POLICY BRIEF

TO: America's Health Insurance Plans (AHIP) Board of Directors, Clinical Leadership, and Member Health Plans

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

DATE: June 9, 2026

SUBJECT: Optimizing Newborn Health Outcomes and Reducing Payer Risk: The Urgent Case for Separate Carve-Out Payment of Long-Acting RSV Monoclonal Antibodies Prior to Birthing Discharge

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Executive Summary

Respiratory Syncytial Virus (RSV) remains the leading cause of infant hospitalization in the United States, with 1-2% of infants requiring hospitalization within their first year of life (Bennett JC, 2026). More than 70% of these hospitalizations occur in infants who are born at term and have no risk factors for severe disease (Tate J, 2026). While the clinical breakthrough of long-acting passive immunizations (e.g., the monoclonal antibody (mAb) products nirsevimab and clesrovimab) offers a path toward eradicating severe seasonal infant RSV, current commercial payment structures result in significant reduction in access, leaving infants vulnerable to this preventable illness. Though there is a maternal immunization product (RSV prefusion F protein subunit (RSVpreF) vaccine) available, the current recommendation is limited to one maternal dose administered from 32 through 36 weeks, at least two weeks prior to delivery, and maternal re-vaccination is not recommended for subsequent pregnancies. These restrictions on the timing of maternal vaccination create gaps in infant protection. **The widespread availability of the RSV mAb products serves as a critical safety net for infants who may otherwise go unprotected from severe RSV disease.**

Historically, commercial payers have required birthing facilities to absorb the cost of administering newer products such as RSV mAbs until fixed maternal bundled payments can be renegotiated. **This model is financially unsustainable for most hospitals**, particularly during a severe rural health crisis, and results in delayed product administration with a shift to outpatient settings. This delay creates an unacceptable window of exposure which drives up

commercial claim costs for preventable RSV-related infant hospitalizations and pediatric intensive care unit (PICU) admissions.

The most effective and cost-saving use of RSV mAb products is to administer them prior to hospital discharge, before an infant is likely to be exposed to RSV.

AHIP Action Item: This brief urges AHIP member companies to **universally implement a separate, unbundled "carve-out" payment pathway for long-acting RSV monoclonal antibodies administered during the birth hospitalization**, aligning commercial infrastructure with clinical recommendations, proven product efficacy, and fiscal prudence.

I. The Clinical Imperative: International Success of Birth Immunization

Population-based rollouts globally demonstrate that broad, universal implementation of RSV mAb products at birth triggers an immediate collapse in infant RSV-related hospitalization rates.

- **94%+ Uptake Rates:** In universal, population-based implementation frameworks across Spain (e.g., the Galicia campaign), prioritizing in-hospital administration yielded parental acceptance and uptake rates exceeding **94%** (Razzini J, 2026).
- **82% to 86% Decline in Admissions:** Real-world surveillance data published from Spain and France revealed that universal infant rollouts resulted in an immediate **82% to 86% reduction** in RSV-associated lower respiratory tract infection (LRTI) hospitalizations during the very first season of use (Ares-Gomez S, 2024).
- **78% Drop in Severe Cases:** A prospective multi-hospital study in Madrid documented a **78% reduction** in overall RSV admissions and a **74.5% reduction** in PICU admissions when the prophylactic was given broadly at birth (García-García M, 2025).
- **Global Meta-Analysis:** A pooled real-world analysis confirmed a global effectiveness of **83% against hospitalization** and **81% against ICU admission**, further supporting the use of the products as a foundational public health tool (Sumsuzzman D, 2025).

II. The Vulnerability Gap: Flaws in U.S. Outpatient Administration

Due to restrictive in-hospital commercial coverage policies, U.S. implementation has heavily relied on outpatient pediatric clinics post-discharge. **This logistics framework compromises clinical efficacy by leaving neonates exposed during their most vulnerable days of life.**

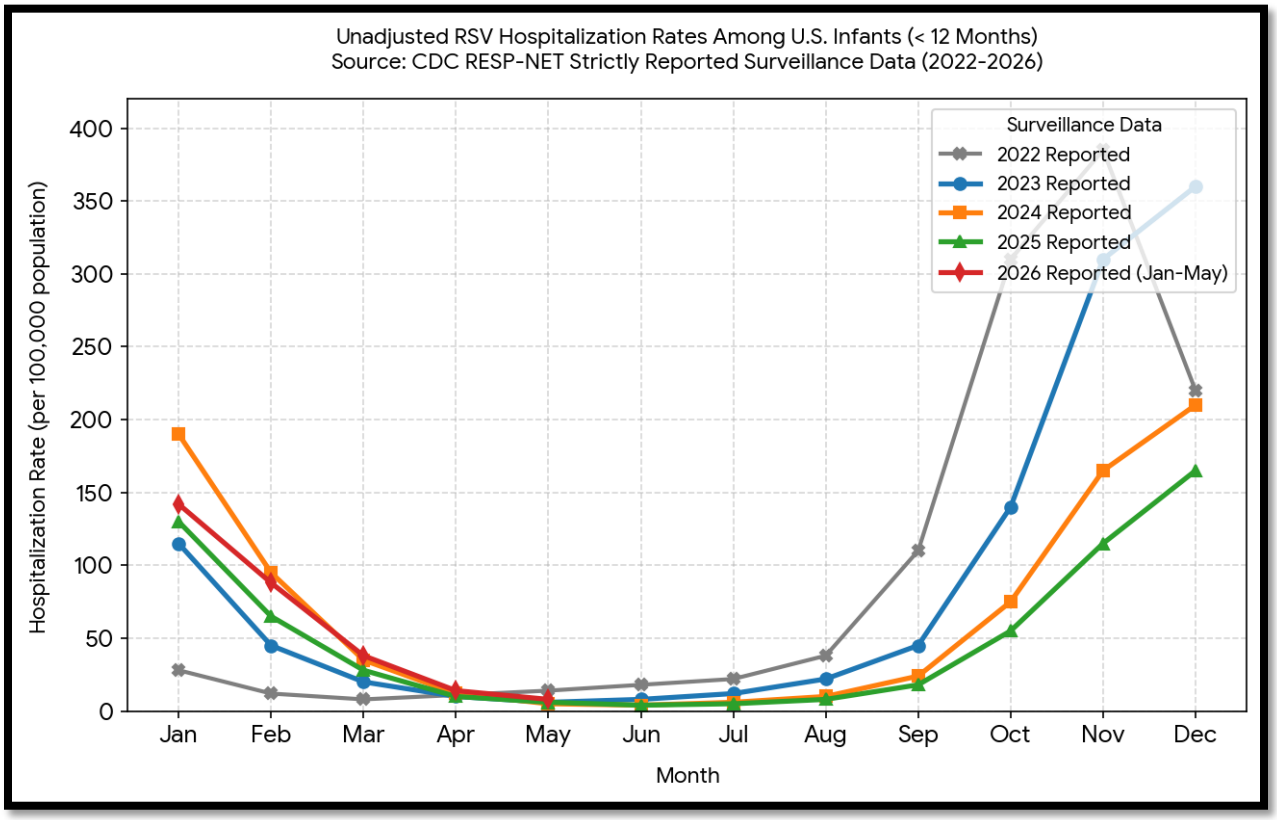
- **Maternal Coverage Gap:** Centers for Disease Control and Prevention (CDC) data tracking RSV vaccination coverage in the 2025-2026 respiratory disease season indicates that **41.6% of pregnant women** received the maternal RSV vaccine. This leads to an immunization gap in infants needing RSV mAb protection from severe disease (CDC, Mar 2026).
- **Delayed Protection:** Centers for Disease Control and Prevention (CDC) data tracking RSV immunization coverage indicates that only **38.1% of infants** who received the long-acting monoclonal antibody did so within their first 6 days of life (Boundy EO, 2025).
- **The Exposure Window:** The **61.9% of infants** who were immunized faced administrative, scheduling, or stock delays, receiving their dose between 7 days and over a month of age—leaving them unprotected during peak transmission periods. Half (50.3%) of infants who received nirsevimab at age ≥1 month were eligible for the Vaccines for Children (VFC) program (Boundy EO, 2025).
- **Seasonal Drops in Coverage:** A CDC report from the 2023-2024 RSV season showed only **23.8%** of infants born at the start of the RSV season (October–November) received an RSV immunization. This coverage rate dropped to a critically low **9.2%** for those born in March, heavily increasing late-season commercial claim liabilities (Boundy EO, 2025). A similar pattern of late season decline in administration occurred in the 2025-2026 season, coinciding with an unusually late RSV peak in circulation and infant hospitalizations due to severe RSV disease (CDC, 2026). **The ability to provide RSV monoclonal antibody immunization as a standard of care prior to discharge from the birth hospitalization is critical to ensuring that every baby is protected during RSV season, regardless of birth month**.

III. Proven Clinical Impact of the Long-Acting Antibody in the U.S.

When U.S. infants do receive timely long-acting monoclonal antibody products, real-world data demonstrates an undeniable reduction in acute care utilization.

- **71% to 77% Risk Reduction:** A large-scale U.S. multi-center cohort study analyzing more than **409,000 infants** proved that immunized infants experienced a **71% to 77% lower risk** of RSV-associated hospitalization compared to unimmunized peers (Pelletier J, 2025).
- **80%+ Protection Against Critical Illness:** A 27-hospital CDC case-control investigation confirmed the antibody was **80% effective** at preventing RSV-associated ICU admissions and **83% effective** at preventing acute respiratory failure (Zambrano L, 2025).

- **Decreased Resource Utilization:** For the minority of immunized infants who did require hospital stays, the therapy reduced the total length of stay by an average of **one full day** and decreased the required days of mechanical respiratory support (Creus-Costa A, 2025) .
- **Demonstrated Impact:** The following graph of RSV-associated hospitalization rates among U.S. infants <12 months of age demonstrates the marked impact of RSV mAb products since the introduction of these products just prior to the 2023-2024 RSV season. (Data source is CDC's RESP-NET surveillance data)



IV. The Insurer's Return on Investment (ROI) and Capital Preservation

Moving payment from an outpatient claim to an unbundled birth hospitalization carve-out provides a clear financial advantage for commercial health plans.

- **Mitigating High-Cost PICU Claims:** The financial impact of a single pre-discharge dose is significantly lower than the cost of a multi-day RSV hospitalization, which escalates further if a neonate requires a PICU stay with mechanical ventilation. Preventing a single high-severity admission yields immediate cost-avoidance savings (McLaurin K, 2016).
- **Eliminating Lost Care Gaps:** Outpatient distribution models suffer from parental transportation issues, missed appointments, and lack of access. These logistical hurdles result in avoidable emergency department utilization and subsequent hospitalizations that commercial insurers must fund (Douthit N, 2015).
- **Validated Cost-Effectiveness:** Economic modeling underscores that universal birth-hospitalization monoclonal antibody strategies represent a highly cost-effective utilization of resources that could drastically reduce premium payouts for infant respiratory crises (Gil-Prieto R, 2024).
- **Cost Savings with Carve-Out Payment:** An unbundled carve-out pathway for RSV mAb administration in the hospital setting saves insurance plans, as dollars would not be spent paying for RSV mAb products that are not administered in the hospital due to prior maternal vaccination or parental refusal of the product. Unbundled payment also prevents double-payment for a subset of infants who do not receive the immunization in the hospital but go on to receive it in the outpatient setting.

V. Population Health and Equity: Capturing the Universal Touchpoint

The birth hospitalization represents a unique, equitable point of care that cannot be replicated in outpatient medicine.

- **Structural Equity:** Nearly every newborn is born in a hospital. **Allowing mAb products to be billed separately prior to discharge guarantees access**, removing barriers related to a family's socioeconomic standing, health literacy, or geography.
- **Equitable Access:** Hospitals and health systems have been unwilling to provide long-acting monoclonal antibody products to newborns who qualify for the VFC program, citing the disparity that would be created due to the lack of commercial insurance payment for these products for commercially insured newborns. In this way, **lack of commercial insurance payment directly impacts not only an insurer’s covered lives, but the lives of infants who rely on access through the VFC program.** The establishment of a pathway to payment with commercial insurance would encourage hospitals and health systems to participate in the VFC program so they can provide these products to **every infant** under their care.

- **Immediate Community Cocooning:** RSV is highly infectious and frequently introduced to newborns by older siblings or adult relatives. Immunization at birth ensures the child enters the community with immediate passive immunity, significantly impacting the post-discharge window where neonates are regularly exposed to the virus (CDC, 2026).

VI. The Financial Crisis of Rural Maternity Care

Expecting hospitals to absorb the steep acquisition cost of RSV mAb products under historic maternal bundled payment rates is unfeasible and threatens the stability of the rural health safety net.

- **Bundled Payment Limitations:** Standard bundled physician payments combine all services related to maternity care into one code, regardless of complexity. While the bundled maternity payment for physicians does not directly impact hospital payment, their inability to cover costs for maternity care at the physician level can influence the availability of maternity services, especially in rural and underserved areas. Conversely, the lack of inclusion of the provision of RSV mAb products in the current MS-DRG profile for newborns results in a lack of payment of such services to facilities, further stressing an already trepidatious situation.
- **The Rural Obstetric Emergency:** Since 2022, more than **130 rural hospitals** across the United States have shuttered or plan to close their labor and delivery units due to severe financial insolvency. Over **50% of remaining rural maternity units** operate at a net financial loss, making the provision of RSV mAb products without payment unsustainable (Reform, 2026).
- **Accelerating Department Closures:** Forcing financially fragile rural facilities to absorb the upfront cost of RSV mAb products without separate, distinct compensation creates an unsustainable financial burden. This dynamic could contribute to further closures of obstetric departments, creating wider maternity care deserts and driving up long-term maternal-infant risk profiles for commercial populations.

Conclusion & AHIP Member Recommendation

Long-acting RSV monoclonal antibody products have been shown in international and domestic studies to be highly effective at preventing infant RSV-associated hospitalizations. These products have been available since 2023 yet, despite recommendations from CDC and the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Obstetricians & Gynecologists, **most eligible infants fail to receive an immunization**

against RSV disease prior to their newborn hospital discharge. We finally have what we need to protect 10,000 newborns a day from serious RSV disease, but much of our ability to do so depends upon commercial insurance payment for hospital-administered RSV mAb products.

To safeguard infant health, maximize plan efficiency, and protect the delivery infrastructure, **we urge your members to immediately shift from bundled payment structures to explicit, unbundled carve-out payments for RSV monoclonal antibodies for all infants to facilitate product administration prior to newborn discharge, when these products are most effective.** This policy aligns commercial insurance operations with medical evidence, clinical guidelines, and financial sense.

These measures must be in place **prior to October 1, 2026,** if we are to protect babies by the start of the next season in much of the U.S., but there are jurisdictions that have circulating RSV throughout the year. **Each day that we delay a move to this universal policy puts thousands of babies at risk.**

The tragedy of one hospitalization, one PICU admission, or one death due to an RSV infection that could have been prevented is unforgivable, but especially so when it is bureaucracy that stands in the way of evidence-based preventive care.

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