



Association of
Immunization
Managers

October 9, 2026

Kate Berry
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

Re: Payment for Hospital Administered RSV Monoclonal Antibodies

Dear Ms. Berry,

As we have just entered the fourth season in which we have the opportunity to protect infants from severe respiratory syncytial virus (RSV), **we again urge commercial health plans to accept line-item billing and provide appropriate payment for the acquisition and administration of long-acting RSV monoclonal antibody (RSV mAb) products during the birth hospitalization for every eligible infant.** This policy would align payment with recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP), who agree that it is preferable to administer RSV mAb products **prior to hospital discharge, when they can be most effective in preventing serious RSV-related disease.**^[1, 2] This policy also aligns with recent evidence reaffirming the safety and effectiveness of RSV mAbs in reducing the risk of severe RSV and RSV-related hospitalization in infants.^[3]

RSV remains the most common cause of hospitalization among U.S. infants. CDC recommends that all eligible infants born during October through March be protected with an RSV mAb product. Nirsevimab was licensed by the U.S. Food and Drug Administration (FDA) in July 2023, and clesrovimab, licensed in 2025, provides a second long-acting option for infants entering their first RSV season.^[1, 4] The 2026-2027 respiratory disease season marks the fourth season for which we have safe and effective immunization options for protecting infants from severe RSV disease.

Though there is a maternal immunization product (RSV prefusion F protein subunit (RSVpreF) vaccine) available as well, the current recommendation for the maternal RSV vaccine is for one dose during 32-36 weeks of pregnancy given at least two weeks prior

to delivery, and not eligible for maternal re-vaccination in subsequent pregnancies. The recommended timing for the maternal RSV vaccine is from September 1 through March 1, reflecting the anticipated longer RSV season, as observed during the 2025-2026 respiratory disease season.^[5]

The evidence supporting the use of RSV mAb products has strengthened since our April 2026 letter to AHIP. In a U.S. cohort of 409,723 infants during the 2024-2025 season, RSV-associated hospitalization occurred in 0.4% of infants who received nirsevimab and 1.2% of those who did not. After adjustment, **nirsevimab receipt was associated with a 77% lower hazard of RSV-associated hospitalization.** A separate CDC investigation found nirsevimab to be 80% effective against RSV-associated intensive care unit admission and 83% effective against RSV-associated acute respiratory failure.^[8,9]

A 2026 population-based French study also demonstrates why ready access to infant antibody must remain available even as maternal vaccination expands. Among 42,560 matched newborns, **nirsevimab administered before hospital discharge was associated with a 26% lower adjusted hazard of RSV-associated hospitalization than maternal RSVpreF vaccination.** It was also associated with lower hazards of PICU admission, ventilatory support, and oxygen therapy. These findings do not diminish the value of maternal vaccination; they confirm that both recommended pathways are important and that health plans should support the option clinically indicated for each mother-infant pair.^[7]

The birth hospitalization is the most reliable opportunity to close the gap between recommendation and protection. CDC's first multistate analysis found that only 29% of infants born from October 2023 through March 2024 were protected through maternal vaccination or nirsevimab during the first season of availability. Among infants who received nirsevimab, only 38.1% received it during the first six days of life. CDC specifically identified cost concerns and the expense of stocking nirsevimab as reasons hospitals may not include it in routine newborn care, and called for greater birthing-hospital participation in the Vaccines for Children program.^[10]

As we described in our earlier letter and policy brief, the commercial payment gap affects infants beyond the commercially insured population. **Hospitals have reported that they cannot sustainably provide these products without payment for commercially insured newborns.** Most, therefore, do not offer it to any infant, because offering it only to Vaccines for Children-eligible infants would create an inequitable standard of care. **Commercial payment policy is what determines whether a hospital builds the inventory, workflow, standing orders, data reporting, and staff training needed to protect all eligible newborns before discharge.**

Separate payment makes economic sense for health plans. A 2026 U.S. study estimated a mean hospital cost of \$13,941 for a laboratory-confirmed RSV hospitalization among

children younger than age five and projected approximately \$1.4 billion in annual hospital costs; 63% of hospitalizations occurred in otherwise healthy children. Those figures do not include every emergency department visit, outpatient encounter, family expense, or longer-term consequence of severe illness. **Payment for an RSV mAb dose administered before discharge should therefore be evaluated against the acute care claims it can prevent, not only against the historic newborn case rate.**^[11]

Line-item payment is a targeted solution. It pays for the product only when it is administered, avoids requiring hospitals to finance inventory or absorb acquisition costs, and permits plans to verify eligibility and prevent duplicate payment. For an eligible infant who would otherwise receive the same covered product days or weeks later in an outpatient setting, hospital payment changes the timing and site of administration while closing an avoidable period of vulnerability. **Earlier protection reduces the risk that an infant will miss the intervention entirely because of access, scheduling, transportation, or product-availability barriers.**

We appreciate AHIP's May 11, 2026, response and its statement that AHIP does not direct individual plan contracting. We are not asking AHIP or its members to establish a collective price or uniform contract term. **We are asking AHIP to make its members aware of a recurring access barrier, communicate the evidence and clinical urgency, encourage each plan to establish an appropriate payment pathway, and convene a discussion of workable approaches that individual plans may adopt independently.**

AHIP's response also noted the American Medical Association's (AMA) work to unbundle global maternity payment. That change does not resolve this issue. The 2027 CPT revisions divide professional maternity services into antepartum, labor management, delivery, and postpartum phases. AMA expressly notes that these professional codes carry no direct practice-expense costs because facility costs are incurred by the facility. The revisions do not establish payment to a hospital for an RSV mAb product acquired for and administered to the newborn, who is a patient separate from the mother. Whether a plan uses a diagnosis-related group (DRG), case rate, or another contracted facility-payment method, **a specific pathway is still needed to recognize this separately acquired infant product.**^[12]

We therefore ask AHIP to take the following steps early in this 2026-2027 RSV season:

- **Provide education to member plans regarding the recommendations for hospital administration of RSV mAb products as published by the CDC and the AAP and**

urge plans to examine the potential cost savings that can result from administration of RSV mAb products prior to hospital discharge.

- Encourage plans to apply coverage consistently across inpatient and outpatient settings and to allow timing that reflects CDC and AAP guidance and local RSV epidemiology.
- Share a model operational approach or examples of successful plan-hospital payment pathways, while leaving each plan to make its own independent coverage and contracting decisions.
- Assist with convening AHIP member plans and the clinical and public health organizations represented in this letter to identify and remove remaining implementation barriers.

RSV prevention just entered its fourth season. The clinical question is settled: RSV mAb products prevent hospitalizations and severe disease, and CDC recommends administration during the birth hospitalization for eligible infants born during the RSV season. **The unresolved issue is whether hospitals will be paid when they follow that recommendation.** [1, 2, 8, 9]

A health plan should not default to paying for an avoidable RSV admission because its payment policy prevented a newborn from receiving protection from RSV prior to leaving the hospital. **We respectfully request a meeting with AHIP and interested member plans within 30 days to discuss what steps can be taken to resolve this ongoing issue that continues to leave infants vulnerable to a disease we can prevent.** AIM and the organizations that joined this letter stand ready to work with you on a prompt, practical solution.

Sincerely,
Association of Immunization Managers
Alliance for Women's Health and Prevention
American Academy of Pediatrics
American Academy of Pediatrics, DC Chapter
National Coalition for Infant Health
Association of State and Territorial Health Officers
Infectious Diseases Society of America
March of Dimes
Pediatric Infectious Diseases Society
Society for Maternal-Fetal Medicine
Vaccinate Your Family

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3. Senerth E, Sheikholeslamian SM, Babatunde I, et al. RSV Immunization Effectiveness and Safety for the 2026-2027 Respiratory Season. JAMA. Published online September 02, 2026. [Source](#)
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5. Society for Maternal-Fetal Medicine (SMFM). SMFM Statement: Respiratory Syncytial Virus Immunization in Pregnancy. Washington, DC: SMFM; 2026. Retrieved September 29, 2026. [Source](#)
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