NORTHEAST
BUSINESS GROUP ON HEALTH

Vaccine Update – Executive Summary

This document summarizes the January 2026 federal changes to the U.S. childhood immunization schedule and highlights what they mean for employers and working families. It explains which vaccines shifted to shared clinical decision-making, outlines potential impacts on coverage, school requirements, and employee communications, and flags emerging workforce and equity risks.

Employers can use this guide to align with health plans, prepare HR and managers for employee questions, update clear and neutral communications, and anticipate operational and reputational implications as vaccination policies and state requirements continue to evolve.

Summary of Changes:

On January 5th HHS announced an unprecedented overhaul of the US childhood immunization schedule, paring the number of universally recommended immunizations from 17 to 11. The new vaccination policy takes effect immediately.

The new childhood schedule is now divided into three separate categories:

1. Recommended for all children
2. Recommended for certain high-risk groups or populations
3. Based on shared clinical decision-making (SCDM)

NEW SCHEDULES[1]

Immunizations Recommended for All Children

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	7 mos	8 mos	12 mos	15 mos	18 mos	19 mos	20-23 mos	2-3 yrs	4-6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Diphtheria, tetanus, acellular pertussis (DTaP < 7 yrs)			1st dose	2nd dose	3rd dose				4th dose					5th dose											
Tetanus, diphtheria, acellular pertussis (Tdap ≥ 7 yrs)																			1st dose						
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	3rd dose			3rd/4th dose																	
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose			4th dose																	
Inactivated poliovirus (IPV < 18 yrs)			1st dose	2nd dose	3rd dose									4th dose											
Measles, mumps, rubella (MMR)								1st dose						2nd dose											
Varicella (VAR)								1st dose						2nd dose											
Human papillomavirus (HPV)																			1st dose						

Some children should get this dose of vaccine at this age depending on their dose series

1 https://www.hhs.gov/childhood-immunization-schedule/index.html

NORTHEAST
BUSINESS GROUP ON HEALTH

Immunizations Recommended for Certain High-Risk Groups or Populations

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	7 mos	8 mos	12 mos	15 mos	18 mos	19 mos	20-23 mos	2-3 yrs	4-6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Respiratory syncytial virus (RSV-mAb)[1]	1 dose																								
Respiratory syncytial virus (RSV-mAb)[2]	1 dose						2nd dose																		
Hepatitis B (HepB)[3]	1st dose	2nd dose			3rd dose																				
Dengue[4]																	3 dose series								
Meningococcal ACWY[5]			2, 3, or 4 doses series																						
Meningococcal B[6]																		1 dose							
Hepatitis A (HepA)[7]					1 dose																				

[1] All children whose mother did not have the vaccine should get one dose.
[2] High-risk children, such as those with chronic lung disease, should receive a second dose at ages 8 to 19 months.
[3] Vaccination recommended for infants born to women who tested positive for the hepatitis B virus or whose status is unknown.
[4] Recommended ONLY if living in areas with endemic dengue AND with a laboratory confirmation of previous dengue infection.
[5] For high-risk groups (e.g., those with anatomic or functional asplenia or HIV infection), those traveling to countries with hyperendemic or epidemic meningococcal disease, and first-year college students living in residential housing, vaccination is recommended.
[6] Recommended for high-risk groups, e.g., with anatomic or functional asplenia, and during outbreaks.
[7] Vaccination recommended for international travel to areas with high or intermediate hepatitis A endemicity.

Immunizations Based on Shared Clinical Decision-Making

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	7 mos	8 mos	12 mos	15 mos	18 mos	19 mos	20-23 mos	2-3 yrs	4-6 yrs	7 yrs	8 yrs	9 yrs	10 yrs	11 yrs	12 yrs	13 yrs	14 yrs	15 yrs	16 yrs	17 yrs
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	3rd dose																				
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)					2 doses first year, then 1 dose annually								1 dose annually												
Influenza (IIV3, ccIIV3) OR					2 doses first year, then 1 dose annually					OR							1 dose annually								
Influenza (LAIV3)													2 doses first year, then 1 dose annually				1 dose annually								
Hepatitis A (HepA)								2-dose series																	
Hepatitis B (HepB)*			1st dose	2nd dose	3rd dose																				
Meningococcal ACWY																			1st dose					2nd dose	
Meningococcal B																								2 or 3 doses	

Some children should get this dose of vaccine at this age depending on their dose series

* For parents deciding whether to vaccinate for HepB in infants born to women who tested negative for the hepatitis B virus, it is suggested that the initial dose is administered no earlier than 2 months of age.

NORTHEAST
BUSINESS GROUP ON HEALTH

KEY CHANGES:

- The most notable are the 6 vaccines moved from 'recommended to SCDM' – these are: Hepatitis B SCDM first dose starts at 2 months for non-high-risk populations; Rotavirus; Influenza; Hepatitis A except for high-risk groups related to travel destinations; Meningitis MenACWY and MenB except for high-risk groups; and RSV.Recommended for all children

POTENTIAL ISSUES/CONCERNS FOR EMPLOYERS:

1. **Confusion about what's still recommended and covered**
   The schedule now has three categories (all children / high-risk / shared clinical decision-making). That complexity can fuel confusion, call-center volume, and inconsistent messaging across pediatric practices, plans, and pharmacies. Employees may also worry vaccines are no longer covered if they're not universally recommended. HHS says vaccines on the prior schedule remain covered without cost-sharing through ACA plans and federal programs (e.g., Medicaid/CHIP/VFC), however this is not guaranteed under existing statutory and payer frameworks, particularly for SCDM recommendations.
2. **School/childcare requirement volatility (state-by-state)**
   Federal recommendations don't automatically change state mandates, but many states align school entry requirements with CDC guidance over time creating a moving target for working parents and employer communications.
3. **Employer Vaccine Programs**
   Employers that promote family vaccination (flu clinics, pharmacy vouchers, navigation) may face employee questions about why the company promotes a vaccine that is now "optional"/SCDM, and more need for clinical navigation rather than simple "everyone should get X" messaging.
4. **Equity risk**
   Shared decision-making tends to advantage families with stable primary care access, health literacy, and time thus potentially widening disparities in vaccine uptake, illness burden, and missed work among lower wage/hourly workers.
5. **Employee relations and reputational risk**
   Vaccination is polarizing. A visible employer stance either strongly promoting or going quiet on vaccination could trigger employee dissatisfaction. The schedule changes heighten the need for neutral, science based, choice-supporting communications grounded in benefit access and pediatrician consultation.

NORTHEAST
BUSINESS GROUP ON HEALTH

WHAT EMPLOYERS CAN DO NOW:

1. Align with your health plan(s)/PBM: confirm coverage language + billing guidance for vaccines in SCDM/high-risk categories.
2. Update employee communications: “Coverage remains; talk with your child’s clinician; here’s how to find in-network pediatric care/pharmacy;: recommended expert advice e.g. American Academy of pediatricians - https://downloads.aap.org/AAP/PDF/AAP-Immunization-Schedule.pdf ”
3. Prepare managers/HR for a spike in questions during flu season and back-to-school periods.
4. Track state school/childcare requirement changes where you have large employee populations.

ADDITIONAL CONCERNS:

- Rapid or politicized changes risk undermining confidence in vaccines and public health institutions.
- Increased infection rates resulting in more missed work from parents caring for common childhood infections, as well as, infectious diseases such as measles and chicken pox entering the workplace and disrupting work.
- Potential that will SCDM vaccines may no longer receive liability protections as part of the Vaccine Injury Compensation Program (VICP). If this were to happen then there is a concern that some of these vaccines could be taken off the market due to litigation exposure concerns by manufacturers.