
# Vaccines for Covid-19:
# Final Policy Recommendations

**July 28, 2026**

# Policy Recommendations

## Introduction

The following policy recommendations reflect the main themes and points made during the Policy Roundtable discussion at the June 25, 2026 New England CEPAC public meeting on the use of vaccines for the prevention of Covid-19 (Spikevax® [Moderna]; mNEXSPIKE® [Moderna]; COMIRNATY® [Pfizer, BioNTech]; and Nuvaxovid® [Sanofi, an updated version of the prior Novavax vaccine]). At the meeting, ICER presented the findings of its revised report on these vaccines and the New England CEPAC voting council deliberated on key questions related to their comparative clinical effectiveness, special ethical priorities and benefits beyond health, and long-term value for money at current prices. Following the votes, ICER convened a Policy Roundtable of one patient group, one consumer group, one clinical expert, one subject matter expert, and two payer representatives to discuss how best to apply the evidence and votes to real-world practice and policy. The discussion reflected multiple perspectives and opinions, and therefore, none of the statements below should be taken as a consensus view held by all participants.

A recording of the conversation can be accessed here, and a recording of the voting portion of the meeting can be accessed here. More information on Policy Roundtable participants, including conflict of interest disclosures, can be found in the appendix of this document. ICER's report on these treatments, which includes the same policy recommendations, can be found here.

The roundtable discussion was facilitated by Sarah Emond, President and Chief Executive Officer at ICER. While the roundtable was not tasked with making recommendations about who should and should not be vaccinated against Covid-19 (that is the purview of public health leaders and clinical societies), the roundtable did touch on a number of themes around rebuilding trust, future research needs, and health system readiness. Those themes are organized by audience and summarized below.

## Health Equity

***Action is required in multiple spheres and by multiple parties to increase the likelihood that access to vaccines for Covid-19 will be equitable moving forward.***

- **Coverage/Cost:** It is incumbent upon private payers to continue their public commitment to cover Covid-19 vaccines with zero cost sharing. Public payers and public health authorities at all levels can work to ensure that those in the United States (US) who do not have insurance can receive Covid-19 vaccines without cost. Manufacturers should continue to price vaccines in alignment with their value. To maximize vaccination rates, providers must

know, at the time they are interacting with a patient, that they will be paid for the vaccine and its administration.

- **Information/Confusion:** Vaccine information sharing works best when all parties commit to provide honest, transparent information on the benefits and harms of Covid-19 vaccination in various subgroups. Attempting to avoid discussing subgroups with small benefits or where there are knowledge gaps will lead to continued loss of trust in the public health system and will fail to support individuals in their vaccine decision making. Provision of information needs to take into account barriers due to community trust, medical literacy, groups that do not speak English, and misinformation spread on social media. It is unhelpful to blame/shame people and groups who make decisions about vaccines that do not align with then best available evidence. As with many other aspects of shared decision making, adequate compensation of primary providers for cognitive activities such as counseling patients about vaccines would be broadly helpful in supporting informed decisions by patients.

- **Access to Vaccination:** Communities may lack access to vaccination because of limited availability of medical providers. This can be due to factors such as communities where medical care is physically distant, such as rural communities. Availability of vaccination through pharmacists practicing to the top of their licenses can be extremely helpful in boosting availability. Through thoughtful regulation (for example, allowing standing orders for vaccine prescriptions), states and the federal government can foster a policy environment where pharmacists are permitted to easily administer appropriate vaccines.

## Research

***Vaccine Efficacy: Research is needed in specific areas where we currently have inadequate information on the benefits, harms, and burdens of Covid-19 vaccination.***

- **Vaccination in Pregnancy:** ICER's review concluded that there are important benefits to newborn babies from vaccinating women during the third trimester of pregnancy. However, this conclusion was based on biologic plausibility that considered efficacy earlier in the pandemic, effectiveness of other third-trimester vaccinations, and recent data on Covid-19 antibody transfer to the fetus. This is likely to be unpersuasive to many inside and outside of the medical community. Randomized trials are likely to be required to provide specific estimates of benefit and to confirm the safety of third-trimester vaccination for Covid-19.

- **Vaccination in Older Infants:** Infants ages 6-12 months are at high risk from Covid-19 infection. They are also a group who can likely respond to immunization, have lost maternal antibodies, and for whom some in society have high concerns about vaccine safety. Randomized trials could confirm the safety and efficacy of Covid-19 vaccination in this population.

- **Transmission:** It is unclear in 2026 whether vaccination has important effects on rates of transmission of Covid-19 within a community, a household, a long-term care facility, or a hospital. Some of these questions can likely be answered with observational studies while others may require clinical trials, but answering these questions will support vaccine decision making and could inform our understanding of vaccination effectiveness in health care workers and frontline workers outside of health care (teachers, transportation workers, grocery store workers, etc.).

- **Long Covid:** While we heard substantial hope that vaccination for Covid-19 will reduce rates of the chronic-fatigue type of Long Covid after mild illness, no high-quality evidence exists. Better definitions of this form of Long Covid are required to inform the design of randomized trials focused on answering whether vaccination can prevent Long Covid.

- **Vaccine Composition and Administration:** Currently, most people who are vaccinated receive Covid-19 vaccine annually, though recommendations for twice yearly vaccination exist for some patient groups. Randomized trials can help determine the most appropriate vaccination interval and how often vaccines should be retargeted to circulating strains of SARS-CoV-2.

- **Research that is <u>Not Required</u>:** Covid-19 vaccination is safe and beneficial in older adults and in many groups with comorbidities, though perhaps not in those with conditions or therapies leading to immune deficiency. Limited research resources would be better spent on other important research needs as noted above, as opposed to determining the exact efficacy in these populations. Further, males ages 12-24 are at very low risk from Covid-19 and likely also at very low risk of developing myocarditis from Covid-19 vaccination in 2026, although this exact risk is difficult to know and would be extremely difficult to study. The resources needed to conduct trials to exactly measure the benefits and harms in this population would be better spent on other pressing research questions; reasonable recommendations can be made based on what is already known.

***Vaccine Decision Making: Research is needed in how best to counter misinformation and support individuals and groups in making informed decisions.***

Even before the pandemic, there was growing skepticism in the US around vaccines and vaccination. It is imperative to approach this as a question amenable to research and understanding rather than as a political or social movement leading to anger and shaming. Many groups have developed strategies for discussing preventive care in underserved communities, such as the National Health Council's Trusted Messengers program, but vaccine decision making has become a particular issue of concern for multiple groups throughout the US. Public health leaders can build on programs like Trusted Messengers to rebuild trust in the science of vaccination.

## Federal Agencies

At the same time that there has been loss of trust by various US groups in the value of expertise, there has been loss of trust in the medical community in the reliability of the federal government in making recommendations for care. It is imperative that US recommendations objectively consider best available evidence and not allow preconceived notions about any particular treatment or therapy to affect judgments. Similarly, it is imperative that health professionals not assume that a governmental recommendation is incorrect because of concerns about those who made the recommendation. We note that many countries other than the US make risk-based recommendations for Covid-19 vaccination rather than broadly recommending vaccination, although the specific recommendations and groups considered at risk vary from country to country.[1-3] Public health leaders may consider many factors when making the ultimate recommendations on vaccination, which may include a recommendation that broad vaccination is appropriate in the US. Rebuilding trust in the vaccination ecosystem requires transparency and clarity in how different factors and considerations, beyond demonstrated benefits of immunization across the entire population, were weighed in crafting those ultimate recommendations.

## Public Health Messaging

The loss of trust in the Advisory Committee on Immunization Practices (ACIP), the previous central decision maker for US vaccine recommendations, has led to multiple groups taking on the task of making recommendations. This has the possibility of increasing confusion and anxiety, but it is common for there to be preventive recommendations that are not in complete alignment and it is possible for providers to assist patients in understanding where guidelines agree and disagree. That being said, there are new efforts to create a centralized mechanism for vaccine recommendations in the absence of a functional ACIP; in such a situation, broad participation across relevant stakeholder groups will strengthen ultimate recommendations.

- **Explaining Covid-19 Vaccine Recommendations**. When it comes to crafting vaccine recommendations, public health officials will grapple with evidence gaps, disagreements about strength of evidence, and places where individual patient values and preferences lead to different decision making. Public health recommendations frequently need to include considerations other than the best available evidence, such as access to care, ease of implementation, population health goals, and management of costs. Clearly highlighting these issues in the ultimate recommendations will help rebuild trust.

# References


1. Public Health Agency of Canada. Summary of NACI statement of June 2026: Guidance on the use of COVID-19 vaccines starting fall 2026. Accessed June 29, 2026. https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-guidance-covid-19-vaccines-starting-fall-2026.html
2. NHS. COVID-19 vaccine. Accessed June 29, 2026. https://www.nhs.uk/vaccinations/covid-19-vaccine/
3. Australian Center for Disease Control. COVID-19. Accessed June 29, 2026. https://immunisationhandbook.health.gov.au/covid-19

# Appendix

Appendix Tables 1 through 3 contain conflict of interest (COI) disclosures for all participants at the June 25, 2026 Public meeting of the New England CEPAC.

**Appendix Table 1. ICER Staff and External Collaborators Conflict of Interest Disclosures**

| ICER Staff and External Collaborators | Conflict of Interest |
|---|---|
| **Sophia Cassim, BA**<br>Research Assistant<br>Institute for Clinical and Economic Review | No conflicts to disclose. |
| **Harry Gyimah Gyamfi, MSc**<br>Research Assistant<br>Skaggs School of Pharmacy and Pharmaceutical Sciences<br>University of Colorado Anschutz Medical Campus | No conflicts to disclose. |
| **Avery McKenna, BS**<br>Research Lead<br>Institute for Clinical and Economic Review | No conflicts to disclose. |
| **R. Brett McQueen, PhD**<br>Associate Professor<br>Skaggs School of Pharmacy and Pharmaceutical Sciences<br>University of Colorado Anschutz Medical Campus | Dr. McQueen received compensation from Sanofi for a special speaker series in April 2024 and January 2026 related to the cost-effectiveness of screening for type 1 diabetes and fees for reviewing a project attempting to improve early diagnosis of type 1 diabetes. |
| **Daniel A. Ollendorf, PhD, MPH**<br>Chief Scientific Officer and Director of HTA Methods and Engagement<br>Institute for Clinical and Economic Review | No conflicts to disclose. |
| **Marie Phillips, BA**<br>Health Economics Research Assistant<br>Institute for Clinical and Economic Review | No conflicts to disclose. |
| **Lisa A. Prosser, PhD**<br>Marilyn Fisher Blanch Research Professor of Pediatrics<br>University of Michigan | No conflicts to disclose. |
| **Marina Richardson, PhD, MSc**<br>Associate Director, HTA Methods and Health Economics<br>Institute for Clinical and Economic Review | No conflicts to disclose. |
| **David M. Rind, MD, MSc**<br>Chief Medical Officer<br>Institute for Clinical and Economic Review | No conflicts to disclose. |
| **Antal Zemplenyi, PhD**<br>Assistant Research Professor<br>Skaggs School of Pharmacy and Pharmaceutical Sciences<br>University of Colorado Anschutz Medical Campus | No conflicts to disclose. |

**Appendix Table 2. New England CEPAC Panel Member Participants Conflict of Interest Disclosures**

| New England CEPAC Member | Conflict of Interest |
|---|---|
| **Rena Conti, PhD**<br>Professor, Questrom School of Business, Boston University | No conflicts to disclose. |
| **Marthe Gold, MD, MPH**<br>Senior Research Scholar, New York Academy of Medicine | No conflicts to disclose. |
| **Yngve Falck-Ytter, MD, AGAF**<br>Professor of Medicine, Case Western Reserve University; Chief, Gastroenterology and Hepatology VA Northeast Ohio Healthcare System, Cleveland* | Yngve Falck-Ytter served as a methodologist for an Infectious Diseases Society of America (IDSA) guideline on Covid-19 vaccination. |
| **David Kim, PhD**<br>Assistant Professor, University of Chicago* | No conflicts to disclose. |
| **Donald Kreis, JD**<br>Consumer Advocate, N.H. Office of the Consumer Advocate | No conflicts to disclose. |
| **Julie Kueppers, PhD, NP**<br>Vice President, Clinical Alera Group, Quantum Health | No conflicts to disclose. |
| **Aaron Mitchell, MD, MPH**<br>Assistant Attending, Memorial Sloan Kettering Cancer Center | No conflicts to disclose. |
| **Jim Rebitzer, PhD**<br>Peter and Deborah Wexler Professor, Boston University Questrom School of Business | No conflicts to disclose. |
| **Joseph Ross, MD, MHS**<br>Professor of Medicine and Public Health, Yale University | No conflicts to disclose. |
| **Stephanie Vail, PharmD, MPH, BCPP, BCPS, FCCP**<br>Professor, University of New England School of Pharmacy | No conflicts to disclose. |
| **Rishi Wadhera, MD, MPP, MPhil**<br>Associate Professor, Harvard Medical School; Associate Director, Smith Center for Outcomes Research at Beth Israel Deaconess Medical Center | No conflicts to disclose. |
| **Jason H. Wasfy, MD, MPhil**<br>Associate Professor, Harvard Medical School, Director of Outcomes Research, Mass General Brigham Cardiology Division | No conflicts to disclose. |
| **Stuart Winston, DO**<br>Cardiologist in the Sub-Specialty of Cardiac Electrophysiology, Trinity Health IHA Medical Group, Ann Arbor, MI; Physician Lead, Professional Enhancement Program, Trinity Health IHA Medical Group, Ann Arbor, MI* | No conflicts to disclose. |

*Member of Midwest CEPAC

**Appendix Table 3. Policy Roundtable Participants and COI Disclosures**

| Policy Roundtable Participant | Conflict of Interest |
|---|---|
| **Kate Berry, MPP**<br>Senior Vice President, Clinical Innovation, AHIP | Kate Berry is a full-time employee of AHIP. |
| **Omar A. Escontrías, DrPH, MPH**<br>Chief Programs & Research Officer, National Health Council | Omar A. Escontrías is a full-time employee of the National Health Council. Half (50%) of the National Health Council's annual funding is from health care companies. Pfizer and Sanofi are industry members of the National Health Council, and they support the organization through membership dues and special projects. |
| **Elbert Huang, MD, MPH**<br>Professor of Medicine and Public Health Sciences, University of Chicago | No conflicts to disclose. |
| **Kimberly Leonard**<br>Medicaid Pharmacy Director, Office of Health Insurance Programs, New York State Department of Health | Kimberly Leonard is a full-time employee of the New York State Department of Health. |
| **Leigh Purvis, MPA**<br>Prescription Drug Policy Principal, AARP | Leigh Purvis is a full-time employee of AARP. A sizable share of AARP's funding comes from royalties from third-party providers of member benefits programs—the largest of these royalty agreements is with UnitedHealthcare. |
| **Jason L. Schwartz, PhD**<br>Associate Professor, Department of Health Policy and Management, Yale School of Public Health | No conflicts to disclose. |