

A Legislative Alternative to “No Cause” Liability in Blood Products Litigation

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Introduction

Recently, tort law commentators have discovered truth in Justice Holmes' maxim that "hard cases make bad law."¹ In particular, commentators have criticized cases in which courts have relaxed the traditional rule of causation, permitting plaintiffs to recover damages without connecting their harm to a specific defendant.² A notable example has arisen in the context of litigation involving Factor VIII concentrate, a pharmaceutical product used by hemophiliacs to replace the clotting protein missing in their blood.³

Pharmaceutical companies have manufactured Factor VIII concentrate since the 1970s, processing the pooled blood plasma of thousands of individuals.⁴ Initially, Factor VIII concentrate improved many hemophiliacs' quality of life.⁵ In the early 1980s, however, portions of the nation's blood supply, including plasma collected to process Factor VIII concentrate, became

1. See Susan R. Poulter, *Science and Toxic Torts: Is There a Rational Solution to the Problem of Causation*, 7 HIGH TECH. L.J. 189, 197 (1992); Laura A. Abrams, Comment, *The DES Dilemma: A Study in How Hard Cases Make Bad Law*, 59 U. CIN. L. REV. 489 (1990); see also James A. Henderson, Jr. & Aaron D. Twerski, *Doctrinal Collapse in Products Liability: The Empty Shell of Failure to Warn*, 65 N.Y.U. L. REV. 265, 310 (1990). In a dissenting opinion in *Northern Sec. Co. v. United States*, Justice Holmes wrote:

Great cases like hard cases make bad law. For great cases are called great, not by reason of their real importance in shaping the law of the future, but because of some accident of immediate overwhelming interest which appeals to the feelings and distorts the judgment. These immediate interests exercise a kind of hydraulic pressure which makes what previously was clear seem doubtful, and before which even well settled principles of law will bend.

193 U.S. 197, 400-01 (1904) (Holmes, J., dissenting).

2. See *supra* note 1 and articles cited therein; see also Andrew R. Klein, *Beyond DES: Rejecting the Application of Market Share Liability in Blood Products Litigation*, 68 TUL. L. REV. 883 (1994) (discussing litigation involving Factor VIII concentrate); David M. Schultz, *Market Share Liability in DES Cases: The Unwarranted Erosion of Causation in Fact*, 40 DEPAUL L. REV. 771 (1991) (discussing DES litigation); Nancy Lee Firak, *The Developing Policy Characteristics of Cause-in-Fact: Alternative Forms of Liability, Epidemiological Proof and Trans-Scientific Issues*, 63 TEMP. L.Q. 311 (1990) (discussing use of statistical probabilities to prove actual causation).

3. *Doe v. Travenol Labs., Inc.*, 698 F. Supp. 780 (D. Minn. 1988); *McKee v. Miles Labs., Inc.*, 675 F. Supp. 1060 (E.D. Ky. 1987), *aff'd*, 866 F.2d 219 (6th Cir. 1989). For a general discussion of the nature of Factor VIII concentrate and the plight of hemophiliacs, see Ron J. Perey, *Hemophiliacs, Transfusions, and AIDS*, 14 TRIAL DIPL. J. 137, 137-46 (1991).

4. Klein, *supra* note 2, at 907 & nn.126-28 (citing Perey, *supra* note 3, and various cases); see also Linda Bean, *No Class Action in Hemophilia-AIDS Suits*, N.J. L.J., May 2, 1994, at 8 (concentrate is "produced by a process that uses the blood plasma of 20,000 to 150,000 donors per batch"); Peter Finn, *Hemophiliacs with AIDS Cry Murder; Firms Blamed for HIV Infection*, Hous. Chron., Jan. 9, 1994, at 4 ("Each dose [of factor concentrate] is drawn from the pooled blood plasma of up to 20,000 people.").

5. Hemophilia treatments prior to the advent of concentrates involved whole blood transfusions, which carried a serious risk of vascular overload, or slow in-hospital infusions with "cryoprecipitate," a frozen portion of plasma rich in the Factor VIII protein. See Perey, *supra* note 3, at 141. Concentrates, however, permit hemophiliacs to quickly reconstitute the product with water and treat themselves at home. Concentrates thus "freed many [hemophiliacs] from the emergency room and lifelong struggles with pain and disability." Elizabeth Kastor, *Blood Feud: Hemophiliacs and AIDS*, WASH. POST, May 10, 1993, at B1, B6.

tainted with the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immune Deficiency Syndrome (AIDS).⁶ As a result, many hemophiliacs became infected with the deadly virus.⁷

During the past decade, HIV-infected hemophiliacs have filed an increasing number of lawsuits against Factor VIII concentrate manufacturers.⁸ Many such litigants, however, face an insurmountable hurdle to recovery because they cannot identify the manufacturer of the concentrate that caused their infection.⁹ In response to this problem, one state supreme court¹⁰ and one federal district court¹¹ have permitted hemophiliac plaintiffs to proceed on a "market share liability" theory, effectively eliminating the need for these plaintiffs to prove actual causation.¹² As this author has argued, however, the extension of market share liability to blood products litigation makes little sense. The extension threatens the availability of blood products for many hemophiliacs. It also runs counter to every state's prohibition against the

6. See Finn, *supra* note 4 (reporting that by the early 1980s, 90% of the nation's Factor VIII concentrate supply was contaminated with HIV); Bean, *supra* note 4, at 8 ("One donor with AIDS can contaminate an entire lot and infect every patient who takes the medication."); Klein, *supra* note 2, at 908.

7. See Finn, *supra* note 4 (reporting that by January 1994, 2,000 hemophiliacs in the United States had died of AIDS; 9,000 were infected with HIV); Mireya Navarro, *Hemophiliacs Demand Answers as AIDS Toll Rises*, N.Y. TIMES, May 10, 1993, at A1 (reporting that by 1985, 70% of the nation's hemophiliacs had become infected with HIV through the use of clotting factors); Linda A. Johnson, *Lawsuit: Drug Companies Negligent of AIDS Risks; Infections Could Have Been Prevented, Suit Says*, LEGAL INTELLIGENCER, April 12, 1994, at 3 (reporting that an estimated 12,000 American hemophiliacs suffer from HIV infection or AIDS); Brad Evenson, *Lack of Compensation One More Blow to a Very Sick Man*, OTTAWA CITIZEN, March 26, 1994, at B1 (reporting that approximately 45% of Canadian hemophiliacs are infected with HIV caused by "tainted blood").

8. See Finn, *supra* note 4 (discussing factor concentrate litigation and reporting class action lawsuit filed in Chicago on September 30, 1993); Johnson, *supra* note 7, at 3 (same); cf. Bean, *supra* note 4, at 8 (reporting that a Pennsylvania state court judge refused to certify class action lawsuit in factor concentrate case). Plaintiffs in factor concentrate lawsuits often assert that manufacturers acted negligently in processing the concentrate by failing to adequately warn doctors and hemophiliacs of known risks associated with concentrate and by collecting plasma from individuals at high risk for HIV infection. See Klein, *supra* note 2, at 908 (citing *Jones v. Miles Labs., Inc.*, 700 F. Supp. 1127, 1128-29 (N.D. Ga. 1988), *aff'd*, 887 F.2d 1576 (11th Cir. 1989); *McKee v. Miles Labs., Inc.*, 675 F. Supp. 1060, 1061-64 (E.D. Ky. 1987), *aff'd*, 866 F.2d 219 (6th Cir. 1989)); see also Finn, *supra* note 4; Johnson, *supra* note 7, at 3.

9. Under traditional tort theory, these plaintiffs cannot maintain a cause of action because they cannot prove cause in fact. To prove cause in fact, a plaintiff must demonstrate that his injury would not have occurred but for a specific defendant's act or omission. W. PAGE KEETON, ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 41, at 265 (5th ed. 1984). For a thorough examination of the cause in fact element in tort law, see Paul J. Zwier, "Cause in Fact" in Tort Law — A Philosophical and Historical Examination, 31 DEPAUL L. REV. 769 (1982).

10. *Smith v. Cutter Biological, Inc.*, 823 P.2d 717 (Haw. 1991).

11. *Ray v. Cutter Lab.*, 754 F. Supp. 193 (M.D. Fla. 1991).

12. Market share liability permits a plaintiff in a products liability action to recover damages against a group of defendants based on the amount of product each defendant sold in a geographic area, regardless of whether the plaintiff can connect her harm to a specific defendant's product. The theory was developed in cases involving the prescription drug diethylstilbestrol (DES). See *infra* note 16 and cases cited therein.

application of strict liability in blood litigation.¹³ Two federal district courts recently have concurred, rejecting the application of market share liability in blood products cases.¹⁴

Rejecting market share liability in blood products litigation, however, raises a troubling quandary. Innocent individuals are infected with a deadly virus and need immediate assistance. But, absent the tort system, no mechanism for compensation exists. In response to similar dilemmas, commentators and judges often have asserted that the legislative branch of government should provide relief.¹⁵ Legislation proponents, however, have been less than successful in actually formulating workable alternatives to the tort system.¹⁶

13. At the heart of this argument is the fact that Factor VIII concentrate, unlike DES, does not present a uniform risk of harm to users. All DES was chemically equivalent. Thus, the risk to every DES user was identical. Factor VIII concentrate, on the other hand, is not chemically equivalent. Rather, Factor VIII concentrate is only dangerous if it is infected with virus. Unlike DES, therefore, some concentrate presented no risk at all to users. The odds that a particular lot of concentrate was infected depended on a number of factors, including where source plasma was collected and how carefully donors were screened. See Klein, *supra* note 2, at 912-28; *infra* notes 14-15.

14. Doe v. Cutter Biological, 1994 WL 184830 (D. Idaho May 12, 1994); Kellar v. Cutter Labs., No. 88-14059-CIV-RYSKAMP, slip op. at 2 (S.D. Fla. Feb. 24, 1992). Judge Ryskamp explained:

The characteristics of the Factor VIII concentrate industry . . . make it an inappropriate one for the application of market share liability The collection of Factor VIII from pools of donors, the fact that each manufacturer retains its own manufacturing process, should make Factor VIII manufacturers liable to degrees that vary from their market share [Further,] Factor VIII, unlike asbestos or DES, is not inherently dangerous. While every exposure to either DES or asbestos is harmful, this is not necessarily the case with Factor VIII. The policy behind the market share liability principle that the manufacturer contributed to the risk of harm is therefore absent.

Id. at 9-10.

15. See Smith v. Cutter Biological, Inc., 823 P.2d 717, 736 (Haw. 1991) (Moon, J., concurring in part and dissenting in part) (disagreeing with the majority's application of "market share liability" to a blood products case because "[t]here are too many unanswered questions of social, economic, and legal import which only the legislature, with its investigative powers and procedures, can determine"); Mulcahy v. Eli Lilly & Co., 386 N.W.2d 67, 76 (Iowa 1986) ("[A]warding damages . . . by means of a court-constructed device that places liability on manufacturers who were not proved to have caused the injury involves social engineering more appropriately within the legislative domain."); Roger S. Fine, *A Personal Perspective from the "Manufacturer"*, 55 BROOK. L. REV. 899, 903 (1989) ("[L]et us go back to the days when there was a real difference between the judicial and legislative branches. When a court is faced with a problem that is a social one rather than a legal one, we defer to the legislature, which has far more flexibility and power to mold solutions that match our problems."); Stephen A. Spitz, *From Res Ipsa Loquitur to Diethylstilbestrol: The Unidentifiable Tortfeasor in California*, 65 IND. L.J. 591, 634 (1990) ("A readily apparent issue concerns the role of courts in addressing the existing harm [M]any situations are better left in the legislative domain and/or are best addressed by providing administrative remedies.").

16. Several notable attempts include the National Childhood Vaccine Injury Act of 1986, 42 U.S.C. § 300aa-1 to -34 (1988) [hereinafter NCVIA], the National Swine Flu Immunization Program of 1976, 42 U.S.C. §§ 201, 247b, and the Black Lung Benefits Act of 1972, 30 U.S.C. §§ 901-945. See generally ENTERPRISE LIABILITY FOR PERSONAL INJURY 441-86 (A.L.I. Reporters' Study 1991). Tellingly, Congress enacted these statutory schemes before the development of any new expansive tort theory in their respective subject areas. As Professor Sugarman has noted, judicial expansion of an existing tort law structure can make tort law harder to supplant: "As the system grows, the stakes increase, and these interests find more reasons to fight the displacement of tort. At the same time liberalizing tort law takes time, talent, and attention away from work on superior compensation plans."

This Article proposes an administrative scheme to compensate hemophiliacs infected with HIV through the use of blood products. The proposal is narrowly focused—it suggests replacing tort law only for hemophiliacs who would otherwise rely on expansive tort theories, such as market share liability, due to their inability to prove causation.¹⁷ At the same time, the proposal encourages claimants who can identify a culpable defendant to remain in the tort system, allowing the threat of litigation to deter negligent conduct.¹⁸ Finally, the proposal is faithful to legislative determinations that prohibit the application of strict liability to blood processors.¹⁹

More broadly, the Article challenges those who assert that discrete proposals to replace small areas of the tort system are unwise, and that only proposals for wholesale revisions of the tort system merit serious consideration.²⁰ In response, the Article provides an example of a narrow, but workable, scheme that actually can compensate a group of injured individuals, while also providing a structural model for future tort law alternatives.

Stephen D. Sugarman, *Doing Away with Tort Law*, 73 CAL. L. REV. 555, 592 (1985).

Litigation involving DES appears to prove Professor Sugarman's point. In these cases, many women developed a specific form of cancer attributable to DES taken by their mothers years earlier. Most of these young women, however, could not prove causation because they could not identify the company that manufactured the DES taken by their mothers. In several states, courts adopted a new tort theory known as market share liability, allowing DES plaintiffs to proceed without proving actual causation. See *Conley v. Boyle Drug Co.*, 570 So.2d 275 (Fla. 1990); *Hymowitz v. Eli Lilly & Co.*, 539 N.E.2d 1069 (N.Y.), *cert. denied*, 493 U.S. 944 (1989); *Martin v. Abbott Labs.*, 689 P.2d 368 (Wash. 1984); *Collins v. Eli Lilly Co.*, 342 N.W.2d 37, (Wis.), *cert. denied*, 469 U.S. 826 (1984); *Sindell v. Abbott Labs.*, 607 P.2d 924 (Cal.), *cert. denied*, 449 U.S. 912 (1980).

Despite the new theory, several commentators advocated the enactment of an administrative compensation scheme as a superior method to compensate women injured by DES. See O. Lee Reed & John L. Watkins, *Product Liability Tort Reform: The Case for Federal Action*, 63 NEB. L. REV. 389, 461-71 (1984); Schultz, *supra* note 2; Victor E. Schwartz & Liberty Mahshagian, *Failure to Identify the Defendant in Tort Law: Towards a Legislative Solution*, 73 CALIF. L. REV. 941, 941-75 (1985); Cynthia L. Chase, Note, *Market Share Liability: A Plea for Legislative Alternatives*, 1982 U. ILL. L. REV. 1003, 1003-43 (1982); Andrew B. Nace, Note, *Market Share Liability: A Current Assessment of a Decade-Old Doctrine*, 44 VAND. L. REV. 395, 436-38 (1991). However, perhaps due to the "stakes" and "interests" identified by Professor Sugarman, neither Congress nor any state legislature enacted a compensation scheme for DES victims.

17. See *infra* Part II.

18. See *infra* notes 30-31, 64, 77-86 and accompanying text.

19. The Article proposes achieving this goal through a financing mechanism that requires concentrate manufacturers to fund compensation only for individuals infected with HIV after the scientific community concluded that the virus was blood transmissible. In this way, the scheme roughly equates liability with industry culpability. In short, the goals of the compensation scheme proposed herein are: (1) the provision of a reliable source of compensation for innocent HIV-infected hemophiliacs; (2) the retention of potential tort liability to deter negligent conduct where a hemophiliac can prove that his infection is the result of a particular blood processor's conduct; and (3) the formulation of a scheme that is consistent with state prohibitions against the application of strict liability in blood litigation.

20. See *infra* note 23 and accompanying text.

II. Jurisdiction

A. *Defining the Boundaries*

As Professor Robert L. Rabin has written, “[t]he starting point in any discussion of the components of an administrative compensation scheme is the boundaries question—the determination of which claims fall within the system and which remain under the domain of tort.”²¹ This Article suggests a narrow boundaries definition: A blood products scheme should compensate claimants infected with HIV through the use of factor concentrate²² only where the claimant cannot identify the manufacturer of the concentrate that caused his harm. By limiting access in this manner, the scheme will compensate HIV-infected hemophiliacs who are unable to prove causation in a tort case, thereby removing from the tort system those cases that tempt courts to rely on expansive theories such as market share liability.

B. *Defending the Narrow Focus*

Some commentators strongly criticize proposed compensation schemes with narrow boundary definitions. These critics contend that such proposals are myopic, solving the tort system’s narrow problems while ignoring or exacerbating its broader deficiencies.²³ The hemophilia/AIDS dilemma, however, presents a situation in which a narrowly-tailored scheme makes perfect sense. As detailed below, a narrowly-focused blood products scheme

21. Robert L. Rabin, *Some Thoughts on the Efficacy of a Mass Toxics Administrative Compensation Scheme*, 52 MD. L. REV. 951, 964 (1993).

22. Most hemophiliacs use a product called Factor VIII concentrate, which replaces the Factor VIII clotting protein in their blood. A smaller number use a similar product called Factor IX concentrate. Pery, *supra* note 3, at 138; Sheryl Stolberg, *Cruel Link: Hemophilia and AIDS*, L.A. TIMES, Aug. 31, 1994, at A1; *see also* Doe v. Miles Labs., Inc., 927 F.2d 187, 189 (4th Cir. 1991) (“Factor IX products are generally produced to treat hemophiliacs with hemophilia-B, a hereditary blood clotting disorder characterized by Factor IX deficiency, but may also be used to treat rare non-hemophilia bleeding disorders.”). This Article will use the terms “factor concentrate,” “concentrate,” or simply “blood products” in reference to either product.

23. For example, Professor Sugarman has written:

[P]eople notice that tort law is not doing an adequate job on a particular issue which concerns them. They then seek various reforms without attempting to solve interrelated problems about which they may know and care little. The result, however, can be an overall pattern that looks like a crazy quilt. One steps back and asks, “why these victims and not others?”

Sugarman, *supra* note 16, at 626.

Similarly, Professor Pierce has written that various incremental changes are often inconsistent conceptually and functionally, and most are too limited in scope to offer any real promise for improving the allocation of safety-related resources Since the problems are global and are deeply embedded in the basic rules of the present legal system, the narrow scope of most studies limits their value as a basis for constructive change. Richard J. Pierce, *Encouraging Safety: The Limits of Tort Law and Government Regulation*, 33 VAND. L. REV. 1281, 1282-83 (1980).

presents a realistic opportunity to help many victims of HIV-tainted blood products. Additionally, such a scheme would limit forces that have dramatically increased the costs of non-tainted products for non-infected individuals. Finally, a narrowly-tailored scheme (in conjunction with the tort system) would allow tort law's deterrent effect to operate efficiently.

First, a narrowly-focused blood products scheme presents a realistic opportunity to help many victims of HIV-tainted blood products. Few people expect that Congress will soon enact legislation to replace broad components of the common law tort system.²⁴ Thus, large-scale reform proposals provide little promise of assistance to injured individuals who find scant relief in the current tort system. On the other hand, narrowly-tailored proposals have enjoyed at least limited legislative and social success.²⁵ These successes should be viewed, not as a "crazy quilt" of special interest concessions,²⁶ but as models of how to help individuals who face obstacles to obtaining compensation in tort.

Second, enactment of a narrowly-focused compensation scheme in the blood products area would alleviate a horribly ironic dilemma: that the litigation efforts of HIV-infected hemophiliacs have increased the economic

24. While this generalization does not prove the superiority of "small scale" schemes, it certainly helps justify serious consideration of such schemes, especially where potential claimants have nowhere else to turn. In similar contexts, others agree. For example, in discussing proposals for enterprise liability (including proposals involving administrative compensation schemes), Professors Kenneth Abraham, Robert Rabin, and Paul Weiler have written:

[W]e are aware of intriguing speculations about whether the nation would be better off dispensing with tort litigation entirely, leaving the injury field to these alternative regimes. Perhaps because of our more pragmatic bent—taking the world as it is, not as some of us might dream it should be—we did not propose such a political nonstarter. Our Study accepts the continuing reality and value of tort law—a system of civil liability, primarily shaped by judges and juries, enforced by victims themselves against enterprises responsible for their injury—as an instrument that should, and will, remain available for other kinds of injury problems not adequately dealt with in either the private marketplace or the political and regulatory arenas.

Kenneth S. Abraham et al., *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 SAN DIEGO L. REV. 333, 360 (1993). See also Robert L. Rabin, *Some Reflections on the Process of Tort Reform*, 25 SAN DIEGO L. REV. 13 (1988) (arguing that successful enactment of broad-based no-fault schemes has been dependent on a political environment in which sweeping social reform movements were proposed).

25. One example is the National Childhood Vaccine Injury Act (NCVIA), see *supra* note 16, enacted in 1986 to compensate children who suffer injurious side effects caused by childhood vaccinations. Commentators have generally praised the NCVIA for stabilizing vaccine prices and alleviating fears of vaccine shortages. See Kellen F. Cloney, Comment, *AIDS Vaccine Manufacturers v. Tort Regime: The Need for Alternatives*, 49 WASH. & LEE L. REV. 559, 596 (1992); H. William Smith III, Note, *Vaccinating AIDS Vaccine Manufacturers Against Product Liability*, 42 CASE W. RES. L. REV. 207, 228 (1992). Some individuals, however, have questioned the effectiveness of the NCVIA. See Warren E. Leary, *Panel Discounts Many Adverse Effects Tied to Childhood Vaccines*, N.Y. TIMES, July 5, 1991, at A10, cited in Rabin, *supra* note 21, at 960 n.53; Laura Mazzuca, *Shot Through with Problems: A Partial Success, Vaccine Injury Fund Faces Case Logjam, Funding Shortfalls*, BUS. INS., Aug. 24, 1992, at 1. Other examples of "narrow scope" compensation schemes include the National Swine Flu Immunization Program of 1976 and the Black Lung Benefits Act of 1972. See *supra* note 16.

26. See Sugarman, *supra* note 16, at 626.

burdens on hemophiliacs who are not infected with HIV. As the *New York Times* recently reported: "For many hemophiliacs infected with HIV, money has become a primary issue. [But] those who have not yet had symptoms of illness are struggling with another legacy of HIV—skyrocketing prices for factor that is now purified."²⁷ Actual and threatened broad-based litigation contribute to these skyrocketing prices, and these dramatic price increases have made factor concentrate effectively unavailable to many hemophiliacs who rely on the product for survival.²⁸ A narrowly-focused compensation scheme would curb this trend by removing from the tort arena the most strongly contested and expensive type of blood products lawsuits—those in which causation is unclear.²⁹

Finally, a narrowly-focused blood products scheme would allow a scaled-down litigation threat to operate as a more efficient deterrent to negligent conduct by concentrate manufacturers. By including only individuals who cannot prove causation, the scheme separates the wheat from the chaff—removing from the tort system claims that the system cannot handle well, while leaving in the tort system claims that the system can handle fairly and efficiently.³⁰ As a result, a blood products manufacturer would still need

27. Navarro, *supra* note 7, at B2. At first glance, the emergence of highly-purified factor concentrate, processed through the most sophisticated and expensive viral inactivation techniques, appears to be an indisputably positive occurrence for blood product users. See, e.g., Stolberg, *supra* note 22, at A18. Critics, however, castigate manufacturers for creating concentrate shortages by focusing production efforts on the "safest" concentrate and ceasing production of "intermediate grade" (and less expensive) concentrate. See Jeff Lyon, *A Matter of Life & Death*, CHI. TRIB., April 23, 1989, §10 (Magazine), at 17. But given current litigation threats and scientific uncertainty regarding the effects of HIV exposure on even HIV-positive hemophiliacs, economics and common sense dictate no other course. See Klein, *supra* note 2, at 920-21 & nn.191-92.

28. See Lyon, *supra* note 27, at 12 ("The average adult hemophiliac who in 1987 paid \$10,000 a year for treatment is suddenly facing annual drug bills ranging from \$60,000 to \$100,000 a year."); Navarro, *supra* note 7, at B2 (reporting that one dose of purified clotting factor can cost more than \$1000, leading to annual costs of \$50,000 to \$100,000 for some hemophiliacs); see also Diane Hirth, *Legislators Reluctant to Cover Expensive Health Measures*, ORLANDO SENTINEL, Mar. 2, 1994, at C1 (citing example of hemophiliac whose clotting factor costs are \$40,000 a year and suggesting that costs are higher for others); Johnson, *supra* note 7, at 3 (describing hemophilia as "the most financially catastrophic illness because of the exorbitant cost for clotting factor"). Litigation costs also may lead to product shortages for hemophiliacs who need factor concentrate. See Klein, *supra* note 2, at 919-21; see also Lyon, *supra* note 27 (quoting blood products industry spokesmen who attribute increased factor concentrate costs, in part, to the costs of products liability litigation).

29. The risks associated with this continued rise in product cost increase as the nation grapples with issues of health and insurance reform. For example, when the Florida legislature recently considered a proposed basic health care benefits package, it excluded coverage for blood products. A spokesman for the Florida Agency for Health Care Administration was quoted as stating: "We'd love to have everything in there, but the cost would be excessive. . . . You've got to make choices. Doing this thing was rough." Hirth, *supra* note 28, at C1.

30. Professor Sugarman recently insinuated as much by suggesting that "small injury cases" be among the first removed from the tort system. Stephen D. Sugarman, *Proposals For Reform*, 15 U. HAW. L. REV. 659, 664-65 (1993). Although Professor Sugarman focused on "small injury cases," the size of cases is only relevant because of the tort system's inability to efficiently handle that category of claims. *Id.* The same argument can be made regarding cases of indeterminate cause.

to anticipate tort liability for its own conduct; a manufacturer would not, however, need to fear tort liability based on the conduct of others.³¹

In short, a narrowly-focused compensation scheme makes good sense in the blood products realm, particularly where victims of HIV-tainted blood products cannot prove that the conduct of any particular concentrate manufacturer caused their harm. A narrowly-focused scheme presents a realistic opportunity for helping victims of HIV-tainted blood products; it limits forces contributing to the skyrocketing prices of non-tainted products; and it permits tort law's deterrent effect to operate more efficiently.

II. Financing

Once a compensation scheme establishes boundaries, it must address the issue of financing. Understandably, most schemes seek significant financing from entities that engage in activities that harm claimants.³² Compelling blood products manufacturers to fund a compensation scheme, however, raises a unique problem: Every state prohibits the imposition of liability on blood processing entities for injuries caused by blood products absent proof of negligent conduct.³³ If a compensation scheme compels financial participation from blood processors without regard to fault, the scheme risks becoming a *de facto* no fault system at odds with each state's express policy determination.³⁴

To solve this problem, this section of the Article proposes a financing mechanism that links industry funding and industry fault. The section first

31. Such a fear exists in jurisdictions that apply market share liability. This leads to a problem that some commentators describe as "overdeterrence." See Klein, *supra* note 2, at 927 n.218 (citing Keith C. Miller & John D. Hancock, *Perspectives on Market Share Liability: Time for a Reassessment*, 88 W. VA. L. REV. 81, 103 (1985)). Economists, however, would still fault the system proposed herein unless the compensation scheme required each manufacturer to contribute a sum so that "an injurer's liability to the system . . . equal[s] the total cost of the risk the injurer imposes on the affected population." Jennifer H. Arlen, *Compensation Systems and Efficient Deterrence*, 52 MD. L. REV. 1093, 1100 (1993). While this proposal might not completely satisfy an economist in this regard, the proposal would undoubtedly improve the current situation, consisting of a litigation patchwork that includes the possibility of market share liability. See, e.g., *infra* notes 77-89 and accompanying text (discussing compensation for nonpecuniary losses as a means of accounting for efficiency concerns).

32. Professor Rabin notes that "[t]ypically, a no-fault scheme is financed through charges imposed on those parties engaged in the injury-producing activity." Rabin, *supra* note 21, at 976. He points to several existing and proposed compensation schemes as examples. For instance, the NCVIA imposes an excise tax on each dose of childhood vaccine dispersed, *id.* at 958; the Superfund proposal would impose a tax on the production of toxic chemicals, crude oil, and the disposal of hazardous waste, *id.* at 961; and the Chemical Injury Liability Act (referred to by Professor Rabin as the ELI proposal) would impose a tax on chemical and petroleum production, *id.*

33. See *infra* note 36.

34. While Congress may well have the power to enact such a system, respect for such a unanimity of policy determinations dictates special concern and at least a serious effort at finding a funding solution that is consistent with these judgments. See *infra* note 127; see also *infra* Part II.A (discussing blood shield statutes and the policy behind their enactment).

discusses the need for a fault-contribution equivalency by briefly reviewing state laws that protect blood processors from no-fault liability. The section then suggests the establishment of a “presumed negligent” date, after which the scheme (for financing purposes) will assume that HIV transmission through blood products resulted from industry negligence. With the “presumed negligent” date established, the section next proposes a system of industry taxation pegged to concentrate sales and the likely date on which each claimant became infected with HIV.³⁵ Finally, the section asserts that the proposed financing scheme would promote fairness and efficiency, especially when compared to the current state of blood products tort law.

A. *Blood Shield Laws*

By either legislative enactment or judicial decision, all fifty states and the District of Columbia preclude the application of no-fault liability in blood or blood products tort litigation.³⁶ The proposed Restatement (Third) of Torts:

35. Using these mechanisms, industry taxes would fund compensation for claimants infected after the presumed negligent date. General congressional appropriations would fund compensation for claimants infected before the presumed negligent date. The industry, therefore, would provide funding only for the compensation of injuries that occurred after the earliest time at which the industry could be considered negligent for failing to warn of the risk of HIV transmission through the use of factor concentrate. See *infra* part II.B-C.

36. ALA. CODE § 7-2-314(4) (1975); ALASKA STAT. § 45.02.316(e) (1962); ARIZ. REV. STAT. ANN. § 32-1481(A)-(B) (1956); ARK. CODE ANN. §§ 20-9-802, 4-2-316(d)(i) (Michie 1987); CAL. HEALTH & SAFETY CODE § 1606 (West 1990); COLO. REV. STAT. ANN. § 13-22-104(1)-(3) (West 1989); CONN. GEN. STAT. ANN. § 19a-280 (West 1986); DEL. CODE ANN. tit. 6, § 6-2-316(5) (1974); FLA. STAT. ANN. ch. 672.316(5) (Harrison 1980); GA. CODE ANN. §§ 51-1-28(a)-(b), 11-2-316(5) (1982); HAW. REV. STAT. §§ 325-91, 327-51 (1988); IDAHO CODE § 39-3702 (1993); ILL. ANN. STAT. ch. 745, para. 40/2 (Smith-Hurd 1993); ILL. REV. STAT. ch. 745, para. 40/3 (1988); IND. CODE ANN. § 16-8-7-2(a)-(b) (Burns 1993); IOWA CODE ANN. § 142A.8 (West 1989); KAN. STAT. ANN. § 65-3701 (1992); KY. REV. STAT. ANN. § 139.125 (Baldwin 1991); LA. CIV. CODE ANN. Art. § 2322.1 (West 1979); ME. REV. STAT. ANN. tit. 11, § 2-108 (West 1993); MD. CODE ANN., HEALTH-GEN. § 18-402 (1994); MASS. GEN. LAWS ANN. ch. 106, § 2-316(5) (West 1990); MICH. COMP. LAWS ANN. § 333.9121(1)-(3) (West 1992); MISS. CODE ANN. § 41-41-1 (1972); MO. STAT. § 431.069 (Vernon 1992); MONT. CODE ANN. §§ 50-33-102, 50-33-103, 50-33-104 (1993); NEB. REV. STAT. § 71-4001 (1990); NEV. REV. STAT. ANN. § 460.010 (Michie 1991); N.H. REV. STAT. ANN. § 507.8-b (1983); N.M. STAT. ANN. § 24-10-5; N.Y. PUB. HEALTH LAW § 580.4 (McKinney 1990); N.C. GEN. STAT. § 130A-410 (1994); N.D. CENT. CODE § 41-02-33 (1981); OHIO REV. CODE ANN. § 2108.11 (Anderson 1994); OKLA. STAT. ANN. tit. 63, § 63-2151 (West 1984); OR. REV. STAT. § 97.300(1)-(2) (1993); PA. CONS. STAT. ANN. § 42-8333 (1982); R.I. GEN. LAWS § 23-17-30 (1989); S.C. CODE ANN. § 44-43-10 (Law Co-op 1985); S.D. CODIFIED LAWS ANN. § 57A-2-315.1 (1988); TENN. CODE ANN. §§ 47-2-316(5) (West 1986); TENN. CODE ANN. § 68-32-102 (1992); TEX. CIV. PRAC. & REM. CODE ANN. §§ 77.001-77.004 (West 1992); UTAH CODE ANN. § 26-31-1 (1989); VA. CODE ANN. § 32.1-297 (Michie 1991); WASH. REV. CODE ANN. § 70.54.120 (West 1992); W.VA. CODE § 16-23-1 (1991); WIS. STAT. ANN. § 146.31(1)-(3) (West 1989); WYO. STAT. § 35-5-110 (1994). Minnesota, New Jersey, and the District of Columbia are the only jurisdictions without blood shield statutes. In each jurisdiction, however, courts have refused to impose liability on blood distributors. See *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1058-60 (D.D.C. 1987), *aff'd in part and vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988); *Balkowitsch v. Minneapolis War Memorial Blood Bank, Inc.*, 132 N.W.2d 805, 810-11 (Minn. 1965); *Brody v. Overlook Hosp.*, 317 A.2d 392, 398 (N.J. Super. Ct. App. Div. 1974), *aff'd*, 322 A.2d 596 (N.J. 1975). For a brief discussion of the development of

Products Liability incorporates this overwhelming view: "A seller of human blood products or human tissue is subject to liability for harm to persons caused by product defects if, at the time of sale, the seller failed to exercise reasonable care in obtaining, processing or selling the blood product or tissue."³⁷

Courts have prohibited the application of no-fault liability to hospitals,³⁸ blood banks,³⁹ and blood processors⁴⁰ alike. In such cases, courts have recognized the need to ensure an affordable, adequate supply of blood and blood products for those who need them.⁴¹

This limitation on liability (and its underlying premise) is especially compelling in cases involving blood products users. Normally, courts and commentators justify the imposition of strict liability as a means of shifting injury costs to product sellers that can spread the costs among a large consumer base.⁴² This justification weakens when applied to blood products

blood shield statutes, see Klein, *supra* note 2, at 913-15.

37. RESTATEMENT OF TORTS (THIRD): PRODUCTS LIABILITY § 4B (Prelim. Draft No. 2, May 19, 1994).

38. See *Cutler v. Graduate Hosp.*, 717 F.Supp. 338 (E.D. Pa. 1989); *Kozup v. Georgetown University*, 663 F. Supp. 1048, 1058-59 (D.D.C. 1987) (citing *Fisher v. Sibley Memorial Hosp.*, 403 A.2d 1130 (D.C. 1979)), *vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988); *Zichichi v. Middlesex Memorial Hosp.*, 528 A.2d 805 (Conn. 1987); *Gibson v. Methodist Hosp.*, 822 S.W.2d 95 (Tex. App. 1991).

39. See *Samson v. Greenville Hosp.*, 368 S.E.2d 665 (S.C. 1988); *Shelby v. St. Luke's Episcopal Hosp.*, 1988 WL 28996 (S.D. Tex.); *Howell v. Spokane & Inland Empire Blood Bank*, 785 P.2d 815 (Wash. 1990).

40. See *Doe v. Miles Lab., Inc.*, 927 F.2d 187 (4th Cir. 1991); *Coffee v. Cutter Biological*, 809 F.2d 191 (2d Cir. 1987); *Doe v. Travenol Lab., Inc.*, 698 F. Supp. 780 (D. Minn. 1988); *Doe v. Cutter Lab., Inc.*, 703 F.Supp. 573 (N.D. Tex. 1988); *Jones v. Miles Lab., Inc.*, 705 F. Supp. 561 (N.D. Ga. 1987), *aff'd*, 887 F.2d 1576 (11th Cir. 1989); *McKee v. Miles Lab., Inc.*, 675 F. Supp. 1060 (E.D. Ky. 1987), *aff'd*, 866 F.2d 219 (6th Cir. 1989); *Rogers v. Miles Lab., Inc.*, 802 P.2d 1346 (Wash. 1991).

41. The Washington Supreme Court's recent statement is especially clear:

First, the societal need to ensure an affordable, adequate blood supply furnishes a persuasive reason for distinguishing between victims of defective blood and victims of other defective products. Second, strict liability cannot provide an incentive to promote all possible accident prevention at a time when there was no possible means of screening the blood for HIV. Third, although producers may be in a better position to spread the costs, it is not in society's best interest to have the price of a transfusion reflect its true costs.

Howell, 785 P.2d at 822. For a similar policy statement in the context of a case against a blood processor, see *Doe*, 698 F. Supp. at 782 ("Hemophiliacs . . . depend on the availability of Factor VIII Concentrate which has lengthened and improved the quality of their lives. Because the market for these products is small, their availability would be threatened if the cost of the inherent risk of HIV infection were imposed on the manufacturer [regardless of fault]."). See also COLO. REV. STAT. § 13-22-104(1) (West 1989) ("It is, therefore, the public policy of this state to promote the health and welfare of the people by . . . limiting the legal liability arising out of such scientific procedures to instances of negligence or willful misconduct."); N.D. CENT. CODE § 43-17-40 (1981) ("It is, therefore, the public policy of this state to promote the health and welfare of the people by limiting the legal liability arising out of such scientific procedures to instances of negligence or willful misconduct."); TEX. CIV. PRAC. & REM. CODE ANN. § 77.002 (West 1986) ("It is therefore the public policy of this state to promote the health and welfare of the people by limiting the legal liability arising from those scientific procedures to instances of negligence.").

42. See, e.g., GUIDO CALABRESI, THE COSTS OF ACCIDENTS 39-40 (1970).

manufacturers because the number of hemophiliacs (who would bear the greatest portion of costs) is extremely small.⁴³ With a very small consumer base over which to spread costs, the imposition of strict liability would pose a serious threat to the availability of factor concentrate due to increased cost or reduced production—a potentially deadly situation to people who rely on blood products to survive. As the Washington Supreme Court recently explained: “It would be unrealistic to expect such a small number of hemophiliacs to be able efficiently to spread the costs associated with liability insurance The end result for [factor concentrate] would be that the product would not be available to those who need it.”⁴⁴

B. *Contribution and Fault*

Thus, to promote the welfare of all hemophiliacs, a compensation scheme should avoid imposing a form of strict liability on blood products manufacturers. Instead, a compensation scheme should attempt to link financial responsibility with culpability in obtaining industry funding.

To achieve this goal, the level of industry funding should correlate with the cost of compensating those claimants infected with HIV from concentrate after April 1984—the time when the scientific community reached a consensus that HIV was blood transmissible.⁴⁵ The scheme thereby links culpability⁴⁶ and responsibility: The blood products industry will compensate only individuals infected with HIV after the earliest possible time the industry could be considered negligent for a failure to warn of the HIV risk associated with factor concentrate.⁴⁷ For compensation of claimants infected through the use

43. Klein, *supra* note 2, at 917 & nn.178-79.

44. *Rogers v. Miles Lab., Inc.*, 802 P.2d 1346, 1351-52 (Wash. 1991). See Klein, *supra* note 2, at 917 & n.179.

45. See *Doe v. Miles Lab., Inc.*, 927 F.2d 187, 190, 192 (4th Cir. 1991); *Kirkendall v. Harbor Ins. Co.*, 887 F.2d 857, 860 (8th Cir. 1989); *McKee v. Miles Lab., Inc.*, 866 F.2d 219, 224 (6th Cir. 1989); *Kozup v. Georgetown Univ.*, 663 F. Supp. 1048, 1052 (D.D.C. 1987), *vacated in part on other grounds*, 851 F.2d 437 (D.C. Cir. 1988).

46. This is true where the “culpability” is associated with a factor concentrate. The “culpability” meant here is that associated with a factor concentrate manufacturer’s failure to warn of the risk of HIV transmission or its failure to screen plasma donors adequately for signs that they might carry HIV. This “culpability” is not based on manufacturers’ alleged negligence in failing to develop processing techniques that inactivate HIV in blood products. This proposal’s failure to account for allegations of manufacturing negligence is purposeful. Considering that aspect of the problem would require individualized fact finding regarding the actions of each manufacturer at many possible times. Such fact finding would inevitably be complicated and adversarial, defeating the scheme’s goal of quickly compensating HIV-infected hemophiliacs. Cf. Schwartz & Mahshagian, *supra* note 16, at 970-71 (suggesting that industry contribution to legislative fund in DES realm relate to factors such as share of market and degree of culpability).

47. Some individuals have argued that the industry should have warned factor concentrate users of the risk of HIV transmission as early as 1982. See *Moore v. Armour Pharmaceutical Co.*, 1990 WL 369571 at *3 (M.D. Fla.); see also *United Blood Serv. v. Quintana*, 827 P.2d 509, 512 (Colo. 1992) (citing affidavit of AIDS Clinical Research Center doctor stating that “as of January 1983 there was ample evidence available to the medical community . . . that the AIDS virus was transmissible in blood

of concentrate before April 1984, Congress should provide funding from general revenue.⁴⁸

C. *Fact Finding*

The implementation of a financing allocation based on a likely date of infection (LDI) would require a fact finder to consider each claimant's history of blood product use.⁴⁹ Admittedly, gathering and evaluating such information would diminish a scheme's ability to handle claims quickly. Several fact finding methods, however, could minimize administrative delays.

One way that scheme administrators could collect information relevant to a LDI determination would be to require that claimants provide administrators with all information necessary to the determination. Under this approach, claimants would provide scheme administrators with information concerning their product use history and scientific or medical documentation concerning conclusions to be drawn from such information.⁵⁰ Placing full responsibility on claimants, however, would greatly increase the cost of access to the system. It also might inhibit the system's ability to develop internal consistency in handling similarly-situated claimants—particularly if different experts found varying LDIs based on similar product usage records.⁵¹

and blood products," and that hemophiliacs were among the highest risk groups for AIDS). Courts, however, have rejected such arguments. *See Doe*, 927 F.2d at 194; *see also Kozup*, 663 F. Supp. at 1054. *But see Walls v. Armour Pharmaceutical Co.*, 832 F. Supp. 1505, 1518-19 (M.D. Fla. 1993) ("[P]laintiff presented the jury with numerous documents generated between July 1982 and July 1983 reflecting [a concentrate manufacturer's] growing knowledge that hemophiliacs using concentrate were being diagnosed with AIDS and that a blood borne, transmissible agent was spreading the disease via concentrate products produced from pools of plasma drawn from thousands of unscreened donors.").

48. This suggestion does not open the scheme to attack as a proposal for ever-increasing federal spending. It is unfortunate but obvious that the pool of claimants infected with HIV by factor concentrate before 1984 will gradually diminish. Thus, the "general funds" portion of the compensation fund also will gradually diminish. Ultimately, industry contribution will fund the entire scheme. Division of responsibility is not entirely untested. For example, Congress similarly designed the NCVIA to split financing based on product usage date along such lines. Under the NCVIA, general congressional appropriations fund compensation for injuries caused by pre-1988 vaccinations. An excise tax on vaccine manufacturers funds compensation for injuries caused by post-1988 vaccinations. 42 U.S.C. §§ 4131-4132 (1988). *See Cloney, supra* note 25, at 595 n.23.

49. Most hemophiliacs use concentrates over the course of a lifetime, including (for those alive at the time) dates before and after the "presumed negligent" date. Scheme administrators, therefore, must determine when each claimant used the concentrate that caused his HIV infection. The problem is more complicated in the blood products setting than it is in the vaccine setting because individuals use vaccines during a very confined time period.

50. A medical specialist would likely need to certify these conclusions. Requiring individualized determinations, however, could raise issues of scientific credibility and consistency—the very issues that plague product liability litigation and the very issues that an administrative compensation scheme should seek to avoid.

51. Allowing interested parties, such as manufacturers, to challenge individual findings would not solve this problem. Rather, allowing such parties to dispute individual claims would simply import litigation's inefficiencies into the administrative scheme.

A superior method for ascertaining LDIs would begin with Congress commissioning a study to create a table establishing uniform LDIs based on the quantity of concentrate used by a claimant and the dates on which the concentrate was used. For example, heavy product use during the years before the "presumed negligent" date would likely lead to a LDI prior to April 1984. Conversely, a small amount of product use before the presumed negligent date and heavy use thereafter might lead to an opposite conclusion. With such a table established, the scheme would require claimants to provide only documentation of product use history.⁵² Scheme administrators would then compare such documentation with the uniform table to determine LDI.

While the development of such a table might increase the scheme's implementation costs, it invariably would save money in the long term, particularly when compared to litigation in which LDI often becomes a highly contested issue.⁵³ Additionally, the establishment of a table would improve the scheme's ability to maintain internal consistency. This, in turn, would allow attorneys to give better advice to infected hemophiliacs. It also would allow Congress to set appropriation and taxation levels with more confidence.⁵⁴ Controversy associated with LDI determinations will, of course, diminish over time, as an increasing majority of claimants will have received concentrate only after 1984.

D. Collection Methodology

After determining which claimants should receive compensation from revenue generated by a blood products tax, a scheme must establish a method for collecting such revenue. Kenneth Abraham has described two methods through which compensation schemes can collect revenue from risk-creating entities: (1) quantity-based charges and (2) quality-based assessments "supplemented by experience-rating that would vary assessments in accordance with the number of injuries clearly caused by an enterprise's activities."⁵⁵

52. In helping determine the funding source of each claim, a LDI table would serve a purpose similar to that of the NCVIA's Vaccine Injury Table. See 42 U.S.C. § 300aa-14(a) (providing "a table of vaccines, the injuries . . . resulting from the administration of such vaccines, and the time period in which the first symptom . . . is to occur after vaccine administration for purposes of receiving compensation under the Program").

53. LDI is a highly contested issue in factor concentrate litigation because it is important for a plaintiff to prove that a manufacturer's negligence caused his infection. If a manufacturer can show that a plaintiff was infected with HIV from concentrate sold before the mid-1980s, then it can likely show that the plaintiff's injury was not caused by its negligence. See *supra* notes 45-47 and accompanying text. If a plaintiff can show an LDI after the mid-1980s, however, the opposite is likely true.

54. A third option might require that an expert panel of scientists consider the product use history of each individual claimant. This option, however, would increase costs and would not be likely to improve the scheme's efficiency or consistency.

55. Kenneth S. Abraham, *Individual Action and Collective Responsibility: The Dilemma of Mass Tort Reform*, 73 VA. L. REV. 845, 890 (1987).

This Article suggests that Congress adopt a quantity-based approach, imposing a tax on the sale of factor concentrate to fund the compensation of hemophiliacs infected with HIV from blood products after April 1984.⁵⁶

The primary benefit of a quantity-based assessment is its simplicity of administration,⁵⁷ no minor point given the LDI complexities already included in this proposal. The use of a quantity-based assessment also avoids the difficult issue of how to “experience-rate” a competitive pharmaceutical market in which each industry member uses proprietary production techniques.⁵⁸

A major criticism of quantity-based charges (and the primary reason that some commentators support quality-based assessments) is that quantity-based charges do little to deter negligent conduct or to increase the safety of risk-producing activities.⁵⁹ Some commentators doubt the validity of this criticism.⁶⁰ Even these scholars, however, suggest that “[f]airness considerations serve as an alternative rationale for creating as close a linkage

56. This suggestion is modeled on the NCVIA, which is partially financed through an excise tax on each dose of vaccine disbursed. 26 U.S.C. §§ 4131, 9510 (1988). See *supra* note 48 (describing NCVIA funding scheme). Proposals to compensate individuals injured through exposure to toxic substances have also suggested quantity-based funding from risk-creating entities. See Jeffrey Trauberman, *Statutory Reform of “Toxic Torts”: Relieving Legal, Scientific, and Economic Burdens on the Chemical Victim*, 7 HARV. ENVTL. L. REV. 177, 270, 272-77 (1983) (Proposed Chemical Injury Liability Act §§ 208, 211, 212); Rabin, *supra* note 21, at 961 & n.58 (citing Superfund proposal for taxing petroleum and chemical production and hazardous waste disposal). Cf. Price-Anderson Act, 42 U.S.C. §§ 2210(b),(e) (1988 & Supp. V 1993) (financing nuclear power plant accident compensation by requiring each nuclear licensee to purchase private liability insurance and contribute to a common compensation fund in the event of a nuclear accident at any plant); Rabin, *supra* note 21, at 955 (discussing same).

57. See Abraham, *supra* note 55, at 890-91. Law and economics scholars argue that increased administrative costs do not alone justify the avoidance of experience rating contributions to compensation schemes. Rather, such scholars assert that a risk-benefit analysis should drive a scheme’s funding methodology. See Arlen, *supra* note 31, at 1099.

58. See *Kellar v. Cutter Lab.*, No. 88-14059-CIV-RYSKAMP, slip op. at 9 (S.D. Fla. Feb. 24, 1992); *Doe v. Cutter Biological*, 852 F. Supp. 909, 913 (D. Idaho 1994) (holding use of market share liability inappropriate for blood products due to varying production processes). The blood products market contrasts with that for childhood vaccines, where most manufacturers have monopolies on the particular vaccine they manufacture. See Rabin, *supra* note 21, at 958.

59. See Arlen, *supra* note 31, at 1099 (advocating “experience rating” in schemes designed to compensate victims of toxic hazards to make each injurer more directly bear the costs of the risks created); see also Abraham, *supra* note 55, at 890 (arguing that quantity-based charges might have “no effect on the level of safety at which the activities using these substances were conducted, because the charges levied would not vary with these levels of safety”).

60. See Rabin, *supra* note 21, at 977 (“From a deterrence standpoint, it is far from clear that the choice between a flat-tax and a risk-sensitive schedule of charges makes any substantial difference.”); cf. Abraham, *supra* note 55, at 891 (“[T]he shift to funds financed by these enterprises would neither sacrifice the incentive-creating capacity of the mass tort system nor increase it substantially.”). In addition, it is arguable that blood shield statutes demonstrate legislative determinations that efficiency should not assume a primary role in imposing liability on blood processors. Indeed, if efficient deterrence is understood as making an injurer’s expected liability equal to the total expected cost of risk imposed on others, see Arlen, *supra* note 31, at 1097, the blood shield statutes must serve some other purpose. Therefore, arguments for elevating efficient deterrence to the level of a primary goal in other compensation scheme contexts, see *id.* at 1104-05, might not be persuasive in the blood products realm.

as possible between risk-producing activities and financial responsibility for consequences."⁶¹

Several factors diminish these concerns in the factor concentrate area. First, the blood products industry has developed processing techniques that have significantly reduced concentrates' viral risks.⁶² Therefore, the need for safety improvements is not as pressing for blood products as it is for other products, such as toxic chemicals. Second, this proposal's narrow scope (and concurrent retention of the tort system) itself creates a deterrent against negligent conduct. More precisely, if one blood processor fails to observe the new industry standard, that failure likely would allow an HIV-infected hemophiliac to connect his infection to that particular processor's product. Proof of causation and negligence then would allow a plaintiff to obtain compensatory (and perhaps punitive) damages in the tort system, a result that any rational manufacturer would seek to avoid. Finally, removing difficult causation cases from the tort system surely will promote fairness and efficiency by reducing litigation costs associated with attempts to prove (or disprove) causation. Removing difficult cases from the tort system also should reduce discovery costs, expert witness fees in individual cases, and the lost value of time between the filing of a lawsuit and the actual receipt of a damage award, if one is forthcoming at all.⁶³

In sum, money from both general appropriations and a quantity-based excise tax should fund a blood products compensation scheme. The excise tax funds should provide money to compensate individuals infected with HIV from concentrate used before April 1984. General funds should compensate individuals infected with HIV from concentrate used after that date. This system will allow a compensation scheme to avoid conflict with blood shield laws. At the same time, the system will provide a fair and efficient mechanism through which many HIV-infected hemophiliacs can receive compensation for their injuries.

61. Rabin, *supra* note 21, at 977.

62. See Stolberg, *supra* note 22, at A19.

63. See Gary T. Schwartz, *The A.L.I. Reporters' Study*, 15 U. HAW. L. REV. 529, 537 (1993) (estimating that for every dollar that comes into the tort system, only forty or fifty cents ends up compensating injured victims); Sugarman, *supra* note 16, at 598-603 (discussing enormous transaction costs involved in Agent Orange, Bendectin, IUD, and asbestos litigation). Professor Schwartz states: Now if tort law is regarded as a device for achieving either deterrence or fairness, that 50 percent overhead may not be all that troubling. Tort law may be succeeding in preventing large numbers of terrible accidents; or, tort law might be keenly valuable as a way of achieving fairness. But when tort law is considered from the perspective of efficiently compensating accident victims, its very high overhead becomes quite hard to justify.

Schwartz, *supra*, at 537.

III. Compensation

An administrative compensation scheme's ultimate success lies in the method by which it compensates claimants. As Professor Abraham has written: "In a very real sense the measure of compensation adopted by a fund would be the key to its feasibility, because the cost of compensating victims through a fund inevitably would be a prime issue in evaluating the proposals for establishing it."⁶⁴

A blood products compensation scheme should fully compensate claimants for medical expenses and lost income attributable to HIV infection. The scheme also should award each HIV-infected claimant a fixed sum as compensation for pain and suffering. Finally, the scheme should provide for the recovery of reasonable attorneys' fees and expenses.⁶⁵

As detailed below, providing recovery in this manner will help the scheme serve several of its goals. First, the scheme will quickly compensate HIV-infected hemophiliacs for actual damages associated with HIV infection. Second, the scheme will promote efficiency in a way that does not discourage the production of affordable blood products. Third, the scheme will encourage claimants who can prove the traditional tort elements of duty, breach, and causation to seek recovery through the tort system rather than through the administrative process.

A. *Medical Expenses and Lost Income*

A blood products compensation scheme should fully compensate claimants for medical expenses and lost income attributable to HIV infection.⁶⁶ To facilitate such compensation, the scheme should require claimants to provide administrators with documentation of such loss when filing an initial petition.⁶⁷

The scheme should pattern its filing procedures on those of the NCVIA. Under the NCVIA, a claimant files a petition with the United States Court of Federal Claims.⁶⁸ The clerk of the court then forwards the petition to a chief

64. Abraham, *supra* note 55, at 894.

65. The proposal would not allow punitive damage awards. *See infra* note 89.

66. Such compensation should be provided to hemophiliac claimants or, if the claimant has died, to family members in the form of a death benefit. *Cf.* 42 U.S.C. § 300aa-15(a) (1988) (NCVIA provision on compensation).

67. Therefore, a claimant's initial petition will provide documentation of product use, *see supra* notes 52-53 and accompanying text, and information regarding medical costs and lost income attributable to HIV infection. While compiling such information will require effort, it is effort that would also be expended in prosecuting a tort claim. Thus, requiring a claimant to provide such information does not conflict with the scheme's goal of increasing the speed at which injured claimants can be compensated.

68. 42 U.S.C. § 300aa-11(a)(1) (1988). *See* Charles F. Hagan, *Vaccine Compensation Schemes*, 45 FOOD DRUG COSM. L.J. 477, 481 (1990).

special master for assignment to a special master. The special master reviews the claimant's documentation and returns to the court proposed findings of fact and conclusions of law.⁶⁹ Under a similar blood products process, the clerk also would assume responsibility for reviewing a claimant's product use information and recommending a LDI based on the table described above.⁷⁰

After the special master forwarded her findings, the court of claims would have the information necessary to make a compensation award and to establish a LDI for the purpose of determining funding allocation. e whether the claimant will be paid out of industry contributions or general funds.⁷¹ Within a reasonable time,⁷² therefore, the court would issue a ruling stating a measure of HIV-related damages and a LDI.⁷³

As with the NCVIA, a blood products scheme should restrict a claimant's ability to appeal these rulings. The scheme could allow a claimant to seek de novo review of the special master's damages determination from the court of claims. The scheme also could allow claimants to appeal the court of claims' decision to a federal appeals court.⁷⁴ Unlike the NCVIA, however, a blood products scheme should provide claimants no opportunity to rebuke the ultimate conclusion and file a tort claim.⁷⁵

In sum, a blood products compensation scheme should provide claimants with full compensation for medical expenses and lost income attributable to their HIV infection. Such an award would provide money to HIV-infected hemophiliacs who desperately need funds to pay medical and living expenses. Even with limited procedures for reviews and appeals, the process surely will move more quickly than a lawsuit involving disputes over negligence and causation.

B. *Pain and Suffering*

A more difficult compensation issue involves awards for nonpecuniary damages, such as pain and suffering. The provision of some recovery for nonpecuniary loss deserves serious consideration because such awards could

69. 42 U.S.C. § 300aa-12 (1988). Under the NCVIA, a petitioner may object to such findings, and the court will conduct a de novo review of the special master's findings. *Id.* Petitioners can appeal the court's ultimate determination to the United States Court of Appeals for the Federal Circuit. *Id.* § 300aa-12(f).

70. See *supra* notes 52-54 and accompanying text.

71. Ultimately, the special master or the court also will have to review a fee petition. See *infra* Part III.C.

72. The NCVIA requires the court of claims to render judgment within 365 days after the filing of a petition. 42 U.S.C. § 300aa-12 (1988).

73. The LDI finding will determine the funding source for the claimant's compensation. See *supra* Part II.B.

74. See *supra* note 70.

75. See *infra* notes 102-04, 113-17 and accompanying text.

improve the scheme's ability to deter risk-causing activity by the blood processing industry.⁷⁶ This is especially important since the proposed scheme already protects the industry from financial responsibility for a defined portion of claims.⁷⁷

Nonpecuniary damage awards, however, raise significant concerns. First, the inclusion of nonpecuniary awards would increase the need for individualized fact discovery, diminishing the scheme's ability to provide compensation quickly. Further, the amorphous nature of such awards would likely increase claimants' requests for reviews and appeals.⁷⁸ As Professor Abraham has noted in considering compensation alternatives to mass tort litigation: "The availability of pain and suffering damages from a fund might complicate (or bankrupt) it to the point of failure."⁷⁹

Professor Abraham, however, has identified several responses that could limit such complications while ensuring that risk creators bear a greater share of the costs associated with their activities.⁸⁰ One of Professor Abraham's responses (the provision of fixed, scheduled death benefits keyed to normal life expectancy) could be modified to work in the blood products realm.⁸¹ Such a modification could provide for a fixed award (either a lump sum or a

76. Professor Arlen, for example, criticizes Professor Rabin's proposed toxics administrative compensation scheme because Professor Rabin would exclude nonpecuniary loss from his system. Arlen, *supra* note 31, at 1099-1100. Professor Arlen states that while "[s]uch a limitation appears to promote efficient risk-spreading by victims, [e]conomic analysis of insurance reveals that rational individuals do not fully insure against all pecuniary and nonpecuniary losses associated with injury (or death). Thus, full compensation recovery exceeds the recovery level that permits victims to spread risk efficiently." *Id.* at 1100-01. Professor Arlen, therefore, suggests that Professor Rabin could improve his proposal by requiring each risk creator to pay an amount into a general fund that would include the risk of causing nonpecuniary damages. *Id.* at 1102.

77. The proposal excludes the industry from contributing to the compensation of claimants infected with HIV before April 1984. *See supra* Part II.B. Some might argue that this exclusion prevents efficient deterrence. Without full cost internalization, it could be argued, an injurer's actual costs will never equal the true costs of its activities. The injurer, therefore, might conduct its activities without an adequate level of care. *See Arlen, supra* note 31, at 1097.

78. For similar reasons, Professor Abraham is skeptical of compensation schemes that allow recovery for pain and suffering: "A fund almost certainly would have to deny compensation for such intangible losses, because the limitation of recovery to more objectively provable out-of-pocket losses would be necessary both to avoid disputes not easily resolved without fact-finding proceedings and to limit the total cost of providing compensation." Abraham, *supra* note 55, at 894-95.

79. *Id.* at 895. The Superfund Report, for example, proposes a compensation scheme that would not allow any recovery for pain and suffering damages. *See Rabin, supra* note 21, at 961 & n.63.

80. Abraham, *supra* note 55, at 895-96.

81. *Id.* *See also* Trauberman, *supra* note 57, at 277-78 (proposing section of Chemical Injury Liability Act that would include an "annual hazard fee" to approximate risk-generating characteristics of substances produced by entities contributing to funding); Rabin, *supra* note 21, at 961. Another of Professor Abraham's proposed responses would be the creation of a new form of quasi-subrogation action. "[T]his cause of action could be allowed against a particular enterprise only under circumstances where an award of punitive damages would have been available had individual tort claims for compensatory damages not been foreclosed by the adoption of the fund." Abraham, *supra* note 55, at 896. A similar action would not work well in this proposed scheme because claimants cannot prove actual causation and, therefore, could not argue that punitive damages would deter the willful or reckless conduct of any particular entity. *See infra* note 89.

lifetime annuity) to approximate nonpecuniary damages for each claimant. The provision of a fixed award would alleviate concerns that the scheme does not force potential injurers to internalize the true costs of their activities. At the same time, the scheme could administer such awards without a serious loss of operational efficiency.

The use of a lump sum payment to compensate HIV-infected hemophiliacs also has precedent: In Canada, the federal government has offered uniform payments to HIV-infected hemophiliacs if recipients agree to forgo lawsuits against the federal and provincial governments, hospitals, the Red Cross, factor concentrate manufacturers, and insurance companies.⁸² As of March 1994, reports indicate that the program will include a \$22,000 up-front payment; annual payments of \$30,000 to infected persons for life; \$20,000 a year to surviving spouses for five years; and \$4000 a year to each surviving dependent child for five years.⁸³

Combining Professor Abraham's proposal with the Canadian system, a blood products scheme could award each claimant a fixed payment as rough compensation for pain and suffering.⁸⁴ The amount of the lump sum payment would be based on the amount of funding that Congress makes available for the program. However, Congress should set the amount lower than an average tort award to avoid making the scheme an attractive haven for those who can prove causation in the tort system.⁸⁵

In short, this Article suggests a compromise solution to the problem of compensating HIV-infected hemophiliacs for nonpecuniary damages: the provision of a uniform payment to each claimant, either through a lump sum

82. See Clyde F. Farnsworth, *Canadian Hemophiliacs Face AIDS*, N.Y. TIMES, May 1, 1994, at 9; Rebecca Wigod, *Tainted Blood Victims Advised Not to Consider Filing Lawsuits*, VANCOUVER SUN, Mar. 15, 1994, at B4.

83. Wigod, *supra* note 83, at B4. In Canada, the national government has public health responsibility for regulating blood (which is considered a drug under Canadian law) and is subject to liability for negligence in exercising its responsibility. The Canadian government faced a serious problem when it learned that forty-seven percent of all Canadian hemophiliacs were infected with HIV prior to 1985. There are an estimated 1,000 Canadians who contracted AIDS through blood products. In addition, blood transfusion recipients still face an estimated 1 in 50,000 chance of HIV infection, based on the possibility of a plasma donor being infected with HIV but not yet having developed the HIV antibody that screening mechanisms detect. Farnsworth, *supra* note 83, at 9.

84. Unlike the Canadian system, this proposal suggests no continuing survivor payments. Rather, lost income payments would help compensate spouses and dependents for actual losses.

85. In addition, providing uniform payments for blood products injuries makes more sense than in other realms (such as toxic-related injuries). Although pain and suffering is certainly an individualized concept, each claimant in a blood products scheme will have the same injury (HIV infection and ultimately AIDS) instead of a wide variety of injuries (for example, toxic exposure could lead injuries ranging from minor irritations to fatal cancer). Further, a lump sum payment would alleviate concerns of severe undercompensation that might arise if payments were made on an annual basis until death. Cf. Keith M. Garza, *Administrative No-Fault Recovery For Transfusion-Related HIV Infection*, 1993 DEF. COUN. J. 384, 388-89. In this respect, claimants who happen to enter the system when they are suffering from more developed effects of HIV infection will receive the same compensation as those in the earlier stages of the disease.

or a lifetime annuity. This compromise serves all three of the goals identified at the outset of this section. First, it helps the scheme provide claimants with compensation quickly by reducing the need for individualized fact discovery. Second, it promotes efficiency by forcing entities that contribute to the fund to internalize a truer measure of their activities' risks.⁸⁶ Third, it encourages claimants who can prove the traditional tort elements of duty, breach, and causation to seek compensation through the tort system rather than through the administrative scheme.⁸⁷

C. Fees and Expenses

An additional goal of a blood products compensation scheme should be to reduce the noncompensatory expenses that plague tort litigation.⁸⁸ The provision of some fee and expense restrictions within a scheme would serve this goal. A compensation scheme, however, must be cautious in limiting the recovery of fees and expenses to avoid discouraging attorneys from representing claimants in the process.⁸⁹ To control costs and to encourage representation, a blood products compensation scheme should adopt a fee recovery provision similar to that set forth in the NCVIA. The scheme also should adopt judicial interpretations of the NCVIA section regarding the calculation of attorneys' fees.⁹⁰

The NCVIA provides that “[i]n awarding compensation on a petition filed under [this Act] the special master or court shall also award as part of such compensation an amount to cover—(A) reasonable attorneys’ fees, and (B) other costs, incurred in any proceeding on such petition.”⁹¹ The court of

86. An economist, however, might still contend that the proposal falls short of accomplishing this goal because it does not experience rate—taking into account the risk-creating behavior of each entity that contributes to funding. See Arlen, *supra* note 31, at 1099; see also *supra* note 61.

87. For reasons similar to those discussed in this section, the scheme should not permit the imposition of punitive damages. Cf. 42 U.S.C. § 300aa-15(d)(1) (1988) (prohibiting punitive or exemplary damages under NCVIA). Punitive damages are designed to punish wrongdoers and deter willful or reckless conduct. See Keeton, *supra* note 9, § 2, at 9-12. These purposes would not be fulfilled where a claimant failed to prove causation; if a claimant could not connect his harm to the conduct of any particular entity, the imposition of punitive damages might unfairly punish a nonculpable actor. Additionally, punishing entities that did not act in a willful or reckless fashion could deter beneficial, rather than harmful, conduct. See *supra* note 31 (discussing the concept of overdeterrence).

88. See Schwartz, *supra* note 64, at 537 (“[T]ort law delivers compensation in a way that entails very high administrative costs. For every dollar that comes into the system, perhaps only 40 or 50 cents winds up in the pockets of injured victims. The overhead, then, is 50 percent or more.”); Sugarman, *supra* note 16, at 598 (“It is tragic to spend such enormous sums in litigation in order to produce such a relatively puny compensation fund.”).

89. See DiFilippo v. Beck, 520 F. Supp. 1009, 1015 & n.7 (D. Del. 1981) (noting that a “limitation of attorney’s fees allowable may affect an attorney’s willingness to accept an initial retainer”); see also Lawrence B. Lambert, *Murder By Numbers: Calculating Reasonable Attorney Fees Pursuant to Attorney Charging Liens*, 45 FLA. L. REV. 135 (1993).

90. See *infra* note 94 and accompanying text.

91. 42 U.S.C. § 300aa-15(e) (1988).

claims has ruled that administrators should calculate fees using a "lodestar" method: the product of reasonable hours expended multiplied by a reasonable hourly rate.⁹²

Adoption of the NCVIA rule would allow scheme administrators and judges to monitor fees and expenses, yet retain sufficient flexibility to adjust amounts in unusual circumstances. Further, the adoption of judicial interpretations of the NCVIA's provision would reduce extraneous litigation surrounding fees and expenses.⁹³ Finally, the adoption of the NCVIA rules will help reduce overhead costs that plague tort litigation. Indeed, under the NCVIA itself, fees and expenses constitute only a small percentage of total award costs.⁹⁴

IV. Tort Access

In many compensation schemes, a complicated issue arises when proponents consider the extent to which claimants can retain access to the tort system. Professor Rabin has explained: "The question is whether the tort system can remain open as a 'fail-safe' alternative without diverting so many cases from a *well-functioning* administrative scheme as to make the reform effort meaningless."⁹⁵ In some ways, this issue exposes an inherent problem in broad scope proposals: Such schemes seem generally superior to tort law, but no proponent can comfortably draw a line where the scheme fully supersedes tort law.⁹⁶ Because this Article's proposal has a narrow focus, however, the problem of determining tort access is diminished: A blood products scheme should replace the tort system only in situations in which the

92. See *Doe v. Secretary of Health and Human Services*, 19 Cl. Ct. 439, 452-53 (1990). An attorney petitioning for fees must maintain adequate records to support hours claimed for services provided. The court must deem the claimed time, as well as the rate charged, reasonable under all facts and circumstances. *Monteverdi v. Secretary of Health and Human Services*, 19 Cl. Ct. 409, 414 (1990). The NCVIA provides for reasonable fee recovery even where a good-faith claimant is unsuccessful in a compensation petition. 42 U.S.C. § 300aa-15(e) (1988); *Cain v. Secretary of Health and Human Services*, No. 91-817V, 1992 WL 379932, at *1 (Cl. Ct. Dec. 3, 1992).

93. See Garza, *supra* note 86, at 386 & n.11 (noting that the provision of the NCVIA permitting the recovery of attorneys' fees generated "substantial caselaw").

94. As of July 17, 1990, NCVIA petitioners had received \$56.8 million through the compensation fund, while fees and expenses amounted to only \$1.6 million—approximately 3% of the total award figure. Smith, *supra* note 25, at 227-28 & n.139 (citing Andrew Blum, *Plaintiffs Refile Suits on Vaccine*, NAT'L L.J., Oct. 1, 1990, at 3). The figure is especially impressive compared to estimates that fees and expenses in tort litigation amount to 40-50% of compensation. See *supra* note 64.

95. Rabin, *supra* note 21, at 976.

96. Although Professor Rabin ultimately counsels against retaining a supplementary tort system in his proposal for a legislative alternative to mass toxic torts, he also states that a "principal aim of retaining a residual tort remedy is to address the relatively small percentage of cases that involve very serious injuries." *Id.* at 974. Professor Arlen criticizes the latter statement, arguing that individuals with clear claims to recovery would be "the very victims who should be channeled into a compensation system." Arlen, *supra* note 31, at 1096.

tort system works poorly because a potential plaintiff cannot prove causation.⁹⁷ In other situations, the tort system should remain encouraged and preferred.

A. *Limitations and Complications*

An explication of two scheme features illuminates the above-stated point. First, the proposed blood products scheme will render “source” causation irrelevant.⁹⁸ A claimant will provide scheme administrator only s with evidence of “substance” and “exposure” causation—that is, proof that he used factor concentrate⁹⁹—but not with evidence of which entity manufactured the concentrate that caused the infection. The scheme, therefore, will provide an attractive option for infected individuals who would otherwise encounter difficulty obtaining compensation in the tort system.

Second, a claimant who files a petition for administrative compensation must permanently waive his right to bring a tort action against any blood processor, insurer, or health care provider for damages related to his HIV infection.¹⁰⁰ The permanent waiver requirement coalesces with this Article’s premise that “no cause” liability in blood litigation should be unavailable.¹⁰¹ Claimants who waive their right to sue are likely to be individuals with no viable cause of action anyway.¹⁰²

97. See *supra* notes 21-22 and accompanying text; see also notes 9-14, 17-18 and accompanying text.

98. In this context, proof of “source” causation refers to evidence that identifies the manufacturer of the concentrate that caused the claimant’s infection. See Abraham, *supra* note 55, at 860 (distinguishing “substance,” “source,” and “exposure” causation).

99. Under this proposed scheme, special masters should possess such evidence at each claim’s outset, as each claimant would be required to provide product use information to help determine LDI. See *supra* notes 52-53 and accompanying text.

100. The Canadian government requires a similar waiver in exchange for compensatory payments to HIV-infected hemophiliacs. In contrast, the NCVIA allows claimants to reject a special master’s damage award and file a tort action. 42 U.S.C. § 300aa-11(a)(2) (1988). The NCVIA, however, creates disincentives to do so, including rules that provide vaccine manufacturers with a tort defense based on adequate warning to doctors (the learned intermediary defense), a defense based on compliance with the Food, Drug and Cosmetic Act, and a rule prohibiting the award of punitive damages in tort. *Id.* § 300aa-22. See Rabin, *supra* note 21, at 959. Two proposals to replace tort law for injuries caused by exposure to toxic substances also would allow access to the tort system with certain built-in deterrents. For example, the Superfund Proposal provides that if tort recovery is less than twenty-five percent more than the scheme’s no-fault award, the claimant/plaintiff must pay court costs and expert fees to the defendant and compensate the fund for all payments previously disbursed. *Id.* at 961-62 & nn.64-66 (citing Superfund Report at 181-83). The proposed Chemical Injury Liability Act would require reimbursement to the fund before a claimant files suit. Trauberman, *supra* note 57, at 286 (proposed section 218(c)(2)(A)).

101. See *supra* notes 8-14 and accompanying text. Ideally, a federally-enacted blood products compensation scheme would expressly preempt any state law that permits the imposition of tort liability without proof of actual causation. Such a rule, of course, would prohibit the use of market share liability in blood products litigation.

102. Additionally, legislation should impose an ethical obligation on attorneys to inform potential clients of the availability of the scheme as a means of compensation. Cf. 42 U.S.C. § 300aa-10(b) (1988)

The features set forth above will make the compensation scheme an attractive and secure option for potential claimants without the ability to prove source causation. The scheme provides near-certain compensation, compared to a questionable (and contested) opportunity for compensation through the tort system. Thus, the compensation scheme will handle the tort claims that are the most expensive and inefficient to litigate.¹⁰³ The tort system would retain only a narrow category of blood products actions: cases where a plaintiff is confident that he can prove actual causation.¹⁰⁴ As discussed throughout this Article, allowing the tort system to resolve these claims promotes efficient deterrence and fairness: the threat of litigation encourages manufacturers to continue developing safer products. At the same time, eliminating the threat of judicially-imposed group responsibility reduces the risk of overdeterrence and free riding.¹⁰⁵ Further, the retention of tort law in cases of certain source causation appeals to notions of fairness and should make the proposal more politically palatable.¹⁰⁶

The scheme as outlined above, however, neglects one potential group of claimants: those hemophiliacs who can prove source causation, but who were infected before the presumed negligent date of April 1984. These victims are unlikely to succeed in a tort action because they cannot prove fault, yet the proposed scheme fails to provide specifically for their compensation. The most decent way to help this group of claimants is to allow them access to the system although the scheme is designed for no cause cases. General congressional appropriations should fund compensation for such claimants, as their LDIs would be before the presumed negligent date.¹⁰⁷ Despite political difficulties in obtaining funding, it is hard to imagine any group of claimants more worthy of support. These individuals have been infected with HIV through no fault of their own. Further, the companies that made the product

("It shall be the ethical obligation of any attorney who is consulted by an individual with respect to a vaccine-related injury or death to advise such individual that compensation may be available under the program for such injury or death."); see Garza, *supra* note 85, at 386.

103. With similar reasoning, Victor Schwartz and Liberty Mahshigian proposed a "narrow focus" alternative to DES litigation. See Schwartz & Mahshigian, *supra* note 16, at 966-67.

104. In other contexts, such a proposal would be unrealistic. For example, in many toxic tort cases, connecting harm (for example, cancer) to any single substance is virtually impossible. In the blood products setting, however, it is very possible that a product user or his medical facility would retain records of product use and that such use will be limited to one brand of concentrate. Indeed, even in the DES context, where the availability of records is sparse due to the long latency between product use and injury, Schwartz and Mahshigian proposed a compensation scheme that would exclude cases where proof of causation exists. *Id.* at 966.

105. See *supra* note 31 and accompanying text (discussing overdeterrence).

106. See Rabin, *supra* note 21, at 977 ("Fairness considerations serve as an alternative rationale for creating as close a linkage as possible between risk-producing activities and financial responsibility for the consequences.").

107. See *supra* note 48 and accompanying text (responding to objection that this arrangement intolerably increases federal spending). Congressional provision of funds for these cases avoids imposing no-fault liability and therefore conflicting with state blood shield laws. See *supra* notes 45-48 and accompanying text.

leading to their infection were also likely faultless. Finally, the amount of money needed to compensate these claimants will diminish over time as more claimants will have used concentrate only after 1984.¹⁰⁸

B. *Gatekeeping*

In addressing access to the tort system, a compensation scheme must also consider potential claimants who have filed tort claims before the scheme's implementation. At one extreme, a scheme could allow access to every individual who ever filed a claim for injuries relating to HIV infection through the use of blood products. At the other extreme, a scheme could deny access to any person who filed a tort claim before the scheme's enactment. Identifying an acceptable middle ground, however, is not nearly as easy as defining the extremes.

This Article suggests a middle-ground solution that uses the NCVIA as a model.¹⁰⁹ First, a blood products scheme should grant individuals with claims pending at the time of enactment a defined period (before tort adjudication) in which to dismiss their claims and enter the compensation scheme. Second, the scheme should allow limited access to those with previously adjudicated tort claims.

1. *Claimants with Pending Tort Claims*

For claimants with trial court actions pending at the time of enactment, a blood products scheme should look to the NCVIA for a general framework. The NCVIA provides:

A plaintiff who on the effective date of [the Act] has pending a civil action for damages for a vaccine-related injury or death may, at any time within 2 years after the effective date of [the Act] or before judgment, whichever occurs first, petition to have such action dismissed without prejudice or costs and file a petition [under the Act] for such injury or death.¹¹⁰

108. *See supra* note 48. Additionally, there seems little risk that opening the door to such claimants will flood the system with individuals who can prove source causation and who were infected after the presumed negligent date. The financial incentives for such claimants to use the tort system (access to higher pain and suffering awards, possible punitive damages, and attorneys' fees on a contingent basis rather than the lodestar method) should suffice to keep such claims, for the most part, out of the compensation scheme and in the tort system. *See supra* notes 85-86, 89-92 and accompanying text; *cf.* Schwartz & Mahshigian, *supra* note 16, at 967-68 ("The legislative system is 'standby equipment' for the tort system, a vehicle to provide relief where the tort litigation system fails. The damage amount should reflect that fact and be limited to the claimant's true excess economic losses.").

109. 42 U.S.C. § 300aa-11(a)(4)-(8) (1988).

110. *Id.* § 300aa-11(a)(5)(A).

Building on this framework, a blood products scheme must include several additional features. First, a blood products scheme should clearly—and permanently—preclude claimants who do not petition within the stated time frame from filing a claim under the compensation scheme.¹¹¹ Second, the scheme should explicitly require potential claimants to choose the scheme before filing any pre-trial dispositive motion (for example, a summary judgment motion on liability). Indeed, throughout its provisions, the scheme should emphasize that it is impermissible for individuals to gamble in the tort system and rely on the scheme as a backup. Similarly, a blood products scheme should require claimants to dismiss pending actions with prejudice before entering the administrative process. The Act should contain no hint that a claimant can return to the tort system once he gains access to the compensation scheme.¹¹²

2. *Claimants with Adjudicated Tort Claims*

Potential claimants with previously-adjudicated tort claims present a different challenge. A simple solution is to draw a clean line at the date of enactment. Prohibiting entry to individuals who used the tort system before

111. The scheme should similarly deny access to persons who file tort claims after the date of enactment. *Cf.* 42 U.S.C. § 300aa-11(a)(6) (Supp. 1991) (“If a person brings a civil action after November 15, 1988 for damages for a vaccine-related injury or death associated with the administration of a vaccine before November 15, 1988, such person may not file a petition under subsection (b) of this section for such injury or death.”). Similarly, individuals who have lost in trial courts, but who have appeals pending, should be permitted access to the scheme if they agree to dismiss their appeals. *See* 42 U.S.C. § 300aa-11(a)(8) (Supp. 1991) (“If on [October 1, 1988,] there was pending an appeal or rehearing with respect to a civil action brought against a vaccine administrator or manufacturer and if the outcome of the last appellate review of such action or the last rehearing of such action is the denial of damages for a vaccine-related injury or death, the person who brought such action may file a petition under [this Act] for such injury or death.”).

112. *Cf.* *Amendola v. Dept. of Health and Human Services*, 989 F.2d. 1180, 1187 (Fed.Cir. 1993). In *Amendola*, the Amendolas brought a medical malpractice action against a doctor in 1985, predicated on injuries caused by childhood vaccinations. In 1989 (approximately one year after the NCVIA’s effective date), a jury rendered a verdict in favor of the doctor. The Amendolas then sought to file a claim under the NCVIA. The court refused to permit the Amendolas to proceed with their NCVIA claim, finding the claim untimely. The court held that “Congress’ purpose is both clear and clearly evidenced by the statutory framework. The statute provides a strong bias in favor of bypassing the civil litigation route in favor of compensation claims under the Act.” *Id.* at 1184. *Amendola*, however, points out a lack of clarity in the NCVIA’s “gatekeeping” provisions. In particular, the Act can be read to permit the type of petition brought by the Amendolas; it provides: “If in a civil action brought against a vaccine administrator or manufacturer before the effective date of this subpart damages were denied for a vaccine-related injury or death . . . the person who brought such action may file a petition under [this Act] for such injury or death.” 42 U.S.C. § 300aa-11(a)(4) (1988) (emphasis added). Technically, the Amendolas were denied damages in a lawsuit “brought against a vaccine administrator or manufacturer before the effective date of” the Act. To avoid this problem, a provision similar to § 300aa-11(a)(4) in a blood products compensation scheme must make clear that waiting for a judgment in a pending action waives access to the scheme. *Cf.* 42 U.S.C. § 300aa-11(a)(7) (1988) (“If in a civil action brought against a vaccine administrator or manufacturer for a vaccine-related injury or death damages are awarded under a judgment of a court or a settlement of such action, the person who brought such action may not file a petition under [this Act] for such injury or death.”).

the scheme's effective date would improve the scheme's clarity in administration and would reduce its operational costs. On the other hand, denying compensation to innocently injured individuals due to the fortuity of their infection date (or perhaps due to their promptness in filing suit) seems highly unfair. Again, this Article suggests a middle-ground solution based on a modification of a NCVIA provision.

Section 300aa-11(a)(4) of the NCVIA provides:

If in a civil action brought against a vaccine administrator or manufacturer before the effective date of [the Act] damages were denied for a vaccine-related injury or death or if such civil action was dismissed with prejudice, the person who brought such action may file a petition under [the Act] for such injury or death.¹¹³

A blood products scheme should contain two modifications to section 300aa-11(a)(4). First, to avoid the ambiguity present in the NCVIA, a blood products compensation scheme must clarify that its analogous section applies only to claims brought and decided before the scheme's effective date. The scheme must not allow potential claimants to wait out a case that is pending on the scheme's effective date.¹¹⁴ Rather, claimants with pending tort claims must determine a course of action consistent with the rules set forth above.¹¹⁵

The provision, however, must account for the concern that providing compensation to claimants with previously-adjudicated claims could greatly increase the scheme's costs.¹¹⁶ This Article, therefore, suggests reducing or eliminating the proposed lump sum pain and suffering payment to claimants in this category.¹¹⁷ By providing compensation for medical expenses and lost income, the scheme would avoid completely denying recovery to some injured individuals. At the same time, however, the scheme would control costs and mitigate the unfairness of forcing industry members to bear costs twice for the same claim: once in litigation, and then again to compensate the same claimant through the scheme.¹¹⁸

113. 42 U.S.C. § 300aa-11(a)(4) (1988).

114. *See supra* note 111.

115. *See supra* notes 111-12 and accompanying text.

116. Aside from the obvious expense of compensating these individuals, including this group of claimants in the compensation scheme also would increase non-compensatory costs because the scheme's administrative expenses would be in addition to (rather than in place of) litigation costs. The justification for including these claimants, therefore, not on economics, but instead on a moral belief that society should compensate such individuals.

117. *See supra* notes 82-86 and accompanying text. Such claimants should receive full compensation, however, for medical expenses and lost income. *See supra* Part III.A and accompanying text.

118. Of course, reducing or eliminating the pain and suffering component of an award again raises the argument that the scheme is not promoting efficiency. *See supra* notes 31, 77-78 and accompanying text. The problem of reduced cost-internalization, however, is less compelling in dealing with claimants

In sum, a blood products compensation scheme should provide generous access to potential claimants who became infected with HIV through blood products before the scheme's enactment. The scheme, however, should vigilantly ensure that administrative access precludes further tort litigation, thus allowing the scheme to increase cost efficiency rather than work in the opposite direction.

Conclusion

This Article proposes a focused legislative plan to assist victims of a tragic aspect of the AIDS crisis: hemophiliacs infected with HIV through the use of pharmaceutical products processed from blood. The Article suggests a plan with a narrow focus—an administrative compensation scheme designed to assist hemophiliacs who have tenuous access to the tort system because they cannot connect their infection to the conduct of any specific blood products manufacturer. For such individuals, the proposed scheme would provide nearly universal compensation for pecuniary damages related to HIV infection. For hemophiliacs who can prove fault and causation, however, the tort system would remain the preferred compensation route, with the possibility of both pecuniary and nonpecuniary (including punitive) damages fully available.

In designing this scheme, this Article has considered tort law's traditional goals—compensation, deterrence, and justice—without emphasizing any one goal over the others.¹¹⁹ In considering the compensation goal, this Article set forth a mechanism by which many HIV-infected hemophiliacs could receive

who have already litigated their claims than with claimants who have not done so. In the former situation, risk creators have likely incurred substantial costs. Even if such costs are not directly related to a claimant's pain and suffering, the costs are quite real and must be internalized by the entities.

119. See, e.g., Sugarman, *supra* note 16, at 559 (criticizing "devotees of economics who emphasize the deterrence goal, moral philosophy fanciers who emphasize the justice goal, and enterprise liability scholars who emphasize the compensation goal"); Robert L. Rabin, *Environmental Liability and the Tort System*, 24 Hous. L. Rev. 27, 43 (1987) (citing GUIDO CALABRESI, *THE COSTS OF ACCIDENTS* (1970)) (identifying general goals of tort law as "accident prevention, victim compensation, and minimal administrative expense"). This article has purposely avoided attempting to serve a punitive goal. See *id.* (expressing skepticism at the concept of retribution as a goal of tort law). In this sense, the Article agrees with Professors Abraham, Rabin, and Weiler, who find attempts to serve such a goal through the development of compensation schemes little more than a fruitless morality play:

Even when the source of the immediate product disaster was deliberate profiteering, rather than unfortunate (albeit negligent) human error, the executives actually guilty of such misdeeds do not personally pay the awards. Moreover, the culpable executives have often left the business long before the consequences of their misdeeds come to light. The reality of all high-stakes litigation—even medical malpractice, in which the nominal defendant is usually an individual doctor—is that some corporate enterprise or other entity will actually pay the award with money that is then deducted from taxable income. The ultimate burden of both jury awards and legal costs, then, is shifted to the shareholders, employees, and customers of the company or the industry, even though none of these groups had any personal culpability for the victim's injury.

Abraham, et al., *supra* note 24, at 339.

compensation for medical expenses and lost income that might otherwise be unavailable. On the other hand, this Article recognized that a workable scheme might need to limit (or in some cases eliminate) nonpecuniary compensation, including recovery for pain and suffering. In considering the deterrence goal, this Article suggested a fixed component in some awards that would approximate nonpecuniary damages—a component that law and economics scholars find important to achieving efficient deterrence. On the other hand, out of concerns for administrative fairness and to achieve more comprehensive compensation, the proposal suggested a limitation on nonpecuniary damage awards and counseled against experience rating each manufacturer's contribution to the scheme. Finally, this Article attempted to present a proposal that would be fair to a variety of interested parties—not only HIV-infected hemophiliacs, but also non-infected hemophiliacs who need affordable blood products, concentrate manufacturers in a competitive environment, and state legislatures that have articulated clear policy statements concerning the imposition of liability for injuries caused by blood and blood products.¹²⁰

Some might view the proposal contained in this Article as too narrow¹²¹ or outdated in its approach.¹²² Even advocates of broad legislative directives, however, admit that all legislation must be judged by certain norms, the heart of which include a sense of fairness and purpose.¹²³ This Article is motivated by such a sense and, hopefully, has proposed the creation of a system in which a hard case will actually make good law.

120. Although Congress could almost certainly supersede state-enacted blood shield laws, the wisdom of doing so is dubious. Even if a federally-enacted strict liability rule in the area of blood products did not directly affect the current blood products market, it would make industry skeptical of future state attempts to encourage certain activity by limiting potential liability. Entities that engage in such activity would rightly hesitate, feeling that if injuries occurred, the federal government might obliterate the state law protection. Such a situation could make it more difficult for the states to encourage important activities, like the development of an AIDS vaccine. Indeed, the states are currently ahead of the federal government in this area, providing companies with liability protection to encourage research. *See, e.g.*, CONN. GEN. STAT. § 19a-591b (Supp. 1994); CAL. HEALTH & SAFETY CODE § 199.45 (West 1990).

121. *See supra* note 23 and accompanying text.

122. *See* Edward L. Rubin, *Law and Legislation in the Administrative State*, 89 COLUM. L. REV. 369 (1989). Professor Rubin articulates a theory of legislation in which he envisions legislatures issuing goal-oriented directives to other branches of government rather than setting forth "rules that displace or supplement the common law." *Id.* at 369. Thus, Professor Rubin encourages the initiation of all types of policy through broad mandates—the "initiation of governmental power to achieve particular results, ranging from securities regulation to public welfare to environmental protection." *Id.* at 372.

123. Professor Rubin identifies three norms that must guide the enactment of modern legislation: (1) the legislature should exercise political control over administrative agencies; (2) legislation must be fair and not oppress private persons; and (3) legislation should be effective and achieve the purpose for which it was designed. *Id.* at 408-09. According to Rubin: "[l]egislation is the mechanism by which . . . positive norms of fairness are implemented; if we cannot legislate effectively, we shall fail to produce a regime that we regard as just." *Id.* at 409.

