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MISSING MARKETS FOR INNOVATION: EVIDENCE FROM NEW USES OF EXISTING DRUGS

Eric Budish
Maya M. Durvasula
Benjamin N. Roin
Heidi L. Williams

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ABSTRACT

For large classes of potential inventions, intellectual property rights that are available on paper are either not possible or not profitable for firms to enforce in practice. In this paper, we show that these missing incentives yield quantitatively significant underinvestment in research and development. We develop a simple model that formalizes the conditions under which such missing markets for innovation arise. We identify an empirical setting—research into new uses for existing drugs—in which there is sharp variation in the enforceability of intellectual property rights on otherwise comparable inventions over time. We show that when intellectual property rights become unenforceable, research investment and commercialization nearly cease. In doing so, we test two claims central both to our model and the innovation literature more generally—that stronger intellectual property protection does, in fact, induce investment, and that heterogeneity in the availability of these rights distorts investment. The welfare consequences of inadequate incentives in our empirical context are large. Our estimates suggest that 200-800 new uses for existing drugs would have been developed under counterfactual policies. Measures of the value of these uses drawn from existing literature suggest that the social cost of this particular missing market is on the order of several trillion dollars.

Eric Budish
University of Chicago
Booth School of Business
and NBER
eric.budish@chicagobooth.edu

Maya M. Durvasula
Stanford University
mdurvas@stanford.edu

Benjamin N. Roin
Independent Researcher
bnroin@gmail.com

Heidi L. Williams
Dartmouth College
Department of Economics
and NBER
heidi.lie.williams@dartmouth.edu

1 Introduction

Most inventions are far more costly to discover and develop than they are to imitate and reproduce. Economists have long recognized that, absent some mechanism that allows inventors to recoup their investments in these processes of research and development, competitive markets will therefore offer insufficient incentives for innovation (Nelson, 1959; Arrow, 1962; Nordhaus, 1969). Policies based on this idea go back at least half a millennium to 15th century Italy and are enshrined in the U.S. Constitution.[1]

In this paper, we investigate the idea that, for large classes of potentially valuable inventions, intellectual property rights that exist "on paper" are impossible to enforce in practice. When this is the case, intellectual property rights provide zero private sector incentive for research and development. We show that there are many scientifically feasible, socially valuable inventions that are missing as a result.

Consider three hypothetical inventions: a rigorously tested regimen of nutritional supplements that reduces the risk of developing Alzheimer's disease for adults or that improves cognitive development for babies; a manufacturing process that would substantially increase the precision of pharmaceutical manufacturing and reduce the risk of large-scale medicine recalls; and a motorcycle helmet that outperforms existing alternatives on metrics of safety and comfort, available for sale on an online platform.[2] For each, an inventor could file for some form of intellectual property protection—likely, a patent from an entity like the U.S. Patent and Trademark Office.[3] Here, the problem of interest to this paper arises.

Most forms of intellectual property rights, including patents, are not self-enforcing. An inventor must be able both to identify instances of infringement and to take effective legal action to stop it. But when it is difficult to determine, say, that someone is combining widely-available supplements in a way that infringes on a patent or that a bottle of pills was manufactured using a protected method, inventors will be unable to enforce their patents simply because they cannot observe in-

[1] Article I, Section 8, Clause 8 ("[t]o promote the Progress of Science and useful Arts, by securing for a limited Time to Authors and Inventors the exclusive Right to their respective Writings and Discoveries").

[2] We choose, for the sake of illustration, three types of socially valuable inventions—methods primarily used by consumers, methods primarily used by firms, and easily imitable products. For a discussion of the value of rigorous evaluation of health interventions, see Mozaffarian et al. (2011); for a discussion of the difficulty of establishing such an evidence base, see Oster (2024). For a discussion of the social costs of low-quality methods of pharmaceutical manufacturing, see Price (2014); for an analysis of the consequences of low pharmaceutical manufacturing quality—which can trigger contamination events and large-scale recalls—see Yurukoglu et al. (2017). For an example of the consequences of easy imitation of critical protective products like motorcycle helmets, see https://www.congress.gov/117/meeting/house/114092/documents/HMKP-117-JU00-20210929-SD217.pdf.

None of these products are amenable to protection with trade secrecy, as each must be publicly disclosed to end users and regulators as a condition of sale. In Section 2, we develop a framework that identifies instances in which trade secrecy is likely to be an effective incentive for innovation. Mansfield (1986) and Moser (2005) provide empirical evidence on the practical importance of secrecy.

[3] We use the term "invention" in the same manner as the literature on economic growth, to refer to any instance of knowledge production, whether in the form of physical products, sets of instructions, or pieces of information (Arrow, 1962; Romer, 1994; Jones, 2005). It may surprise some readers that all three inventions described in the text are likely eligible for patent protection. This reflects, in part, the distinction this paper draws between the availability of patent protection and the enforceability of patent protection. Section 2 provides a primer on the standards for patentability in the United States.

fringement. And even when an inventor can observe, for instance, that dozens of small, overseas sellers are offering motorcycle helmets that infringe her rights, a patent is of little use if there is no viable party against whom she can file suit.

This paper argues that these legal and practical gaps in intellectual property protection are widespread and shows that their social costs are significant. We develop a simple theoretical framework that uses the characteristics of inventions to identify settings in which gaps in intellectual property protection translate into missing private incentives for investment. We identify one such setting—research into new therapeutic uses for existing drugs—where the enforceability of intellectual property rights on otherwise comparable inventions changes sharply over time and hence allows us to test the link between intellectual property rights and private incentives central to this paper. When intellectual property rights become unenforceable, we show that research and development essentially cease.

We begin by formalizing the heterogeneity that generates these differences in enforceability across inventions. We introduce a model in the style of Nordhaus (1969), in which intellectual property rights confer some period of time under monopoly. To the standard framework, we add three complications. First, some inventions can be profitably commercialized while remaining secret. In these cases, firms can recoup their investments in research and development without formal grants of intellectual property—so long as they can maintain trade secrecy. Second, only some inventions are eligible for formal intellectual property protection. By law, others are not. Third, of those inventions that are eligible for intellectual property rights, only some can be protected by rights that are enforceable in practice.

We say that a *missing market* arises when formal intellectual property rights are necessary to incentivize research and development, but such rights are either unavailable or unenforceable. Note that this characterization rules out a standard policy solution to the problem of inadequate incentives for innovation: canonical models linking intellectual property rights to incentives embed the idea that sufficiently strong property rights—that is, longer or broader periods of market exclusivity—can make any invention profitable to develop (e.g., Nordhaus, 1969; Gilbert and Shapiro, 1990; Klemperer, 1990). When gaps in incentives arise because intellectual property rights are completely unavailable or unenforceable, there are no "Nordhaus parameters" that can induce private investment.

This model allows us to identify large classes of potential inventions, across sectors of the economy, where missing markets are likely to arise. Our empirical analysis focuses, however, on a specific context—investments into new uses for existing drugs—where sharp variation in the enforceability of intellectual property rights over time allows us to test for evidence of a missing market.

To fix ideas about the institutional features that enable this test, an example is helpful. In 1995, the U.S. Food and Drug Administration (FDA) approved Glucophage (metformin hydrochloride) as a treatment for diabetes.[4] Generic versions of the drug entered the market in 2002. Around

[4]NDA #020357, approved on 03 March 1995.

this time, oncologists began to document tentative evidence that metformin may also be effective at treating or preventing cancer. Though these researchers proceeded with various "preclinical" studies, commercial interest in funding a clinical trial validating metformin as a treatment for human cancer was nonexistent (Gale and Gerlin, 2012). The problem? There is no mechanism that would allow a private firm to *sell* the knowledge that this existing drug could be used in a new way.[5]

To be clear, the USPTO would likely have granted a patent on the use of metformin to treat cancer, and the FDA would then have barred other firms from marketing generics for this use.[6] But once the information about metformin's value as a treatment for cancer became publicly known, any patient or their physician could make use of the information freely—by using or prescribing the generic version—without compensating the firm that undertook the expensive clinical trial. And even if that firm could detect unauthorized use, enforcement would be practically impossible: the only parties on whom liability would definitively fall would be the patients using the drug to treat their own cancer.[7] Decades after preliminary evidence first emerged, whether metformin has potential as a treatment or even potentially as a preventative for cancer is an open question that "still warrant[s] well-designed clinical investigation" (Lord and Harris, 2023).

In most missing markets identified by our model, intellectual property rights are unenforceable from the moment that they are granted. Observe, however, that patents on new uses for metformin become unenforceable many years after commercialization, only when generic versions of the drug are approved for sale. This delay—a feature of the regulatory structure for pharmaceuticals in the United States—provides our research design. For a period in each new drug's life, the FDA bars the entry of generic competitors. During this time, a single firm controls the market and can set a price for its drug that reflects all commercialized uses. So long as the firm retains market exclusivity, it is compensated for both the original use and any new uses. Patents on new uses are, thus, perfectly enforceable. But after generic entry, as the metformin case illustrates, the likelihood that the firm can enforce such a patent drops essentially to zero.

Mapping this variation to our framework yields three predictions. First, firms will have the strongest incentives to invest in new uses for existing drugs soon after initial approval. Second, as market exclusivity expiration approaches, the number of years in which investments in new uses will yield profits declines—and thus, incentives should fall. Third, exclusivity expiration creates a missing market for new uses, and private research and development should cease.

Testing these predictions is the focus of our empirical work. To do so, we construct new data tracing research and development investments associated with all new drugs approved by the FDA between 1985 and 2014. We collect records of re-approvals for new uses, as well as indicators of

[5] Gale and Gerlin (2012) includes portions of an interview with one oncologist, who indicated that she was ready to begin work on this lead around 2002 but was unable to garner support from any private firm, noting that "*When they realized the results wouldn't be available until they lost their patent, they pulled out*" (emphasis added).

[6] Section 3.2 provides details on the availability of, both, patents on methods of using existing drugs for new therapeutic indications and FDA-administered regulatory exclusivities that serve the same purpose.

[7] Section 3.2 elaborates on the difficulties of enforcement in this context. In a small number of cases, hospitals, physicians, and pharmacists may share in the liability—though suits against them for patent infringement are rare: it is rarely advantageous for firms to sue their own (repeat) customers. A generic manufacturer that encourages infringement of a patent may also be liable, though there are several statutory protections that limit the viability of many such cases.

upstream investments in basic research and early-stage commercialization. To characterize trends in investment around market exclusivity expiration, however, we must first define some measure that captures the point in time when the firm expects its intellectual property rights to lapse and, hence, its drug to be vulnerable to generic competition. We draw on legal and regulatory analyses, as well as newly-digitized records of the intellectual property rights associated with each drug in our data, to propose and validate such a measure of expected exclusivity expiration.[8]

Using these data, we show that investments in new uses for existing drugs closely track our predictions. At peak, ten years before market exclusivity expiration, seven percent of drugs in our sample are re-approved for at least one new use. In each subsequent year the likelihood of re-approval declines monotonically and falls to roughly zero following market exclusivity expiration. The vast majority of new uses ever approved by the FDA for our sample of drugs were approved prior to exclusivity expiration. We document comparable trends in clinical trials, which decline sharply in frequency over a drug's life cycle. Together, these pieces of evidence are consistent with—though not dispositive of—the existence of a missing market for new uses following generic entry.

There are two natural alternative explanations. If the set of "scientific opportunities" for new uses is gradually exhausted, research investments may naturally decline over a drug's lifecycle. Alternatively, firms may recognize that generic entry is imminent and strategically sequence research and development to bring all viable new uses to market during this initial profitable period. On the basis of two additional empirical exercises—one documenting that longer periods of market exclusivity induce additional commercialization of new uses, and one showing that commercialization of related products on which intellectual property rights remain enforceable does not drop off at the same time—we argue that both alternative explanations are unlikely.

First, we provide causal evidence that increasing the duration of market exclusivity increases the number of new uses that are commercialized. This test relies on the observation that firms in the pharmaceutical sector have strong incentives to file key patents on new drugs at the time of invention, often many years before drugs are approved for sale. Sizable delays between invention and approval—due to required clinical trials and regulatory delays—mean that certain drugs have many more years of effective market exclusivity than do others, for reasons unrelated to their potential for new uses (Roin, 2013; Budish et al., 2015; Gilchrist, 2016). We use this variation in the market exclusivity provided to drugs in our sample to show that drugs with longer periods of exclusivity have more commercialized new uses, consistent with the idea that when opportunities to develop new uses arise stochastically, only those firms with sufficient remaining market exclusivity can pursue them.

Second, we establish that the enforceability of intellectual property rights is the mechanism driving our results. Not all re-approvals of existing drugs face the same enforceability problem as new uses once generic entry occurs. We show that although the likelihood that a drug in our sample is ap-

[8] A separate paper, Durvasula et al. (2023), serves as a "user's guide" to the datasets and measurement strategies employed in this paper's empirical analyses; in particular, it introduces and validates the contents of the primary dataset we use to capture patent protection and assesses alternative measures of market exclusivity.

proved for a new use falls essentially to zero when market exclusivity expires, the likelihood that it is re-approved for other types of uses—such as a new patient population, dosage, or strength—falls far less sharply. Moreover, the likelihood that it is re-approved as part of a "fixed dose combination" actually increases. Fixed dose combinations bundle multiple drugs into a single "dosage form"—for example, metformin combined with glyburide in the branded drug Glucovance. Such combinations are regulated as distinct new drugs and, as such, receive their own regulatory protections that block generic entry. Continued investment into fixed dose combinations after the innovator drug's exclusivity expires provides evidence in support of two conclusions. First, it demonstrates that scientific opportunities for innovation do not coincidentally vanish at this point in a drug's lifecycle. Second, it confirms that our measure of market exclusivity accurately reflects firms' expectations about enforceability.[9] Taken together, this body of evidence provides support for the idea that there are scientifically feasible new uses for existing drugs that are not profitable to develop given the structure of existing incentives.

These empirical exercises allow us not only to establish the existence of a missing market, but also to quantify the social value of missing research investments. Our estimated elasticity implies that if intellectual property rights on new uses were enforceable, there would be between 0.1 and 0.4 additional new uses per drug. As roughly 2,000 drugs that satisfy our sample criteria have been approved since the modern FDA was created in 1962, this implies between 200 and 800 missing new uses. To offer a sense of magnitudes, we draw on existing estimates of the social value of new drugs and adopt an intentionally conservative figure, valuing each missing use at $0.5 billion per year. The net present value of missing research and development in this market, then, is on the order of $2.5 to $10 trillion.

Although our back-of-the-envelope estimates of the social cost of missing new uses are rough, they are consistent with evidence offered by the scientific literature. Scientists characterize the relatively small number of chemicals that have ever been approved as drugs by the FDA as "promiscuous," by which they mean that a drug that is sufficiently effective at treating *some* human disease to clear the threshold for FDA approval is very likely to be effective in the treatment of *many* diseases (Wermuth, 2006). Dozens of studies have validated this prediction. Gelijns et al. (1998), for example, document that within a sample of "blockbuster" drugs sold in 1993, nearly 90 percent had important uses beyond those for which they were originally approved. Against these estimates, our estimated range of 0.1 to 0.4 new uses per drug appears, if anything, conservative.

The idea that there are insufficient private incentives to develop new uses for existing drugs has been a long-standing concern for legal scholars, scientists, and policymakers (Gelijns et al., 1998;

[9] Our framework and this empirical test hint at one perverse consequence of gaps in the enforceability of certain intellectual property rights. When patents are not enforceable, firms have strong incentives to seek out alternative mechanisms that allow them to exclude their competitors from the market. The example of fixed dose combinations highlights one such option: firms might respond to the effective expiration of intellectual property rights on one drug by developing related products on which intellectual property rights remain enforceable—a practice sometimes referred to as product hopping (Carrier and Shadowen, 2016). We do not undertake a complete welfare analysis and thus do not weigh in on the social costs of these practices, but emphasize that one cost of incomplete or unenforceable patent rights not captured by our analysis is any deadweight loss associated with "self help" solutions.

Mossinghoff, 1999; Eisenberg, 2005; US Institute of Medicine, 2008; Rai, 2012; Roin, 2014; Sachs et al., 2017; Conti et al., 2020; EveryCure, 2025). This paper is, to the best of our knowledge, the first to formalize the source of missing incentives in this setting theoretically and to document underinvestment empirically. We confirm that the scale of underinvestment is extraordinarily large. As advances in health data infrastructure and screening technology reduce the cost of discovering potential new uses, the problem may only be growing (Collins, 2011b,a, 2012; Collins and Varmus, 2015).

Evidence of a quantitatively significant missing market for new uses provides, as well, clear empirical support for the paper's simple model of intellectual property and innovation incentives. Our framework embeds and formalizes two ideas that have appeared in various forms and under many names across much of the legal and economic scholarship on incentives for innovation—that formal intellectual property rights are not necessary to incentivize the development of certain inventions (e.g., Mansfield et al., 1981; Teece, 1986; Mansfield, 1986; Levin et al., 1987; Cohen et al., 2000; Moser, 2005), and that formal intellectual property rights cannot incentivize the development of others (e.g., Nelson, 1959; Arrow, 1962; Teece, 1986; Lemley and Shapiro, 2005; Eisenberg, 2005; Abramowicz, 2007; Kapczynski and Syed, 2012; Rai, 2012; Budish et al., 2015). In theoretical and empirical studies that aim to inform the design of optimal patent policy, however, every invention is assumed patentable (and patent-protected), and every patent perfectly enforceable (e.g., Machlup, 1958; Nordhaus, 1969; Scherer, 1972; Nordhaus, 1972; Klemperer, 1990; Gilbert and Shapiro, 1990; Scotchmer, 1991; Budish et al., 2015). Our modifications to the standard Nordhaus (1969)-style framework, though simple, capture the importance of legally-protected secrecy as a complement to patent protection. In particular, we formalize and test an idea central to the legal analysis in Kapczynski and Syed (2012)—that there are "domain[s] of innovation, that patents, whatever their scope, cannot adequately address."

The theoretical predictions generated by this model hinge on a causal link between intellectual property protection and incentives for innovation. Although decades of theory and centuries of policymaking have assumed such a relationship—that longer and broader intellectual property rights induce greater investment—there is remarkably little direct empirical support, owing to the difficulty of identifying meaningful variation in the protection provided to otherwise comparable inventions. A small number of papers—notably, Lerner (2002) and Sakakibara and Branstetter (2001)—have leveraged changes in national patent laws to test for such a relationship, but have found no effect, likely because country-level changes have relatively small impacts on global markets for innovation. Budish et al. (2015) document evidence consistent with the idea that longer patent terms induce additional research investments, but are unable to rule out corporate short-termism as an alternative explanation. The model we introduce in this paper implies an alternative research design, which allows us to test for direct evidence that intellectual property rights affect the level of research and development by leveraging variation in the *enforceability* of intellectual property rights across inventions. The missing markets problem, here, creates variation in the effective patent terms (years before generic entry) provided to otherwise comparable investments (new uses). We find that in-

creases in patent term cause increases in the number of new uses brought to market and—with the caveat that this estimate is specific to our empirical context—estimate the elasticity of research and development with respect to patent term.

We contribute more broadly to closely related literatures that study how property rights affect incentives for investment (e.g., Moser, 2005; Budish et al., 2015; Hodgson, 2024; Dix and Lensman, 2024) and how under-provision of incentives yields missing research and development (e.g., Budish et al., 2015; Krieger et al., 2022; Michelman and Msall, 2024; Dix and Lensman, 2024). Our model includes, as a special case, the problem of interest in Budish et al. (2015), who study incentives for the development of cancer treatments. Our model also includes the problem of interest in Dix and Lensman (2024), who investigate incentives for combining existing cancer drugs into new treatment regimens. We view Dix and Lensman (2024) as highly complementary to our paper. While we use a theoretical framework to clarify the missing markets problem and use reduced form empirical analysis, including quasi-random variation in market exclusivity, to quantify missing innovation, their paper builds a dynamic structural model that enables this quantification and allows for the assessment of counterfactual policies. Our paper also offers a clarification on the problem studied in Dix and Lensman: missing incentives for combinations of complementary products, in that setting, are not the result of property rights that are *unavailable* ($p_{\text{eligible}} = 0$ in our model) but rather property rights that are *unenforceable* because of generic drug availability ($p_{\text{enforce}} = 0$). Finally, our data and research design provide the first empirical evidence in support of an assumption central to the structural literature on innovation more broadly: there is a causal link between intellectual property rights and research investment.

This paper proceeds as follows. Section 2 introduces our conceptual framework. Section 3 provides context on the problem of new uses. Section 4 describes our data and measurement. Section 5 presents three sets of evidence that, together, establish the existence of a missing market for new uses for existing drugs. In Section 6, we present evidence on the magnitude of missing investment—in terms of missing "uses" and dollars of social value. In Section 7, we use our framework to summarize opportunities to "fix" the problem of missing markets when standard intellectual property levers are unavailable, before concluding.

2 Characterizing Missing Markets for Innovation

Not all inventions can be protected from imitation with grants of intellectual property rights—either because these rights are not available by law or because available rights are not enforceable in practice.[10] For certain inventions, these gaps in protection have no impact on incentives for research and development. For others, incomplete intellectual property rights yield *missing markets* for

[10] As the introduction suggests, there are two categories of intellectual property rights of interest in this paper: grants that confer monopoly or monopoly-like rights—patents, copyrights, contract-law forms of intellectual property—which must be actively enforced; and trade secrets, which provide a default protection to inventions if the inventor took active steps to avoid disclosure. When we refer to formal grants of intellectual property rights that must be enforced, we are referring to the first category. There are other forms of intellectual property (e.g., trademarks) that neither provide monopoly rights nor have as their goal the provision of incentives for innovation.

innovation.

This Section develops, in two parts, a simple framework that formalizes this heterogeneity. The first part introduces a set of complications to a standard Nordhaus (1969)–style model and, in doing so, allows us to define the conditions that give rise to a missing market. The second part transforms this model into a classification exercise, which uses characteristics of inventions to identify contexts where missing markets are likely to arise.

2.1 Defining Missing Markets

2.1.1 Preliminaries

A representative firm must decide whether to commercialize a potential invention, the characteristics of which it regards as exogenous.[11] Commercialization refers to the (costly) process of bringing a product or idea to market—running clinical trials to satisfy regulatory requirements, expanding manufacturing capacity to allow for production at scale, etc.

The starting point for this model is a Nordhaus (1969)–style framework, as adapted by Budish et al. (2015). A potential invention is characterized by the following sets of parameters, the first six of which are common to prior work.

- **Timing parameters**: The firm must decide whether to commercialize the potential invention in year t_{invent}, which we normalize to zero. Commercialization involves a deterministic delay t_{comm}.
- **Cost of commercialization**: To commercialize the potential invention, the firm incurs—in net present value terms at t_{invent}—a cost c.
- **Likelihood of successful commercialization**: Commercialization may not be successful.[12] We denote the probability of success by p_{comm}. We restrict consideration to potential inventions for which p_{comm} is greater than zero.
- **Obsolescence risk**: If an invention is successfully commercialized, it may lose usefulness over time as new, substitutable alternatives are brought to market. This is captured with an exogenous risk of obsolescence $1-\gamma$ in each year following t_{comm}.
- **Discount factor**: The firm discounts future profits by a factor δ.
- **Monopoly profits and social value**: A commercialized invention that is not obsolete and produced by the firm as a monopolist yields profits π per year. The invention also yields social value v^{monop} when priced by the monopolist and v when priced by the social planner, where $v > v^{\mathsf{monop}}$.

[11] We use the term "invention" to refer to any instance of knowledge production—including in the form of physical products, sets of instructions, and pieces of information (Arrow, 1962; Romer, 1994; Jones, 2005).

[12] In our empirical context, for example, clinical trials may fail to enroll enough patients or may indicate that a drug is ineffective as a treatment for a particular disease.

To this standard framework, we add three sets of parameters.

- **Secrecy**: Some inventions can be profitably commercialized while remaining secret. That is, even without a formal grant of intellectual property, the risk of imitation is low. The parameter $p_{\text{secret}} \in [0,1]$ captures the likelihood that the invention remains secret—and, thus, profitable—upon commercialization.[13] After commercialization, the firm risks losing secrecy. We capture this by assuming the firm faces an exogenous risk $1-\eta$ of losing secrecy each year following commercialization.

- **Eligibility**: Not all inventions are eligible for protection with grants of intellectual property rights. The probability that a commercialized invention satisfies these eligibility requirements is given by $p_{\text{eligible}} \in [0,1]$. The associated protection lasts for t_{patent} years.

- **Enforceability**: Grants of intellectual property rights are not self-enforcing. To enforce these rights, the firm must seek out instances of imitation and successfully bring suit against each infringer. The probability that the firm can successfully enforce its intellectual property rights is $p_{\text{enforce}} \in [0,1]$.

In Section 2.2, we discuss factors that affect the value of each parameter.

2.1.2 Monopoly Duration

For each potential invention, there is some period in which the firm will, in expectation, earn monopoly profits. The firm's expected time under monopoly depends on the mechanism used to deter imitation: secrecy or formal intellectual property rights.

If the invention is protected by secrecy, the expected time under monopoly is given by

$$T_{\text{secret}} = p_{\text{comm}} \cdot p_{\text{secret}} \cdot \sum_{t_{\text{comm}}}^{\infty} (\delta\gamma\eta)^t. \tag{1}$$

In words, time under secrecy T_{secret} is determined by (i) the likelihood of successful commercialization p_{comm}, (ii) the likelihood that secrecy effectively deters imitation p_{secret}, and (iii) the number of years in which secrecy is maintained, adjusted for discounting (by δ), the risk of obsolescence (by γ), and the risk of losing secrecy (by η).

If, instead, the invention is protected by a formal grant of intellectual property (e.g., a patent), the expected time under monopoly is given by

$$T_{\text{patent}} = p_{\text{comm}} \cdot p_{\text{eligible}} \cdot p_{\text{enforce}} \cdot \sum_{t_{\text{comm}}}^{t_{\text{patent}}} (\delta\gamma)^t. \tag{2}$$

In words, time under intellectual property protection T_{patent} is determined by (i) the likelihood of successful commercialization p_{comm}, (ii) the likelihood that the invention is eligible for intellectual

[13] One could, instead, interpret $1 - p_{\text{secret}}$ as the fraction of monopoly profits lost to imitation in the absence of a formal intellectual property grant.

property protection p_{eligible}, times the likelihood that the intellectual property rights can be enforced p_{enforce}, and (iii) the expected duration of effective intellectual property protection $t_{\text{patent}} - t_{\text{comm}}$, adjusting for discounting and obsolescence risk.

2.1.3 Incentives to Invest

A profit-maximizing firm will commercialize a potential invention if and only if the expected profits exceed the costs of commercialization. Define T^* as the firm's expected time under monopoly under whichever of trade secrecy and patent protection yields more time in expectation:

$$T^* = \max(T_{\text{secret}}, T_{\text{patent}}). \tag{3}$$

The firm will pursue the invention if and only if

$$T^* \cdot \pi - c \geq 0. \tag{4}$$

If $T_{\text{secret}} > T_{\text{patent}}$ then the firm chooses trade secrecy and T^* is given by (1). Otherwise, the firm chooses intellectual property protection and T^* is given by (2).

2.1.4 Missing Markets

Definition 1 (Missing Market)**.** A missing market arises when an invention's expected time under monopoly T^* is zero. That is, both $T_{\text{secret}} = 0$ and $T_{\text{patent}} = 0$.

With (1)–(3), we can write the expected time under monopoly T^* for all potential inventions as:

$$T^* = \max\left(p_{\text{comm}} \cdot p_{\text{secret}} \cdot \sum_{t_{\text{comm}}}^{\infty} (\delta\gamma\eta)^t, p_{\text{comm}} \cdot p_{\text{eligible}} \cdot p_{\text{enforce}} \cdot \sum_{t_{\text{comm}}}^{t_{\text{patent}}} (\delta\gamma)^t\right). \tag{5}$$

Assume that the invention is plausibly successful $p_{\text{comm}} > 0$, not immediately obsolete $\gamma > 0$, and that the firm is not completely impatient $\delta > 0$. Under what more substantive conditions is $T^* = 0$? There are two primary cases.

The first case arises if trade secrecy is ineffective and the invention's patent term is too short relative to the time it takes to bring the invention to market. Formally, $p_{\text{secret}} = 0$ and $t_{\text{patent}} < t_{\text{comm}}$. This case is discussed in Budish et al. (2015), who show that firms underinvest in such projects with long time horizons.

A second case, our focus here, arises if trade secrecy is ineffective and the invention is either not eligible for intellectual property protection or the available intellectual property rights are unenforceable. Formally, $p_{\text{secret}} = 0$ and either $p_{\text{eligible}} = 0$ or $p_{\text{enforce}} = 0$.

Observe that the first case reflects, in effect, a misalignment of timing parameters. The gap in incentives that generates a missing market there can be corrected by policy changes that restructure intellectual property rights—for example, by altering the time required for commercialization t_{comm} (e.g., by offering accelerated approval paths), the time provided by a grant of intellectual

property t_{patent} (e.g., by extending patent terms), or the relationship between the invention's timing parameters t_{invent}, t_{comm}, and t_{patent} (e.g., by starting patent terms at commercialization instead of invention). These shifts, discussed in Budish et al. (2015), can yield a non-zero T^* and thus restore incentives for innovation.

But in the second case, our focus, these types of policy solutions are unavailable. Because intellectual property rights are either unavailable or unenforceable, standard innovation policy tools that rely on tweaks to the structure of property rights are inapplicable.

Proposition 2 (No Nordhaus Parameters)**.** *If* $p_{\text{secret}} = 0$ *and either* $p_{\text{eligible}} = 0$ *or* $p_{\text{enforce}} = 0$*, then neither longer* $(t'_{\text{patent}} > t_{\text{patent}})$ *nor broader* $(\pi' > \pi)$ *patent terms make commercialization profitable.*

Theoretical studies of innovation and intellectual property rights often characterize optimal policy in terms of two "Nordhaus parameters"—t_{patent} (capturing patent duration) and π (capturing patent breadth).[14] Implicit in these analyses is the idea that careful calibration of these dimensions of intellectual property rights can, in fact, strike an optimal balance between incentives for innovation and deadweight loss. But when intellectual property rights are unavailable or unenforceable, changes to these Nordhaus parameters t_{patent} and π have no impact on the firm's investment decision in (4).

2.2 Identifying Missing Markets

In Section 2.1, we introduce three parameters—$p_{\text{secret}}, p_{\text{eligible}}, p_{\text{enforce}}$—that affect both whether an invention is commercially viable and whether standard levers of innovation policy can be used to calibrate incentives for innovation. This section provides context on each parameter.

2.2.1 p_{secret} : Can the invention be profitably commercialized while remaining secret?

For many inventions, both private and social value come entirely from public disclosure. Consider inventions that are, in effect, "recipes" (Jones, 2023) or sets of directions—such as regimens of diet and exercise (Section 1), instructions for the use of an existing drug in the treatment of a new disease (Section 3), or protocols for the use of checklists to reduce the risk of medical error (Gawande, 2009; Kapczynski and Syed, 2012). Each of these inventions consists entirely of the knowledge that some series of steps will yield a particular outcome. Under some circumstances, firms can implement restrictions that limit how widely this information will diffuse—for example by binding recipients contractually with non-disclosure and non-compete agreements (Singh and Marx, 2011; Johnson et al., 2023; Reinmuth and Rockall, 2023). Without these types of contractual restraints, however, secrecy is not viable.

[14] See Gilbert and Shapiro (1990) and Klemperer (1990) for models of patent breadth. Gilbert and Shapiro (1990) define patent breadth as the profit parameter π—that is, as the flow rate of profit available to the firm so long as the patent is in force. Klemperer (1990) defines patent breadth in a spatial horizontal differentiation model, where greater breadth gives the firm greater market power and hence greater profits in equilibrium.

For other types of inventions, secrecy is impractical. If an invention must be placed on display to facilitate sale, it cannot be kept secret. Even if disclosure of an invention is not immediate upon sale, it may be necessary to persuade a potential customer to make a purchase. If, say, a physician determining whether to adopt a new diagnostic test requires detailed assurances about the nature of the technology, secrecy may be destroyed in the process of sale (Arrow, 1962).[15] When there are no circumstances under which the invention can be commercialized while remaining secret, p_{secret} takes a value of zero.

Existing work has identified some settings in which p_{secret} is clearly positive (e.g., Mansfield, 1986; Levin et al., 1987; Cohen et al., 2000; Moser, 2005, 2007).[16] Manufacturing processes used entirely within a firm—including proprietary recipes, like the formula for Coca-Cola (Carr and Choi, 2023)—can be held as secrets for as long as the firm can limit their public disclosure.[17] Other inventions may be amenable to secrecy simply because they are complex or otherwise difficult to reverse engineer. Vaccines are a classic example. Even when the chemical makeup of a vaccine is known, the technical know-how required to produce a product that is stable and safe for use in human patients poses a substantial barrier to replication (Price et al., 2020).[18] Outside of markets for health technologies, engineered secrecy is quite common. Every aspect of the "fuzzy logic" used to modulate cooking time and temperature within the award-winning Zojirushi rice cooker has been held as a trade secret since its introduction in the 1980s; the key piece of technology is embedded within the product in a way that ensures that disassembly will destroy the relevant piece (Santo, 2023).

When secrecy is a commercially viable option, state and federal laws in the United States pro-

[15] This observation in Arrow (1962) is often described as Arrow's Information Paradox.

[16] In a now classic survey, Mansfield (1986) posed questions to a randomly drawn set of 100 firms from twelve industries in the United States, intended to understand the extent to which patent protection—as opposed to secrecy—was seen as vital to the development of new inventions. In particular, the survey asked respondents to estimate the share of its recent inventions that would have been developed had patent protection not been available. For firms in the textile, rubber, motor vehicle, and office equipment industries, where key processes and products could be held as secrets, respondents indicated that the absence of patent protection would have made no difference. Consistent with our emphasis in this paper, however, firms developing products with a close nexus to human health—in the pharmaceutical industry—suggested that the majority of their inventions would not have been developed. Moser (2005) provides complementary evidence, that inventors in the 19th century in countries without patent laws disproportionately concentrated in industries where secrecy was thought to be effective. Moser (2007) provides a test of this idea by leveraging a breakthrough—the publication of the periodic table in 1896—that made it easier for competitors to reverse engineer chemical innovations. When the cost of reverse engineering dropped—in our framework, when p_{secret} fell close to zero—inventors' propensity to patent increased.

[17] In the case of the Coca-Cola formula, efforts to preserve the secrecy are wide-ranging. The formula itself is locked in a vault, which visitors are invited to inspect only from the outside: https://www.worldofcoca-cola.com/explore-inside/explore-vault-secret-formula. A very small number of employees have access to the formula itself, each of whom is bound by a set of non-compete and non-disclosure agreements. For all other employees, the company tracks their movements within its facilities and monitors their use of internal servers: https://www.bloomberg.com/news/features/2023-05-11/the-plot-to-steal-the-secret-coke-can-liner-formula.

[18] In 2021, it was widely reported that a team of scientists at Stanford had reverse engineered the Moderna COVID-19 vaccine, using a sample of vaccine collected from a garbage can. As the scientists themselves clarified, however, they had not actually reverse engineered the vaccine; they had determined, only, its chemical sequence. This information alone was not sufficient to enable imitation or reproduction without additional reverse-engineering of the methods used to produce the commercially-available version of the product. For a longer discussion, see Gault (2021).

vide formal trade secret protection.[19] As far as legally enforceable intellectual property rights go, trade secrecy is both expansive and fragile. Protection lasts until secrecy is destroyed, which may mean that protection is indefinite. But any instance of disclosure, reverse-engineering, or independent discovery is secrecy-destroying. So long as the owner takes "reasonable efforts" to maintain secrecy, these laws provide recourse in instances of misappropriation—but cannot restore an already-disclosed secret.

2.2.2 p_{eligible} : Is the invention eligible for a legally-enforceable intellectual property grant?

In the United States, government-granted intellectual property rights take many forms—including patents (utility, design, plant), copyrights, and regulatory exclusivities. Whether any invention can be protected by intellectual property rights depends both on the subject matter of the invention and on the invention's specific characteristics. Certain inventions fall within categories of subject matter excluded from specific forms of protection (e.g., most forms of DNA are ineligible for patent protection), and some inventions may be ineligible for all forms of government-administered intellectual property rights (e.g., most databases, which cannot be protected by copyrights or patents).

Patent law, in particular, draws strict boundaries around eligible subject matter. Utility patents may not be granted on inventions that claim abstract ideas, natural laws, or physical phenomena. Judicial decisions in recent years—in particular, *Mayo v. Prometheus*, *Association for Molecular Pathology v. Myriad Genetics*, and *Alice Corp. v. CLS Bank*—have clarified these restrictions and, in doing so, substantially narrowed the set of patentable potential inventions.[20] At present, inventions determined (by the United States Patent and Trademark Office or a court) to claim abstract ideas or natural phenomena without adding an additional "inventive step" —such as sequences of isolated genomic DNA,[21] methods for processing loan information through a clearinghouse,[22] and computer programs that automatically categorize digital images[23]—are ineligible for patent protection.

Even if an invention's subject matter is eligible for protection, it may fail to meet other statutory requirements. Copyright protection, for example, attaches only to works that meet a minimum threshold of originality (U.S. Copyright Act, Title 17), and patents are granted only on inventions that are novel, non-obvious, and useful (35 U.S.C. §§ 101, 102, 103). Roin (2009) observes that statutory requirements in the patent context have the effect of generating large classes of potentially valuable health technologies that cannot be protected.

[19] For example, Uniform Trade Secrets Act (with 1985 Amendments), 14 U.L.A. 437 (2005); Cal. Civ. Code §§ 3426–3426.11; Defend Trade Secrets Act of 2016, 18 U.S.C. §§ 1836–1839.

[20] See Mayo v. Prometheus, 566 U.S. 66 (2012) (holding that a claimed method optimizing drug dosages based on natural correlations is not patent eligible because it recites a law of nature without adding an inventive concept beyond routine practices); Association for Molecular Pathology v. Myriad Genetics, 569 U.S. 576 (2013) (holding that naturally occurring DNA sequences—even when isolated—are not patent eligible, though cDNA may be eligible because it is not naturally occurring); and Alice Corp. v. CLS Bank, 573 U.S. 208 (2014) (holding that claims directed to abstract ideas implemented on generic computer technology are not patent eligible absent an inventive concept).

[21] Association for Molecular Pathology v. Myriad Genetics, 569 U.S. 576 (2013).

[22] Buysafe, Inc. v. Google, Inc., 765 F.3d 1350 (Fed. Cir. 2014).

[23] Content Extraction and Transmission, LLC v. Wells Fargo Bank, 776 F.3d 1343 (Fed. Cir. 2014).

As the introduction suggests, the boundaries of patent-eligible subject matter, in particular, may not be wholly intuitive. The two hypothetical "method" inventions described there—a program of diet and exercise and a new process for pharmaceutical manufacturing—are both likely to satisfy existing requirements, provided they include some "inventive step" (and, of course, satisfy other requirements of novelty, non-obviousness, and usefulness). Although clearing these hurdles may be challenging for a program of diet and exercise, the U.S. Patent and Trademark Office has granted patents on weight-loss diet regimens that restrict certain food groups and introduce specific supplements,[24] protect cells against chemotherapy,[25] and employ specific methods of treating carbohydrate-rich foods to reduce their glycemic indices.[26] In the manufacturing example, new processes might be protected by process patents that claim a novel process or by product patents that claim a new piece of equipment.[27]

In our model, p_{eligible} takes a value of zero when an invention falls squarely within a category excluded from protection by law. While there remain many categories of inventions for which patent eligibility is clear—where $p_{\text{eligible}} = 1$—recent shifts in legal standards have introduced considerable uncertainty in both the tests used to determine eligibility and in the validity of previously-issued patents (Hoyt, 2022). For many inventions, then, p_{eligible} lies between zero and one.

2.2.3 p_{enforce} : Can the firm profitably enforce any intellectual property grant?

Even when an invention is eligible for formal grants of intellectual property protection, not all intellectual property rights are enforceable. Though many factors affect this enforceability, we highlight three: whether the firm can observe instances in which its rights are infringed, whether enforcement against particular defendants is practical and profitable, and whether the underlying intellectual property grant is strong enough to permit litigation.

If a firm cannot observe instances in which its intellectual property rights are infringed, those rights are unenforceable, and p_{enforce} takes a value of zero. Of course, for many inventions, unauthorized uses—like "knockoffs" of luxury handbags (for details on unauthorized copying in fashion, see Hemphill and Suk, 2008) and counterfeit consumer electronics (for a discussion, see Robbins, 2018)—are readily apparent. Advances in technology, including reverse-image searching, digital watermarking, and algorithmic plagiarism detection, have continued to expand the types of infringement that are easy for inventors to detect (Eckhause, 2022).

In many contexts, however, infringement can be extremely difficult to observe. Manufacturing processes crucial to the success of an industry can easily be copied and used internally by competing firms, with no external indication of infringement (Price, 2014). When firms are unable to protect these processes with secrecy, they may be able to find alternative ways of creating observability. Teece (1986) highlights one strategy used by firms that license methods of petroleum refining to

[24] U.S. Patent No. 5,855,949 – Dietary system high in oil intake for the treatment of obesity.

[25] U.S. Patent No. 8,865,646 B2 – Dietary compositions and methods for protection against chemotherapy, radiotherapy, oxidative stress, and aging.

[26] U.S. Patent No. 8,568,820 B2 – Method of treating carbohydrate rich foods for reducing their glycemic indices.

[27] See, e.g., U.S. Patent No. 10,106,974 B2 – Flexible manufacturing system.

other parties within the industry: the sellers included, in their patent-protected processes, a specialized chemical catalyst produced only by the original seller. To use the method, other firms were required to purchase this input controlled by the patent-holding firm, thus deterring unauthorized imitation. Other mechanisms, including intermediaries (e.g., regulators and large institutions), can have a similar effect (Kapczynski and Syed, 2012).

Even if infringement is observable, enforcing intellectual property rights may still not be practical or profitable. One difficulty arises from legal rules that specify who, technically, infringes certain patents. In the United States, patents on methods—specific ways of using a product or carrying out a set of instructions—are directly infringed only by the individual or entity performing each step of the method.[28] To understand what this means in practice, consider the case of a firm that holds a patent on a method for using orthodontic retainers to straighten teeth. A competitor that copies the product and sells its own retainers to be used in the same way may not, technically, infringe the patent. Instead, infringement will occur each time a patient uses the copycat retainer to straighten her teeth—thus *performing* the method. To enforce its patents, the innovator would have to file suit against each retainer-wearing defendant. One advantage relative to our empirical context is that the innovator in this hypothetical would not necessarily be suing its *own* customers. In general, though, consumers are rarely attractive defendants in cases like this, both because these suits are likely to engender backlash and because they have comparatively shallow pockets that limit the extent of any recovery. Many are likely to be essentially "judgment proof," either because they lack financial resources or because they are beyond the practical reaches of litigation.

Finally, even when infringement is observable and a suitable defendant can be identified, firms may be deterred from enforcing intellectual property rights if they are concerned about risks associated with litigation. Not all grants of intellectual property rights are valid in a legal sense, which the scrutiny of litigation is likely to uncover. Lemley and Shapiro (2005) document that roughly half of all litigated patents are invalidated. If the firm anticipates a high probability of invalidation, it may opt not to enforce its rights at all.

2.2.4 Summary

Figure 1 summarizes the conditions under which gaps in the availability or enforceability of intellectual property rights give rise to a missing market, in the sense of Definition 1.

[28] Direct infringement is governed by 35 U.S.C. § 271(a), which states: "[W]hoever without authority makes, uses, offers to sell, or sells any patented invention, within the United States or imports into the United States any patented invention during the term of the patent therefor, infringes the patent." Patent holders can also sue parties that have facilitated infringement, even if they themselves have not directly infringed. Federal law recognizes two forms of indirect infringement: inducement (35 U.S.C. § 271(b)) and contributory infringement (35 U.S.C. § 271(c)). For a primer, see Part III of Masur and Ouellette (2025).

3 The New Uses Problem

3.1 Background

Effective therapies exist for only a fraction of known diseases. As of 2025, treatments have been developed for approximately 20 percent of recognized medical conditions (EveryCure, 2025). Among the subset of diseases with well-characterized molecular causes—those linked to specific genetic mutations, protein dysfunctions, or other biochemical abnormalities—this figure is lower; there, effective therapies were available, as of 2011, for roughly five percent (Collins, 2011b).

Scientists have long argued that efforts to repurpose existing drugs are among the most cost-effective ways of expanding access to high-quality medical treatments. Some have suggested that systematic efforts to develop new uses for existing drugs could "convert cancer into a treatable chronic disease" (Telleria, 2012), unlock treatments for many or all of the 8,000 rare diseases (Muthyala, 2011), and yield breakthroughs in diseases that have long resisted therapeutic intervention, such as Alzheimer's (Corbett et al., 2012; Butcher, 2013). Recent efforts to leverage artificial intelligence to identify potential new uses are premised on the same idea (EveryCure, 2025).

From a practical perspective, drug repurposing has clear advantages over de novo drug discovery. Any drug that is repurposed has necessarily already undergone long, costly clinical trials that establish its safety. Repurposing, then, requires only producing proof of efficacy in a new therapeutic context. Years—or, in some cases, decades—of clinical experience have likely uncovered natural leads for these new uses, streamlining the standard processes of trial-and-error to identify disease targets. As a result, efforts to commercialize new uses are faster, cheaper, and more likely to succeed than de novo drug development programs. While de novo drug development efforts typically take 12 to 16 years to bring products to market, new uses can be commercialized on a 3 to 12 year horizon (Dudley et al., 2011). And while the cost of developing a drug "from scratch" can exceed $1 billion, new uses can be commercialized for roughly $300 million (Sahoo, 2007). A final advantage: the Institute of Medicine estimates that 30 percent of repurposed drug trials succeed, compared to just 10 percent for new drugs (Collins, 2011a).

Yet, investment in repurposing is quite rare (EveryCure, 2025). Part of the challenge is thought to be timing. Evidence on new uses often emerges only with substantial delay, typically long after the original drug's patent has expired. Gelijns et al. (1998) observe that "it took half a century for the cardiovascular benefits of aspirin, the most widely used drug in the world, to be recognized, and nearly 40 more years before it was widely used for cardiovascular indications." By this time, generic use is widespread, and any firm will likely struggle to recoup the investment required to satisfy regulatory requirements.

Even when drugs are not formally repurposed, patients may receive prescriptions for new uses "off-label." In certain fields—notably, oncology—off-label prescribing is common, especially for patients who lack other treatment options (Saiyed et al., 2017). But many instances of off-label prescribing are, at best, ineffective and, at worst, actively harmful (Eguale et al., 2012). Radley et al. (2006) examine prescribing practices for 169 commonly prescribed drugs and catalogue high

rates of off-label use unsupported by scientific evidence. Even when evidence supports such use, various barriers—such as insurer reluctance to cover off-label prescriptions and limited physician knowledge of treatment options—can limit adoption. Berger et al. (2021) provide evidence consistent with the idea that large-scale diffusion of new uses occurs only following formal regulatory approval. The authors compare changes in the size of a drug's market after a clinical trial documents a link between the drug and a new use to changes after that new use is approved, formally, by a regulator. They find significant increases in market size only after the latter event. That is, formal regulatory approval appears key to facilitating market adoption.

3.2 A Missing Market for New Uses

In this section, we show that the conditions that give rise to a missing market are satisfied in the case of new uses for existing drugs. To illustrate, we walk through each step of the stylized classification exercise introduced in Section 2.

p_{secret} : **Can the invention be profitably commercialized while remaining secret?** ***No.***

It is difficult to imagine how the information that a drug has a new therapeutic use could be profitably commercialized while remaining secret. In the United States, federal law requires drugs to carry labels specifying each FDA-approved therapeutic indication.[29] This legal requirement aside, secrecy is impractical. A new use has economic value only if it is disclosed: physicians must know when to prescribe the drug, pharmacists know when to dispense it, patients must know how to take it, and insurers must know how to process reimbursements. Like other inventions that are essentially "recipes," a new use must be disclosed. Thus, $p_{\text{secret}} = 0$.

p_{eligible} : **Is the invention eligible for a legally-enforceable intellectual property grant?** ***Yes.***

In the United States, new uses for existing drugs are eligible for two distinct forms of intellectual property protection. First, they may be protected by method-of-use patents. Even if a drug has already been commercialized (and its active ingredient is already protected by a patent), firms may seek patent protection for methods of using a drug to treat a new disease or condition. [30]

Second, new uses are eligible for regulatory exclusivities administered by the FDA. The FDA grants a three-year period of "new clinical investigation exclusivity" (NCI) to incentivize firms to develop new indications, dosage regimens, patient populations, or formulations of previously

[29] See 21 U.S.C. § 352(f); 21 C.F.R. § 201.57(c).

[30] In re Marshall, 578 F.2d 301, 304 (C.C.P.A. 1978). Recall that our definition of p_{eligible} captures only subject matter eligibility. New uses may be ineligible for patent protection for other reasons, including failure to satisfy statutory requirements of novelty and non-obviousness. Later in a drug's lifecycle, as observational evidence cataloguing potential leads in scientific journals accumulates, both may be important barriers to patent protection. Nonetheless, federal courts have consistently granted patents on new uses for existing drugs. See Illumina, Inc. v. Ariosa Diagnostics, Inc., 967 F.3d 1319, 1325 (Fed. Cir. 2020) (holding that "method of treatment claims are patent-eligible"). See also Vanda Pharmaceuticals Inc. v. West-Ward Pharmaceuticals International Ltd., 887 F.3d 1117, 1134–36 (Fed. Cir. 2018) (holding that claims directed toward particular methods of treatment are patent eligible); Nat. Alternatives Int'l, Inc. v. Creative Compounds, LLC, 918 F.3d 1338, 1344 (Fed. Cir. 2019) (determining that "[t]hese are treatment claims and as such they are patent eligible").

approved drugs. During this three-year exclusivity period, the FDA will not approve applications from generic competitors for the specific use protected by NCI exclusivity.[31] The limits of this restriction are worth emphasizing: when NCI exclusivity is in force, the FDA may still approve generic competitors for *other* indications. That is, a brand name firm with NCI exclusivity protecting one approved use may still face generic competition for other, unprotected uses.

Thus, new uses may be protected by both patents and regulatory exclusivities. Hence, $p_{\text{eligible}} = 1$.

p_{enforce} : **Can the firm profitably enforce any intellectual property grant?** ***Only for a fixed period of time.***

Patents on new uses for existing drugs are fully enforceable so long as the drug itself faces no generic competition. If there are no generic versions of a drug, a single firm controls the market and can set a price for its drug that reflects all of the uses that it has developed (even if it may not be able to perfectly price discriminate).

The Hatch Waxman Act of 1984 created the regulatory system for generic drugs in the United States.[32] The key idea is that generic firms do not need to conduct independent, costly clinical trials as a condition of approval. Instead, generic drugs may be approved if sponsors satisfy two requirements. First, the generic firm must prove that its product is chemically equivalent to the original brand name drug. Second, for whatever scope of approval it seeks—intended use(s), product form, patient population, etc.—it must demonstrate that any relevant brand name drug patents are invalid, not infringed, or expired.[33] Until all patent challenges are resolved, the FDA will not approve the competitor; patents on the brand name drug itself and patents on uses of the drug are perfectly enforceable as a result.[34]

Once any generic entry occurs, enforceability of intellectual property rights on new uses collapses. The problem, for the brand name firm, is two-fold. First, they must identify instances in which a generic drug approved by the FDA for some use a is instead used for the new use b. Second, they must be able to successfully file and win a lawsuit or otherwise put an end to infringement.

Neither is practical. First, the brand name firm can neither observe when the generic is pre-

[31] To qualify for new clinical investigation exclusivity, the innovator firm must perform clinical studies defined by the FDA as "an investigation in humans, the results of which (1) have not been relied upon by FDA to demonstrate substantial evidence of effectiveness of a previously approved drug product for any indication or of safety in a new patient population, and (2) do not duplicate the results of another investigation relied upon by FDA to demonstrate a previously approved drug's effectiveness or safety in a new patient population." 21 C.F.R. §314.108.

[32] The Hatch Waxman Act is formally titled the Drug Price Competition and Patent Term Restoration Act of 1984. Pub. L. No. 98-417, 98 Stat. 1585 (codified in sections of 15, 21, and 35 U.S.C.).

[33] The list of relevant patents is provided by the brand name drug and listed in a regulatory document maintained by the FDA, colloquially referred to as the "Orange Book." We provide details on this patent list, which is central to our empirical analysis, in Section 4.4.

[34] If a generic firm markets its product without FDA approval, it faces civil liability, criminal charges, and regulatory penalties under, for example, 21 U.S.C. § 355(a), which prohibits introduction into commerce of a "new drug" without approval; 21 U.S.C. § 331(d), which specifically prohibits introducing or delivering for introduction into interstate commerce any unapproved new drug; and 21 U.S.C. § 352, which allows the FDA to intervene in instances of drug "misbranding." The FDA can immediately seek injunctions to halt sales, issue warning letters, seize the offending products, or recommend criminal prosecution.

scribed or purchased, nor what disease target it is used for. Second, even if the brand name firm could observe infringement of a new use patent, the nature of liability in this setting makes enforcement unattractive. Generic firms typically rely on the Hatch Waxman Act's "skinny labeling" provisions, which allow them to market drugs without formally infringing method-of-use patents by omitting patented uses from their labels.[35] And courts have consistently shielded generic manufacturers from patent infringement liability unless they explicitly induce infringing use. This means that a generic manufacturer faces no legal repercussions even if its drug is used widely for unapproved uses, so long as it does not actively encourage or facilitate that use.[36] Instead, liability is likely to fall on those parties who actually "practice" the method of using a drug in violation of a patent—physicians who dispense drugs in in-patient settings and patients who comply with medical instructions at home. Technically, each risks a lawsuit. But even setting aside the impracticability of filing expensive lawsuits against entities with limited capacity to pay damages, Eisenberg (2005) notes that it is rarely a winning strategy for firms to sue their own customers en masse. For extended discussions of these institutional details, see Eisenberg (2005) and Roin (2014).

Thus, before generic entry, p_{enforce} takes a value of one: the brand name firm can fully enforce its portfolio of intellectual property rights. After generic entry, p_{enforce} falls to zero. It is generic entry, then, that creates a missing market in the sense of Definition 1.

3.3 Empirical Signatures

The conditions described in Section 3.2 generate testable empirical predictions. Consider an innovator drug that is approved by the FDA at time $t = 0$. For some period of time, the innovator has effective market exclusivity. And during this time, patents on new uses are fully enforceable. Since each new use that is commercialized yields monopoly profits until exclusivity expires, incentives for investing in new uses are strongest at $t = 0$. As exclusivity expiration approaches, the length of time during which any newly-identified use can be protected from competition drops: a new use identified at year $t+1$ has one fewer year of enforceability than a use identified at year t.

This framework, thus, suggests three empirical signatures of a missing market for new uses:

1. Firms will have the strongest incentives to invest in discovering and commercializing new uses immediately following initial approval, when the potential duration of enforceable monopoly rights is longest.

2. As the date of market exclusivity expiration approaches, incentives to invest in new uses decline monotonically, as the expected time under monopoly for a new use decreases with each year.

[35] Generic applicants submit "section viii" statements, which certify that patents do not cover the uses of the drug for which the generic seeks approval. The generic firm must submit, alongside a section viii statement, a proposed label for their product that omits any part of the brand name drug's label associated with uses still protected by patent.

[36] Warner-Lambert v. Apotex Corp., 316 F.3d 1348 (Fed. Cir. 2003). For a discussion of changes in this area of case law that post-date our period of analysis, see Sherkow and Gugliuzza (2026).

3. Upon generic entry and market exclusivity expiration, p_{enforce} drops to zero. Investment in new uses should, thus, fall to zero.

Section 4 introduces data that allow us to test these predictions empirically. Tests are introduced in Section 5.

4 Data and Measurement

4.1 Example: Lilly's Gemzar

The data we construct are best introduced with an example. In 1996, the FDA approved Lilly's Gemzar for the treatment of pancreatic cancer.[37] The molecule in Gemzar responsible for its pharmacological action—its *active moiety*—is called gemcitabine.[38]

In the 1980s, scientists at Lilly began to develop gemcitabine as an antiviral. In early preclinical studies in the 1990s, however, an internal research group documented that the drug was effective at killing leukemia cells *in vitro*, and effort shifted to investigate the drug's potential as a treatment for cancer (for a history, see Hertel et al., 1990). Lilly sponsored a set of clinical trials that supported its initial approval for the treatment of pancreatic cancer, but also investigated other potential uses, including as a treatment for smallpox, hepatitis, and various types of cancer. The FDA re-approved Gemzar for several additional uses: in 1998 for the treatment of non-small cell lung cancer, in 2004 for the treatment of breast cancer, and in 2006 for the treatment of ovarian cancer.[39] By 2010, at the time of first generic entry, sales of Gemzar generated approximately $800 million per year.[40]

To test for a missing market for new uses, we would like to collect data on each of these investments into Gemzar, over time and, in particular, in relation to the end of its period of market exclusivity. In light of the discussion in Section 3, patent expiration itself may be an imperfect proxy for this exclusivity period, as certain portions of patent term may be unenforceable in practice. The timing of generic gemcitabine approval validates this concern. Per the FDA's "Orange Book" database—an administrative record that collects all patents on approved drugs for which a claim

[37] NDA #020509. See https://www.accessdata.fda.gov/drugsatfda_docs/nda/pre96/020509Orig1s000rev.pdf.

[38] Though the distinction between a drug's "active moiety" (the key pharmacological agent) and its "active ingredient" (the pharmacological agent, plus any stabilizing chemicals) is quite technical, it is significant for regulatory determinations that hinge on a drug's novelty and, as relevant here, for our data construction. Use of active moieties instead of active ingredients simplifies a series of medication name matching procedures. Concretely, Gemzar's "generic name" or "active ingredient" is often listed across databases as *gemcitabine*, *gemcitabine hydrochloride*, or *gemcitabine hci*. Each is chemically and therapeutically equivalent, but this type of variability in the extra inactive compounds (salts and esters) attached to the drug makes the string matching central to our empirical work extremely challenging. For each, the active moiety is *gemcitabine*. Appendix A.1.3 provides more details on the distinction between these objects, on the value of using active moieties to implement a series of string matches across datasets, and on our crosswalk from various forms of drug names (as are listed in nearly all input datasets) to active moieties.

[39] Non-small cell lung cancer: NDA #020509, supplement #005; Breast cancer: NDA #020509, supplement #029; Ovarian cancer: NDA #020509, supplement #039

[40] See https://www.sec.gov/Archives/edgar/data/818686/000081868611000014/gemzar260111.htm ("Annual sales of Eli Lilly and Company's Gemzar® were approximately $814 million in the United States in 2010, based on IMS sales data").

of patent infringement could "reasonably be asserted"—Gemzar was protected by two patents.[41] The first-filed (and first-expiring) patent covered gemcitabine's chemical structure, while the second covered a method of using chemicals like gemcitabine to treat tumors in mammals.[42] The first generic version of Gemzar was approved on November 15, 2010, the day the chemical patent expired. The method-of-use patent, which remained in force until May 7, 2013, thus did not fully block generic entry.[43]

Section 4.2 details our approach to identifying drugs, like Gemzar, for which we track research investments into new uses. Section 4.3 introduces our measures of research investment—scientific publications, clinical trials, and re-approvals for new uses. In Section 4.4, we return to the challenge of determining a drug's period of market exclusivity using data on generic entry and patent expiration. Section 4.5 summarizes our data construction and presents basic summary statistics. Appendix A provides additional details.

4.2 Measuring Drug Approvals

We construct a census of new drugs approved by FDA between 1985 and 2014 using an administrative database, Drugs@FDA.[44] We classify a drug as an *innovator* and include it in our primary sample if it satisfies two criteria:

1. It was approved under a New Drug Application (NDA).

2. It represents the first approval of a unique combination of chemical components.

The first restriction limits our analysis to small-molecule drugs, which are relatively simple, stable chemical compounds synthesized through chemical processes. It excludes biologic drugs—large,

[41] The formal name of the "Orange Book" administrative record is *Approved Drug Products with Therapeutic Equivalence Evaluations*. Details on its history and contents are available in Durvasula et al. (2023). The main text of the Orange Book collects records of "therapeutic equivalence evaluations" for approved drugs—determinations of the equivalence of generic products to approved brand name drugs. When we refer to the Orange Book, we are referring to its appendices, which collect records of all patents and "regulatory exclusivities" associated with each brand name drug. These records were made available as part of the 1984 Hatch Waxman Act, and coverage extends only to small molecule (i.e., non-biologic) drugs. The Hatch Waxman Act is formally called the Drug Price Competition and Patent Term Restoration Act. It is codified at 21 U.S.C. ch. 9 § 301. 21 C.F.R. 314.54 lays out the listing requirements for patents and regulatory exclusivities.

[42] The first patent is U.S. Patent No. 4,808,614 (granted February 29, 1989), and the second patent is U.S. Patent No. 5,464,826 (granted November 7, 1995). Originally, both were set to expire 17 years after issuance: February 28, 2006 and November 7, 2012, respectively.

[43] This simplified description of patent protection, litigation, and generic approval for Gemzar captures the details that are central to our empirical analysis. In Durvasula et al. (2023), we offer a much more extensive case study of Gemzar.

[44] Our sample begins in 1985, one year after the 1984 Hatch Waxman Act introduced the modern system of pharmaceutical patent protection and generic drug regulation. The Hatch Waxman Act increased terms of patent protection for certain new drugs and introduced a new regulatory pathway for generic entry. From a practical perspective, it led to the creation of the Orange Book database that is central to our measurement of market exclusivity, introduced in Section 4.4. We select 2014 as an end point for two reasons. First, a key table in the Drugs@FDA database that we use to identify re-approvals of drugs for new indications is unavailable in later years (from the middle of 2016 on), and we have been unable to obtain analogous records via Freedom of Information Act requests. Second, for drugs approved in later cohorts, measures of market exclusivity may be censored (e.g., if a firm is still applying for new patents or regulatory exclusivities).

complex molecules derived from living organisms—which are subject to distinct legal and regulatory frameworks in the United States.[45]

The second restriction ensures that we focus on research incentives in the period following a drug's first approval.[46] Many drugs are approved under multiple brand names over time, usually after generic entry; these are often cases in which brand name products can capture some substantial premium over generic alternatives (Bronnenberg et al., 2015). Acetaminophen, for example, is available both as a generic and under the brand names "Tylenol" and "Panadol." Ibuprofen, too, is available both as "Advil" and "Motrin." We keep only the first of these brand name approvals.

For each approval and re-approval event in our sample, we construct data on the drug's uses—the specific indications for which it is approved—building on a method described in Berger et al. (2021).[47] We collect text descriptions of these uses from multiple sources, including FDA approval packets, company press releases, scientific articles, and other publicly available records. Whenever possible, we use the FDA's full-text drug labeling service (FDALabel) to retrieve official drug labels. We supplement data on labels, which are primarily available from 2005 forward, with data from drug approval packets, dated company press releases, scientific articles, and other internet searches. To standardize uses across drugs, we assign each approval or re-approval one or more International Classification of Diseases codes, based on its Tenth Revision (ICD-10). These alphanumeric codes systematically classify diseases, symptoms, and related health conditions.

4.3 Measuring Research Investments

For each drug in our sample, we construct three measures of research and development into new uses: scientific publications, clinical trials, and FDA re-approvals for new uses.

Scientific Publications We collect records of scientific publications from the National Library of Medicine's PubMed database. PubMed indexes nearly every biomedical publication and, importantly for this analysis, curates links to chemicals mentioned in the text of each paper. For each innovator drug, we identify all publications indexed with its chemical components. We track, also, whether each scientific publication received any funding from a public agency.

To match drug names in FDA records to standardized PubMed terms, we develop a crosswalk procedure, detailed in Appendix A.2. In short, we clean and standardize drug names from FDA administrative records, then iteratively link them to standardized forms of chemical names in PubMed.

[45] Biologic drugs include gene therapies, monoclonal antibodies, and vaccines. A different set of statutes govern federal research incentives for biologics, and the FDA applies a different set of standards for generic ("biosimilar") approval. One important distinction, from the perspective of our empirical analysis, is that our data construction relies on the existence of a mapping between small-molecule drug patents and approved drug products, the Orange Book. No analogous regulatory document exists for biologic drugs. Frakes and Wasserman (2025) hand-review drug patent filings to construct what is, to our knowledge, the most complete listing of biologics patents.

[46] This restriction is similar to, but not the same as, the regulatory designation of "new molecular entity" (NME). NMEs are a strict subset of our sample. See Appendix A.1.2 for details.

[47] We are grateful to Ben Berger, Amitabh Chandra, and Craig Garthwaite for sharing a crosswalk between drugs and indications, which covers a subset of our period of interest. We build on Berger et al. (2021) to produce a crosswalk between drugs and uses that covers our full sample period.

This process successfully maps approximately 75 percent of drugs in our final sample to a PubMed term.

Clinical Trials We use clinical trial activity as a proxy for drug commercialization. To maximize coverage over our sample period, we compile trial records from four sources: NDA Pipeline (1982-2001), Pharmaprojects (1995-2010), Cortellis (1995-2016), and ClinicalTrials.gov (2010-2016). As with scientific publication records, the challenge in using these data is that drug names in FDA administrative records often do not match those in these external databases. Unlike PubMed, however, where drug names are indexed with standardized terms, clinical trial databases often contain inconsistent formatting and typographical errors. We develop a distinct linkage procedure for each database, which relies largely on standardization by hand, detailed in Appendix A.3. This approach successfully matches nearly 70 percent of drugs in our final sample to at least one clinical trial record.

Our final dataset includes trial records for all four sources. To avoid concerns about inconsistencies in coverage, double-counting, and other errors in measurement across datasets, our primary measure of trial activity is a binary indicator that takes a value of one if an innovator drug has any active clinical trial in a given year and zero otherwise.

New Use Re-Approvals FDA administrative records classify applications into three types: new applications, supplemental applications, and generic drug applications. We collect records of all approvals within the supplemental applications category that were tagged as "new and modified indications." As a point of comparison, we also collect records of all other re-approvals associated with supplemental applications.

4.4 Measuring Market Exclusivity

The framework introduced in Section 2 offers a simple prediction: when intellectual property rights on new uses become unenforceable, private firms will lose any incentive to pursue further research and development. It is the entry of substitutable generic competitors that creates the problem of enforceability. Empirically, then, we are interested in measuring trends in investment and commercialization in the periods around expected market exclusivity expiration.[48]

The most natural empirical proxy for a firm's expectation of the time when it will lose market exclusivity is the date on which generic entry actually occurs. This should reflect market participants' rational expectations. However, the difficulty in using the date of generic approval as a proxy for expected market exclusivity expiration is that more than half of innovator drugs in our sample (548 / 990, 55 percent) do not experience generic entry during our sample period. This is a well known phenomenon (see Scott Morton, 1999) and not peculiar to our data. Although a series of

[48] Durvasula et al. (2023) offers an extended discussion of both the legal and empirical challenges associated with measuring market exclusivity.

legal reforms in the 1980s—including the 1984 Hatch Waxman Act itself—are credited with increasing generic entry for small-molecule drugs, FDA (2025) lists more than 350 ever-approved small-molecule drugs with no active patents (or regulatory exclusivities) for which there is no associated generic version.[49]

An alternative proxy might be the date on which the patent or patents on the drug expire. By construction, we observe at least one form of intellectual property for every drug in our sample. There are three challenges with constructing such a measure. First, new drugs approved for sale in the United States are, often, protected both by patents and by non-patent "regulatory exclusivities." The FDA will deny approval to a competing generic product so long as certain exclusivities are in force, and these exclusivities may run sequentially or concurrently with patents.[50] Second, new drugs are, increasingly, protected by many patents, not all of which will block generic competition.[51] The median innovator drug approved in 1990 was protected by a single patent grant. In 2014, the median drug had five associated patents. These patent portfolios can confer periods of nominal market exclusivity that far exceed that provided by a single patent—though as the Gemzar case highlights, not every patent will limit generic entry. Third, and relatedly, would-be generic competitors are incentivized—as part of the regulatory design of the 1984 Hatch Waxman Act—to "challenge" patents on brand name drugs by asserting that any patents in force are invalid, unenforceable, or not infringed by the generic.[52] Successful challenges allow generic entry before the expiration of all patents. Any potential measure based on the expiration of patents, then, must account for the likelihood that each patent and regulatory exclusivity will successfully block generic entry.

With these practical limitations in mind, our primary measure of market exclusivity is constructed as follows. We use the actual date of generic approval if generic entry occurs before the expiration of all of the drug's patents and exclusivities. Otherwise, we assume that firms expect all patents and regulatory exclusivities to bind and use the latest expiration date.[53] Formally, for each drug, we define the year that market exclusivity expires as

$$\text{market exclusivity} = \min\{\text{generic approval}, \text{expiration of all patents/exclusivities}\}.$$

[49] Scott Morton (1999) documents similar patterns and analyzes the determinants of these generic entry decisions. For a recent analysis of challenges that limit generic entry in the "patent afterlife," see Hemel and Ouellette (2023a). There are fewer small-molecule drugs without generic entry in FDA (2025) than in our data because FDA (2025) covers an additional eleven years of generic drug approvals.

[50] Regulatory exclusivities are often called quasi-patents, in recognition of the fact that they also allow a firm to exclude its competitors from the market for some fixed period of time. They differ from patents, however, in two key regards. First, regulatory exclusivities in the pharmaceutical sector are awarded by the FDA on the basis of its own assessments of a product. Second, exclusivities are self-enforcing.

[51] For more details on "patent portfolios" in pharmaceutical markets, see Hemphill and Sampat (2012); Durvasula and Ouellette (2026).

[52] 21 U.S.C. § 355(j)(5)(B)(iv). For instance, the first (successful) generic challenger receives a bounty in the form of exclusive rights to the generic market for a 180-day period.

[53] We restrict consideration to the four regulatory exclusivities that we determined, in Durvasula et al. (2023), are "generic blocking" in the sense that the FDA will not approve a generic form of the active moiety while these exclusivities are in place: new chemical entity exclusivity, orphan drug exclusivity, pediatric exclusivity, and Generating Antibiotic Incentives Now exclusivity. Technically, there are sixteen types of FDA-granted regulatory exclusivities. Table 5 in Durvasula et al. (2023) provides a list.

In effect, we are selecting an upper bound on the firm's expected period of market exclusivity. In Section 5.2, as a robustness check, we define an additional measure of market exclusivity, *minimum patent exclusivity*, that uses only the first expiring patent.

To construct our primary exclusivity measure for each innovator drug in our sample, we collect records of generic competitor approval and records of all patents and exclusivities. Specifically, we identify the first approval of a generic competitor for each drug in our sample in Drugs@FDA, as the first approval of the same combination of active moieties via the FDA's generic approval pathway.[54] We also collect records of patents and regulatory exclusivities in the Orange Book, as digitized in the NBER Orange Book Dataset, for each of our sample years. Appendix Figure A1 plots the distribution of this market exclusivity measure for our sample of innovator drugs. The median drug in our sample receives 13.37 years of market exclusivity (mean, 12.90 years) and receives 8.37 years of protection from its first-expiring patent (mean, 9.35 years).

4.5 Sample Construction & Summary Statistics

There are 1,102 drugs that meet our criteria for innovator drugs. We further restrict consideration to drugs with at least one patent or regulatory exclusivity. We also exclude a small number of observations that predate the modern FDA, for which our measure of market exclusivity takes a negative value.[55] This yields a final sample of 990 drugs. Table 1 presents summary statistics.

5 Empirical Evidence

We establish the existence of a missing market for new uses with three types of evidence. First, the framework in Section 2 applied to this context (see Section 3.3) suggests specific empirical signatures: firms will have the strongest incentives to invest in new uses soon after initial approval;

[54]This definition of generic approval introduces an important simplification. Generics are typically approved at the level of a particular product (e.g., gemcitabine in a one gram injectable form) and may not be approved for every dosage or form that is available for the brand name product. In some cases, these limited approvals reflect the existence of patents and exclusivities that protect some forms of a drug but not others. The full details of the Gemzar case study are reported in Durvasula et al. (2023), which provides additional context on this type of product-by-product entry. In other cases, limited entry is part of a negotiated settlement. A second feature of this definition is neither an assumption nor simplification, but a piece of institutional context worth noting: we focus on the timing of generic approval, rather than generic entry. Hemphill and Sampat (2012) establish that these two dates are typically close in time. In a small number of cases, however, there may be lengthy delays between generic approval and entry—if, for example, there is some agreement between the parties to delay generic entry.

[55]There are nine drugs that are excluded because their periods of measured market exclusivity are negative: NDA #19008 (bretylium); NDA #19931 (sulfacetamide); NDA #21794 (dapsone); NDA #22041 (hydroxocobalamin); NDA #22556 (carbinoxamine); NDA #50606 (vancomycin); NDA #50640 (oxacillin); NDA #50763 (mitomycin); NDA #204031 (acetaminophen; oxycodone). For each, we review FDA records and drug approval histories to understand why generic entry appears to predate NDA approval. In each case, although our data construction method properly captures the first NDA approved by the modern FDA—that is, since the 1962 passage of the Kefauver–Harris Amendment to the Federal Food, Drug, and Cosmetic Act created the modern regulatory system—we did not capture an earlier NDA approved by the pre-1962 FDA. Generic versions of these drugs were approved before the NDAs that we flagged as innovators. There are a small number of other conceptual difficulties that arise when drugs in our sample are grandfathered into new regulatory schemes introduced in the 1960s and 1980s. We offer an extended discussion in Durvasula et al. (2023).

incentives decline as market exclusivity expiration approaches; and incentives fall to zero after exclusivity expiration. Section 5.1 provides support for each in our data. Second, although these empirical signatures are consistent with a missing market, their interpretation hinges on a causal link between market exclusivity and investments in new uses. Section 5.2 documents evidence of this relationship. In so doing, it allows us to recover the elasticity of research investment with respect to the duration of intellectual property protection, an object of independent interest. Third, the key mechanism generating the empirical signatures of a missing market in our framework is the enforceability of intellectual property rights. Section 5.3 provides direct evidence that changes in enforceability generate the patterns documented in Section 5.1.

5.1 Investigating the Empirical Signatures of a Missing Market

Figure 2, Panel A and Figure 3, Panel A present trends in the probability that a drug is re-approved for any new use in each year (y-axis). Panel A of Figure 2 plots this probability in each year relative to the drug's initial approval (x-axis). Consistent with our predictions, the probability of any re-approval peaks shortly after initial approval, then declines monotonically. At this peak ($t = 2$ through $t = 5$ years after initial approval), approximately five percent of drugs are re-approved for a new use each year. Recall that different drugs in our sample receive different periods of market exclusivity, with a median and mean of about 13 years. Within 15 years of initial approval, the likelihood of re-approval for a new use is approximately zero.

Panel A of Figure 3 plots the same data capturing probability of re-approval for a new use, but instead uses the time relative to the drug's market exclusivity expiration as the x-axis. With this reorientation, note again that the probability that a new drug is re-approved for a new use peaks early in its lifecycle, declines monotonically as exclusivity approaches, and then is approximately zero after exclusivity expiration. The peak is ten years prior to exclusivity expiration ($t = -10$), when seven percent of drugs are re-approved for at least one new use.[56] Figures 2 and 3 pool trends for all 990 innovator drugs in our sample. Figure 4 confirms that these trends are robust to the use, instead, of balanced panels, in which we have data on each drug in each year relative to market exclusivity expiration for five- and ten-year windows around expiration. Appendix B shows that our

[56] In Figure 3, we include each of the 990 innovator drugs in our primary sample for every year in which data are available. This means that the sample of drugs shifts across points in Figure 3. This changing sample composition generates the non-monotonic trend between $t = -20$ and $t = -17$. Consider, for instance, a drug approved in the year 2000 that receives ten years of market exclusivity, and recall that our data include observations through 2014. In Figure 3, this drug appears in the sample plotted at each point between $t = -10$ and $t = 4$. Other versions of this exercise aim to address these changes in sample composition in various ways. Figure 4 takes a balanced panel approach, in which we require data on each drug in each year and confirms that this non-monotonicity is corrected when we address changing sample composition. Appendix B.1 collects additional exercises that cut our data differently. Appendix Figure A3 splits each drug's market exclusivity into five periods and plots trends across periods, rather than over calendar time. With this modification, we find, as predicted, that the probability of approval is highest just after initial approval, then declines monotonically before falling nearly to zero following exclusivity expiration. Appendix Figure A4 addresses the issue of changing sample composition by inspecting trends in the probability of re-approval for drugs that receive exactly the same period of market exclusivity (e.g., for the cohort of drugs that receive 12 years of exclusivity). This restriction eases interpretation at the cost of substantially increasing the noisiness of these plots; though each cohort restriction drops upwards of ninety percent of our data, the three empirical signatures are qualitatively unchanged.

results are robust to several other cuts of the data.

While Figure 2, Panel A and Figure 3, Panel A focus on the likelihood that any new use is re-approved in each year, Panel B in each presents the cumulative share of new uses approved over time. Of the 511 new uses of innovator drugs approved by the FDA in our data, roughly 95 percent were approved before market exclusivity expiration. Put differently, less than five percent of new use approvals associated with the nearly 1,000 innovator drugs in our sample—twenty-three new uses total—occurred after intellectual property rights became unenforceable.

Figures 2 through 4 document patterns that are consistent with—though not dispositive of—the existence of a missing market for new uses. There remain two sets of questions. First, do trends in FDA approvals fully capture relevant research and development? Second, could alternative explanations—such as a natural decline in scientific leads over a drug's lifecycle, or strategic sequencing of investments to commercialize uses before exclusivity expiration—account for the observed patterns? We take up the first question here, and then turn to the second in Sections 5.2 and 5.3.

On the question of whether our data capture all relevant research and development, one possibility is that firms shift investment away from the original innovator product at exclusivity expiration and continue developing new uses under separate NDAs for the same active moiety. Our main analysis tracks re-approvals associated with the 990 innovator drugs in our primary sample for which measures of market exclusivity are cleanly defined. Any reallocation of research effort would lead our analyses to underestimate investment. In general, the scope for this concern in our data appears limited: the median innovator drug is associated with a single NDA.[57] In Appendix B.4, we show that the three empirical signatures are unchanged when we track re-approvals at the active-moiety level: 92 percent of new use approvals occur before exclusivity expiration with this change, compared to 95 percent when we track re-approvals at the innovator drug level. This pattern is consistent with our model's prediction that incentives to invest in new uses tied to any form of an active moiety collapse once generics enter, since generic competitors are substitutes for all formulations of the drug.

A second possibility is that firms continue to validate new uses after exclusivity expiration but forego FDA approval, relying instead on diffusion through off-label prescribing. If so, Figures 2 through 4 would reflect gaps in regulatory approval, not missing research. Yet as Section 3.1 discusses, off-label prescribing typically relies on more limited evidence than the costly clinical trials necessary for formal approval of a new use. If firms were still investing in efforts to validate new uses after exclusivity expiration, we would expect to see continued activity in other measures of research investment, such as clinical trials and scientific publications.

Figure 5 plots trends in both measures and shows otherwise: investment in each falls substantially around exclusivity expiration.[58] Panel A plots the probability that any clinical trial studying

[57] Appendix A.1.4 offers additional details.

[58] Appendix Figure A6 plots trends in both measures relative to each drug's year of initial approval. This reorientation clarifies that the decline in scientific publications begins roughly thirteen years after initial approval, the time of market exclusivity expiration for the median drug in our sample.

an innovator drug is active in each year relative to exclusivity expiration. This measure includes not only trials validating new uses, but also phase IV surveillance studies, academic refinements of clinical practice, and foreign regulatory studies.[59] Even with this broad definition, trial activity declines sharply over the drug lifecycle. The likelihood of an active clinical trial peaks 18 years before exclusivity expiration, when close to half of innovator drugs are under study in at least one trial, and falls sharply and monotonically thereafter.

Panel B of Figure 5 plots the number of scientific publications studying each innovator drug in each year relative to exclusivity expiration. Publication activity also declines by roughly a factor of two over the twenty-year window around exclusivity expiration. Appendix Figure A7 clarifies the source of this decline by separately plotting trends for publications with and without public funding. The volume of publicly funded publications remains essentially constant—around ten per year across the entire period. The decline is driven entirely by a drop off in privately funded publications, consistent with our predictions about trends in private incentives.

Taken together, trends in other measures of research investment suggest that firms stop investing in new uses after exclusivity expiration. We now turn to the second question: whether alternative explanations, other than a missing market created by unenforceable intellectual property rights, account for the observed patterns.

5.2 Estimating the Causal Effect of Exclusivity on Research Investment

If gaps in private incentives cause the trends in Figures 2 through 5, then drugs with longer periods of market exclusivity should have a larger number of realized new uses, as longer exclusivity periods (T^*) increase expected profitability ($T^*\pi$). This Section leverages sources of variation in the periods of market exclusivity provided to innovator drugs that are plausibly unrelated to the drugs' underlying scientific potential to provide this causal evidence.

5.2.1 Investigating the effect of market exclusivity on the quantity of new uses

Our empirical analyses use a measure of market exclusivity for which there is substantial variation across drugs in our sample: the average innovator drug receives 12.9 years of exclusivity, but drugs at the 10th and 90th percentiles of this measure receive, respectively, 5.5 and 42.5 years.[60] These differences arise in two ways. First, recall that our primary measure of market exclusivity is intended to account for various complicating aspects of patents on pharmaceuticals—in particular, that most innovator drugs in our sample are protected by multiple overlapping patents and regulatory exclusivities, only some of which are likely to bind. These secondary patents and regulatory exclusivities can, in some cases, push a drug's market exclusivity period beyond the statutory twenty-year patent

[59] As Section 4 noted, constructing clinical trial data that covers our time period of interest requires drawing on four distinct sources of data, with different amounts of detail for each study. Gaps in trial sponsor and phase information limit our ability to refine this sample to include a narrower set of trials. Even if we had sponsor information, the fact that trials may be run by entities other than the firm that eventually markets a drug make this type of restriction conceptually challenging to implement.

[60] Appendix Figure A1 plots the distribution of this measure.

term. Second, various delays in the drug development process can erode a drug's effective patent life. Firms in the pharmaceutical sector have strong incentives to file primary patents on innovator drugs as soon as possible—both to protect their investments from competitors and to avoid creating "prior art" that would make the drug unpatentable for lack of novelty.[61] At least three types of delays between patent filing and initial drug approval can decrease effective patent terms: commercialization lags due to differences in clinical trial lengths (Budish et al., 2015), delays in clinical trial initiation (Gilchrist, 2016), and delays in patent prosecution (USPTO, 2025).

Panel A of Figure 6 plots the relationship for drugs in our sample between our measure of market exclusivity and the number of realized new uses as a binned scatterplot with an overlaid line of best fit. Panel A of Table 2 formalizes this relationship in a regression framework. In particular, for innovator drug i, we estimate the regression

$$y_i = \alpha + \beta \cdot \text{exclusivity}_i + \mu + \varepsilon_i \tag{6}$$

where the dependent variable y_i captures the number of re-approvals of innovator drug i for a new or modified indication and μ is an approval year fixed effect. The estimate of interest is β, the coefficient on our measure of each drug's market exclusivity duration in years, exclusivity_i. Columns (1) and (2) report results using the measure of market exclusivity introduced in Section 4.4—the earlier of generic approval and the expiration of all patents and exclusivities. The relationship between this measure of exclusivity and the quantity of realized new uses is positive and significant in all specifications, with and without the approval year fixed effect μ. We return to an economic interpretation of these estimates below and in Section 6.

Of course, market exclusivity terms are not randomly assigned across drugs. To the extent that firms apply for secondary patents with the goal of delaying generic entry, one may be concerned that firms can, in effect, endogenously determine the length of this period. Panel A of Figure 6 and Panel A of Table 2 may then capture several related effects, including the causal effect of longer market exclusivity on investment and the strategic behavior of firms that choose to extend periods of exclusivity on certain drugs.

To address this concern, we construct an alternative measure of market exclusivity that captures the three sources of variation that decrease effective patent term—clinical trial durations, clinical trial delays, and patent prosecution delays—but excludes all secondary patents. For each drug, we define its *minimum patent exclusivity* as the time between its initial approval and the expiration of its earliest patent and all FDA-administered regulatory exclusivities. By focusing on the minimum period of exclusivity—rather than the maximum period that firms can secure by accumulating secondary patents—we retain variation across drugs driven only by these delays. On this measure, the average drug in our sample has 9.4 years of (minimum patent) exclusivity; the 10th and 90th percentiles of this measure are 5 and 35 years.[62]

[61] Roin (2013), Budish et al. (2015) and Durvasula and Ouellette (2026) provide additional context on firms' incentives to file patents early in the research and development process.

[62] Appendix Figure A2 plots the distribution of this measure. In 52 cases (five percent), this minimum patent measure

Panel B of Figure 6 plots the relationship between this minimum patent measure of exclusivity and the number of realized new uses. In Panel B of Table 2, Columns (3) and (4) reproduce the regression specifications introduced above. Again, the relationship between these measures is positive and significant.

Our preferred estimates are reported in Columns (2) and (4) of Table 2, Panel A and include year of approval fixed effects, which account for the concern that earlier-approved drugs have had more years in which to realize additional new uses. In both specifications, the estimated coefficient is roughly 0.02.

There is one additional econometric challenge for this exercise, which arises because nearly three-quarters of innovator drugs in our sample ($N = 725$, 73 percent) have zero re-approvals for new uses: the existence of a mass point at zero may bias our estimates (e.g., Mullahy, 1998). To address this concern, in Panel B of Table 2, we report estimates from a two-part model that considers the extensive and intensive margins separately. On the extensive margin, we recode the outcome variable y_i to take a value of one if there are any re-approvals of innovator drug i and zero otherwise. We report estimates from a logit model. On the intensive margin, we restrict consideration to those drugs with at least one re-approval and estimate, via ordinary least squares, the effect of market exclusivity on the number of re-approvals.

On the extensive margin, we find a significant, positive relationship across specifications between the duration of market exclusivity and the approval of any new indication. Estimated coefficients—0.026 in Column (1) and 0.042 in Column (2)—suggest that an additional year of market exclusivity increases the odds of observing any re-approval for a new use by a factor on the order of two to four percent.[63] Though the intensive margin restriction leaves us underpowered, estimated coefficients from each specification are positive and comparable in magnitude to those reported in Panel A, but none are significantly different from zero.

In addition to providing support for the existence of missing incentives for investment in new uses, this empirical exercise speaks directly to a long-standing open question in the law and economics of innovation: do longer periods of intellectual property protection *cause* additional investments in research and development? That more new uses are commercialized when drugs receive longer periods of market exclusivity provides, to our knowledge, the first direct evidence that the answer to this question is yes.

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of exclusivity is longer than a statutory twenty-year patent term. This arises, in nearly all cases, because the earliest-expiring patent was filed after the drug's initial approval. While it is generally true, as we note above, that firms have strong incentives to file key patents before approval, this is not always the case. On inspection, many of these later-filed patents appear to be method-of-use patents on drugs for which there is no Orange Book patent protecting the active ingredient. We are unaware of data that would allow us to examine Orange Book patents in our data that are method-of-use versus active ingredient patents; the only effort to implement this type of categorization, to our knowledge, is Kapczynski et al. (2012), who do so for a subset of the Orange Book by reading the text of each patent and assigning labels by hand.

[63] We obtain these estimates by exponentiating the logit coefficients to obtain the corresponding odds ratios: $e^{\beta} - 1$. The coefficient of interest β in Column (1) is 0.026, which corresponds to an odds ratio of $e^{0.026} - 1 \approx 0.026$, or a 2.6% increase in odds per year.

5.2.2 Interpreting these estimates as an elasticity

This empirical exercise also yields an estimate of the elasticity of research investments with respect to market exclusivity. This elasticity is a key parameter for the design of optimal patent policy that has been challenging to estimate (Nordhaus, 1969; Budish et al., 2016).[64] Though it is necessarily specific to our empirical context, it is directly relevant to any efforts to alter the structure and availability of intellectual property rights. In Section 6, we use this elasticity to estimate the number of uses that would have been developed had intellectual property rights on new uses been enforceable for a longer period of time, to offer a rough quantification of the social costs of inadequate incentives for investment.

Returning to Table 2, Panel A, these regression estimates lend themselves to a straightforward interpretation: an additional year of market exclusivity would yield, on average, 0.02 new uses. To realize one additional new use per drug would, thus, require providing an additional 50 years of exclusivity on average.

To contextualize this estimate relative to prior work, we calculate the implied elasticity in percentage terms. We benchmark both the dependent variable (the number of new use approvals) and our measures of exclusivity at their sample means. Let $\bar{y} = 0.52$ be the average number of new use approvals per innovator drug and $\bar{x}$ be the average years of exclusivity (12.90 for our primary measure and 9.35 for the "minimum patent" measure). The point elasticity at the mean is given by $\beta \cdot \frac{\bar{x}}{\bar{y}}$.

Given our coefficient estimate of 0.02, this implies elasticities of approximately 0.35 and 0.49, using respectively our minimum patent exclusivity measure and standard market exclusivity measure.[65] These estimates suggest that doubling the average market exclusivity would increase the expected number of re-approvals by approximately 35 to 49 percent. Another interpretation is that adding one year of market exclusivity increases the average number of approvals for new uses by 0.02—roughly a 3.8 percent increase relative to the average of 0.52.

Budish et al. (2015) and Abrams (2009) offer two points of comparison. Budish et al. (2015) estimate the semi-elasticity of research investment with respect to a one-year change in the commercialization lag—t_{comm} in Section 2—for new cancer therapies as 7-23 percent. Abrams (2009) uses changes in the duration of patent term introduced by the adoption of the 1995 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to estimate the responsiveness of patent filings to changes in patent term length—t_{patent} in Section 2. In that context, a one year increase in patent term is estimated to generate a 66 percent increase in patent filings.

That our estimate is smaller than that in either Budish et al. (2015) or Abrams (2009) is, in several ways, unsurprising. First, note that our context may provide the cleanest setting in which

[64] A survey article by Budish et al. (2016) writes: "A key parameter needed to inform optimal patent policy design is the elasticity of research investments with respect to the patent term. Estimating this elasticity is conceptually difficult because it requires constructing a counterfactual in which we can infer that some scientifically feasible inventions would have been brought to market under an alternative patent policy design. Despite a near half-century of research effort, we have essentially no credible empirical evidence on this elasticity."

[65] Minimum patent measure: $= 0.02 \times \frac{9.35}{0.52} \approx 0.35$.
Market exclusivity measure: $= 0.02 \times \frac{12.90}{0.52} \approx 0.49$.

to isolate the effect of intellectual property duration on research investments. Budish et al. (2015) capture an effect that reflects both patent duration and corporate short-termism and, thus, may be an over-estimate. We expect Abrams (2009) to offer an over-estimate as well, given the context of the policy change used to generate this elasticity: TRIPS changed both the expected patent term for certain inventions and the structure of intellectual property rights more generally. For some inventors, holding patent rights under the new system was preferable for reasons unrelated to the duration of the term. It is unsurprising that our estimate, drawn from a more precise research design, is smaller in magnitude.

That being said, a second explanation for the difference in magnitude is that, in many ways, our context is narrow. Inventions in our setting are clinically validated links between drugs and new diseases, which in effect function as improvements to existing products. Eisenberg (2005) provides an additional explanation: qualitative evidence suggests that firms may be hesitant to invest in new uses for commercially successful drugs if there is some risk that additional clinical trials will yield "bad news," such as large numbers of adverse events in a particular patient population, that would threaten the profitability of the entire market.

5.3 Establishing Enforceability as the Mechanism

Section 2 introduces a framework in which the enforceability of intellectual property rights is the key determinant of the availability of incentives. Section 5.1 documents evidence of a sharp decline in investment and commercialization at the time of exclusivity expiration—when intellectual property rights become unenforceable—that is consistent with this hypothesized relationship. This Section introduces an empirical test that provides direct evidence that the mechanism creating a missing market for new uses is the unenforceability of intellectual property rights.

Recall that a missing market for new uses arises at the time of generic entry because a generic drug approved only to treat disease a can often be used "off-label" to treat diseases b, c, d etc., even if a brand name firm holds patents on those uses. Patents on new uses are, in our framework, unenforceable because the generic drug is perfectly substitutable for the brand name drug.

Not all re-approvals of existing drugs face the same enforceability problem at the time of generic entry. Generic competitors must individually challenge patents and demonstrate bioequivalence for each distinct formulation. If other patents and exclusivities that protect certain dosages, forms, and patient populations of a brand name drug remain in force, generic products will be approved narrowly. For example, in the case of Gemzar (see Section 4.1), the first generic competitor approved was allowed to market only one strength of the drug, its 2-gram version. Patents and regulatory exclusivities blocked generic entry on the 1-gram and 200-milligram versions. For many other innovator drugs in our data, generic competitors are initially approved only for one patient population (e.g., adult, not pediatric) or in one form (e.g., tablet, not liquid).

Thus, at the time of initial generic entry, intellectual property rights on forms of an innovator drug that are not perfect substitutes for the approved generic may remain partially enforceable ($p_{\text{enforce}} \in (0,1)$), even as the probability of enforcing intellectual property rights on information

about new uses falls to zero ($p_{\text{enforce}} = 0$).

To assess this prediction in our data, we first consider the likelihood that an innovator drug is re-approved in each relative year for any reason—including for addition of a new strength, dosage, or patient population. This trend is depicted graphically in Panel A of Figure 7. Visually, we find a much more gradual decline in re-approvals around the time of market exclusivity expiration than that documented in Figure 3, consistent with the idea that firms may retain some incentive to invest in new forms of existing drugs that are not direct substitutes for early generic competitors. Recall that 95 percent of successfully commercialized new uses linked to innovator drugs were approved prior to market exclusivity expiration. When we consider, instead, re-approvals of an innovator drug for any reason, this estimate falls to 71 percent.

We test this idea more directly by considering the case of fixed dose combinations—drugs dispensed as single "dosage forms" (e.g., a single tablet) that contain two or more distinct drugs.[66] The widely-used HIV treatment and preventive Truvada, for instance, is a single tablet that contains two distinct drugs, emtricitabine and tenofovir disoproxil fumarate, neither of which on its own offers the same therapeutic benefits.[67] Even if the components of a fixed dose combination are available in generic form, the combination form is often preferred by patients and providers, as it can simplify complex treatment regimens and increase prescription adherence.[68] Existing generics, then, are not perfect substitutes.

We examine whether firms shift investments toward fixed dose combinations as exclusivity expiration approaches. Specifically, we restrict attention to innovator drugs composed of a single active moiety and track combination products containing the same moiety. Figure 7 Panel B documents that, in the year of exclusivity expiration, the likelihood that a new indication for a combination drug is approved more than doubles relative to the previous year. The likelihood of a combination approval remains at this elevated level in the following years, as the likelihood of new use re-approvals on the innovator drug itself falls to zero.

This fact has two additional implications worth emphasizing. First, that the number of approvals of fixed dose combinations *increases* at the time of market exclusivity expiration counsels against the idea that scientific opportunities coincidentally drop off at this point in time. Second, that the change in approval patterns arises in the year that our measure assigns as the expected point of

[66] Note a point of potential confusion. Dix and Lensman (2024), discussed in the introduction, considers a special case of the new uses problem: the combination of existing cancer drugs into new cancer treatments. These kinds of combinations are distinct in form, function, and regulation from the fixed dose combinations that we consider in this test of our mechanism. Combination cancer therapies include components that are dispensed separately in in-patient settings; each component is regulated as a distinct drug. Fixed dose combinations are dispensed as single products, which are regulated themselves as new drugs.

[67] Truvada (emtricitabine; tenofovir disoproxil fumarate), NDA#021752, was approved by the FDA on August 2, 2004. A generic version, manufactured by Teva Pharmaceuticals, was approved on June 8, 2017. Emtricitabine was approved on July 2, 2003, and a generic approved on April 17, 2017. Tenofovir disoproxil fumarate was first approved on October 26, 2001, and a generic was approved on January 17, 2012.

[68] Combination drugs have many advantages for patients, chief among which is simplicity. The development of the first single-tablet regimen for HIV, Atripla (Efavirenz/emtricitabine/tenofovir), was lauded as a significant improvement for patients, many of whom had previously been taking up to 36 distinct pills per day. See Pollack (2006). Analyses of claims data suggest that treatment adherence is higher in single-tablet regimens than in multi-tablet regimens. See Silverman (2018).

market exclusivity expiration suggests that we are accurately capturing firm expectations.[69]

6 Quantification

Section 5 collects evidence from three empirical tests that, together, provide evidence in support of the existence of a missing market for new uses. This section leverages the elasticity of research investment with respect to market exclusivity calculated in Section 5.2 to develop a rough quantification of the social value of this missing innovation. We proceed in three steps. First, we use our elasticity estimate to estimate how many additional new uses would have been realized, had they received longer periods of market exclusivity. Second, we use estimates from the existing literature to give a sense of magnitudes for the value of a missing use. Third, we calculate the net present value of missing innovation.

6.1 How Many New Uses are Missing?

Figure 6 and Table 2 indicate that more new uses are commercialized when innovator drugs have longer periods of market exclusivity. We use this elasticity to develop an estimate of how many new uses would have been developed had intellectual property rights on these inventions been fully enforceable. As discussed in Section 3, the existing scientific literature provides little guidance on the absolute number of potential new uses for each drug, other than to suggest that most existing drugs likely have many therapeutic targets.

To estimate the number of missing new uses, we will consider how many new uses would have been developed under counterfactual periods of market exclusivity. As a lower estimate, suppose that the average innovator drug received a five-year exclusivity extension—in effect, offering five years of exclusivity for new uses commercialized at the end of the observed period of market exclusivity in our data. Five-year extensions are common: new chemical entities have received five-year market exclusivity grants since the 1984 Hatch Waxman Act, and certain new antibiotics now receive five-year grants as part of a package of 2012 reforms (Durvasula et al., 2023). As an upper estimate, suppose that a new use identified at the end of the innovator drug's period of market exclusivity received its own fully enforceable exclusivity period of twenty years, the duration of the standard patent term. Note that this exercise is intended to offer a sense of magnitudes, not to function as a proposal for policy; Section 7 discusses mechanisms to create incentives for investment in new uses (and in missing markets more generally) that do not require this style of blunt, costly exclusivity extension.

Estimates from Columns (2) and (4) of Table 2, Panel A imply that a five year extension would yield 0.10 new uses per innovator drug (i.e., $0.02 \times 5 = 0.10$) and that a twenty year extension

[69] The pattern we are documenting is consistent with practices that are often labeled as "product hopping" (Carrier and Shadowen, 2016), wherein firms respond to the loss of market exclusivity on one product by directing innovation toward products that are still protected by enforceable patents.This practice can impose real social costs. We do not undertake a complete welfare analysis of innovation decisions around exclusivity expiration, but note that any such analysis must take care to account for both incentives for innovation and the deadweight loss associated with delayed generic entry.

would yield 0.40 new uses per drug (i.e., $0.02 \times 20 = 0.40$). Since 1962, when the modern FDA was established, the agency has approved roughly 2,000 drugs that satisfy our sample criteria. Thus, our estimates indicate that between 200 and 800 additional new uses would have been developed had market exclusivity been extended along these lines.

6.2 How Valuable are New Uses?

Though previous studies have concluded that, in general, new drugs significantly increase life expectancy, there is enormous heterogeneity in estimates of social value.[70] Philipson and Jena (2006) estimate, for example, that the social value of survival gains from breakthrough HIV/AIDS therapies in the late 1980s was $1.4 trillion over a twenty-year period in the United States alone; Yin et al. (2012) estimate that early tyrosine kinase inhibitors, which transformed the treatment of leukemia and other cancers, produced roughly $6 billion per year immediately following initial approval. Other studies suggest that many "me-too" drugs—products that provide little clinical differentiation from existing therapies—contribute little in the way of social value (Dranove et al., 2014). Rather than aggregating heterogeneous case studies, we adopt an approach standard in studies of cost-effectiveness, which values new therapeutics in terms of quality-adjusted life years (QALYs) that capture improvements in both well-being and life expectancy in standardized units.

Based on a survey of existing literature, we select values for the following: (i) the incremental QALYs generated by a new drug relative to the standard of care; (ii) the social value of one QALY, per patient, per year; and (iii) the patient population treated. These quantities, scaled by a factor that reflects the lower average value of new uses compared to initial approvals, give our estimate of social value as $V = Q \times P \times N \times \theta$, where Q denotes incremental QALYs per patient, P is the value per QALY, N the number of patients, and θ a scaling factor for new uses.

Shafrin et al. (2023) estimate that the average drug approved by the FDA between 2011 and 2021 added 1.04 QALYs per patient relative to the standard of care, based on published cost-effectiveness analyses available for roughly half of all approvals.[71] For our back-of-the-envelope calculation, we round this to $Q = 1$. In the United States, cost-effectiveness analyses typically value one QALY at $P = \$100,000$.[72] For patient population, we assume that $N = 10,000$, a conservative estimate given industry reports suggest that specialty drugs are used to treat 10,000 to 50,000 patients per year, with an average market size of 40,000. (IQVIA Institute for Human Data Science, 2021). Under these assumptions, the annual social value of an initial approval ranges from $1 billion (1× 100,000 × 10,000) and $5 billion (1 × 100,000 × 50,000).

[70] This reflects the inherent difficulty of this exercise. Trusheim et al. (2010) write, "[i]t is difficult if not impossible to quantify reliably, objectively and unambiguously the extent to which new biopharmaceuticals embody significant innovation and address unmet medical needs." This difficulty arises, in part, because drugs may be both scientific advancements—which offer little therapeutic impact for current cohorts of patients but enable follow-on innovation—and therapeutic advancements—which immediately improve patient health.

[71] The authors note that many drugs provided less than 0.5 QALYs and a small number provided multiple QALYs. Note that the Shafrin et al. (2023) sample does not include the restriction that new drugs are "innovators" (the first approvals of a unique combination of active moieties) and hence is more expansive.

[72] Cutler (2004) also values life-years at $100,000, though Hemel and Ouellette (2023b) note that this estimate is "extraordinarily low relative to the values that federal agencies use in other contexts."

We next scale these values to reflect evidence that new uses are, on average, less valuable than initial approvals. Vokinger et al. (2023) find that roughly one-third of new uses have high therapeutic value compared to half of initial indications, based on a sample of drug approvals from the United States and European Union between 2011 and 2020. In oncology, Michaeli et al. (2022) find that first indications deliver nearly twice the QALY gain per patient—around 0.99 QALYs—relative to second or third indications, which average approximately 0.5–0.6 QALYs.[73] On the basis of these estimates, we set $\theta = 0.5$ and assume that new uses are half as valuable as initial approvals. Applying this factor implies that the average social value of a new use lies between $0.5 billion and $2.5 billion.

Given the considerable uncertainty in each of element of this measure, we select the more conservative $0.5 billion estimate for our back-of-the-envelope calculation of the social value of missing new uses.

6.3 Valuing the Missing Market for New Uses

To quantify the social cost of a missing market for new uses, we calculate the present value of a single missing new use, as

$$PV = \frac{\text{annual social value}}{r - g}$$

where r and g are the social discount rate and long-run population growth rate, respectively. We choose standard, conservative values for each and let $r = 0.05$ and $g = 0.01$. Using the estimate that a new use approval generates $0.5 billion in social value per year, the present value of one missing new use approval is thus $12.5 billion.

Scaling this by our estimate of the number of missing new uses (200 to 800) implies that the social cost of a missing market for new uses is on the order of $2.5 to $10 trillion from 1962 to 2014. Although these estimates are necessarily imprecise, the qualitative conclusion is clear: in just one market, the social costs of the missing markets problem appear to be extraordinarily large.

7 Discussion

In this paper, we investigate the idea that there are large classes of potential inventions for which private incentives to invest in research and development are missing. We develop a theoretical model that clarifies conditions under which these incentive gaps arise—when inventions are at risk of immediate imitation in the absence of intellectual property protection, but intellectual property rights are either unavailable or unenforceable—and predicts that *missing markets* will arise across sectors

[73] As complementary evidence, we assess one measure of value—market size—in our own data, using data drawn from the Medical Expenditure Panel Survey on prescriptions written for diseases associated with initial approvals and new uses. In roughly one quarter (26 percent) of cases, new uses are approved for indications in different disease areas than the initial approval (where disease areas are defined broadly, e.g., ICD-10 Category G: Diseases of the Nervous System, Category J: Diseases of the Respiratory System). Although the exercise is necessarily rough, we find that, on average, the market size for a new use is roughly 70 percent that of each drug's initial indication.

of the economy. In doing so, we formalize a set of ideas that have long been central to theoretical studies of innovation and intellectual property—that stronger and broader intellectual property rights induce additional investment in research and development, and that not all inventions are amenable to protection with any existing form of intellectual property. Our empirical work offers, to our knowledge, the first direct tests of both. We identify a setting, investments into new uses for existing drugs, in which there is sharp variation in the enforceability of intellectual property rights on otherwise comparable inventions over time. In this setting, intellectual property rights shift from perfectly enforceable to wholly unenforceable at a measurable point in time. We show that when enforceability drops to zero, so too does private investment. Plausibly exogenous variation in these periods of enforceability allows us to provide causal evidence that longer periods of (enforceable) intellectual property protection yield higher levels of research and development.

We use this elasticity of research and development with respect to intellectual property duration to estimate the number of additional new uses that would have been commercialized had intellectual property rights been fully enforceable. That is, we quantify, roughly, the size and value of a missing market for new uses. We estimate that, since 1962, between 200 and 800 new uses would have been commercialized but for these gaps in intellectual property protection. Estimates from the scientific literature on the therapeutic potential of existing drugs suggest that this range is, if anything, conservative (Gelijns et al., 1998; Wermuth, 2006). Using measures of the value of a new use drawn from the literature, we estimate that the social cost of this *particular* missing market is on the order of $2.5 to $10 trillion in present value terms. Although these estimates are necessarily rough, they suggest that the social costs of the missing markets problem, in general, may be extraordinarily large.

The potential scale of the missing markets problem makes more salient the question of solutions. Is it possible to "fix" a missing market? Our theoretical model rules out one standard tool, patent policy, typically deployed to correct inadequate incentives for innovation. Necessarily, neither longer nor broader periods of formal intellectual property protection—what we term "Nordhaus parameters"—affect incentives to develop potential inventions in missing markets.

Our model does, however, offer a structured way to identify alternatives. Consider a stylized version of (4) that captures the conditions under which a firm receiving a grant of intellectual property will commercialize an invention—if and only if

$$p_{\text{eligible}} \cdot p_{\text{enforce}} \cdot (\text{timing parameters})\pi - c \geq 0.$$

To create incentives for innovation, policymakers could intervene on the two parameters that directly generate the missing market, p_{eligible} and p_{enforce}, the profitability of commercialization π, or the cost of commercialization c. We discuss each of these possibilities, briefly, in turn.

Eligibility rules for intellectual property rights are not immutable; a series of Supreme Court decisions imposed novel restrictions on patentability in the early 2000s, and policymakers have

proposed new legislation that would expand the scope of patentable subject matter.[74] But any change to the expansiveness of intellectual property rights would affect all inventions, across sectors, and requires careful consideration of Nordhaus (1969)-style tradeoffs between creation of incentives for innovation and the deadweight loss of monopoly pricing. The dearth of empirical evidence on key aspects of this relationship makes it challenging to confidently assess the consequences of changes to p_{eligible} at present.

To address enforceability, one can imagine a variety of context-specific solutions. Advances in technology might allow firms to observe instances in which their intellectual property rights are infringed. In the context of new uses for existing drugs, integrated electronic health records can allow firms to monitor prescribing and impose indication-specific pricing; Roin (2014) sketches how this data infrastructure might be constructed, and Pearson et al. (2016) describes one attempt to implement such a system for cancer therapies in Italy. Changes to p_{enforce} will also have the effect of creating monopoly rights where they do not currently exist, so require the same consideration of Nordhaus (1969)-style tradeoffs.

Although the probability that an invention could be profitably commercialized under secrecy p_{secret} does not appear in this stylized equation, it is implicit. Recall that, in our framework, a firm will choose secrecy if it offers a longer period of time under monopoly than does a grant of intellectual property rights. When intellectual property rights are unavailable or unenforceable, it may be possible to create innovation incentives by enabling secrecy where it was not previously available. Recent advances in cryptography—specifically, "zero knowledge proofs," which allow one party to prove to another that they possess certain information without revealing the information itself (see e.g., Goldwasser et al., 2019)—suggest one potential class of mechanisms. There are, of course, important costs associated with more expansive secrecy, which can disrupt knowledge diffusion and spillover production. And there are contexts, likely including our empirical setting, where complete disclosure of socially valuable information is unavoidable.

When changes to p_{secret}, p_{eligible}, and p_{enforce} are infeasible, "pull incentives" that create profitability by guaranteeing compensation for successful research and development may be a viable alternative (see, for example, Barder et al., 2005 and Snyder et al., 2020). Any pull mechanism must include elements analogous to the parameters p_{eligible}, p_{enforce}, and π in our framework. A funder must determine the conditions under which an inventor is eligible for, say, a prize or advanced market commitment payout; develop a credible mechanism that guarantees compensation to the first inventor who satisfies the requisite conditions (thereby enforcing against copycats); and offer a payment that substitutes for the quasi-rents promised by intellectual property rights.[75] In the new uses context, a funder could commit to paying a certain price per dose for new uses of an existing drug up to some preset market size, following validation in a well-designed clinical trial.[76]

[74] See, for example, S. 1546 – Patent Eligibility Restoration Act of 2025.

[75] For details on how these three elements were operationalized to incentivize investment in the pneumococcal vaccine, see Kremer et al. (2020).

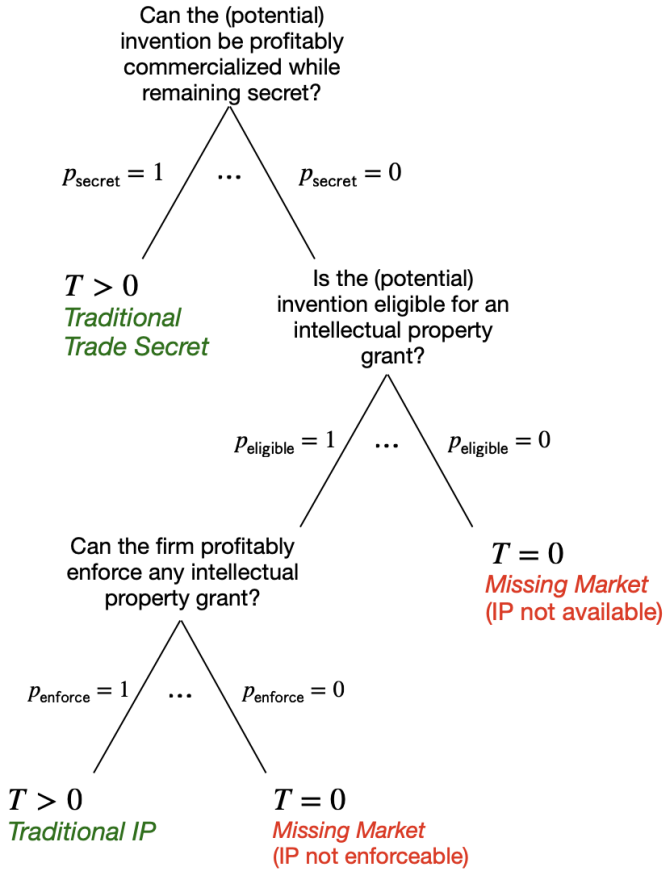
[76] We are grateful to Chris Snyder for discussions that motivated this example. For details on ongoing efforts to design such a mechanism to incentivize investment in new uses for existing drugs, see https://marketshaping.uchicago.edu/winner/repurposing-generic-drugs/.

Finally, and most directly, either a public or private sector funder could pay the cost of development c. This is sometimes called "push" financing (see, for example, Ahuja et al., 2021 and Castillo et al., 2021). The core challenge is informational: can the funder properly determine c, identify the appropriate recipient, and monitor effort? In settings where missing inventions are thought to be "technologically close" (Kremer et al., 2020) direct funding may be especially attractive.

Interventions on any of these margins bring with them important tradeoffs, which we do not attempt to resolve here. Still, one conclusion is clear: the social returns to improved innovation incentives may be extraordinarily large. In the single market we study, the potential gains are measured in trillions of dollars. Extending such mechanisms across the broader landscape of missing markets could enable progress on some of the thorniest challenges of our time.

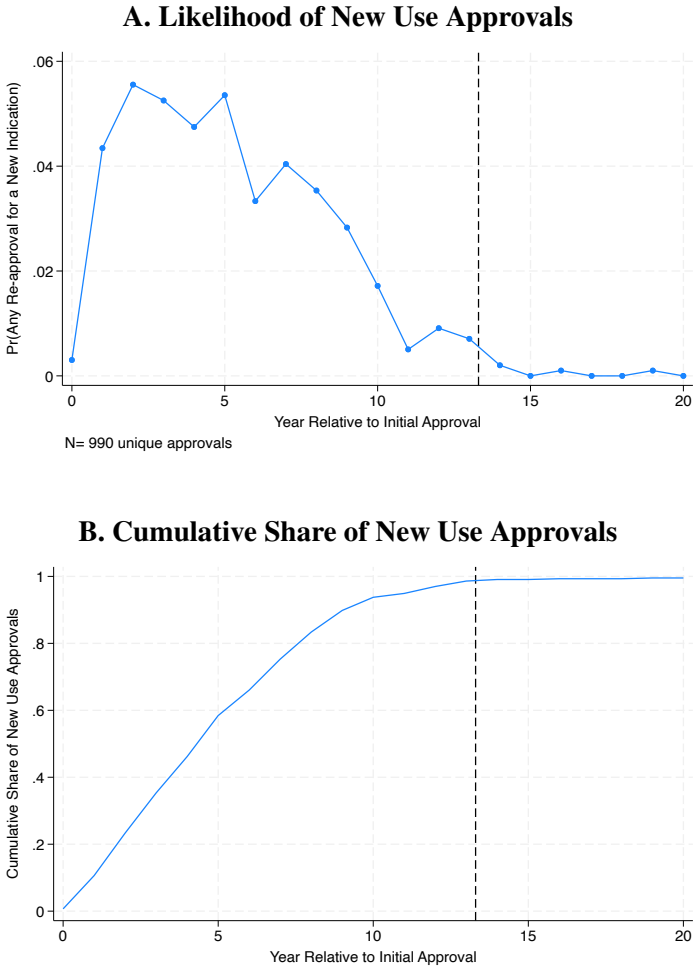
Figures and Tables

Figure 1: Missing Markets for Innovation



Notes: Figure summarizes the framework introduced in Section 2.1.

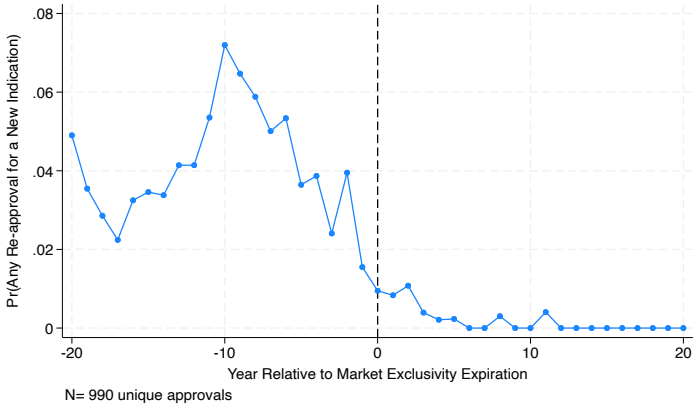
Figure 2: New Use Approvals Relative to Initial Approval



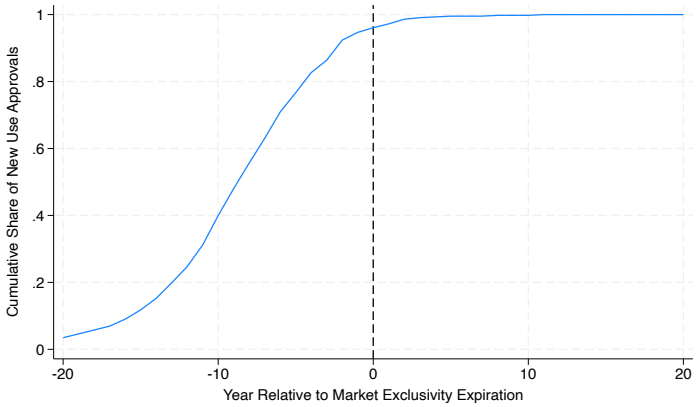
Notes: Panel A plots the probability of re-approval for a new use for the sample of innovator drugs defined in Section 4.5 ($N = 990$). Panel B plots the cumulative share of new use approvals by each year for the same sample. Both panels plot trends relative to the drug's initial approval by the FDA. Vertical lines plot median market exclusivity duration ($t = 13.3$ years).

Figure 3: New Use Approvals Relative to Exclusivity Expiration

A. Likelihood of New Use Approvals



B. Cumulative Share of New Use Approvals

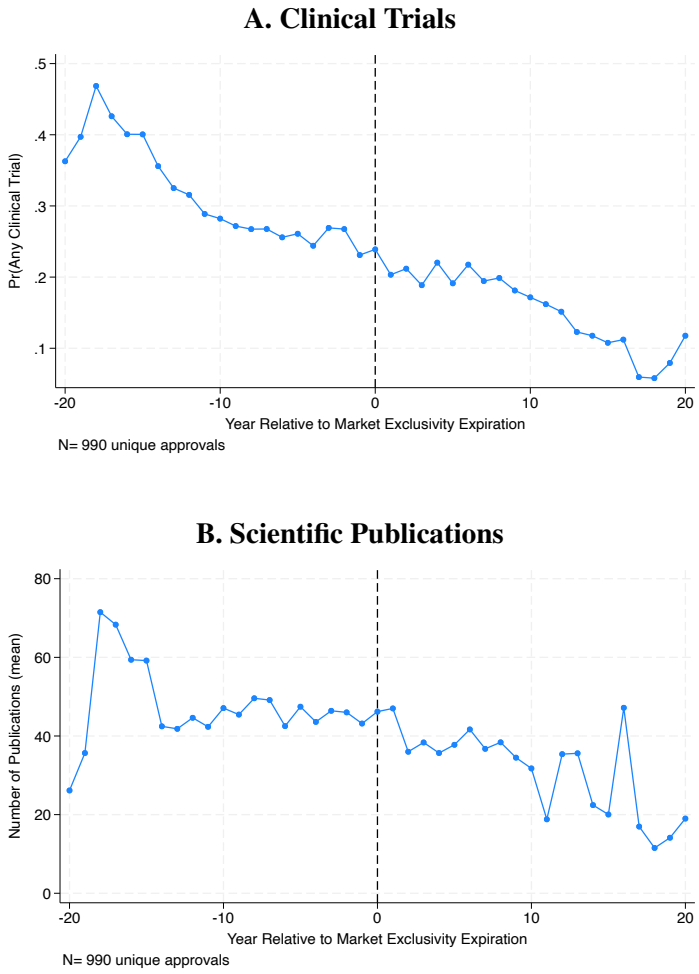


Notes: Panel A plots the probability of re-approval for a new use for the sample of innovator drugs defined in Section 4.5 ($N = 990$). Panel B plots the cumulative share of new use approvals by each year for the same sample. Both panels plot trends relative to market exclusivity expiration. Market exclusivity expiration, marked with vertical lines in both panels, is defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties. We plot the probability of re-approval for a new indication for the twenty years preceding and following exclusivity expiration for all drugs in our sample.

Figure 4: New Use Approvals, Balanced Panel

Notes: Figure plots the probability of re-approval for a new use for the sample of innovator drugs defined in Section 4.5. Panel A is a ten-year balanced panel ($N = 124$), meaning that we observe data for each drug in each of the twenty years plotted. Panel B is a five-year balanced panel ($N = 415$), meaning that we observe data for each drug in each of the ten years plotted. Market exclusivity expiration is defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties.

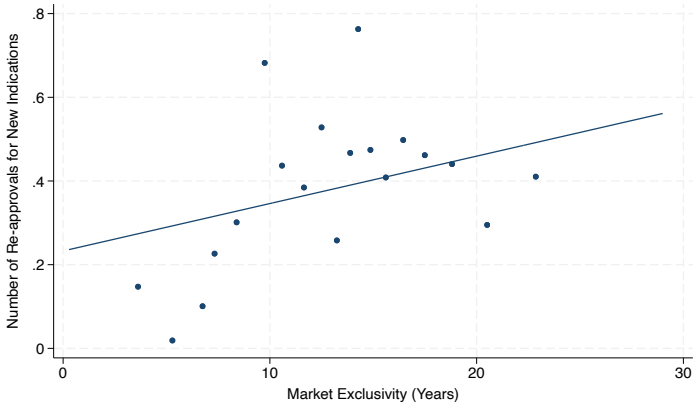
Figure 5: Other Research Investments Relative to Exclusivity Expiration



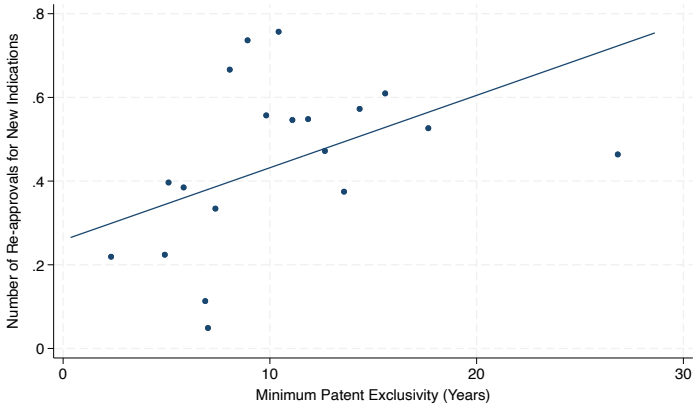
Notes: Panel A plots the probability of any active clinical trial in each relative year for the sample of innovator drugs defined in Section 4.5 ($N = 990$). We plot the probability of any active clinical trial in each of the twenty years preceding and following exclusivity expiration for all drugs in our sample. Panel B plots the average number of scientific publications published in each relative year for the same sample. We plot the average number of scientific publications indexed in PubMed associated with the innovator drug in the twenty years preceding and following exclusivity expiration for all drugs in our sample. Market exclusivity expiration is defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties. Appendix Figure A6 plots trends in clinical trials and publications relative to initial approval.

Figure 6: Quantity of New Uses by Exclusivity Duration

A. Market Exclusivity

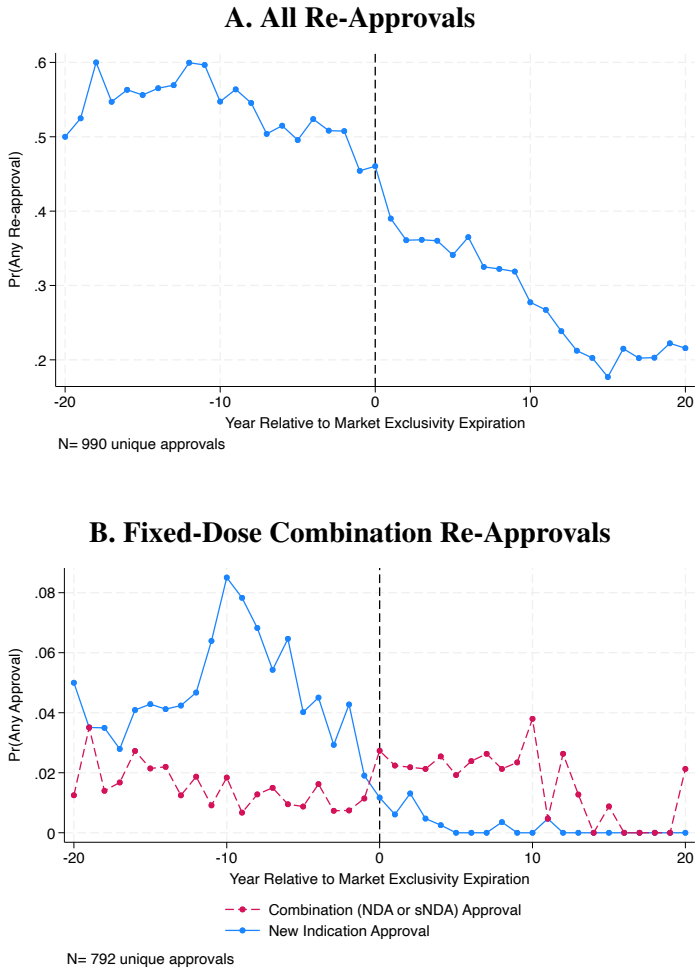


B. Minimum Patent Exclusivity



Notes: Figure plots the relationship between a measure of market exclusivity (x-axis) and the number of re-approvals for new uses (y-axis) for the sample of innovator drugs defined in Section 4.5 ($N = 990$). Both the x- and y-axes are residualized by the year of innovator drug approval, as year of approval is mechanically related to the total number of realized new uses. The scatterplot is binned into ventiles of market exclusivity (20 bins), with the mean value of the exclusivity measure added back to facilitate interpretation. A line of best fit is included. Panel A uses a measure of exclusivity that captures the number of years between the drug's initial approval and the earlier of the expiration of all patents and regulatory exclusivities or generic approval. Panel B uses a measure of exclusivity that captures the number of years between the drug's initial approval and expiration of the earliest expiring patent and all regulatory exclusivities.

Figure 7: Other Re-Approvals Relative to Exclusivity Expiration



Notes: Panel A plots the probability of any re-approval (e.g., new use, new dosage form, etc.) for the sample of innovator drugs defined in Section 4.5 ($N = 990$). Panel B plots two measures of FDA approvals for a subset of innovator drugs with a single active moiety ($N = 792$): re-approval for a new indication and re-approval as a combination drug. Market exclusivity expiration is defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties.

Table 1: Summary Statistics

	Mean	Median	SD	Min.	Max.	# obs.
Years to Generic Entry	11.27	11.47	4.52	0.21	28.19	442
Market Exclusivity (years)	12.90	13.37	5.48	0.18	42.46	990
Minimum Patent Exclusivity (years)	9.35	8.37	4.55	0.18	35.32	956
Number of Re-Approvals	14.87	11	13.43	0	87	990
Number of Re-Approvals (new/modified indication)	0.52	0	1.18	0	10	990

Notes: Table shows summary statistics for the sample of innovator drugs defined in Section 4.5 ($N = 990$). Innovator drugs are defined as the first FDA approvals of unique combinations of active moieties.

Table 2: Market Exclusivity and New Indication Approvals

Panel A: *re-approvals for new/modified indication*

	(1)	(2)	(3)	(4)
Market Exclusivity	0.013	0.020	—	—
(years)	(0.006)	(0.006)		
Minimum Patent Exclusivity	—	—	0.037	0.023
(years)			(0.008)	(0.008)
Approval Year FEs	no	yes	no	yes
Observations	990	990	990	990
Panel B: Two-part model				
Extensive Margin	*any re-approvals for new/modified indication*			
Market Exclusivity	0.026	0.042	—	—
(years)	(0.012)	(0.014)		
Minimum Patent Exclusivity	—	—	0.083	0.059
(years)			(0.015)	(0.018)
Approval Year FEs	no	yes	no	yes
Observations	990	990	990	990
Intensive Margin	*# re-approvals for new/modified indication*			
Market Exclusivity	0.015	0.020	—	—
(years)	(0.017)	(0.018)		
Minimum Patent Exclusivity	—	—	0.017	0.011
(years)			(0.021)	(0.022)
Approval Year FEs	no	yes	no	yes
Observations	256	256	256	256

Notes: Table shows the relationship between measures of market exclusivity and the number of realized new uses, estimating (6) in the text. Observations are the sample of innovator drugs defined in Section 4.5. Robust standard errors reported in parentheses. We report estimates using two measures of exclusivity: market exclusivity captures the number of years between the drug's initial approval and the earlier of the expiration of all patents and regulatory exclusivities or generic approval, and minimum patent exclusivity captures the number of years between the drug's initial approval and expiration of the earliest expiring patent and all regulatory exclusivities. Panel A reports estimates for a pooled sample, estimated via ordinary least squares. Panel B reports estimates from a two-part model, as described in Section 5.2. All specifications include approval year fixed effects.

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A Data Construction

A.1 Drug Approvals

Our primary source of data on drug approval and generic entry is the **Drugs@FDA** database, which is provided online and regularly updated by the U.S. Food and Drug Administration (FDA). With the exception of the following categories, this database contains most novel drug products:

- drugs not approved by the FDA
- drugs under review by the FDA for which action has not yet been taken
- over-the-counter (OTC) products approved for marketing through any process other than the submission of a New Drug Application (NDA) or a Biologic License Application (BLA)
- drugs sold outside of the U.S. that are not approved for marketing within the U.S.
- dietary supplements, which do not require FDA approval for domestic sale
- biological products (regulated by the Center for Biologics Evaluation and Research)
- animal drugs (regulated by the Center for Veterinary Medicine)

We use data from three Drugs@FDA files:

1. Application-level data: *application.txt*
2. Product-level data: *Product.txt*
3. Supplemental approval data: *RegActionDate.txt*

The Drugs@FDA data structure changed on 06 November 2016. After this date, many details in the Supplemental Approval data file were no longer available, and the file *RegActionDate.txt* was no longer published.[77] We use the latest available version of the database referred to as "Drugs@FDA 1.0," dated 25 October 2016, obtained via the Internet Archive's Wayback Machine.

A.1.1 Background on the FDA approval process and data files

With few exceptions, drugs that are prescribed in the United States must first be approved by the FDA. FDA approval indicates that, for its intended population, a drug's benefits outweigh both known and potential risks.[78] A brief primer on the vocabulary of drug applications and key features of the approval process provides helpful context for the data in this paper.

Application numbers: The FDA assigns six-digit application numbers to three key types of applications: new drug applications (NDAs); abbreviated new drug applications (ANDAs), and

[77] We have been unable to obtain analogous records from the FDA covering more recent years.
[78] See https://www.fda.gov/drugs/development-approval-process-drugs for details.

biologic license applications (BLAs). Each application may be differentiated by its: (i) unique active ingredients; (ii) dosage form; and (iii) strength.

New drug applications (NDAs): An NDA is submitted when there exists sufficient evidence on the safety and effectiveness of a drug to meet the FDA's requirements for new drug marketing. NDAs are typically submitted for all novel, brand name drugs.

Abbreviated new drug applications (ANDAs): An ANDA is submitted for the approval of a generic drug that is the "therapeutic equivalent" of any previously approved drug. Drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents and if they can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling.

Biologic license applications (BLAs): A BLA is an application submitted for the approval of a biological product.

Application-level data The Application data file contains information on 20,560 drug approvals; 15,341 are NDAs, 5,082 are ANDAs, and 137 are BLAs.

Product-level data The Product data file contains information for each application that includes—among other variables—a record of drug ingredients that are associated with each application. Specifically, the file includes the following variables:

Active ingredients: An active ingredient in a drug is defined by the FDA as any component that provides pharmacological activity or another direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease. Several NDAs and ANDAs may have the same active ingredients.

Dosage form: A dosage form is the physical form in which a drug is both produced and dispensed. These include tablets, capsules, and injectable forms.

Strength: The strength of a particular drug product captures how much of the active ingredient is present in each dosage form.

Supplemental approval data The RegActionDate data file contains records of all approvals associated with each NDA and ANDA. This file contains 128,906 approvals, which correspond to 17,299 unique application numbers. In addition to initial marketing approvals, this file contains records of "supplementary new drug applications" (sNDAs).

An sNDA is an application to the FDA requesting some change to the agency's approval for the drug. Changes may include new or modified indications, modifications to the labeling (i.e., the packaging affixed to a dispensed prescription), a new route of administration, or a new patient population for the drug. All changes of this kind must be approved by the FDA to ensure that the conditions that supported initial approval are still satisfied.

There are more than 50 categories of approval actions that can be granted using an sNDA. These approval types include standard approvals (which appear in our data as "N" type approvals), presubmissions ("M"), and manufacturing changes ("SCM"). For each approval, the FDA includes its action date, the date on which the application was approved.

A.1.2 Identifying "innovator" drugs

We use data from Drugs@FDA to define our base sample of new medicines. We call a drug an **innovator** if it meets the following criteria:[79]

1. It was approved under a New Drug Application (NDA) to the FDA.

2. It is the first approval of a unique combination of components

Determining whether a drug meets the first criterion is straightforward. Records in the Drugs@FDA database (applications file) are assigned one of three application types: "A" (abbreviated new drug application), "B" (biologics license application), or "N" (new drug application). We restrict consideration to applications of type "N."

Determining whether a drug meets the second criterion is more challenging—and foreshadows the medication name matching procedures discussed throughout this appendix. The core challenge is determining what constitutes a *unique component* in a drug. Many drugs are part of "substance sets" that include closely related products, which are pharmacologically and physiologically equivalent. Consider a drug molecule that contains a hydrogen atom. Replacing this hydrogen with "a metal or its equivalent" will form a salt, while replacing it with "an organic radical" will form an ester (Ward (2019), citing Amarin Pharm. Ireland Ltd. v. FDA, 106 F. Supp. 3d 196, 199 n.1 (D.D.C. 2015)). In many cases, these slight modifications have no clinically significant effects. However, these modified forms often appear as distinct active ingredients in the Drugs@FDA database. For example, our data includes both *acetazolamide* and its salt form *acetazolamide sodium* as active ingredients. If we treated unique active ingredient strings as unique drug components for the purpose of constructing this sample, we would overcount the number of innovator products by incorrectly categorizing salts, esters, and other small chemical modifications to drugs as entirely new inventions.

Instead, we follow the FDA's own practice when evaluating the novelty of products and define innovator drugs in terms of unique *active moieties*: the part of the larger molecule that is responsible for the physiological or pharmacological action of the drug substance.[80] For the example above, *acetazolamide* is the active moiety in both *acetazolamide* and *acetazolamide sodium.* Thus, we construct our sample of innovator drugs by identifying the initial approvals of unique combinations of *active moieties* by the FDA.

[79] This is conceptually similar to, but not the same as, the FDA classification "new molecular entity" (NME). NMEs are defined as new drugs whose active ingredients are chemical substances that are marketed for the first time in the United States. Put differently, NMEs are drugs for which the FDA has not previously approved some component. NMEs are a strict subset of our sample definition. Our modification is to include first approvals of unique combinations of ingredients, even if every component has been previously approved by the FDA.

[80] Debates about whether the FDA should refer to "active ingredients" or "active moieties" when, for example, making determinations about various types of market exclusivity have been ongoing since the 1980s. See Ward (2019) for a more detailed discussion.

Active moiety crosswalk To the best of our knowledge, there is no standard crosswalk from active ingredient strings, as appear in Drugs@FDA, to active moieties.[81] We construct such a crosswalk, using the Drugs@FDA Product file as our input data.[82]

We begin by standardizing strings of active ingredients recorded in the database. We ensure text is lower case, components (for drugs that are combinations of multiple ingredients) are alphabetized and separated by semicolons, and extraneous punctuation is removed. Next, we separate each active ingredient string into its component parts. For example, *abacavir; lamivudine; zidovudine* is split into its three pieces. For each component in a drug, we manually review PubChem, chemistry textbooks, and online resources to identify the active moiety in the drug. We reconstruct strings for combination drugs, again ensuring that the component active moieties are alphabetized and formatted consistently.

Of the 25,976 unique active ingredient strings in our data, we determine that the active moiety and active ingredient are identical in 12,510 cases.

Defining our sample We drop 6 application numbers that are present in the Application file but do not have corresponding data in the Product file. All application numbers in the Product file have matching data in the Application file.

We begin by constructing a sample of initial drug approvals. We focus on records with an "N" (standard approval) doctype designation in the Supplement data file. There are 140 unique applications with multiple associated "N" approvals. For these 140 cases, we select the earliest approval recorded as the initial approval date for that application. We also drop 1,126 applications for which we never observe an "N" approval in our data. Thus, we construct a preliminary dataset that includes 16,171 initial approvals.

We merge these records onto the Application and Product files to yield a dataset with information on initial drug approval and product characteristics for 15,361 applications. Excluded from this sample are 836 applications without records in the Product and Application files, and 4,895 applications that have records in the Product and Application files but no corresponding approval histories in the Supplement file.

Finally, we impose the two restrictions described above to construct a sample of innovator drugs, which are unique at the active moiety level. We begin by dropping 122 drugs approved under

[81] The International Nonproprietary Names (INN) initiative maintained by the World Health Organization attempts to deal with exactly this problem. The description of the INN program reads: "When the INN Programme was initiated, it was decided that in such situations, in order to limit the number of published INNs, an INN should be selected for one member of such a group only. This approach, which concerns especially substance sets formed by salts or esters of the same active moiety was validated in the 20th report of the WHO Expert Committee on Nonproprietary Names for Pharmaceutical Substances (Technical Report Series No. 581)." See https://www.who.int/publications/i/item/inn-05-167-3 for details. INNs, however, may not always map onto drugs names as used in the United States. For example, "paracetamol" (commonly used in countries where British English is used) is the INN for "acetaminophen," the drug often marketed under the brand name Tylenol.

[82] In the interest of developing resources that can be re-used in research, we use the most current version of the Drugs@FDA database at the time this work was completed, dated 05 January 2023, for this particular exercise. All other analyses use an older version of Drugs@FDA (Drugs@FDA 1.0) that contains information on product re-approvals central to our analysis.

BLAs.[83] We drop 77 instances in which active moiety groups have no products that were approved under NDAs.[84] We drop 737 drugs based on their dates of approval: 250 instances in which drugs were initially approved before 1962, when the Kefauver-Harris Drug Amendment was signed into law; and 487 drugs approved between 1962 and 1985, when the regulatory structure introduced by the 1984 Hatch Waxman Act was implemented.[85]

We identify **1,102** unique combinations of active moieties that meet our criteria for "innovator" drugs. Our analyses restrict consideration to the **990** drugs with at least one patent or regulatory exclusivity.

A.1.3 Linking "innovator" drugs to generic competitors

We designate any drug that is approved under an ANDA a "generic."[86] There are 8,322 application numbers in our dataset approved under ANDAs. To determine the first generic entrant for an innovator drug, we consider the set of all ANDAs with identical sets of active moieties and select the drug product with the earliest approval date. If there are multiple generic drugs within an active ingredient group being approved on the earliest date—which occurs for 186 unique products—we designate the drug with the lowest application number as the earliest generic entrant. This selection procedure has no impact on our analysis, which does not depend on the identity of the first generic entrant.

A.1.4 Counting approvals and re-approvals

We construct two measures of drug approvals and re-approvals. As noted above, a drug's initial approval is identified by searching for records with an "N" (standard approval) doctype, and we ensure that there is only one initial approval per drug. We construct a measure of "all approvals" associated with a drug, by identifying all approvals without an "N" doctype. Supplementary approvals associated with doctype "SE1" are approvals for new indications. We count SE1 approvals to generate a measure of approvals for new uses. Our primary analyses record re-approvals associated with an innovator drug (i.e., regulatory actions under the same new drug application associated with the innovator approval). In robustness checks, we instead collect re-approvals associated with

[83] Most BLAs are approved through the FDA's Center for Biologics Evaluation and Research (CBER). The sample of BLAs approved through CDER and indexed in Drugs@FDA is not representative of biologic drugs as a class.

[84] Examination of these cases indicates that these are instances where products were either (i) never approved as FDA brand name drugs (e.g., application number 077394 was processed as an abbreviated new drug application in 2005, corresponding to "sodium bicarbonate" - baking soda); or (ii) correspond to innovator drugs that were approved before our dataset begins in 1962 (e.g. various applications related to penicillin, which was widely used beginning in the 1940s).

[85] The Kefauver-Harris Drug Amendment, often referred to as the "Drug Efficacy Amendment," introduced the requirement that drug manufacturers demonstrate the effectiveness and safety of drugs before approval. Manufacturers were also required, after this point, to disclose accurate information about side effects. Cheap generic drugs could no longer be re-branded as brand name (expensive) drugs and re-marketed as "breakthroughs."

[86] This designation is standard and consistent with FDA language. In FDA documents, ANDA and 'generic' are often used interchangeably. See https://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/AbbreviatedNewDrugApplicationANDAGenerics/default.htm for Drugs@FDA descriptions of ANDAs for generic products

all NDAs that include the same active moiety. Concretely, consider the case of ranitidine, most commonly marketed under the brand name Zantac. Ranitidine was first approved by the FDA in 1983 as a treatment for peptic ulcers. It was subsequently re-approved under 11 additional NDAs, with distinct brand names. Our primary analysis focuses on re-approvals for new indications associated with only the first NDA. In robustness analyses, we consider re-approvals associated with any ranitidine NDA. Note that ranitidine is an outlier in terms of total number of associated NDAs: the median innovator drug in our data is approved under just one NDA and only 43 drugs are approved under more than five NDAs.

A.2 Scientific publications

We collect a measure of research investments from the National Library of Medicine's PubMed database. PubMed collects information on biomedical scientific publications, with curated links to chemicals mentioned in the text of each paper. Chemical names are standardized to match terms in the "Medical Subject Headings" (MeSH) vocabulary, a controlled thesaurus maintained by the NLM. As of 2022, there were more than 30,000 entries in MeSH. Each MeSH term has an associated unique ID (UI). It is important to note that although each term corresponds to at most one UI, one UI can be associated with multiple synonymous terms. If chemical names are tagged with UIs, then, the numerical identifiers can allow us to identify and properly group synonyms.

For each active moiety in our innovator drug sample, we identified the corresponding MeSH term and UI. We used a crosswalk between MeSH terms and UIs drawn from the PubMed database.[87] When active moiety strings matched the text description of MeSH terms precisely, we assigned both the MeSH term and UI to the active moiety. When there was no precise match, we searched the web-based MeSH browser, to determine if there may be an alternative formatting, spelling, etc. that resulted in a match. In our sample of 1,102 innovator products, we successfully identified a MeSH UI for 810 (74 percent).

Comparatively few combination drugs have associated MeSH UIs. When MeSH terms exist for combination drugs, formatting is standardized (e.g. "hydrocortisone, urea drug combination" (MeSH UI: C010017)). However, of the 351 combination drugs in our sample of innovator products, only 78 have a MeSH UI.

For the set of non-combination drugs, we impute zero publications if there is no associated MeSH UI. For the sample of combination drugs, we proceed differently. We collect counts of all publications that reference every component of the combination drug (e.g., for "hydrocortisone, urea drug combination," we collect all publications that reference both "hydrocortisone" and "urea"). In our primary analyses, we use these counts as our measures of scientific publications.

We also collect flags from PubMed that indicate whether a publication received any funding

[87] Specifically, we used the "chemicals" table from the bulk version of PubMed. We constructed a list of all unique MeSH terms reported in the "substname" field and their associated UIs reported in the "substUI" field. As these fields are added by indexers at the National Library of Medicine (and not constructed by authors themselves), we did not verify the accuracy of these substname-substUI links. However, we did note that, as expected, each substname is associated with one substUI and that the same substUI is associated with multiple substnames.

Table A1: Clinical Trials Datasets

dataset	version	file names	years of coverage	proprietary
NDA Pipeline	received in April 2007	nda_trials.dta	1982–2001	no
Pharmaprojects	current through May 2011	trend_accnum_year.dta	1995–2010	yes
Cortellis	received in 2016	trialid_singledata.dta trialid_drug_primary_intervention.dta	1995–2015	yes
ClinicalTrials.gov	downloaded from AACT; version dated 20220728	studies.txt; browse_interventions.txt; interventions.txt; interventions_other_names.txt	2010–2016	no

Notes:

from a public agency. We draw on information from the "grants" table of PubMed and designate a publication as having any public funding if there is any entry associated with one of three variables in PubMed: Grant ID, Acronym (Grant Agency), Grant Agency.

A.3 Clinical trials

A.3.1 Datasets

We collect information on clinical trials as one measure of drug development. To maximize coverage over our sample period, we draw records from four datasets. Table A1 summarizes the coverage of each dataset.

NDA Pipeline

We collect records from the NDA Pipeline dataset, maintained by F-D-C Reports. The NDA Pipeline is a reference document covering drug developments during the previous calendar year. Each observation includes a text description of the stage of development for a given drug compound. We use data from 1982 to 2001.

Pharmaprojects

We collect additional information on drug development between 1995 and 2010 from Pharmaprojects, a proprietary dataset that records events associated with drugs at various stages of the development pipeline.[88] Pharmaprojects is compiled and sold by Citeline. Employees gather information from company websites, reports, and press releases. Every company in the database verifies information related to their listed drugs. Pharmaprojects reports trials that are newly initiated and ongoing in each annual report.

[88] Our version of Pharmaprojects is current through May 2011.

Citeline's documentation associated with the dataset notes: "There is continual two-way communication between Pharmaprojects staff and their contacts in the pharmaceutical and biotechnology industries; both to gather new data and importantly, to verify information obtained from other sources."

Cortellis

We also collect records on drug development between 1995 and 2015 from Cortellis, a proprietary dataset that, like Pharmaprojects, records details on drug development activity.[89]

ClinicalTrials.gov

We supplement these records with data drawn from ClinicalTrials.gov, the largest repository of clinical trial records in the world, for clinical trials initiated between 2010 and 2016. Since 2007, sponsors of trials regulated by the U.S. Food and Drug Administration are required, by law, to register clinical trials with ClinicalTrials.gov. Since 2005, registration in a global registry has been required as a condition of publication in any journal associated with the International Committee of Medical Journal Editors.

A.3.2 Data construction

NDA Pipeline

NDA Pipeline records include the following information: document publication year, firm name, trade name of drug, generic name of drug, abbreviation of drug name, description of study, status, and miscellaneous notes. We identify developments about clinical trials by searching for keywords within the "status" variable. Specifically, we keep records where the status variable includes either "phase" (as in, "Phase I trial") or "clinical." We drop records where the description includes either "preclinical" or "preclinical."

As these records are intended to provide annual updates on drug development pipelines, clinical trial records are best interpreted as reports of trials that were active in the year prior to publication. That is, they reflect firm decisions about project *continuation*, rather than project *initiation*. Since these documents were published one year after the relevant clinical developments, we subtract one from the year of publication to generate a variable capturing the year in which a trial was conducted.

We link records to our baseline sample of FDA-approved active moieties using the generic name of the drug. We standardize the formatting of the string (remove punctuation, alphabetize components, remove extraneous characters, etc.) and attempt two merges. First, we attempt to merge the generic name of the drug in this dataset to the active ingredients associated with our baseline sample. For observations that do not successfully merge, we next attempt to link generic

[89] Details on the contents of Cortellis are available here: https://cortellislabs.com/api/clinical/. There are a small number of records for trials initiated before 1995, which appear to be incomplete (e.g., there is one trial in the Cortellis data that is active in the year 1981). We do not include these records in our sample.

names to the active moieties associated with our baseline sample. We impute annual trial counts of zero for all active moieties approved during this time period.

Our final dataset includes records associated with 543 FDA-approved active moieties (or combinations) tested between 1981 and 2000. The most studied drugs in our sample are paclitaxel and thalidomide.[90]

Pharmaprojects

We use data from Pharmaprojects on the status of drug development projects. We collect information on clinical trial developments by, similarly, searching within a variable about project status ("originator status"). As with NDA Pipeline data, we keep records where the status variable includes either "phase" (as in, "Phase I trial") or "clinical." We drop records where the description includes either "preclinical" or "preclinical." Pharmaprojects records provide annual updates on drug development projects and, thus, also capture project *continuation*, rather than project *initiation.*

Our linking procedure with Pharmaprojects data is identical to the linking project for NDA Pipeline. We link records to our baseline sample of FDA-approved active moieties using the generic name of the drug. We standardize the formatting of the string (remove punctuation, alphabetize components, remove extraneous characters, etc.) and attempt two merges. First, we attempt to merge the generic name of the drug in this dataset to the active ingredients associated with our baseline sample. For observations that do not successfully merge, we next attempt to link generic names to the active moieties associated with our baseline sample. We impute annual trial counts of zero for all active moieties approved during this time period.

Our final dataset includes records associated with 613 FDA-approved active moieties (or combinations) tested between 1995 and 2011. The most studied drug in our sample is paclitaxel.

Cortellis

We also collect data from Cortellis that—like the Pharmaprojects data—collects data on drug development typically sold for the purposes of "competitive intelligence." Cortellis includes one record per clinical trial and includes variables that capture start year and end year. We transform these data into records that indicate whether a given trial on a drug was active in each year.

Our linking procedure with Cortellis data is identical to that used for NDA Pipeline and Pharmaprojects. We, again, impute annual trial counts of zero for all active moieties approved during this time period.

Our final dataset includes records associated with 990 FDA-approved active moieties (or combinations) tested between 1995 and 2016. The most studied drug in our sample is docetaxel.

[90] Paclitaxel is a type of chemotherapy that can treat various forms of cancer, originally approved in 1992. See https://www.nytimes.com/2005/01/08/business/new-form-of-breast-cancer-drug-approved.html. Thalidomide was approved by the FDA in 1998 to treat leprosy and has since been reapproved to treat various forms of cancer. Given its (notorious) history of causing birth defects, its distribution is tightly controlled. See https://www.nytimes.com/1998/07/17/us/thalidomide-approved-to-treat-leprosy-with-other-uses-seen.html.

ClinicalTrials.gov

We use data from ClinicalTrials.gov to supplement records from NDA Pipeline, Pharmaprojects, and Cortellis. Although ClinicalTrials.gov was made available to the public in 2000, we collect records beginning in 2010, by which time trial registration had become more common.[91] We collect records of all trials, regardless of trial phase, that were active between 2010 and 2016. ClinicalTrials.gov allows us to construct two measures of trial activity: trial initiation decisions (using trial start years) and trial continuation decisions (using trial active years). To facilitate integration with NDA Pipeline and Pharmaprojects data, our main analyses use trial continuation decisions measured using trial active years. There are a number of concerns about the completeness and accuracy of ClinicalTrials.gov records (see, for example, Zarin et al. (2017); Tse et al. (2018)). Given these limitations, we report analyses that consider the likelihood of any clinical trial associated with a given drug in each year, rather than considering the total number of trials.

As ClinicalTrials.gov is administered by the National Library of Medicine, we follow the same procedure to link records used for PubMed data. Trial sponsors report the interventions (therapies, behavioral treatments, drugs, etc.) associated with each study using standardized MeSH terms, in the file *browse_interventions*. We link MeSH terms associated with clinical trials to the MeSH terms associated with each drug in our baseline sample. We impute annual trial counts of zero for all active moieties approved during this time period with no matching trial records.

Our final dataset includes records associated with 1,013 FDA-approved active moieties (or combinations) tested between 2010 and 2016. The most studied drug in our sample is docetaxel.

A.3.3 Clinical trials sample

We construct a sample of clinical trials by appending records for NDA Pipeline, Pharmaprojects, and ClinicalTrials.gov. Our primary measure of trial activity is an indicator variable that takes a value of one if there was any active clinical trial associated with an innovator drug in a given year. Although our data do enable us to consider the total volume of clinical trials, we prefer to focus on a binary measure to avoid introducing concerns about differences in measurement and coverage across the four datasets.

A.4 Drug-disease crosswalk

We construct data on the specific therapeutic uses (indications) associated with each drug approval and re-approval in our sample. For each approval/re-approval event, we collect text descriptions of the associated indications from a variety of sources. Where possible, we use FDA application number and date of (re-)approval to retrieve the relevant drug label from the FDA's full-text drug

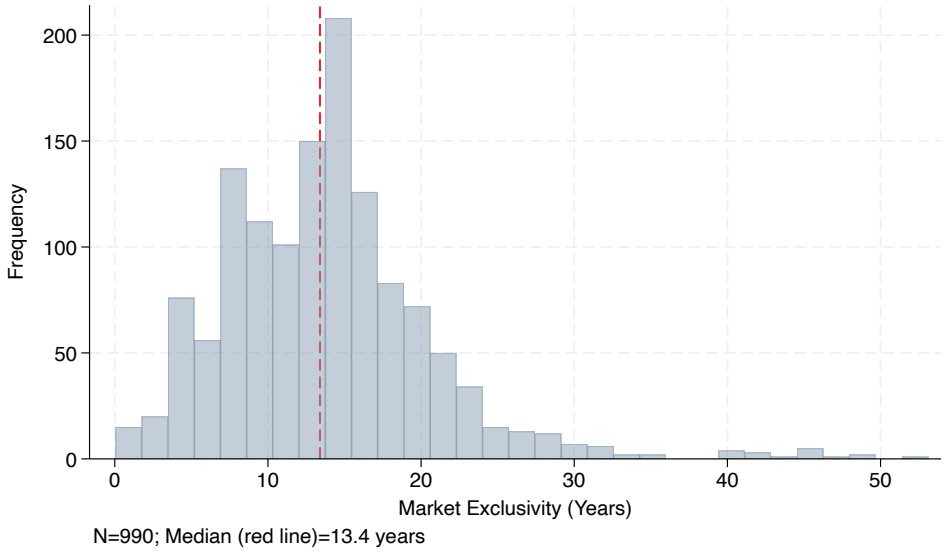
[91] In 2005, the International Committee of Medical Journal Editors (ICMJE) began requiring trial registration as a condition of publication. In 2007 the requirements for submission to ClinicalTrials.gov were expanded after Congress passed the Food and Drug Administration Amendments Act of 2007 (FDAAA) (PDF). Section 801 of FDAAA (FDAAA 801) required more types of trials to be registered and additional trial registration information. For more details, see https://clinicaltrials.gov/ct2/about-site/history.

product labeling service, FDALabel.[92] We supplement data on labels—which are primarily available from 2005 forward—with data from drug approval packets[93], dated company press releases, scientific articles, and other internet searches.

For each text description, we identify a set of associated alphanumeric codes from the International Classification of Diseases, Tenth Revision (ICD-10), a classification system of diagnosis codes representing conditions and diseases, related health problems, abnormal findings, signs and symptoms, injuries, and external causes of injuries and diseases. We use online searches to identify an initial set of "likely" ICD-10 codes. We verify the accuracy of these codes using online code look-up tools, intended for hospital staff who are completing billing tasks.[94] A second researcher verified the accuracy of a random 20 percent sample of codes. We report the most granular ICD-10 code available, though it is common for analyses using ICD-10 codes to use truncated versions. Concretely, instead of using **G43.1** (Migraine with Aura), we use **G** (Diseases of the Nervous System) and **G43** (Migraine).

A.5 Distribution of Market Exclusivity

Figure A1: Market Exclusivity



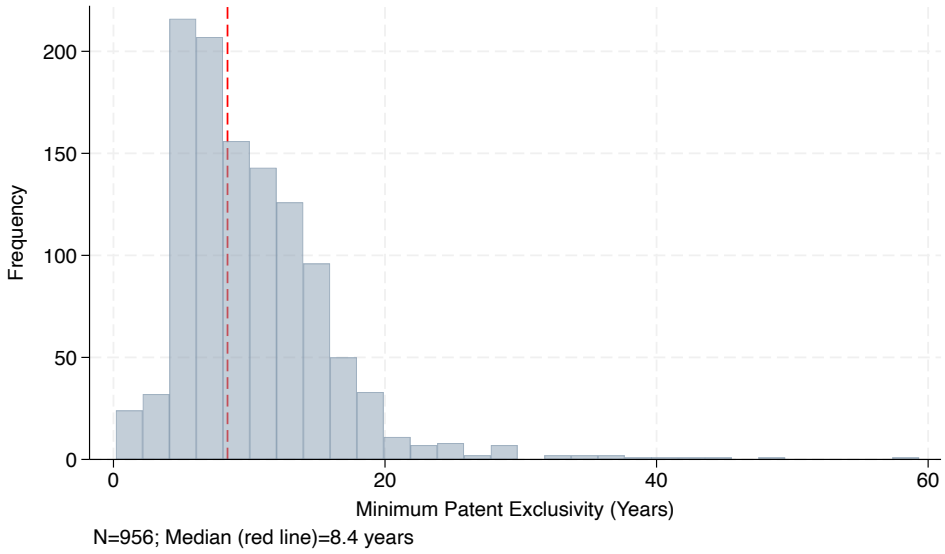
Notes: Figure is a histogram that plots the distribution of the market exclusivity measure defined in the text as the number of years between an innovator drug's initial approval and the earlier of the expiration of all patents and regulatory exclusivities and generic entry. The distribution of this measure is plotted for the sample of innovator drugs defined in Section 4.5.

[92] https://www.fda.gov/science-research/bioinformatics-tools/fdalabel-full-text-search-drug-product-labeling

[93] Drug approval records are available for many drugs beginning in 1995 through the Drugs@FDA interactive search tool: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm

[94] For example, https://icdcodelookup.com/icd-10/codes

Figure A2: Minimum Patent Exclusivity



Notes: Figure is a histogram that plots the distribution of the minimum patent exclusivity measure defined in the text as the number of years between an innovator drug's initial approval and the expiration of all regulatory exclusivities and the earliest expiring patent. The distribution of this measure is plotted for the sample of innovator drugs defined in Section 4.5.

B Additional Results

B.1 Empirical signatures

Figures 3 and 4 plot trends in the probability that an innovator drug is re-approved for a new use around market exclusivity expiration using two different samples. In Figure 3, we include each of the 990 innovator drugs in our primary sample for every year in which data are available. This means that the sample of drugs shifts across points in Figure 3. This changing sample composition generates the non-monotonic trend between $t = -20$ and $t = -15$. Consider, for instance, a drug approved in the year 2000 that receives ten years of market exclusivity, and recall that our data include observations through 2014. In Figure 3, this drug appears in the sample plotted at each point between $t = -10$ and $t = 4$. This same drug will not appear in Figure 4, as the balanced panel specifications require, respectively, ten and twenty years of data both before and after market exclusivity expiration. In this Section, we introduce two additional ways of presenting trends in the probability of re-approval, which confirm that the three empirical signatures introduced in Section 3.3 are robust to alternative cuts of our data.

First, we modify the exercise in Figure 3 to address the fact that drugs in our sample receive varying durations of market exclusivity. For each drug, we normalize market exclusivity to one

and consider trends in the likelihood of re-approval for a new use in each of five periods prior to exclusivity expiration. Under this scaling, the date of initial approval is assigned $t = -1$ and the date of market exclusivity expiration occurs at time $t = 0$.[95] We divide the period of market exclusivity into five equal intervals: $t = [-1.0, -0.8)$, $t = [-0.8, -0.6)$, $t = [-0.6, -0.4)$, $t = [-0.4, -0.2)$, and $t = [-0.2, 0)$. To facilitate comparison with Figure 3 and the three empirical signatures introduced in Section 3.3, we include an additional time period after exclusivity expiration that, for each drug, has the same duration as one of these bins (i.e., $[0, 0.2)$). For example, for a drug with twenty years of market exclusivity, each period includes four years of data; for a drug with five years of market exclusivity, each period includes one year. We thus compare trends in the likelihood of re-approval across relative phases of a drug's lifecycle rather than in calendar time.

Figure A3 plots the probability that a drug is re-approved for a new use in each of these six periods. The probability that drug is re-approved for a new use is highest in the second period (the first period that does not include initial approval), at which time nearly seven percent of drugs are re-approved at least once. The probability of re-approval declines monotonically in each subsequent period and falls below one percent in the first period after exclusivity expiration. These trends are consistent with the three empirical signatures of a missing market for new uses introduced in Section 3.3.

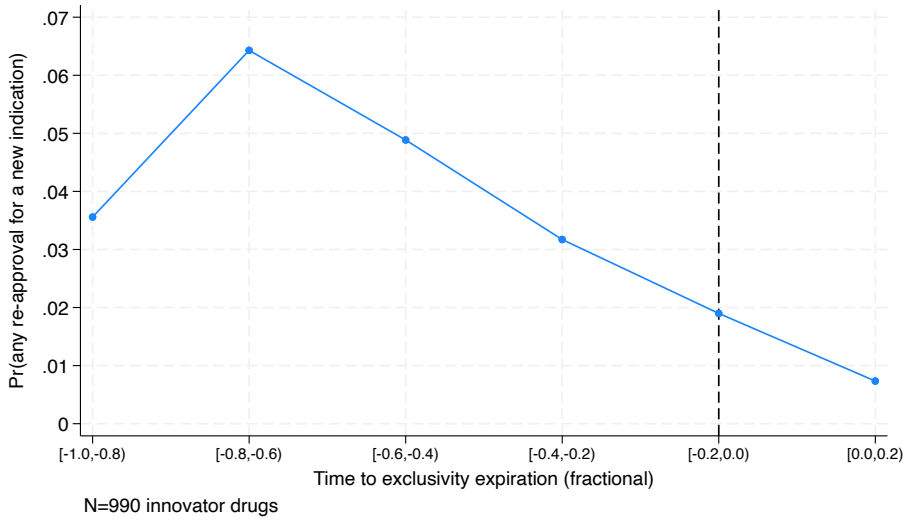
Second, we inspect trends in the probability of re-approval for a new use within cohorts of drugs that receive the same number of years of market exclusivity. Specifically, for all drugs that receive x years of market exclusivity, we plot all data prior to exclusivity expiration and include five years of data following expiration. That is, for each cohort of drugs with x years of exclusivity, we plot $t = -x$ through $t = 5$. As the median drug in our sample receives 13 years of market exclusivity and the modal drug receives 14 years, we separately consider $x = \{12, 13, 14, 15\}$. There are 59 drugs with $x = 12$, 70 drugs with $x = 13$, 120 drugs with $x = 14$, and 85 drugs with $x = 15$.

Although each of these cohorts includes at least 50 innovator drugs, it is worth emphasizing a tradeoff inherent in this style of sample restriction. We gain, with this approach, the ability to compare investments in new uses over time for drugs with identical lifecycle durations. However, we lose more than ninety percent of our sample with each of these cuts. Given that many drugs are never approved for a new use—the rationale behind the two-part model in Section 5.2—these data are likely to be quite noisy.

Nonetheless, the trends in Figure A4 for drugs with exactly $x = \{12, 13, 14, 15\}$ years of market exclusivity remain consistent with the three empirical signatures of a missing market. For each cohort, the probability that a drug is re-approved for a new use increases sharply in the years following initial approval (marked with a dotted grey line), peaks soon thereafter, then declines. In each case, the probability of re-approval for a new use falls to zero within two years of exclusivity expiration. Unsurprisingly, given the comparatively small samples, these trends are noisier than those in Figures 2, 3, and 4, but each is consistent with the idea that incentives for investment are high but declining

[95] Note that our data record the precise dates of initial approval, market exclusivity expiration, and re-approval, so we are able to construct these periods precisely.

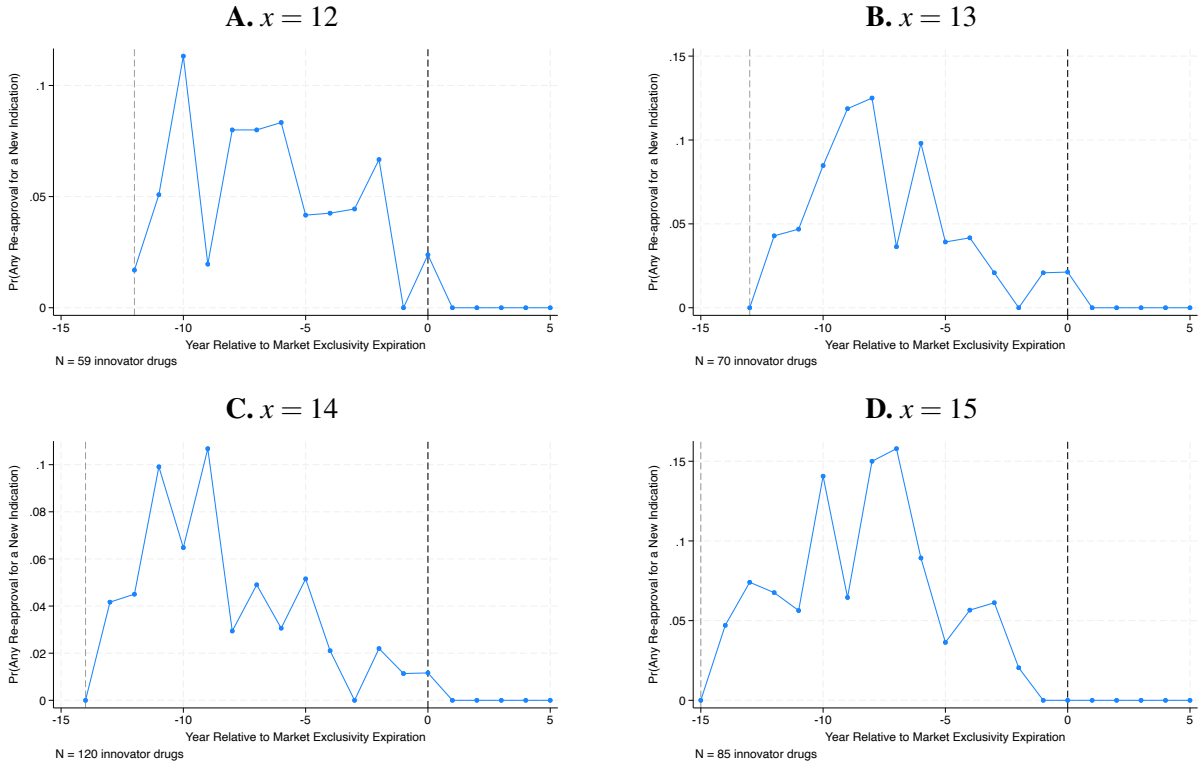
Figure A3: Fractional Exclusivity Periods



Notes: Figure plots the probability of re-approval for a new use for the sample of innovator drugs defined in Section 4.5 in each of six periods relative to market exclusivity expiration ($N = 990$). Market exclusivity expiration is defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties. We split each drug's period of market exclusivity into five periods of equal length and plot the probability of re-approval in each of these periods; we consider trends in a sixth period following exclusivity expiration, set to the same length.

prior to exclusivity expiration and zero afterward.

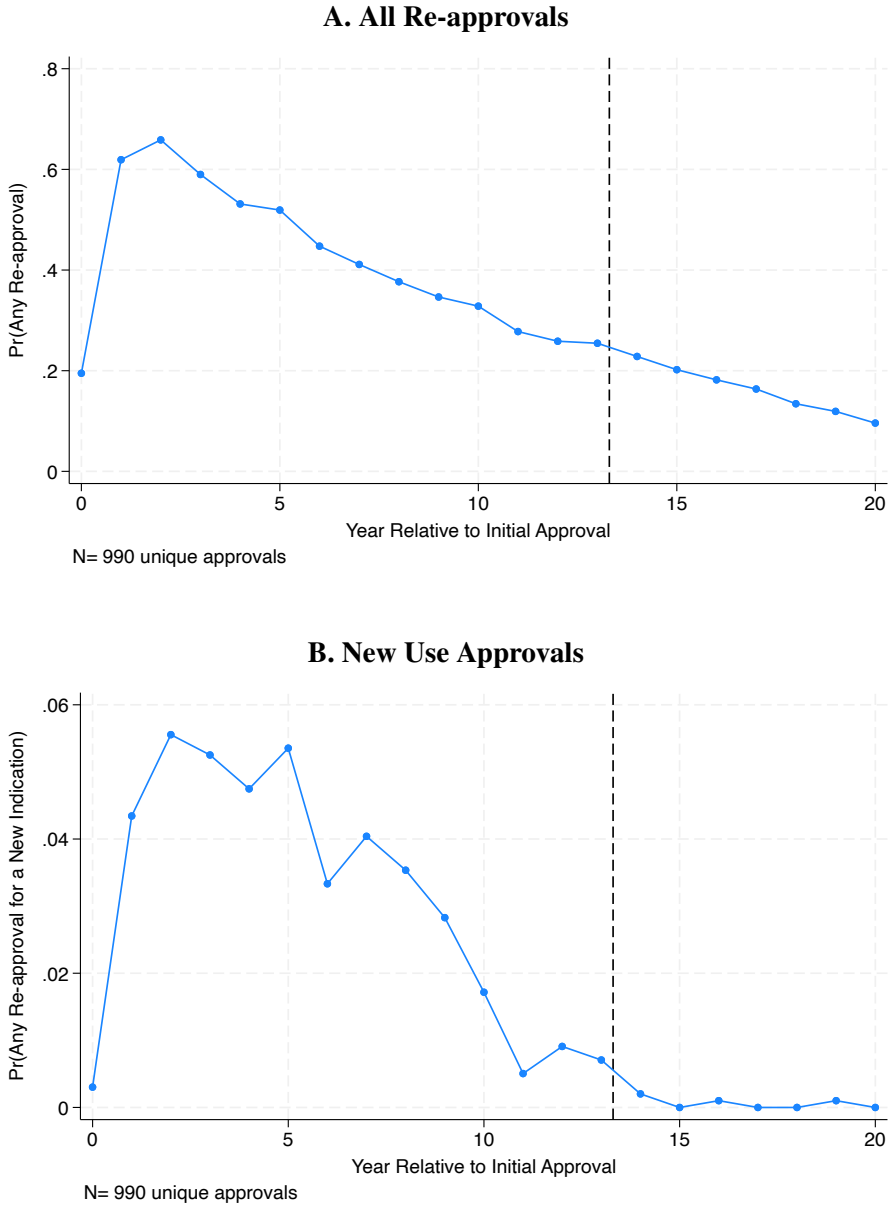
Figure A4: Exclusivity Cohorts



Notes: Panels plot the probability of re-approval for a new use for samples of innovator drugs with exactly x years of market exclusivity, where $x = \{12, 13, 14, 15\}$. Trends are relative to market exclusivity expiration, defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties. We select $x = 12, 13, 14, 15$, which capture the period around median market exclusivity (13.3 years).

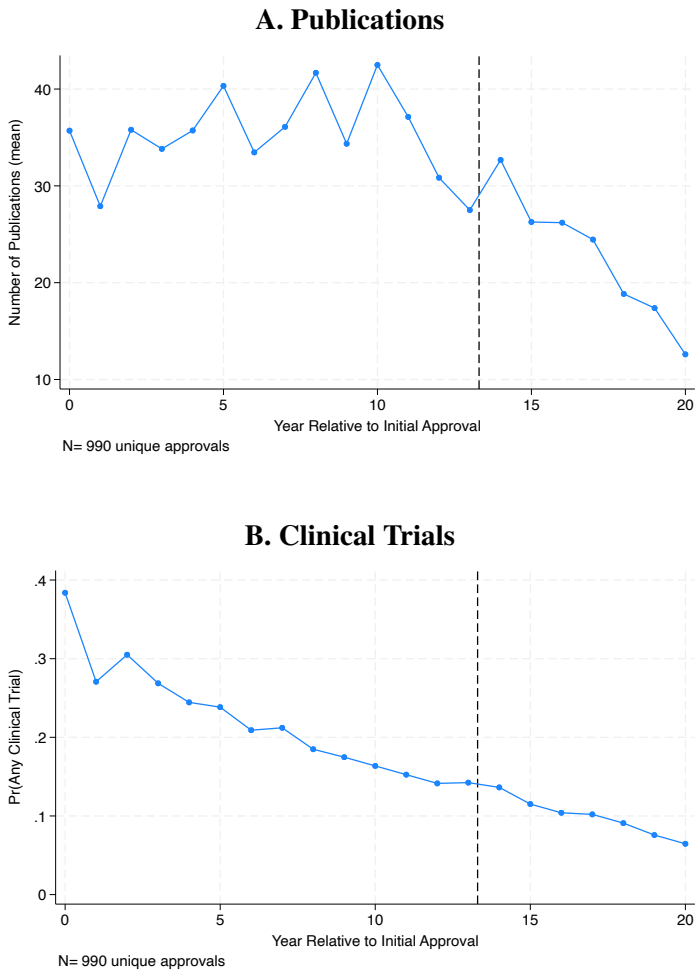
B.2 Year relative to initial approval

Figure A5: FDA Approvals Relative to Initial Approval



Notes: Panel A plots the probability of any re-approval (e.g., new use, new dosage form, etc.) for the sample of innovator drugs defined in Section 4.5 in calendar time. Panel B plots the probability of re-approval for a new use for the sample of innovator drugs defined in Section 4.5 ($N = 990$).

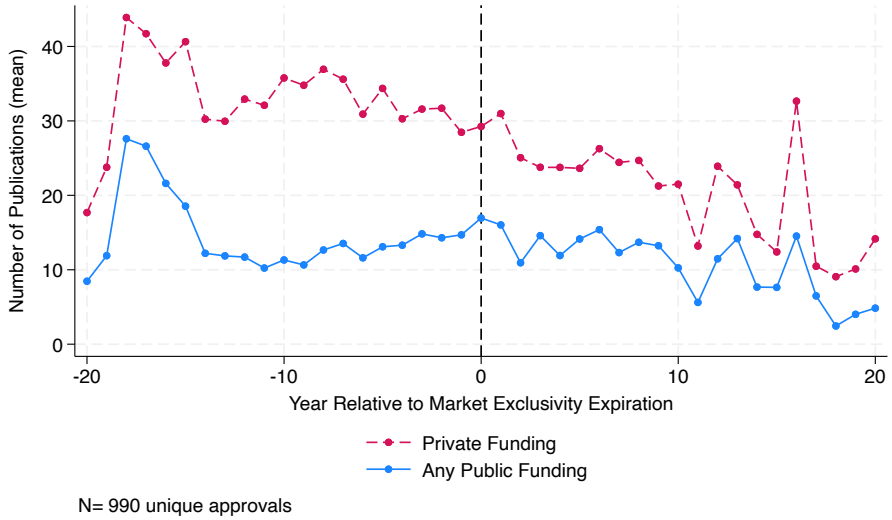
Figure A6: Research Investments Relative to Initial Approval



Notes: Panel A plots the average number of scientific publications published in each year for the sample of innovator drugs defined in Section 4.5 relative to initial approval. Panel B plots the probability of any active clinical trial in each year for the same sample of innovator drugs, also in each year relative to initial approval.

B.3 Scientific Publications

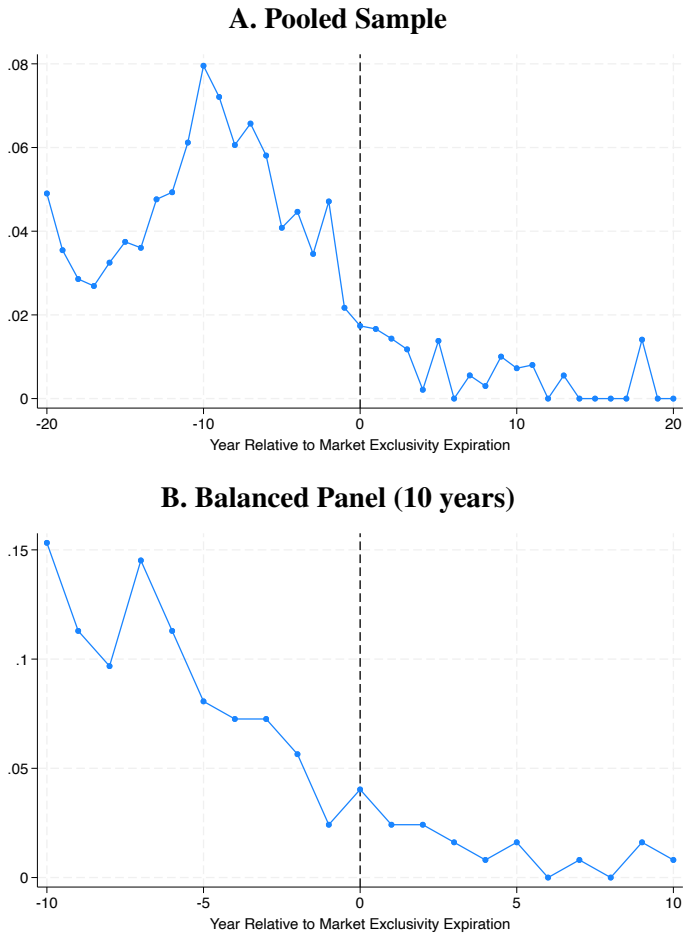
Figure A7: Scientific Publications Relative to Exclusivity Expiration



Notes: Figure plots the average number of scientific publications published in each relative year for the sample of innovator drugs defined in Section 4.5 ($N = 990$). Publication counts are plotted separately for publications that acknowledge receiving any public research support (blue solid line) and publications that do not (red dashed line). Market exclusivity expiration dates are defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties.

B.4 New use approvals associated with any NDA

Figure A8: Probability of Re-Approval (All NDAs)



Notes: Panel A plots the probability of re-approval for a new use for all active moieties associated with the sample of innovator drugs defined in Section 4.5 ($N = 990$). Panel B is a ten-year balanced panel ($N = 124$). Trends are relative to market exclusivity expiration for the innovator NDA, defined as the earlier of two events: expiration of all patents and regulatory exclusivities linked to the innovator drug in the FDA's Orange Book, or FDA approval of a generic drug with an identical set of active moieties.