Respiratory Virus Coverage Analysis

High-level summary: This coverage analysis outlines the current coverage landscape for commercial and government payers, along with certain programs, regarding the COVID-19 and flu vaccines and RSV immunizations. The first chart flags risks and impending disruption to certain vaccines across payers, while the second chart provides a detailed road map and recommendations to navigate policy changes. This document will be updated regularly, as reflected in the header.

Summary: Respiratory Season Vaccine Preparation
Focus Areas for Payers

Key:	Status Quo/Stable	Risk of Disruption	Impending Disruption

	Flu	**COVID-19**	**RSV**
Commercial *Coverage mandate tied to CDC Immunization Schedules*	CDC recommends only non-thimerosal-containing vaccine. Must still be covered through current plan year; plan to decide coverage after that. Non-thimerosal-containing vaccine must be covered	CDC/ACIP have not yet made recommendations with respect to 2025-2026 COVID-19 vaccine, so no coverage mandate (except for 2024-2025 vaccine)	CDC recommendation stable
Medicare *Only for RSV, coverage mandate tied to CDC Immunization Schedules*	Part B/Medicare Advantage coverage required by statute	Part B/Medicare Advantage coverage required by statute	Part D coverage without cost sharing required for RSV when CDC recommended; CDC recommendation stable
Medicaid/CHIP (other than Medicaid-covered children under 21) *Coverage mandate tied to CDC Immunization Schedules*	CDC recs only non-thimerosal-containing vaccine; states may decide to stop covering given updated CDC recommendation. Non-thimerosal-containing vaccine must be covered	CDC/ACIP have not yet made recommendations with respect to 2025-2026 COVID-19 vaccine, so no coverage mandate (except for 2024-2025 vaccine)	CDC recommendation stable
Medicaid-covered children under 21	Statutory mandate to cover all medically necessary vaccines; if Vaccines for Children coverage changes, some disruption, even if coverage still required	Statutory mandate to cover all medical necessary vaccines; if Vaccines for Children coverage changes, some disruption, even if coverage still required	CDC recommendation stable
Vaccines for Children	ACIP sets coverage	CDC/ACIP have not yet made recommendations with respect to 2025-2026 COVID-19 vaccine	ACIP recommendation stable

For details, please refer to the Coverage Analysis grid below.

COMMON HEALTH Coalition
Together For Public Health

Respiratory Virus Coverage Analysis

Last Updated August 20, 2025

Common Health Coalition – Coverage Analysis

The below chart analyzes the source of current coverage requirements for COVID-19 and flu vaccines / RSV immunizations, and potential implications if the Advisory Committee on Immunization Practices ("ACIP") should withdraw a recommendation for such vaccines and the CDC should adopt such recommendation in its immunization schedules ("CDC Schedules"). Note that recommendations may vary by subpopulation (e.g., pregnancy). See Appendix A for current COVID-19 vaccine recommendations for each population. FDA labeling for vaccines is independent of CDC's recommendations, although changes to FDA labeling could prompt ACIP or CDC to reconsider the recommendations, as well as affect what is considered the standard of care under state law.

Payer/ Program	Coverage Requirements	When Changes Take Effect	Options to Continue Coverage without Cost Sharing
Commercial Coverage			
Employer-Sponsored Health Plans and Individual Market Insurance, including Marketplace Plans ("Commercial Plans")	**Tied to CDC Schedules.** • Commercial plans "must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for… Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the [ACIP] of the [CDC] with respect to the individual involved (for this purpose, a recommendation from the [ACIP] of the [CDC] is considered in effect after it has been adopted by the Director of the [CDC], and a recommendation is considered to be for routine use if it is listed on the [CDC Schedules])". 45 CFR § 147.130(a); 42 U.S.C. § 300gg-13(a)(2)). • A recommendation for "shared clinical decision making" meets this definition and is required to be covered without cost-sharing. CDC, ACIP Shared Clinical Decision-Making Recommendations (2025).	Mandatory coverage remains in effect through the last day of the plan year. • A plan or issuer that is required to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section on the first day of a plan year (in the individual market, policy year), or as otherwise provided in paragraph (b)(3) of this section, must provide coverage through the last day of the plan or policy year, even if the recommendation or guideline changes or is no longer described in	Plans may voluntarily choose to offer coverage for additional preventive services beyond those mandated by the ACA. • Some states may require Department of Insurance approval prior to implementing a material change to covered benefits. States can mandate additional benefits for Qualified Health Plans (QHPs), but: • "a State may require that a qualified health plan offered in such State offer benefits in addition

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		paragraph (a)(1) of this section, during the applicable plan or policy year. 45 C.F.R. § 147.130(b)(2)(i)	to the essential health benefits," but must "defray the cost of any additional benefits..." (42 U.S.C. § 18031(d)(3)(B); 45 C.F.R. § 155.170). Depending on state law, states may also be able to mandate additional benefits for state-regulated plans.
Medicare			
Medicare Part B	**Not Tied to CDC Schedules.** • Medicare Part B, including Medicare Advantage plans, are required by statute to cover influenza, pneumococcal, hepatitis B (for at-risk individuals), and COVID-19 vaccines. Social Security § 1861(s)(10)(A), 42 U.S.C. § 1395x(s)(10)(A), (B), (C), (E) (2023); *see also* 42 CFR 410.57.	N/A	N/A
Medicare Part D	**Tied to CDC Schedules.** • CMS requires Part D plans to cover all commercially available vaccines, unless covered under Part B (e.g. flu, COVID-19). (See CMS, Medicare	Sponsors can begin to impose cost-sharing as of the date of the CDC Director's approval of a removal of the vaccine from	Even if not in the CDC schedules, an FDA-approved vaccine may be a covered Part D drug, which the plan sponsor may choose to include on its

Payer/ Program	Coverage Requirements	When Changes Take Effect	Options to Continue Coverage without Cost Sharing
	Prescription Drug Benefit Manual ch. 6 § 30.2.7 (2016)). However, plans may impose coinsurance or copayments for vaccines not on the CDC schedule, and may use drug utilization management tools to facilitate use of vaccines in line with ACIP recommendations. *Id*. • Adult vaccines recommended by ACIP are covered without cost-sharing. (Social Security Act § 1860D-2(b)(8), 42 U.S.C. 1395w-102(b)(8) (2023)). This cost-sharing requirement applies to vaccines that are recommended by ACIP, and adopted by the CDC director, for use in adults when administered consistent with the recommendation to an adult. (42 CFR. § 423.100(g)). Part D plans must not apply cost-sharing for vaccines administered on or after the day a new ACIP recommendation is adopted by the CDC Director, as reflected on the CDC website. *Id*. § 423.120(g). This applies to all categories of ACIP recommendations, including those that are specified as based on shared clinical decision-making. (CMS, Contract Year 2023 Program Guidance Related to Inflation Reduction Act Changes to Part D Coverage of Vaccines and Insulin (2022)). This cost-sharing requirement also applies to vaccines that ACIP recommends for use in limited populations and circumstances, when provided in such limited populations or circumstances. *Id*	the CDC Schedules, if no formulary change is made. • "If ACIP withdraws a recommendation for a previously recommended vaccine such that the vaccine no longer meets the definition of an ACIP-recommended adult vaccine, Part D sponsors are not required to submit a negative change request and may immediately apply cost sharing for the vaccine for dates of service after the 'effective date of the ACIP recommendation.'" 42 CFR § 423.120(e)(2) • However, sponsors may not impose prior authorization (or other negative formulary changes) without prior approval from CMS. 42 CFR § 423.120(e)(3).	formulary and, at its option, set a $0 cost-sharing. 42 U.S.C. 1395w-102(e)(1), 1395w-111(i). Prior to the enactment of the IRA, CMS routinely encouraged, but did not require, Part D plan sponsors to place vaccines on a $0 cost-sharing tier. See, e.g., Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter 209-210 (2019).
Medicaid and CHIP			

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Medicaid and CHIP Adults Age 21+	**Tied to CDC Schedules.** • For Medicaid expansion adults, minimum coverage is defined by the same essential health benefits that apply to individual and small group health insurance. (SSA § 1937(b)(5); 42 CFR § 440.347(a)). As described above, the benefit must include, at a minimum, no-cost coverage for vaccines recommended for "routine use" on the CDC Schedules, including vaccines with indications for shared clinical decisionmaking. Under this standard, states are required to cover any Schedule vaccines and are not required to cover any non-Schedule vaccines, regardless of shared clinical decisionmaking. The clarification regarding shared clinical decision making appears in CMS SHO# 23-003 (p.5 n.20) as applied specifically to Medicaid coverage for expansion adults. • Medicaid is required to cover, without cost sharing, ACIP-recommended vaccines for the non-expansion adults in Medicaid. Social Security Act §§ 1902(a)(10)(A), (C)(iv), 1905(a)(13)(B), 42 U.S.C. §§ 1396a(10)(A), (C)(iv), 1396d(a)(13)(B) (2023). In CMS SHO# 23-003 (p. 7), CMS interpreted that standard to include "any category of ACIP recommendations," including recommendations with shared clinical decisionmaking and travel-related recommendations. and travel-related recommendations. • In Medicaid, cost sharing is prohibited for all pregnancy-related services. Thus, if a state chooses to cover prenatal COVID-19 vaccines in Medicaid, the state is prohibited from imposing cost sharing. (SSA § 1916(a)(2)(B)).	States do not require a State Plan Amendment to restrict vaccine coverage to match updated ACIP recommendations. For Medicaid and CHIP adults, state plans certify that the state will cover all federally required vaccines (*i.e.*, in accordance with CDC recommendations). The state plan does not list out all vaccines and indications covered at any given time.	To cover vaccines beyond the statutory baseline, a state might choose to list additional vaccines in its state plan. But many states reserve discretion in their state plans to use agency regulations, guidance, or fee schedules to itemize the specific list of optional services covered in a given benefit category. Depending on what the state plan says now, a state may be able to maintain coverage based on prior, more expansive ACIP recommendations without the need for a State Plan Amendment.

Payer/ Program	Coverage Requirements	When Changes Take Effect	Options to Continue Coverage without Cost Sharing
	However, note that there is currently no CDC recommendation with respect to the COVID-19 vaccine in pregnant women (see Appendix A). • For pregnant adults under CHIP, states must cover, without cost sharing, all adult vaccines recommended by ACIP for individuals age 19 or older enrolled in CHIP. Social Security Act § 2103(c)(12). In CMS SHO# 23-003 (p. 7), CMS interpreted that standard to include "any category of ACIP recommendations," including recommendations with shared clinical decisionmaking and travel-related recommendations.		
Medicaid Children and Youth Age <21 Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT")	**Not tied to CDC Schedules.** • Under the federal requirement for Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT"), state Medicaid programs must cover any vaccine deemed medically necessary for Medicaid-enrolled children and youth under the age of 21, regardless of whether it is recommended by ACIP or furnished through Vaccines for Children. SSA § 1905(r)(1)(A)(i). • In CMS SHO# 23-003 (p.3), CMS confirmed that EPSDT coverage includes "non-ACIP-recommended vaccines and vaccine administration … if the service is determined to be medically necessary based on an individualized assessment and state medical necessity criteria." ACIP recommendations, FDA labeling and other clinical considerations and guidelines could be relevant to whether a state would consider a vaccine medically necessary. • Cost sharing is prohibited for all services to Medicaid-enrolled children under age 18. For youth between 18 and 21, cost sharing is determined in	While coverage is not tied to the CDC Schedules, as a practical matter, if VFC is no longer covering a certain vaccine (as discussed below), that can create operational issues as providers often use VFC supplies for these populations.	N/A

Payer/ Program	Coverage Requirements	When Changes Take Effect	Options to Continue Coverage without Cost Sharing
	accordance with the individual's eligibility group (i.e., expansion vs non-expansion). • Federal law prohibits cost sharing for any pregnancy-related services. For example, while CDC no longer offers a COVID-19 vaccine recommendation for pregnant use, if a prenatal COVID-19 vaccine is covered for a pregnant person –including under the EPSDT mandate –the state may not impose cost sharing. SSA §§ 1916(a)(2)(A)-(B), 1916A(b)(3)(B)(ii)-(iii)); 42 C.F.R. § 447.56(a)(1)(i)–(ii) & (a)(2)(iii).		
VFC and Other Federal Programs			
Vaccines for Children ("VFC")	**Tied to CDC Schedules.** • "The Secretary [of HHS] shall use, for the purpose of the purchase, delivery, and administration of pediatric vaccines under this section, the list established (and periodically reviewed and as appropriate revised) by [ACIP]". (SSA § 1928(e)). This requirement applies regardless of whether the recommendation involves shared clinical decision-making. See also the CDC's website VFC: Information for Parents ("The VFC Program covers all vaccines included in the pediatric immunization schedules that are determined by [ACIP].")	A few months. • Vaccines removed from ACIP recommendation are no longer procured by VFC for routine use once CDC updates the VFC vaccine price list, which is the operational document used by providers and states to determine coverage and reimbursement. This administrative process typically takes a few months.	N/A

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CDC Section 317 Immunization Program	**Tied to CDC Schedules.** Section 2 of the Section 317 Provider Agreement states that: Vaccine doses will be administered in compliance with the most recent immunization schedule, dosage, and contraindications established by the Advisory Committee on Immunization Practices (ACIP) unless: a) in making a medical judgment in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the patient; or b) the patient declines particular immunizations	Immediately upon CDC Director approval of updates to CDC Schedule.	N/A
Indian Health Service ("IHS")	**Not tied to CDC Schedules.** • IHS follows ACIP recommendations as the standard of care, although this is not governed by statute. In practice, all ACIP-recommended vaccines for routine use are included on the IHS National Core Formulary, meaning every IHS facility is expected to have those vaccines available, and IHS health facilities provide ACIP-recommended immunizations to patients as part of their regular preventive services, generally at no cost to the patient (consistent with IHS's no-charge policy for eligible AI/AN beneficiaries). • IHS providers can continue to offer vaccines based on clinical judgment even if they are no longer ACIP-recommended. There is no requirement that IHS stop offering a vaccine just because ACIP withdrew its	No immediate requirement to stop providing vaccines when ACIP withdraws recommendations, as IHS providers retain clinical discretion to continue based on medical judgment.	N/A IHS will continue to provide all medically indicated vaccines without cost-sharing to AI/AN patients under its care, as part of the federal trust responsibility. The scope of what providers determine to be medically indicated may narrow. Vaccines for minors are usually obtained through the VFC (which relies on the ACIP list) or purchased with IHS funds. If necessary, IHS could use

Payer/ Program	Coverage Requirements	When Changes Take Effect	Options to Continue Coverage without Cost Sharing
	recommendation. IHS clinicians may still administer any FDA-approved vaccine if deemed medically necessary or requested by the patient.		its discretionary healthcare funds to purchase a vaccine which is no longer on the VFC list. As a practical matter, if VFC is no longer covering a certain vaccine (as discussed below), that can create operational issues as providers often use VFC supplies for these populations.
Veterans Health Administration ("VHA")	**Tied to CDC Schedules.** The VHA is required to provide "preventive health services," which includes "immunizations against infectious diseases, including each immunization on the recommended adult immunization schedule at the time such immunization is indicated on that schedule[.]" 38 U.S.C. § 1701(9). " The term "recommended adult immunization schedule" means the schedule established (and periodically reviewed and, as appropriate, revised) by the Advisory Committee on Immunization Practices established by the Secretary of Health and Human Services and delegated to the Centers for Disease Control and Prevention." 38 U.S.C. § 1701(10). VHA directives reference CDC schedules. For example, "Influenza vaccine is any FDA approved, commercially available product recommended by the Centers of Disease Control and Prevention (CDC) for the prevention of influenza in a particular season." VHA DIRECTIVE 1192.01, August 10, 2020.	VHA coverage not statutorily required once CDC schedules are updated.	VHA will continue to provide all medically indicated vaccines without cost-sharing to veterans under its care. The scope of what providers determine to be medically indicated may narrow.

Appendix A

Updated CDC Recommendations for 2024 - 2025 COVID-19 Vaccines

Effective May 29, 2025, the Centers for Disease Control & Prevention (CDC) updated the COVID-19 vaccine recommendations in its Immunization Schedules for adults and for children & adolescents.[1] The chart below summarizes CDC's changes as to the *type* of vaccine recommendation for each population (routine use, shared clinical decision making, or no recommendation).[2]

Comparison of CDC's COVID-19 Vaccine Recommendations for Select Populations, as Published in the Immunization Schedules Before and After May 29, 2025

Population	Prior Recommendation	New Recommendation
• **Neither Pregnant Nor Immunocompromised: Adults, Ages 18 and Up**[3]	**Routine use**, including the latest booster	
• **Neither Pregnant Nor Immunocompromised: Children & Youth, Ages 6 Months to 17 Years**	**Routine use,** including the latest booster	**Shared clinical decision making** as to both initial vaccination and boosters[4]
• **Pregnant, Any Age**	**Routine use**, including the latest booster	**No recommendation** ("No Guidance/ Not Applicable")[5]
• **Immunocompromised,**[6] **Any Age**	**Routine use**, including the latest booster; shared clinical decision making for additional doses beyond the recommended number[7]	

[1] Health and Human Services (HHS) Secretary Robert F. Kennedy previewed these changes in an a May 27 announcement posted to X. @SecKennedy, X (May 27, 2025), https://x.com/seckennedy/status/1927368440811008138?s=46&t=4wz-6cMxurEYtiMNsYMFcw.

[2] This chart does not address differences in CDC's recommendations across populations as to specific vaccine products or the number of doses.

[3] The adult section in this chart combines three sets of recommendations: the recommendation from the Children and Adolescent Schedule for age 18, and the recommendations from the Adult Schedule for ages 19–64 and ages 65 and up.

[4] Specifically, for healthy children and youth, the updated Immunization Schedule says: "Where the parent presents with a desire for their child to be vaccinated, children 6 months and older may receive COVID-19 vaccination, informed by the clinical judgment of a healthcare provider and personal preference and circumstances."

[5] In the PDF version of CDC's Adult Immunization Schedule, the notes on COVID-19 expressly state that the recommendation applies only to non-pregnant adults. By contrast, in the Adult Immunization Schedule embedded on CDC's website, and in both versions of the Child and Adolescent Immunization Schedule, the notes do not specify "non-pregnant." That said, in both versions of both Schedules, the chart of vaccine schedules by medical indication lists pregnancy as "No Guidance/Not Applicable." Pregnancy is not, however, listed as a contraindication for COVID-19 vaccine.

[6] For purposes of CDC's COVID-19 vaccine recommendations, the "immunocompromised" category includes individuals who are "moderately or severely immunocompromised," as well as individuals with HIV infection CD4 percentage under 15% or CD4 count under 200/mm.

[7] As originally updated on May 29, 2025, the Immunization Schedule appeared to shift the COVID-19 vaccine recommendation for immunocompromised children and youth to shared clinical decision making as to the *standard* vaccination recommendation, as well as optional additional vaccinations. However, CDC subsequently amended the Schedule to maintain the prior recommendation of routine use for standard vaccination, but shared clinical decision making for optional additional vaccines. This latter approach is consistent with the Secretary's announcement, which focused on modifying the recommendation for "healthy" children and pregnant people, without commenting on the schedule for immunocompromised children.

About the Common Health Coalition (CHC)

Founded in 2023, the Common Health Coalition (CHC) brings together leading health organizations in pursuit of a reimagined health system, one in which the nation's healthcare and public health systems no longer work in parallel, but hand in hand, with better health for all as the common goal. The Coalition encompasses 300+ members across the country. CHC is working with providers, payers, public health agencies, and other key actors to develop and implement a coordinated strategy for the continued coverage, access, and uptake of COVID-19 and flu vaccines and RSV immunizations. Focusing on the fall respiratory season, CHC is building consensus on industry best practices for vaccine access, analyzing and navigating the evolving coverage and regulatory landscape, and developing tools that promote a shared understanding of key issues and impacts across all stakeholders.

Visit us at commonhealthcoalition.org