GLOBAL HEALTHY LIVING FOUNDATION

Why States Should Protect Pharmacy Vaccine Access

WHY STATES SHOULD PROTECT PATIENT ACCESS TO PHARMACIST IMMUNIZATION DURING FEDERAL REGULATORY UNCERTAINTY

A RESILIENT LEGAL FRAMEWORK FOR ADULT PHARMACIST IMMUNIZATION AUTHORITY



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Executive Summary

Adult vaccination access in the United States is now inseparable from community pharmacy practice. Recent evidence demonstrates that pharmacies are a major site of adult vaccination across multiple vaccine categories, including COVID-19, influenza, pneumococcal disease, and herpes zoster. In addition, nearly nine in ten Americans live within five miles of a community pharmacy, low-income communities have more pharmacy locations and operating hours than physician practices, and historical claims analyses find lower payments per vaccination in pharmacies. Pharmacist authority therefore represents an opportunity to expand access, advance equity, reduce healthcare spending, and improve affordability.

Federal and state legal and regulatory frameworks allowing pharmacist immunization authority have not kept pace with this reality. The U.S. Food and Drug Administration (FDA) determines whether to approve or authorize a vaccine for a particular use. The Advisory Committee on Immunization Practices (ACIP), whose recommendations the Centers for Disease Control and Prevention (CDC) ordinarily adopts, determines how it should be used in the civilian population. Many state laws make ACIP action, publication, a state list, a protocol, or a prescription a precondition to pharmacist administration. When the federal process stalls, those dependencies can block pharmacy access to FDA-approved vaccines because pharmacists cannot immunize.

The economic consequences are hard to ignore. A 2014 claims study found an average 26% physician-office payment premium across zoster, pneumococcal, and influenza vaccination. A later scenario analysis applied that historical differential to projected pharmacy respiratory syncytial virus (RSV) use and estimated $1.3 billion to $2.1 billion in additional outlays if every projected pharmacy recipient instead used a physician office. This analysis illustrates the system's financial exposure and, most importantly, the unnecessary financial and economic burden on the already stretched U.S. healthcare system.

State action should follow a clear hierarchy:

1. Preferred — accepted standard of care. Authorize trained pharmacists to act consistently with professional competence, FDA status, current evidence, patient-specific factors, and enforceable safety duties.

2. Fallback — objective dual trigger. Authorize administration when either FDA status or an ACIP/CDC recommendation supports the relevant adult use.

3. Minimum — one self-executing federal gate. If ACIP remains the trigger, eliminate downstream prescriptions, prescriber agreements, statewide protocols, state vaccine lists, and publication delays.



PART I

Adult Vaccination in the United States

Adult Vaccination in the U.S. Depends on Community Pharmacists and Pharmacies

Community pharmacies are no longer a marginal vaccination channel. A 2023 report using IQVIA claims data found that pharmacies administered more than 90% of adult coronavirus disease 2019 (COVID-19) vaccinations, 60%–70% of adult influenza vaccinations during the third and fourth quarters, and approximately 40%–50% of adult pneumococcal vaccinations during the same period.[1] A more recent study found that pharmacies administered 88.6% of herpes zoster vaccinations among adults aged 65 and older in 2023.[2] A CDC analysis of vaccination settings during the 2023–2024 respiratory virus season similarly found that pharmacies were the most commonly reported setting for adult influenza, updated COVID-19, and respiratory syncytial virus (RSV) vaccinations.[3] Together, these findings demonstrate that the U.S. healthcare delivery system relies on community pharmacies and pharmacists for adult immunization.

13

Medicare beneficiaries who used both types of services made a median of **13 community-pharmacy visits** while seeing a primary care provider only **seven times**

7

Pharmacies also combine geographic reach with repeated contact. A nationwide analysis found that **88.9% of the U.S. population lived within five miles of one and 96.5% lived within ten miles**.[4] In a separate national sample of 681,456 Medicare beneficiaries who used both types of services, patients made a median of 13 community-pharmacy visits while seeing a primary care provider only seven times during that time period.[5] The pharmacy advantage was larger in rural than metropolitan areas and appeared in every

state and all but nine counties studied.[5] These visits create recurring opportunities to review vaccine history, answer questions, recommend a vaccine, and administer it during an encounter the patient was already engaging in.

That access advantage matters most in low-income communities. Compared with physician practices that provided vaccines, a 2022 study found 15.1% more physical pharmacy locations and 95.7% more pharmacy operating hours in low-income communities. When the comparator was limited to physician practices with Medicare Part D billing capability, the differences were larger: **203% more pharmacy locations and 415% more operating hours**.[6] The finding does not mean every community has adequate access. Transportation barriers, pharmacy and physician office closures and consolidation, and understaffing at community pharmacies remain real, but it shows that restricting pharmacy vaccination removes a disproportionately available point of care from communities with fewer conventional options.

Pharmacy hours of operation convert physical presence into usable access. In a national study of more than 6.25 million vaccinations, 30.5% were administered outside traditional clinic hours: 17.4% on weekends, 10.2% in the evening, and 2.9% on holidays.[7] That flexibility has economic value for lower or hourly-wage workers. In 2024-2025, only 63% of full-time, single-job workers in the lowest earnings quartile reported access to paid leave, compared with 91% in the highest quartile.[8] A walk-in or same-day pharmacy encounter can therefore avoid not only an appointment and a second trip, but also lost wages or the need to request time away from work.

Furthermore, the COVID-19 pandemic demonstrated that pharmacy reach can be mobilized on a national scale. Community pharmacists and their teams administered **more than 270 million COVID-19 vaccine doses**, and the author estimated that pharmacist-led programs accounted for more than half of all U.S. COVID-19 vaccinations during the period studied.[9] That record matters beyond emergencies: states already depend on a trained, distributed workforce with cold-chain, documentation, counseling, and adverse-event response capabilities.

Finally, broader literature supports the same direction of effect. A systematic review and meta-analysis by Isenor et al. found increased vaccine coverage in every study when pharmacists acted as educators, facilitators, or vaccinators.[10] A later international systematic review concluded that pharmacy-based immunization improved access and territorial equity, with results shaped by local financing, regulation, and health-system design.[11] These findings do not establish that pharmacy authority alone determines national coverage. They do establish that pharmacists are a proven component of multi-provider immunization systems and that legal restrictions can suppress a delivery channel already used by patients.

REGULATORY FRICTION IS ASSOCIATED WITH LOWER UPTAKE

For the past several decades, state laws have used several pathways to govern pharmacist vaccination. For example, states authorize independent initiation, a statewide standing order, a protocol agreed upon with an individual prescriber, a patient-specific prescription, a state vaccine list, or some combination of these steps. Each additional action can create a period in which a vaccine is federally available and clinically indicated but cannot be delivered by a pharmacist without a second administrative or regulatory transaction.[12] The burden is most visible for a new vaccine or revised indication for an already approved vaccine.

For example, a 2025 IQVIA analysis compared 2023 adult uptake across state authority categories for respiratory syncytial virus (RSV), 20-valent pneumococcal conjugate vaccine (PCV20), and shingles. Relative to states allowing independent pharmacist administration or a statewide standing order, average RSV uptake among adults age 60 and older was 3% lower in protocol states and **14% lower in prescription states**.[13] Average PCV20 uptake was 13% lower for adults age 18 and older and 9% lower for adults age 65 and older in protocol states; average shingles uptake among adults age 50 and older was 10% lower in protocol states.[13] These findings are consistent across vaccines with the predictable effect of adding transaction costs to a time-sensitive service.

Lower RSV uptake

14%

Average RSV uptake among adults age 60 and older in prescription states, relative to states allowing independent pharmacist administration or a statewide standing order (2023).

The same analysis translated the observed associations on a potential scale. It estimated that matching uptake in the least restrictive states could correspond to approximately 534,000 additional RSV recipients in protocol states and 123,000 in prescription states, approximately 828,000 additional PCV20 recipients, and approximately 953,000 additional shingles recipients.[13] The policy relevance lies in magnitude: even a small percentage-point difference becomes material when applied across an adult population, especially for vaccines administered seasonally or soon after a new recommendation or FDA approval.

PAYMENT AFFECTS CAPACITY, BUT PAYMENT IS NOT SCOPE

Legal authority is only one lever impacting pharmacists' authority to immunize. Pharmacies must acquire vaccine inventory, finance product carrying costs, schedule and train staff, maintain cold-chain and emergency supplies, screen patients, report doses, submit claims, and absorb denials or inadequate administration fees. An IQVIA analysis of adult Medicaid fee-for-service (FFS) influenza vaccination estimated average total reimbursement of approximately $12. After controlling for state income, education, and provider reimbursement, **a $13 increase in total pharmacy reimbursement was associated with a 5.6 percentage-point increase** in the adult Medicaid FFS influenza vaccination rate.[14] These findings underscore that nominal authority cannot produce capacity when payment fails to cover delivery costs.

Site-of-care evidence also indicates that pharmacy vaccination can reduce spending. Singhal and Zhang found mean payments of approximately $168.50 in pharmacies versus $208.72 in physician offices for zoster vaccination, $54.98 versus $65.69 for pneumococcal vaccination, and $21.57 versus $29.29 for influenza vaccination. Expressed as a physician-office premium over the pharmacy amount, those differences were 24%, 19%, and 36%, respectively, an average of 26% across the three vaccines.[15]

Table 1 Mean Payment per Vaccination by Site of Care[15]

Vaccine	Pharmacy	Physician office	Physician-office premium
Zoster	$168.50	$208.72	24%
Pneumococcal	$54.98	$65.69	19%
Influenza	$21.57	$29.29	36%
Average across the three vaccines			**26%**

Source: Singhal and Zhang, 2014. Payments are approximate means; the premium is the physician-office amount over the pharmacy amount.

A study by Prosser and colleagues estimated per-person delivery costs of $11.57 in a pharmacy, $17.04 in a mass-vaccination program, and $28.67 in a physician office.[16] They concluded that nontraditional settings, especially pharmacies, were likely cost-saving for healthy adults aged 50 to 64.[16] These findings highlight how pharmacy-based immunization can avoid the facility, scheduling, and professional overhead embedded in a separate office encounter.

A 2024 policy analysis applied the 26% historical physician-office premium to then-estimated RSV vaccine costs. Assuming every person projected to use a pharmacy instead gets vaccinated in a physician office, the analysis estimated $1.3 billion to $2.1 billion in additional vaccination outlays for one season.[12] The findings show how a site-of-care differential can compound the financial burden of immunizing millions of patients, adding pressure to an already overextended U.S. healthcare economy.

Regardless of the financial benefits, scope and payment should remain analytically separate. Expanding authority does not guarantee that pharmacies will stock a vaccine, and improving reimbursement does not cure a legal prohibition. A sound state framework does both: it removes unnecessary permission gates while promoting adequate, transparent payment for the clinical work required to vaccinate safely. That combination protects independent and rural pharmacies, reduces avoidable referrals, and reduces overall healthcare expenditures.

ADULT VACCINE UPTAKE HAS MEASURABLE HEALTH AND ECONOMIC CONSEQUENCES

Although vaccines are among the most cost-effective healthcare interventions, analytical studies are still needed to demonstrate their economic value.[17] A recent economic analysis estimated that influenza imposed approximately $29 billion in U.S. cost of illness during the 2023-2024 respiratory season, including approximately $16 billion in direct medical costs and $13 billion in productivity losses.[18]

Scenario modeling estimated that matching the recent peak adult vaccination rate observed in 2021-2022 could have prevented more than 8,000 deaths and avoided approximately $3 billion in economic losses in 2024.[18] These studies illustrate the opportunity cost when policy turns a convenient vaccination encounter into a delayed referral or a missed dose.

Approximately
$29B

U.S. cost of illness from influenza during the 2023-2024 respiratory season, including approximately $16 billion in direct medical costs and $13 billion in productivity losses.

The burden extends across adult vaccine-preventable diseases. A national cost-of-illness model estimated approximately $9 billion in economic burden in 2015 from diseases associated with ten adult vaccines; about $7.1 billion, nearly 80%, was attributed to unvaccinated adults.[19]

Multiple studies provide real-world evidence and concrete examples beyond influenza. For example, in a 2026 observational claims study of U.S. adults, hospitalized all-cause pneumonia rates were lower in 2017–2019 than in 2008–2009 across every age group studied: adults age 18–49 (48% lower), 50–64 (10% lower), 65–74 (20% lower), and 75 and older (18% lower).[20] In another study, the adjuvanted recombinant zoster vaccine **reduced herpes zoster and postherpetic neuralgia by 91.3% and 88.8%**, respectively, in adults aged 70 and older.[21] Together, these findings show that vaccination programs can reduce severe disease.



PART II

Advisory Committee on Immunization Practices (ACIP) Uncertainty Creates a State-Law Access Problem

WHY ACIP HAS MATTERED

The FDA and ACIP answer different questions. FDA approval or authorization addresses whether a particular product meets federal standards for specified uses. ACIP evaluates how an approved or authorized vaccine should be used across the civilian population, considering safety, efficacy, effectiveness, epidemiology, disease burden, feasibility, economics, contraindications, and special populations.[22,23] The distinction matters for state drafting: FDA status establishes a lawful product and use, while ACIP ordinarily translates product-level evidence into population-level clinical policy.



ACIP's Evidence to Recommendations framework and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) process make much of that reasoning publicly reviewable.[24] Workgroups typically evaluate evidence before a public vote, and the committee receives liaison, federal, and public input.[23,24] That process can surface implementation questions, supply, equity, dosing intervals, coadministration, and risk-based criteria that product approval alone does not resolve. It is one reason clinicians, health departments, insurers, and state legislatures have treated an ACIP recommendation as a trusted coordinating signal.

ACIP also provides institutional infrastructure. Its charter calls for multidisciplinary expertise, federal management and support, evidence review, public input, and updates to child, adolescent, and adult schedules. Its meetings are open to the public. The May 2026 Federal Register notice estimated annual operating costs of roughly $1.2 million when federal personnel, internal costs, member expenses, and reimbursable costs are combined.[23,25] That infrastructure helps explain why ACIP guidance

has become more than clinical advice: it is embedded in federal coverage statutes, the Vaccines for Children (VFC) program, clinical schedules, state laws, and insurer operations.[12,23,25,35,36]

This architecture produces efficiency when the process is timely and trusted, but it also concentrates dependencies. A single recommendation may simultaneously affect clinical guidance, pharmacist scope, public purchasing, employer-plan obligations, Medicare or Medicaid cost sharing, pharmacy system edits, and patient communication. State law should benefit from ACIP's expertise without making the committee's uninterrupted operation the sole legal condition for a qualified pharmacist to act.

THE PRESENT DISRUPTION IS PROCEDURAL AND PROSPECTIVE

Federal vaccine governance has been unpredictable since May 2025. The U.S. Department of Health and Human Services (HHS) directed changes to COVID-19 recommendations outside the customary ACIP process; in June 2025, HHS removed all 17 sitting ACIP members and began appointing replacements. Medical and public-health organizations filed suit in July 2025.[26,27,28] In March 2026, the U.S. District Court for the District of Massachusetts concluded that the plaintiffs were likely to succeed on their Administrative Procedure Act claims, stayed the challenged appointments and votes, and granted preliminary relief. The order is not a final judgment on the merits.[28]

The government appealed, and the litigation is ongoing.[29] The CDC canceled ACIP's March and June 2026 meetings because of the litigation while continuing to list an October meeting.[30] In May, CDC re-established the committee's charter after withdrawing an earlier renewal notice because the prior charter had lapsed following an administrative notice error.[25] Charter re-establishment did not, by itself, resolve the injunction, membership dispute, or pending appeal.

The practical risk is not that every past recommendation automatically disappears. Courts and agencies can preserve, restore, or clarify existing guidance. CDC stated on September 1, 2026, for example, that influenza recommendations from the July 2025 schedule remained in effect for the 2026-2027 season while legal uncertainty continued.[31]

The harder problem is prospective: who will review a new vaccine, a revised age group, an added indication, a product-specific safety signal, or a future seasonal formulation in a timely way if the ordinary ACIP process cannot function consistently?

That prospective uncertainty has immediate operational effects even before a court enters final judgment. Manufacturers, health departments, plans, pharmacies, prescribers, and patients must decide which products to purchase, how to build claims edits, which populations to message, and which source of guidance controls. A state scope law that waits for a later federal publication or secondary state action magnifies those uncertainties; a self-executing rule contains them.

HOW FEDERAL UNCERTAINTY PROPAGATES THROUGH STATE LAW

In states where pharmacist authority depends directly or indirectly on ACIP action, federal uncertainty becomes a state-law access constraint. The dependency may be explicit, such as a statute requiring an ACIP recommendation. It may also be sequential: ACIP or CDC acts, then a state agency must amend a list or protocol, a pharmacy must secure a prescriber agreement, or a patient must obtain a prescription.[12] The precise number and classification of affected states changes as statutes and rules evolve; the policy case does not depend on a single count. It depends on whether the law creates avoidable time between clinical availability and pharmacy delivery.

This structure creates four recurring failure modes.

- First, a new FDA-approved vaccine may be clinically appropriate but legally unavailable for pharmacists to immunize while the state waits for ACIP.
- Second, an ACIP recommendation may exist, but state law may require an official publication of ACIP recommendation or an additional state action.
- Third, a recommendation framed as risk-based or individual decision-making may be difficult to operationalize when the pharmacist lacks complete clinical records.
- Fourth, a stayed or contested federal action can leave pharmacists uncertain about which recommendation legally controls their practice.

Shared clinical decision-making (SCDM) illustrates the implementation problem. Discussion and informed consent already occur in routine practice whether led by a pharmacist, physician, or other authorized immunizer. The added federal category changes the default and may require more individualized documentation.[32] In a national physician survey, **90% to 95% of respondents said SCDM recommendations required more time than routine recommendations**, 64% to 76% said they created confusion, and only about 42% understood the associated insurance coverage.[33] A separate claims study found that up-

take of the 13-valent pneumococcal conjugate vaccine (PCV13) among Medicare beneficiaries age 65 and older declined from more than 70% to less than 60% after the 2019 SCDM policy enactment.[34] The study did not establish that SCDM alone caused the decline, but it documents the operational friction surrounding a more complex recommendation category.

For pharmacists, complex risk criteria can convert a same-day opportunity into a records request or referral, particularly when the pharmacy cannot see a diagnosis, laboratory result, or provider notes. The solution is not to eliminate clinical judgment. It is to keep legal scope broad enough for the pharmacist to obtain relevant information, apply the standard of care, consult or refer when necessary, and document the decision, rather than making a categorical legal barrier the default. Interoperable records and immunization registries improve that judgment; they should support authority, not substitute for it.

COVERAGE IS A SEPARATE BUT CONSEQUENTIAL ACIP DEPENDENCY

For non-grandfathered commercial coverage subject to the Affordable Care Act's (ACA's) preventive-services requirement, plans generally must cover vaccines without cost sharing for immunizations with an ACIP recommendation in effect for the individual.[35] The Inflation Reduction Act (IRA) similarly made ACIP-recommended adult vaccines covered under Medicare Part D available without cost sharing beginning in 2023 for seniors and extended related protections to Medicaid later that year.[36]

If ACIP cannot issue or update a recommendation, the immediate coverage effect will depend on the product, population, plan, timing, and whether an earlier recommendation remains in effect. The largest prospective risk concerns a new vaccine, a new indication or age group, or a future update that has not yet acquired the recommendation needed to activate a federal zero-cost mandate. A plan may voluntarily cover the service, but voluntary coverage is not a legally enforceable zero-cost obligation for the patient.

State authority is also incomplete by design. States can regulate fully insured individual and group plans, Medicaid programs within federal parameters, and state employee benefits. Still, ERISA §514, 29 U.S.C. §1144, limits state reach over self-funded employer plans; separate federal law limits state authority over federal programs. A state coverage backstop can therefore protect many residents without solving the national problem. That jurisdictional limit strengthens the case for keeping professional scope independent: a state should not add its own access barrier merely because it cannot guarantee every patient's federal coverage pathway.

States should monitor benefit design, network participation, claim rejection, administration payment, and patient cost sharing

within their jurisdiction. But lawmakers should not fold those questions into the professional-scope trigger. A pharmacist may be legally authorized even when a particular plan does not pay, and an insurer may cover a vaccine that a restrictive scope law prevents a pharmacist from administering. Clear statutes should say which issue they are solving.

PROFESSIONAL SOCIETIES ARE VALUABLE BACKSTOPS, NOT PLUG-IN ACIP REPLACEMENTS

The American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), and other professional societies possess substantial clinical expertise and have responded to federal disruption with evidence-based recommendations. AAP publishes a distinct annual childhood and adolescent immunization schedule and describes an evidence-review process led by its Committee on Infectious Diseases.[37] ACOG publishes maternal immunization guidance for pregnant, postpartum, and lactating patients.[38] ACP supports evidence-based adult immunization practices and provides resources for internal medicine.[39] These contributions can preserve clinical continuity for the populations each organization serves.

They do not, however, automatically replace ACIP's national institutional function. Their missions are population- or specialty-specific. Their guidance does not carry ACIP's statutory role under the ACA or the VFC program. They do not collectively produce one cross-population national schedule through a single public process, and they are not uniformly required to maintain open meetings, public-comment opportunities, standing vaccine workgroups, a federal secretariat, published conflict-management rules, or the resources to evaluate every newly licensed vaccine and indication on a predictable timetable.[23,24,25]



The relevant question is not whether these organizations can produce high-quality recommendations; they can. The question is whether any organization or coalition is willing and able to sustain the full replacement function: dedicated funding, multidisciplinary membership, continuous horizon scanning, standing workgroups, rapid review after FDA action, epidemiology and implementation analysis, public meetings, transparent evidence frameworks, conflict-of-interest safeguards, publication, communication, and durable legal recognition across states and insurers.

Regional alliances can coordinate recommendations more rapidly and reduce near-term fragmentation. The West Coast Health Alliance, for example, was created to coordinate vaccine guidance across participating states when federal recommendations became contested.[40] Yet a regional coalition still depends on state resources and cannot, by itself, activate federal coverage law or create one national standard. The same guidance may carry different legal effects on opposite sides of a state line.[35,36]

Litigation status should be kept in perspective. Several professional societies are plaintiffs in the pending federal case.[28] Seeking judicial relief to preserve existing processes or issuing emergency clinical guidance does not create a standing national vaccine-review institution. Nor does participation in litigation, by itself, establish an improper motive. The durable policy question is institutional capacity and accountability, not speculation about why an organization entered the debate.

States may recognize society guidance as an interim clinical source, particularly within a standard-of-care model. They should be cautious about naming several organizations as alternative statutory gatekeepers. If recommendations diverge, pharmacists and patients could face a new hierarchy problem: which source controls, on what date, for which population, and for what legal purpose? **A temporary backstop should therefore be explicit, reviewable, and time-limited.** It should not become a fragmented permanent substitute for a nationally coordinated process.



PART III

A Tiered State Policy Framework

States do not need to resolve the federal litigation to protect adult pharmacy access. They can modernize their own professional-practice laws now.

The following options are ranked from most durable to minimum acceptable reform. Each option preserves individual clinical judgment and ordinary professional discipline; the difference is how much external process the statute makes a condition of legal authority.

PREFERRED: REGULATE THROUGH AN ACCEPTED STANDARD OF CARE

The strongest solution is a standard-of-care practice model. Instead of defining pharmacist authority by enumerating specific vaccines or incorporating a single outside list, the state authorizes a trained pharmacist to initiate and administer adult immunizations consistent with the accepted standard of care. The standard is informed by the pharmacist's education and training, FDA labeling or authorization, current scientific evidence, reliable clinical guidance, patient-specific information, contraindications and precautions, informed consent, and the resources and setting in which care is delivered.

California's Assembly Bill 1503 (AB 1503), effective January 1, 2026, illustrates the approach. The California Board of Pharmacy states that pharmacist authority to independently initiate and administer vaccines for persons age three and older transitioned to a standard-of-care practice model. California defines accepted standard of care by reference to what a prudent and reasonable pharmacist with similar education, training, experience, resources, and setting would do in a similar situation.[41,42] For this paper's adult focus, the relevant point is the architecture: authority follows professional competence and accountability rather than a closed vaccine list.

A standard-of-care model is not deregulation. It replaces inflexible process mandates with enforceable professional duties. A pharmacist should decline or refer when the available information, training, staffing, equipment, or patient condition makes administration unsafe. States may retain neutral safety requirements such as accredited immunization training, cardiopulmonary resuscitation (CPR) certification, emergency-response capability, informed consent, recordkeeping, immunization information system reporting, adverse-event reporting, and referral for needs outside the pharmacist's competence. Those requirements should govern how care is delivered, not operate as a duplicative permission chain for each vaccine.

A well-drafted standard also clarifies evidence hierarchy without freezing it in time. FDA labeling and authorization establish the product's lawful parameters; ACIP, CDC, state health departments, specialty societies, peer-reviewed evidence, and recognized compendia may inform appropriate care. No single source should be the exclusive gate. Boards retain authority to investigate departures from accepted practice, while pharmacists retain the ability to respond when guidance changes faster than a legislature or rulemaking calendar.

FALLBACK: FDA STATUS OR ACIP/CDC RECOMMENDATION

Where standard-of-care reform is not politically feasible, states should adopt an objective dual trigger. A qualified pharmacist may independently initiate and administer an adult vaccine if either: (1) FDA has approved or authorized the vaccine for the relevant adult use and the pharmacist acts consistently with the applicable label or authorization; or (2) ACIP or CDC has recommended the vaccine for the patient or population, including a risk-based or individual decision-making recommendation.

The FDA pathway prevents ACIP delay or dysfunction from becoming a categorical state-law prohibition. The ACIP pathway preserves authority when a federal recommendation is clinically broader, more specific, or operationally useful. In both cases, the trigger answers only whether the service falls within legal scope. The pharmacist must still determine whether vaccination is appropriate for the individual patient. Coverage also remains separate, as the FDA status alone does not activate every federal zero-cost mandate.

The dual trigger should contain patient-safety guardrails rather than second permissions. A pharmacist should document the evidence source relied upon, screen for contraindications and precautions, provide the applicable vaccine information, obtain consent, report the dose, and refer when necessary. A board may issue nonbinding implementation guidance and discipline unsafe care. It should not be able to suspend statutory authority through inaction.

Drafting should be explicit about timing. Authority should not depend on later incorporation into an annual immunization schedule, publication in the Morbidity and Mortality Weekly Report (MMWR), adoption of a state list, or issuance of a second state protocol. The statute should identify the earliest reliable public federal action that triggers authority and specify how an emergency authorization, label revision, recommendation amendment, withdrawal, or safety restriction affects existing authority.

MINIMUM: MAKE ACIP/CDC AUTHORITY SELF-EXECUTING AND REMOVE DOWNSTREAM GATES

If lawmakers insist on retaining ACIP as the legal trigger, the recommendation should be the final gate. Once the state-defined federal recommendation event occurs, a trained pharmacist should be able to initiate and administer the adult vaccine independently, without additional authorization. The rule should apply equally to routine, risk-based, and individual decision-making recommendations unless the statute includes a clinically justified exception.

- **No patient-specific prescription.** The patient should not need a separate prescriber visit solely to authorize administration.
- **No prescriber-specific protocol.** A pharmacy's access should not depend on negotiating and maintaining an agreement with an individual physician.
- **No statewide protocol as a condition precedent.** A health department may issue clinical guidance, but failure to update a standing order should not suspend statutory authority.
- **No separate state vaccine list.** The state should not require duplicative listing after federal action.
- **No publication lag.** The statute should use the earliest reliable public recommendation event rather than the next annual schedule or later republication.

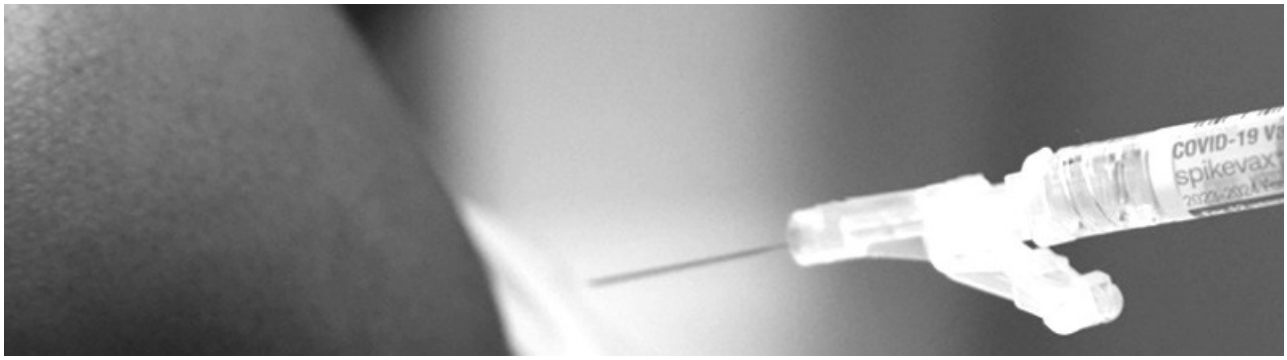
This option is less resilient because it still depends on ACIP's ability to act. It is nevertheless materially better than an ACIP trigger followed by a second and third layer of state or prescriber approval. The reform also clarifies accountability: if access stops, policymakers and the public can identify the single unresolved federal event rather than trace a chain of silent state approvals.

CROSS-CUTTING IMPLEMENTATION MEASURES

Whichever scope model a state chooses, implementation determines whether authority becomes access. States should ensure timely pharmacy access to immunization registries and relevant clinical information; require prompt bidirectional reporting; align age, training, supervision, and emergency-preparedness rules across practice settings; and prevent health plans from using network or billing rules to defeat an otherwise covered pharmacy benefit. Clear transition provisions should protect doses administered in good-faith reliance on then-current law or guidance.

Payment policy should recognize the full service, not just the product. Administration rates should account for screening, counseling, documentation, supplies, reporting, inventory financing, waste, and after-hours availability. States should monitor claims denials and whether payment differs solely by professional type for the same covered service. These measures are particularly important for independent, rural, and safety-net pharmacies that cannot spread fixed costs across a large network.

Finally, states should publish a short operational bulletin whenever a new adult vaccine or indication becomes available. The bulletin should identify the governing scope trigger, effective date, eligible ages, controlling safety requirements, registry expectations, and known coverage pathways. A single authoritative notice can reduce hesitation when pharmacies, plans, and patients receive different answers from separate agencies.



Conclusion

The United States has built adult immunization access around pharmacies and pharmacists. Current survey and claims data show that adults commonly receive influenza, COVID-19, RSV, and shingles vaccines in pharmacies. Pharmacies are widely distributed, visited frequently, open beyond traditional clinic hours, and especially prevalent in low-income communities. Historical economic studies also show lower site-of-care healthcare costs.

The public-health value is concrete. Adult vaccination can prevent invasive pneumococcal disease, shingles and chronic neuropathic pain, severe RSV disease, influenza deaths, and billions of dollars in treatment and productivity losses. A policy that preserves a pharmacist's ability to immunize does not guarantee that every eligible adult will be vaccinated. It does preserve one of the most effective opportunities to turn eligibility into receipt.

ACIP remains valuable because it links scientific review to a durable public institution and because federal and state law attach important consequences to its recommendations. The present litigation and meeting disruption reveal the vulnerability created when state pharmacist authority depends entirely on that institution's uninterrupted operation. Restoring a lawful, credible, well-resourced ACIP process is important. It is not a substitute for modernizing state scope laws.

Professional societies can and should provide clinical input, particularly for the populations they serve. But their expertise should not be mistaken for automatic institutional equivalence. A durable replacement would require broad remit, standing resources, transparent review, public accountability, predictable updates, and legal recognition. Until such a structure exists, naming several specialty societies as statutory substitutes risks fragmentation rather than resilience.

States should act in a clear order. First, adopt an accepted standard-of-care model. If that is not feasible, authorize adult pharmacy vaccination upon FDA approval or authorization, or an ACIP/CDC recommendation. At minimum, make ACIP-linked authority automatic and remove prescriptions, prescriber protocols, statewide protocols, state lists, and publication delays.

The immediate state responsibility is straightforward: preserve qualified pharmacists' legal ability to vaccinate adults safely, affordably, and without avoidable delay.

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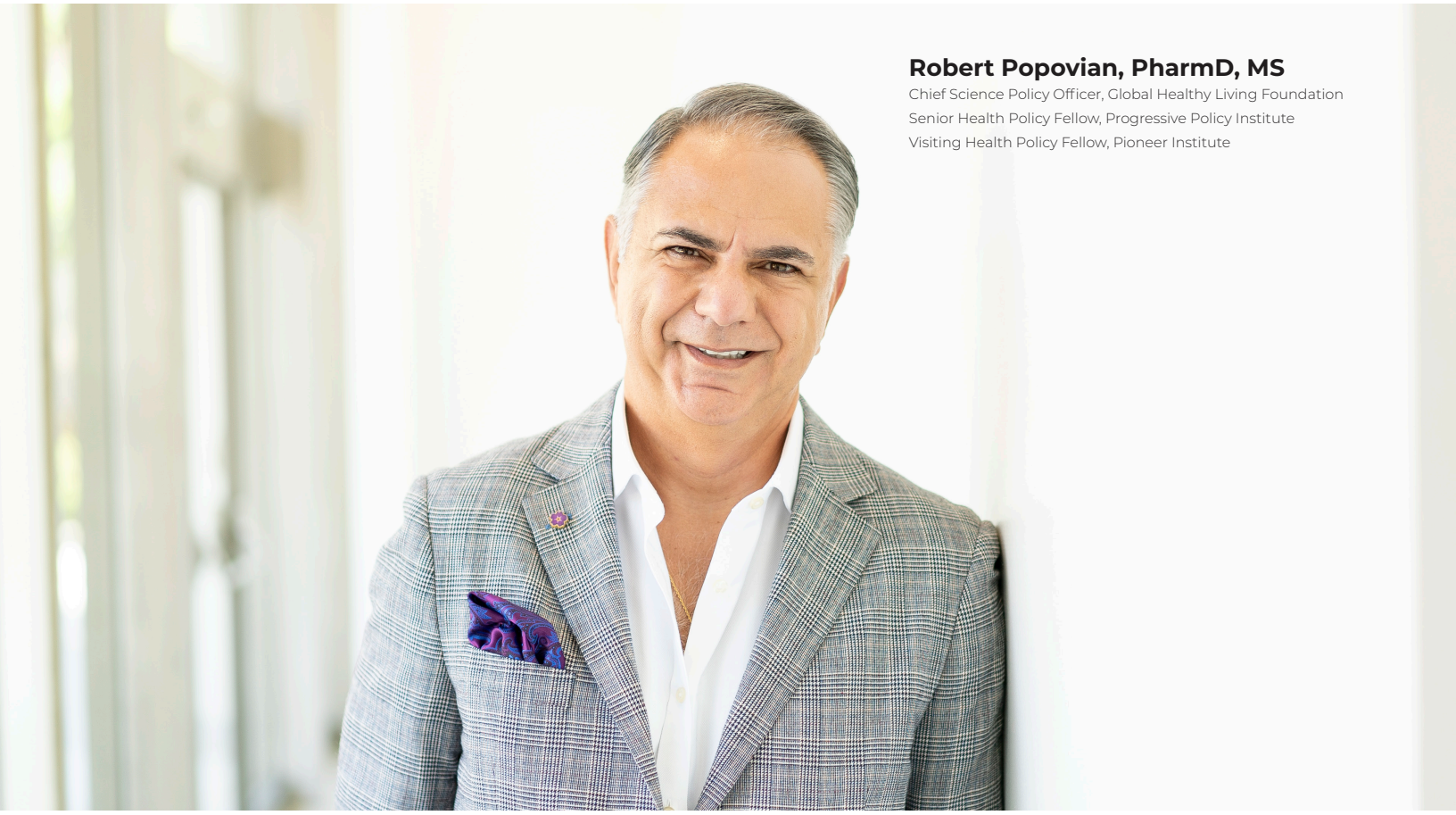
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GHLF's Patient-Focused Economic and Policy Research Division

At the Global Healthy Living Foundation, the Patient-Centered Economic and Policy Research Division conducts original research focused on health policy economics and outcomes research to better understand how current and proposed health policies, regulations, and legislation affect patients' financial, health care, quality-of-life, and other outcomes. We aim to increase transparency and understanding of the public health policies, regulations, and legislation impacting chronic disease patient communities by sharing our research via publication, our website, social media platforms, and conventional media. Our researchers also address these important topics through opinion editorials, speaking engagements, and our world-class podcast series – Healthcare Matters. Our experts have published extensively on the impact of biopharmaceutical and health policies on costs and clinical outcomes in the most prominent medical sources and media publications. They are sought-after speakers, providing briefings and expert reviews for the U.S. Congress, dozens of state legislatures, and at conferences and medical symposiums around the world. Learn more about GHLF's vaccine work at https://ghlf.org/issues/vaccines/.



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