



What Changed, What Matters: Navigating the Latest Vaccine Schedule Updates

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What's happening?

GREAT QUESTION. I THINK WE ARE ALL WONDERING THAT.

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What's happening?

JANUARY 5, 2026

HHS released a memo stating that the CDC's recommendations on childhood vaccines will be updated to align more closely with those of other high-income countries.

The New York Times

Kennedy Scales Back the Number of Vaccines Recommended for Children






Federal health officials now recommend that children be routinely inoculated against 11 diseases, not 17, citing standards in other wealthy nations.



HOW DID WE GET HERE?

Let's take a look...

Where's this coming from?

	TOTAL VACCINE DOSES	DISEASES TARGETED
 UNITED STATES	72	18
 DENMARK	11	10
 SWEDEN	19	11
 GERMANY	22	15
 JAPAN	28	14

*Presented at the December
5th, 2025 ACIP Meeting*



WHY this is misleading:

Counts doses, not protection

- Multiple doses \neq more vaccines or higher risk.

Inflates totals with annual flu/COVID

- These make up a large share of lifetime doses.

Miscounts combination vaccines

- One shot protecting against multiple diseases is often counted as several.

Ignores how safety is actually evaluated

- Dose counts don't measure safety, effectiveness, or outcomes.

Antigen exposure associated with childhood vaccines is like a drop in the ocean compared to the environmental exposure a child encounters everyday.



Misconception: More vaccines are more dangerous.

It's true children born before the 1990s received fewer vaccines than today's kids, but there were fewer vaccines available.

Let's look at the facts...

NORTH DAKOTA STATE UNIVERSITY
CENTER FOR IMMUNIZATION RESEARCH AND EDUCATION


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Today, the Trump Administration is proud to announce the United States of America's updated Childhood Vaccination Schedule. This Schedule is rooted in the Gold Standard of Science, and widely agreed upon by Scientists and Experts all over the World. Effective today, America will no longer require 72 "jabs" for our beautiful, healthy children. We are moving to a far more reasonable Schedule, where all children will only be recommended to receive Vaccinations for 11 of the most serious and dangerous diseases. Parents can still choose to give their children all of the Vaccinations, if they wish, and they will still be covered by insurance. However, this updated Schedule finally aligns the United States with other Developed Nations around the World. Congratulations to HHS Secretary Bobby Kennedy, CDC Acting Director Jim O'Neil, FDA Commissioner Marty Makary, CMS Administrator Dr. Oz, NIH Director Jay Bhattacharya, and all of the Medical Experts and Professionals who worked very hard to make this happen. Many Americans, especially the "MAHA Moms," have been praying for these COMMON SENSE reforms for many years. Thank you for your attention to this matter!


DONALD J. TRUMP
PRESIDENT OF THE UNITED STATES OF AMERICA

European Country



11 injections

United States



72 injections

Source: HHS Assessment of U.S. Childhood and Adolescent Immunization Schedule Compared to Other Countries – 1/5/26

More Childhood Vaccines - But Fewer Antigens

Number of Immunogenic Proteins and Polysaccharides Contained in Vaccines Over the Past 100 Years

1900		1960		1980		2000		2025	
Vaccine	Protein	Vaccine	Protein/Sugar	Vaccine	Protein/Sugar	Vaccine	Protein/Sugar	Vaccine	Protein/Sugar
Smallpox	~200	Smallpox	~200	Diphtheria	1	Diphtheria	1	Diphtheria	1
TOTAL	~200	Diphtheria	1	Tetanus	1	Tetanus	1	Tetanus	1
		Tetanus	1	WC pertussis	~3000	Acellular pertussis	2-5	Acellular pertussis	2-5
		WC pertussis	~3000	Polio	15	Polio	15	Polio	15
		Polio	15	Measles	10	Measles	10	Measles	10
		TOTAL	~3217	Mumps	9	Mumps	9	Mumps	9
				Rubella	5	Rubella	5	Rubella	5
				TOTAL	~3041	Hib	2	Hib	2
						Varicella	69	Varicella	69
						Pneumococcus	8	Pneumococcus	16-21
						Hepatitis B	1	Hepatitis B	1
						TOTAL	123-126	Rotavirus	11-16
								Hepatitis A	4
								TOTAL	146-160

WC = whole-cell
Offit, CHOP VEC, 2021

More details emerged:

The New York Times

Dec. 19, 2025

R.F.K. Jr. Likely to Swap U.S. Childhood Vaccine Schedule for Denmark's

The shift would mean fewer shots recommended for children. But a Danish health official found the idea baffling, saying the United States was getting “crazier and crazier in public health.”

On December 19, 2025 news broke about changes to the recommended vaccination schedule.

FOR IMMEDIATE RELEASE
January 5, 2026



U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES


Contact: HHS Press Office

202-690-6343

[Submit a Request for Comment](#)

CDC Acts on Presidential Memorandum to Update Childhood Immunization Schedule

WASHINGTON, D.C. — JANUARY 5, 2026 — Deputy Secretary of Health and Human Services Jim O’Neill, in his role as Acting Director of the Centers for Disease Control and Prevention (CDC), today signed a [decision memorandum*](#) [PDF, 894 KB] accepting recommendations from a [comprehensive scientific assessment](#) [PDF, 1.05 MB] of U.S. childhood immunization practices, following a directive from President Trump to review international best practices from peer, developed countries.

On December 5, 2025, via a [Presidential Memorandum](#) , President Trump directed the Secretary of HHS and the Acting Director of CDC to examine how peer, developed nations structure their childhood vaccination schedules and to evaluate the

HHS announces unprecedented overhaul of U.S. childhood vaccine schedule on January 5, 2026.

New HHS Childhood Immunization Schedule

(released January 5, 2026)

Recommended for all children

- Diphtheria
- Tetanus
- Acellular pertussis (whooping cough)
- Haemophilus influenzae type b (Hib)
- Pneumococcal conjugate
- Polio
- Measles
- Mumps
- Rubella
- Human papillomavirus (HPV)
- Varicella (chickenpox)

Recommended for certain high-risk groups or populations

- RSV*
- Hepatitis A
- Hepatitis B
- Meningococcal

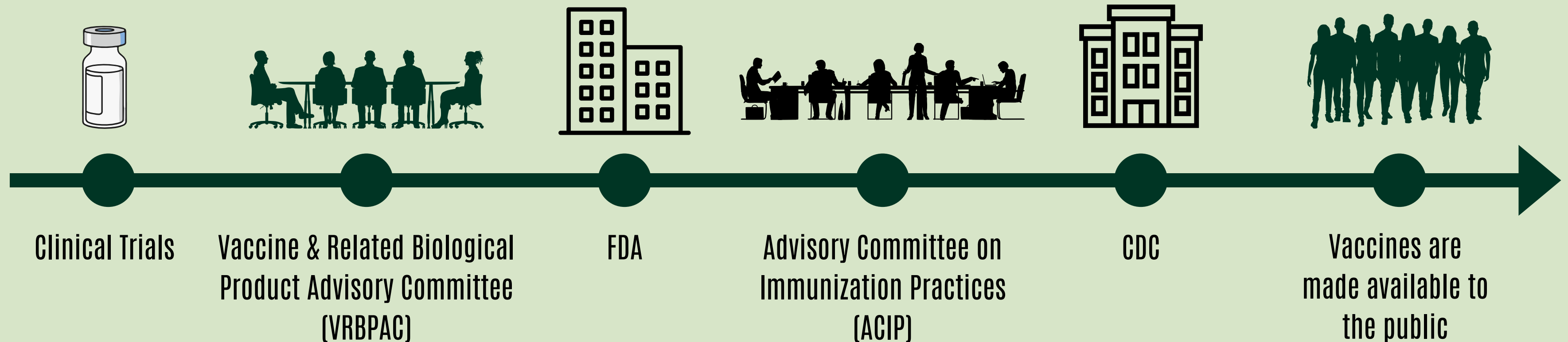
*Note: any children whose mother didn't have RSV vaccination during pregnancy should get one dose of RSV monoclonal antibody

Recommended based on shared clinical decision-making

- Rotavirus
- COVID-19
- Influenza (flu)
- Hepatitis A
- Hepatitis B
- Meningococcal

Vaccine Recommendation & Approval Process

TRADITIONALLY



FDA approval determines whether a vaccine can be used.

ACIP recommendations determine how vaccines are used in public health practice.

CDC director approval > publish official guidance > U.S. routine immunization schedule

BOTH VRBPAC and ACIP include public, documented deliberation

What does VRBPAC do?

Independent panel of career scientists and vaccine experts

Reviews manufacturer licensure or EUA applications

Evaluates safety, efficacy, and appropriate use

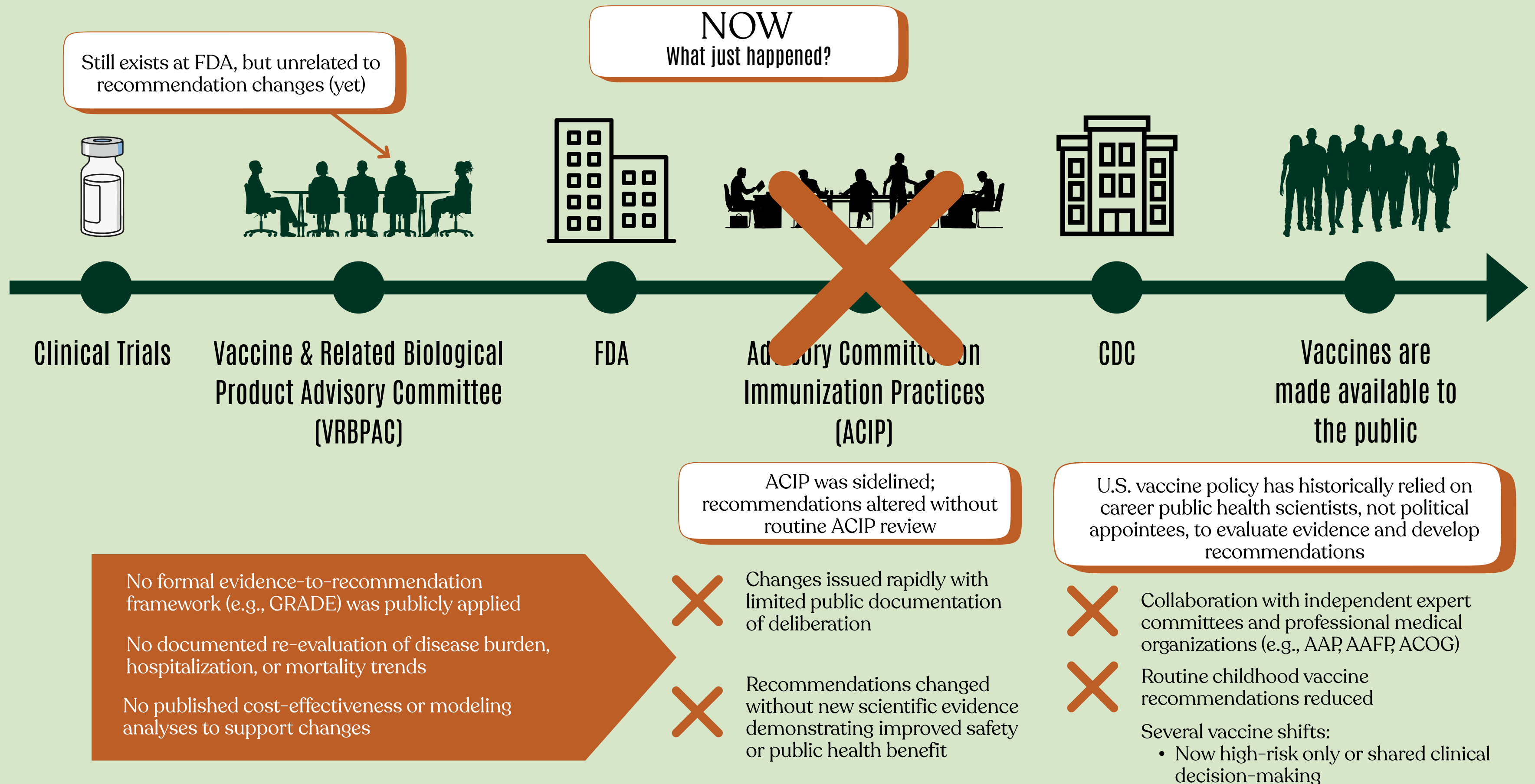
What does ACIP do?

Independent medical & public health experts vote on recommendations using:

- ✓ GRADE framework
- ✓ Epidemiology & disease burden
- ✓ Population-specific analysis

Public opinion informs communication and implementation - not scientific evidence thresholds.

Vaccine Recommendation & Approval Process



Denmark Vaccine Schedule

LET'S DIVE DEEPER



“

The assessment reviewed 20 peer, developed nations and found that the U.S. is a global outlier among developed nations in both the number of diseases addressed in its routine childhood vaccination schedule and the total number of recommended doses but does not have higher vaccination rates than such countries. In fact, many peer nations that recommend fewer routine vaccines achieve strong child health outcomes and maintain high vaccination rates through public trust and education rather than mandates.

HHS Press Release, January 5, 2026

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How do vaccine schedules compare?

THE U.S. IS AT THE UPPER END BUT STILL PART OF THE SAME OVERALL PATTERN

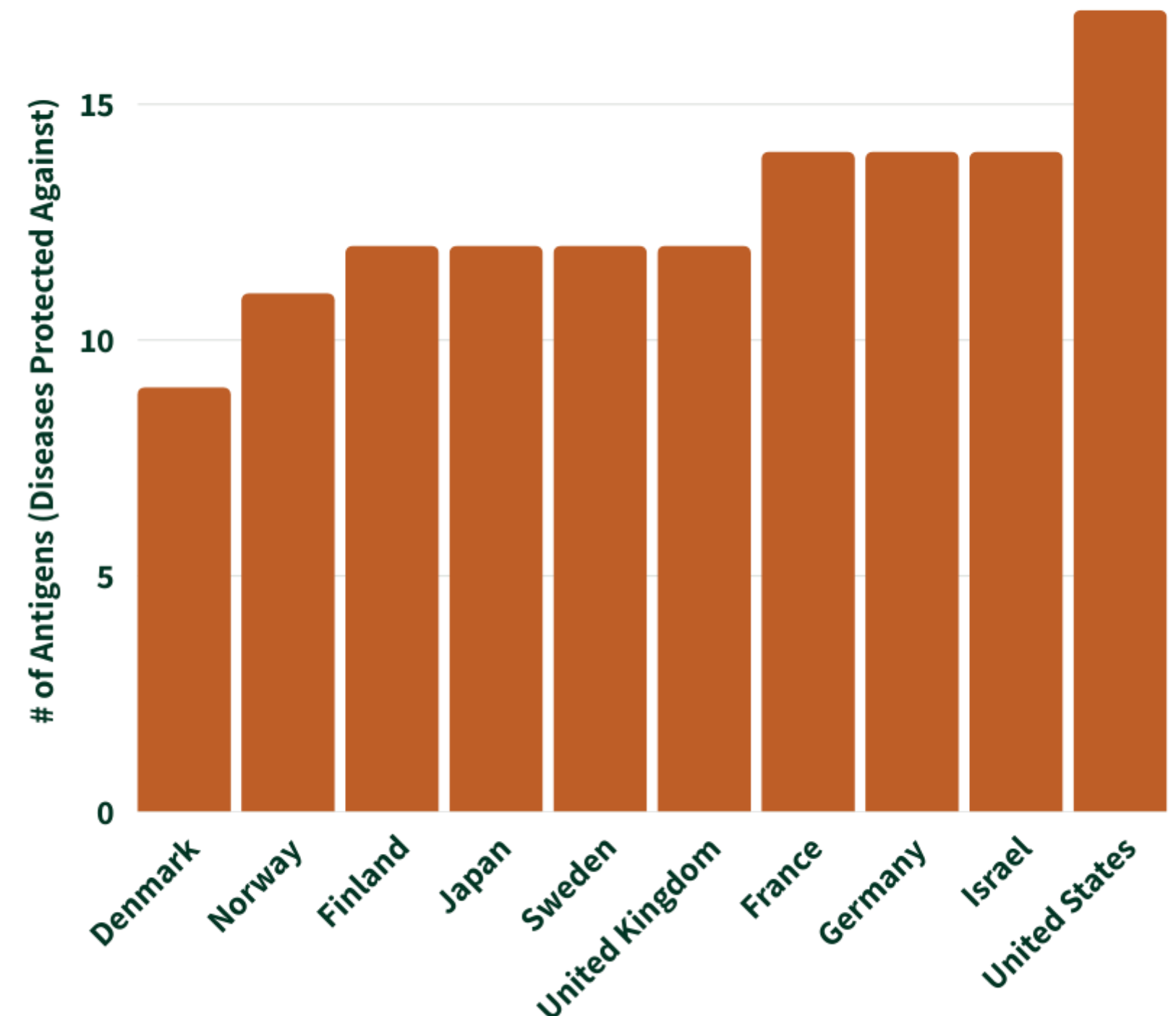
Most industrialized nations fall within a tight band (11–14 diseases) by age 5.

Denmark is at the bottom, protecting against ~9 diseases, well below every comparator—including its Nordic neighbors.

The U.S. schedule is on par with Germany, France, and Israel.



Total Cumulative Vaccine Antigens Covered
By Age 5



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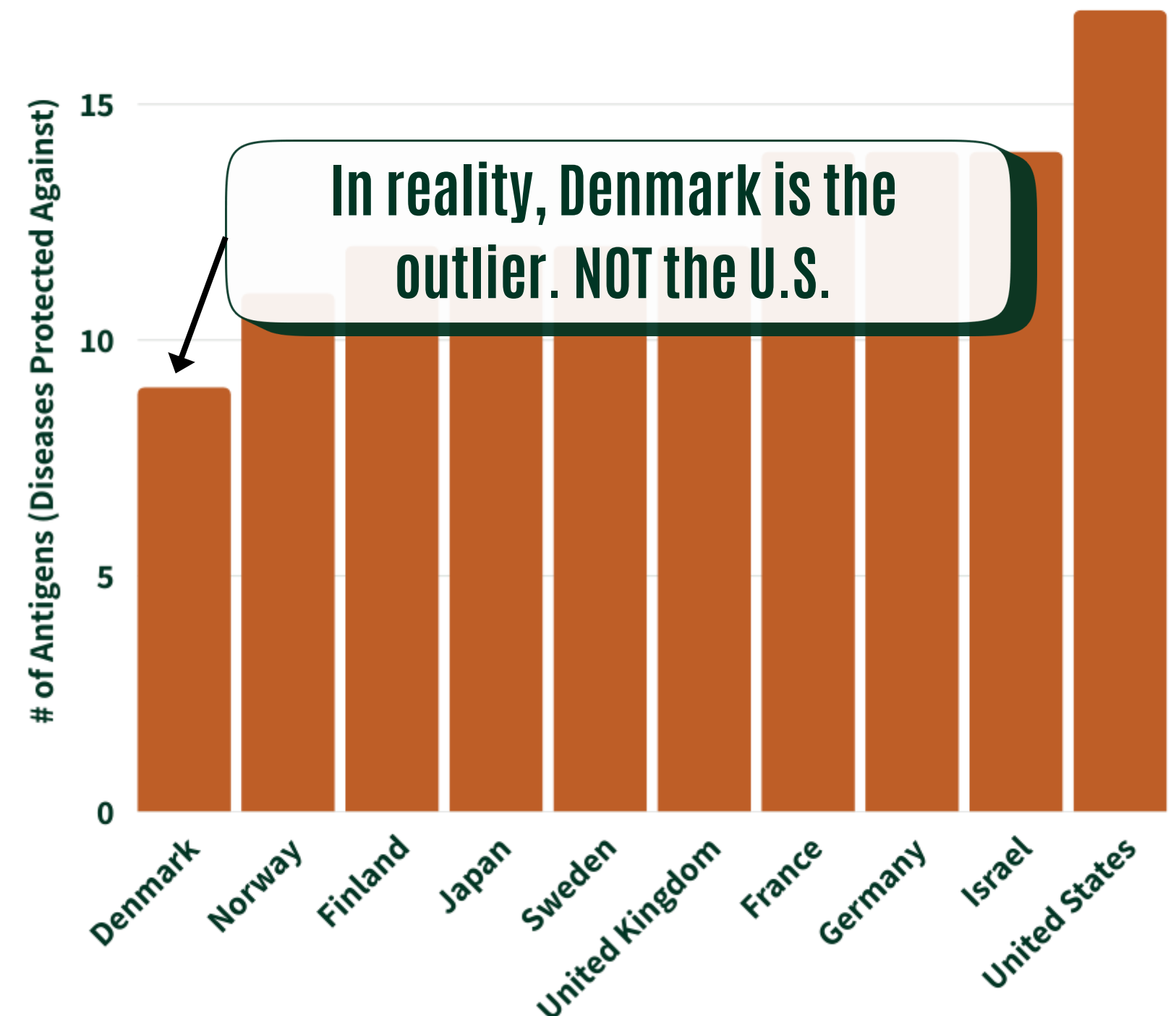
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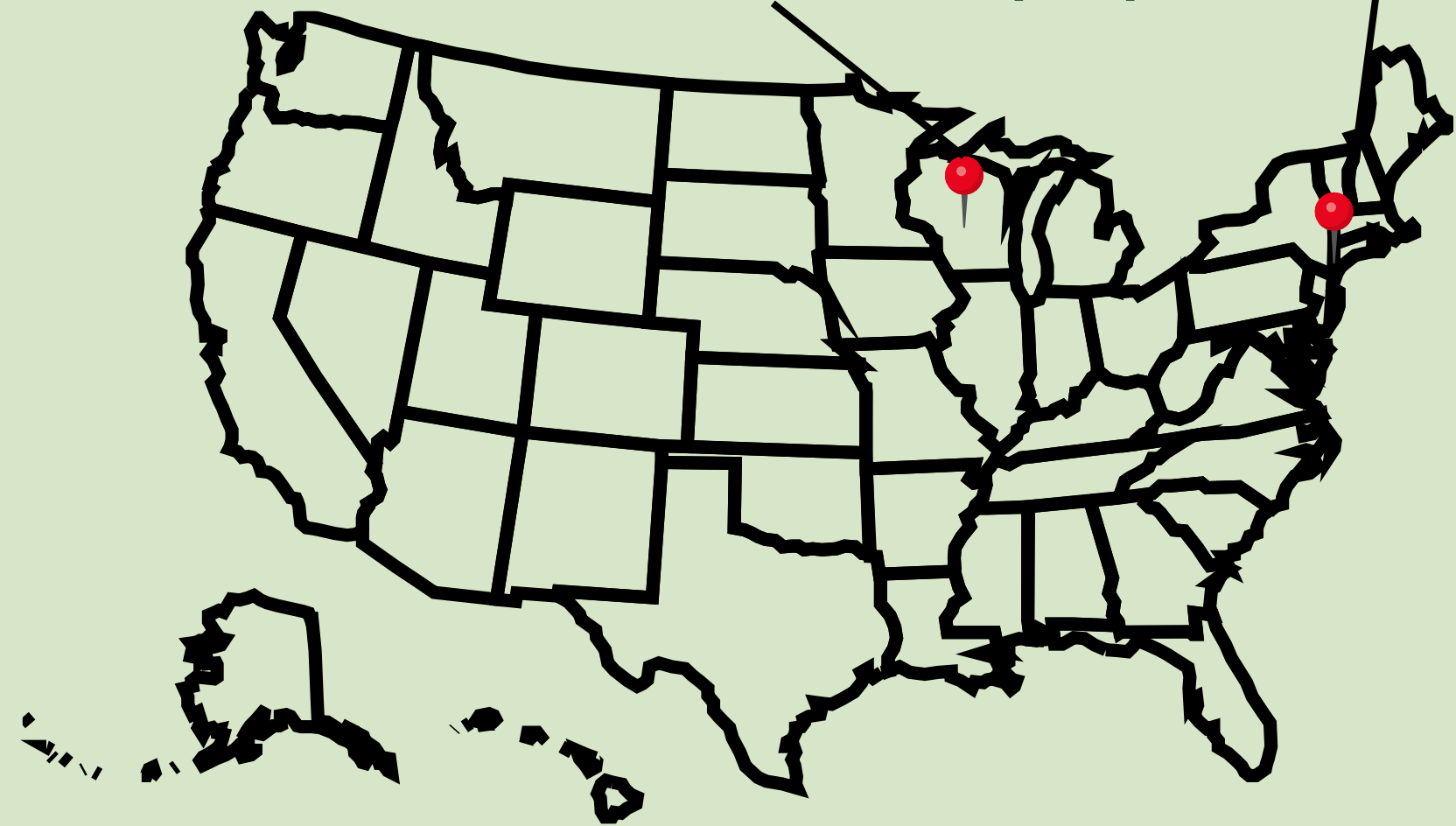


Comparing population size:



Denmark = ~6 million people

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Wisconsin
~6 million people

New York City
~8 million

U.S. = ~343 million people

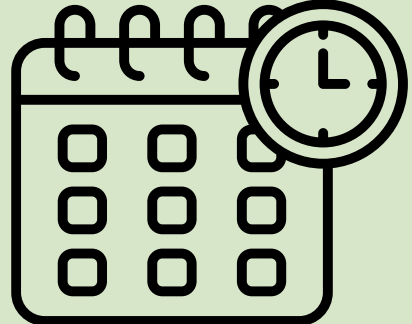
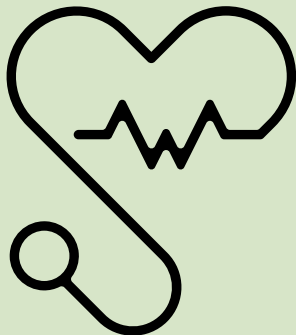

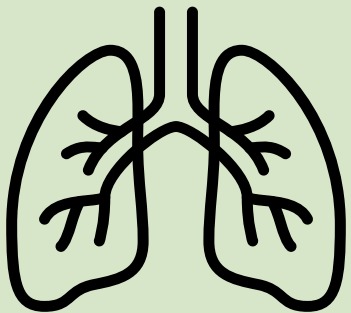

Comparing Universal Vaccine Recommendations

	RSV	Hep B	Rotavirus	Tetanus	Diphtheria	Pertussis	Hib	Pneumococcal	Polio	Flu	Measles	Mumps	Rubella	Varicella	Hep A	HPV	Meningococcal	Encephalitis	Japanese	BCG (TB)
United States	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Australia		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓			
Canada	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓			
Denmark				✓	✓	✓	✓	✓	✓		✓	✓	✓			✓				
Germany	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓			
Japan		✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓		✓		✓	✓	
Netherlands	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			✓	✓			
United Kingdom		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓			

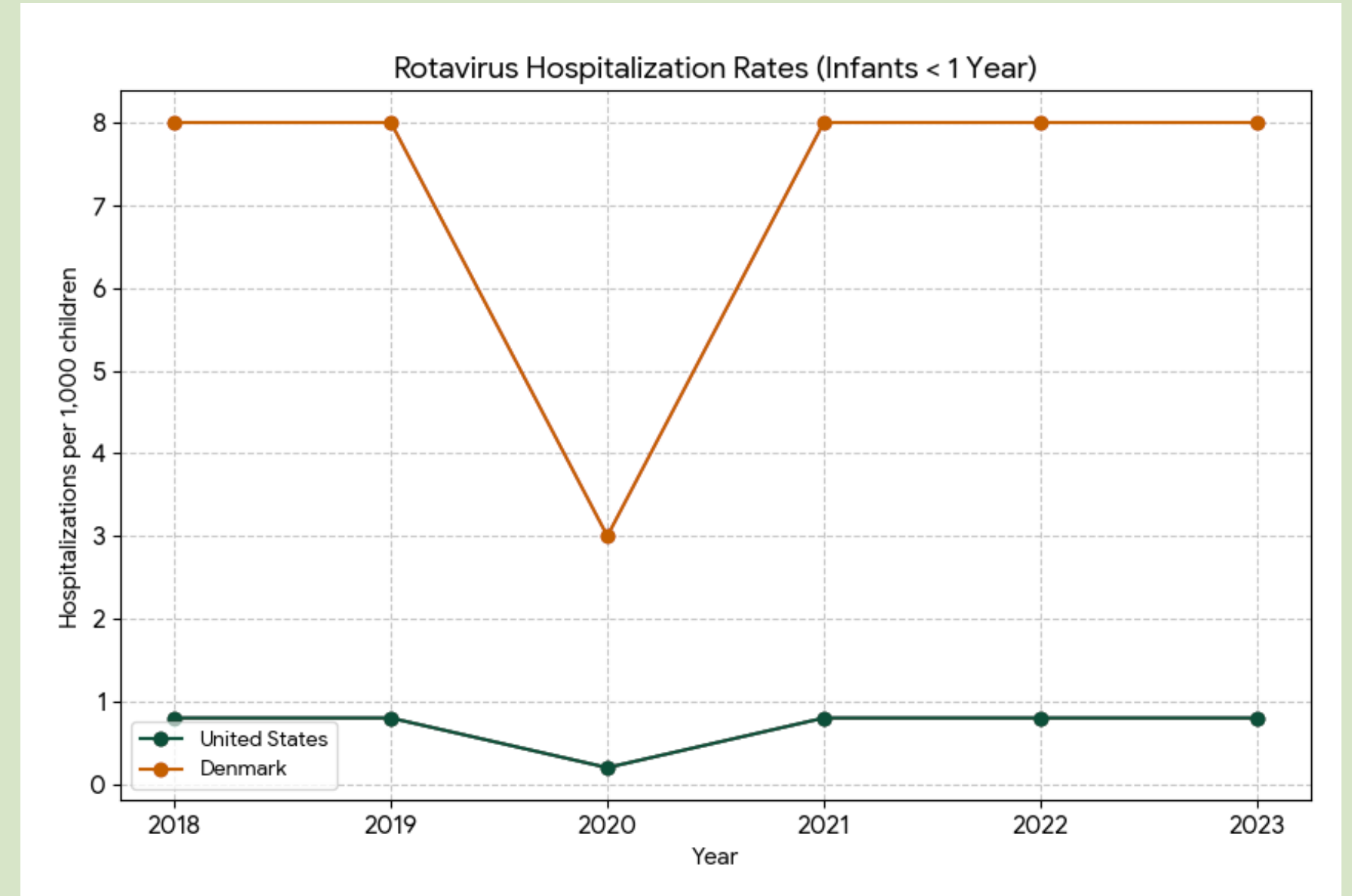
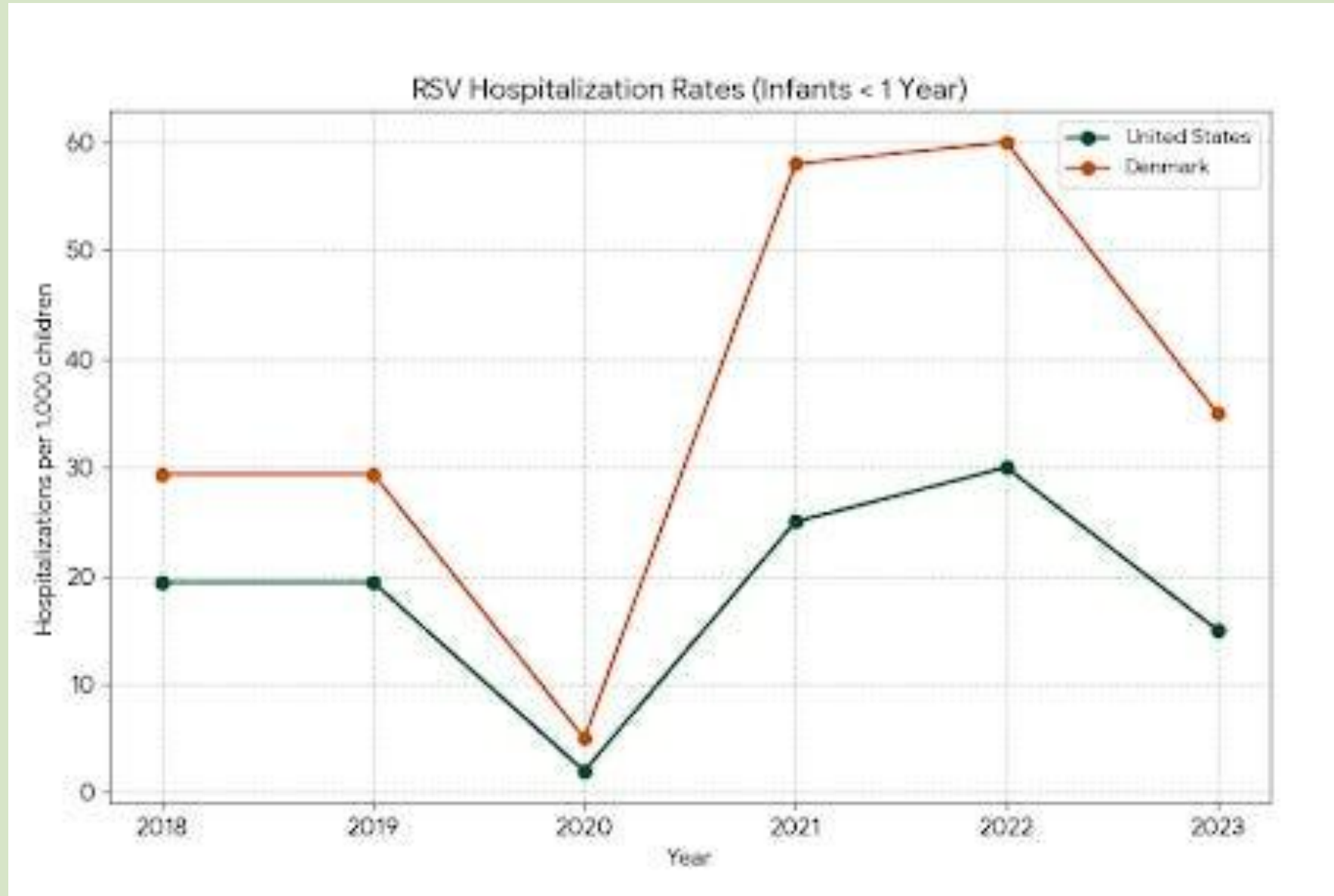
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Australia		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓			
Canada	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓			
Denmark				✓	✓	✓	✓	✓	✓		✓	✓	✓			✓				
Germany	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓			
Japan		✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓		✓		✓	✓	
Netherlands	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			✓	✓			
United Kingdom		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓			

Denmark's Higher Threshold for Preventable Disease: RSV & Rotavirus

	<div>Every Year in Denmark</div> <div>NO vaccines recommended</div>	<div>Every Year in United States</div> <div>BEFORE Vaccines</div>	<div>Every Year in United States</div> <div>AFTER Vaccines</div>
	<div>1,200</div> <div>children are hospitalized with severe dehydration caused by rotavirus</div>	<div>~70,000</div> <div>children are hospitalized by rotavirus</div>	<div> 80%</div> <div>decrease (~11,000-14,000 hospitalization/yr)</div>
	<div>2,800</div> <div>babies are hospitalized with pneumonia caused by RSV</div>	<div>~80,000</div> <div>RSV-associated hospitalizations in infants <7 months</div>	<div> 50%</div> <div>decrease (~30,000-40,000 hospitalization/yr)</div>

Denmark's Higher Threshold for Preventable Disease: RSV & Rotavirus



Denmark's universal healthcare system tolerates thousands of preventable hospitalizations annually for diseases that the U.S. prevents primarily through immunization.

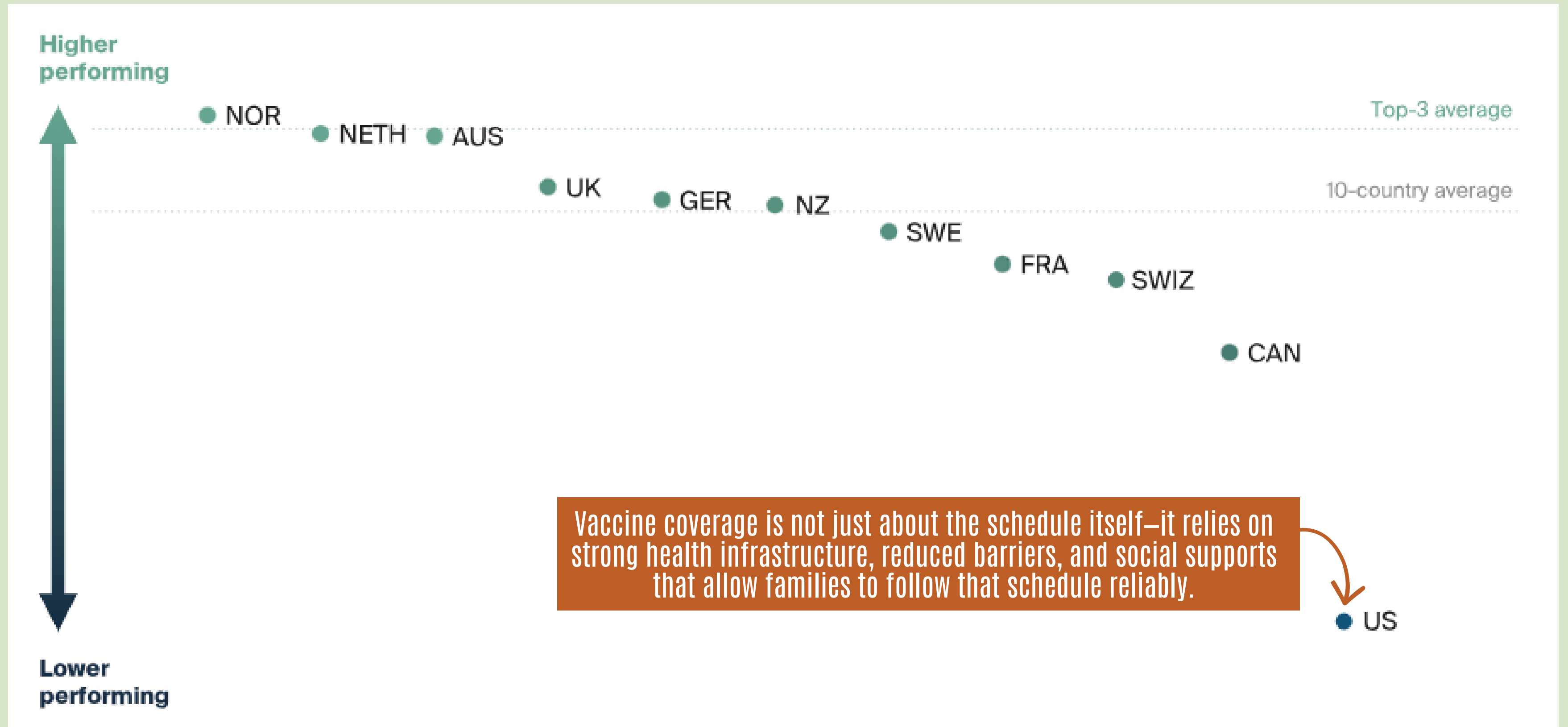
What is the difference between the U.S. and Denmark's pediatric vaccination schedules?



Where schedules differ, it's usually a matter of balancing disease burden, cost, and public health strategy.

Vaccine / Disease	United States (CDC)	Denmark (SSI)	Key Context	Burden Pre-vaccine (U.S.)	Burden Post-Vaccination (U.S.)
Hepatitis B	Yes* (universal, birth dose ≤24 hrs + series)	No (targeted to infants of HBV-positive mothers)	U.S. uses universal birth dose as a safety net for missed screening/follow-up		
Rotavirus	Yes (routine infant series)	No	Prevents infant hospitalizations	Hospitalizations : 55,000-70,000 per year Deaths: 20-60 per year	Rare; national totals not routinely published
Varicella (Chickenpox)	Yes	No	Denmark accepts higher varicella disease burden	Hospitalizations 10,500–13,500/year Deaths: 100-150/year	
Hepatitis A	Yes	No	Reflects lower endemic risk in Denmark	Hospitalizations : 3000-7000 per year; Deaths: 96 per year (average 1990-2004)	118 deaths (2022)
Influenza	Yes (annual for all ≥6 months)	No (risk-based; programs vary by year)	Annual flu alone inflates U.S. dose counts dramatically		
Meningococcal (MenACWY)	Yes (routine adolescents)	No	U.S. targets school/dorm outbreak risk		
COVID-19	Yes (included in routine framework)	No (offered, not routine)	Recent, evolving policy difference		
RSV (monoclonal)	Yes	No (RSV monoclonal antibodies for only high-risk infants)**		50,000-80,000 hospitalizations annually in children under 5	80% effective at preventing ICU admission and 83% effective at preventing acute respiratory failure

Comparative Health Care System Performance Scores



Why it works in Denmark:

Universal healthcare

46 weeks of paid parental leave

Near universal prenatal screening

Centralized medical records

Reliable follow-up



Why it DOESN'T work in the U.S.:

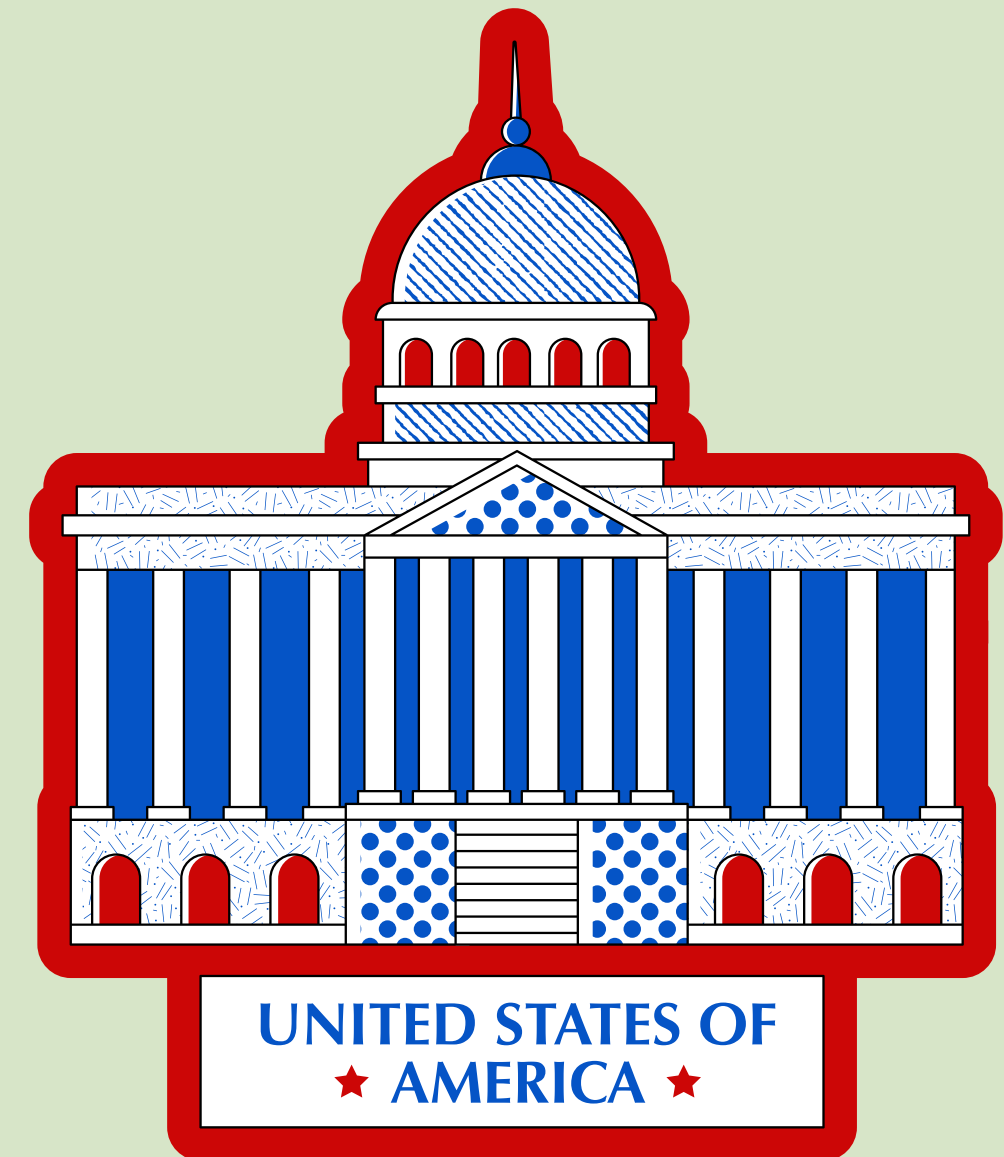
Larger, more diverse population

NO universal healthcare

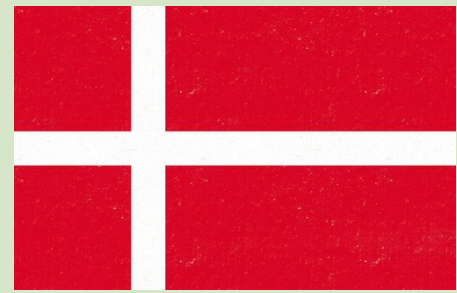
Lack of guaranteed paid parental leave

Fragment care delivery

Worse baseline health metrics



Hepatitis B Prevention Depends on Systems: Not Schedules



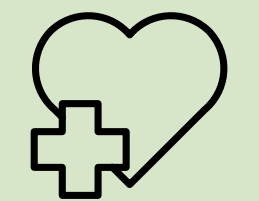
Denmark



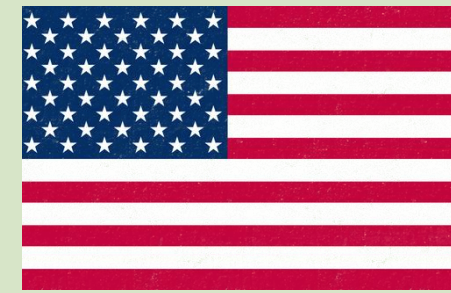
Screens nearly 100% of pregnant women for hepatitis B



Vaccinates only infants at known risk



Reliable maternal–infant follow-up, centralized records and guaranteed care



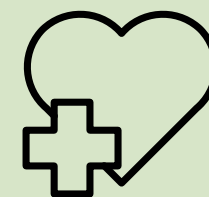
U.S.



12–18% of pregnant people are **not** tested for hepatitis B



Universal birth dose for all infants (AAP)



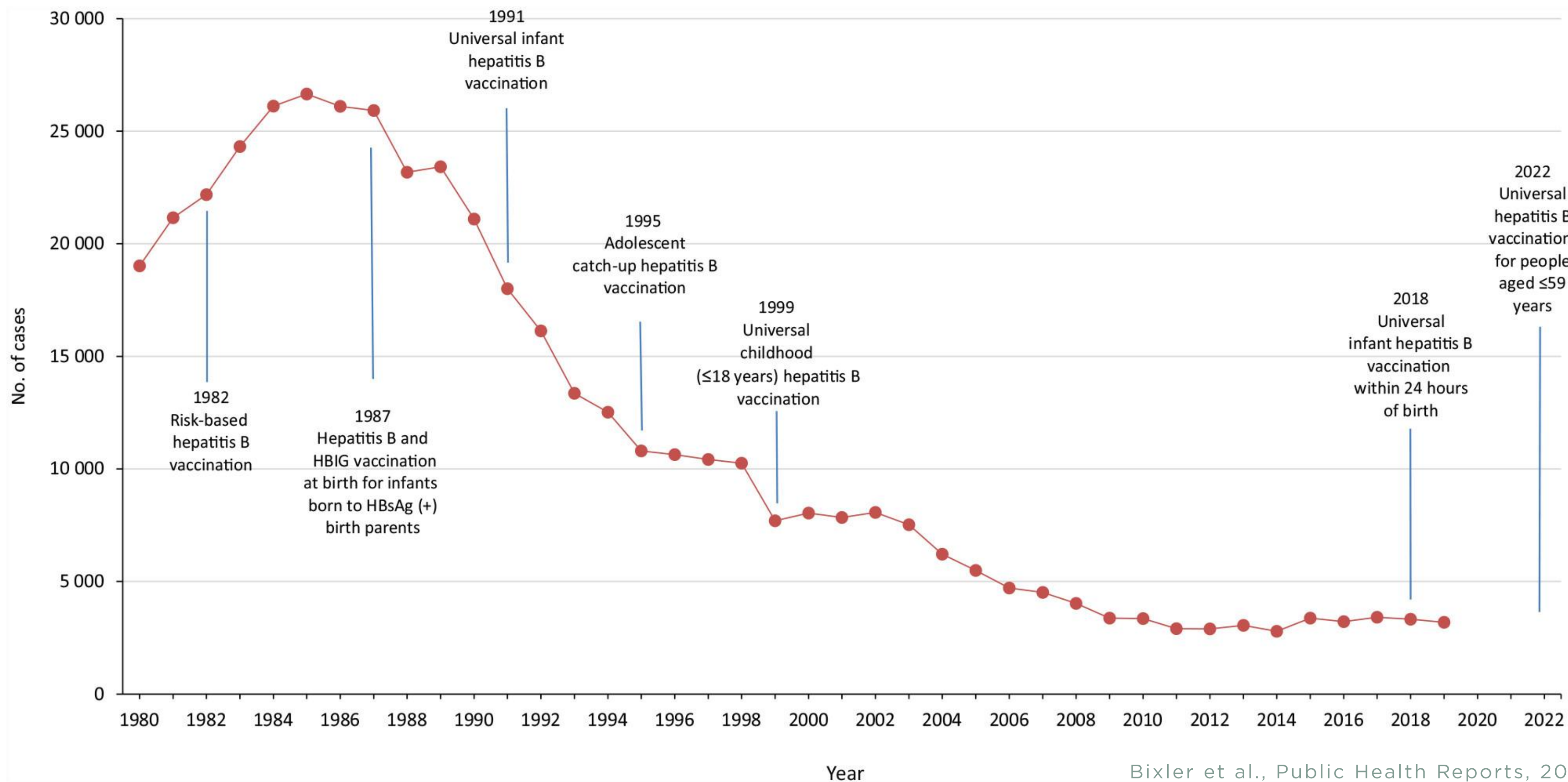
Only 35% of those who test positive complete follow-up care and U.S. has fragmented records/inconsistent care.

Universal birth-dose recommendations exist to protect infants when screening and follow-up fail.

When hepatitis B is transmitted at birth, 90% of infants develop chronic infection—and up to 25% will die from related disease later in life. Missed prevention has lifelong consequences.

- Maternal screening for hepatitis B is important—but not perfect.
- Rare errors can occur (missed infections, late exposures, or false negatives).
- The birth dose of the hepatitis B vaccine acts as a safety net—protecting newborns immediately, regardless of testing limitations.

Reported cases of acute hepatitis B and key hepatitis B vaccine recommendations from the Centers for Disease Control and Prevention (CDC), United States, 1980–2022.



- Since 1980, over 1 billion doses of hepatitis B have been given.
- Before 1991, ~18,000 U.S. children were infected annually—half at birth.
- Universal infant vaccination cut childhood hepatitis B infections by 95%.

Ok – so what does the U.S. schedule look like now?

LET'S LOOK AT THE NEW SCHEDULE IN GREATER DETAIL



U.S. Childhood Vaccination Schedule:

What Changed (Jan 2026)

- Recommended for all kids
- Recommended for high-risk
- Recommended for high-risk, shared clinical decision making for others
- Shared clinical decision-making

Adapted from Yale SPH Graphic

PREVIOUS SCHEDULE

Chickenpox
Diphtheria
Hib
HPV (2 doses)
Measles
Mumps
Pneumococcal
Polio
Rubella
Tetanus
Whooping cough
RSV
Hepatitis A
Hepatitis B
Meningococcal ACWY
COVID-19
Flu
Rotavirus
Dengue
Meningococcal B

NEW SCHEDULE (JAN 2026)

Chickenpox
Diphtheria
Hib
HPV (1 dose)
Measles
Mumps
Pneumococcal
Polio
Rubella
Tetanus
Whooping cough
Dengue
RSV
Hepatitis A
Hepatitis B
Meningococcal ACWY
Meningococcal B
COVID-19
Flu
Rotavirus

Recommended for all babies whose mothers did not receive the maternal RSV vaccine

Right Time Best Protection

The vaccine schedule isn't just about which vaccines children receive.

WHEN they receive vaccination	Practical - designed to align with routine well-child visits	It isn't safer to space out vaccines
<ul style="list-style-type: none">• Each dose is timed to protect children before they're most likely to encounter certain infections and at the ages when their immune system responds most effectively.	<ul style="list-style-type: none">• Many vaccine doses are aligned with routine well-child visits to make staying on track easier for families.	<ul style="list-style-type: none">• Spacing out vaccines or delaying them doesn't provide extra safety or a better immune response.

The American Academy of Pediatrics (AAP), which represents more than 70,000 pediatricians, still recommends the previous schedule.

FIND THE AAP
SCHEDULE HERE



Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the **Notes** that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the outlined purple bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine and other immunizing agents	Birth	1 mos	2 mos	4 mos	6 mos	8 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Respiratory syncytial virus (RSV-mAb [nirsevimab, clesrovimab])	1 dose during RSV season depending on maternal RSV vaccination status (See Notes)					1 dose nirsevimab during RSV season (See Notes)												
Hepatitis B (HepB)	1 st dose	2 nd dose			3 rd dose													
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, and acellular pertussis (DTaP <7 yrs)			1 st dose	2 nd dose	3 rd dose				4 th dose				5 th dose					
Haemophilus influenzae type b (Hib)			1 st dose	2 nd dose	See Notes			3 rd or 4 th dose (See Notes)										
Pneumococcal conjugate (PCV15, PCV20)			1 st dose	2 nd dose	3 rd dose			4 th dose										
Inactivated poliovirus (IPV)			1 st dose	2 nd dose	3 rd dose							4 th dose						See Notes
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)						1 or more doses of 2025–2026 vaccine (See Notes)						1 dose of 2025–2026 vaccine (See Notes)						
Influenza						1 or 2 doses annually (See Notes)									1 dose annually (See Notes)			
Measles, mumps, and rubella (MMR)						See Notes		1 st dose					2 nd dose					
Varicella (VAR)								1 st dose					2 nd dose					
Hepatitis A (HepA)						See Notes		2-dose series (See Notes)										
Tetanus, diphtheria, and acellular pertussis (Tdap ≥7 yrs)															1 st dose			
Human papillomavirus (HPV)															2-dose series	See Notes		
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)															1 st dose		2 nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)																		See Notes
Respiratory syncytial virus vaccine (RSV [Abrysvo])																		Seasonal administration during pregnancy if not previously vaccinated
Dengue (DEN4CYD: 9–16 yrs)																		Seropositive in areas with endemic dengue (See Notes)
Mpox																		

Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups or populations

Recommended vaccination for those who desire protection

Recommended vaccination based on shared clinical decision-making

Is this even legal?

G R E A T Q U E S T I O N . . .

- The federal government generally *can* issue changes to immunization schedules and health guidance under statutory authority but must respect administrative law requirements.
- Courts could find parts of the process unlawful if agencies fail to justify decisions or follow required procedures.
- State laws that incorporate CDC schedules by reference may remain in force unless explicitly changed - so legality at federal level does not automatically change legal requirements in all states.



1-dose HPV Vaccination

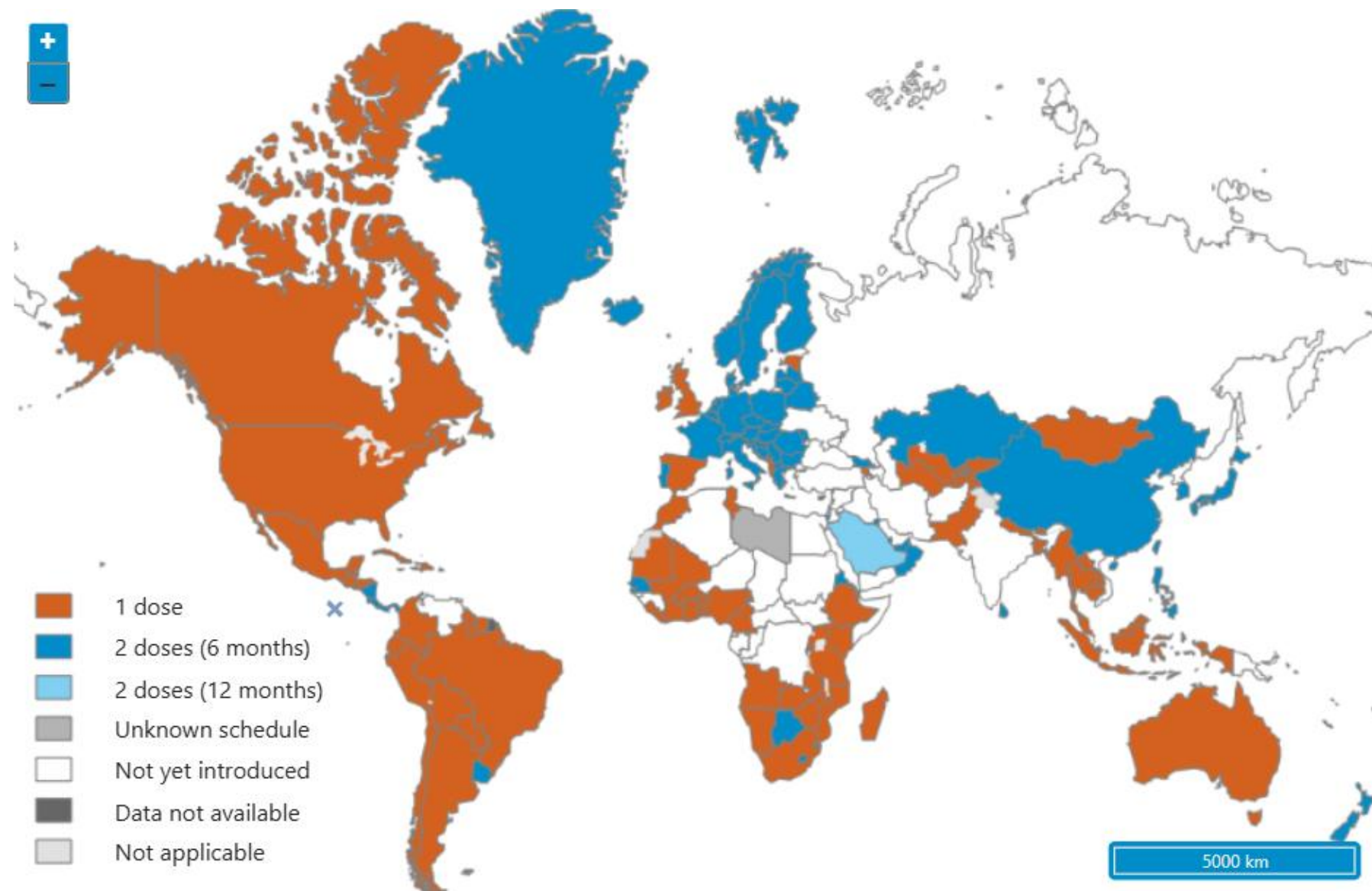
EVIDENCE VS. POLICY

What the Evidence Shows

- Strong protection against HPV-16/18 (causing most cervical cancers)
- ESCUDDO trial (20,000+ participants): 1 dose non-inferior to 2 doses
- $\geq 97\%$ effectiveness against HPV-16/18 (bivalent & 9-valent vaccines)

HPV vaccination Programme Schedule

9 - 14 YEARS OLD



Data pulled 1/8/2026

What countries currently have
a 1-dose series?

89 Countries
Including UK and Australia

IMPORTANT DIFFERENCE

Many countries successfully vaccinate earlier in adolescence using national school programs - a strategy linked to higher coverage and long-term prevention.

A majority of countries allow HPV vaccination starting at age 9, maximizing protection, completion, and convenience - yet RFK Jr's schedule skips this critical window.

Does 1-dose provide adequate protection?

BEYOND CERVICAL CANCER

What about protection against other HPV disease (head and neck cancers, genital warts, and Recurrent Respiratory Papillomatosis [RRP])?



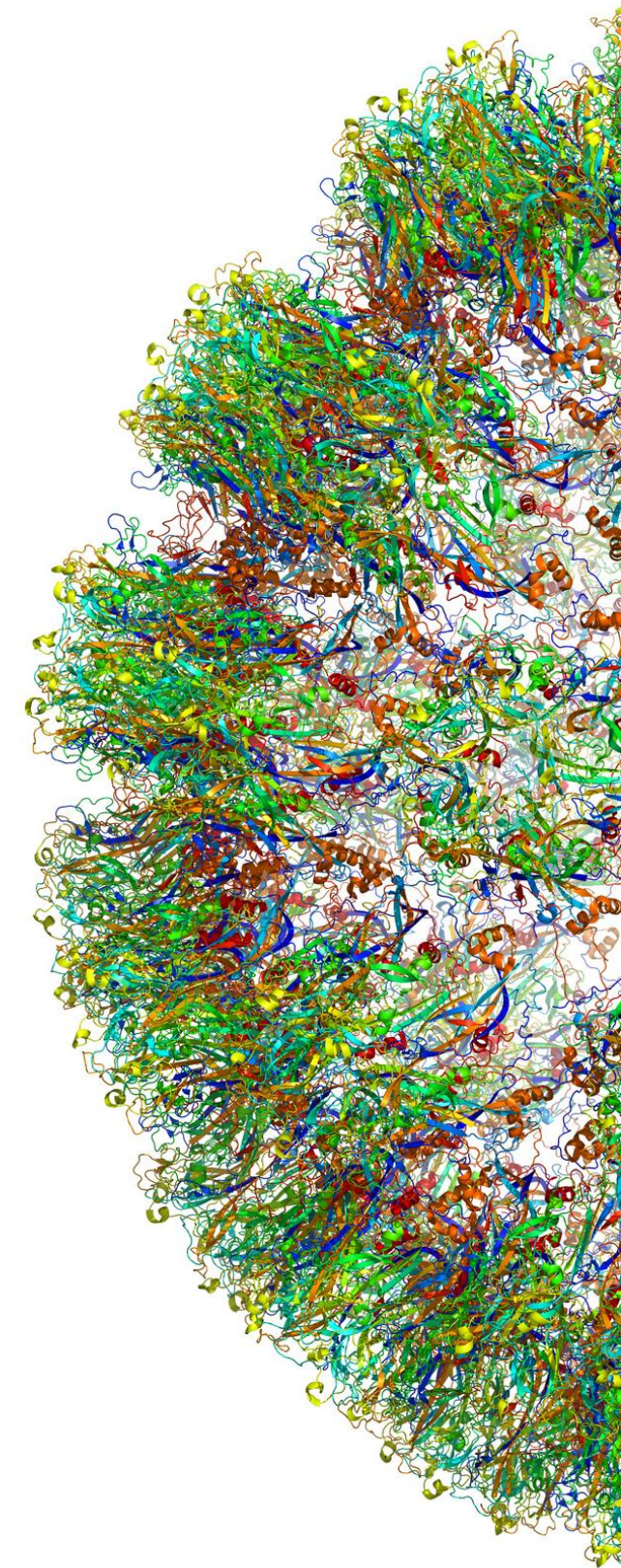
1 in 4 people who receive only one dose may not mount an antibody response against important strains.

STUDY FOLLOW-UP: STILL GATHERING LONG-TERM DATA

It's likely that protection from one dose will be long-lived. However, the longest period of follow-up has only been 5 years.

20%

Nearly 20% didn't make detectable antibodies against HPV 6 after a single dose.



1-dose HPV Vaccination

EVIDENCE VS. POLICY

What We Still Don't Know

- Long-term durability of protection
- Protection against non-cervical HPV disease (head and neck cancers, genital warts, recurrent respiratory papillomatosis [RRP])
- Which groups still need multiple doses (older adolescents, immunocompromised)

WHY THIS MATTERS

The HHS move was made without standard expert review.

Expert groups (AAP, ACOG) suggest the evidence is promising - *but process matters.*

Professional guidance still recommends completing the full series.

Shared Clinical Decision-Making

WHAT WE KNOW NOW



Shared Clinical Decision- Making (SCDM)

WHAT IS IT?

“Individually based and informed by a decision process between the health care provider and the patient or parent/guardian.”

“Unlike routine, catch-up, and risk-based recommendations, shared clinical decision-making vaccinations are not recommended for everyone in a particular age group or everyone in an identifiable risk group.”

Classic examples: meningococcal B vaccines in adolescents and HPV vaccination for adults 27-45 years old

Who is considered a healthcare provider with regards to SCDM?

Primary care
physicians

Specialists

Advanced
Practice
Providers (PAs
& NPs)

Registered
nurses

Pharmacists

Scope of the Change

ROUTINE RECOMMENDATIONS ESTABLISH DEFAULTS.

Automatic prompts in electronic health records.

Shape provider discussions and when to have them.

Send a signal about what the weight of evidence supports.

CHANGES WILL BE FELT DIFFERENTLY.

Clinics, health systems, and states must now decide how to operationalize SCDM, who is authorized to act, and under what conditions.

THE FRAMING IS STRATEGIC.

Technically, all vaccines are available and covered.

This creates confusion among patients and providers.

It will lead to lower vaccine uptake.



SCDM can present numerous challenges for providers - balancing communication and comprehensive education on vaccination



Missed opportunities to vaccinate

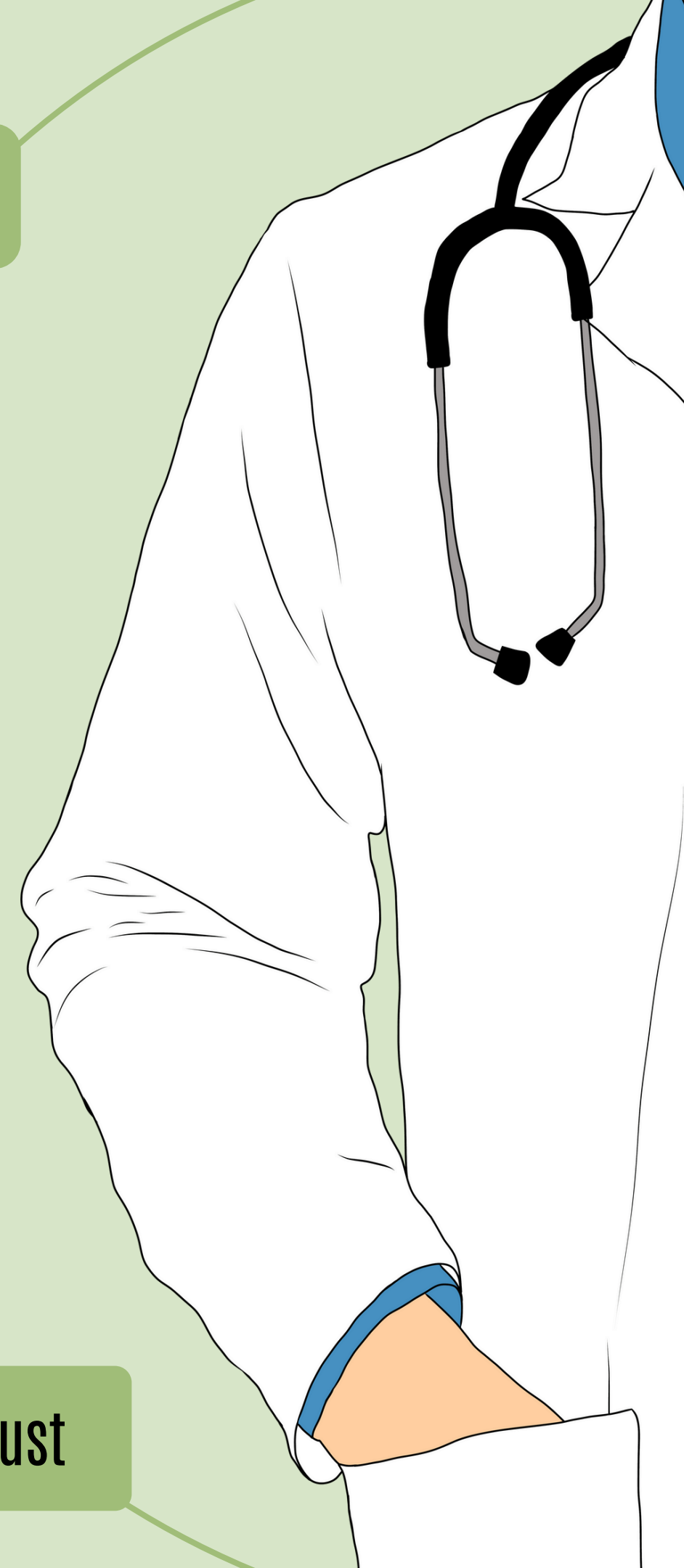
Limited consultation time

Resource constraints

Diverse cultural beliefs

Varying health literacy levels

Increases in misinformation and mistrust



With this SCDM model – who can give vaccines?

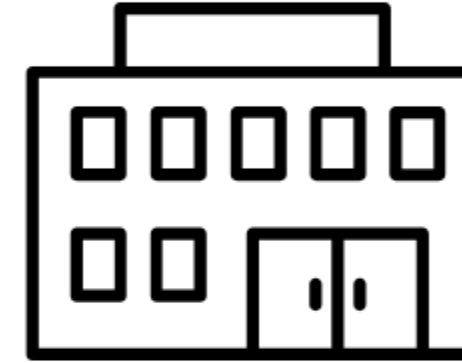
NOTE: May vary by state



CLINICS



PHARMACY



PUBLIC HEALTH

What DOES change:
When a vaccine is under SCDM, the vaccinator should engage in a documented risk/benefit discussion with the patient within their scope of practice.

Standing Orders STILL apply.

- Standing orders are already used for many SCDM vaccines and are compatible with protocol-based care

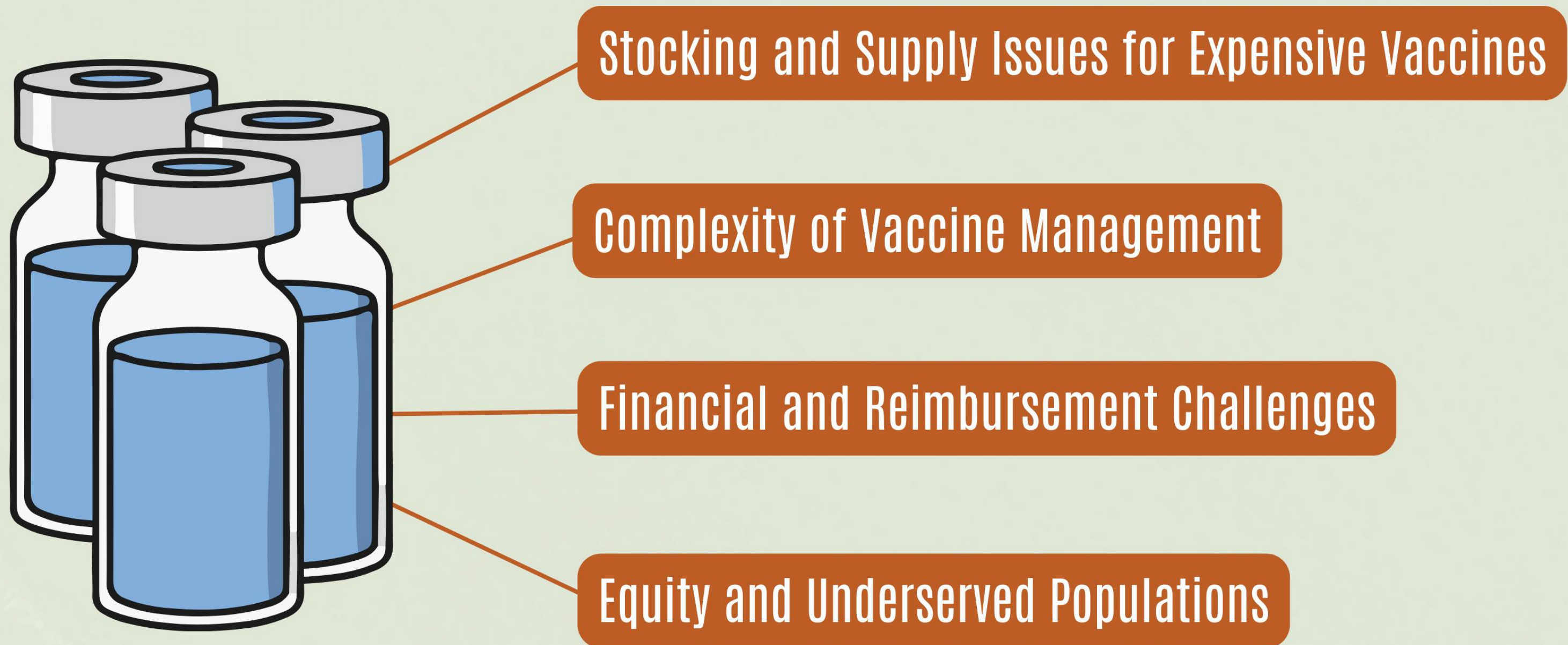
Pharmacists are legally authorized (under ND state law and scope of practice - 3 years and older) to:

- Assess patients, engage in SCDM, administer vaccines without a physician's direct order - already routine for adult vaccines.

Health departments operate under medical director-approved protocols and standing orders.

- SCDM fits within these frameworks. Vaccinations do not require individual prescriptions for each patient.

But long-term, real-world implementation of SCDM can influence vaccine supply, stocking, and access in ways that matter for providers and patients:



Shared Clinical Decision- Making

WHAT DOES THE U.S. PUBLIC
THINK?



1 in 5 believe shared decision-making means that “taking the vaccine may not be a good idea for everyone but would benefit some.”



1 in 4 think that shared decision-making means talking to family.

Only
33%

thought they could engage in a SCDM
conversation about vaccines with a pharmacist.

What about insurance coverage?

WHAT WILL AND WON'T BE COVERED?

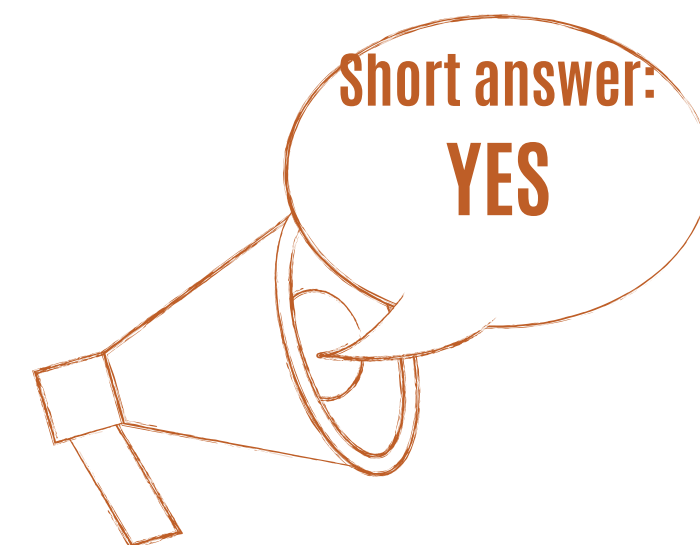


Will insurance cover vaccines

EVEN IF THEY'RE NOT ON THE
SCHEDULE?

- The administration said that all vaccines covered by federal insurance programs—Medicaid, CHIP, and the Vaccines for Children program - **remain covered**.
- Most private insurers also continue coverage with no cost-sharing through 2026.

In the future: HPV vaccination may be impacted by new recommendations. If a child is getting two doses, the second dose may not be covered under this new directive.



“

Health plans are committed to maintaining and ensuring affordable access to vaccines. Health plan coverage decisions for immunizations are grounded in each plan's ongoing, rigorous review of scientific and clinical evidence, and continual evaluation of multiple sources of data.

Health plans will continue to cover all ACIP-recommended immunizations that were recommended as of September 1, 2025, including updated formulations of the COVID-19 and influenza vaccines, with no cost-sharing for patients through the end of 2026.

-AHIP

”

Will this change access in the future?

POSSIBLY

When vaccines shift to “shared decision-making” or “high-risk only,” insurers may reconsider no-cost coverage - small wording changes can have major downstream effects.



Potential downstream Impact

- Higher out-of-pocket costs for families
- Inconsistent coverage across plans and states
- Greater access gaps for low-income and uninsured children
- Increased confusion for parents and clinicians

Potential Implications

Politicized schedule changes and reduced routine recommendations may discourage vaccine manufacturing, and ultimately MAY limit U.S. access and supply.

Reduced Manufacturer Incentive to Produce Vaccines

- Unpredictable demand makes U.S. vaccine markets less attractive
- Manufacturers may scale back production or exit the U.S. market
- Fewer companies willing to invest in vaccines with weakened recommendations

Shrinking Vaccine Supply & Access

- Fewer vaccine options for clinicians and patients
- Increased risk of shortages or delayed availability
- Limited access for high-risk, rural, and underserved populations

Long-Term Impact on Innovation & Preparedness

- Reduced investment in new or improved vaccines
- Slower response to emerging disease threats
- Greater reliance on fewer manufacturers, increasing fragility of supply

When routine recommendations are weakened, manufacturers lose incentive to make vaccines—putting long-term access, supply stability, and public health at risk.

Returning to “gold standard” of research

YEAH, WE HAD QUESTIONS TOO.



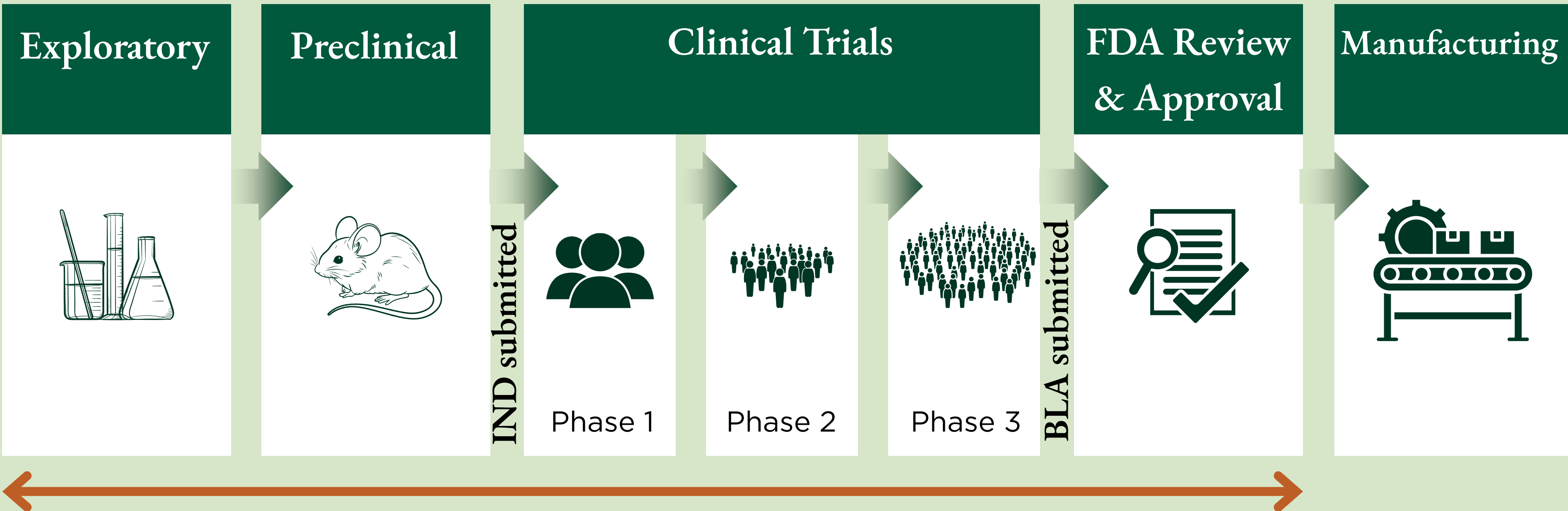
“

The accepted recommendations recognize there is a need for more and better gold standard science, including placebo-controlled randomized trials and long-term observational studies to better characterize vaccine benefits, risks, and outcomes. HHS agencies are called on to fund this gold standard science for all vaccines on the schedule.

HHS Press Release, January 5, 2026

”

Vaccine Development - Traditional Timeline



What is in a placebo?

Saline (0.9% sodium chloride)

- Matches osmotic pressure of human tissues
- Example: Jonas Salk's 1954 poliovirus trial

Antigen-free formulation

- Contains all components except the antigen
- Example: Hepatitis B candidate vaccine trial—control contained adjuvant only
- Useful when adjuvant may cause side effects
- Helps differentiate reactions caused by antigen vs. other ingredients

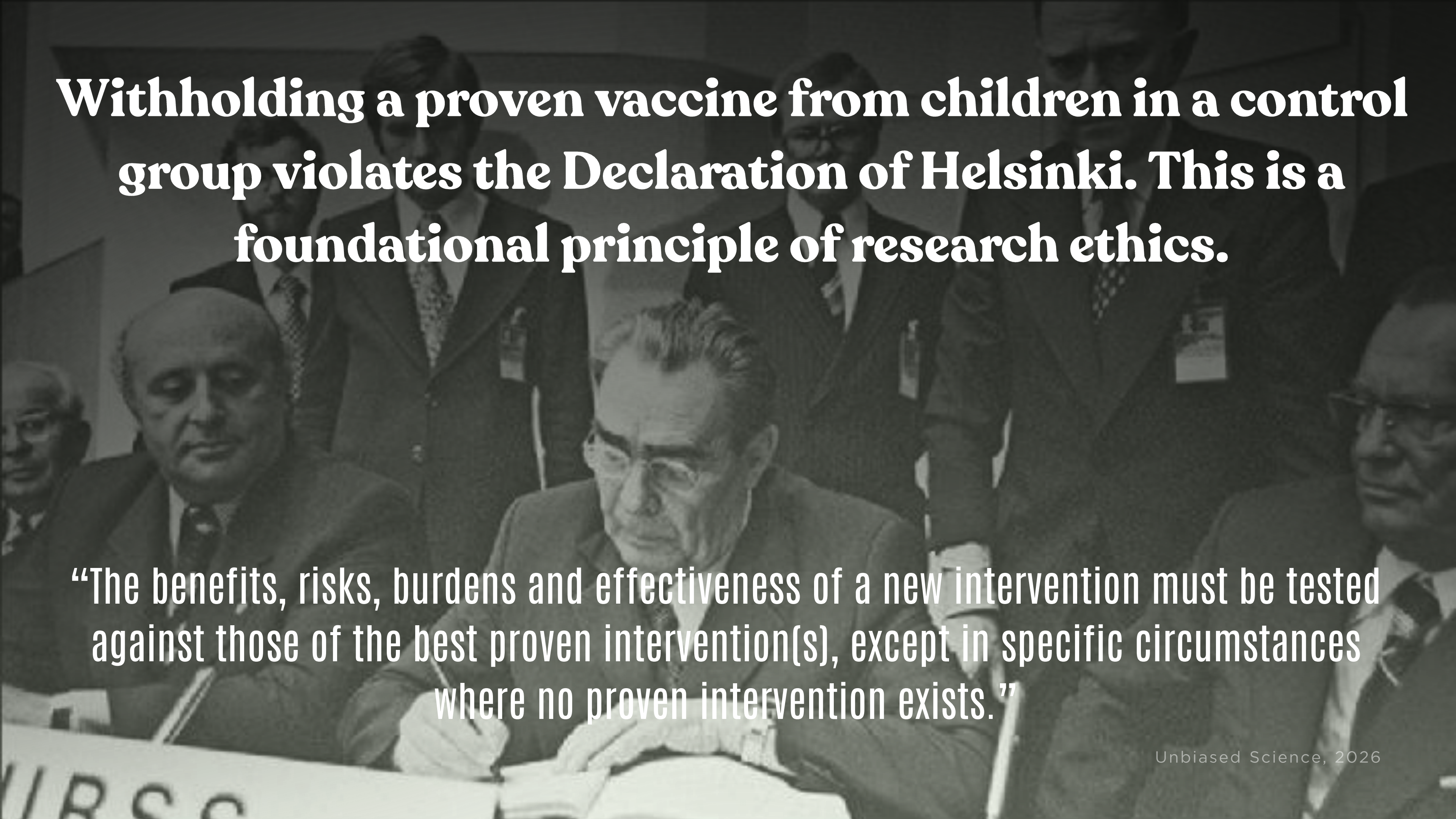


The 1954 polio vaccine trials were a landmark in public health and clinical research — both for their scope and for the clarity they provided on vaccine effectiveness. But they also carried a human cost that helped push the field toward stronger ethical protections.

Today:

- True saline placebos aren't used by default in vaccine trials when doing so would leave participants vulnerable without justification.
- Ethics and science are complementary — you can maintain rigorous evaluation using other designs that prioritize safety.





Withholding a proven vaccine from children in a control group violates the Declaration of Helsinki. This is a foundational principle of research ethics.

“The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in specific circumstances where no proven intervention exists.”

Evolution of Vaccine Trials: Placebo vs Comparative Design

Vaccine / Year	Participants	Trial Design	Key Outcome	Notes / Impact
Polio (1954)	~1.8M children (vaccine, placebo, observed)	Double-blind RCT with saline placebo	80-90% effective	Cases dropped 58,000 → 161; set standard for large trials
Measles (1968)	444 children	RCT: 4 vaccines vs placebo	Strong immune response	Early multi-vaccine comparison
Rotavirus (2009)	69,589 infants	Blinded placebo-controlled RCT	Safe & effective	143M vaccinated; 18.7M severe cases prevented
Rotavirus P2-VP8 (2020)	617 participants	Double-blind RCT with saline placebo	Strong immune response	Modern use of true placebo when ethical
Pertussis (1988-2014)	3,801-9,829 children / adults	Placebo-controlled for new tech, later comparative RCTs	78-80% efficacy	Shift from placebo → comparative trials as vaccines existed

The Testing Progression:

How Vaccine Trials Evolve

New Vaccine Technology

- Starts with true saline placebo trials
- Must establish basic safety before any other comparisons

Iterations of Proven Technology

- May use active placebos or comparator vaccines
- Only after the platform's basic safety is established

Competing Products

- Often compared to existing licensed vaccines
- Must first demonstrate basic safety or have done so in previous studies
- Focus on proving "non-inferiority" to existing options

“

The way vaccines are studied in the United States is considered by most health organizations across the world as the gold standard of care. To require current, approved vaccines to be re-examined is unnecessary, unethical and will only lead to the suffering and death of more children from vaccine-preventable diseases.

Sean O'Leary, MD, MPH, FAAP, American Academy of
Pediatrics Chair of the Committee on Infectious Diseases

5/15/2025

”

Vaccines save lives.

NOT POLITICS - PURE TRUTH.



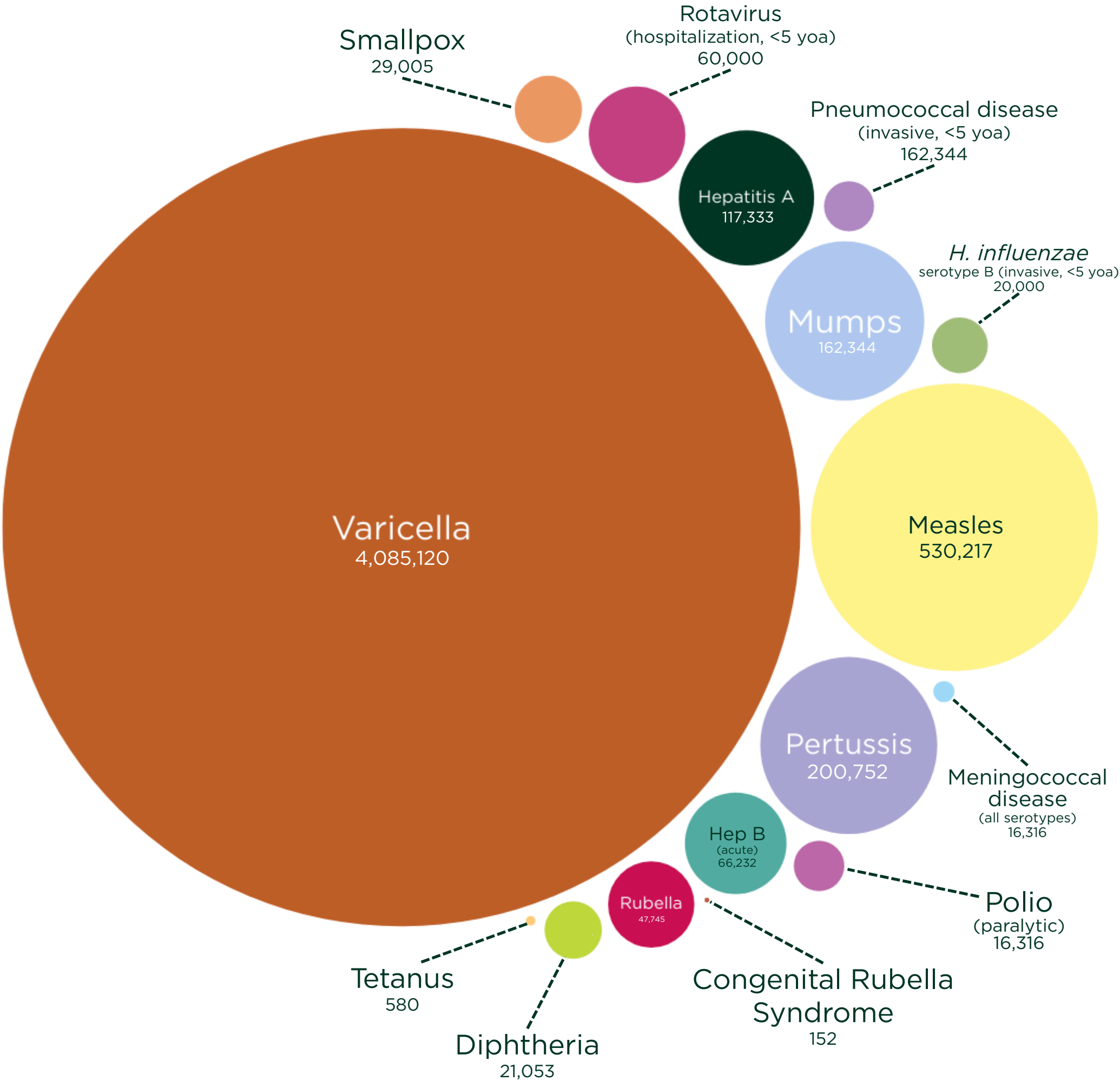
Vaccines have
saved 6 lives a
minute,
every minute,
for five decades.



Vaccines Work

ANNUAL MORBIDITY FROM VACCINE-PREVENTABLE DISEASES: PAST VS. PRESENT

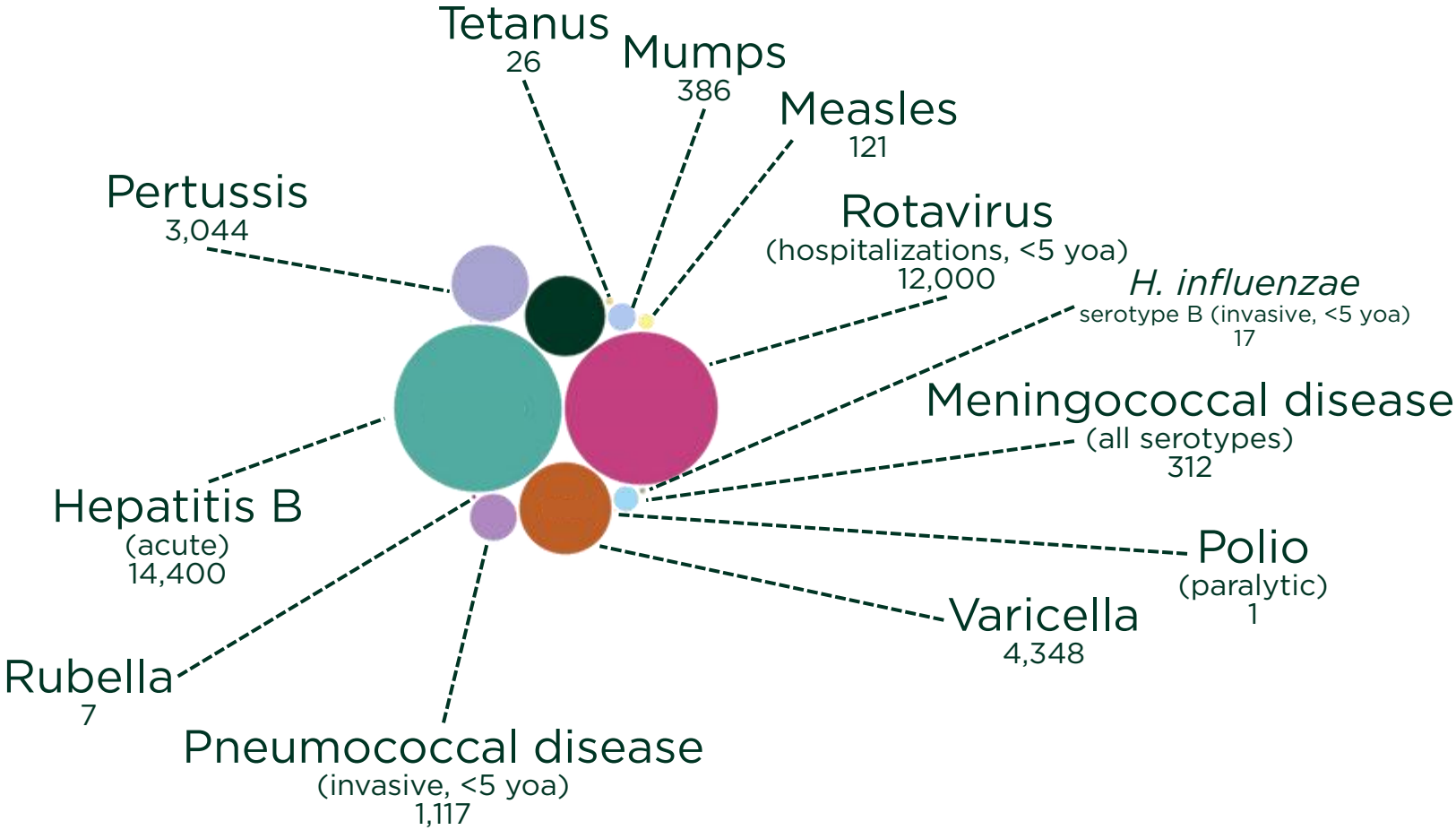
Disease	20th Century Annual Morbidity	Current Reported Cases	% Decrease
Diphtheria	21,053		
<i>H. influenzae</i> serotype B	20,000		
Hepatitis A	117,333		
Hepatitis B (acute)	66,232		
Measles	530,217		
Meningococcal disease	2,886		
Mumps	162,344		
Pertussis	200,752		
Pneumococcal disease	16,069		
Polio (paralytic)	16,316		
Rotavirus	60,000		
Rubella	47,745		
Congenital Rubella Syndrome	152		
Smallpox	29,005		
Tetanus	580		
Varicella	4,085,120		



Vaccines Work

ANNUAL MORBIDITY FROM VACCINE-PREVENTABLE DISEASES: PAST VS. PRESENT

Disease	20th Century Annual Morbidity	Current Reported Cases	% Decrease
Diphtheria	21,053	1	>99%
<i>H. influenzae</i> serotype B	20,000	17	>99%
Hepatitis A	117,333	(est) 3,300	97%
Hepatitis B (acute)	66,232	(est) 14,400	78%
Measles	530,217	121	>99%
Meningococcal disease	2,886	312	89%
Mumps	162,344	386	>99%
Pertussis	200,752	3,044	98%
Pneumococcal disease	16,069	1,117	93%
Polio (paralytic)	16,316	1	100%
Rotavirus	60,000	(est) 12,000	80%
Rubella	47,745	7	>99%
Congenital Rubella Syndrome	152	0	>99%
Smallpox	29,005	0	100%
Tetanus	580	26	96%
Varicella	4,085,120	4,348	>99%

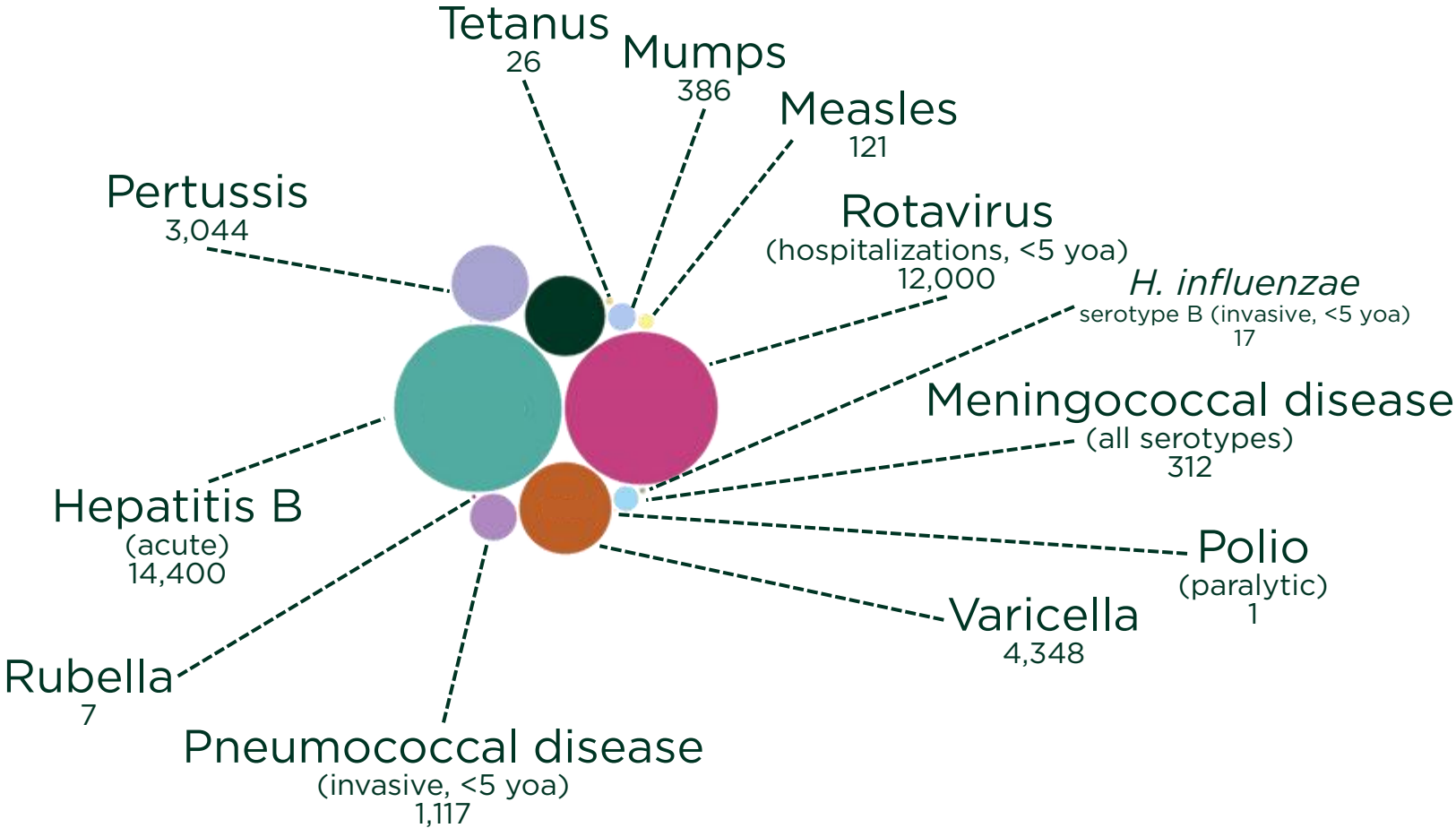


Smallpox: 0
Congenital Rubella Syndrome: 0

Vaccines Work

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Smallpox: 0
Congenital Rubella Syndrome: 0



Impact of Vaccines in the U.S.

**CDC estimates that
vaccination of children born
between 1994-2023 will:**

PREVENT

500+ MILLION

illnesses will be prevented

1+ MILLION

deaths will be prevented

RESULTING IN

\$540 BILLION

direct savings

\$3,000,000,000

societal savings

Vaccine- preventable diseases are already returning.

**WEAKENING THE SCHEDULE WILL NOT REVERSE
THIS TREND - IT WILL ACCELERATE IT.**

The New York Times

Childhood Vaccination Rates Have Dropped Again, C.D.C. Data Shows

The new report paints a sobering picture of immunizations as infectious diseases like measles surge across the United States.

abcNEWS

Flu-like illness activity now at highest rate on record, new CDC data shows

There have been at least 120,000 hospitalizations so far, the CDC says.

By [Dr. Jade Cobern](#), [Mary Kekatos](#), and [Youri Benadjaoud](#)
January 5, 2026, 10:52 AM



US exceeds 1,900 measles cases as outbreaks expand

CIDRAP

[Stephanie Soucheray, MA](#), December 10, 2025



Changes to the vaccine schedule don't stay on
paper. They affect coverage, access, and
uptake - and disease follows.

We are already at the breakpoint.

SMALLPOX

Before vaccines:

- Highly contagious, devastating disease
- Up to 30% fatality rate
- Survivors often scarred, blinded, or disabled
- Caused widespread fear, outbreaks, and mass death



NORTH DAKOTA STATE UNIVERSITY
CENTER FOR IMMUNIZATION
RESEARCH AND EDUCATION

This **was** smallpox. The world will never again witness the suffering that was caused by this virus...

Thanks to vaccines.

Conis, NYT, 2025

These new
changes are
based in politics.

The science has
not changed.



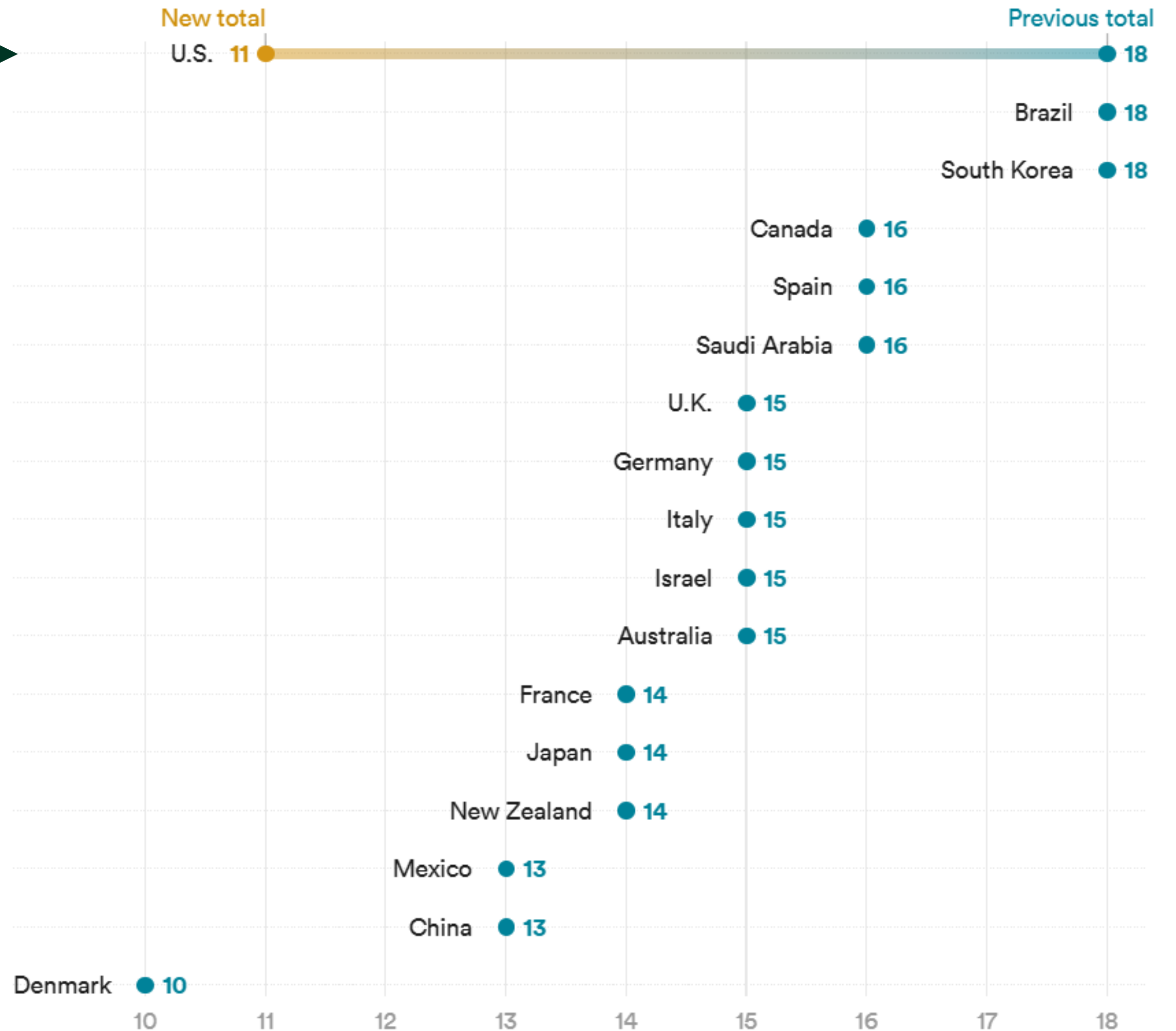
United States drastically reduces number of recommended vaccines

TOTAL NUMBER OF VACCINES RECOMMENDED TO ALL CHILDREN BY NATION

Branswell, STAT, 2026.

Note: For the purposes of this analysis, STAT has counted RSV antibody products towards a country's vaccine total, if it recommends the shot for all babies.

Chart: J. Emory Parker and Helen BranswellSource: STAT analysis of national vaccine schedules



Based in Science?

NOTE: Based on data from September 2025.



Only 1 in 4 Americans
believe the current
administration's vaccine
recommendations were
based on scientific evidence
and facts.

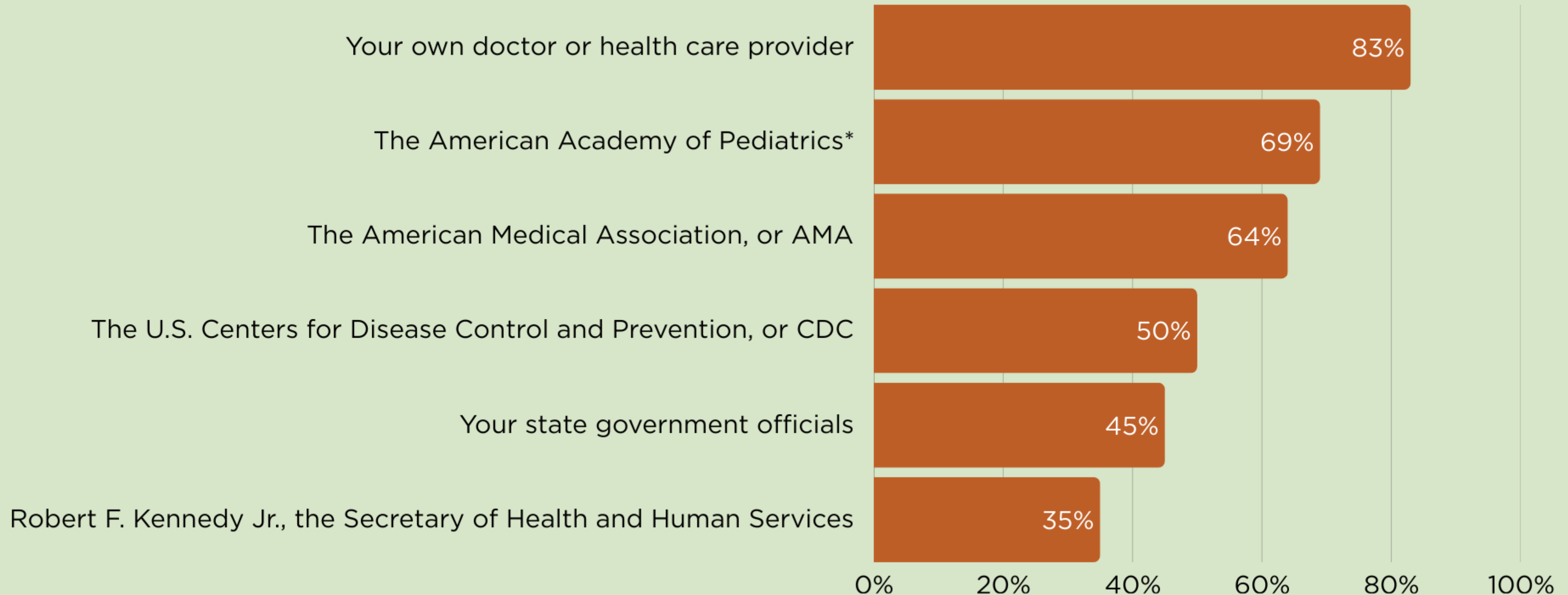
Science and Evidence: Navigating Uncertainty

- Science rarely gives absolutes; recommendations reflect the best available evidence.
- Transparency about what we know—and what we don't—builds patient trust.
- Clear communication about uncertainty strengthens credibility and supports informed decisions.



Most of the Public Trust Doctors and Physician Associations for Reliable Vaccine Information

Percent who say they have a great deal or a fair amount of trust in the following to provide reliable information about vaccines:



*Among parents or guardians of a child under the age of 18 living in their household.
KFF Tracking Poll on Health Information and Trust (September 23-29, 2025)

Good News!

PAYMENT FOR IMMUNIZATION COUNSELING WHEN VACCINES AREN'T ADMINISTERED

Code selection is based on the total time spent in counseling on immunizations that ultimately were not administered on the date of service (DOS).

Documentation should indicate:

- Immunization(s) counseled on
- The conversation
- The reason vaccine was declined and/or reason for patient's under-immunization status



New Current Procedural Terminology (CPT) codes

Code	Descriptor
90482	Immunization counseling by physician or other QHP when immunization(s) is not administered by provider on the same DOS; 3 minutes up to 10 minutes
90483	Greater than 10 minutes up to 20 minutes
90484	Greater than 20 minutes

*In effect as of January 1, 2026

TAKE AWAYS

WHAT WE HOPE YOU TAKE AWAY FROM TODAY

The schedule changes are not based on new safety or efficacy data.

States, not the federal government, set school vaccination requirements.

Standard review processes were skipped—no public comment, deliberation, or formal evidence evaluation.

Major medical organizations continue to support previous schedule.

The U.S. is **NOW** an outlier, most countries like Australia, UK, Germany, Japan, among others – recommend vaccinations against 14+ diseases.

This comes as vaccine-preventable diseases are rising and more U.S. children are experiencing vaccine preventable morbidity and mortality.

Navigating the Bumpy Vaccine Waters

YOU guide families through uncertainty.

YOUR recommendations shape uptake and protection.

YOUR expertise saves lives.



Questions?

THANK YOU FOR LISTENING - A recording will be available on our YouTube following the event. We are NOT offering CE for this special event.

SPECIAL THANKS TO:

- LAUREN DYBSAND, MPH
- KYLIE HALL, MPH
- MAEVE WILLIAMS
- JULIANNA BUDNICK, MPH

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