAMA 1948, 1952 (2000) ("A regimen that requires misoprostol to be given in an office setting 2 days after mifepristone, followed by 4 hours of observation, . . . is unnecessarily restrictive and creates scheduling and additional cost barriers to women."); Sarah Lueck, *Groups Offer Abortion-Drug Variations*, WALL ST. J., Oct. 30, 2000, at B2. *See generally* Lars Noah, *Informed Consent and the Elusive Dichotomy Between Standard and Experimental Therapy*, 28 AM. J.L. & MED. 361, 397-99 (2002) (discussing the FDA's recognition of the legitimacy of "off-label" use).

71. In contrast, any more onerous restrictions would have confronted serious preemption (among other) objections:

To the extent that recent Supreme Court [decisions] have reinvigorated implied preemption in cases where state law stands as an "obstacle" to the achievement of federal purposes, one could argue that any state efforts to prohibit or restrict distribution of mifepristone would create an impermissible conflict with federal law. After all, the Clinton administration actively encouraged the introduction of mifepristone in the U.S. market, and it took some unprecedented steps to facilitate FDA approval. It would not necessarily matter that the new administration fails to share the goals that inspired the agency's earlier licensing decision.

Noah, *supra* note 1, at 601 (footnote omitted).

72. *See* May Annexion, *Pentazocine Reclassified in Illinois*, 240 JAMA 2234, 2234 (1978); *see also* Steve Sternberg, *Growing Alarm over Migraine Drug's Addictive Potential*, USA TODAY, June 16, 1997, at 6D (reporting that ten states had listed the migraine headache drug butorphenol tartrate (Stadol[®]) as a controlled substance while the DEA had not yet done so even though its manufacturer and the FDA belatedly recommended such a classification).

follow suit in 2011.⁷³ In 2006, responding to its use in cooking methamphetamine, Congress demanded that pseudoephedrine, an active ingredient previously found in numerous OTC cough-cold products, remain in an intermediate “behind-the-counter” status.⁷⁴ A pair of states now require a prescription for pseudoephedrine,⁷⁵ and Alabama went so far as to prohibit the sale of any products containing this ingredient unless they had incorporated abuse-resistant features, though the state repealed this restriction four years later just before it would have taken effect.⁷⁶

73. See Schedules of Controlled Substances: Placement of Carisoprodol into Schedule IV, 76 Fed. Reg. 77,330, 77,358 (Dec. 12, 2011) (codified as amended at 21 C.F.R. § 1308.14(c)(6) (2015)); *id.* at 77,342, 77,358 app. A (identifying seventeen states that had classified the drug as a controlled substance); Jennifer A. Fass, *Carisprodol Legal Status and Patterns of Abuse*, 44 ANNALS PHARMACOTHERAPY 1962, 1963 & tbl.1 (2010) (identifying eighteen states that had done so). Classification as a controlled substance would only amount to a ban if the drug gets assigned to Schedule I.

74. See Combat Methamphetamine Epidemic Act of 2005, Pub. L. No. 109-177, § 711(b)(1), 120 Stat. 192, 258-61 (2006) (codified at 21 U.S.C. § 830(e) (2012)); see also *id.* § 711(g), 120 Stat. at 263 (savings clause); Note, *Cooking up Solutions to a Cooked up Menace: Responses to Methamphetamine in a Federal System*, 119 HARV. L. REV. 2508, 2519, 2524-29 (2006) (applauding Congress’s decision not to preempt more restrictive state laws).

75. See Abby Goodnough, *States Battling Meth Makers Look to Limit Ingredients: Unable to Stop the Illicit Use of Decongestants, Officials Weigh Requiring Prescriptions*, N.Y. TIMES, Mar. 29, 2011, at A19 (“Faced with a surging methamphetamine problem, a number of states are weighing contentious bills this spring that would require a doctor’s prescription for popular decongestants like Sudafed. . . . Two states, Mississippi and Oregon, already require prescriptions . . .”). Wholly apart from the operation of the express preemption clause for OTC drugs, such a requirement appears to represent a fairly direct conflict with federal law. See Noah, *supra* note 41, at 368 & n.53, 381-82.

76. See 2005 Ala. Laws 181 (H.B. 152) (codified at ALA. CODE § 20-2-190(c)(1)(a) (2008)) (“On or after October 1, 2009, no product containing ephedrine or pseudoephedrine shall be sold in this state unless the product is manufactured in such a manner that the ephedrine or pseudoephedrine cannot be extracted so as to be used as an ingredient in the production of methamphetamine.”), *repealed by* 2009 Ala. Laws 283 (S.B. 47). Thus, like the invalidated hydrocodone rule in Massachusetts, the state had sought to force manufacturers to reformulate products that satisfied FDA requirements. It would take a few years more before abuse-resistant pseudoephedrine products (e.g., Nexafed[®] to replace Sudafed[®]) became available. See Albert W. Brzeczko et al., *The Advent of a New Pseudoephedrine Product to Combat Methamphetamine Abuse*, 39 AM. J. DRUG & ALCOHOL ABUSE 284, 289 (2013); Christine Byers, *Drug Firm Sees Profit in Meth Bill: Missouri Measure Would Exempt Product Resistant to Meth Cooks’ Methods*, ST. LOUIS POST-DISPATCH, Mar. 29, 2012, at A1; see also Jennifer Corbett Dooren, *Decongestants Get Makeover to Keep Them over the Counter*, WALL ST. J., May 9, 2006, at D3 (explaining that incentives created by other restrictions had prompted

In some cases, states may legislate in anticipation of federal approval; for instance, with controversial new drugs intended for use in food-producing animals pending before the FDA, a few states enacted prohibitions.⁷⁷ In other cases, states may act in anticipation of federal withdrawal of a previously issued license; for instance, just one week before the FDA decided to rescind approval,⁷⁸ the Florida board of medicine severely restricted the use of the diet drugs fenfluramine (Pondimin[®]) and dexfenfluramine (Redux[®]).⁷⁹ In sharp contrast, Tennessee's board had entirely prohibited the use of these drugs starting in 1991, though the state legislature overrode that ban just months prior to the FDA's withdrawal.⁸⁰ In 2014, the Minnesota

some manufacturers to replace pseudoephedrine with the somewhat less effective ingredient phenylephrine).

77. See Lars Noah, *Whatever Happened to the "Frankenfish"?: The FDA's Foot-Dragging on Transgenic Salmon*, 65 ME. L. REV. 606, 614 (2013) (explaining that "some states already have acted preemptively against transgenic fish: a few banned their use in aquaculture within state borders"); Gregory D.L. Morris, *Two States Enact BST Moratoria*, CHEMICAL WK., May 9, 1990, at 10 (reporting that Wisconsin and Minnesota barred the use of recombinant bovine somatotropin (rbST) "for one year from the day of FDA approval"); Keith Schneider, *U.S. Approves Use of Drug to Raise Milk Production*, N.Y. TIMES, Nov. 6, 1993, § 1, at 1 ("Thousands of farmers in the Upper Middle West joined with [activist Jeremy] Rifkin in a grass-roots campaign that succeeded in persuading the state legislatures of Wisconsin and Minnesota three years ago to enact temporary moratoriums on the use of the drug in the event it was approved. The state moratoriums have since expired."); see also Dan L. Burk, *The Milk Free Zone: Federal and Local Interests in Regulating Recombinant BST*, 22 COLUM. J. ENVTL. L. 227, 264 (1997) ("[L]egislation hostile to rbST might take the form of a ban on the hormone Although no such legislation is currently in force, some states enacted bans during the pendency of Monsanto's application for FDA approval of rbST, and various states and localities have contemplated bans since approval was obtained."); Lars Noah, *Managing Biotechnology's [R]evolution: Has Guarded Enthusiasm Become Benign Neglect?*, 11 VA. J.L. & TECH. 4, ¶ 40 (2006) (discussing rbST).

78. See Gina Kolata, *2 Top Diet Drugs Are Recalled Amid Reports of Heart Defects*, N.Y. TIMES, Sept. 16, 1997, at A1; see also Steven R. Salbu, *The FDA and Public Access to New Drugs: Appropriate Levels of Scrutiny in the Wake of HIV, AIDS, and the Diet Drug Debacle*, 79 B.U. L. REV. 93, 124-32 (1999).

79. See Mark Maremont, *Florida Moves to Restrict Use of Diet Drugs*, WALL ST. J., Sept. 9, 1997, at B12; see also Bill Bergstrom, *State Ban of Fen-Phen to Become Permanent*, MIAMI HERALD, Sept. 30, 1997, at 5B. In contrast to Zohydro, however, this action came in response to emerging safety concerns not fully appreciated by the FDA when it originally had approved these drugs. See Gregory D. Curfman, Editorial, *Diet Pills Redux*, 337 NEW ENG. J. MED. 629 (1997) (summarizing these newly appreciated risks). In a sense, Florida simply beat the FDA to the punch.

80. See TENN. COMP. R. & REGS. 0880-02-.14(3)(C) (1992), superseded in part by statute, 1997 Tenn. Pub. Acts 236, § 3 (codified at TENN. CODE ANN. § 63-6-

legislature enacted a statute banning most uses of the antibacterial agent triclosan because of emerging safety concerns, but it specifically excluded products approved by the FDA for consumer use,⁸¹ which represents either a concession to the inability of a state to override a federal licensing decision or an overabundance of caution to avoid confronting an issue that might prompt litigation.

In short, states have on occasion attempted to nullify FDA decisions to approve a product. The obverse situation—namely, state efforts to disregard federal *nonapproval* decisions—has attracted far more attention in recent years. In particular, nearly half of the states have adopted laws authorizing the medical use of marijuana notwithstanding its continued status as a Schedule I (illicit) drug under federal law,⁸² much less the failure of the FDA to approve its use.⁸³ Similarly, after the FDA acted against amygdalin (Laetrile) in

214(m)-(n) (2015)); Ann Hardie, *The Diet Drug Debate: Weighing the Risks—Millions Helped, but Worry Grows as Use Expands*, ATLANTA J.-CONST., June 5, 1997, at C1 (“[T]he Tennessee Legislature [just] lifted a six-year ban on phen-fen because Tennessee residents were going to other states to get the pills.”). Because the 1991 regulation also had covered any derivative forms of fenfluramine, it prevented the prescribing of Redux immediately upon the FDA’s approval of that drug in 1996.

81. See 2014 Minn. Laws ch. 277, § 8(2) (May 16, 2014) (codified at MINN. STAT. § 145.945(2) (2015)); Megan Gannon, *Cancer Tied to Common Antibacterial Ingredient*, WASH. POST, Nov. 25, 2014, at E5 (“Minnesota became the first state to pass a law banning triclosan, though that rule won’t go into effect until 2017.”); Brian Palmer, *Ban on an Antimicrobial Ingredient Raises Questions*, WASH. POST, June 3, 2014, at E6 (“It was a bold move, because the [FDA] is currently reviewing the safety and efficacy of triclosan. By acting now, Minnesota lawmakers effectively preempted the FDA.”). In 1997, the FDA had approved the use of triclosan in Colgate’s Total[®] toothpaste with a claim that it can help fight gingivitis. See Matthew Perrone, *Popular Chemical Under FDA Review*, BOS. GLOBE, May 3, 2013, at B9.

82. See Kevin P. Hill, *Medical Marijuana for Treatment of Chronic Pain and Other Medical and Psychiatric Problems: A Clinical Review*, 313 JAMA 2474, 2475 (2015) (“23 states and the District of Columbia have enacted medical marijuana laws to facilitate access to marijuana as a treatment for a variety of medical conditions.”); *id.* at 2476-77 tbl.1 (summarizing these various laws); see also Todd Grabarsky, *Conflicting Federal and State Medical Marijuana Policies: A Threat to Cooperative Federalism*, 116 W. VA. L. REV. 1, 10-20 (2013). Congress recently (and only partially) relented. See Consolidated and Further Continuing Appropriations Act of 2015, Pub. L. No. 113-235, § 538, 128 Stat. 2130, 2217 (2014) (providing that appropriations for the Department of Justice cannot be used to prevent the implementation of medical marijuana laws in thirty-two listed states and the District of Columbia).

83. See *Gonzales v. Raich*, 545 U.S. 1, 28 (2005) (“[T]he dispensing of new drugs, even when doctors approve their use, must await federal approval.”); Deepak Cyril D’Souza & Mohini Ranganathan, Editorial, *Medical Marijuana: Is the Cart*

the 1970s, numerous states legalized the use of this purported treatment for cancer.⁸⁴ Like marijuana, amygdalin can be produced locally, typically by using apricot kernels; unlike marijuana, the drug does not qualify as a controlled substance, so mere possession would not violate federal law.⁸⁵

“Right to try” laws represent the most recent example of state legislation attempting to stake out a more permissive policy than has the federal government. Enacted in two dozen states and under consideration in several others, these laws purport to allow desperately ill patients to access investigational drugs not yet approved by the FDA.⁸⁶ Although it has become somewhat more flexible about allowing terminally ill patients not enrolled in clinical trials to request supplies from manufacturers,⁸⁷ the agency rejected broader initiatives that would routinely allow patient access before

Before the Horse?, 313 JAMA 2431, 2431 (2015) (“For most of the conditions that qualify for medical marijuana use, the evidence fails to meet FDA standards.”); Noah, *supra* note 35, at 60 (“[U]nlike chemicals synthesized by pharmaceutical companies, the FDA could not effectively exercise its regulatory authority to demand proof of safety and efficacy over a raw product with variable composition that individuals can grow in their homes.”); Claire Frezza, Note, *Medical Marijuana: A Drug Without a Medical Model*, 101 GEO. L.J. 1117, 1134-38 (2013); Serge F. Kovalski, *Medical Marijuana Research Hits Wall of U.S. Law*, N.Y. TIMES, Aug. 10, 2014, at A4 (“[I]t does not see much potential for developing marijuana in smoked form into an approved prescription drug.”).

84. See *United States v. Rutherford*, 442 U.S. 544, 554 n.10 (1979); see also Charles G. Moertel et al., *A Clinical Trial of Amygdalin (Laetrile) in the Treatment of Human Cancer*, 306 NEW ENG. J. MED. 201, 201 (1982).

85. See Noah, *supra* note 54, at 187 n.162; see also Barrie Cassileth, *Beyond the Mainstream: Laetrile by Any Other Name Is Still Bogus*, L.A. TIMES, Jan. 1, 2001, at F1; Marc Kaufman, *FDA Is Moving to Halt Online Sales of Laetrile; Sites Promote Unapproved Cancer Therapy*, WASH. POST, Sept. 7, 2000, at A2; cf. Donald G. McNeil, Jr., *A New Strain of Yeast Can Produce Narcotics*, N.Y. TIMES, Aug. 14, 2015, at A18 (reporting that, in spite of the latest advances in genetic engineering to allow for the production of the hydrocodone and other opioids in the laboratory rather than deriving them from opium poppies, there is no imminent danger of “home-brewed heroin” and the like).

86. See Naomi Lopez Bauman, Opinion, *Cancer Moonshot Needs FDA to Get out of the Way*, USA TODAY, Feb. 5, 2016, at 7A; see also Rebecca Dresser, *The “Right to Try” Investigational Drugs: Science and Stories in the Access Debate*, 93 TEX. L. REV. 1631, 1640-47 (2015) (summarizing the debate over these measures); Kelly Servick, *“Right to Try” Laws Bypass FDA for Last-Ditch Treatments*, 344 SCIENCE 1329, 1329 (2014).

87. See, e.g., Notice of Availability, Individual Patient Expanded Access Applications: Form FDA 3926; Draft Guidance for Industry, 80 Fed. Reg. 7318, 7319 (Feb. 10, 2015); Expanded Access to Investigational Drugs for Treatment Use, 74 Fed. Reg. 40,900, 40,942-45 (Aug. 13, 2009) (codified at 21 C.F.R. pts. 312 & 316 (2015)).

approval.⁸⁸ Moreover, pharmaceutical companies sponsoring clinical trials of investigational drugs would violate federal law if they supplied such products to patients without first securing a waiver from the FDA, so these state laws seem to represent little more than symbolic gestures.⁸⁹ In practice, the agency routinely grants such requests, but manufacturers may have entirely valid reasons not to seek waivers.⁹⁰ Although these various more permissive state laws also demonstrate a lack of respect for the judgments of federal officials, the constitutional assessment developed in Part II focuses on the conflicts that arise when states opt for a more (as opposed to less) restrictive approach than the FDA.⁹¹

88. See Abigail All. for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 699-700 (D.C. Cir. 2007) (en banc); see also Seema Shah & Patricia Zettler, *From a Constitutional Right to a Policy of Exceptions: Abigail Alliance and the Future of Access to Experimental Therapy*, 10 YALE J. HEALTH POL'Y L. & ETHICS 135, 174-89 (2010) (critiquing proposals to further expand access).

89. See Patricia J. Zettler & Henry T. Greely, *The Strange Allure of State "Right-to-Try" Laws*, 174 JAMA INTERNAL MED. 1885, 1885 (2014); *id.* at 1886 (drawing a parallel to the Zohydro dispute in Massachusetts); see also Jessie Hellmann, *Bills Would Give Terminally Ill Access to Experimental Drugs*, CHI. TRIB., Mar. 8, 2015, at A6 ("[E]ven backers of the idea say they don't know of anyone who has benefited from recent [state] attempts to expand access."); Julie Turkewitz, *Patients Seek "Right to Try" New Drugs*, N.Y. TIMES, Jan. 11, 2015, at A16 ("The laws do not seem to have helped anyone obtain experimental medicine, as the drug companies are not interested in supplying unapproved medications outside the supervision of the F.D.A. But that seems almost beside the point to the Goldwater Institute, the libertarian group behind legislative efforts to pass Right to Try laws."); *id.* (explaining that a new law in Colorado "does not require companies to provide the treatment, nor does it mandate that insurance companies cover it").

90. See Brady Dennis & Ariana Eunjung Cha, *In 3 States, Dying Patients Will Soon Get the "Right to Try" Unproven Drugs*, WASH. POST, May 17, 2014, at A3 ("It's unclear how many drugmakers might be willing to make use of the state laws at the risk of angering federal regulators."); Peter Loftus & Dan Frosch, *States Open to Drug Options—Expanding Experimental Therapies to the Dying Gains Traction Among Lawmakers*, WALL ST. J., May 19, 2014, at A3 ("Drug makers and the FDA have expressed concerns about the state proposals."); *id.* ("Providing early access to experimental drugs poses a dilemma for companies and federal regulators who don't want to jeopardize patient safety or the integrity of clinical trials needed to get new drugs on the market."); Katie Thomas, *Company Creates Panel for Access to Trial Drugs*, N.Y. TIMES, May 7, 2015, at A1 ("The F.D.A. typically signs off on use of unapproved drugs, but not until the company agrees. But [for a variety of reasons] saying yes is not so simple . . .").

91. Interestingly, one scholar who has focused on marijuana laws viewed this mirror-image problem as relatively uncomplicated. See Robert A. Mikos, *On the Limits of Supremacy: Medical Marijuana and the States' Overlooked Power to Legalize Federal Crime*, 62 VAND. L. REV. 1421, 1422 (2009) ("When Congress

Products liability litigation offers another illustration of this problem.⁹² Under state tort law, a few courts have allowed juries to find that an FDA-approved drug suffered from a defective design, which amounts to a conclusion that the manufacturer should never have marketed this particular pharmaceutical product notwithstanding the favorable judgment of an expert regulatory agency.⁹³ For instance, in *Tobin v. Astra Pharmaceutical Products, Inc.*,⁹⁴ a pregnant woman developed serious cardiac problems while taking ritodrine (Yutopar[®]). The plaintiff prevailed at trial on her design defect and failure-to-warn claims, after her experts identified numerous methodological flaws in the clinical trials submitted to the FDA, which members of the agency's advisory committee also had criticized. The federal appellate court in *Tobin* affirmed, concluding that, notwithstanding the fact of FDA approval (and the absence of any evidence of fraud in securing that approval or contrary postapproval data), the jury could have decided that the manufacturer should never have marketed the drug because it had no good evidence of effectiveness in improving neonatal outcomes.⁹⁵

legalizes a private activity that has been banned by the states, the application of the Supremacy Clause is relatively straightforward: barring contrary congressional intent, such state laws are unenforceable"); *id.* at 1426 (emphasizing the need "to distinguish between (1) federal laws authorizing conduct banned by the states (under which state power is significantly constrained), and (2) federal laws banning conduct authorized by the states (under which states wield considerably more power)"); *id.* at 1480 (elaborating on this distinction); see also Ernest A. Young, *Modern-Day Nullification: Marijuana and the Persistence of Federalism in an Age of Overlapping Regulatory Jurisdiction*, 65 CASE W. RES. L. REV. 769, 791 (2015).

92. More typically, nullification refers to the power of jurors to disregard applicable law as instructed by a judge. See Lars Noah, *Civil Jury Nullification*, 86 IOWA L. REV. 1601, 1603-06 (2001); cf. Sanford Levinson, *The Twenty-First Century Rediscovery of Nullification and Secession in American Political Rhetoric: Frivolousness Incarnate or Serious Arguments to Be Wrestled with?*, 67 ARK. L. REV. 17, 43-44 (2014) (contrasting jury nullification with efforts by state officials to resist federal law). In the cases discussed here, however, state law expressly invites jurors to disregard the licensing decisions of federal agency experts.

93. See Lars Noah, *This Is Your Products Liability Restatement on Drugs*, 74 BROOK. L. REV. 839, 852 (2009) ("A conclusion that a prescription drug has a design defect may well amount to a command that would deprive other patients of access to the product."); see also *id.* at 851 ("One central objection to the recognition of a broader form of 'product category' liability is that it would allow courts to decide that lawfully marketed products should not be available to consumers.").

94. 993 F.2d 528 (6th Cir. 1993) (applying Kentucky law).

95. See *id.* at 537-40; see also *Wimbush v. Wyeth*, 619 F.3d 632, 641-46 (6th Cir. 2010) (reversing summary judgment granted to the defendant on the basis of implied preemption of a negligence claim under Ohio law brought on behalf of a

Somewhat remarkably, the *Products Liability Restatement* cited *Tobin* with approval.⁹⁶

Indeed, if a patient experienced a side effect while taking Zohydro that the manufacturer had adequately warned about, then (under the tort law of Massachusetts as elsewhere) he or she could claim a defective design in this drug given the availability of safer substitutes.⁹⁷ The prospect that such a claim might succeed, and that it could lead to the imposition of a hefty fine (i.e., an award of damages),⁹⁸ would make manufacturers think twice before marketing an FDA-approved drug—in fact, that is precisely the stated goal of those who favor allowing jury scrutiny in such circumstances.⁹⁹ In

patient who died from primary pulmonary hypertension asserting that the manufacturer should never have brought the diet drug Redux[®] (dexfenfluramine) to market notwithstanding receipt of FDA approval with labeling that warned of precisely this risk); *id.* at 645 (favorably citing *Tobin* as involving a case of “pre-approval design defect”). For my detailed critique of *Tobin*, see Noah, *supra* note 93, at 869-71 (concluding that the court “turned a complex risk-utility judgment, using data from less than ideal clinical trials, into a no-brainer by allowing the jury to conclude that the drug was totally ineffective”).

96. See RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 6 cmt. f & illus. 1 (1998); see also *id.* cmt. b, at 146 (“[U]nqualified deference to these regulatory mechanisms is considered by a growing number of courts to be unjustified. An approved prescription drug or medical device can present significant risks without corresponding advantages.”); James A. Henderson, Jr., *Prescription Drug Design Liability Under the Proposed Restatement (Third) of Torts: A Reporter’s Perspective*, 48 RUTGERS L. REV. 471, 492 (1996) (conceding that section 6(c) “allows courts to second-guess the FDA on the . . . question of whether a drug approved by the FDA and marketed by a defendant should *not* have been approved and marketed,” though trusting that that would occur “only in relatively rare cases”); James A. Henderson, Jr. & Aaron D. Twerski, Essay, *Drug Designs Are Different*, 111 YALE L.J. 151, 174 (2001) (“By countenancing a finding that a defendant’s drug is, essentially, worthless, section 6(c) tacitly assumes that the FDA will occasionally approve (or fail to order withdrawal of) a drug that should not be allowed on the market.”).

97. See Richard C. Ausness, *The Role of Litigation in the Fight Against Prescription Drug Abuse*, 116 W. VA. L. REV. 1117, 1123-24 (2014); Noah, *supra* note 93, at 844-48, 862-63.

98. See Lars Noah, *Rewarding Regulatory Compliance: The Pursuit of Symmetry in Products Liability*, 88 GEO. L.J. 2147, 2159 (2000) (“The [U.S. Supreme] Court recognized that damage awards predicated on a manufacturer’s departure from the common-law standard of reasonable care potentially have as much of a regulatory effect as positive law requirements reflected in state statutes or rules.”).

99. See *id.* (“Critics of the regulatory compliance defense respond that a tort judgment does not dictate any alteration of primary conduct, but in the next breath they emphasize the need to retain the threat of liability to serve a deterrent function

that case, state law appears to pose much the same conflict as if opposition to the sale of an FDA-approved product had emanated from the executive or legislative branch.¹⁰⁰ Although the Supreme Court has decided that manufacturers of medical devices may invoke an express preemption clause as a defense to tort claims so long as their product has secured a full license from the FDA,¹⁰¹ it has not extended similar protection to manufacturers of approved drug products given Congress's failure to so specify in statute.¹⁰²

II. ASSESSING THE CONSTITUTIONAL OBJECTIONS

Although it continues to make references back to the Zohydro litigation, this Part considers more generally the potential constitutional obstacles to state efforts at banning FDA-approved drug products: implied preemption, the dormant Commerce Clause doctrine, and principles of substantive due process. In a handful of cases addressing challenges to state laws applied to the sale and use of pharmaceuticals, the United States Supreme Court has offered some guidance that may help to clarify the extent to which state officials can attempt to countermand FDA licensing judgments.

A. Implied Preemption

As explained previously, Judge Zobel's implied preemption analysis in the Zohydro litigation suffered from any number of

given the often inconsequential administrative sanctions. They can't have it both ways.").

100. See *id.* at 2160 (“[J]uries indirectly—and inconsistently—but unmistakably do set product safety standards in this country. Once we accept the notion that jurors effectively regulate with their verdicts, one may ask whether this arrangement makes sense.”); Noah, *supra* note 93, at 851-52 (elaborating).

101. See *Riegel v. Medtronic, Inc.*, 552 U.S. 312, 322-30 (2008); see also Noah, *supra* note 93, at 913 (suggesting that preemption “may better define those contexts where courts should decline to engage in duplicative design defect review—namely, those devices that have undergone full premarket review and approval, at least where the FDA has made a particular judgment about a feature challenged by the plaintiff”).

102. See *Wyeth v. Levine*, 555 U.S. 555, 567-81 (2009); see also Ashutosh Bhagwat, *Wyeth v. Levine and Agency Preemption: More Muddle, or Creeping to Clarity?*, 45 TULSA L. REV. 197, 210-17, 220-30 (2009); Douglas G. Smith, *Preemption After Wyeth v. Levine*, 70 OHIO ST. L.J. 1435, 1458-80 (2009); David C. Vladeck, *Deconstructing Wyeth v. Levine: The New Limits on Implied Conflict Preemption*, 59 CASE W. RES. L. REV. 883, 904-18 (2009). Section II.A discusses an important exception.

weaknesses.¹⁰³ Nonetheless, the Supremacy Clause may still operate to erect a constitutional barrier against state efforts to prohibit the sale of FDA-approved products. Article VI of the U.S. Constitution provides that “the Laws of the United States . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”¹⁰⁴ Congress sometimes expressly preempts state law. Alternatively, courts may find that federal law on a subject impliedly preempts state law, either because Congress has entirely occupied a field or in the event of a conflict between federal and state law; the latter category of implied preemption may arise either by virtue of an impossibility of dual compliance or insofar as state law would stand as an obstacle to the accomplishment of the purposes underlying federal law.¹⁰⁵

The U.S. Supreme Court has offered important guidance about the application of implied preemption principles in its latest decision involving tort claims brought against drug manufacturers. In *Mutual Pharmaceutical Co. v. Bartlett*,¹⁰⁶ the plaintiff suffered a devastating injury after using sulindac, a nonsteroidal anti-inflammatory drug (NSAID).¹⁰⁷ The product that she had ingested came from a generic rather than a brand-name drug manufacturer, and the Supreme Court previously had recognized an implied preemption defense to inadequate warning claims against such defendants because, unlike brand-name companies, generic sellers lacked the power to revise

103. See *supra* notes 28-44, 53-57 and accompanying text.

104. U.S. CONST. art. VI, cl. 2.

105. See Lars Noah, *Reconceptualizing Federal Preemption of Tort Claims as the Government Standards Defense*, 37 WM. & MARY L. REV. 903, 907 (1996). For more recent discussions of this increasingly convoluted subject, which include references to the latest case law and commentary, see Gregory M. Dickinson, *An Empirical Study of Obstacle Preemption in the Supreme Court*, 89 NEB. L. REV. 682 (2011); Daniel J. Meltzer, *Preemption and Textualism*, 112 MICH. L. REV. 1 (2013); and David S. Rubenstein, *The Paradox of Administrative Preemption*, 38 HARV. J.L. & PUB. POL’Y 267, 274-82 (2015).

106. 133 S. Ct. 2466 (2013).

107. See *id.* at 2471-72. The FDA had approved Clinoril® (sulindac) in 1978, more than a quarter of a century before Ms. Bartlett ingested a generic version. See *id.* at 2471. Just one year after the plaintiff suffered her injury, the agency decided to strengthen information in the product’s labeling about the possibility of serious skin reactions. See *id.* at 2472. Thus, although a substantial amount of time had elapsed since original approval (during which time more risk information came to light and newer substitutes became available), shortly before this case went to trial the FDA had expressed its continued endorsement of the drug’s relative safety and efficacy.

their FDA-approved labeling unilaterally.¹⁰⁸ In *Bartlett*, the plaintiff had asserted both failure-to-warn and design defect claims; the federal district court granted summary judgment to the defendant on the former theory, however, because the plaintiff's physician admitted that he had not consulted the product's labeling.¹⁰⁹ The jury returned a sizeable verdict on the design defect claim, but, in the end, a bare majority of the Supreme Court found this theory preempted as well.¹¹⁰

Writing for the majority, Justice Alito concluded that the plaintiff's design defect claim represented nothing more than a preempted failure-to-warn claim in disguise.¹¹¹ He reasoned that the seller of an FDA-approved drug enjoyed no flexibility to modify the composition of the product without seeking a new license from the agency.¹¹² According to the majority, this meant that the plaintiff's design defect claim amounted instead to an objection to the product's labeling, and, because it sold a generic rather than brand-name

108. See *PLIVA, Inc. v. Mensing*, 131 S. Ct. 2567, 2574-82 (2011). I do not believe that this parsing of the relevant labeling regulations genuinely distinguishes the case from *Wyeth v. Levine*, 555 U.S. 555 (2009). See *NOAH, supra* note 4, at 557 (“The four dissenters pointed out that the same contingency had existed in *Levine* (insofar as the CBE regulation allowed innovator companies to make unilateral revisions to risk labeling only during an interim period before the FDA decided whether or not to allow it) without the Court in that case finding any conflict between federal and state law.”); *id.* (“Notwithstanding the Court’s effort to distinguish *Levine*, does the similarity between the two cases noted by the dissenters mean that a bare majority of the justices (three of whom had, after all, dissented in *Levine*) already doubts the continuing viability of *Levine*’s holding?”). For a sampling of the generally negative scholarly reception that *Mensing* has received, see Stacey B. Lee, *PLIVA v. Mensing: Generic Consumers’ Unfortunate Hand*, 12 *YALE J. HEALTH POL’Y L. & ETHICS* 209, 235-45 (2012); Daniel Kazhdan, Note, *Wyeth and PLIVA: The Law of Inadequate Drug Labeling*, 27 *BERKELEY TECH. L.J.* 893, 901-07, 913-26 (2012); and Fabian Nehrbass, Comment, *Save Now, Pay Later: The Unfortunate Reality of PLIVA v. Mensing*, 73 *LA. L. REV.* 1155, 1166-82 (2013).

109. See *Bartlett*, 133 S. Ct. at 2472.

110. See *id.* at 2472, 2480.

111. See *id.* at 2470, 2475-76; *id.* at 2474 (“Since Mutual did not have the option of changing sulindac’s design, New Hampshire law ultimately required it to change sulindac’s labeling.”).

112. See *id.* at 2475 (“[W]ere Mutual to change the composition of its sulindac, the altered chemical would be a new drug that would require its own NDA to be marketed in interstate commerce. . . . [B]ecause of sulindac’s simple composition, the drug is chemically incapable of being redesigned.”).

product, the defendant would violate federal law if it strengthened the warnings without first securing FDA approval.¹¹³

Justice Alito did not, however, view state tort law as impliedly preempted because it would stand as an obstacle to—or otherwise frustrate the purposes underlying—federal law; instead, he thought that the defendant would have found it impossible to comply with both federal and state law.¹¹⁴ Plaintiff had argued that the defendant could have declined to market its FDA-approved version, but the majority regarded this option as plainly preempted.¹¹⁵ Plaintiff also had argued that the defendant could have continued marketing the drug with the understanding that it might have to pay damages for any injuries that resulted, but again the majority saw such an obligation as impermissibly flying in the face of FDA approval.¹¹⁶

113. See *id.* at 2479-80; *id.* at 2476 (“[F]ederal law prohibited Mutual from taking the remedial action required to avoid liability under New Hampshire law.”); *id.* at 2479 (“[S]tate-law design-defect claims like New Hampshire’s that place a duty on manufacturers to render a drug safer by either altering its composition or altering its labeling are in conflict with federal laws that prohibit manufacturers from unilaterally altering drug composition or labeling.”); *id.* (arguing that “the dissent is reduced to fighting a rearguard action against [*PLIVA v. Mensing*’s] reasoning”).

114. Indeed, the majority had not even mentioned obstacle preemption in its summary of basic preemption doctrine. See *id.* at 2473; see also Meltzer, *supra* note 105, at 4-6 & n.28 (making the same observation about the plurality opinion in *Mensing*, and suggesting that they had taken a cue from Justice Thomas’ concurrence in *Levine*). In previously elaborating on his objections to obstacle preemption, see *Wyeth v. Levine*, 555 U.S. 555, 594-604 (2009) (Thomas, J., concurring in the judgment), Justice Thomas noted a preference for a somewhat broader inquiry into whether a “direct conflict” existed than suggested by the “physical impossibility” test, see *id.* at 589-90 (“For example, if federal law gives an individual the right to engage in certain behavior that state law prohibits, the laws would give contradictory commands notwithstanding the fact that an individual could comply with both by electing to refrain from the covered behavior.”).

115. See *Bartlett*, 133 S. Ct. at 2477 (“We reject this ‘stop-selling’ rationale as incompatible with our pre-emption jurisprudence. Our pre-emption cases presume that an actor seeking to satisfy both his federal- and state-law obligations is not required to cease acting altogether in order to avoid liability.”); *id.* (“The incoherence of the stop-selling theory becomes plain when viewed through the lens of our previous cases. In every instance in which the Court has found impossibility pre-emption, the ‘direct conflict’ between federal- and state-law duties could easily have been avoided if the regulated actor had simply ceased acting.”); *id.* at 2470 (“[A]dopting the . . . stop-selling rationale would render impossibility pre-emption a dead letter and work a revolution in this Court’s pre-emption case law.”); *id.* at 2478 (It would mean that “the vast majority—if not all—of the cases in which the Court has found impossibility pre-emption, were wrongly decided.”).

116. See *id.* at 2477 n.3 (noting that *PLIVA v. Mensing* “forecloses any argument that impossibility is defeated by the prospect that a manufacturer could ‘pa[y] the state penalty’ for violating a state-law duty”); see also *id.* at 2479 (“[T]he

The majority left open the possibility that a plaintiff could assert a “parallel” claim in the event that significant new risk information “not before the FDA” triggered an obligation under the FDCA to unilaterally withdraw a still approved product.¹¹⁷

At the outset of his dissent, Justice Breyer explained as follows:

It is not literally impossible here for a company . . . to comply with conflicting state and federal law. A company can comply with both either by not doing business in the relevant State or by paying the state penalty, say damages, for failing to comply with, as here, a state-law tort standard.¹¹⁸

Nonetheless, Breyer conceded that obstacle preemption might come into play in such circumstances,¹¹⁹ and he imagined that “the more medically valuable the drug, the less likely Congress intended to permit a State to drive it from the marketplace,”¹²⁰ but he concluded that the parties had made no such showing.¹²¹ The government had filed an amicus brief arguing in favor of implied preemption in this case; for a variety of reasons, however, Breyer declined to defer to the agency’s apparently inconsistent litigating positions, though immediately thereafter (and without any hint of irony) he quoted with approval from an amicus brief filed on behalf of two *former* FDA commissioners.¹²²

distinction between common law and statutory law is irrelevant to the argument at hand: In violating a common-law duty, as surely as by violating a statutory duty, a party contravenes the law.”); *id.* at 2474 n.1 (“[M]ost common-law causes of action for negligence and strict liability do not exist merely to spread risk, but rather impose affirmative duties.”); Steven A. Schwartz, Note, “*A Distinction Without a Difference*”?: Bartlett *Going Forward*, 84 *FORDHAM L. REV.* 325, 347-66 (2015) (discussing disagreement among lower courts on the question of whether different tests of design defect under state law might alter the preemption analysis, and concluding that it should have no impact).

117. *See Bartlett*, 133 S. Ct. at 2477 n.4.

118. *Id.* at 2480-81 (Breyer, J., joined by Kagan, J., dissenting).

119. *See id.* at 2481 (“[S]tate law that requires a company to withdraw from the State or pay a sizable damages remedy in order to avoid the conflict between state and federal law may nonetheless stan[d] as an obstacle to the accomplishment of the federal law’s objective, in which case the relevant state law is pre-empted.”).

120. *Id.*

121. *See id.* at 2482 (“I have found no convincing reason to believe that removing this particular drug from New Hampshire’s market, or requiring damage payments for it there, would be so harmful that it would seriously undercut the purposes of the federal statutory scheme.”).

122. *See id.* at 2481-82. At no point, however, did the majority make reference to the government’s brief.

In a far lengthier dissenting opinion, Justice Sotomayor elaborated on many of the same points made by Justice Breyer.¹²³ She emphasized that the receipt of a federal license to market a product did not itself require any particular conduct by the licenseholder that might conflict with state law; indeed, sellers of FDA-approved drugs occasionally withdraw them from the marketplace unilaterally (and a separate provision of the FDCA may obligate them to do just that),¹²⁴ so design defect claims that might create added incentives to take precisely such a step would in no sense conflict with federal law: “Impossibility does not exist where the laws of one sovereign permit an activity that the laws of the other sovereign restricts or even prohibits.”¹²⁵

Approved NDAs represent more than simply federal permission to market a pharmaceutical product, however; they amount to licenses, which qualify as a form of intangible property entitled to constitutional recognition.¹²⁶ Indeed, one of the Supreme Court’s very first conflict preemption decisions involved a federal shipping permit that the State of New York inappropriately had declined to recognize in issuing a steamboat monopoly to someone else.¹²⁷ For similar reasons, a state could not decline to recognize a

123. See *id.* at 2482 (Sotomayor, J., joined by Ginsburg, J., dissenting).

124. See *id.* at 2491-92 & n.9; *id.* at 2484 (“[T]he FDA’s permission to market a drug has never been regarded as a final stamp of approval of the drug’s safety.”).

125. *Id.* at 2486; see also *id.* (“[I]f federal law permitted (but did not require) a labeling practice that state law prohibited, there would be no irreconcilable conflict; a manufacturer could comply with the more stringent regulation.”); *id.* at 2492 (“New Hampshire’s design-defect cause of action thus does no more than provide an impetus for an action that is permitted and sometimes encouraged or even required by federal law.”); *id.* (“Congressional intent to pre-empt . . . cannot be gleaned from the existence of federal specifications that apply to the product if it is sold.”).

126. See Noah, *supra* note 1, at 594-99 (evaluating procedural due process and regulatory takings objections to proposed federal efforts to revoke or limit the scope of an approved NDA); Noah, *supra* note 41, at 385-91 (same). The FDA occasionally permits the sale of pharmaceutical products without issuing a license, see *id.* at 368, 370 (discussing the monograph system used for many nonprescription drugs), which seemingly would make an implied preemption argument against state prohibitions on the sale of such drugs more difficult, but an express preemption clause sometimes applies in this situation, see *id.* at 382 & n.122.

127. See *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211-12, 221, 240 (1824); *id.* at 210 (framing the question as “whether the laws of New-York . . . have, in their application to this case, come into collision with an act of Congress, and deprived a citizen of a right to which that act entitles him”); see also Joseph F. Petros III, Note, *The Other War on Drugs: Federal Preemption, the FDA, and Prescription Drugs*

controversial patent issued by the U.S. Patent and Trademark Office on the ground that it viewed the subject matter as inappropriate for protection as intellectual property.¹²⁸

Justice Sotomayor also argued that New Hampshire's recognition of design defect claims did not dictate any particular change in the conduct of defendants,¹²⁹ and the opportunity to either pay compensatory damages or exit the market would defeat any claim of impossibility.¹³⁰ Although conceding that obstacle preemption nonetheless might exist even in such circumstances,¹³¹ she doubted that it would ever frustrate federal purposes to allow tort

After Wyeth v. Levine, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 637, 648-49 (2011) ("The similarities between *Gibbons* and the modern question of FDA preemption for prescription drugs are striking. . . . [They both] involve some sort of 'license' granted by the federal government to carry on in a venue of interstate commerce."). See generally Norman R. Williams, *Gibbons*, 79 N.Y.U. L. REV. 1398 (2004) (offering a thorough account of this litigation, and explaining at length why Chief Justice Marshall opted for a contrived reading of the Federal Navigation Act of 1793 as preempting the monopoly granted by New York rather than resting the decision on his detailed exposition of the dormant Commerce Clause doctrine).

128. See *Jacobs Wind Elec. Co. v. Fla. Dep't of Transp.*, 919 F.2d 726, 728 (Fed. Cir. 1990) (noting that "a state court is without power to invalidate an issued patent"); Camilla A. Hrdy, *State Patents as a Solution to Underinvestment in Innovation*, 62 U. KAN. L. REV. 487, 535-36 (2013) ("Once a U.S. patent is issued to an inventor pursuant to the Patent Act, states are generally bound by the Supremacy Clause to respect and uphold that right."); see also Adam Mossoff, *Patents as Constitutional Private Property: The Historical Protection of Patents Under the Takings Clause*, 87 B.U. L. REV. 689, 700-14 (2007); cf. *Biotech. Indus. Org. v. District of Columbia*, 496 F.3d 1362, 1374 (Fed. Cir. 2007) (holding that the Patent Act impliedly preempted a local drug price control law). *But cf.* *Biotech. Indus. Org. v. District of Columbia*, 505 F.3d 1343, 1350 (Fed. Cir. 2007) (Dyk, J., dissenting from denial of rehearing en banc) ("[P]atent law does not preempt or conflict with state and federal statutes regulating or prohibiting the sale of patented products."); NOAH, *supra* note 4, at 877 ("What if D.C. officials regarded the sale of an FDA-approved product as posing a serious danger to the public health—could they ban its local sale, notwithstanding the resulting interference with the patent-holder's ability to generate a profit?").

129. See *Bartlett*, 133 S. Ct. at 2486-91 (Sotomayor, J., dissenting); *id.* at 2488 ("New Hampshire law imposed no duty on Mutual to change sulindac's chemical composition."); *id.* at 2489 ("[Its] design-defect law did not require Mutual to do anything other than to compensate consumers who were injured by an unreasonably dangerous drug.").

130. See *id.* at 2491 ("[T]he manufacturer may still choose between exiting the market or continuing to sell while knowing it may have to pay compensation to consumers injured by its product.").

131. See *id.* at 2492-93; see also *id.* at 2486 ("Courts may find that state laws that incentivize what federal law discourages or forbid what federal law authorizes are pre-empted for reasons apart from impossibility . . .").

claims against the sellers of FDA-approved drugs.¹³² Sotomayor accused the majority of relying on “an implicit and undefended assumption that federal law gives pharmaceutical companies a right to sell a federally approved drug free from common-law liability,”¹³³ and she cited the government’s amicus brief as conceding “the absence of textual support in the FDCA for the idea that an approved drug must be made available in any particular State.”¹³⁴ In the end, of course, the dissenters’ various arguments lost out in this case.

Whatever one may think about its implied preemption analysis on the failure-to-warn claim (or whether sellers can warn their way out of duties to redesign products under the risk-utility test), the majority’s treatment of the plaintiff’s design defect claim portends far broader consequences. First, it seemingly would apply with equal force to sellers of brand-name drug products,¹³⁵ thereby putting an end to peculiar decisions such as *Tobin*.¹³⁶ Second, entirely beyond tort litigation, the majority’s analysis suggests that FDA drug approval would impliedly preempt state positive law as well.¹³⁷ For

132. See *id.* at 2493-94.

133. *Id.* at 2483; see also *id.* at 2490 (“Though the majority insists otherwise, . . . it appears to rely principally on an implicit assumption about rights conferred by federal premarket approval under the FDCA.”); *id.* at 2491 (“Because the majority does not rely on obstacle pre-emption, it must believe that a manufacturer that received FDA premarket approval has a right . . . to keep its drug on the market unless and until the FDA revokes approval . . .”).

134. *Id.* at 2494.

135. See *id.* at 2471 (majority opinion) (“Once a drug—whether generic or brandname—is approved, the manufacturer is prohibited from making any major changes to the ‘qualitative or quantitative formulation of the drug product, including active ingredients, or in the specifications provided in the approved application.’ 21 C.F.R. § 314.70(b)(2)(i).”); *id.* at 2494-95 (Sotomayor, J., dissenting) (“[P]remarket review, by definition, prevents manufacturers from unilaterally changing their products’ designs. That is true, for example, of the designs (*i.e.*, the chemical composition) of brand-name drugs under the FDCA no less than it is for generic drugs.” (footnote omitted)); see also Noah, *supra* note 93, at 861-63 (explaining that pharmaceutical manufacturers cannot readily modify the designs of their products).

136. *Tobin v. Astra Pharm. Prods., Inc.*, 993 F.2d 528, 537-40 (6th Cir. 1993) (sustaining a judgment for the plaintiff premised on the claim that a defect existed in the design of ritodrine from the moment that the FDA approved this drug); see also *supra* notes 94-96 and accompanying text (discussing this decision).

137. See *Bartlett*, 133 S. Ct. at 2478 n.5 (suggesting that the imposition of tort liability is akin to a state “directly prohibiting the product’s sale”); *id.* at 2479 (“[S]tatutory ‘mandate[s]’ do precisely the same thing [as the threat of adverse tort judgments]: They require a manufacturer to choose between leaving the market and accepting the consequences of its actions (in the form of a fine or other sanction).”). Then again, to the extent that such decisions reflect the conservative wing’s hostility toward tort law, perhaps those Justices would express greater sympathy for states’

some reason, however, Judge Zobel had not cited *Bartlett* to buttress her sense that federal law preempted Massachusetts's effort to ban Zohydro, perhaps because she thought that the case before her raised questions of implied preemption based solely on frustration of purposes rather than impossibility of dual compliance.¹³⁸ Even so, if the relatively more attenuated command of design defect scrutiny in tort law created an actual conflict with federal law governing FDA-approved drugs, then surely an outright sales prohibition imposed by state officials would do so.

B. Dormant Commerce Clause

The U.S. Constitution has no “dormant commerce clause” as such. Instead, this judicially crafted doctrine springs by negative implication from the power of Congress “[t]o regulate Commerce with foreign Nations, and among the several States.”¹³⁹ The doctrine bears some similarity to preemption, with Article I's enumeration of the power to regulate interstate commerce itself arguably triggering the Supremacy Clause even if Congress has not yet acted pursuant to that authority or has done so in a way that does not have preemptive effect.¹⁴⁰ In recent years, however, the dormant Commerce Clause

rights when positive law comes into conflict with FDA approval. Conversely, the four members of the Court's liberal wing seemed somewhat more open to the idea that state positive law might trigger impossibility preemption. *See, e.g., id.* at 2485 (Sotomayor, J., dissenting) (hypothesizing a conflict related to ingredient disclosure requirements even though a company could comply with both federal and state law by not selling in the state with the more restrictive approach); *id.* at 2488 (contrasting the threat of liability with “a legal mandate . . . to take (or refrain from taking) a specific action”); *id.* at 2491 n.8 (same). The Court unanimously found obstacle preemption in several comparable earlier cases. *See supra* note 44.

138. Instead, she distinguished *Wyeth v. Levine*, which the Commonwealth had relied upon. *See Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 1454696, at *2 (D. Mass. Apr. 15, 2014) (“*Wyeth* is a drug labeling [tort] case, and defendants present no evidence or persuasive argument that its reasoning should control in this different context.”).

139. U.S. CONST. art. I, § 8, cl. 3. *See generally* Brannon P. Denning, *Reconstructing the Dormant Commerce Clause Doctrine*, 50 WM. & MARY L. REV. 417 (2008); Barry Friedman & Daniel T. Deacon, *A Course Unbroken: The Constitutional Legitimacy of the Dormant Commerce Clause*, 97 VA. L. REV. 1877 (2011).

140. *Cf.* Garrick B. Pursley, *Dormancy*, 100 GEO. L.J. 497, 561-65 (2012) (drawing comparisons to preemption doctrine); *id.* at 501 (“Dormancy holdings mean that state power to take the action is constitutionally precluded *ex ante*, while preemption holdings mean that action otherwise within states' constitutional power is *contingently* unconstitutional because of a conflict with federal law.”).

doctrine has played a somewhat more limited role in displacing state authority than has preemption.

During the mid-twentieth century, Supreme Court decisions in this area spoke of ensuring the free flow of trade throughout the country.¹⁴¹ Nowadays, the dormant Commerce Clause doctrine consists of a pair of inquiries. First, does a state or local law expressly discriminate against foreign businesses? If out-of-state commercial actors face greater barriers than comparable entities situated within the state, then a court will subject the law to heightened scrutiny.¹⁴² Only rarely will a facially discriminatory law survive such scrutiny.¹⁴³ Second, assuming that the challenged law draws no distinction between local and out-of-state businesses, does it nonetheless unduly interfere with interstate commerce? If a state burdens commercial activity with entities in other states, then a court will subject the law to a milder form of scrutiny, asking whether the particular local purpose served by the restriction outweighs its

141. See *H. P. Hood & Sons, Inc. v. DuMond*, 336 U.S. 525, 539 (1949) (“Our system, fostered by the Commerce Clause, is that every farmer and every craftsman shall be encouraged to produce by the certainty that he will have free access to every market in the Nation . . .”); *McLeod v. J. E. Dilworth Co.*, 322 U.S. 327, 330 (1944) (“The very purpose of the Commerce Clause was to create an area of free trade among the several States.”); *Baldwin v. G. A. F. Seelig, Inc.*, 294 U.S. 511, 527 (1935) (“[T]he police power may [not] be used by the state of destination with the aim and effect of establishing an economic barrier against competition with the products of another state . . .”); see also Norman R. Williams, *The Foundations of the American Common Market*, 84 NOTRE DAME L. REV. 409, 423-37, 447-51 (2008).

142. See, e.g., *Granholt v. Heald*, 544 U.S. 460, 472-76, 489-93 (2005) (invalidating Michigan and New York laws that made it hard or impossible for out-of-state wineries to ship directly to customers); *Gen. Motors Corp. v. Tracy*, 519 U.S. 278, 307 n.15 (1997) (“[I]f a State discriminates against out-of-state interests by drawing geographical distinctions between entities that are otherwise similarly situated, such facial discrimination will be subject to a high level of judicial scrutiny even if it is directed toward a legitimate health and safety goal.”); *Or. Waste Sys., Inc. v. Dep’t of Env’tl. Quality*, 511 U.S. 93, 99 (1994) (“As we use the term here, ‘discrimination’ simply means differential treatment of in-state and out-of-state economic interests that benefits the former and burdens the latter. If a restriction on commerce is discriminatory, it is virtually *per se* invalid.”).

143. See *Camps Newfound/Owatonna, Inc. v. Town of Harrison*, 520 U.S. 564, 582 (1997) (noting that such scrutiny “is an extremely difficult burden, so heavy that facial discrimination by itself may be a fatal defect”). For a rare exception, see *Maine v. Taylor*, 477 U.S. 131, 148-52 (1986) (sustaining a state’s prohibition on the importation of live baitfish because it represented the only way of protecting local waters and fish populations from the threat posed by invasive species and parasites).

adverse impacts on foreign businesses.¹⁴⁴ Although this basic framework has become relatively well established over the last half century, the doctrine routinely gets criticized for its fluid and unpredictable application.¹⁴⁵

The pharmaceutical industry has tried on more than one occasion to use the dormant Commerce Clause doctrine to fend off local regulation.¹⁴⁶ In 2003, the Supreme Court unanimously rejected

144. See *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970) (“Where the statute regulates even-handedly to effectuate a legitimate local public interest, and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is *clearly excessive* in relation to the putative local benefits.” (emphasis added)); see also *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 472-73 (1981) (upholding a state ban on the sale of milk in nonreturnable plastic containers because it imposed a “relatively minor” burden on interstate commerce, insofar as it continued to allow for the free flow of milk products and cartons across the state’s borders, but produced substantial benefits in terms of “promoting conservation of energy and other natural resources and easing solid waste disposal problems”); *Raymond Motor Transp., Inc. v. Rice*, 434 U.S. 429, 441-48 (1978) (invalidating under this test Wisconsin restrictions on the length of trucks). Thus, unlike obstacle preemption, with its focus on federal purposes, balancing under the dormant Commerce Clause doctrine inquires about state purposes and their weightiness.

145. See, e.g., *Dep’t of Revenue of Ky. v. Davis*, 553 U.S. 328, 360 (2008) (Scalia, J., concurring in part) (calling on the Court to “abandon the *Pike*-balancing enterprise altogether and leave these quintessentially legislative judgments with the branch to which the Constitution assigns them”); *Am. Trucking Ass’n v. Mich. Pub. Serv. Comm’n*, 545 U.S. 429, 439 (2005) (Thomas, J., concurring in the judgment) (“[T]he negative Commerce Clause has no basis in the text of the Constitution, makes little sense, and has proved virtually unworkable in application, . . . and, consequently, cannot serve as a basis for striking down a state statute.”); *W. Lynn Creamery, Inc. v. Healy*, 512 U.S. 186, 210 (1994) (Scalia, J., concurring in the judgment) (referring to it as a “quagmire”); *id.* at 217 (Rehnquist, C.J., dissenting) (complaining of a “messianic insistence on a grim sink-or-swim policy of laissez-faire economics . . . under the dormant Commerce Clause, a policy which bodes ill for the values of federalism which have long animated our constitutional jurisprudence”); Earl M. Maltz, *How Much Regulation Is Too Much—An Examination of Commerce Clause Jurisprudence*, 50 GEO. WASH. L. REV. 47, 48-64, 85-87 (1981).

146. The industry’s trade association, the awkwardly named Pharmaceutical Research and Manufacturers of America (PhRMA), brought several of these lawsuits. See, e.g., *PhRMA v. Cty. of Alameda*, 768 F.3d 1037, 1041-46 (9th Cir. 2014) (rejecting constitutional challenge to an ordinance that required companies selling pharmaceuticals in the county to establish drug take-back programs for the purpose of guarding against improper consumer disposal of products potentially harmful to the environment or subject to abuse); *PhRMA v. Thompson*, 362 F.3d 817, 827 (D.C. Cir. 2004) (rejecting objection to a special rebate requirement adopted in Michigan); see also *Pharm. Care Mgmt. Ass’n v. Rowe*, 429 F.3d 294, 311-13 (1st Cir. 2005) (rejecting challenge to a Maine law that imposed special

such an effort, upholding the State of Maine's program that threatened to offer less favorable Medicaid coverage for drugs unless companies also granted rebates on those products when used by uninsured patients not eligible for Medicaid.¹⁴⁷ The industry had argued, for instance, that the law impermissibly impacted company pricing decisions in other states, but the Court found nothing problematic about such an alleged extraterritorial effect.¹⁴⁸ Efforts to control drug prices through state payment decisions differ, of course, from laws that bar pharmaceutical products at the border and prevent patients with private insurance coverage (or personal means) from making use of them.

Even state laws that do not discriminate on their face may founder if the balancing inquiry reveals that a restriction serves no purpose other than to protect local businesses.¹⁴⁹ In this vein, one should note that state prohibitions on the sale of pharmaceuticals—products that typically originate outside of a state—sometimes will work to the benefit of local suppliers of competing services.¹⁵⁰ Thus, if a powerful new drug threatened established providers (e.g., surgeons or hospitals) of nonpharmaceutical treatments for the same

duties of disclosure on pharmacy benefit managers in their dealings with health insurers).

147. See *PhRMA v. Walsh*, 538 U.S. 644, 670 (2003); see also *id.* at 684 (O'Connor, J., concurring in part and dissenting in part). In a far more fractured aspect of the case, the Court also rejected an implied preemption challenge. See *id.* at 662-68 (plurality opinion); *id.* at 670 (Breyer, J., concurring in part and concurring in the judgment); *id.* at 674 (Scalia, J., concurring in the judgment); *id.* at 675 (Thomas, J., concurring in the judgment).

148. See *id.* at 669-70 (majority opinion); see also Brannon P. Denning, *Extraterritoriality and the Dormant Commerce Clause: A Doctrinal Post-Mortem*, 73 LA. L. REV. 979, 990-92 (2013) (arguing that *PhRMA v. Walsh* marked the Court's abandonment of a freestanding rule against extraterritorial regulation under the dormant Commerce Clause doctrine); Peter Felmlly, Comment, *Beyond the Reach of the States: The Dormant Commerce Clause, Extraterritorial State Legislation, and the Concerns of Federalism*, 55 ME. L. REV. 467, 483-514 (2003) (arguing that courts should keep the extraterritoriality principle distinct).

149. See *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 350-54 (1977).

150. Cf. *Gen. Motors Corp. v. Tracy*, 519 U.S. 278, 298 (1997) (“[A]ny notion of discrimination assumes a comparison of substantially similar entities.” (footnote omitted)); *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 473-74 (1981) (“A nondiscriminatory regulation serving substantial state purposes is not invalid simply because it causes some business to shift from a predominantly out-of-state industry [i.e., plastic resins used to make nonreturnable milk jugs] to a predominantly in-state industry [i.e., pulpwood used to make paperboard milk cartons].”).

disease or condition, then a state prohibition might violate the doctrine's antiprotectionism principle. For instance, psychologists might fear losing business after the introduction of a remarkably effective new antidepressant,¹⁵¹ even if psychiatrists would relish the prospect; cosmetic surgeons might worry that they would get fewer customers if physicians could prescribe an amazing new wrinkle-reducer;¹⁵² or any gynecologists who make a living from performing abortions might regard FDA approval of abortifacient drugs as siphoning away potential patients. Even if these illustrations seem far-fetched as likely grounds for a state ban on a particular drug, they do point up the fact that some (invariably local) health professionals may stand to benefit from such a prohibition and their advocacy of such action might disclose a protectionist purpose should lawmakers concur.

How would Massachusetts's effort to ban Zohydro fare under the dormant Commerce Clause doctrine? As noted previously, Judge Zobel had declined to reach this question,¹⁵³ and it seemed at least slightly misplaced in that case because, as it turned out, the financial consequences of the Commonwealth's prohibition would have fallen most heavily on an in-state company.¹⁵⁴ On its face, the emergency

151. This may help to explain why psychologists in some states have sought limited prescribing privileges. See Brent Pollitt, *Fool's Gold: Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority*, 29 AM. J.L. & MED. 489, 512 (2003) ("Psychologists seeking prescriptive authority appear blinded by their own self-interest associated with prescribing medication . . ."); *id.* at 521 ("[T]he psychologists seeking prescriptive authority view the situation as a 'turf' war They recognize that psychopharmaceutical treatment continues to gain in popularity with insurance companies and patients, and they want to ensure their place in the future of mental health treatment."); James E. Long, Jr., Note, *Power to Prescribe: The Debate over Prescription Privileges for Psychologists and the Legal Issues Implicated*, 29 LAW & PSYCHOL. REV. 243, 250 & n.54 (2005); *id.* at 244-56 (discussing new laws in Louisiana and New Mexico).

152. See James F. Peltz, *Botox Maker Adds Wrinkle to Lineup; Allergan Agrees to Buy Kythera, Developer of Kybella, Which Treats Double Chins*, L.A. TIMES, June 18, 2015, at C1 (reporting that Botox generates revenues of more than \$2 billion annually, adding that the FDA recently approved an injectable drug to eliminate submental fat).

153. See *supra* note 27 and accompanying text.

154. See Yvonne Abraham, *Fighting, Then Fueling, Drug Abuse*, BOS. GLOBE, Apr. 10, 2014, at A1 ("Out front in all of this controversy has been a company called Zogenix, out of San Diego. But Zogenix has only a license to market the drug. The actual outfit behind Zohydro is a Waltham company named Alkermes Zogenix markets the drug and takes heat from critics, but Alkermes owns Zohydro, manufactures it, and stands to make mountains of money from it.");

regulation applied to all extended-release pure hydrocodone products that lacked abuse-resistant features, whether sold by a local or foreign manufacturer, though Zogenix objected that (at least initially) only Zohydro fell into this narrowly defined class.¹⁵⁵ Nothing suggested that this public health regulation served merely as pretext to favor local interests.

Under the balancing test utilized for restrictions that have only an incidental effect on interstate commerce, the interest asserted by Massachusetts would, however, confront the conflicting judgment of federal regulatory officials. True, particular states may experience higher-than-average problems with the misuse of prescription drugs,¹⁵⁶ and the FDA's licensing decisions may focus too narrowly on just the risks and benefits to patients while failing to fully consider societal consequences, but the DEA's scheduling choices presumably would have taken that broader view.¹⁵⁷ On the other side of the ledger, the FDA's approval decision suggests that depriving

Barry Meier, *Addiction Specialists Wary of New Painkiller*, N.Y. TIMES, Nov. 16, 2013, at B3. In contrast, imagine that Connecticut, home of the companies' chief rival Purdue, had taken a similar step.

155. Similarly, although the regulation clearly sought to encourage Zogenix to seek FDA approval for a reformulated product that incorporated abuse-resistant features, it did not appear to operate in an impermissibly extraterritorial fashion. *Cf.* Donald H. Regan, *Siamese Essays: (I) CTS Corp. v. Dynamics Corp. of America and Dormant Commerce Clause Doctrine; (II) Extraterritorial State Legislation*, 85 MICH. L. REV. 1865, 1899-900 (1987) (explaining that, although Michigan would have the power to prohibit smoking within the state notwithstanding adverse effects on an out-of-state industry, it could not prohibit cigarette manufacturing in North Carolina in an effort to guard against blackmarket sales).

156. See Leonard J. Paulozzi et al., *Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines—United States, 2012*, 63 MORBIDITY & MORTALITY WKLY. REP. 563, 564 (2014); *cf.* Darlena Cunha, *Chronic Pain Meets Worries About Opioid Addiction*, WASH. POST, Feb. 2, 2016, at E1 (“The United States uses 80 percent of the world’s opioids, . . . yet it makes up less than 5 percent of the world’s population.”). Apart from undoubted demographic variations, states may take different approaches to law enforcement, supervision of physicians, and treatment of addiction.

157. See *supra* note 35. Strangely enough, in objecting to the FDA's approval of rbST, which promised to increase milk production in dairy cows, some critics evidently worried about human misuse of this non-scheduled drug. See Burk, *supra* note 77, at 290 (“[P]ossible substance abuse of rbST by bodybuilders and athletes has been cited as a concern. . . . A legislative ban on rbST itself might be rationally related to such a concern, provided once again that some evidence can be produced of the likelihood of abuse.”).

legitimate patients of access would represent something of a hardship to them.¹⁵⁸

Courts have offered little guidance on how to value the adverse consequences of a state effort to restrict commerce.¹⁵⁹ In one recent decision, a federal appellate court sustained a county ordinance that obligated pharmaceutical manufacturers to establish a program to take back and safely dispose of unused drugs. In rejecting the industry's dormant Commerce Clause challenge, the court emphasized the relatively trivial financial burden imposed by such a requirement: At most, it would cost little more than 0.1% of the revenues generated by those companies in that county.¹⁶⁰ A sales prohibition would, of course, represent a far more onerous restriction: The manufacturer(s) of a banned drug would face what amounts to a 100% tax in that jurisdiction.¹⁶¹ Even if viewed from the

158. *Cf.* Noah, *supra* note 93, at 855 (warning of “the twin dangers of tunnel-vision (risk-utility judged solely from a [tort] plaintiff’s perspective) and preference aggregation (risk-utility evaluated from a societal perspective), both of which might unduly sacrifice the needs of a minority of patients for whom the risk-utility balance differs from either the particular victim or the norm” (footnote omitted)); *id.* at 872-73 (illustrating with the infamous teratogen thalidomide).

159. *Cf.* Dep’t of Revenue of Ky. v. Davis, 553 U.S. 328, 353-55 (2008); Hunt v. Wash. State Apple Advert. Comm’n, 432 U.S. 333, 346-48 (1977) (rejecting the petitioner’s objection that the respondent had failed to demonstrate that any of its members satisfied the \$10,000 amount-in-controversy prerequisite for exercising jurisdiction); *id.* at 347 (“[The] object [of this litigation] is the right of the individual Washington apple growers and dealers to conduct their business affairs in the North Carolina market free from the interference of the challenged statute. The value of that right is measured by the losses that will follow from the statute’s enforcement.”); Pike v. Bruce Church, Inc., 397 U.S. 137, 145-46 (1970) (concluding that the \$200,000 it would cost one grower to construct a new packing facility was a burden that outweighed the state’s asserted interest in protecting the reputation of Arizona producers).

160. *See* PhRMA v. Cty. of Alameda, 768 F.3d 1037, 1045 (9th Cir. 2014) (“The county compares the cost of running the disposal program (\$530,000–\$1,200,000 per year) to the manufacturers’ revenue-stream in Alameda County (approximately \$950 million per year) to conclude that the burden is minimal.”); *cf.* Noah, *supra* note 41, at 389-90 & n.155 (explaining that projected health system savings from prematurely switching prescription drugs to OTC status would translate into hundreds of millions of dollars in financial losses suffered by the manufacturers of those products).

161. *Cf.* Dean Foods Co. v. Wis. Dep’t Agric., 478 F. Supp. 224, 231-32 (W.D. Wis. 1979) (calling a statute that appeared to prohibit the sale of an imitation chocolate milk product “the most burdensome, gross, and radical of the alternative means available,” and granting a preliminary injunction on dormant Commerce Clause grounds), *after reargument*, 504 F. Supp. 520, 528-29 (W.D. Wis. 1980) (conceding that this may have represented a misinterpretation of the statute as applied to the plaintiff’s product); Maltz, *supra* note 145, at 77 (“The hypothetical

perspective of aggregate sales around the country, a prohibition in one state would entail an average loss of 2% of projected revenue,¹⁶² which for a “blockbuster” drug (defined as a product generating sales exceeding \$1 billion annually¹⁶³) would come to over \$20 million each year; to a giant pharmaceutical manufacturer such as Pfizer,¹⁶⁴ such a loss might amount to little more than petty cash, but smaller companies with only a handful of products could not so easily shrug it off. Like the vast majority of FDA-approved drugs, Zohydro would not have reached blockbuster status, but it represented the only product in the portfolio of Zogenix.

C. Substantive Due Process

In its Fourteenth Amendment, the U.S. Constitution includes the following language:

No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.¹⁶⁵

Like the parallel clause demanding that federal actors ensure due process, the United States Supreme Court has interpreted this language as offering both procedural and substantive protections.¹⁶⁶

contemplates the severest possible interference with a person’s right to sell goods in interstate commerce—a total interdiction.”).

162. The 2% figure reflects one state out of fifty. Although states range dramatically in size, Massachusetts happens to account for approximately 2% of the nation’s population. See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2012, at 18 tbl.13, <http://www.census.gov/prod/2011pubs/12statab/pop.pdf> [<https://perma.cc/95J6-7B8T>].

163. See Stacy Lawrence, *Billion Dollar Babies—Biotech Drugs as Blockbusters*, 25 NATURE BIOTECH. 380, 380 (2007); Jonathan D. Rockoff, *The Next Blockbuster: Drug Scouts Chase Hot Prospects*, WALL ST. J., Mar. 10, 2014, at A1.

164. See Robert Weisman, *Pfizer Gets an Open Vibe; New Kendall Square Research Center Fosters Collaborative Approach to Drug Development*, BOS. GLOBE, June 15, 2014, at G1 (“Part of the challenge is Pfizer’s sheer size—its market value exceeds \$187 billion. That means the pharma giant, in order to grow, must constantly bring out new drugs, particularly so-called blockbusters that ring up annual sales of \$1 billion or more . . .”).

165. U.S. CONST. amend. XIV, § 1.

166. See *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (plurality opinion) (“We have long recognized that the [Fourteenth] Amendment’s Due Process Clause, like its Fifth Amendment counterpart, guarantees more than fair process. . . . The Clause also includes a substantive component that provides heightened protection against government interference with certain fundamental rights and

If, for instance, a state actor summarily confiscated a patient's supply of lawfully dispensed drug products, then notions of procedural due process typically would entitle that individual to an official explanation and some sort of hearing, among other potential remedies. (In addition, selective enforcement may trigger an affiliated objection on equal protection grounds.) Here, however, the question focuses on state efforts to bar (across the board) pharmaceutical access before dispensing, so the due process question would arise primarily in its substantive dimension.

Normally, state laws challenged as violating notions of substantive due process enjoy a presumption of regularity and need only satisfy extremely deferential judicial review. So long as a legislative choice passes the "rational basis" test, judges must not superimpose their own views of sensible public policy.¹⁶⁷ Indeed, courts need not even find that state actors in fact invoked plausible grounds for making a particular choice—it suffices that the legislature could have had such purposes in mind. Only if a law burdens some "fundamental right," which springs from the reference to "life, liberty, or property" in the text (or if, under equal protection, it uses a "suspect classification" such as race), must courts engage in more searching constitutional scrutiny.¹⁶⁸ For purposes of triggering heightened—whether intermediate or strict—scrutiny, courts have struggled in deciding what qualifies as a fundamental right.¹⁶⁹

liberty interests."); *cf.* Ryan C. Williams, *The One and Only Substantive Due Process Clause*, 120 *YALE L.J.* 408, 509-12 (2010) (concluding that originalism would assign divergent meanings to the due process clauses in the Fifth and Fourteenth Amendments, with only the latter having a substantive dimension). In any event, the focus here shifts from the rights of sellers to the rights of buyers.

167. *See* *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313-16 (1993); *Heller v. Doe*, 509 U.S. 312, 319-21 (1993).

168. *See* *Reno v. Flores*, 507 U.S. 292, 301-02 (1993); *see also* Richard H. Fallon, Jr., *Strict Judicial Scrutiny*, 54 *UCLA L. REV.* 1267, 1273-74, 1283-84, 1293-94, 1298-301 (2007) (summarizing the different modern tiers of constitutional review and their use in early substantive due process cases); Stephen A. Siegel, *The Origin of the Compelling State Interest Test and Strict Scrutiny*, 48 *AM. J. LEGAL HIST.* 355, 358-61 (2006) (same); *id.* at 393-94, 397-98, 406 (discussing the different functions potentially served by strict scrutiny); Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 *VAND. L. REV.* 793, 815 (2006) (finding that, in recent years, restrictions on fundamental rights survive 24% of the time); *id.* at 862-66 (elaborating).

169. *Compare, e.g., Obergefell v. Hodges*, 135 S. Ct. 2584, 2602 (2015) (extending a fundamental right of marriage to same-sex couples), *with id.* at 2616-23 (Roberts, C.J., dissenting) (lambasting the majority's due process analysis), *and id.* at 2632-41 (Thomas, J., dissenting) (same). *See generally* Daniel O. Conkle, *Three Theories of Substantive Due Process*, 85 *N.C. L. REV.* 63 (2006); Stephen Kanter,

In connection with therapeutic products, the Supreme Court has rejected the argument that physicians or patients enjoy a fundamental right of access to pharmaceuticals for uses not approved by the FDA. Although it previously had recognized that patients enjoyed a fundamental right to decline life-saving interventions,¹⁷⁰ the Court found no affirmative right of access for those seeking physician-assisted suicide.¹⁷¹ It seemed, however, that five of the Justices would have recognized a right to obtain medication for palliative purposes even if the use of such drugs might hasten death,¹⁷² which at least suggests the possibility of a comparable right of access for patients without a terminal illness if appropriate use of the drugs would not pose any likelihood of fatality.¹⁷³

Similarly, lower courts have rejected claims to a constitutional right of access to potentially life-saving drugs not (yet) approved by

The Griswold Diagrams: Toward a Unified Theory of Constitutional Rights, 28 CARDOZO L. REV. 623 (2006); Brian Hawkins, Note, *The Glucksberg Renaissance: Substantive Due Process Since Lawrence v. Texas*, 105 MICH. L. REV. 409 (2006).

170. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990) (“[F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”); *id.* at 287-89 (O'Connor, J., concurring).

171. See *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (concluding that the claimed right was neither “deeply rooted in this Nation’s history and tradition” nor “implicit in the concept of ordered liberty”); *id.* at 735 (holding that the state’s prohibition survived review under the rational basis test); see also *Vacco v. Quill*, 521 U.S. 793, 800-01, 808-09 (1997) (rejecting an equal protection challenge to a New York statute that prohibited anyone from assisting suicide notwithstanding the fact that another statute had authorized competent patients to decline resuscitation efforts); Lars Noah, *Turn the Beat Around?: Deactivating Implanted Cardiac-Assist Devices*, 39 WM. MITCHELL L. REV. 1229, 1260-67 (2013) (discussing these decisions in the context of patient requests to discontinue the use of life-sustaining medical devices).

172. See, e.g., *Glucksberg*, 521 U.S. at 792 (Breyer, J., concurring in the judgment) (suggesting that the Court might hold it unconstitutional “were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life”); see also Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1234-35 (1997); Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 908-09 (1998).

173. See Beth Packman Weinman, *Freedom from Pain: Establishing a Constitutional Right to Pain Relief*, 24 J. LEGAL MED. 495, 528 (2003) (“While [Justice Breyer] does not explicitly state that barriers to adequate pain treatment in nonterminal patients also would potentially represent a constitutional violation, such a conclusion seems implicit in his reasoning.”); *id.* at 529 (“It seems logical to imply from Justice Stevens’ argument that he would support a constitutional right to pain treatment that does not hasten death for nonterminal pain.”).

the FDA,¹⁷⁴ much less to drugs not even undergoing clinical trials in the hopes of eventually securing a license from the agency.¹⁷⁵ What, however, about patients seeking access to a federally licensed pharmaceutical product for life-saving or other approved uses in a state that has decided to prohibit its distribution; would that not substantially burden patients' rights to make sometimes profound or sensitive decisions about their medical care?¹⁷⁶ Note that this does not amount to claiming an affirmative right of government-subsidized availability but only demanding that state officials not stand in the way of a patient's freedom—typically with a physician's assent—to make use of a product that has satisfied requirements for federal licensure.¹⁷⁷

174. See Abigail All. for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 701, 711-13 (D.C. Cir. 2007) (en banc) (focusing on investigational drugs that have successfully completed Phase I trials sought by terminally ill patients lacking other options); *id.* at 701 (“We do not address the broader question of whether access to medicine might ever implicate fundamental rights.”); CareToLive v. von Eschenbach, 525 F. Supp. 2d 952, 965-66 (S.D. Ohio 2007) (rejecting constitutional objections to the FDA’s delay in approving an active cellular immunotherapy (Provenge[®]) for metastatic prostate cancer); Smith v. Shalala, 954 F. Supp. 1, 3-4 (D.D.C. 1996) (antineoplastons for use in cancer); *supra* notes 86-90 and accompanying text (discussing these issues in connection with state “right to try” laws); see also Lars Noah, *Too High a Price for Some Drugs?: The FDA Burdens Reproductive Choice*, 44 SAN DIEGO L. REV. 231, 248 (2007) (“[C]ourts consistently ha[ve] rejected claims that persons had any special right of access to pharmaceutical products. Although patients enjoyed an interest in making choices about their medical care, the government could decline to allow the sale of drugs until the manufacturer proved their safety and effectiveness.”).

175. See Raich v. Gonzales, 500 F.3d 850, 864-66 (9th Cir. 2007) (marijuana); Carnohan v. United States, 616 F.2d 1120, 1122 (9th Cir. 1980) (amygdalin); Rutherford v. United States, 616 F.2d 455, 457 (10th Cir. 1980) (same); Pearson v. McCaffrey, 139 F. Supp. 2d 113, 123 (D.D.C. 2001) (marijuana); Seeley v. State, 940 P.2d 604, 612-19, 622 (Wash. 1997) (same); see also *supra* notes 82-85 and accompanying text (elaborating on these issues); *cf.* Kulsar v. Ambach, 598 F. Supp. 1124, 1125-26 (W.D.N.Y. 1984) (rejecting a claimed right of access to adrenal cortex extract, a purported treatment for hypoglycemia withdrawn from market by the FDA).

176. The Court has offered various descriptions of the requisite threshold before a burden suffices to trigger heightened scrutiny. See, e.g., Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 876-77 (1992) (plurality opinion) (“placing a substantial obstacle in the path” of exercising rights creates an “undue burden”); Norman v. Reed, 502 U.S. 279, 288-89 (1992) (“severe restriction”); Zablocki v. Redhail, 434 U.S. 374, 386-87 (1978) (“significantly interfere”).

177. See John A. Robertson, *Embryo Culture and the “Culture of Life”*: Constitutional Issues in the Embryonic Stem Cell Debate, 2006 U. CHI. LEGAL F. 1, 7-16; *id.* at 9 (“It would be surprising if state action that diminished the ability to stay alive did not receive the same scrutiny as infringement of the more particular

The Supreme Court has treated choices about procreation as central aspects of a person's liberty and associated rights to privacy.¹⁷⁸ As noted previously, it long ago invalidated state laws barring the use of contraceptive products after the FDA had authorized their sale.¹⁷⁹ In those cases, the Court rejected the claim that guarding against promiscuous behavior qualified as a compelling governmental interest.¹⁸⁰ Along similar lines, its recognition of a fundamental right to abortion presumably would prevent a state from entirely barring access to mifepristone, the abortifacient drug that gets used exclusively before viability.¹⁸¹ Conversely, medical interventions such as fertility drugs designed to

rights which being alive makes possible.”); *id.* at 10 (“[T]he right to use safe and effective medical treatments could also be grounded in liberty rights to be free of pain or disability.”); *id.* at 17-18 (conceding that the FDA could act to ensure the safety and effectiveness of therapies derived from embryonic stem cells (ESCs)); *id.* at 31 (concluding that “the state could not ban safe and effective [i.e., FDA approved] ESC treatments”).

178. See, e.g., *Lawrence v. Texas*, 539 U.S. 558, 564-66, 573-74 (2003); *Hodgson v. Minnesota*, 497 U.S. 417, 434 (1990) (“A woman’s decision to conceive or to bear a child is a component of her liberty that is protected by the Due Process Clause”); *Carey v. Population Servs. Int’l*, 431 U.S. 678, 685 (1977) (“The decision whether or not to beget or bear a child . . . holds a particularly important place in the history of the right of privacy [D]ecisions whether to accomplish or to prevent conception are among the most private and sensitive.”).

179. See, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 485-86 (1965); see also *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2779-80 (2014) (citing *Griswold* for the proposition that, “[u]nder our cases, women (and men) have a constitutional right to obtain contraceptives”); *Casey*, 505 U.S. at 852 (reading *Griswold* and its progeny as protecting “the decision to use contraception”); *supra* notes 60-61 and accompanying text (elaborating); cf. *Heinzerling*, *supra* note 64, at 965 & n.271 (asserting incorrectly that “contraception is the only category of drug product regulated by the FDA that has constitutional stature,” citing as support for the negative part of her claim only the unsuccessful litigation that asserted a right of access to *investigational* drugs).

180. See, e.g., *Carey*, 431 U.S. at 694-96 (plurality opinion); *Griswold*, 381 U.S. at 498-99 (Goldberg, J., concurring); *id.* at 505-06 (White, J., concurring in judgment). This has not kept good Catholics from continuing to try and justify such prohibitions. See, e.g., Patrick A. Shrake, Comment, *Griswold at 40: The State’s Compelling Interest in Banning Contraceptives*, 2 U. ST. THOMAS L.J. 475, 485-507 (2005) (arguing that products designed to impair fertility induce (by definition) an unhealthy condition, non-barrier contraceptives carry the risk of serious side effects, and all contraceptives facilitate promiscuous behavior, which purportedly threatens the institution of marriage, increases divorce rates, and promotes the spread of sexually transmitted diseases).

181. See *Noah*, *supra* note 1, at 602-03; see also *supra* note 69 and accompanying text (revealing that the lower courts presently are divided over lesser state restrictions on the use of mifepristone).

facilitate childbearing also seemingly would enjoy some constitutional protection.¹⁸²

Outside of the realm of procreative rights, however, guidance becomes harder to find. For instance, could state lawmakers ban a pharmaceutical product known to cause serious birth defects because they feared that its accidental use during pregnancy would necessitate abortions?¹⁸³ What about drugs other than contraceptives that some worry may promote undesirable behaviors, such as pharmaceutical products that guard against the consequences of certain sexually transmitted diseases (STDs)? Surely no one would consider banning HIV treatments on this ground,¹⁸⁴ but what if a state such as Kansas decided to prohibit the use of Gardasil[®]—a vaccine approved by the FDA to prevent the STD human papillomavirus (HPV), which sometimes causes cervical cancer—out of fears that it might promote sexual promiscuity among teenagers?¹⁸⁵ As suggested

182. See Lars Noah, *Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation*, 55 FLA. L. REV. 603, 659-65 (2003) (discussing scholarly debates about the right to make use of fertility treatments); *cf. id.* at 664 (“[C]onstitutional regard for procreative liberties should not stand as an obstacle to the withdrawal of fertility drugs if the FDA decides that they no longer represent safe and effective products, just as it would not prevent the agency from denying a marketing application for a new fertility drug that failed to satisfy normal criteria for approval.”).

183. *Cf.* Noah, *supra* note 174, at 250-52 (discussing the possibility of such moral objections to the use of FDA-approved teratogens that would necessitate the concomitant use of contraception); Robertson, *supra* note 177, at 17-31 (explaining that interests in protecting preimplantation embryos and fears of descending the slippery slope toward human cloning could not justify a state prohibition on the use of FDA-approved ESC treatments); *id.* at 24 (“If moral repugnance is not an acceptable basis for denying a person sexual intimacy or reproductive freedom, it should not justify denying the right to life and health on which sexual freedom and the exercise of other liberties depend.”).

184. *Cf.* Eryn Brown & Adolfo Flores, *HIV/AIDS: A Dose of Dispute: Truvada Reduces the Chances of HIV, but Some in the Gay Community Call It a “Party Drug” That Encourages Risky Behavior*, L.A. TIMES, Dec. 3, 2014, at AA1 (reporting that proponents of pre-exposure prophylaxis (PrEP) object that critics are “engaging in what they call a shaming exercise similar to the disapproval unmarried women faced 50 years ago when they demanded access to the birth control pill”); John Ritter, *Ads Linked to Rise in Rate of HIV Infections: City Considers Ban on Drug Billboards*, USA TODAY, Apr. 6, 2001, at 4A (reporting that San Francisco considered prohibiting any print advertisements in bus shelters of drugs for the treatment of AIDS because of concerns that they conveyed an overly optimistic message about their safety and effectiveness and might undermine efforts to encourage safer sex).

185. See Rob Stein, *Cervical Cancer Vaccine Gets Injected with a Social Issue; Some Fear a Shot for Teens Could Encourage Sex*, WASH. POST, Oct. 31,

previously, the fact that the CDC has recommended such immunizations would bolster an obstacle preemption argument,¹⁸⁶ but the question here asks whether individuals wishing to use this vaccine would enjoy any constitutional right to do so. What if a state such as Florida banned erectile dysfunction drugs out of concerns that they promoted promiscuity and the spread of STDs among aging Baby Boomers?¹⁸⁷

In *Whalen v. Roe*,¹⁸⁸ the Supreme Court rejected a substantive due process challenge to New York legislation that had required the use of triplicate prescription forms (with a copy sent to state officials) for purposes of monitoring the use and abuse of Schedule II drugs.¹⁸⁹ These recordkeeping requirements plainly exceeded those

2005, at A3; see also Jonathan T. Scott, Note, *The Difficult Road to Compelling Vaccination for Sexually Transmitted Diseases—How Gardasil and Those to Follow Will Change the Way That States Require Inoculation*, 97 KY. L.J. 697, 710 (2008-2009) (“[B]ecause many religious groups believe in celibacy before marriage, the issue of abstinence will likely become a decisive issue in the Gardasil debate.”); *id.* at 711 (“To many, STD vaccination may encourage the breaking of the Seventh Commandment and undermine the institution of marriage. Similarly, STD vaccination could threaten religious teachings from other religious groups concerning the sanctity of marriage.”). In fact, several states had considered mandating the use of Gardasil, which triggered an outcry from some corners. See R. Alta Charo, *Politics, Parents, and Prophylaxis—Mandating HPV Vaccination in the United States*, 356 NEW ENG. J. MED. 1905, 1906 (2007); Jason L. Schwartz & Laurel A. Easterling, *State Vaccination Requirements for HPV and Other Vaccines for Adolescents, 1990-2015*, 314 JAMA 185, 186 (2015) (“Why HPV vaccine requirements have not been more widely implemented is unclear, but may reflect reluctance among states to revisit the contentious political climate surrounding requirement proposals in 2006-2007.”).

186. See Rob Stein, *Routine HPV Vaccination Recommended for Boys*, WASH. POST, Oct. 26, 2011, at A2 (reporting that the CDC had issued its recommendation for use in pre-teen girls shortly after the FDA approved the drug in 2006). Thus, the fact that the CDC added Gardasil to its recommended vaccine schedule seems far more relevant for preemption purposes than the mere fact of FDA approval. See *supra* note 36 and accompanying text.

187. See Barbara Marshall, *Sex and the Single Senior*, PALM BEACH POST (Fla.), Oct. 23, 2010, at 1D, 2010 WLNR 21377442; see also Diedtra Henderson, *Sex Drugs Called Avenue to HIV*, BOS. GLOBE, Sept. 26, 2005, at E1 (reporting that the FDA had scheduled a public meeting to discuss such concerns); Sabin Russell, *San Francisco Doctor Wants Viagra to Be Controlled Substance*, S.F. CHRON., Aug. 24, 2004, at B1 (reporting that the director for STDs at the City’s health department had petitioned the FDA to restrict such drugs); cf. Anupam B. Jena et al., *Sexually Transmitted Diseases Among Users of Erectile Dysfunction Drugs: Analysis of Claims Data*, 153 ANNALS INTERNAL MED. 1, 1, 5-6 (2010) (finding that such concerns are overstated).

188. 429 U.S. 589 (1977).

189. See *id.* at 597-604.

imposed by Congress, but they did not in any way appear to conflict with or frustrate the purposes of the federal Controlled Substances Act.¹⁹⁰ Plaintiffs did not, however, make any argument under the Supremacy Clause, relying instead on the Fourteenth Amendment and claiming, among other things, that the reporting requirement would interfere with patients' privacy-based rights to make independent decisions about the use of drugs.¹⁹¹ The Court held that the reporting mechanism imposed no serious burden on such choices.¹⁹²

In further explaining this decision, Justice Stevens remarked: "Although the State no doubt could prohibit entirely the use of particular Schedule II drugs, it has not done so. This case is therefore unlike those in which the Court held that a total prohibition of certain conduct was an impermissible deprivation of liberty."¹⁹³ Although the Court had no particular product before it, any members of the class of Schedule II drugs that New York might have decided to ban—i.e., reclassify as Schedule I—presumably would have had approval from the FDA (on top of its classification under the federal Controlled Substances Act as a Schedule II drug), putting aside the

190. *Cf. supra* note 29 and accompanying text (discussing the CSA's savings clause). Indeed, the federal government has encouraged all states to establish such prescription drug monitoring systems. *See* Cynthia Billhartz Gregorian, *Addiction to Painkillers Is a Growing Problem: How to Kick It*, WASH. POST, Dec. 5, 2010, at A13 ("Forty-three states have passed legislation to do just that, although only 33 states have money to fund them."); *see also* Ashley Dutko, Note, *Florida's Fight Against Prescription Drug Abuse: Prescription Drug Monitoring Program*, 34 NOVA L. REV. 739, 747-54 (2010); Melody Petersen & Barry Meier, *Few States Track Prescriptions as Way to Prevent Overdoses*, N.Y. TIMES, Dec. 21, 2001, at A1 (reporting that doctors and drug companies had opposed such efforts in the past).

191. *See Whalen*, 429 U.S. at 598-600.

192. *See id.* at 602-04; *id.* at 606 ("[T]his record does not establish an invasion of any right or liberty protected by the Fourteenth Amendment.").

193. *Id.* at 603 (footnote omitted); *see also id.* at 603 n.30 ("It is, of course, well settled that the State has broad police powers in regulating the administration of drugs by the health professions."). The decisions cited by the Court as support for the first quoted sentence stand for the unremarkable proposition that states can sanction drug abusers and enjoy primary authority in regulating medical professionals, but they did not suggest any power to ban the use of pharmaceutical products in treating legitimate patients. *See id.* (citing *Robinson v. California*, 370 U.S. 660, 664-65 (1962); *Barsky v. Bd. of Regents*, 347 U.S. 442, 449 (1954); and *Minn. ex rel. Whipple v. Martinson*, 256 U.S. 41, 45 (1921)). Although *Martinson* arguably came closest to supporting the *Whalen* Court's point, that decision long predated any sort of federal licensing system for drugs, and *Robinson's* extended quotation of the relevant passage from *Martinson* in the same year that the FDA initiated its modern system for drug approval represented nothing but dicta.

possibility that state lawmakers sought only to make a symbolic gesture or acted preemptively in anticipation of FDA approval.¹⁹⁴ In order to pose the question more concretely, did *Whalen* foreclose the possibility that patients in Massachusetts might have enjoyed a constitutional right of access to the Schedule II drug Zohydro?¹⁹⁵ Does the Supreme Court's dictum go so far as to suggest that a state could altogether bar access to a drug without particularly good reason (as implied by the first sentence quoted above),¹⁹⁶ or did the Court instead mean that a state might well have good reasons for doing so (as implied by reading the second sentence quoted above as a limitation on the first and in view of the fact that, by definition, Schedule II drugs carry a high potential for abuse)?¹⁹⁷ Only rarely have courts or commentators referenced this passage from *Whalen*, much less tried to make sense of it.¹⁹⁸

194. The fact that a drug substance appears in Schedule II does not invariably mean that the FDA has approved a product with that active ingredient. After all, pure hydrocodone carried such a classification for more than forty years before the agency approved Zohydro. *See supra* note 13 and accompanying text. Of course, the only Schedule II drugs possibly affected by the more limited state law upheld in *Whalen* must have had FDA approval because otherwise a physician would have been unable to prescribe them.

195. Judge Zobel had cited *Whalen* only for the basic proposition that “the Commonwealth’s police powers permit it to regulate the administration of drugs by the health professions.” *Zogenix, Inc. v. Patrick*, No. 14-11689-RWZ, 2014 WL 3339610, at *4 (D. Mass. July 8, 2014), *vacated in part*, 2014 WL 4273251 (D. Mass. Aug. 28, 2014).

196. *See People v. Privatera*, 591 P.2d 919, 923 (Cal. 1979) (“If the state has the power to ban a drug with a recognized medical use because of its potential for abuse, then—given a rational basis for doing so—the state clearly has the power to ban a drug [amygdalin] not recognized [by the FDA] as effective for its intended use.”). Laetrile did not, however, qualify as a controlled substance much less one in Schedule II. *See supra* notes 84-85 and accompanying text.

197. *See* Elizabeth G. Patterson, *Health Care Choice and the Constitution: Reconciling Privacy and Public Health*, 42 RUTGERS L. REV. 1, 29-30 n.149 (1989) (“[T]his dictum appears to reflect a perception that the public interest behind such a prohibition would be strong, rather than that the right to privacy would not be implicated.”); *see also Whalen*, 429 U.S. at 592-93 (“Our concern is limited to Schedule II which includes the most dangerous of the legitimate drugs.”).

198. *See, e.g., Borucki v. Ryan*, 827 F.2d 836, 841 n.7 (1st Cir. 1987) (“Additional factors apparently underlying the Court’s ruling were that the State could have proscribed use of the drugs entirely”); *State v. Wiedeman*, 835 N.W.2d 698, 709 (Neb. 2013); *Doe v. Axelrod*, 527 N.Y.S.2d 385, 401 (App. Div. 1988); Margaret B. Hoppin, Note, *Overly Intimate Surveillance: Why Emergent Public Health Surveillance Programs Deserve Strict Scrutiny Under the Fourteenth Amendment*, 87 N.Y.U. L. REV. 1950, 1968 & n.89 (2012); *see also* B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 304 (2007) (recognizing that “the Court’s

The freedom to make choices about medical interventions seems to differ constitutionally from other choices in the marketplace of consumer goods and services.¹⁹⁹ Thus, the Supreme Court held that the State of Nebraska could not ban one of two recognized methods of late-term abortion without including an exception when necessary to protect a woman's health,²⁰⁰ while only a few years later it decided that Congress could conclude otherwise.²⁰¹ Although such medical procedures do not undergo any form of federal licensure,²⁰² this pair of decisions might help to explain what makes a state

statements about outlawing certain drugs were pure dicta"); Note, *Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana*, 118 HARV. L. REV. 1985, 1996 n.61 (2005) (suggesting why "this point should be treated with care").

199. See *Whalen*, 429 U.S. at 603 ("Nor can it be said that any individual has been deprived of the right to decide independently, with the advice of his physician, to acquire and to use needed medication."); Hill, *supra* note 198, at 305-13, 329-32, 341-45 (discussing the Supreme Court's treatment of autonomy in making choices about medical care); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1827 (2007) ("[T]o impose a substantial burden on the patient's right to protect her life through medical procedures, the government should have to show that it has an extremely powerful reason for burdening the right and that the burden is genuinely necessary because the government's goals can't be achieved in less burdensome ways." (footnote omitted)).

200. See *Stenberg v. Carhart*, 530 U.S. 914, 930-38 (2000); see also *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 327-28, 331 (2006) (holding that state restriction on minors' access to abortion required a health exception); Hill, *supra* note 198, at 310, 319-20, 322-25 (finding a more limited recognition of this exception in the Court's subsequent rejection of a challenge to the federal prohibition on this same abortion procedure); Volokh, *supra* note 199, at 1826 ("Postviability abortions cannot be distinguished on the ground that they involve the woman's reproductive choice. After viability, the time for that choice has passed, and the right to get a therapeutic abortion is a consequence of the woman's medical self-defense right, not her abortion-as-choice right."). Commentators invoking the health exception required by the Supreme Court for abortion restrictions do so in order to claim a substantive due process right of terminally ill patients without other options to access *investigational* drugs; surely such a constitutional claim more readily embraces a right of access to therapeutic products that already have received FDA approval.

201. See *Gonzales v. Carhart*, 550 U.S. 124, 161-67 (2007). For a vague parallel in the context of pharmaceuticals, consider methaqualone, which the FDA had approved for the treatment of insomnia but Congress later overrode and dictated its placement in Schedule I. See Pub. L. No. 98-329, 98 Stat. 280 (1984); see also Noah, *supra* note 35, at 59 ("Congress concluded that methaqualone offered no advantages over other products that posed less of a risk of abuse.").

202. See Lars Noah, *Medicine's Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373, 447-49 (2002).

prohibition on an FDA-approved pharmaceutical product problematic. If the agency has not approved a particular drug (or has withdrawn such an approval), then generally no one in the country can secure access to it;²⁰³ if, however, the agency has issued a license but one state acts to disregard it, then persons in that state (and only that state) cannot take advantage of a pharmaceutical product even though it has received official sanction. In short, upon FDA approval the baseline shifts from nonavailability to availability for patients, which a particular state's prohibition then would unsettle in a way that restricted the freedom to make potentially critical medical choices.

The act of federal licensure, even if not enough to trigger implied preemption under the Supremacy Clause, seems to make the state's burden of justification nearly impossible in the event that some form of heightened scrutiny applies.²⁰⁴ Under what circumstances might a state have a substantial (much less a compelling) interest in barring access to a drug that the FDA just approved, and could it not typically serve any such interest by means more narrowly tailored than an outright prohibition on sale?²⁰⁵ Massachusetts plainly disagreed with the agency's risk-benefit judgment when it licensed Zohydro, but how seriously could a reviewing court take the contrary views of state officials in light of that approval,²⁰⁶ and did not the state—as amply revealed by the steps that it took after issuance of the preliminary injunctions—have more

203. Similarly, once Congress banned partial birth abortion, Nebraska presumably could resurrect its earlier prohibition (carrying more draconian penalties than imposed under federal law) without running afoul of the Fourteenth Amendment.

204. See Sarah Ricks, *The New French Abortion Pill: The Moral Property of Women*, 1 YALE J.L. & FEMINISM 75, 90-92, 99 (1989) (arguing that FDA approval would make it impossible for individual states seeking to prohibit use of the drug to invoke safety rationales if challenged as burdening the right to privacy).

205. Cf. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687-88 (1977) (“A total prohibition against sale of contraceptives, for example, would intrude upon individual decisions in matters of procreation and contraception as harshly as a direct ban on their use. Indeed, . . . since more easily and less offensively enforced, [it] might have an even more devastating effect . . .”).

206. If courts could freely disregard the FDA's risk-benefit judgment, then, because prescription drugs invariably carry a risk of serious side effects, state officials wanting to ban a pharmaceutical product could simply point to the risk labeling approved by the agency as the basis for asserting a safety rationale for their action. See Shrake, *supra* note 180, at 488-89; *id.* at 492 (“Because these admittedly adverse health consequences [of hormonal contraceptives] are conceded, there would be no need for a state even to prove its case.”).

nuanced mechanisms of control at its disposal?²⁰⁷ Then again, Zohydro hardly qualifies as a life-saving drug, and patients in severe pain would still have any number of long-acting opioid analgesic substitutes available to them.²⁰⁸

CONCLUSION

Not surprisingly, the question posed at the outset does not admit of an easy answer. In certain circumstances, states may enjoy the authority to prohibit the sale of an FDA-approved pharmaceutical. The constitutional analysis—whether framed in terms of implied preemption, dormant Commerce Clause doctrine, or substantive due process—may depend on answers to several subsidiary questions: Did the federal government actively encourage the introduction or use of the product; how much time has elapsed since the FDA licensed it (and has new information emerged that might alter the agency’s original risk-benefit judgment); does the product offer significant benefits to patients who find themselves in dire straits (or wish to exercise their recognized rights in making procreative choices); does it pose significant risks to patients or others (reflected, for instance, with a Schedule II designation); and

207. See *supra* notes 45-51 and accompanying text. When the State of Florida faced an epidemic of opioid abuse, it successfully tackled unscrupulous suppliers (so-called “pill mills”) rather than the drug products themselves. See Hal Johnson et al., *Decline in Drug Overdose Deaths After State Policy Changes—Florida, 2010-2012*, 63 MORBIDITY & MORTALITY WKLY. REP. 569 (2014); see also Barry Meier & Sabrina Tavernise, *States Push to Curb Painkiller Overuse*, N.Y. TIMES, Mar. 12, 2016, at B1 (“[T]he pace of activity in states has grown so intense that experts are having difficulty keeping track. Currently, there are about 375 proposals in state legislatures that would regulate pain clinics and several aspects of prescribing painkillers,” and Massachusetts just enacted legislation that allows physicians to prescribe no more than a seven-day supply of such drugs after an injury or surgery.).

208. Cf. Noah, *supra* note 93, at 865 (“[A]re powerful analgesics properly dismissed as merely ‘lifestyle’ drugs? Contraceptives sometimes get trivialized in this fashion.”); *id.* at 866 (“In the final analysis, all drugs are, to one degree or another, lifestyle drugs.”). If, however, some patients could not tolerate any of the alternatives, see *id.* at 849 & n.39, 855-56 (explaining the flaws in assuming therapeutic substitutability), then a state prohibition would deprive them of access to palliative care in seeming contravention of the Court’s guidance in the physician-assisted suicide cases, see *supra* note 173 and accompanying text; see also *Stenberg v. Carhart*, 530 U.S. 914, 934 (2000) (“A rarely used treatment might be necessary to treat a rarely occurring disease that could strike anyone—the State cannot prohibit a person from obtaining treatment simply by pointing out that most people do not need it.”).

does the state's contrary judgment reflect special local conditions or concerns? Because pharmaceuticals run the gamut on these various measures, a state's decision to deprive patients of access to a drug licensed by the FDA would not invariably run afoul of the Constitution, unless, of course, one takes seriously the Supreme Court's expansive approach to implied preemption in its latest tort decision, *Mutual Pharmaceutical Co. v. Bartlett*.²⁰⁹ The recent experience with Zohydro in Massachusetts nicely posed the relevant questions, but the resolution of the resulting litigation unfortunately offered little in the way of persuasive answers.

209. 133 S. Ct. 2466 (2013); *see also supra* Section II.A (elaborating).