Advisory Commission on Childhood Vaccines

June 7, 2013

88th Meeting

Teleconference Minutes

Members Present

David King, Chair
Charlene Douglas, Ph.D.
Kristen Feemster, M.D.
Edward Kraus, J.D.
Ann Linguiti Pron, DPN, CPNP, RN
Luisita dela Rosa
Jason Smith, J.D.
Sylvia Fernandez Villareal, M.D.

Welcome, Report of the Chair and Approval of Minutes
Mr. David King, ACCV Chair

Noting a quorum present, Mr. King called the meeting to order and, after introductions, noted that this virtual meeting included an expanded interactive capability. He commented that verbatim transcripts are no longer prepared for the regular meetings of the Commission, but that each meeting is recorded and that the recordings will be available on the DVIC web site. He also announced that there are two opportunities for public comment on the agenda, the first exclusively for comments concerning the meeting agenda, and the second, at the end of the meeting, for any comments that members of the public would like to offer. If an individual is not able to attend the meeting and make a comment, or desires to offer an expanded comment, such comments may be submitted to the Commission at any time before or after the meeting.

Mr. King explained that there was interest at the last meeting in establishing a workgroup to collect and consider various case data that might become available. However, there was no Commission member who was willing to assume the responsibility of chairing that workgroup, which makes it impractical to establish the workgroup. He invited any member amenable to considering that task to contact Ms. Herzog.

Public Comment on Agenda Items

There were no individuals who requested time to make a comment.

Approval of March 2013 Minutes

On motion duly made by Mr. Kraus and seconded by Dr. Douglas, the minutes of the March 17, 2013 meeting were unanimously approved.

Report from the Division of Vaccine Injury Compensation
Dr. Vito Caserta, Acting Director

Dr. Caserta briefly reviewed the agenda for the teleconference. He provided some data on the number of claims filed to date, which appear to be in line with the numbers for the previous year, and the adjudications, which are also comparable to the past few years. He noted that, in the past few years, settlements have become the predominant route to adjudication, at an annual rate of about 80%. He

expressed the opinion that a settlement is a good mechanism that allows both parties to negotiate an acceptable agreement.

Dr. Caserta commented that the annual level of total compensation has been steadily increasing, and should reach over $200 million in the current fiscal year. He added that compensation to date already exceeds the total compensation for 2012. The Trust Fund stands at $3.4 billion, annual income to date is $86 million, $56 million from excise tax revenues levied on vaccine doses sold, and $30 million from interest on the corpus of the trust fund.

Concerning significant activities and events, Dr. Caserta mentioned an article in Judicial Watch that was written based on information derived from a FOIA request. The article contended that HPV vaccine appeared to be unsafe based on the number of concessions and the amount of compensation awarded. The article resulted in a challenge to the Canadian Immunization Committee from a private ethicist in Canada. The challenge indicated that Canada should not allow the use of HPV vaccine. That Committee has requested information from DVIC, which will be provided shortly. The Global Vaccine Initiative Alliance (GAVI), an international public-private funding group dedicated to the promotion of vaccine availability in Third World Countries, has also requested information from DVIC. Dr. Caserta explained that basing such a claim on this data from the Program is misleading to assess risk because, most adjudications are by settlement, and in settlements DVIC maintains its position that there was no vaccine causation of the alleged injuries.

Dr. Caserta noted that there is a chart on the DVIC web site that provides data on compensated claims, the number of vaccine injuries and deaths related to those claims, and the compensation awarded. Since that limited data has the same limitations as the data discussed in the Judicial Watch article, that is, lack of a valid analysis of the risks related to the claims, his office has designed a new web page that includes more complete data – numbers of concessions, settlements and court decisions, and the total number of vaccines distributed, which allows a comparison between the number of claims and the number of vaccines made available. Dr. Caserta added that the new web site includes detailed definitions of compensable case, conceded case, settlements, and non-compensable/dismissed cases. There was a brief discussion about whether the total number of vaccines distributed was less helpful than total number of vaccines administered. Several points were made including the fact that collecting reliable data from the thousands of distribution points (doctor's offices, public health facilities, storefronts, etc.) was a daunting challenge, whereas reporting doses distributed by manufacturers was more manageable. It was also observed that the economic imperative to avoid waste was motivation to use as many of the doses distributed as possible. There was a comment that, although not perfect, the doses distributed offered a reasonable estimate of consumption.

Noting that the Notice of Proposed Rulemaking (NPR) for the rotavirus vaccine is pending final approval, Dr. Caserta commented that the Department is awaiting a response from OMB for a waiver to OMB review. If granted the approval process would be considerably shortened.

He added that the NPR proposed changes to the Vaccine Injury Table, approved by the Commission in March 2012 that incorporates the findings of the 2012 IOM report, was a much more complicated process and it is still under HRSA review. He expressed the opinion that the NPR would be submitted to the Department before the next ACCV meeting.

To provide a better understanding of the process by which an NPR becomes a Final Rule, Dr. Caserta briefly outlined the process by which a new Notice of Proposed Rulemaking (NPR) wind its way through the system to become a Final Rule published in the Federal Register. After the NPR is initially developed, it is reviewed by the ACCV and then reviewed and approved by HRSA, working with the Office of General Counsel. The proposed rule is sent on to the DHHS executive secretary, which makes it available to other interested agencies within DHHS for review and comment. Any comments are considered by the Secretary and, if the proposed rule is approved it is sent on to OMB, which similarly makes it available to interested federal agencies outside DHHS. OMB review can take up to 90 days.

When all comments are considered and addressed, the NPRM published in the Federal Register and it is open for public comment for 180 days. If comments from the public are received they are reviewed by VICP, working with OGC, and the Final Rule is written, including an explanation of why any public comments were accepted or rejected. After final HRSA review, and a final review by OMB and the Secretary, the Final Rule is published in the Federal Register. Dr. Caserta added that the process is lengthy and may take from 18 to 24 months to complete.

Report from the Department of Justice
Vincent J. Matanoski, J.D.
Deputy Director, Torts Branch, Civil Division

Mr. Matanoski referenced the DOJ Power Point materials (DOJ PP), dated June 7, 2013, as part of his presentation.

Mr. Matanoski began with DOJ's statistical report for the time period of February 16, 2013 – May 15, 2013 (DOJ PP at 2-4). During this reporting period, 96 new petitions were filed. No petitions for autism were filed. Of those, 66 were filed on behalf of adults and 30 for minors, with the majority of petitions alleging injuries from seasonal influenza vaccinations. He predicted that the number of filings appears on track with the previous year, and should reach about 400 new petitions for the fiscal year. For this quarter, 338 petitions were adjudicated with 84 compensated and 254 not compensated/dismissed. Of the 84 claims compensated, five were conceded by HHS (all five were by decision adopting a proffer). Of the 79 cases compensated but not conceded by HHS, 1 was by decision awarding damages and 78 were by decision adopting a stipulation. There were three claims voluntarily withdrawn; all three were non-autism claims.

Mr. Matanoski identified the glossary of terms (DOJ PP at 5-7) together with the wire diagram depicting case processing (DOJ PP at 8) and the appeals chart (DOJ PP at 9-10). These have been presented at past meetings. Turning to appellate activity in at the U.S. Supreme Court, Mr. Matanoski noted that the Court issued its decision in *Sebelius (HHS) v. Cloer* on May 20, 2013. (DOJ PP at 11). The Court affirmed the *en banc* decision issued by the U.S. Court of Appeals for the Federal Circuit (CAFC) awarding attorneys' fees and costs in time-barred cases provided that the petition was filed in good faith with a reasonable basis. This decision could have significant impact on the Program since there are approximately 1,000 pending "time-barred" petitions in the Omnibus Autism Proceeding that could seek fees. Working with the Court, Mr. Matanoski and petitioners' counsel are considering a process to streamline eligibility for fees in those cases. He predicted that adjudication of attorneys' fees will likely involve significant DOJ resources given the fact-specific nature of determining reasonable basis in time-barred claims. Turning to appellate activity at the CAFC, Mr. Matanoski discussed three recently decided cases in appeals brought by petitioners. (DOJ PP at 12). *Shapiro v. HHS*, involved a fact-based dispute about whether or not the alleged injury occurred before the vaccination or shortly afterwards. The CAFC affirmed the special master's dismissal based on evaluation of the expert testimony, finding no legal error. In a 2-1 decision, the CAFC in *Figueroa v. HHS*, reversed the special master's decision dismissing the case (which had been affirmed by the U.S. Court of Federal Claims (CFC)), and remanded the case to the special master for further proceedings. In *Figueroa,* the CAFC found that the personal representative of the estate had standing to file a petition seeking compensation for personal injuries to the decedent, while he was alive, after the decedent's death, even though the death was not caused by the vaccine or alleged vaccine-related injuries. According to the CAFC, petitioner's alleged vaccine-injury claim survived his death even though the death was not vaccine-related. Mr. Matanoski predicted that this case could impact the Program as cases brought by an estate where the death was not vaccine-related will involve litigation as to the cause of a decedent's alleged vaccine-related injuries. Finally, the CAFC affirmed the dismissal of *Hrieche v. HHS*, as time-barred. There were four new appeals to the CAFC, two filed by petitioners and two by the DOJ. (DOJ PP at 13). *Lalonde v. HHS*, was filed by petitioner seeking review of the CFC's affirmance of the special master's decision denying entitlement based on evaluation of expert testimony. Petitioners also sought review in *Issac v. HHS*. There, the CFC affirmed the special master's decision denying entitlement based on expert testimony involving the concept of molecular mimicry,

together with evaluation of a thirty-year-old case report, and evidence from the Institute of Medicine. The government appealed the CFC's reversal of the special master's dismissals in the cases of *Snyder v. HHS* and *Harris v. HHS.* Both cases involved claims related to the genetic mutation, SCN1A/Dravet's Syndrome, which the special master found caused the alleged seizure disorder in both cases. Turning to appellate activity at the CFC, Mr. Mantanoski noted that four cases were recently decided. (DOJ PP at 14). In *Barnette v. HHS*, the CFC affirmed the special master's decision denying entitlement where the special master found that the vaccine did not significantly aggravate an underlying genetic condition, SCN1A/Dravet's Syndrome. *LaLonde v. HHS*, was discussed above. *Eisler v. HHS*, involved a redaction issue. In *Graves v. HHS*, the CFC reversed a decision by the special master awarding $60,000 in pain and suffering for petitioners' daughter, who experienced seizures prior to her death. In so doing, the CFC set aside the special master's findings as inconsistent with the Act, and determined that petitioners were entitled to the maximum $250,000 damages cap. Notwithstanding past award calculations, the CFC found that the special master erroneously based his award amount on comparisons with other similar cases, as opposed to determining an amount for pain and suffering, and then reducing that award to $250,000, if it exceeded the cap. Here, the CFC determined that an award of pain and suffering would exceed $250,000, thus the maximum amount of the damages cap was appropriate. Mr. Mantanoski predicted that this decision could impact the Program in terms of seeing higher pain and suffering demands seeking the maximum $250,000 damages cap. Mr. Matanoski expressed that the Act does not mandate a fixed amount for pain and suffering; rather, there should be latitude in arriving at an appropriate award relative to the alleged injuries. No new appeals were filed in the CFC. (DOJ PP at 15). There are no oral arguments scheduled this quarter. (DOJ PP at 16)

Turning to the slides entitled Adjudicated Settlements (DOJ PP at 17-25), Mr. Matanoski noted that 78 cases were settled during the current reporting period. At the Commission's request from the past meeting asking for an apportionment of settlements between adults and minors (under age 18 years), Mr. Matanoski reported that of the 78 settlements this quarter, it appeared that 66 were for adults and 12 for minors. Because the information derives from the petition, he cautioned that it is subject to the caveat that pleadings can be re-captioned during the pendency of the claim if a child reaches the age of majority. He observed that most of the settlements involved injuries allegedly caused by the seasonal flu vaccine. Approximately 65% of the petitions filed identified seasonal flu alone and/or in conjunction with other vaccines. Guillain-Barré Syndrome continued to be the predominant alleged injury. Most of the cases, 88%, were resolved within three years. Broken down, 27% resolved within a year; 38% within two years; and 23% within three years. There were five petitions that took between 5-13 years. The length of time was attributed to administrative issues such as obtaining medical records and/or having the case in an omnibus proceeding, as opposed to delay by the parties. Mr. Matanoski recalled that DOJ started providing this information in response to a prior Commission's request to review case processing time. Mr. Matanoski concluded his remarks by addressing the issue of "data mining" from settlements, in response to a specific request from the Process Working Group. Mr. Matanoski began by reiterating that the process is like a crucible. Releasing further information from individual settlements raises confidentiality issues, and does not lend itself to reliable safety evaluation. Counseling against attempts to gain vaccine safety information from individual settlements, Mr. Matanoski reiterated that there are innumerable reasons that parties settle a case - many of which are unrelated to science - making the value of such data highly suspect, if not completely useless. The settlement process is legal, not scientific, based on a preponderance of evidence and how a court might determine the outcome of a case. There is no reliable correlation between that process and vaccine safety. There is also an increasing trend for claimants to demand privacy and confidentiality with regard to details in the court record and in the settlements, which is required by the Vaccine Act. This is an important privacy protection for individual claimants. Mr. Matanoski reiterated that the quarterly stipulation breakdown discloses as much information as is permissible without breaching confidentiality provisions of the Act about individual settlements. The data provided identifies the vaccine or vaccines involved in a claim, the alleged injury or injuries, and case duration from filing to settlement.

During discussion, Mr. Kraus acknowledged the confidentiality issues while reiterating his position that with 90% of adjudications being achieved by settlement, the unavailability of information about the details of the settled claims and the process of arriving at settlement is a continuing concern in terms of providing valuable information to the public. He added that it should not be prejudicial to petitioners to

reveal settlement amounts in each case since that information is in the public record. Mr. Matanoski responded that the amount of an individual settlement has no relevance to safety issues and that aggregate data on settlement amounts is readily available. Further, he reminded the Commission of the Act's established mechanism to evaluate vaccine safety using medical and scientific bodies such as the IOM to conduct research.

During further discussion related to Congressional intent behind the pain and suffering cap, Mr. Matanoski commented that Congress was aware of the import of the relatively high $250,000 maximum pain and suffering provision and wanted to make the Program attractive to injured individuals who at the time still had the option to sue the vaccine manufacturer.

Review of Vaccine Information Statements,
Mr. Skip Wolf and Ms. Jenifer Hamborski, CDC

Mr. Wolf explained there was only one VIS to review, for the Tdap vaccine, which had been previously reviewed and revised. This review was prompted by new recommendations regarding pregnancy. He noted that the format had been revised to reflect the standard format for all VISs. Mr. Wolf invited comment section by section, noting that under the second section, Tdap Vaccine, the new recommendation for pregnant women called for a Tdap vaccination during every pregnancy. There was an observation that the requirement for a Td booster every ten years could be modified if an individual receives a Tdap vaccination during a pregnancy, essentially allowing the clock to start again.

Mr. Wolf commented that at the last ACCV meeting a recommendation was accepted to change the title of the section in all VISs from "Precautions" to "Some people should not get this vaccine." Asked about the lack of a contraindication warning if an individual has severe autoimmune disease, Dr. Caserta stated that there was no such contraindication recommended for Tdap vaccine. In fact studies have shown that the vaccine in individuals with severe autoimmune disease is protective and clearly beneficial. Mr. Wolf noted that the text of the section was unchanged from the earlier Td/Tdap VIS wording. In addition, under the Risks of Vaccine Reaction section, there is no evidence that there is any difference in the risks for either of the two vaccines. Dr. Caserta suggested that there should be some indication of the time frame for adverse reactions relative to the administration of the vaccine. Mr. Wolf recalled that he and Dr. Shimabukuro were tasked at the last meeting to develop wording about the risks of shoulder pain or injury (SIRVA), a task that should be completed before the next ACCV meeting. The wording would be added to all VISs.

Mr. Wolf concluded the discussion, noting that there were no changes in sections 5, 6 and 7.

Report from the Process Workgroup,
Luisita dela Rosa, Chair

Ms. dela Rosa reported that a recommendation had been approved at the last meeting to extend the statute of limitations for filing claims. After that meeting it was noted that there was no effective date in the resolution, and at a subsequent meeting the WG agreed that the proposed recommendation should be revised to reflect an effective date, which would coincide with the date of enactment of the resolution.

At the same meeting the Workgroup considered increased benefits cap for pain and suffering, and for death, and agreed that the cap for both should be tied to the consumer price index for urban consumers (CPI-U). When enacted the cap provisions should apply to all pending cases and all claims filed on or after the enactment date. The cap would go into effect in the year that the decision is made regarding pain and suffering, and the year of death for the death benefit. On motion duly made by Mr. Kraus, and seconded by Ms. Pron, the motion to that effect was unanimously approved.

Report on the ACCV and NVAC Maternal Immunization Workgroups,
Dr. Kristen Feemster, Commission Member

Background

Ms. Anna Jacobs, Office of General Counsel, provided background for the presentations related to maternal immunization injury claims. As with other injuries pursued under the VCIP, the claimant must prove eligibility, that a covered vaccine or any other vaccine was administered to the individual in an appropriate time frame, and that the alleged injury is either covered under the Vaccine Injury Table, or provide evidence that the vaccine caused the injury alleged. The claim may be for an alleged injury to the mother or for an alleged injury to the unborn fetus as a direct result of the mother's inoculation. However, in the latter case, the special masters who hear cases have not reached a consensus. In general the federal government has not accepted the premise that a claim can be made for a second party, the fetus. Petitioners have contended that the statute does cover such circumstances. Resolution of this issue will rely on case law that develops through decisions and appeals. To date no appeals have reached the Federal Circuit. In addition, the issue is complicated when new vaccines are developed that may be recommended for pregnant women but not for routine administration in children.

Finally, the issue must be considered in light of the CICP, under which regulations have been established that provide compensation protection to a child who survives birth with an injury that can be shown to have been caused by a vaccine received by the mother during pregnancy. Ms. Jacobs stated that the Secretary has asked that ACCV and NVAC consider the issue related to maternal immunization.

Report of ACCV Maternal Immunization Workgroup

Dr. Feemster explained that recommendations for immunizing women during pregnancy are expanding. The Advisory Commission on Immunization Practices (ACIP) currently recommends that all pregnant women at 20 weeks or greater gestational age receive Tdap during each pregnancy and that all pregnant women receive inactivated influenza vaccine. New vaccines against respiratory syncytial virus (RSV) and Group B *Streptococcus* are currently under development and, if approved, would likely be exclusively recommended for pregnant women. These current and potential future recommendations address the increased risk of morbidity and mortality associated with influenza in pregnant women and also protects young infants by preventing transmission of pertussis, influenza, RSV, Group B *Streptococcus* and tetanus. Studies have shown that maternal immunization is effective in preventing many of these diseases. Young infants are especially at risk for poor outcomes associated with these diseases and are too young to be vaccinated. Maternal immunization can decrease the risk of exposure by preventing disease in mothers and also provide protection to the young infant through the passage of maternal antibodies.. Current studies show that maternal immunization benefits the mother and the infant, and have not identified any vaccine-related adverse events specific to vaccinated pregnant women and their infants. There is evidence that vaccines do not increase risk for specific adverse outcomes, including teratogenicity, growth or functional impairment, spontaneous abortion or preterm birth, small for gestational age or birth defects. Although there is a theoretical possibility of risk if live vaccines are administered, and they are contraindicated for pregnant women, there is no evidence of fetal infection or malformations in births from women who were inadvertently vaccinated with a live vaccine.

Successful implementation of recommendations for maternal immunization will require that women and health care providers have confidence in vaccines, know that the healthcare community will continually monitor the safety and efficacy of vaccines, and be aware that the VICP is available when a vaccine is administered during pregnancy.

Dr. Feemster reviewed the history of the workgroup, which was convened in June 2012 to consider a response to four charges from the Commission for vaccines administered during pregnancy. The workgroup met at least every two months, developed a working relationship with the NVAC Maternal Immunization Working Group, and arrived at the proposed recommendations which would be discussed at this meeting. The four charges addressed by the workgroup focused upon the following areas:

- Charge 1: Eligibility for compensation for injuries from vaccines not currently covered by the vaccine injury compensation program. This would include vaccines recommended for pregnant women but not recommended for routine administration to children. Under the statute, such

vaccines would not be covered by the program. There are no currently recommended vaccines that fit this condition. However, it is likely that both an RSV and Group B Streptococcus vaccine will be licensed for exclusive administration to pregnant women in the future.

- Charge 2: Eligibility for compensation for injuries sustained by a live-born infant from covered vaccines received by the mother while the infant was in utero. This would include covered vaccines currently recommended for administration during pregnancy as well as covered vaccines that are not routinely recommended but may be sometimes given during pregnancy. While the mother is the recipient of such vaccines, the group also considered eligibility of the infant.
- Charge 3: Review the current vaccine safety monitoring infrastructure in light of expanding recommendations for maternal immunization.
- Charge 4: Review ACCV membership guidelines and consider inclusion of individuals who provide care to pregnant women to reflect changes in VICP

Dr. Feemster discussed the recommendations that the workgroup developed:

- ***The Secretary should pursue expanded coverage under the VICP to include vaccines that are recommended for categories other than children (e.g., pregnant women) and are not recommended for routine administration in children*.**

The Secretary could pursue a legislative amendment to effect the provisions of the recommendation, which would be a specific, definitive action, but one that could take significant time, would be influenced by the political process, and which in the end might fail. The Secretary could turn to administrative rule-making to adopt a broader interpretation of the present statute (e.g., to interpret the statute such that an infant could be considered the beneficiary of maternal immunization through the maternal antibodies that would be created by the vaccines). This is an expeditious and flexible approach to policy change, but may have unanticipated consequences since other vaccines recommended for individuals other than children could affect significant VICP program changes and increase expenditure of resources. This approach also requires acceptance of a broad interpretation by the Secretary that the approach is legally permissible and in consonance with the intent of the legislation.

- ***The Secretary should support eligibility to pursue compensation for injuries sustained by a live-born infant whose mother receives a vaccine while the infant is in utero. The Secretary may consider support of a statutory amendment, administrative rulemaking (both discussed above) or support for a litigation strategy (e.g., pursue a policy to develop case law that supports the recommendation).***

It was noted that the Department of Justice actually determines litigative strategies, so the recommendation is for the Secretary to *support, not initiate, legislative* strategies. The considerations that apply to pursuing either amendment or rulemaking are the same as those discussed in the first recommendation. In addition, rule-making is a public process that may reassure the public of the benefits of the changes but, since the court has the final word in the matter of claims, the final rule may not be binding.

- ***The Secretary should continue to support the various systems in place to monitor safety during pregnancy, including the Vaccine Adverse Event Reporting System (VAERS), pregnancy registries maintained by vaccine manufacturers, the more controlled surveillance through the Vaccine Safety Data Link, and the new Vaccines and Medications in pregnancy Surveillance System (VAMPSS) recently established to conduct prospective, case-controlled surveillance of vaccine exposure and outcomes during pregnancy.***

- ***The Secretary should consider having a health professional with expertise in obstetrics as one of the health professionals required to be a member of the Commission under the ACCV charter.***

That charter states that the ACCV should be composed of nine members, including three health professionals not employed by the federal government, two of whom should be pediatricians. The health professionals must have expertise in pediatric health care, and the epidemiology and etiology of childhood diseases, including adverse events related to vaccines.

Presentation by NVAC,
Dr. Catherine Torres

Dr. Torres explained that there are several illnesses that can be prevented by vaccines that affect pregnant women and their neonates – tetanus (very high rate in developing countries, very low rate in the U.S.); influenza (high morbidity/mortality rates from pandemics and seasonal flu, which can be significantly reduced by immunizing expectant mothers); and pertussis, which is a threat to infants less than three months of age, when they are too young to be immunized. Dr. Torres commented that Healthy People 2020 included goals to reduce pertussis in children under a year of age, and increase the percentage of pregnant women who receive flu vaccine (53% of pregnant women receive flu vaccine). ACIP recommended flu vaccine for pregnant women in 1995, and in early 2013 recommended that pregnant women receive a Tdap booster in the third trimester of each pregnancy.

Dr. Torres briefly described the National Vaccine Advisory Committee, formed in 1987, that makes recommendations to the Director of the National Vaccine Program (the Assistant Secretary of Health). In August 2012 NVAC established a Maternal Immunization Working Group (MWIG) to review maternal immunization, identify barriers to optimize maternal immunization, and to make recommendations on those issues. NVAC is addressing uncertainties about vaccine liabilities that may discourage health care providers from recommending/providing vaccines to pregnant women, and may impact progress is development of new vaccines. NVAC's goals include:

- Improve communications about safety and efficacy of recommended vaccines;
- Maximize the likelihood that maternal health care providers will recommend appropriate maternal immunizations;
- Improve financing for immunization services during and after pregnancy;
- Increase use of electronic health records to strengthen surveillance efforts; and
- Address issues related to current vaccine liability to overcome barriers that would inhibit maternal immunization.

The MIWG focuses its recommendations on three of five National Vaccine Plan goals – to enhance vaccine safety; to enhance informed vaccine decision-making; to support efforts to maintain a stable supply of vaccines, and improve access and better use of recommended vaccines in that supply. Next steps for the MWIG will be to submit draft recommendations to the NVAC in June, complete a final draft after comments from NVAC and submit a recommendation report in September. The last step in the fall of 2013 will be to begin looking at barriers to developing new vaccines specifically for pregnant women.

Discussion

Asked about specific recommendations for the new vaccines, it was noted that the vaccines are not yet fully developed and recommendations would follow final formulation. It was also noted that it is important to include the new vaccines under the VICP in order to successfully complete the development process. Manufacturers are not enthusiastic about pursuing vaccine development unless there is high confidence that they will be covered.

The Commission commented on each charge/recommendation in order.

There was a brief discussion about the possibility that Recommendation 1, concerning expanding coverage to a number of vaccines being recommended for categories other than children, could create additional burdens on the VICP, both in terms of adding new vaccines to the Vaccine Injury Table, the concomitant administrative costs, burdens on the courts, and increased liability from recommended vaccines not yet added to the Table. There was also a suggestion that the recommendation be narrowed to include only pregnant women and the following wording was recommended:

Recommendation 1. The Secretary should pursue expanded coverage under the VICP to include vaccines that are recommended for routine administration to pregnant women, and are not recommended for routine administration in children.

On motion duly made and seconded, the Commission unanimously approved Recommendation 1 by a vote of 8 for, none opposed

The Commission agreed that the second recommendation should be revised to specify that compensation could be sought for injuries to an infant whose mother received a covered vaccine

Recommendation 2. The Secretary should support eligibility to pursue compensation for injuries sustained by a live-born infant whose mother receives a covered vaccine while the infant is in utero.

The word "covered" was added to the wording put forth during the earlier discussion of recommendations.

On motion duly made and seconded, the Commission unanimously approved Recommendation 2 by a vote of 8 for, none opposed

The Commission agreed that the third charge referred mainly to information collected during the surveillance process, and there was no recommendation proposed.

The recommendation coming from the fourth charge was a straightforward recommendation that a health care professional specializing in health care of children (specifically an obstetrician) be included in the membership of the Commission. There was a brief discussion of the specific descriptions of Commission membership found in the charter, including the requirement for two "pediatricians." There was agreement that the interpretation of "pediatrician" could include pediatric specialties that include other areas of expertise, such as internal medicine.

Recommendation 3. The Secretary should consider mandating that an obstetrician with maternal-fetal expertise be designated as one of the health professionals required to be a member of the Commission under the ACCV charter.

On motion duly made and seconded, the Commission unanimously approved Recommendation 3 (a response to Charge 4) by a vote of 8 for, none opposed

Mr. King noted that the discussion regarding the recommendations from the Maternal Immunization Workgroup was concluded.

Update from the Immunization Safety Office (ISO),
Dr. Tom Shimabukuro, CDC

Dr. Shimabukuro noted that the ACIP meeting would occur later in June and an update of that meeting would be presented at the next ACCV meeting. At the ACIP meeting there will be presentations related to safety and immunogenicity of Japanese encephalitis vaccine in children; a report from the General Recommendations on Immunization Working Group; an update on human papillomavirus (HPV) vaccine, including a discussion of the Merck Pregnancy Registry for quadrivalent HPV vaccine; and an influenza update, including a vaccine safety update for the 2012-2013 influenza season. Finally, there

will be a major session devoted to rotavirus vaccines that will include review of data from the Vaccine Safety Datalink, VAERS, the Post-Licensure Rapid Immunization Safety Monitoring (PRISM) system, a review of the Australian surveillance experience, and a summary of risks and benefits of rotavirus vaccination in the U.S.

Dr. Shimabukuro commented that the recent outbreak of avian influenza A (H7N9) in China has been in the news and CDC has responded by activating the CDC Emergency Operations Center on April 8, 2013 to support response to the outbreak. A website page is up that provides answers to frequently asked questions (http://www.cdc.gov/flu/avianflu/h7n9-faq.htm) and the Department is coordinating steps to develop H7N9 candidate vaccine viruses for use in vaccine manufacturing. One or more of those candidate vaccine viruses could be used by manufacturers if needed.

There have been several recent publications since the last ACCV meeting. DeStefano et al. concluded that increasing exposure to antibody-stimulating proteins and polysaccharides in vaccines during the first 2 years of life was not related to risk of autism spectrum disorders.

Tseng et al. looked at post licensure surveillance of 13-valent pneumococcal conjugate vaccines, which replaced the 7-valent formulation, and found that compared to the 7-valent pneumococcal conjugate vaccine, no significant increased risk of pre-specified adverse events was identified. There was a non-statistically significant increase in risk for Kawasaki disease that may deserve further investigation.

McNeil et al. analyzed the likelihood of reporting vaccine adverse events to VAERS by primary care providers, a knowledge-attitude-behavior study, and concluded that primary practice area and the practitioners' familiarity with adverse reporting were significantly associated with likelihood of healthcare provider reporting to VAERS.

Irving et al. concluded that there was no statistically significant increase in risk of spontaneous abortion within the four weeks after seasonal inactivated influenza vaccine administration.

Finally, Haber et al. reported that clustering of reported intussusception 3-6 days after initial dose of Rotateq vaccine could suggest a small increased risk of intussusception, which is outweighed by the benefits of rotavirus vaccination. Dr. Shimabukuro added that two additional papers on intussusception would be discussed at the upcoming ACIP meeting in June.

Asked about mandatory reporting to VAERS, Dr. Shimabukuro explained that manufacturers are required to report adverse events in accordance with regulatory requirements, and health care providers are mandated to report adverse event listed on the VAERS table of reportable events, but there is no regulatory requirement for reporting by individuals.

Update on the National Institute of Allergy and Infectious Diseases (NIAID), Claire Schuster, NIAID, NIH

Ms. Schuster commented that NIAID is working with other federal agencies to assess and address the threat of H7N9 influenza, supporting basic research, generating vaccine seed strains that could be used in vaccine manufacture, and planning clinical trials. She noted a paper by Kanekiyo et al published in Nature on May 22, 2013 about an experimental vaccine based on the action of a protein, ferritin, fused with hemagglutinin (HA), that resulted in an enhanced immune response in mice and ferrets. It could be a step towards a universal flu vaccine.

Another breakthrough came from a team led by Philip Dormitzer when the team of international collaborators successfully generated flu vaccine seeds in less than 5 days, by using synthetic genomics technology.

Finally, Ms. Schuster described a clinical trial of a vaccine, ROTAVAC, developed through a public/private collaboration with the government of India, Bharat Biotech International, Ltd, Program for

Appropriate Technology in Health (PATH), NIAID, and other partners. The vaccine reduced severe rotavirus diarrhea by more than half during the first year of life, with protection extending into the second year of life.

Ms. Schuster stated that at the same time the ACCV teleconference was in progress, NIAID was sponsoring in Rockville, Maryland a workshop on *Staphylococcus aureus* vaccines that will address the current state of the science, and invite discussion on future research.

Update on the Center for Biologics, Evaluation and Research (CBER),
LCDR Valerie Marshall, CBER, FDA

LCDR Marshall reported that FDA had approved a supplement for Japanese Encephalitis Vaccine, Inactivated, Adsorbed to extend the age rage to include children 2 months to < 17 years of age. There are no reports of JEV infection occurring in North America, so the risk to residents of the U.S. occurs from travel to endemic regions.

She announced that on May 2 and 3, FDA and NIH co-sponsored a workshop to exchange information with the medical and scientific community about the regulatory and scientific issues associated with fecal microbiota for transplantation (FMT). FMT is used to treat patients suffering from *Clostridium difficile* infection, ulcerative colitis, and other related infections. Clinical studies to evaluate the safety and efficacy of FMT are regulated by FDA.

Finally, CBER participated in a briefing for the Assistant Secretary for Health on the pertussis workshop held on March 6 on the state of the science for pertussis prevention and therapy. CBER discussed clinical development of pertussis vaccines and presented its baboon animal model that was developed to address some of the scientific gaps in knowledge regarding pertussis.

While the risk to people in the United States from H7N9 continues to be low, because of the pandemic potential posed by the virus, FDA with CDC, NIH, and other public health agencies are taking proactive steps in the event that virus becomes transmissible between people. FDA is developing clinical protocols, and is actively engaged with vaccine manufacturers.

Update on the National Vaccine Program Office (NVPO),
Dr. Steve Bende, NVPO

Dr. Bende discussed the policy of the Assistant Secretary for Health, Dr. Howard Koh, to promote an increased participation in immunization by adults. After the 2009 flu pandemic the Department actively promoted immunization successfully in children, pregnant women and for the purpose of reducing disparities – but the response of the adult population was disappointing. A task force was established to focus on adult immunization, made up of federal and non-federal stakeholders, with Dr. Koh as chair. The task force and the Department is also focused on the increasing emergence of pertussis as a health issue. Finally, Dr. Bende mentioned that the Affordable Care Act has a provision that health plans must cover ACIP-recommended vaccines without co-pays or cost-sharing and the issues related to that transition are being addressed. Dr. Bende described the Interagency Immunization Safety Task Force, coordinated by NVPO to ensure effective and consistent discussion of immunization safety issues among the various concerned federal agencies.

The Institute of Medicine will present a discussion of safety of the childhood immunization schedule at the upcoming NVAC meeting. The IOM report recommends continuation of childhood immunization on the present schedule. The IOM report also maintains that randomized, controlled trials of children who are immunized vs. unimmunized would be unethical considering the risks versus benefits of the present program. The current surveillance programs, such as the Vaccine Safety Datalink, are sufficient to provide answers to the question of whether or not to immunize all children and should be further leveraged. The IOM has also accepted a charge from NVPO to develop a prioritization tool that would help researchers decide on which vaccines should be developed and in what order. The IOM is developing a software tool that includes 29 parameters for making that decision.

Dr. Bende commented that there are several working groups active in the immunization area that would be heard from at the NVAC meeting, including the Global Immunization Working Group that develops policy recommendations for the Department's involvement in global programs; the Maternal Immunization Working Group described earlier in the meeting; a working group focused on vaccine hesitancy. It seems that there are isolated areas where hesitancy can lead to lower overall population immunity and make possible isolated outbreaks of disease that can and should be prevented through broad immunization coverage. Finally, there is a new working group on HPV virus that recently issued its first report, discussing the reasons that the initial acceptance of HPV vaccine has been disappointing.

Public Comment

Mr. Wayne Rode, parent of a vaccine-injured child, reiterated his earlier suggestion that public comments should be welcomed from individuals interested in making a comment without having to be present at the meeting, that is, perhaps by e-mail. His main point concerned a proposal by Dr. Caserta to link vaccine dosage to claims that are compensated or dismissed. Mr. Rode felt that it would minimize the number of petitions to make vaccine injury appear to be fewer than is actually the case. He added that VAERS data is difficult to interpret – the number of actual injuries that would qualify for a claim versus the number of individuals who approach attorneys to discuss filing claims versus the number of claims actually filed. He recommended developing a way by which the actual number of doses administered could be compared with the claims filed.

Ms. Theresa Wrangham, representing the National Vaccine Information Center, commented that in light of the need for transparency the public should be able to glean information about the types of compensation awarded by vaccine and by injury, and that information should be aggregated and explained perhaps on an appropriate web site. She added that the same web site might contain information that would explain the various terms related to compensation, injury and vaccines.

Mr. King reiterated an earlier announcement that individuals may submit written comments for inclusion in the public record by sending them to Ms. Andrea Herzog at e-mail address aherzog@hrsa.gov

Future Agenda Items/New Business

Considering the increasing number of claims made by adults, Dr. Pron suggested discussing the charter and the name of the commission at a future meeting. Dr. Caserta commented that currently all of the vaccines covered are childhood vaccines, regardless of the age of the recipient. He added that as the nature of coverage changes, for example, with the addition of obstetrical vaccines for pregnant women, it might be appropriate to look at the issue.

Adjournment

Whereupon, on motion made and unanimously approved, the meeting was adjourned.

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Vito Caserta, M.D. Date
Executive Secretary, ACCV