CENTER FOR UNBIASED SCIENCE & HEALTH

THE REAL ECONOMICS OF PEDIATRIC VACCINATION

Examining the Evidence Behind Claims of Pediatric Vaccine Profits

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EXECUTIVE SUMMARY

Claims that pediatricians recommend vaccines to make a profit have gained traction in recent months, amplified by statements from federal officials and, most recently, a formal investigation launched by the Texas Attorney General. This white paper examines those claims against the actual economics of pediatric vaccine delivery. These claims matter because they erode trust. When parents believe their pediatrician's recommendations are driven by profit rather than their child's health, they're more likely to delay or decline vaccines — putting children at risk for preventable diseases.

Using commercial reimbursement data from four major insurers across all 50 states, state Medicaid fee schedules, and peer-reviewed literature on vaccine financing, we analyzed what pediatricians are actually paid to administer vaccines, and what it costs them to do so.

The data tell a more complicated story than either side suggests. Rather than profiting from vaccines, many pediatric practices struggle financially to provide them. Financial strain is most severe for practices that serve Medicaid-enrolled and uninsured children, as they face inadequate reimbursement that fails to cover actual costs. Payment varies dramatically by state and payer: a practice in Colorado serving commercially insured patients faces entirely different economics than a practice in Mississippi serving predominantly Medicaid patients.

Nearly one in four pediatricians has considered abandoning vaccine delivery — not because they doubt the science, but because the financial burden threatens their practice's viability. Quality incentive payments, often mischaracterized in viral claims, come from insurance companies, not vaccine manufacturers, and they reward comprehensive care quality rather than vaccination volume.

This report walks through the data — administration fees, product reimbursement, state variation, and the economics of serving vulnerable populations — to provide a clear-eyed picture of how vaccine financing actually works.

KEY FINDINGS

- **Pharmaceutical companies do not pay pediatricians to vaccinate children.** Quality incentive payments come from insurance companies, not vaccine manufacturers, and are tied to broad measures of care quality — not vaccination quotas. In fact, it is illegal for vaccine manufacturers to offer financial incentives to physicians for recommending their own vaccines over competitors' products, under federal anti-kickback laws.
- **Viral claims about physician "vaccine bonuses" misrepresent how quality programs work.** These programs reward practices for meeting dozens of care metrics — developmental screenings, chronic disease management, patient satisfaction — of which immunization is one component.
- **Vaccine economics vary dramatically by state and payer.** A practice in Colorado serving commercially insured patients faces entirely different economics than a practice in Mississippi serving predominantly Medicaid patients. There is no single story.
- **Many practices lose money vaccinating Medicaid and uninsured children.** In some states, Medicaid administration payments fall below the actual cost of delivering a vaccine.
- **24% of pediatricians have considered stopping vaccine delivery** — not because they doubt vaccines, but because the financial strain threatens their practice.
- **Vaccines are one of the least profitable services pediatricians provide.** Many practices operate on very thin margins for vaccination services. Pediatricians who break even or earn modest margins are not doing anything wrong — practices need to be financially sustainable to keep their doors open. The claim isn't that profits exist; it's that vaccines are a major profit driver. They're not.

INTRODUCTION

In July 2025, families testified before the U.S. Senate during a hearing titled "Voices of the Vaccine Injured," organized by the Senate Permanent Subcommittee on Investigations. Parents described adverse events following childhood vaccinations, and the hearing quickly became a catalyst for renewed claims about the economics of pediatric vaccination.

Shortly afterward, a debunked claim from a 2016 blog post began recirculating on social media, falsely alleging that insurance companies pay pediatricians substantial bonuses based primarily on vaccination quotas. Multiple fact-checking organizations have thoroughly disputed these misrepresentations of how quality-based payment programs actually function.

On August 8, 2025, Health and Human Services Secretary Robert F. Kennedy Jr. added fuel to the fire, stating in a video posted online that "Doctors are being paid to vaccinate, not to evaluate. They're pressured to follow the money, not the science." This was echoed in a June 30 interview, where he referred to pediatric vaccine recommendations as driven by "perverse incentives."

Most recently, on January 21, 2026, the Texas Attorney General launched a formal investigation into what he described as "unlawful financial incentives" for childhood vaccines, claiming that "Big Pharma and Big Insurance bribe medical providers to pressure parents to jab their kids." The investigation targets major insurers and pharmaceutical manufacturers.

These statements have heightened public skepticism about whether pediatricians recommend vaccines for profit. Pediatricians and public health leaders worry that misinformation may lead parents to view routine vaccine recommendations through a financial lens rather than a child health one. The American Academy of Pediatrics (AAP) has noted that surveys consistently show the opposite: *many pediatric practices struggle financially to provide vaccines, with payments from private insurance and Medicaid varying widely and often failing to cover the actual costs of delivering the vaccines.*

A note before we begin: This is a long, detailed read. We set out to definitively answer whether pediatricians make large profits from vaccines, and that meant digging into every aspect of vaccine economics—from federal reimbursement benchmarks to state-by-state payment variations to the reality of storage costs. Consider this the definitive investigation that puts this myth to rest once and for all. Due to its comprehensive nature, we're publishing this as a white paper.

DATA SOURCE AND METHODOLOGY

We analyzed commercial reimbursement rates to pediatricians for vaccine administration and vaccine products. All data were sourced from the price transparency tool at pediatricsupport.com/analysis-of-codes-affecting-pediatrics, developed through a partnership between Pediatric Management Institute (PMI) and the American Academy of Pediatrics (AAP). Under federal price transparency rules, commercial payers are now required to publish their negotiated rates via publicly available machine-readable files. The tool uses data from TrekHealth.io via PMI's PayerIntel Services, which aggregates these files into an accessible format.

The dataset includes payment rates to pediatricians from four major commercial payers—Aetna, Cigna, UnitedHealthcare, and Blue Cross Blue Shield Plans—across all 50 states and the District of Columbia. Throughout this analysis, we referenced the national Medicare vaccine administration rate ($22.32) as a benchmarking yardstick. We want to be clear: Medicare does not typically cover routine childhood vaccines, and this rate does not determine Medicaid payments. We used it solely as a consistent federal benchmark, representing a federally established payment rate for vaccine administration, to illustrate how state Medicaid rates compare across different payment systems. In general, Medicaid payment rates are lower than Medicare rates, though there is substantial variation across states. We also compared payment levels with the CDC private-sector cost per dose for vaccine drugs (updated January 6, 2026). Because some states participate in Universal Vaccine Purchase (UVP) programs, which change vaccine economics, we reviewed minimum rates overall and separately for non-UVP states.

In addition to analyzing commercial reimbursement data, we conducted an extensive review of peer-reviewed literature on vaccine financing, including national surveys published in *Pediatrics and Academic Pediatrics*, AAP guidance documents, and CDC cost analyses.

We received no funding for this analysis; it is entirely independent.

Jumping ahead to the punchline and the overall takeaway from our analyses: **pediatricians are not getting rich from vaccines**. In fact, many practices lose money or struggle to break even on vaccines.

This report will walk you through the data and demonstrate why the narrative of vaccine profits is not just wrong—it's backwards.

PART I: THE MYTH AND WHY IT MATTERS

THE CLAIM: WHAT IS BEING SAID ABOUT VACCINE PROFITS

The specific claim gaining traction online is that pediatricians receive substantial financial bonuses (sometimes cited as $40,000 or more) for meeting childhood vaccination quotas. This narrative suggests that pediatricians are motivated to recommend vaccines not by medical evidence, but rather by direct financial incentives tied to vaccination rates.

These claims typically reference insurance company "quality bonus" programs, such as Blue Cross Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program. Social media posts and blog articles assert that these programs pay doctors thousands of dollars per patient for maintaining high vaccination rates, creating what critics call "perverse incentives" to over-vaccinate or pressure reluctant parents.

The (**incorrect**) implication is clear: if you follow the money, you'll find that vaccine recommendations are driven by profit, not science.

THE REALITY CHECK: HOW QUALITY PROGRAMS ACTUALLY WORK

Let's examine what these programs actually are and how they function.

What Are Value-Based Payment Programs?

Value-based payment programs are contracts in which insurance companies pay doctors based on the quality of care provided, rather than just the quantity of services delivered. Instead of simply paying for each visit or procedure, insurers reward practices that keep patients healthy and meet evidence-based care standards.

These programs include quality metrics: specific, measurable goals that practices must meet to earn bonus payments. In pediatrics, these metrics typically span dozens of areas, including developmental and behavioral health screening, asthma and chronic disease management, antibiotic stewardship, patient and family satisfaction, preventive care visits, appropriate laboratory testing, and childhood vaccination rates.

The programs are carefully structured to comply with federal anti-kickback, fraud, and self-referral laws, which means they cannot simply pay doctors per vaccine administered. Instead, they must reward broad quality metrics across entire patient populations. For example, Blue Shield of California's value-based payment framework evaluates practices across:

- Resource utilization (emergency room visits, inpatient admissions)
- Clinical quality measures (developmental and behavioral screenings, preventive care)
- Patient experience and satisfaction

Immunization rates are just one small component within this comprehensive evaluation.

And critically: Pharmaceutical companies do not pay pediatricians to vaccinate children. Quality incentive payments come from insurance companies, not vaccine manufacturers. Insurers structure these programs because high-quality preventive care — including vaccination — keeps their members healthy and out of emergency rooms and hospitals. This is not a scheme between drug makers and doctors; it is insurers rewarding the outcomes they want to see across their patient populations. Additionally, strict federal kickback laws prohibit drug manufacturers from offering financial incentives intended to influence a clinician's prescribing behavior for federally insured patients. Prescribers can face serious civil and criminal penalties if they participate in such arrangements.

What the Misrepresented Program Actually Paid

Let's look at the 2016 Blue Cross Blue Shield of Michigan Performance Recognition Program, the specific program misrepresented in viral claims about "$40,000 vaccine bonuses."

According to a BCBSM spokesperson, this particular Michigan program paid between $400 to $9,600 per provider for the childhood vaccination program in 2016. The payment structure was based on the number of eligible children who completed the comprehensive immunization series, with the maximum payment capped at $9,600 per provider. The spokesperson explicitly stated: "The maximum cap of $9,600 per provider meant that no provider could have earned $40,000 for giving vaccinations."

The viral claim overstates the actual payment by more than 300%.

It's worth noting that quality incentive programs vary considerably across insurers and regions. Some programs offer standalone payments for specific metrics like immunization rates, while others bundle vaccination targets with other quality measures such as developmental screenings, chronic disease management, and patient satisfaction scores. Payment structures and caps also differ. We highlight this BCBSM example because it's the specific program misrepresented in the viral "$40,000 bonus" claim, not because it's representative of all incentive programs nationwide.

> ***Source Note:*** *While these 2016 data are now nine years old, they directly address the specific program and timeframe referenced in the persistent online myth.*

The Stakes: Why This Even Matters

If quality bonus programs were creating "perverse incentives" to over-vaccinate, and if vaccines were such a profit center for pediatricians, we would expect to see practices eagerly expanding vaccine services, competing to serve more vaccine-eligible patients, and achieving financial stability through vaccination.

Instead, we see the opposite.

The real story isn't excessive profit; it's that practices are financially struggling so much that they're considering abandoning vaccine delivery altogether.

The 2011 National Survey: A Warning Sign

A 2011 national survey of pediatric and family medicine practices found alarming trends:

- 12% of pediatricians had stopped purchasing certain vaccines due to financial concerns.
- 24% had seriously considered stopping.
- Among those who stopped or considered stopping, reasons included inadequate reimbursement for vaccine or administration costs, inconsistent payer coverage, upfront purchasing costs, and challenges with the federal Vaccines for Children (VFC) program, which provides free vaccines to eligible children but requires practices to absorb administration costs and to maintain separate inventories.

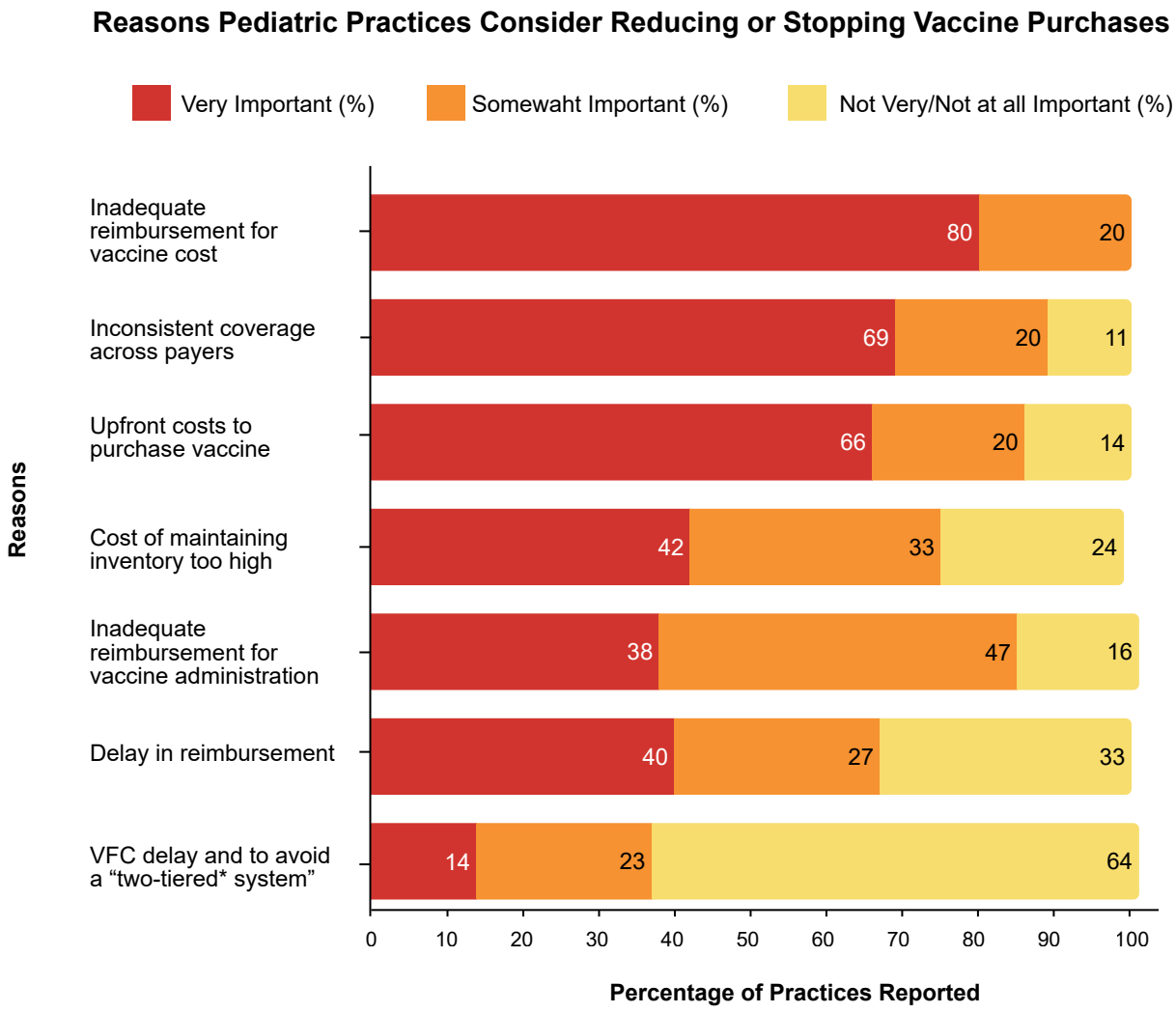


Figure 1. Reasons Pediatric Practices Consider Reducing or Stopping Vaccine Purchases.
Source: Allison et al., Academic Pediatrics, 2017

It's worth repeating: Nearly one in four pediatricians has considered abandoning vaccine delivery. Not because they doubt the value of vaccines, but because the financial burden threatens their ability to keep their clinic doors open, forcing them to fight losses rather than chase profits. The AAP emphasizes that providing vaccines represents one of the largest overhead expenses in pediatric practice, including specialized storage equipment, liability insurance, inventory management software, and dedicated staff time, all of which must be paid whether or not reimbursement is adequate.

> ***Source note:*** *This 2011 survey represents the most comprehensive national data available on this specific question. While some states have updated payment rates since then, no recent national survey has replicated this research. More recent state fee schedules and policy analyses continue to show that payment adequacy remains a persistent challenge, particularly for practices serving Medicaid populations.*

This pattern isn't unique to pediatrics. Adult primary care physicians (PCPs) face the same economic pressures, and many have responded by simply not offering vaccines at all. Many adults today receive their vaccines at pharmacies rather than their PCP's office — not because pharmacies provide better care, but because PCPs can't afford to stock and administer vaccines at a loss. The economics that push adult practices away from vaccines are the same ones straining pediatric practices, with one key difference: pediatricians feel an obligation to vaccinate that keeps them providing the service despite the financial hit.

The contrast with COVID-19 vaccine reimbursement is striking. When COVID-19 vaccines became available, CMS set administration fees at $40–45 per dose — nearly double the $22.32 Medicare benchmark for routine vaccine administration. Even this higher rate came only after pharmacies indicated they wouldn't administer the vaccines for less. If adequate payment was necessary to ensure COVID-19 vaccine access, it raises an obvious question: why are pediatric practices expected to deliver routine childhood vaccines at rates that don't cover their costs?

The Human Cost

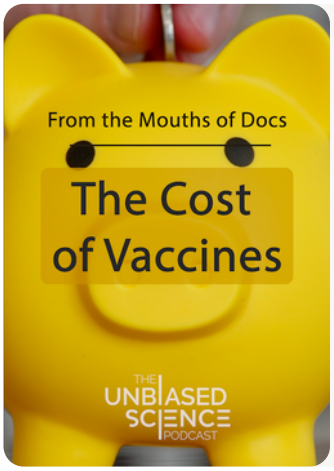
Behind these statistics are real pediatricians serving real communities. Their stories reveal the reality behind the numbers: pediatricians who continue vaccinating despite financial strain and not because of financial gain.

The financial burden of inadequate vaccine reimbursement isn't new, nor is the painful irony of being accused of profiteering. One pediatrician, reflecting on decades of practice, shared:

> *"In 1979 before the IPV (inactivated polio vaccine) days, I gave OPV (oral polio vaccine). The reimbursement from Medicaid was approximately $3.00 less than the cost. I lost money on every dose. Now it is likely that some of those same individuals who benefited from that sacrifice are saying I'm trying to harm their children with dangerous vaccines because of money. It's the ultimate slap in the face."*

This sentiment, financial sacrifice met with accusations of greed, echoes across generations of physicians.

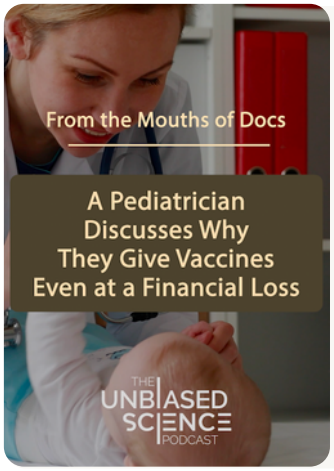
Furthermore, the accusation fundamentally misunderstands how pediatric practices operate. Vaccine payments don't go into physicians' personal bank accounts. They contribute to total practice revenue, which funds the infrastructure that serves children and their families, such as after-hours services, mental health counselors, triage nurses, care coordinators who help families navigate complex medical needs, and community health initiatives. When vaccine reimbursement fails to cover costs, these services become unsustainable. The result isn't wealthy pediatricians—it's practice closures, particularly in underserved areas, forcing independent practices to sell to larger health systems or close their doors entirely.



Story #1 - **Dr. Sian Jones in Nebraska**

Dr. Jones discusses how the true cost of providing vaccines to children extends well beyond the vaccines themselves. The necessary upfront investments in storage, insurance, and administration create significant financial strain on practices. Practices pay substantial funds in advance and wait months for reimbursement. Doctors do this not for profit, but because it is the right thing to do.

A video clip from our conversation with Dr. Jones can be accessed here.



Story #2 - **Dr. Gail Schonfeld in New York**

Dr. Gail Schonfeld pushes back against claims that pediatricians profit from vaccines, explaining that her predetermined $17.85 administration fee doesn't cover her significant infrastructure costs and that she often administers vaccines at a loss to uninsured patients. She emphasizes that pediatricians do this work out of genuine care for children's health, not financial incentive.

A video clip from our conversation with Dr. Schonfeld can be accessed here.

Story #3 - **Dr. Daniel Levy in Maryland**

Dr. Daniel Levy explores how systemic failures in the US healthcare system devastate dedicated pediatricians, making it nearly impossible to operate an independent practice. Drawing on his own experience serving low-income children, he shows how even personal investment and commitment couldn't save his practice from closure.

A video clip from our conversation with Dr. Levy can be accessed here.

THE CONTRADICTION

The economic reality directly contradicts the profit narrative. As the data in the following sections will demonstrate, the real story isn't that all pediatricians are losing money on vaccines. It's that the payment system creates profound disparities. Many practices lose money on every dose administered specifically to vulnerable populations, threatening access to life-saving vaccines for the children who need them most.

PART II: VACCINE ECONOMICS 101

THE TWO-PART PAYMENT STRUCTURE

Understanding vaccine economics starts with one fundamental concept: **providing vaccines involves two completely separate costs, each requiring its own reimbursement**:

1. **The vaccine administration cost** – This is the cost of giving the shot, and includes staff time, supplies, waste disposal, counseling families, and documentation. A 2009 study of pediatric practices found that each injection cost $11.51 to administer. After accounting for inflation and additional documentation and regulatory requirements since 2009, that figure is likely $15 or more today.

   Payers (including private insurance and Medicaid/Children's Health Insurance Program (CHIP)) reimburse this through an "administration fee," to compensate practices for these costs.

2. **The vaccine product cost** – This is what practices pay to purchase the vaccine, plus the substantial overhead required to maintain a vaccine program. According to the AAP, "When all expenses for vaccine products are combined, this results in total expenses at 17% to 28% over acquisition cost." This overhead includes costs such as specialized equipment, storage, monitoring systems, insurance, inventory management, and other expenses associated with maintaining a vaccine program.

   The actual per-dose overhead differs by practice volume and vaccine mix. Using the 17-28% range as a guide, and the current CDC vaccine price list, some examples include:

   - **DTaP** (acquisition cost ~$30): overhead adds ~$5-$8 per dose
   - **Prevnar 20** (acquisition cost ~$275): overhead adds ~$47-$77 per dose
   - **Beyfortus** (acquisition cost ~$556): overhead adds ~$95+ per dose

   Private payers reimburse practices separately for the vaccine product, with payment intended to cover both the acquisition cost and the overhead expenses.

WHY BOTH PAYMENTS MATTER

A practice can lose money in two ways:

1. Inadequate administration fees: If administration fees fall below the actual cost of delivery, the practice loses money on every dose, regardless of whether the vaccine product itself was adequately reimbursed.

2. Inadequate product reimbursement: If product reimbursement only covers the purchase price without accounting for overhead costs, the practice loses money, even if the administration fee was adequate

Many practices face both problems simultaneously.

A REAL-WORLD EXAMPLE: DTaP VACCINE

To make these theoretical numbers more concrete, here is a realistic example using current list prices and typical payment patterns. Actual figures may vary by product, payer, and state. Let's walk through the economics of giving a single DTaP dose in a private pediatric practice today.

As we described above, these might be typical practice costs:

- Cost to give the shot: ~$15
- Vaccine purchase price: ~$30 (CDC private sector price)
- Overhead on the product (17-28%): ~$5 - $8
- Total practice cost: ~$50-$53

Now let's look at the payer scenarios:

In many states, large commercial plans pay enough to cover these costs. Using the PediatricsSupport/PMI price transparency tool, which aggregates negotiated rates for pediatricians from four major national insurers, typical payments for DTaP might look like this:

- Administration payment (code 90460 for IM admin 1st/only component): ~ $28 per dose
- Product payment (code 90700 for Daptacel): ~ $33 per dose (enough to cover the $30 purchase plus some of overhead)
- Total received: ~ $61 per dose.

Against an all-in cost of roughly $50-$53, that leaves a margin of about $8-$11 per dose in this scenario.

> ***A note on 'component':*** *Pediatric vaccine administration can be billed per component using codes 90460/90461 — see Part 3 for details. This example uses a simplified figure for illustration.*

Now compare that to a Medicaid scenario in a low-payment Medicaid state. Medicaid-enrolled children are VFC-eligible, meaning practices receive vaccines at no cost through the federal VFC program. However, as we will explore in detail in Part 4, the federal program covers only the vaccine product itself, but not the infrastructure and labor required to deliver it. Practices still have to pay for all storage, handling, and administrative costs. State Medicaid programs pay only an administration fee, which varies by state, as discussed in Part 3, but which can be lower than the cost to actually administer the vaccine. A representative example might look like:

- Administration payment: ~$12 per dose (e.g., Mississippi Medicaid pays $11.68)
- Product payment: Not applicable
- Total received: ~$12 per dose

If the practice's true cost to store and administer the shot is $20-$23, that means a loss of roughly $8-$11 every time they vaccinate a Medicaid-insured child with DTaP.

This is why the story of vaccine economics isn't "all pediatricians profit" or "all pediatricians lose money". Instead, we can think of it as: "payment varies widely, and many practices serving vulnerable populations lose money on every dose."

PART III: **WHAT THEY ACTUALLY GET PAID**

ADMINISTRATION REIMBURSEMENT: HALF THE PROBLEM

We dove even deeper into the data from the PediatricsSupport/PMI price transparency tool and analyzed vaccine administration payments (CPT code 90460) from the four major commercial payers across all 50 states.

> ***A note on how administration billing works:*** *In 2011, CPT codes for pediatric vaccine administration were restructured to better reflect the counseling work involved in giving combination vaccines. Code 90460 covers the first or only vaccine component administered (with physician counseling), while code 90461 is billed for each additional component. For example, administering MMR — which contains three components— is billed as one unit of 90460 plus two units of 90461. This per-component approach was a significant improvement over the previous per-injection model. However, as we'll see below, Medicaid programs generally don't honor this component-based billing.*

Commercial Payer Reimbursement Data: The Best-Case Scenario

- Mean: $31.80
- Median: $28.43
- Range: $19.28 to $47.42

The majority of commercial payers reimburse above the federal benchmark of $22.32, with most payments falling in the $25-35 range. This represents the most favorable payment scenario for practices.

However, these averages mask significant geographic variation and don't account for:

- Payment denials and clawbacks (reasons can include the patient being too old for coverage, the vaccine being given a few days early, or coverage having lapsed)
- The 68-day median wait for reimbursement
- Administrative costs of billing and claims management
- The fact that many practices serve mixed patient populations–some patients have commercial insurance that pays well, while others have Medicaid or are uninsured, meaning the same practice receives vastly different payments for the same service depending on each child's insurance status.

Medicaid Reimbursement Data: A Starkly Different Picture

Each state sets its own vaccine administration rates, creating enormous variation.

Here are some examples (hyperlinked sources for each state can be found here):

Table 1. **Vaccine Administration Fee (by State).**

State	Administration Fee	Notes
Kentucky (2024)	$27.49	Above federal benchmark ($22.32)
Colorado (2025)	$21.51	Just below federal benchmark
Washington (2025)	$21.01	Just below federal benchmark
Connecticut (2022)	$15.05	Well below federal benchmark
Minnesota (2022)	$12.16	Well below estimated delivery cost (~$15)
Mississippi (2022)	$11.68	Well below estimated delivery cost
Michigan (2022)	$7.00	Well below estimated delivery cost
New Hampshire (2022)	$6.39	Well below estimated delivery cost

Data years vary by state based on most recent publicly available fee schedules.

Table: Unbiased Science • Created with Datawrapper

The AAP has recommended that the first vaccine administration should be reimbursed at $25 to adequately cover the costs of counseling and delivery. As the table shows, many state Medicaid programs fall well short of this recommendation, with some paying less than half the amount.

Compounding this problem, Medicaid programs generally follow a "one shot, one administration payment" rule — they don't honor the component-based billing (90460/90461) that commercial insurers use. A practice giving Pediarix (five components) to a Medicaid patient receives the same single administration fee as a single-component vaccine. This means children on Medicaid — already subject to the lowest reimbursement rates — also don't benefit from the coding improvements designed to better compensate practices for combination vaccine counseling.

> ***Source note:*** *A critical limitation in understanding current Medicaid payment adequacy is the lack of recent comprehensive national data. The 2011 survey remains the most recent nationwide assessment of how Medicaid reimbursement compares to actual costs. While state fee schedules show current rates, there's no systematic national analysis of whether these rates keep pace with rising delivery costs.*

What we do know: the 2011 national survey finding that two-thirds of practices received inadequate Medicaid payments, combined with current state fee schedules showing many rates still below cost, suggests this remains a persistent and widespread problem.

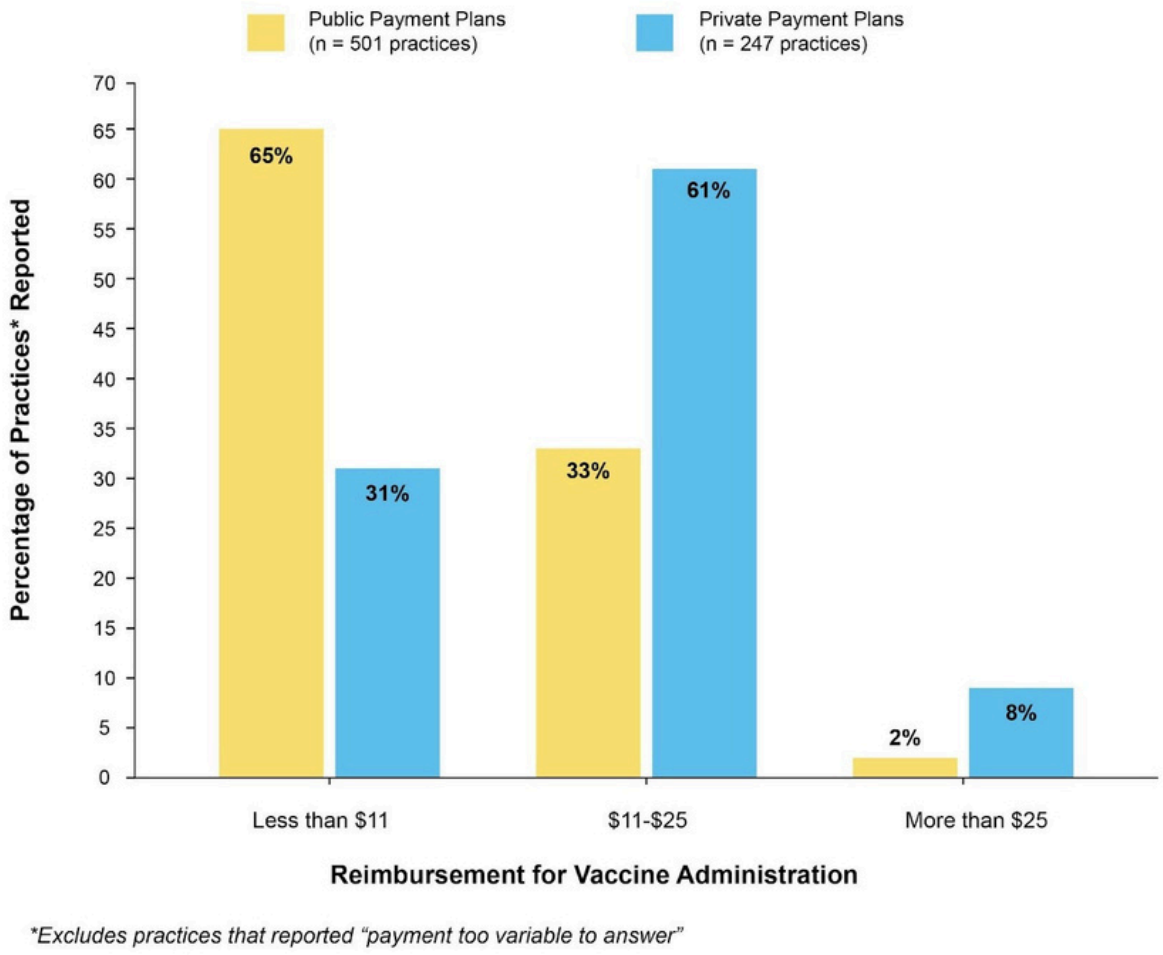


Figure 2. **Estimated Reimbursement for Vaccine Administration by Payer Type.** 2011 national survey: Of the practices reporting, 65% indicated that public payments were less than the lowest cost estimate for vaccine administration (11$), and more than 75% indicated that all payer types provided less than the AAP-recommended level of payment for first vaccine administration ($25). Source: Allison et al., Academic Pediatrics, 2017

PRODUCT REIMBURSEMENT: THE OTHER HALF OF THE PROBLEM

Administration fees are only half the story. Practices must also receive adequate payment for the vaccine product itself. The same 2011 national survey asked practices how reimbursement for vaccine purchase compared to their costs. Only 61-79% of practices (depending on payer) reported that what they were paid for vaccines was at least their purchase price, meaning 21%–39% were paid less than they spent to buy the vaccine. Most practices reported payments at or only slightly above purchase price, not substantially higher.

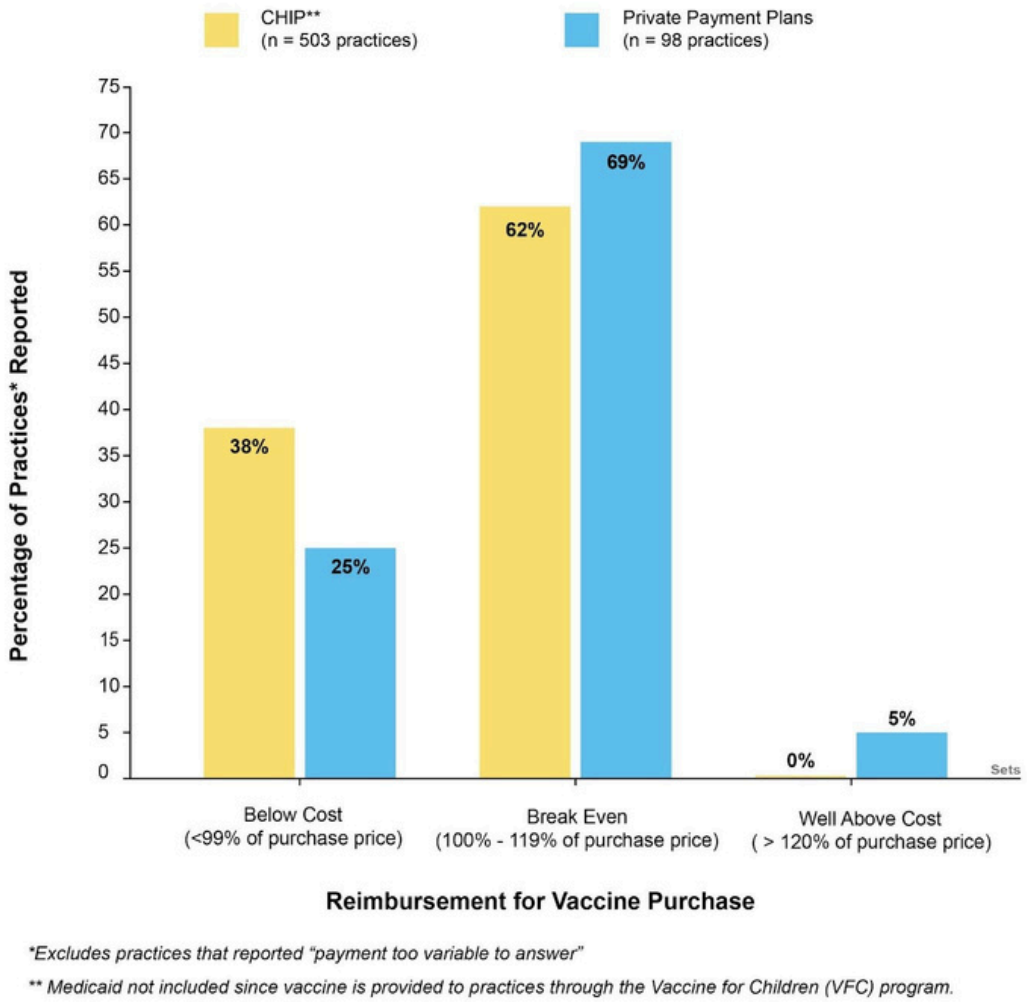


Figure 3. **Reimbursement for Vaccine Purchase by Payer Type.** 2011 national survey: Most practices reported vaccine purchase reimbursement at or below actual costs: 38% of private payers and 25% of CHIP programs paid below cost, while only 5% of CHIP and no private payers reimbursed substantially above cost. Source: Allison et al., Academic Pediatrics, 2017

The math on product markup is deceptive. While older, cheaper vaccines may show a "substantial" percentage markup, the actual dollar amount is minimal. A 20% margin on a $15 vaccine is $3. But newer, more expensive vaccines — HPV, Nirsevimab, Pentacel — often have razor-thin percentage markups despite their high acquisition costs.

Two additional factors make product reimbursement even more precarious:

Wastage: All it takes is one patient changing their mind after an HPV vaccine has been drawn up, and the practice must absorb the full cost of that dose. With margins this thin, a single wasted high-cost vaccine can erase the margin on dozens of other doses.

Price lag: Vaccine manufacturers often raise prices, but payers typically don't adjust reimbursement for 90 days or more — even when manufacturers communicate rate increases in advance. During that window, practices may be "underwater," paying more for the vaccine than they're being reimbursed.

Remember: these figures assessed whether payment covered the purchase price only, not the additional 17-28% overhead costs. When overhead is included, the proportion of practices losing money on vaccine products can increase substantially.‘

PART IV: A SYSTEM OF EXCEPTIONS, WORKAROUNDS, AND UNEVEN PAYMENTS

THE VFC PARADOX: "FREE" VACCINES THAT ACTUALLY COST MONEY

The VFC program serves uninsured, underinsured, Medicaid-enrolled, and American Indian/Alaska Native children. For many practices, this sounds like it should solve the economic problem: the federal government provides vaccines at no cost, eliminating the largest expense.

But "free vaccines" doesn't mean "free to deliver."

UNDERSTANDING VFC ECONOMICS

VFC provides free vaccine products to eligible children, with no upfront purchase costs and no inventory risk from expired vaccines. But there is plenty it doesn't cover. For example, it doesn't cover specialized equipment, storage, monitoring systems, liability insurance, inventory management, and staff time.

Practices receive only administration payments for VFC vaccines, and these payments are typically the lowest in the system. As shown in table 1 above, a number of state Medicaid programs pay administration fees of $12 or less (while the actual cost to safely store and administer that dose is estimated to be higher). In fact, according to a 2016 Health Affairs analysis, practices lose approximately $5-$15 per VFC dose.

THE DOUBLE INVENTORY BURDEN

VFC program rules require practices that serve both VFC-eligible and privately insured children to maintain clearly differentiated inventories. VFC vaccines must be kept separate from private vaccines to ensure that VFC vaccines are administered only to eligible children. This separation requirement means that practices need to duplicate their refrigeration equipment (or have clearly separated storage within units), monitoring systems, inventory management/ tracking, and record-keeping, which adds to the costs.

Borrowing between inventories is permitted only as "a rare, unplanned occurrence," and all instances must be properly documented, reported, and replaced. Practices are essentially running two parallel vaccine programs under one roof, each with its own costs and risks.

THE UNINSURED AND UNDERINSURED CHILDREN

Two groups of children create guaranteed financial losses for private practices: those with no insurance, and those whose insurance doesn't cover vaccines.

Uninsured children are VFC-eligible and can receive free VFC vaccines at private practices. While VFC rules allow providers to charge families an administration fee (up to the state-set regional maximum), practices cannot deny vaccines to children whose families cannot pay this fee.

Underinsured children have insurance, but their insurance doesn't cover vaccines. While this scenario has become less common since the Affordable Care Act mandated vaccine coverage in 2014, it might still affect children with grandfathered insurance plans. These children technically qualify for VFC vaccines, but with a critical limitation—they can only receive VFC vaccines at FQHCs or RHCs, not at private practices. A private practice will use privately purchased vaccines, and VFC rules will not apply; there is no state cap on the administration fee. Practices can charge whatever they want for the vaccine and administration, and they can refuse to vaccinate if the family can't pay.

Table 2. **The Economics of a Private Practice That Cares for Uninsured and Underinsured**

	UNINSURED CHILDREN	UNDERINSURED CHILDREN
Vaccine product cost	$0 (provided by VFC) + overhead	~$30+ (VFC not available, practice must use privately purchased vaccines. Cost depends on vaccine, can be much higher than $30) + overhead
Est. administration cost	~$15	~$15
Reimbursement	from $0 to the state cap, depending on the family's ability to pay	$0 from insurance; amount out-of-pocket depends on the family's ability to pay
Net loss per dose	$0 - ~$15+	$0 if family pays full cost; ~$45+ if family cannot pay

For both groups, private practices face the same three options:

1. Absorb the loss (up to ~$15+ per dose for uninsured; up to ~$45+ per dose for underinsured).
2. Request payment from families using sliding scale fees or full out-of-pocket charges.
3. Turn the child away and refer them to an FQHC, RHC, or health department.

Many pediatricians choose to absorb the loss because they recognize that these families are least able to pay out of pocket and most vulnerable to vaccine-preventable diseases. The underinsured scenario is particularly punishing. Unlike with uninsured children, practices cannot even access free VFC vaccines to reduce their losses. They must pay full price for vaccines that generate zero revenue.

These scenarios represent the clearest examples of how vaccine economics work against profit-motivated behavior: every dose administered to an uninsured or underinsured child represents a guaranteed financial loss. No practice seeking profit would voluntarily put themselves in this position, yet pediatricians routinely absorb these losses to protect their communities.

FQHCs and RHCs can more sustainably serve these populations because they receive federal Section 330 grants and other funding streams specifically designed to support care for uninsured and underinsured patients. Private practices lack these alternative funding sources.

STATE PROGRAMS: DOES UNIVERSAL PURCHASE FIX IT?

Fourteen states have implemented centralized vaccine purchase programs to address vaccine financing challenges for both VFC and privately insured patients. These come in two forms:

Full Universal Vaccine Purchase (UVP) States (10 states): Alaska, Idaho, Maine, Massachusetts, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and Washington. In these states, the government purchases all childhood vaccines and distributes them to providers at no cost.

Universal Select States (4 states): Connecticut, Florida, South Dakota, and Wyoming. These states purchase only certain vaccines centrally, with practices still purchasing others privately.

What UVP Solves:

- Eliminates upfront purchase costs
- Removes inventory risk
- Improves cash flow (no waiting for vaccine reimbursement)
- Reduces financial barriers for practices

What UVP Doesn't Solve:

- Storage and handling costs remain
- Equipment costs remain
- Overhead costs remain
- Administration fees still often inadequate

UVP provides significant relief by removing purchase risk and cash flow challenges. However, practices in UVP states can still lose money on vaccines if administration payments don't cover the true cost of storage, handling, and delivery.

UVP is not a profit generator. It's a partial solution that addresses some, but not all, of the financial challenges in vaccine delivery.

PRIVATE PURCHASING STRATEGIES

For practices in non-UVP states purchasing vaccines privately, there are strategies available to manage costs:

- **Physician Buying Groups (PBGs)** negotiate volume discounts. These are groups of independent medical practices that join together to negotiate better vaccine prices from manufacturers by combining their purchasing volume.
- **Group Purchasing Organizations (GPOs)** aggregate purchasing power. These are third-party companies that leverage the collective buying power of multiple healthcare organizations to negotiate discounted prices on medical supplies and vaccines from vendors.
- **Prompt-pay discounts** (price reductions offered by vaccine manufacturers or distributors when practices pay their invoices quickly) can reduce costs by 1-2%.

But practices still face inventory risk and cash flow challenges even with these strategies.

WHY AVERAGES DON'T TELL THE FULL STORY: A STATE × PATIENT FRAMEWORK

Vaccine financing varies dramatically based on multiple factors that combine to create vastly different economic realities for different practices:

1. The state where the practice operates (and whether it's a UVP state)
2. The payer mix (commercial vs. Medicaid/CHIP)
3. Whether the child receives VFC or privately purchased vaccines
4. Where the child receives care (FQHC, private practice, etc.)

> ***Important Note:*** *Not all children fit neatly into this framework. Underinsured children (discussed above) can only access VFC vaccines at FQHCs or RHCs, creating unique challenges when they visit private practices. Additionally, children in UVP states receive all vaccines through the state program regardless of insurance status, fundamentally changing the economics.*

A pediatrician in Colorado with bulk purchasing and high commercial reimbursement rates faces vastly different economics from a pediatrician in Mississippi receiving the lowest commercial rates, or from a clinician in a Universal Vaccine Purchase (UVP) state like Washington.

THREE REPRESENTATIVE STATES

To illustrate these real-world differences, we analyzed data using representative states.

Colorado (Non-UVP, Higher Commercial Reimbursement):

CO represents states where many practices purchase vaccines privately and receive relatively higher commercial payments. However, many other clinics, especially rural, safety-net, and Medicaid-dominant practices, operate on razor-thin margins and struggle financially to sustain vaccine delivery. This underscores the wide variation that exists even within a single state.

- Commercial insurance reimbursement for vaccine administration: Mean $37.69, Median $42.08
- Medicaid reimbursement for vaccine administration: $21.17
- Generally favorable economics for commercial patients
- Still challenges for high-Medicaid practices

Key Finding: In Colorado, higher commercial payments create sustainable vaccine economics for some practices, but facilities serving predominantly Medicaid patients still face financial pressure, with administration fees of $21.17 barely covering costs.

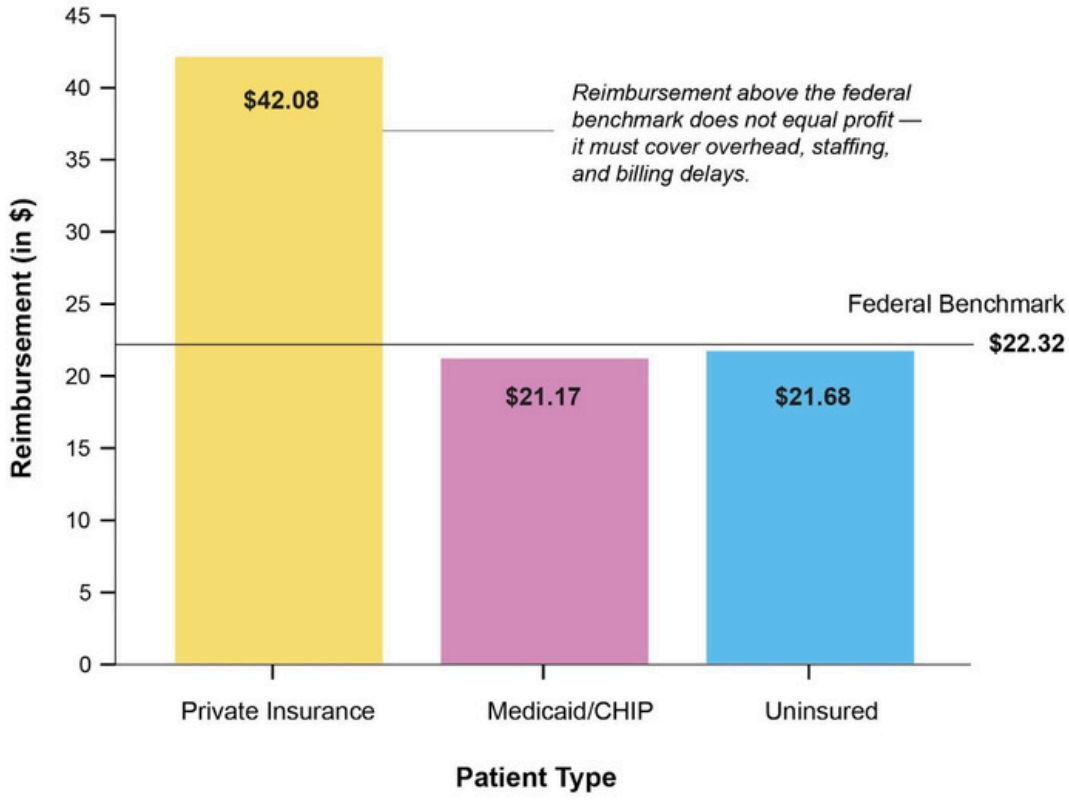


Figure 4. **Colorado (Non-UVP State, Higher Commercial Rates).** Colorado practices receive a median of ~$42 for privately insured children and $21-22 for Medicaid and uninsured patients — a nearly 50% payment gap between commercial and public payer rates**.** Source: Private Insurance, Medicaid/CHIP, Uninsured

Mississippi (Non-UVP, Low Reimbursement):

MS represents the most challenging economic environment for vaccine delivery. While commercial payments average slightly above the federal benchmark, they remain among the lowest in the nation. Combined with a Medicaid-dominant payer mix where many practices serve primarily publicly insured patients, practices frequently report losing money on every dose. This is where the myth of vaccine profits completely collapses.

- Commercial insurance reimbursement for vaccine administration: Mean $25.67, Median $22.15
- Medicaid reimbursement for vaccine administration: $11.68
- Commercial rates among the lowest nationally
- Severe losses for high-Medicaid practices

Key finding: In Mississippi, Medicaid administration payments of $11.68 fall far below both the federal benchmark ($22.32) and actual delivery costs, creating severe losses for practices serving predominantly Medicaid populations.

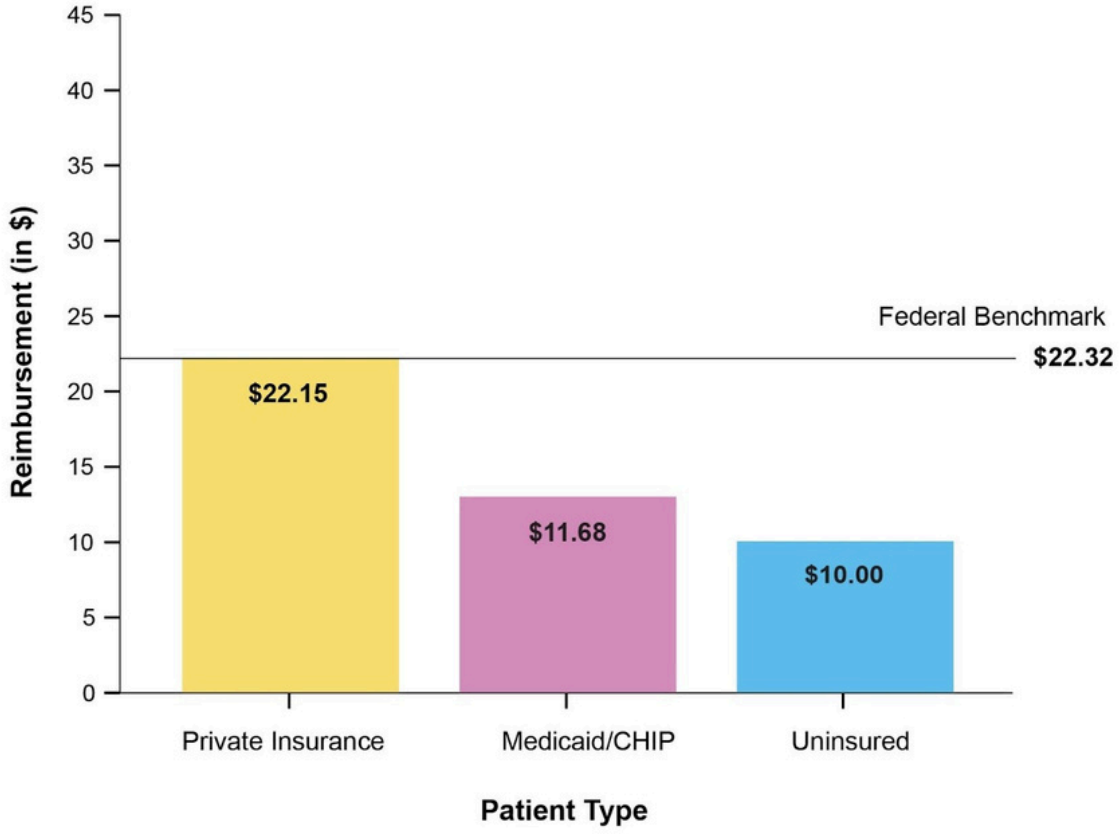


Figure 5. **Mississippi (Non-UVP State, Lowest Reimbursement Rates).** Mississippi practices receive a median of ~$22 for privately insured children but only $10-12 for Medicaid and uninsured patients—rates that fall well below the federal benchmark of $22.32. Source: Private Insurance, Medicaid/CHIP, Uninsured

Washington (UVP State):

WA represents states with centralized vaccine purchasing. While this removes inventory risk and upfront costs, practices still face all administrative and overhead expenses.

- Commercial insurance reimbursement for vaccine administration: Mean $37.81, Median $35.45
- Medicaid reimbursement for vaccine administration: $21.01
- No purchase costs for any childhood vaccines
- Administration payments must cover all delivery costs

Key finding: In Washington's universal purchase system, centralized vaccine procurement eliminates inventory costs, but administration fees must still cover all overhead, counseling, storage, and handling. This leaves some practices with inadequate reimbursement despite removing purchase risk.

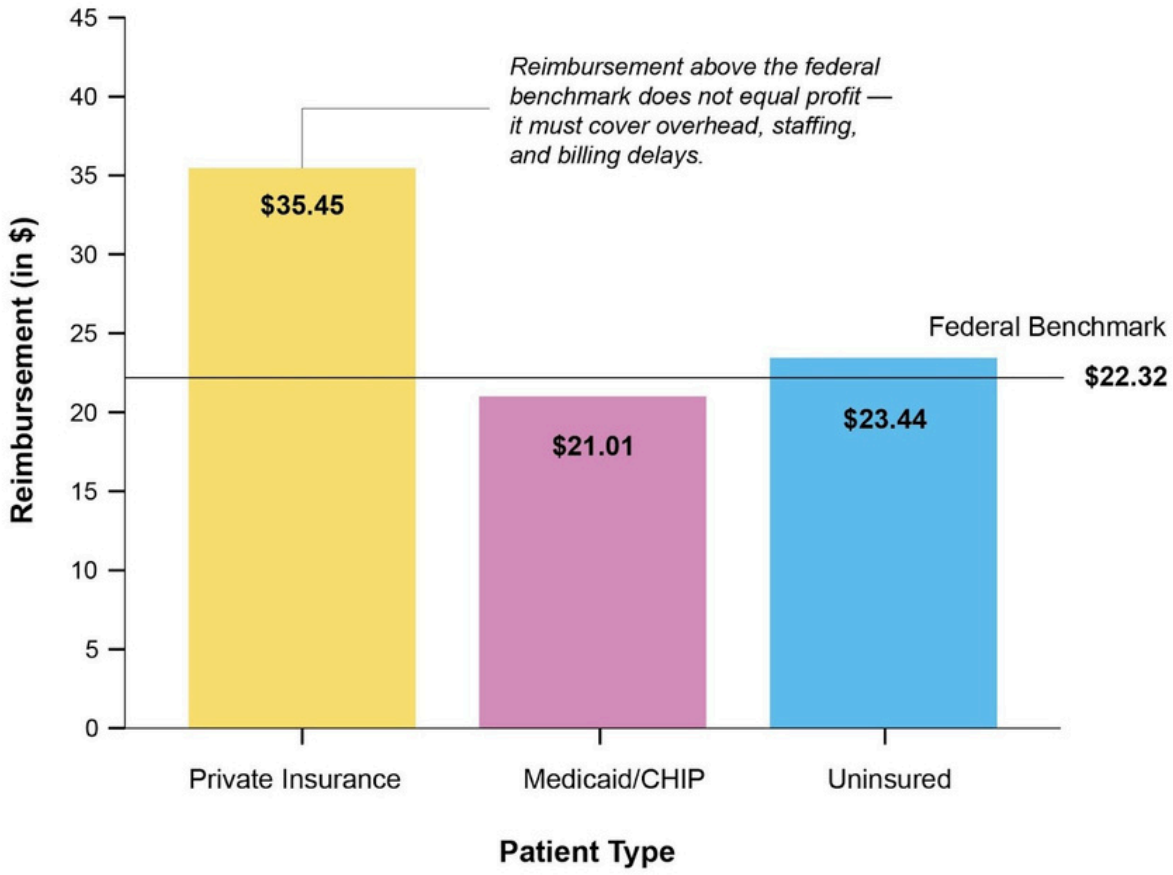


Figure 6. **Washington (UVP State, State Supplies Vaccines, Admin Costs Remain).** In Washington's universal vaccine purchase system, practices receive state-supplied vaccines at no cost but must still bill for administration: they receive a median of ~$35 for private insurance, $21.01 for Medicaid, and $23.44 for uninsured children. Source: Private Insurance, Medicaid/CHIP, Uninsured

THE MATRIX

The figure below illustrates how vaccine economics vary dramatically by geography and patient insurance status. In Colorado, practices can sustain vaccine programs when serving commercially insured patients, but face losses on uninsured children and break-even economics for Medicaid patients. Washington's universal purchase program eliminates vaccine acquisition costs, but administration fees still fall below the federal benchmark for all patient types, with particularly severe underpayment for Medicaid patients. Mississippi represents the worst-case scenario: administration payments fall below costs across all three patient categories, meaning practices lose money on every vaccine regardless of the child's insurance status. This state-by-state, patient-by-patient variation explains why vaccine delivery remains financially viable for some practices while creating unsustainable losses for others, and why the claim of universal vaccine profitability is demonstrably false.

Figure 7. **State & Patient Matrix for Vaccine Administration Payments (per shot).**

Payment disparities persist across state models: Colorado providers earn 50% less for public patients versus private; Washington's free vaccine program still caps admin fees at break-even; Mississippi pays so little that clinics lose money per dose. In all three states, serving uninsured and Medicaid children is financially unsustainable, contradicting profit-motive claims.

PART V: **THE BOTTOM LINE**

The evidence is clear: **Pediatricians do not profit from vaccinating children.**

The economics show the opposite: they often lose money or barely break even.

If profit were the motivator, pediatricians would:

- Provide fewer vaccines, not more
- Refuse to serve Medicaid and VFC-eligible children
- Abandon vaccine delivery entirely (as 24% of pediatricians have considered, and as the majority of adult PCPs have done)
- Focus on treating preventable diseases, which generate far more revenue than preventing them

As one pediatrician said after these claims circulated: *"This idea that we vaccinate kids to make money is misleading and dangerous. We actually overcome obstacles to be able to provide them. If we were motivated by profit, we'd make more money treating the complications of preventable diseases than by preventing them."*

The real story isn't about excessive profits. It's about:

- **Wide payment disparities** that leave practices serving vulnerable populations in financial distress
- **Pediatricians continuing to vaccinate** despite financial losses because it protects children
- **A system that inadvertently creates barriers** to vaccination for the children who need it most
- **Quality programs that reward broad health outcomes**, not vaccination rates

The persistence of misinformation about vaccine economics, despite years of debunking, reflects a pattern: dramatic financial claims spread more readily than the mundane reality that pediatricians vaccinate because it protects children and communities and not because it enriches them.

WHAT THIS MEANS FOR POLICYMAKERS:

The current reimbursement structure creates perverse incentives. When practices lose money on vaccines, especially those serving Medicaid and VFC populations, we risk losing vaccine access in the communities that need it most. Policy solutions should focus on:

- Adequate reimbursement that covers actual costs of vaccine purchase, storage, and administration
- Eliminating payment disparities between public and private insurance
- Supporting practices that serve high proportions of vulnerable children
- Addressing administrative burdens that make vaccine delivery financially unsustainable

If we want universal vaccine access, we need to make it financially viable for practices to provide it.

WHAT THIS MEANS FOR PARENTS AND COMMUNITIES:

When you hear claims that your pediatrician profits from vaccines, consider the source and the evidence. The physicians most committed to vaccination are often those who profit least.

The persistence of vaccine profit myths, despite years of debunking, follows a predictable pattern: dramatic financial claims spread more readily than less dramatic reality. But understanding the actual economics matters — because the people most committed to vaccinating children are often the ones making the least from it.

ABOUT THIS REPORT

This analysis was conducted by the Center for Unbiased Science and Health, a 501(c)(3) nonprofit organization dedicated to improving public understanding of science and health.

We received no funding for this analysis; it is entirely independent.

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