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AdvaMed
Advanced Medical Technology Association

HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

HEARING ON

DISCUSSION DRAFTS CONCERNING PRESCRIPTION DRUG USER FEE ACT REAUTHORIZATION, MEDICAL DEVICE USER FEE AND MODERNIZATION ACT REAUTHORIZATION, DRUG SAFETY, AND CERTAIN PEDIATRIC PHARMACEUTICAL AND DEVICE LEGISLATION

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Written Testimony

AdvaMed, the Advanced Medical Technology Association, represents more than 1600 medical technology companies, affiliates, and subsidiaries. Our members develop and manufacture medical devices, diagnostic products and medical information systems that represent nearly 90 percent of the health care technology products purchased annually in the United States, and nearly 50 percent of those purchased around the world. AdvaMed members range from the largest to the smallest medical technology innovators and companies. More than 70 percent of AdvaMed's core members have less than $30 million in sales annually. AdvaMed is pleased to offer this written testimony on behalf of our members.

AdvaMed believes that the reauthorization of the Medical Device User Fee and Modernization Act (MDUFMA) is good for the public health. It will facilitate the timely and effective review of new medical technologies and bring them to patients as soon as those products can be shown to meet the necessary rigorous FDA requirements. It also ensures that FDA's medical device program will be on sound financial footing. FDA's device program needs sufficient funding to do its job in a timely way, and this bill will ensure that the agency has that funding for the next five years. However, we have serious concerns that other provisions in the proposed discussion drafts will not serve the public health and instead will undermine the intended impact of user fees and FDA's authority to ensure safe and effective devices.

The constructive goals that emerged from FDA and industry discussions to improve medical device regulation are frustrated by the proposed preemption section that would overturn previous clear Congressional intent and court precedent and elevate individualized state decisions over FDA's expert science-based determinations of product safety and effectiveness. On this issue,

we have great concern that the draft not only harms the agency's ability to fulfill its mission to safeguard public health, but also disincentivizes research and development of life saving technologies and diminishes patient access to beneficial technologies. This represents a substantial step back and will cede our nation's leadership in health care innovation. Inclusion of the proposed preemption section may jeopardize industry support for the legislation.

The following summarizes our concerns with the proposals and identifies areas that we believe members of the Subcommittee should examine closely in order to further the public health.

Limitation on Federal Preemption

Section 108 of MDUFMA, which purports to be a "rule of construction," is (1) unnecessary and (2) damaging to medical device innovation and FDA's authority. Specifically, section 108 states "Nothing in this Act or the amendments made by this Act may be construed as having any legal effect on any cause of action for damages under the law of any State (including statutes, regulations, and common law)." It is hard to understand the point of the inclusion of this language in the proposed House bill except as an attempt to create ambiguity regarding the preemptive effect of fee-based agency actions, including approval of premarket applications (PMAs), and to deconstruct the clear Congressional expression of preemption included in the 1976 Medical Device Amendments. Consideration of an issue that would so fundamentally change the FDA regulatory structure should not be included in a bill designed to reauthorize the hiring of additional reviewers at the agency, especially given the importance of reauthorizing the bill before expert reviewers at FDA are notified that the funding, and therefore their jobs, may be in jeopardy.

Manufacturers (and their third party sources of capital that fuel further research and development) require a level of certainty that they will not be subject to state tort liability after spending the vast amounts of time, money, and other resources to adhere to stringent FDA requirements for PMA devices and to obtain FDA's full safety and effectiveness approval of a PMA device. Whether or not section 108 of MDUFMA is an attempt to muddy the waters regarding the preemptive effect of PMAs and device specific reviews, we believe it could have that effect and for that reason should be struck from the proposed House MDUFMA legislation.

Express preemption for medical devices is governed by section 521 of the Federal Food, Drug, and Cosmetic Act (or the FDCA), which expressly preempts state requirements that are "different from or in addition to, any requirement applicable under . . . [the FDCA] to the device, and" which relate "to the safety or effectiveness of the device or to any other matter included in a requirement applicable to the device under" the FDCA. According to the House Committee Report for the 1976 Medical Device Amendments, section 521 was included in the 1976 Amendments because consistency in requirements for medical devices was considered necessary to avoid unduly burdening interstate commerce.

Device specific reviews, such as a PMA, entail a comprehensive review of safety and effectiveness by FDA's expert scientists, physicians and other analysts. The PMA process established by the 1976 Amendments required the most exacting review for the riskiest devices, those in Class III. Additionally these devices were of the most concern, and included those which are either for use in supporting or sustaining human life, or are of substantial importance

in preventing impairment of human health or present an unreasonable risk of illness or injury. The safety and effectiveness of Class III premarket approval devices must be determined with respect to the persons for whom they are intended, with respect to the labeled conditions of use and by weighing any probable benefit to health from the use of the device against any probable risk of injury or illness from such use.

The PMA process is a rigorous, device-specific FDA review as has been recognized by the courts. To obtain PMA approval, a manufacturer must, among other things, submit full reports of investigations that provide a reasonable assurance of the safety and effectiveness of the Class III, PMA device, typically one or more clinical investigations. Breakthrough PMA devices normally are reviewed by an outside panel of experts. The amount and type of data necessary to meet the PMA approval standard of a reasonable assurance of safety and effectiveness requires expert scientific analysis that Congress long ago assigned to FDA and which the agency is uniquely qualified to render. FDA has vigorously advocated preemption in defending its role in determining the safety and effectiveness of devices in recent years.

A substantial majority of courts, including federal circuit courts, have held that the PMA process is the type of device specific review entitled to preemptive effect over state tort claims under section 521 of the FDCA. Nonetheless, there is a small minority of courts that have reached a different conclusion, including one federal circuit court. The Supreme Court has not directly addressed the question, thus some uncertainty remains despite the majority consensus favoring preemption in the federal circuit courts.

In sum, elevating individualized state actions and decisions through tort lawsuits over FDA's expert determination not only undermines FDA's authority regarding product-specific determinations, such as the requirements necessary for PMA approval and adequate device labeling, but also diverts resources from research and development to litigation and insurance. The PMA process applies to the approval of the newest, riskiest, most complex, and some of the most transformative and beneficial devices developed. Innovation leads to earlier disease detection, less invasive procedures, and more effective treatments. The cost of section 108 will be an unnecessary unsettling of the law and resulting additional uncertainty that will likely discourage investment and innovation and delay or deny patients access to devices.

Omission of Third Party Inspection program improvements

The MDUFMA discussion draft fails to address the problems currently plaguing third party inspections, a statutorily authorized program widely recognized as falling short of its potential to improve the inspection process and free up agency resources. AdvaMed was pleased to work with FDA and others in industry to design improvements to the FDCA to both encourage more participation and streamline the currently burdensome third party inspection program. We are extremely disappointed that these much needed improvements were not included in the House bill.

The reality of the situation is that FDA does not conduct inspections as often as they would like. In fact, they inspect facilities every six years on average rather than every two. So to reject a streamlining of this process that allows FDA to better focus their resources where they are most needed is short-sighted at best. In fact, the agreement reached by industry and FDA ensures that

more, not less, information about facilities will be made available to FDA. And at any time, FDA can choose to pursue its own inspection of any facility.

The changes included in the FDA/industry agreement are designed to streamline the process but do not change in any way the strong conflict of interest prohibitions for industry and third party inspectors. For example, the agreement contains provisions that would simplify the eligibility criteria and process by which establishments request an inspection by accredited parties. Those changes were included in the Senate-passed version of the reauthorization. For example, the owner or operator of an establishment is required to submit a notice to FDA that identifies, among other things, the most recent inspection and its classification. Establishments for which FDA classified the most recent inspection as 'official action indicated' would be ineligible for a third party inspection and, unlike under current law, could not submit a petition seeking such an inspection. The Senate bill also eliminated an eligibility requirement that was impractical to satisfy, namely that the owner or operator submit to FDA a statement that the government in a foreign country where the device is, or is intended to be, marketed recognizes an FDA or third party inspection.

Another important change to the program is the elimination on the number of times a company can use a third party inspection. Currently, a company is limited on the number of times it may use a third party inspector to two times. After two third party inspections, FDA must conduct an inspection. The Senate bill eliminates this limitation and allows a company to continue to use third party inspectors as long as the company maintains a good inspection record. Although this limitation is removed in S. 1082, the statute would require that an establishment must continue to have its inspection reports classified as compliant to continue participating in the program.

Under current law, if a manufacturer received a noncompliant inspection from an accredited third party, the company could appeal to the Secretary to remain in the program. This provision is removed from S. 1082.

The authority to conduct inspections at any time remains at the discretion of the FDA. The MDUFMA agreement and the Senate bill allow FDA to consider the goals of international harmonization of quality systems standards thus streamlining overlapping international inspection requirements. Specifically, it would allow FDA to accept international standards reports of certifications, thus providing the Agency the opportunity to receive additional information on a facility so they can focus their resources where they see the most risk. This is another provision that was omitted from the House discussion draft.

The failure to include these process improvements threatens the tenuous existence of the current third party inspection program.

Requirements for Unique Device Identifiers for all implants

The proposed amendment that would require FDA to establish a medical device registry and unique identification system for medical device implants represents a broad expansion of current law without delineating any criteria to govern which implants would be subject to the unique identifier requirements, *i.e.*, it is not risk-based and encompasses all implants regardless of their risk. Under the existing authority of §§ 510(e) and 502(o) of the FDCA, FDA is currently developing regulations for a system of unique device identification for all medical devices. Also, FDA currently has authority to require tracking for the useful life of any Class II or Class III device the failure of which would be reasonably likely to have serious adverse health

consequences, which is intended to be implanted in the body for more than one year, or which is life sustaining or life supporting and is used outside a user facility. FDA considers the following factors in determining whether a tracking order will be issued: likelihood of sudden, catastrophic failure; likelihood of significant adverse clinical outcome; and the need for prompt professional intervention. The agency has issued tracking orders for a number of devices including abdominal aortic aneurysm stent grafts, cardiovascular permanent pacemakers and electrodes, mechanical replacement heart valves, and silicone gel-filled breast implants.

The proposed identification and registry system would be a wholesale and unnecessary expansion of the present system. It could include devices not likely to have catastrophic failures or that are only implanted short term. For example, under the proposed language, sutures and dental implants would be covered. In sum, the proposed new UDI and registry requirements are duplicative and an unnecessary and unduly burdensome expansion of the current system without real public health benefit.

Availability of Pediatric Medical Devices

The device industry is committed to the goal of providing children access to life-saving, life-enhancing medical devices, and we commend Representatives Edward Markey and Mike Rogers for their work on the Pediatric Medical Device Safety and Improvement Act of 2007. AdvaMed has engaged in discussions with the offices of Representatives Markey and Rogers about the device industry's concerns (outlined below) and we are hopeful we can reach an acceptable agreement.

Because FDA has indicated it already has authority to require postmarket surveillance for any device at any time, including at the time of approval or clearance, we believe the language giving FDA authority to require postmarket surveillance as a condition of approval or condition of clearance is unnecessary. Importantly, the language as currently drafted has the unintended consequence of adversely impacting the availability of safe and effective medical devices for the broader population.

We are also concerned that the postmarket surveillance database duplicates an effort that FDA has already undertaken – to create a database of all postmarket surveillance device studies. There is no need to legislate the creation and maintenance of a new database – a costly and expensive proposition.

In addition, as we attack the problem of limited availability of pediatric devices for children, we need to address the root causes – lack of knowledge of pediatric needs and lack of incentives. The market for pediatric uses is often very limited, while the cost of development and regulatory clearance or approval can be comparable to the adult market. Unlike drugs, the kinds of incentives that exist in the Best Pharmaceuticals for Children Act are not available to the device industry. Creating incentives such as improvement in the pediatric HDE program, establishing a new compassionate use pediatric device provision, using existing regulatory mechanisms to facilitate device clearance and approval without reduced safety and efficacy standards for children, or creating tax credits or grant programs for companies developing pediatric devices could improve pediatric device access.

We thank Congressmen Markey and Rogers for their leadership on pediatric issues and look forward to working with them and members of the Subcommittee and the Full Committee to resolve the important, outstanding issues on this legislation.

Clinical Trial Registry and Results Databases

AdvaMed supports patient and doctor access to important information about the health benefits and risks of medical devices. The current language, however, would harm device innovation without any benefit to patients. We support the Senate language which requires disclosure of all clinical trial information once a device is actually available to patients.

In the competitive device environment, protecting proprietary technology is especially important because patents provide little protection for devices. Engineering or design changes can readily negate device patents whereas for drugs, entire molecules are patented, frequently before the first trial begins. As a result, disclosure of the existence of an Investigational Device Exemption (IDE) or related data in a registry could unfairly reveal important proprietary information to competitors who could speed competing devices into trials, obtain FDA clearance or approval and take advantage of the significant benefits associated with being first-to-market. When there is no FDA-approved product, information related to the device design and to the design of the trial and its endpoints is the only intellectual property a company may have.

Such disclosures could have the unintended consequence of eliminating many small device companies from the marketplace. Small companies account for the vast majority of device

innovation and contribute greatly to maintaining strong price competitiveness across the industry.

Differences Between Drugs and Devices

We encourage the House to consider including a recognition of the differences between drug and device trials in their database requirements. The Senate bill, for example, requires early registration of device clinical trials but protects sensitive intellectual property and trade secrets until the device is cleared or approved. In addition, S. 1082 recognizes that the vast majority of device companies are small and allows a link to the FDA-required PMA Summary of Safety and Effectiveness (SSE) or the 510(k) Summary to satisfy the bill's results requirements. More than 70 percent of AdvaMed's members have less than 50 employees and fewer than $30 million in sales annually. They will be unable to manage the extremely burdensome requirements of this legislation. The SSE and 510(k) Summary include a detailed summary of information on the clinical trials that supported the PMA or 510(k) application including information on any adverse events during the trial.

Finally, the discussion draft includes a requirement that any agreement that prohibits an investigator from discussing or publishing the results of a trial must be included in the clinical trials registry and results databases. The provision indicates a fundamental misunderstanding of the current nature of most device clinical trials which are multi-center trials (multiple sites and investigators conduct the trial). While device trials are much smaller than drug trials, they typically require multiple sites to assist with recruitment. FDA may also require multi-center trials in order to see experience over several sites. It is standard procedure to require

investigators to withhold discussing or publishing the results of a trial at their particular site until the data from all of the sites has been aggregated. Discussion or publication of information from one site could provide false or misleading information about the trial and could introduce bias (positive or negative) into the study that could jeopardize the integrity of the trial. Further, premature discussion or publication of one site's trial information could jeopardize publication of the aggregate data later in a peer-reviewed journal. Most medical journals refuse to publish information that has previously been released. Thus, there is a legitimate need for restrictions on discussion or publication until the data has been aggregated. Although there are rational and legitimate reasons to restrict individual investigators from premature release of information, the legislative requirement to reveal these restrictions will unfairly paint sponsors as bad actors.

To ensure continued medical device innovation for patients, AdvaMed recommends that the House legislation:

- Delay disclosure of device clinical trial registration information until the device is cleared or approved.
- Allow device companies to satisfy results requirements via a link to the PMA SSE or 510(k) Summary.
- Eliminate the faulty provision requiring disclosure of agreements that prohibit investigators from prematurely discussing or publishing clinical trial results.

Availability of Advisory Committee members with appropriate expertise

The House bill prohibits an advisory committee member from voting on a matter if that member, or an immediate family member, has a financial interest that could be affected by the committee's advice to FDA. The agency may grant a waiver of this prohibition if a waiver is necessary to afford the advisory committee essential expertise; however, only one waiver may be granted per committee meeting. AdvaMed is extremely concerned that the limitation of one waiver per committee meeting could prevent FDA from convening a panel of experts with the appropriate expertise to address the matter at hand. Because the waivers will be publicly disclosed, thus making the committee process transparent, we do not believe there is any harm in granting more than one waiver to highly qualified experts who bring unique expertise to the committee meeting. Advisory committees have been challenging to form because of the difficulty in recruiting the persons most expert in a type of device. We believe the House's one waiver limitation undermines other elements of this legislation which require FDA to conduct outreach and recruit potential members to advisory committees, including those who have waivable conflicts.

IOM Report on Premarket Notifications

The MDUFMA discussion draft requires an Institute of Medicine (IOM) "study on the appropriate use" of the 510(k) process "to clear medical devices as safe and effective." Although commonly referred to as a "clearance" system, the premarket notification system actually is a classification system which regulates classes of devices according to their risk profile. Congress developed the premarket notification process to mirror the incremental innovation process that occurs in medical technology and where appropriate to help expedite incremental improvements in devices through the regulatory process. Upon submission of a

premarket notification, FDA determines whether the device is "substantially equivalent" to a predicate device. To be substantially equivalent, the device must have the same intended use and the same technological characteristics as the predicate, or if it has different technological characteristics, there must be information submitted to FDA that demonstrates that the device is as safe and effective as a legally marketed device and does not raise different types of safety or effectiveness questions from the predicate device. Many 510(k) devices or their predicates have been on the market more than 30 years (i.e., prior to the Medical Device Amendments of 1976) and their benefits and risks are well-known and well-qualified.

Congress has fine-tuned the 510(k) process over its thirty year history to ensure that FDA has the necessary tools and can devote appropriate resources to devices as needed, including those which present a higher risk. Importantly, The Safe Medical Devices Act of 1990 (SMDA) strengthened the 510(k) premarket notification process by requiring substantial equivalence decisions to be made to currently marketed technology—not to technology that is no longer on the market. This has the effect of ensuring that FDA's substantial equivalence decisions are made to the most advanced technology available. SMDA also required that premarket notification submissions include detailed information concerning potential adverse health effects. Finally, SMDA gave FDA authority to impose a wide range of special controls including performance standards, postmarket surveillance, the submission of clinical data, the development of patient registries, and any other appropriate action needed to provide a reasonable assurance of the safety and effectiveness of a device.

While AdvaMed supports any independent analysis of the premarket notification system to ensure the system is operating to its full potential, because of the complexity of device regulation, any such analysis must be fully informed and include the perspectives of all potentially affected parties. It is important that any IOM review of the 510(k) process include a device representative. AdvaMed would want to ensure that any review of the 510(k) process thoroughly consider the views of its members.

Conclusion

In summary, AdvaMed strongly supports the reauthorization of MDUFMA. However, we have serious concerns with the draft legislation as proposed, and we ask that you consider the changes we have requested to ensure that the final draft accomplishes the goal of ensuring that Americans have access to safe and effective medical technology as soon as possible. We thank the Subcommittee again for its interest in these important regulatory issues. We look forward to working with Congress and the FDA on this legislation.