



Developing an Effective Long-Term Strategy for Post-Marketing Surveillance of Medical Products

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Executive Summary

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The Health Industry Forum is based at Brandeis University and chaired by Professor Stuart Altman. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

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Key Themes for Developing an Effective Long-Term Strategy for Post-Marketing Surveillance of Medical Products

Overview

Participants at this Forum represented key stakeholders in the health care system, including government agencies, private health plans, manufacturers of pharmaceuticals and medical devices, patient advocacy groups, physicians, and academic researchers.

Virtually all Forum participants agreed that the current system for post-marketing surveillance is inadequate and that a new strategy and system are required. This new system must develop active surveillance systems to detect adverse drug event signals more effectively and new processes to evaluate and adjudicate these signals. The system must be able to integrate and rapidly evaluate large amounts of data from different sources. It must also have mechanisms for communicating drug safety information effectively to physicians, patients, and other stakeholders.

Establishing an effective post-marketing surveillance system will require new legislation, increased FDA funding, and new mechanisms to support collaboration among public and private sector stakeholders.

Context

This Forum on Developing an Effective Long-Term Strategy for Post-Marketing Surveillance of Medical Products, held in Washington DC on April 11, 2007, brought together leaders from industry, government, and academia to examine in practical terms how to establish a more effective post-marketing capacity in the US. This report summarizes each of the Forum's discussions, highlighting key points from each.

Key Themes

- **The current post-marketing surveillance system is highly inadequate.**
 There was agreement that the current post-marketing surveillance system is ad hoc, outdated, and inadequate to effectively monitor product safety given the current volume of new and existing therapies. Reliance on voluntary physician reporting of adverse events is incomplete, inconsistent, and slow. The FDA lacks the necessary resources, tools, and expertise to effectively evaluate drug safety signals on an ongoing basis. It also lacks good systems for communicating drug safety problems to key stakeholders. The current system may have been adequate in 1970 but it is not adequate today.
- **A new active post-marketing surveillance system is needed.**
 This new system must use active surveillance to expedite signal detection. This will require that the FDA have access to a broad range of health care data resources to support rapid signal

detection. The FDA also needs additional resources to support evaluation and adjudication of signals.

Forum participants view a stronger post-marketing surveillance system as essential, offering benefits for industry, payers, patients and providers. A speaker from the pharmaceutical industry supported the concept and identified potential benefits for industry.

- **Building blocks for a new system include an entity to integrate data and coordinate analysis.**

Among the necessary building blocks for a new system are an entity (one suggestion included a quasi-governmental public/private entity) charged with overseeing the post marketing data collection and conducting research and analysis. The governance structure for this entity is a major issue to be resolved.

Another building block is a capacity for integrating large amounts of patient data, including claims information and clinical data from electronic medical records. To make the data useful, standard formats must be established that will support analysis that draws on multiple data sets. A number of organizations including the HMO Research Network and a consortium of 19 Blue Cross Blue Shield Plans are working on developing large aggregated claims databases. If this activity is ultimately structured as a public/private partnership, rules establishing who can access the data and for what purposes will be critical.

Additional building blocks include capabilities to rapidly evaluate these new data resources. These include software applications and methodological expertise. Another critical area is more effective communication of drug safety information to key constituents

- **Many participants support new ways of thinking about drug safety.**

Historically drug safety evaluation has been binary and drugs have been approved as safe or rejected as unsafe. But going forward, many participants can envision a world where it is possible to determine for which groups of individuals a drug is safe or unsafe. This will become more feasible as genomics plays an increasingly prominent role in science. Extensive research is needed to make this concept a reality.

Some participants believe that ultimately a model of "conditional approval" may be desirable. Under this model, drugs which have passed certain clinical safety hurdles would be granted conditional approval status, with clear labeling as such. Full approval would be contingent upon establishing that a drug is safe through larger-scale, real-world experience. However, other participants see such an approach as expensive for pharmaceutical companies and impractical for physicians.

The Future of Drug Safety: Recommendations of the IOM

■ Speaker: **Robert Giffin, PhD**, Director, IOM Forum on Drug Discovery, Development and Translation

Overview

The Institute of Medicine (IOM) report on the Future of Drug Safety made sweeping recommendations for improving the U.S. drug safety system. These include enhancing and expanding the FDA's current systems for detecting adverse events, expanding its resources for evaluating safety signals and increasing its authority to require confirmatory post-marketing studies. The IOM also offered recommendations on the FDA's governance and on steps to ensure integrity in the scientific process. Further recommendations include greater flexibility in enforcing regulations—through methods such as drug labels, warnings, active surveillance, and restrictions on direct-to-consumer advertising—and development of plans and resources to improve communications with consumers on drug safety matters.

Context

Dr. Giffin provided an overview of the IOM report on *The Future of Drug Safety* and the recommendations made by the IOM committee formed to create this report. More information about this report can be found on the IOM's web site (www.iom.edu/drugsafety.)

Key Points

■ The IOM focused on the current problems surrounding the US drug safety systems.

The context for the IOM's report is provided on its web site: "In response to the growing public concern with health risks posed by approved drugs, the US Food and Drug Administration (FDA) and the Department of Health and Human Services announced a series of steps to address drug safety, including asking the IOM to convene a committee to assess the US drug safety system and to make recommendations to improve risk assessment, surveillance and the safe use of drugs."

Dr. Giffin indicated that the IOM committee's report focused on addressing the following problems:

- *Chronic underfunding.* The FDA lacks the funding necessary to perform all of its necessary activities.
- *Reliance on industry funding.* Approximately 50% of the FDA budget now comes from industry user-fees, creating concern about potential conflicts.
- *Organizational problems.* Concerns have been raised about the agency's culture, politicization of scientific decisions and industry ties to FDA advisory committee members.
- *Unclear regulatory authority and insufficiently flexible regulatory tools.* The lack of regulatory clarity is particularly an issue for post-marketing requirements.
- *Inadequate quantity and quality of post-approval data, and inadequate capability to systematically monitor drugs' risks and benefits after approval.*

■ The IOM report offered 25 recommendations to address these problems.

The IOM committee summarized its findings as follows:

- There is a perception of crisis that has compromised the credibility of the FDA and the pharmaceutical industry.
- Most stakeholders appear to agree on the need for certain improvements in the system.
- The drug safety system is impaired by serious resource constraints, an organizational culture in the Center for Drug Evaluation and Research (CDER) that is not optimally functional, and unclear and insufficient regulatory authority.
- The FDA and the pharmaceutical industry do not consistently demonstrate accountability and transparency to the public by communicating safety concerns in a timely and effective fashion.

"The take-home message is that the FDA is the nation's 'trusted intermediary' between the pharmaceutical industry and the end users (physicians, pharmacists, and patients)... The FDA must be in command of all the data and both the data and the decisions based on them must be credible."

— Robert Giffin, PhD

Dr. Giffin explained that the IOM report had five chapters and he highlighted specific recommendations of each. (The full text of the recommendations is Exhibit 1 at the back of this report.)

1. **Culture, Structure, and Management.** The IOM recommendations aim to increase stability and decrease politics by establishing a 6-year fixed term for the FDA commissioner, a management advisory board, and a lifecycle approach to drug evaluation and safety by integrating the pre-approval and post-marketing safety staff into the drug review process.

2. **Quality and Credibility of the Science.**

- *Signal generation.* Today, signals are generated through a problematic adverse event reporting system (AERS), which is voluntary and spontaneous. While this system has had successes, it also has significant gaps because of the low rate of physician reporting. The IOM committee recommends enhancing the functionality of the existing AERS system by using new technologies to automate this system (recommendation 4.1).

(Forum participants commented that getting doctors to report adverse events is a weak link in the system. Many physicians view reporting as a significant administrative burden. Many do not see any direct value in adverse event reporting. One important exception is the strong support of pediatricians for reporting adverse vaccine reactions. It is important to make reporting less burdensome through better use of technology and to provide more direct feedback to reporting physicians to increase their support for continued reporting.)

- *Signal generation (continued)*. The IOM recommends that FDA develop more active surveillance capabilities. Among the specific IOM recommendations (4.2) in this area are intra- and extramural programs that can access data from large and automated databases; active surveillance for certain drugs that are of concern; and analysis of drug utilization patterns and background incidence rates for adverse events.
- *Confirmatory studies*. The IOM recommends a public/private partnership to prioritize, plan, and organize funding for confirmatory drug safety and efficacy studies (4.3). The studies would focus on drilling down to better understand the long-term safety profile of approved drugs. Confirmatory studies could also include cost effectiveness and comparative effectiveness.

Other IOM recommendations related to the science of drug safety included recommending scientifically valid and timely evaluations of Risk Minimization Action Plans (RiskMaps) (4.4) and enhanced internal epidemiologic and informatics capabilities within FDA (4.6).

Further recommendations focus on the integrity of the science being performed. These include a Chief Scientist to oversee intra- and extramural research (4.7a), that the majority of advisory committee members are free of conflicts (4.10), that all phase 2-4 clinical trials are posted on clinicaltrials.gov (4.11)—something that is done inconsistently today—and that CDER synthesize post-market study results and explain their significance to the public (4.13). This recommendation is a key part of ensuring that FDA serves its role as a “trusted intermediary.”

3. **Regulatory Authority**. The IOM recognizes that this is a controversial area. The committee’s goal was to codify and give

FDA clear authority for more systematic and consistent application of rules. Specifically the recommendations call for:

- A flexible and enforceable “tool kit” of post-approval regulatory options (5.1) (e.g. conditions and restrictions on promotion and distribution, completion of post-marketing study commitments, etc.). This tool kit might include drug labels and warnings, restrictions on DTC advertising, restricted use, performance of studies, and active surveillance.
 - Clarification of enforcement authority (5.2), which deals with fines, injunctions, and withdrawals.
 - A review of accumulated data within 5-years of approval (5.4).
4. **Communication**. The committee recommends a new FDA advisory committee on communication to advise CDER on communication issues related to efficacy, safety, and utilization during the lifecycle of drugs and other medical products which will help the public get accurate science-based information to use medicines (6.1). The committee also recommends that the new Office of Drug Safety Policy and Communication develop a cohesive risk communication plan (6.2).
 5. **Resources**. Recommendation 7.1 calls for a substantial increase in funding and personnel for the FDA.

“The committee recommends that the Administration should request and Congress should approve substantially increased resources in both funds and personnel for the Food and Drug Administration.”

—From the IOM’s Future of Drug Safety report, recommendation 7.1

Strategies for Establishing an Effective Long-Term Post-Marketing Surveillance Capacity: What, How, and Who?

■ Speaker: **Scott Gottlieb, MD**, Resident Fellow, American Enterprise Institute

Overview

Much must be done to improve the FDA's post-marketing surveillance capabilities. This includes establishing processes for active safety signal detection, improving signal adjudication, and investing in infrastructure (including large population-based data sets and tools for evaluating these data). Getting there, in Dr. Gottlieb's view, requires additional funding for the FDA and significant changes to legislation now under consideration in the Congress.

Many Forum participants also believe a different approach to drug safety is needed. Instead of a binary approach where drugs are deemed safe or unsafe, research should be developed to determine the benefits and risks of different drugs for specific subgroups of patients. This would support prescribing that is more individualized through expanded data on which drugs are safe and unsafe for which patients.

Context

Dr. Gottlieb provided his perspective on the IOM's drug safety report, the political and practical impediments to an improved drug safety system, and strategies for strengthening the FDA and its drug safety programs.

Key Points (Dr. Gottlieb's presentation)

- **Today's drug safety challenges are very different than those of the 1990s.**

A key issue in the 1990s was a concern that the FDA couldn't influence physicians' prescribing behavior. This inability to affect prescribing led to drug recalls. It also led to the creation of a risk management framework where drug sponsors would work with the FDA to provide guidance for physicians and, at times, agree to voluntary restrictions on marketing or distribution. (This risk management framework has worked to a degree.)

Today the key issues relate to the FDA's inability to deal effectively with persistent safety signals. Under the current system it is very difficult to capture the necessary data to evaluate low-probability events or to adjudicate findings in a timely fashion. This is especially true in regard to questions across an entire class of drugs (such as SSRIs and NSAIDs vs. COX 2.) A central problem in the absence of class-effect trials is the inability to pool enough data to rapidly detect safety signals. The FDA lacks both the tools and the resources to do so effectively.

- **The IOM report on drug safety was a missed opportunity.**

Dr. Gottlieb characterized the IOM report as "disappointing." He was concerned that the IOM attempted to offer management advice rather than focusing on its core competency of science. Dr. Gottlieb believes that the IOM could have offered more specific recommendations about improving science and information technology. For example, one recommendation which

would have made sense is for the FDA to increase its use of academic partners to support drug safety studies.

- **Legislation now under consideration won't address the core drug safety problems.**

For example, the Kennedy-Enzi proposal simply codifies the FDA's current approach to risk management. The bill aims to give the FDA additional regulatory authority that will create more leverage with drug manufacturers, but the agency already gets what it wants from drug sponsors. In his view, Title 1 of the legislation simply focuses on old ideas that don't work (i.e. RiskMaps) because they attempt to influence how drugs are prescribed by physicians.

- **Shoring up FDA capabilities to ensure drug safety will require systems for active signal detection and better adjudication.**

Dr. Gottlieb suggested that ideal legislation would focus on near real-time detection. This already exists for devices (which is easier) but is needed for drugs.

"Two near-term goals are active or near real-time detection and better adjudication."

— Scott Gottlieb, MD

Drug safety legislation should provide the FDA with better tools and more resources for adjudicating safety signals. An important strategy is establishing new partnerships to pool data from multiple sponsors and evaluate extraordinary drug safety questions. This requires additional funding. Drug safety legislation must also provide better tools for risk communication, an area where the FDA currently lacks resources and expertise.

- **An effective system requires an infrastructure that yields clean data and expert staff to develop applications.**

The FDA needs enhanced capability to effectively pool, refine, and evaluate datasets to meet public health goals. Creating, managing, and operating this type of infrastructure requires a core group of IT personnel at the FDA who understand the drug approval process and can refine existing software applications and build new ones. These capabilities are critical and are sorely lacking today at the FDA.

Participant Comments

The key topics from the discussion following Dr. Gottlieb's presentation included:

- **Data sets.** There is broad recognition that expanded use of large data sets is required for post-marketing surveillance. It is feasible but not necessarily easy to merge data from multiple sources and there is a need for standards to ensure consistent data collection. The HMO Research Network is one organization working on this problem. In another initiative, 19 Blue Cross and Blue Shield plans have agreed on a common data dictionary, and have combined claims data from 35 to 40 million members into a single

data warehouse. By year end they expect to have records on 75 million members.

- **Role of health insurance claims data.** Health plans represented at the meeting were in strong agreement that they should play a key role in drug safety. Dr. Sam Nussbaum noted that WellPoint has information on what drugs are prescribed and when prescriptions are filled, providing insights into patient compliance. Plans also can link prescribing information to medical claims data and many are focused on conducting more detailed analysis of drug safety and effectiveness. The plans see this type of analytics benefiting the health and wellness of their members. (However, participants offered a number of cautionary notes regarding the potential coding problems that could affect the accuracy of signal detection.)
- **Use of electronic health records (EHRs).** A number of participants argued for greater investment in aggregation and mining of EHR data. EHRs may provide much more detailed clinical information than claims data and may offer a more “real time” view of patient data, while claims data frequently has delays. Other participants pointed out that EHRs are not designed for quality or safety surveillance and lack standardization. Therefore extracting, aggregating and evaluating EHR data will be challenging.
- **Moving from a binary approach to drug safety evaluation to one that is more flexible.** Several participants commented that the way of thinking about drug safety needs to change from a binary perspective of “safe” or “unsafe.” All drugs have side effects for some patients. The reality is that some drugs are also more effective for certain individuals or groups. It would be beneficial to integrate safety evaluations with outcome studies to determine which patients should be treated with which drugs (i.e., the relative risk-benefit equation.) This would require a change in mindset from one of restricting unsafe choices to one of using research to determine what drugs yield the best outcomes for which patients in different situations.
- **Genetic information.** Building on the notion of individualized safety profiles, incorporating genetic information into databases and electronic health records will help researchers evaluate the benefits and risks of drugs for specific patients. One participant

recommended that the government should fund the collection of tissue samples that could be used for research bio-banks. However, other participants noted that the reality of personalized medicine does not yet match the hype.

- **Conditional approval.** One participant raised a proposal put forth by Dr. Brian Strom in a recent JAMA article (May 3, 2006) for conditional approval followed by careful post-market surveillance to evaluate a drug’s safety in the real world. Some participants believe this idea will eventually be implemented in some form, but neither regulators nor industry are ready for such a sweeping change. Others argued that conditional approval is impractical by limiting how physicians can prescribe and changing those restrictions over time. Arguments were also made that funding large-scale post-marketing studies to move a drug from conditional to full approval would not be economically practical for industry.

Other Important Points

- **Epidemiological standards.** A challenge that exists is a lack of consensus on epidemiological standards. Agreement on standards is necessary in a system of automated real-time monitoring for signal detection in order to answer the question, “What is significant?”
- **Working with CDC.** CDC is engaged in real-time data collection and monitoring for a variety of purposes including vaccine safety. There may be opportunities for FDA to collaborate with CDC in monitoring drug safety.
- **Governance.** Data analysis ultimately involves human judgment and many of the organizations involved in this analysis will have agendas and biases. Effective governance of future post-marketing safety initiatives will be extremely important.

Building Blocks for a Post-Marketing Surveillance System

- Speakers: **Janet Woodcock, MD**, Deputy Commissioner, FDA
Arnold Chan, MD, ScD, Senior Scientist, i3 Drug Safety & HSPH
- Respondent: **Adrian Thomas, MD**, Chief Safety Officer, Johnson & Johnson

Overview

There was general consensus among participants that a more effective post-marketing surveillance system is necessary. The key questions involve the scope and structure of such a system. Dr. Woodcock described a surveillance system overseen by a quasi-governmental public/private entity. This entity must have the resources and expertise to integrate data, conduct research and analysis, and effectively communicate results. She believes that industry will ultimately support such a system, but health care providers must be engaged in the development process.

- **A public/private partnership offers the greatest promise for effective post marketing surveillance including data collection, aggregation and evaluation.**

Dr. Woodcock pointed out that a post-market surveillance system must combine basic science and information technology. The new system must not just count problems, but instead develop a capability to evaluate the root causes of a safety problem and initiate strategies for improvement. For example, an HIV drug developed by Glaxo was found to cause anaphylaxis in 1 percent of patients who received it. Through basic scientific analysis, researchers found a genetic basis for certain patients with this problem and developed a test to identify those at risk.

Context

Doctors Woodcock and Chan each presented their observations about the essential building blocks for an effective post-marketing surveillance system. Dr. Thomas provided additional comments from an industry perspective.

Key Points (Dr. Woodcock's presentation)

- **There is currently no "system" for post-marketing surveillance.**

When the statutory framework for the FDA's drug approval process was put in place in the 1960s and 70s, it was a battle to get agreement to require randomized controlled trials before approval. There was little consideration of the need for post-approval safety monitoring. No process was put in place to examine misuse, errors, overuse, or off-label prescribing. This was simply not on the Congress' radar at that time. While much has been learned from post-market research, especially about additional indications, these ad hoc studies hardly constitute a "system" for post-marketing surveillance.

"Everything is ad hoc. There is no systematic way for evaluating the consequences of drug use in the US, or for introducing new interventions."

— Janet Woodcock, MD

The pharmaceutical industry is required to report adverse events to the FDA. Dr. Woodcock described this approach as, "If anything goes wrong, call us." This was an acceptable approach in 1970 when relatively few drugs were available, but the number and scope of pharmaceutical products has expanded tremendously. So too has the recognition that after a drug is approved many unexpected outcomes may occur. For this reason, the lack of a strong post-marketing surveillance system is no longer acceptable.

Dr. Woodcock suggested that a quasi-governmental public/private partnership would be the best structure for a new post-market surveillance capability. This entity would focus on data collection, research, and analysis. It would not have regulatory authority; this would reside solely with the FDA. The data gathered by this new entity could have a variety of uses, but its initial charter would be post-marketing safety. It would have an oversight board, a contracted data management organization, a research consortium, a communications group, and a group to develop consensus methods.

The building blocks of this new system should include:

- *Capacity.* The capacity for rapid signal detection and analysis as well as confirmatory studies.
- *Scope.* A charter to evaluate drug safety in a broad range of populations with diversity in patient characteristics and health care delivery settings. It would also have the capability to analyze a broad range of products and interventions (not just drugs).
- *Science base.* This would require strong links to academia (especially in areas where the FDA lacks expertise). Also needed is an evaluation component to ensure continuous improvement of the post-market surveillance system itself.
- *Operations.* The system's results should be open, available, and transparent to the public. It must develop consensus methods for data analysis and broad stakeholder input.
- *Communication and implementation.* This is an area that is sorely lacking as safety information often fails to penetrate the consciousness of those who use drugs. A new post-market surveillance system must be able to broadly disseminate findings. This includes collaboration with health plans and medical journals.

"It has to be credible, transparent, and generate results that are methodologically correct."

— Janet Woodcock, MD

Key Points (Dr. Chan's presentation)

- **Dr. Chan's thoughts on key building blocks are consistent with ideas expressed by many Forum participants.**

Dr. Chan articulated the following building blocks:

- *Data.* This includes primary and secondary data, including insurance claims data and data from electronic medical records.
- *Integration of data.* This requires the right people, technology, rules, regulations, and data-sharing mechanisms.
- *Methods and tools to analyze data.* This includes a variety of methods including signal detection involving data mining with no prior hypotheses and signal detection based on specific questions. Methods need to be validated and have the optimal balance between false positives and false negatives.
- *Personnel to develop and utilize the system.* There is a need for "drug safety scientists." Developing personnel with the necessary skill sets requires enhanced federal investment in training.
- *Feedback/risk communication.* Needed is an effective feedback loop so that health care providers and patients have updated information.
- *Program/system evaluation.* An important building block is a built-in mechanism to evaluate the effectiveness of the post-marketing program, which is based on empirical data.

Key Points (Dr. Thomas's presentation)

- **Industry can benefit from a consistent post-marketing framework but sees potential threats as well.**

Dr. Thomas said that industry already engages in post-approval monitoring today, but that these activities are frequently ad hoc and reactive. They rarely find answers to the most critical safety questions. Therefore, industry would support a consistent post-marketing surveillance framework and a one-to-many infrastructure to support this framework.

"The question isn't if we should do this, but what we should do and how we should do it."

— Adrian Thomas, MD

However, Dr. Thomas indicated that challenges and threats are also present. One important question involves who will have access to the aggregated data (e.g., plaintiffs' lawyers). In addition, changing the behavior of the physicians and other providers responsible for providing data will be a major challenge. Consensus is also needed about the starting point for this effort. Will it focus on a more modest but achievable set of demonstrations or will it attempt to "boil the ocean" by creating "a comprehensive, nationwide program?"

Participant Comments

The key topics from the participants' discussion of building blocks included:

- **Provider participation.** Several participants commented that getting providers to change behavior and provide more data is achievable but requires incentives. These incentives can include showing physicians that the data they provide is being used. One suggested example was an interactive system that shows whether other physicians have reported similar adverse events.
- **Timing.** Several comments were made about the importance of tools to expedite the time between when a signal is reported and when it is evaluated. This is the key period of uncertainty.
- **Communication.** This was seen by several participants as absolutely critical. Communications must be understandable to the target audience. There is growing expertise in this area, which has been lacking at FDA and is greatly required.
- **Broader scope?** One participant said that beyond just drug safety surveillance, he is interested in a system that provides more comprehensive "coverage" surveillance. By this he means monitoring of all items that are covered to know what is safe and what works best.
- **Devices too.** Any new post-marketing surveillance system must apply not just to drugs but devices as well.

Healthcare Priorities for the 110th Congress

- Speaker: **Wendell Primus, PhD**, Senior Policy Advisor, Speaker's Office
- Moderator: **Stuart Altman, PhD**, Dean, The Heller School, Brandeis University

Overview

Democrats have an ambitious legislative agenda, with the State Children's Health Insurance Program (SCHIP) topping the list. The Democrats want to reauthorize SCHIP and significantly expand its funding. This will require approximately \$50 billion which, because of "PAYGO," will require cuts in other areas of the health care budget such as Medicare Advantage.

Other legislative priorities include: increasing funding for medical research; PDUFA reauthorization; genetic nondiscrimination; mental health parity; health information technology; chronic disease management; and comparative effectiveness.

Beyond these specific legislative efforts, Dr. Primus believes that Democrats need to communicate a more comprehensive message than just broadening access; he wants Democrats to articulate a message focusing on the quality and value of the health care system. And, he believes that true system reform requires changes in physician incentives.

Context

Dr. Primus shared his perspective on the Democrats' health care priorities and the current congressional health care agenda. He responded to questions from participants on a range of issues.

Key Points

- **Democrats have to articulate a clear health care message.**

Dr. Primus believes that Democrats must articulate a message that goes beyond just improving access and showing that Democrats care about the *quality* and *value* of the care delivered in the US health care system.

"Democrats have to articulate a message of not just caring about access, but caring about the quality of the health care system and its value."

— Wendell Primus, PhD

He simplified the Republicans' approach as one where all of the problems of the health care system will be taken care of if consumers become more knowledgeable, buy the right health insurance, have price transparency, and Health Savings Accounts.

He doesn't believe such an approach is the solution. Instead he believes that changing physicians' incentives will be the key to improving quality and lowering costs. Today, incentives favor heavy procedure volume rather than choosing the most effective treatments or preventive care. He sees physicians' incentives as the key to long-term change.

- **Topping the Democrats' health care agenda is SCHIP, with the goal that funding adhere to the "PAYGO" rule.**

Democrats' number one priority is reauthorizing the funding for SCHIP (the State Children's Health Insurance Program).

"Our number one priority is to reauthorize and triple the funding for SCHIP."

— Wendell Primus, PhD

Estimates for the funding required for SCHIP range from \$35 to \$60 billion. Both the House and the Senate have set aside \$50 billion. SCHIP has broad support from many stakeholders who are disappointed that the Bush Administration's budget didn't even provide adequate funding to maintain current SCHIP enrollment levels.

SCHIP expansions must follow the PAYGO rule, where any funding needs to be paid for by decreasing other spending. The spending side of SCHIP is easy; the paygo side is hard. Among the possible sources of paygo funding are:

- *Medicare Advantage.* Receiving particular attention are the private fee-for-service managed care plans. On average these plans receive 12 percent more than traditional Medicare fee-for-service, which is seen by many as not justified. Reducing this difference to zero would save \$65 billion over five years and \$170 billion over ten years. Cutting Medicare Advantage is getting lots of push back, and it is unlikely to move to a completely level playing field,

"Medicare Advantage will be on the chopping block to some extent."

— Wendell Primus, PhD

(Several participants shared concerns about targeting Medicare Advantage. These concerns include the fact that Medicare Advantage is one of the few areas which provides an infrastructure for chronic care management for Medicare beneficiaries. Changes to Medicare Advantage could result in people switching to traditional fee-for-service, resulting in the disassembly of this infrastructure. Dr. Primus encouraged all participants to come forward with data to help educate him and members of Congress).

- *Hospitals.* Dr. Primus believes that hospitals can absorb a small hit to help contribute to the SCHIP expansion. A cut would be more palatable if it were accompanied by banning physician-owned specialty hospitals.
- *Home health care.* A savings opportunity is seen here through a possible small cut in reimbursement.
- *Pharma and biotech.* Companies such as Amgen have reaped tremendous benefits from patent protections (which seem to be extended forever by adding process patents to the originally filed patents) and tremendous payments from Medicare. It is not yet clear how pharma will contribute to SCHIP.

▪ **Other legislative priorities include reauthorizing PDUFA, upping medical research funding, and mental health parity.**

Dr. Primus provided short descriptions of Democrats' other legislative priorities. They are:

- *Stem cell research.* Democrats are bringing legislation on stem cell research. This legislation should pass but will likely be vetoed by the President. There are not yet enough votes to override the veto, although there is a chance this could change.
- *NIH Funding.* The other priority related to research is increasing NIH funding. This doubled from 1997 to 2003, but has since declined by about 12% in real terms. (One participant challenged the government's current paradigm of spending on clinical research, suggesting that a small fraction (e.g., 5 percent) of the NIH budget on research to helping patients identify appropriate care).
- *PDUFA reauthorization.* PDUFA has to be reauthorized. Key issues are increased funding and safety improvements.
- *Genetic Information Nondiscrimination Act.* This legislation, which recently received the strong support of Newt Gingrich, is likely to pass and to receive the President's signature.
- *Wellstone Mental Health Parity Act.* Dr. Primus believes that despite the current disagreements between the House and Senate versions of a mental health parity act (and between Representative Kennedy and his father Senator Kennedy), a mental health parity act is likely to happen.
- *Reduced physician payments.* It is currently planned that Medicare physician payments will be reduced by 10 percent effective January 1, 2008. This needs to be addressed.
- *Comparative effectiveness.* Many Democrats are interested in comparative effectiveness research and want to equip doctors

with better information about what works best. Comparative effectiveness is getting attention in the House and even more so in the Senate. However, this is complicated, and it will take time to develop good legislation that can be agreed to. In addition, despite the interest, there are simply other issues that are considered higher priority than comparative effectiveness, making it likely to be dealt with next year rather than this year.

- *Health Information Technology (HIT).* The Democrats feel strongly that HIT is important but it will require substantial investment.
- *Management of chronic diseases.* This is where the money is. Twenty percent of Medicare beneficiaries represent about 70 percent of Medicare's spending. These individuals tend to have multiple diseases and many see more than 10 doctors each year. Better management of chronic diseases is necessary, through greater use of HIT and management programs, some of which is taking place in demonstration programs. More is needed on this front.

Dr. Primus noted that this list represents a framework for where the Democrats are going, but cautioned that "We're not going to get this all done this year."

"We're not going to get this all done this year."

— Wendell Primus, PhD

Other Important Point

- **Drug Negotiation Bill.** The Bill to allow Medicare prescription drug price negotiation has been among Democrats' legislative priorities, is stalled in the Senate and is unlikely to go forward at this time.

Exhibit 1: Complete Text of Recommendations from the IOM Report: *The Future of Drug Safety*

- 3.1: The committee recommends that the FDA Commissioner should be appointed for a six-year term of office. The Commissioner should be an individual with appropriate expertise to head a science-based agency, demonstrated capacity to lead and inspire, and a proven commitment to public health, scientific integrity, transparency, communication, and inclusion.
- 3.2: The committee recommends that an external Management Advisory Board be appointed by the Secretary of HHS to advise the FDA Commissioner in shepherding the Center (and the Agency as a whole) to implement and sustain the changes necessary to transform the Agency's/Center's culture—by improving morale and retention of professional staff, strengthening transparency, restoring credibility, and creating a culture of safety based upon a lifecycle approach to risk-benefit.
- 3.3: The committee recommends the Secretary of HHS direct the FDA Commissioner and Director of CDER, with the assistance of the Management Advisory Board, to develop a comprehensive strategy for sustained cultural change that positions the agency to fulfill its mission, including protecting the health of public.
- 3.4: The committee recommends that CDER appoint an ODS/OSE staff member to each NDA review team and assign joint authority to OND and ODS/OSE for post-approval regulatory actions related to safety.
- 3.5: To support appropriate balance between the agency's dual goals of speeding access to innovative drugs and ensuring drug safety over the product's lifecycle, the committee recommends that Congress should introduce specific safety-related performance goals in PDUFA IV in 2007.
- 4.1: The committee recommends that in order to improve the generation of new safety signals and hypotheses, CDER (a) conduct a systematic, scientific review of the AERS system, (b) identify and implement changes in key factors that could lead to a more efficient system, and (c) implement statistical-surveillance methods for the automated generation of new safety signals.
- 4.2: The committee recommends that in order to strengthen and test drug safety hypotheses, CDER should (a) increase their intramural and extramural programs that can access and study data from large automated databases and (b) include in these programs studies on drug utilization patterns and background incidence rates for adverse events of interest, and (c) develop and implement active surveillance for specific drugs.
- 4.3: The committee recommends that the Secretary of HHS, working with the Secretaries of Veterans Affairs and Defense, develop a public-private partnership with drug sponsors, public and private insurers, for profit and not for profit health care provider organizations, consumer groups, and large pharmaceutical companies to prioritize, plan, and organize funding for confirmatory drug safety and efficacy studies of public health importance.
- 4.4: The committee recommends that CDER assure the performance of timely and scientifically-valid evaluations (whether done internally or by industry sponsors) of Risk Minimization Action Plans (RiskMAPs).
- 4.5: The committee recommends that CDER develop and continually improve a systematic approach to risk-benefit analysis for use across the FDA in the pre- and post-approval settings.
- 4.6: The committee recommends that in order to improve the postmarketing assessment of drugs, CDER build internal epidemiologic and informatics capacity.
- 4.7: The committee recommends the Commissioner of FDA demonstrate commitment to building the scientific research capacity of the Agency by:
 - Appointing a Chief Scientist in the office of the Commissioner with responsibility for overseeing, coordinating, and ensuring the quality and regulatory focus of the agency's intramural research programs.
 - Designating the FDA's Science Board as the extramural advisory committee to the Chief Scientist.
 - Including research capacity in the mission statement of the FDA.
 - Applying resources for support of intramural research, approved by the Chief Scientist.
 - Ensuring that adequate funding to support the intramural research program is requested in FDA's annual budget request to Congress.
- 4.8: The committee recommends that FDA have its advisory committees review all NME either prior to approval or soon after approval to advise in the process of ensuring drug safety and efficacy or managing drug risks.
- 4.9: The committee recommends that all FDA drug product advisory committees, and any other peer review effort such as mentioned above for CDER-reviewed product safety, include a pharmacoepidemiologist or an individual with comparable public health expertise in studying the safety of medical products.
- 4.10: The committee recommends FDA establish a requirement that a substantial majority of the members of each advisory committee be free of significant financial involvement with companies whose interests may be affected by the deliberation of the committee.
- 4.11: To ensure that trial registration is mandatory, systematic, standardized, and complete, and that the registration site is able to accommodate the reporting of trial results, the committee recommends that Congress require industry sponsors to register in a timely manner at clinicaltrials.gov, at a minimum, all Phase 2 through 4 clinical trials, wherever they may have been conducted, if data from the trials are intended to be submitted to the FDA as part of an NDA, sNDA, or to fulfill a postmarket commitment. The committee further recommends that this requirement include the posting of a structured field summary of the efficacy and safety results of the studies.
- 4.12: The committee recommends that FDA post all NDA review packages on the agency's website.
- 4.13: The committee recommends that the CDER review teams regularly and systematically analyze all postmarketing study results and make public their assessment of the significance of the information with regard to the integration of risk and benefit information.

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