American Cancer Society Cancer Action Network℠

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Vaccination Policies and the Impact on the Cancer Community

The Important Role of Childhood Immunizations

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After surviving stage 2B cervical cancer at age 30, Kate now looks at daughter, Louella, with hope, knowing the Human Papillomavirus (HPV) vaccination can prevent most cervical cancers. Read more about Kate on page 9.

When a bone marrow transplant weakened Tara's immune system, her doctors made clear she could only return to kindergarten if vaccination rates at her school were high enough to protect her. Read more about Tara and her mother, Michele, on page 17.

During leukemia treatment, a common cold sent Mason to the intensive care unit, highlighting the risks routine infections pose for immunocompromised children. Read more about Mason and his mother, Ashley, on page 22.

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ACRONYMS/ABBREVIATIONS

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetricians and Gynecologists
ACS	American Cancer Society
ACS CAN	American Cancer Society Cancer Action Network
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease of 2019
DTaP	Diphtheria, Tetanus, and Pertussis Vaccine
FDA	U.S. Food and Drug Administration
FQHC	Federally Qualified Health Center
HBV	Hepatitis B Virus
HepB	Hepatitis B Vaccine
HHS	U.S. Department of Health and Human Services
Hib	Haemophilus influenzae type b
HPV	Human Papillomavirus
IPV	Inactivated Polio Vaccine
M-CHIP	Medicaid Expansion Children's Health Insurance Program
MMR	Measles, Mumps, and Rubella Vaccine
PCV	Pneumococcal Conjugate Vaccine
RHC	Rural Health Clinic
RSV	Respiratory Syncytial Virus
RV	Rotavirus Vaccine
SCDM	Shared Clinical Decision-Making
Tdap	Tetanus, Diphtheria, and Pertussis Booster Vaccine
VFC	Vaccines for Children Program

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TABLE OF CONTENTS

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PATIENT AND SURVIVOR STORIES

BOXES

FIGURES

MAPS

SURVIVOR VIEWS

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Vaccination Policies and the Impact on the Cancer Community

The Important Role of Childhood Immunizations

EXECUTIVE SUMMARY

Childhood immunizations are one of the most effective public health tools for preventing serious illness, protecting communities, and reducing cancer risk later in life. For people with cancer and their families, maintaining high vaccination coverage among children and the broader community is essential to helping them safely attend school and participate fully in everyday community life. Unfortunately, childhood vaccination rates have declined steadily since 2020, and during the 2024–2025 school year, coverage for all routine kindergarten vaccines fell nationwide. At the same time, nonmedical exemptions from school vaccination requirements continue to rise in many states, driven in part by changes to state exemption policies, creating regional pockets of vulnerability to vaccine-preventable diseases and increasing the risk of outbreaks.

These declines are occurring alongside significant changes to the federal vaccine policymaking process. In 2025 and 2026, updates to the childhood immunization schedule altered long-standing recommendations by reducing the number of vaccines routinely recommended for all children and shifting some vaccines to shared clinical decision-making (SCDM) or to recommendations limited to specific high-risk populations. These changes were not based on new evidence regarding vaccine safety or effectiveness. Patients and families have reported increased confusion and reduced confidence in the nation's childhood immunization framework following the changes.

As federal guidance has become less consistent, states are increasingly asserting independent authority over vaccine policy. While some states have adopted alternative vaccination guidance from established medical and public health organizations to help protect community immunity, others have moved to weaken school vaccination requirements, including expanding nonmedical exemptions. The resulting patchwork of state policies has significant implications for vaccination coverage, equity, and the protection of medically vulnerable populations, including children and adults undergoing cancer treatment and immunocompromised cancer survivors.

Against this backdrop, a 2026 American Cancer Society Cancer Action Network (ACS CAN) Survivor Views[13] survey*, found that cancer patients and survivors consistently emphasize the importance of vaccination to protect themselves and their communities from preventable infectious diseases. Key findings include:

- **A strong majority support school-entry vaccination requirements**, with particularly high support among patients age 65 and older and those currently undergoing treatment.
- **Most cancer patients and survivors believe it is important that people around them are up to date on recommended vaccinations**, including in schools, health care settings, and the broader community.
- **Over three-quarters oppose state policies that limit access to vaccines**, reflecting concern about the impact of reduced vaccination coverage on community immunity.
- Vaccine-related confusion is affecting patient decision-making, with nearly **1 in 6 cancer patients and survivors (16%) reporting that they delayed or skipped a recommended vaccine due to confusion.**

ACS CAN supports evidence-based vaccine policies that prevent cancer, protect cancer patients and survivors, and maintain high levels of community immunity. Preserving strong childhood immunization systems is essential to protecting public health and ensuring that progress against cancer is not undermined.

*ACS CAN Survivor Views is a national research panel of cancer patients and survivors who participate in surveys to provide insights into their experiences and perspectives on public policies that affect people living with cancer.

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1. Why Childhood Vaccinations Matter for the Cancer Community

1.1 The Importance of Childhood Vaccinations

Vaccines are one of the great public health achievements of the 20th century, saving millions of lives and preventing countless illnesses.[1] They remain essential for protecting children's health today. Each year, millions of children and adolescents in the United States are safely vaccinated against serious and preventable diseases such as measles, mumps, rubella, polio, and whooping cough, as well as viruses like human papillomavirus (HPV) and hepatitis B (HBV).[2]

Many cancer patients and survivors have weakened immune systems, and some may be unable to receive certain vaccines or may not develop a strong immune response to vaccination.[3] Childhood vaccinations not only protect individual children from debilitating and potentially deadly diseases but, when vaccination coverage is high, also help protect entire communities by reducing the spread of infectious diseases and supporting community immunity.[4]

Currently, the United States **has the safest vaccine supply** in its history.[2]

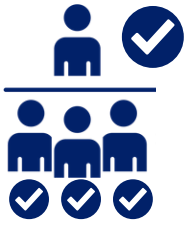
1.2 Safety and Effectiveness of Vaccines

Vaccines are safe and effective. The United States currently has the safest vaccine supply in its history.[2] The safety, effectiveness, and quality of all vaccines used in the United States are regulated by the U.S. Food and Drug Administration (FDA). Before approval, vaccines undergo extensive testing to evaluate their safety, effectiveness, and quality, including multiple phases of clinical trials to assess appropriate dosing and identify potential side effects. Once licensed, vaccines continue to be closely monitored through robust, nationwide safety surveillance systems that track and investigate potential adverse events in real time.[6]

Figure 1: Childhood Vaccines Protect People with Cancer

More than 18 million Americans have a history of invasive cancer.[4] Because cancer and its treatment can weaken the immune system, many patients and survivors face an increased risk from infectious diseases.[3] High childhood vaccination rates help reduce the spread of infection, protecting those most vulnerable.[5]

Reduced Spread = Fewer Exposures

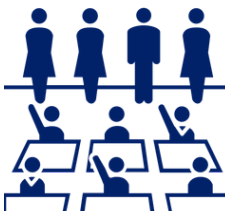


High childhood vaccination rates limit how widely infectious diseases circulate, reducing the number of people exposed.[5]

Community Immunity Protects Those Who Cannot be Vaccinated

When vaccination rates are high, fewer infections circulate, helping protect high-risk people, including many cancer patients who cannot be vaccinated.[5]

Protections Extend Beyond Classrooms



School vaccination requirements protect families and communities, not just students, by reducing the spread of infection beyond the classroom to parents, grandparents, extended families and friends.[7]

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1.3 Childhood Vaccinations that Prevent Cancer

The human papillomavirus (HPV) vaccine and the hepatitis B (HepB) vaccine, both on the routine CDC Childhood and Adolescent Immunization schedule, are powerful tools in the prevention of viruses that cause cancer.

The HepB vaccine, added to the schedule in the early 1990s, has dramatically reduced HBV infections among children and adolescents and lowered the risk of chronic infection and HBV-related liver cancer later in life.[8] When the vaccine series begins at birth, it can reduce a person's risk of developing liver cancer by about 84%.[9]

The HPV vaccine, which was added to the schedule for girls in 2006 and for boys in 2011, has already significantly reduced cervical precancers in women and lowered the risk of HPV-related head and neck cancers among men.[10,11,12] More than a decade of research and safety monitoring has shown the HPV vaccine to be both safe and effective.

Box 1: A Generation Protected: U.S. Cervical Cancer Risk Is Falling in the HPV Vaccine Era[11]

HPV vaccination is a primary driver of the unprecedented decline in cervical cancer risk across successive generations. A 2026 study found a sharp decline in cervical cancer incidence began with the 1988 birth cohort, the first generation eligible for HPV vaccination.

27% **Cervical cancer incidence** among women ages 20–31 was **27% lower during 2016–2021 compared with 2000–2005,** following HPV vaccine availability.

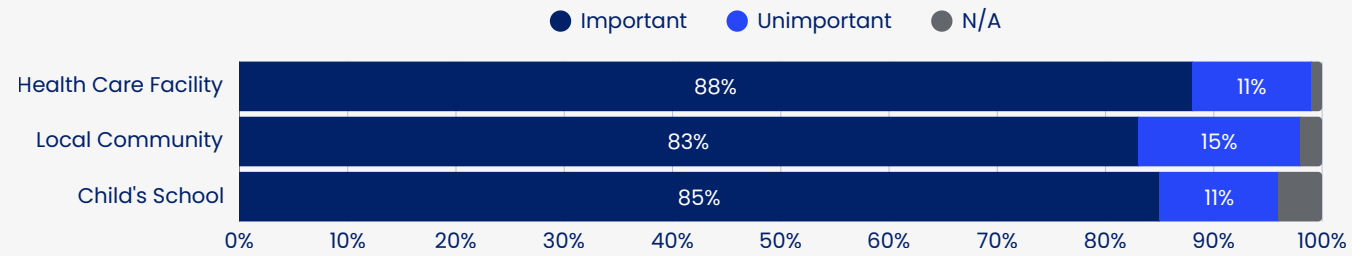
50% Women born in the 1990s **had about half the cervical cancer incidence** of those born in the 1970s.

90% of cervical cancers can be prevented through HPV vaccination. **Countries with high HPV vaccination coverage**, including Australia and the United Kingdom, have seen **dramatic declines in HPV infections** and **cervical precancers** among young women.[4,14]

Survivor Views:
Importance of Community Members' Vaccination Status for Cancer Survivors[13]

Community-wide vaccination plays an important role in protecting people with cancer in the places where they live, learn, and work. Cancer patients and survivors express strong support for vaccination among those around them. Survey results show that 88% feel it is very or somewhat important for others in their health care setting to be vaccinated, 83% feel it is important for people in their community to be vaccinated, and 85% feel it is important that people in their child's school are vaccinated.

Importance of Community Members Being Up to Date on Recommended Vaccinations



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"The HPV vaccine represents hope," Kate says. "Hope that my daughter and future generations of girls will be protected from a cancer that nearly took my life."

Kate was just 30 years old when she was diagnosed with stage 2B cervical cancer. After nearly a year of treatment, including 55 rounds of radiation and 17 rounds of chemotherapy, she was declared cancer-free in 2016.

In 2018, Kate began using her voice to fight back. Through her treatment, she learned that cervical cancer is largely preventable when young people receive the HPV vaccine. According to the Centers for Disease Control and Prevention (CDC), HPV vaccination has reduced infections from the HPV types that cause most cervical cancers by about 88% among teenage girls in the U.S.

Today, Kate is the proud mother of her four-year-old daughter, Louella. She continues to share her story to advocate for health care equity, sustained investment in cancer research, access to lifesaving vaccines and treatments, and greater awareness of the disproportionate impact of cervical cancer on women of color.

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2. How Childhood Vaccine Recommendations Are Made

2.1 The Federal Government's Role in Childhood Vaccination Recommendations

As vaccines became more widely available in the early 20th century, the U.S. recognized the need for a coordinated, evidence-based approach to preventing infectious diseases.[15] In 1964, the CDC established the Advisory Committee on Immunization Practices (ACIP) to provide independent, science-based guidance on vaccine use in civilian populations, drawing on expertise in pediatrics, infectious disease, epidemiology, immunology, and public health. As the number of routinely recommended vaccines increased, ACIP's guidance evolved into a standardized childhood immunization schedule to help clinicians implement recommendations consistently. ACIP recommendations are regularly reviewed and updated as new scientific evidence, safety data, and epidemiologic trends emerge.

Under federal law, most commercial health plans **must cover ACIP recommended services without cost sharing**.[16]

In 1995, the CDC published the first *Recommended Childhood Immunization Schedule*, in conjunction with the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), which consolidated ACIP guidance on childhood vaccines into a single framework that could be updated annually as new evidence emerged.[17]

2.2 Recent Changes to ACIP

On June 9, 2025, the U.S. Secretary of Health and Human Services (HHS) dismissed all 17 sitting members of the ACIP and appointed eight new members two days later.[18] This action departed from established practice, in which ACIP membership has typically transitioned on a staggered basis to preserve continuity and institutional expertise. Several of the ACIP members appointed in 2025 and 2026 have previously expressed views that diverge from the broad scientific consensus on vaccines, prompting concern among medical and public health organizations about the committee's scientific orientation and independence.[19,20]

Figure 2: The Role of the Advisory Committee on Immunization Practices (ACIP) in U.S. Vaccine Policy

What does ACIP do?

- **Establishes national recommendations for vaccine use.** Recommendations become federal guidance after adoption by the CDC.
- Reviews scientific evidence on **vaccine safety, effectiveness, and public health impact** following FDA approval.
- Uses **workgroups** to conduct in-depth evidence reviews.
- Holds **public meetings** to allow for public comment.
- Serves in an **advisory role only.** ACIP does not mandate vaccines.

Who is part of ACIP?

- **Non-governmental voting members** appointed by the HHS Secretary, **traditionally with expertise in pediatrics, infectious diseases, epidemiology, immunology, and public health** and subject to **federal ethics and conflict-of-interest review.**
- Supported by **non-voting ex-officio members** from federal agencies and **liaison representatives** from professional medical organizations.

Why do ACIP recommendations matter?

- Informs the **CDC Recommended Child and Adolescent Immunization Schedule.**
- Establishes **vaccine coverage and access**, for the Vaccines for Children program, private insurance, and Medicaid and Medicaid expansion states.
- **Referenced by many states** in their immunization policy guidelines.

Who relies on ACIP Recommendations?

- **Clinician and public health programs** look to ACIP recommendations to guide routine and catch-up immunizations.
- **Health insurers and federal health programs** rely on ACIP recommendations to determine vaccine coverage and reimbursement.

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ACIP meetings in the same timeframe also have proceeded without the customary participation of CDC subject-matter experts, who have traditionally presented scientific data and analyses to inform committee deliberations and have discontinued or substantially altered long-standing workgroups that were central to facilitating expert engagement and coordination across the immunization community. *For more information on recent legal developments affecting ACIP see Box 2.*

2.3 Changes to the Child and Adolescent Vaccine Schedule

On January 5, 2026, HHS announced revisions to the CDC's Recommended Child and Adolescent Immunization Schedule (see Figure 3).[21] The revised schedule reduced the number of vaccines universally recommended for all children from 17 vaccines to 11 vaccines. Several vaccines previously classified as routine were shifted from routine to shared clinical decision-making (SCDM) (see Box 2) or recommended primarily for specific high-risk populations rather than all children. The changes were not triggered by new evidence regarding vaccine safety or effectiveness and were made outside the established ACIP process, which has historically included evidence review, public discussion, and formal committee recommendations before adoption by the CDC. In response, there were legal challenges (see Box 2) and more than 200 medical and public health organizations called on Congress to investigate the changes and the decision to bypass the ACIP process and public meetings provisions.[22]

Box 2: Legal Developments in Federal Vaccine Policy (March 2026)

As of March 2026, there are two major lawsuits pending in response to the changes at ACIP and modifications to the vaccine schedule. A federal court ruling on March 16, 2026 in American Academy of Pediatrics v. Kennedy temporarily paused (stayed) the appointments of thirteen ACIP members made between June 2025 and January 2026, as well as votes taken by the committee during that period. The CDC's 2026 Child and Adolescent Immunization Schedule issued in January 2026, was also stayed. An appeal by the federal government is expected. As of March 24, 2026 there have been no rulings in the parallel case of State of Arizona v. Kennedy.

Figure 3: 2026 CDC Recommended Child and Adolescent Immunization Schedule

(birth through 18 years of age)

**Italics indicate a change from the 2024 recommendations to the 2026 recommendations.*

***SCDM = Shared Clinical Decision-Making*

Vaccine/Disease	Recommendations
No changes in 2026 recommendations	
Diphtheria, Tetanus, Pertussis (DTaP/Tdap)	Recommended for all children
Haemophilus influenzae type b (Hib)	Recommended for all children
Pneumococcal conjugate (PCV)	Recommended for all children
Polio (IPV)	Recommended for all children
Measles, Mumps, Rubella (MMR)	Recommended for all children
Varicella (chickenpox)	Recommended for all children
Changes in 2026 recommendations	
Human Papillomavirus (HPV)	*Recommended for adolescents (ages 11–12) – dose change from 2 doses to single dose*
Rotovirus (RV)	*SCDM - no longer universal recommendation*
Influenza(Flu)	*SCDM - no longer universal recommendation*
COVID-19	*SCDM - no longer universal recommendation*
Hepatitis A (HepA)	*High-risk children or SCDM - no longer universal recommendation*
Hepatitis B (HepB)	*High-risk infants/children or SCDM - no longer universal recommendation*
Respiratory Syncytial Virus (RSV)	*High-risk groups only*
Meningococcal ACWY	*High-risk groups - no longer universal recommendation for adolscents (11-18 years old)*
Meningococcal B (MenB)	*High-risk groups only - previously SCDM for adolescents (11-18 years old)*

For more information on recent legal developments affecting the CDC Childhood and Immunization Schedule see Box 2.

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2.4 Shift of certain Vaccines to Shared Clinical Decision-Making Designation (SCDM)

Under the updated 2026 Child and Adolescent Immunization schedule, several vaccines previously recommended for routine use among all children were moved to a SCDM designation.[21] SCDM has long been part of discussions between parents and health care providers. These discussions work best when guided by clear recommendations from trusted public health authorities. However, when vaccines previously recommended for routine use are reclassified as SCDM, it can signal that the vaccine is less necessary and not broadly recommended, which may lead to confusion among caregivers. As many states link school-entry requirements to routine recommendations, shifting vaccines to a SCDM designation may result in the removal of some school-entry requirements, reducing vaccination coverage in school settings and weakening community immunity.[23]

National analyses of the pediatric health care workforce show that many rural counties lack pediatricians and that the number practicing in rural areas has declined even as the overall pediatric workforce has grown.[24] In resource-limited settings where structural barriers to health care access persist, time and resources for preventive counseling may be constrained. In this context, shared clinical decision-making (SCDM) classifications may further exacerbate disparities in vaccine uptake.[25,26]

Box 3: What is Vaccine Shared Clinical Decision-making (SCDM)?

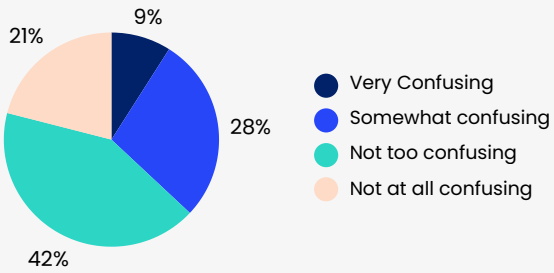
Shared clinical decision-making (SCDM) or individual clinical decision-making, refers to vaccine counseling where a clinician, patient and their parent/guardian discuss the benefits and risks of vaccination for that individual. It is carried out by licensed health care professionals practicing within their scope, which varies by state (for example, physicians, nurse practitioners, physician assistants, registered nurses, and pharmacists).

Nearly 6 in 10 of respondents (59%) in ACS CAN's Survivor Views survey said that **"shared decision-making" designation has made it more confusing** to know which vaccines to receive.[13]

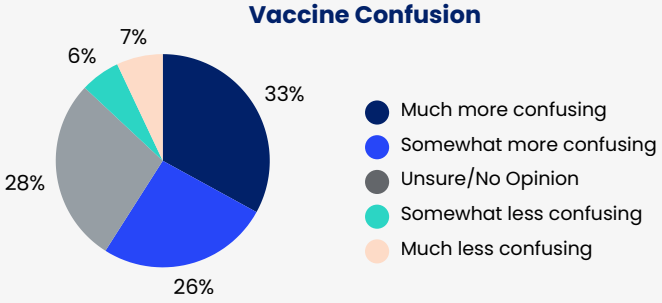
Survivor Views:
Increase in Vaccine Confusion Among Cancer Survivors[13]

News reports, debate, and federal actions related to vaccines have contributed to increased confusion among cancer patients. This comes at a time when vaccination rates for key childhood vaccines are declining, including measles, which has resurged in the past year.[27] The confusion has consequences for cancer patients, **with 1 in 6 (16%) reporting that due to confusion** they **skipped or delayed** receiving a vaccine they would otherwise have received.

Impact of Changes in Recommendations on Vaccine Confusion



Impact of SCDM Recommendations on Vaccine Confusion



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3. How Families Access Childhood Vaccines

3.1 State's Role in Coverage of Childhood Vaccines

Families access vaccines for their children through three primary pathways:

- **Vaccines for Children (VFC) Program**, including children enrolled in Medicaid
- **Children's Health Insurance Program (CHIP)**, including both traditional CHIP and Medicaid-expansion CHIP (M-CHIP)
- **Private insurance**

Parents enroll children in Medicaid or CHIP through state programs, while health care providers determine and document VFC eligibility at the point of care; families do not enroll children directly into the VFC program.

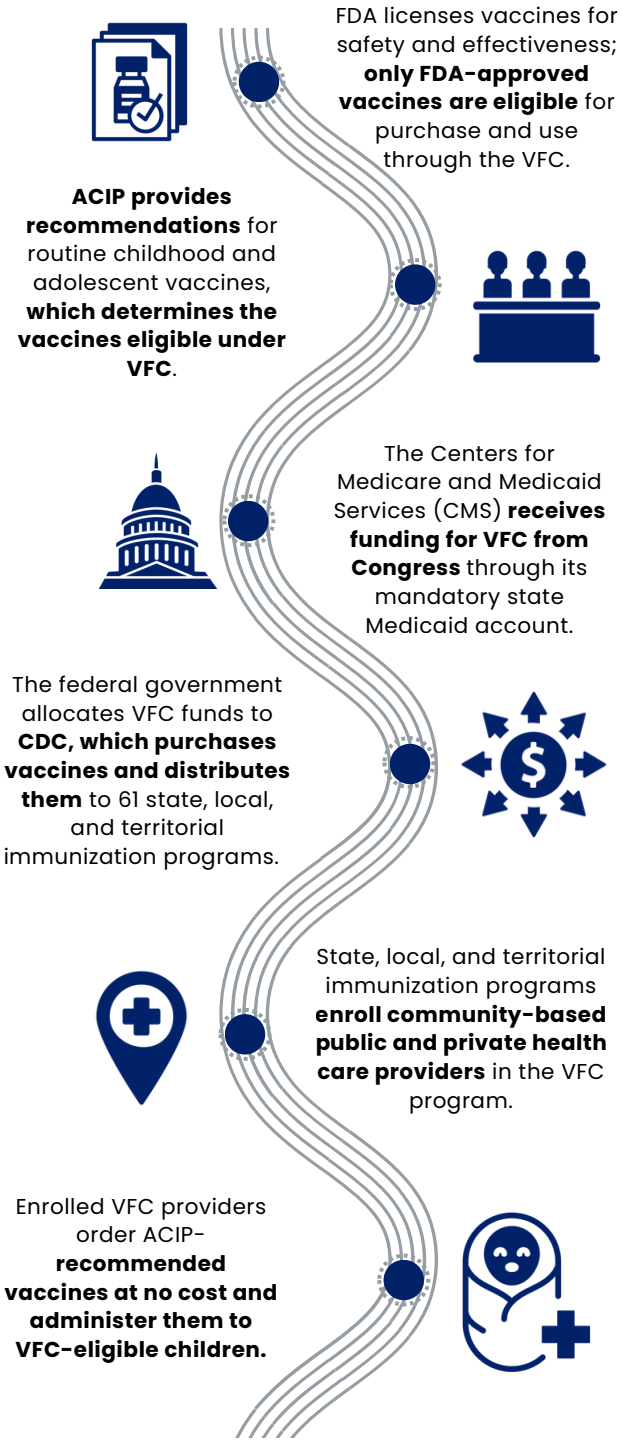
States play a role across pathways by administering Medicaid, CHIP, and VFC; overseeing vaccine distribution; enforcing school vaccination requirements; and maintaining the public health infrastructure necessary to ensure access.

About **half of all U.S. children receive their vaccines** through the federally funded VFC program.[28]

3.2 The Vaccines for Children (VFC) Program

The VFC program was created by Congress in 1993 in response to a large measles outbreak that occurred between 1989 and 1991, which resulted in more than 55,000 cases and over 120 deaths. Most deaths were among unvaccinated children.[28] Investigations showed that many children had missed routine vaccinations because their families could not afford them.[28] VFC was established to remove cost barriers, ensure equitable access to vaccines, and prevent similar outbreaks by improving childhood immunization coverage nationwide. The VFC program plays a vital role in increasing and maintaining high levels of childhood vaccination coverage. In 2023, VFC distributed approximately 74 million pediatric vaccine doses to participating health care provider locations across the country.[29]

Figure 4: Vaccines for Children Vaccine Distribution



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While VFC vaccines are purchased using federal funds, state health department immunization programs are responsible for recruiting, enrolling, and overseeing VFC providers; managing vaccine ordering and allocation; ensuring proper storage; and providing training, technical assistance, and ongoing monitoring of providers.

Although VFC vaccines are provided at no cost, Medicaid reimburses health care providers for the administration of vaccines for Medicaid-enrolled children, with payment rates set by states. Federal law requires Medicaid to cover all ACIP-recommended vaccines for eligible children without cost sharing.

3.3 Children's Health Insurance Program (CHIP)/ Medicaid Expansion (M-CHIP)

CHIP, established in 1997, is a federal–state health insurance program that provides low-cost or no-cost coverage to children and teens in families that earn too much to qualify for Medicaid but still cannot afford private insurance.

Under federal law, all ACIP-recommended vaccines including vaccines listed under SCDM must be covered without cost sharing for children enrolled in CHIP, regardless of whether a state operates CHIP through M-CHIP or as a separate program.[30,31,32]

Box 4: Who is Eligible under the Vaccines for Children Program?

Children are eligible under VFC if they are younger than 19 years old and meet at least one of these criteria:

- Enrolled in Medicaid and Medicaid-expansion CHIP (M-CHIP) eligible children enrolled in VFC
- Uninsured
- American Indian or Alaska Native (as defined by the Indian Health Care Improvement Act)
- Underinsured, but only when they receive vaccines at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)

Though VFC vaccines are provided at no cost, **administering a vaccine still has real costs—staff time, supplies, storage, documentation, and reporting**.

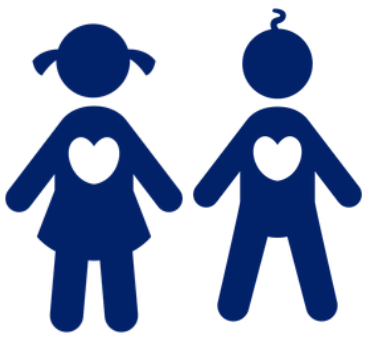
Figure 5: Diseases Prevented by Childhood and Adolescent Vaccines, 1994 vs. 2025[33]

Children today can be **protected against more diseases with the same or fewer injections** than in the past, including the HPV and HepB vaccines, which prevent several types of cancers later in life. Many vaccines are given in combination to protect against multiple diseases in a single injection. Advances in vaccine science mean today's childhood vaccines expose children to far fewer antigens, the parts of a virus or bacteria that trigger the body's immune response, than vaccines used decades ago.[34]

1994

Routine vaccines protected against **8 diseases:**

- Diphtheria
- Tetanus
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Hib



2025

Routine vaccines protected against **16+ diseases:**

- Diphtheria
- Tetanus
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Hib B
- **Hepatitis A**
- **Hepatitis B**
- **Pneumococcal disease**
- **Varicella**
- **Rotavirus**
- **Influenza**
- **Meningococcal disease**
- **Human Papillomavirus**
- **COVID-19**

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3.4 Children Covered under Private Insurance

For children covered under private or employer-sponsored health insurance, most plans are required under federal law to cover all vaccines that have an ACIP recommendation and are adopted by the CDC Director, with no cost sharing when delivered in-network.

3.5 The State's Role in Childhood Vaccinations

States are the linchpin in how families in the U.S. access vaccines. While federal entities such as CDC and ACIP develop national recommendations, states determine how those recommendations are implemented. States establish school and child care vaccination requirements, define allowable exemptions, determine coverage for state-regulated insurance plans, administer Medicaid and CHIP programs within federal standards, and issue clinical and public health guidance to providers and local health departments.

Historically, states have relied heavily on ACIP recommendations and CDC guidance as the evidence-based foundation for vaccine policies. However, in response to recent ACIP and CDC actions on vaccines, including the newly released childhood vaccination schedule, a growing number of states have moved toward asserting more independent decision-making authority over immunization standards. Over half of the states (see Map 1) have indicated they will no longer automatically follow the most recent ACIP childhood vaccine schedule, instead relying on prior state schedules or guidance from other entities, most commonly the AAP and AAFP.[35]

In other states, policymakers have moved in the opposite direction. Efforts to weaken access include lowering school-entry vaccination requirements (see Map 3), expanding nonmedical school exemption policies (see Figure 8), and advancing so-called "medical freedom" legislation (see section 4.4).[36]

In the absence of a clear, credible, and evidence-based federal vaccine framework, states are increasingly adopting different approaches to immunization guidance. The resulting patchwork of policies has significant implications for vaccination coverage and equity, provider practice, public confidence in immunization programs, and the potential for outbreaks of vaccine-preventable diseases.

Box 5: State Authority Over Vaccine Policy

States retain independent authority to set their own immunization recommendations and mandates.

This authority allows states to:

- **Establish vaccination requirements:** Set school entry, childcare, and (in some cases) health care worker immunization requirements, including allowable exemptions.
- **Establish coverage requirements for state-regulated plans:** Determine vaccine coverage standards for state-regulated commercial insurance plans.
- **Issue clinical or public health guidance:** Provide recommendations to clinicians, health departments, and schools regarding vaccine use, implementation, and outbreak response.

Federal law establishes **a floor, not a ceiling, for vaccine coverage**; states and other payers can **choose to cover additional vaccines** beyond those recommended by ACIP.

As a result of changes to ACIP, two major regional public health compacts—**the West Coast Health Alliance**[37] and the **Northeast Public Health Collaborative**[38]—have been formed to coordinate immunization guidance.

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Map 1: States Departing from the CDC Child and Adolescent Immunization Schedule

As of March 2026, 26 states and the District of Columbia have indicated they will no longer follow the most recent federal childhood vaccine schedule, instead relying on prior state schedules or guidance from other entities (most commonly the AAP and AAFP).

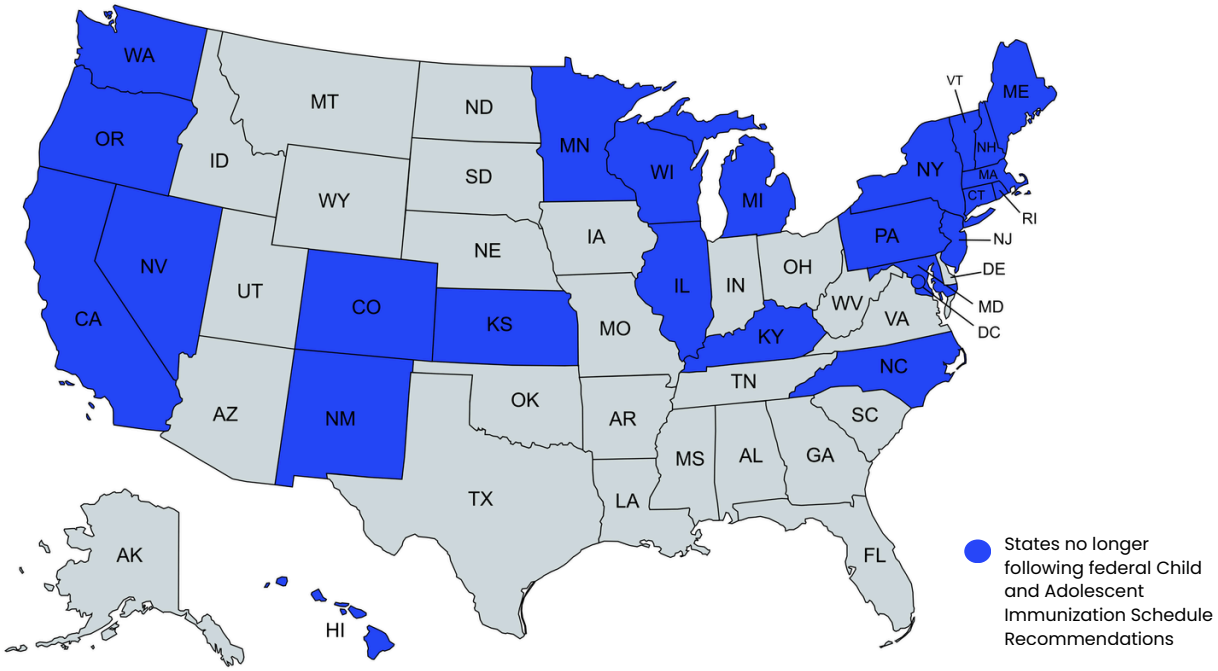

Figure 6: States No Longer following Federal Guidance for the Childhood Immunization Schedule

State	Guidelines Reference	State	Guidelines Reference
California	AAP, ACOG, AAFP	Nevada	Maintaining 2025 schedule
Colorado	AAP	New Hampshire	AAP, AAFP
Connecticut	AAP	New Jersey	AAP
Delaware	AAP	New Mexico	AAP
District of Columbia	AAP, AAFP	New York	AAP
Hawaii	AAP	North Carolina	AAP
Illinois	AAP	Oregon	AAP
Kansas	AAP, AAFP	Pennsylvania	AAP, AAFP
Kentucky	AAP, AAFP	Rhode Island	AAP
Maine	AAP	Vermont	AAP
Maryland	AAP	Virginia	AAP
Massachusetts	AAP	Washington	AAP
Michigan	AAP, AAFP	Wisconsin	AAP
Minnesota	AAP, ACOG, AAFP		

AAP: American Academy of Pediatrics, ACOG: American College of Obstetricians and Gynecologists, AAFP: American Academy of Family Physicians

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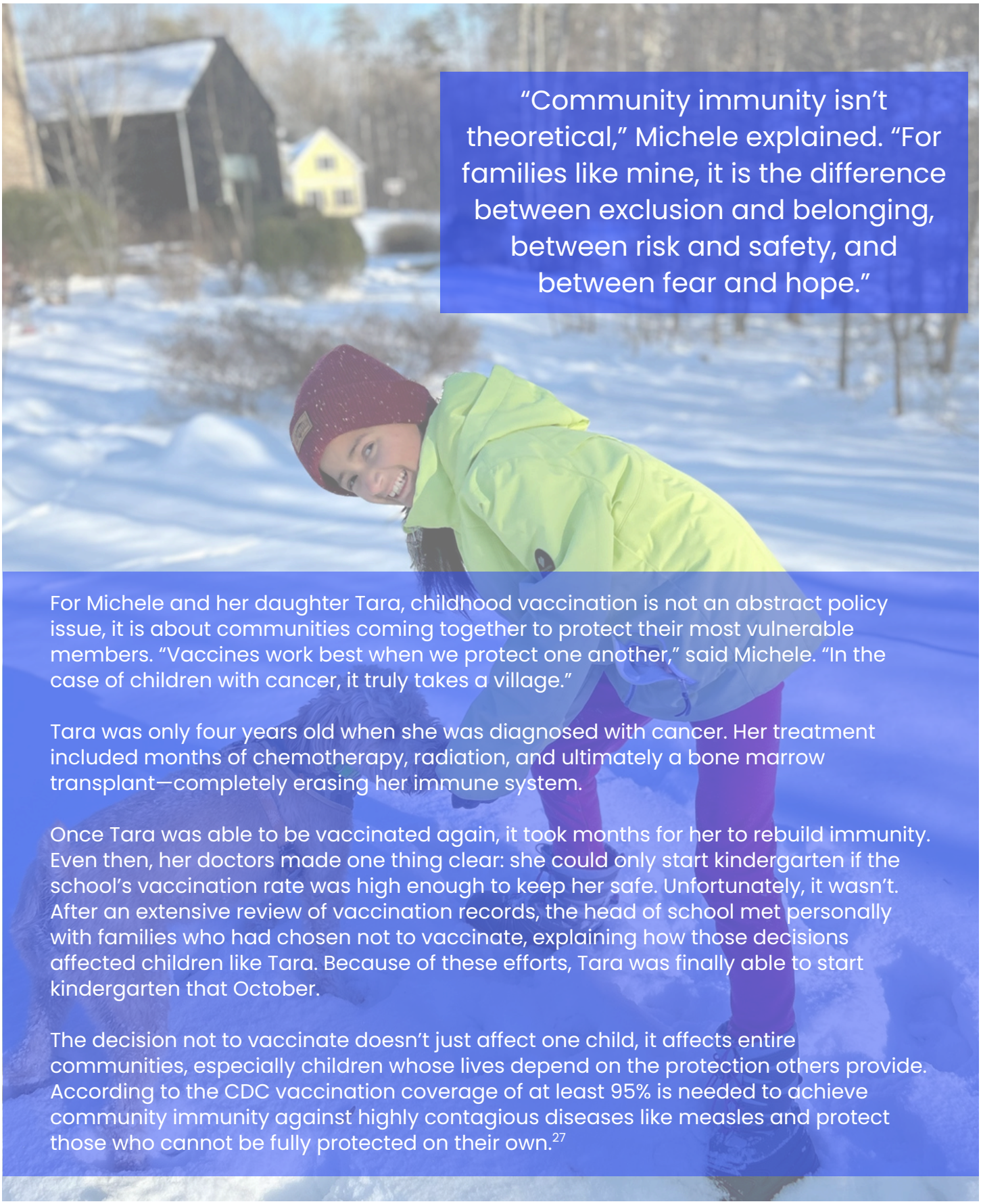

> "Community immunity isn't theoretical," Michele explained. "For families like mine, it is the difference between exclusion and belonging, between risk and safety, and between fear and hope."

For Michele and her daughter Tara, childhood vaccination is not an abstract policy issue, it is about communities coming together to protect their most vulnerable members. "Vaccines work best when we protect one another," said Michele. "In the case of children with cancer, it truly takes a village."

Tara was only four years old when she was diagnosed with cancer. Her treatment included months of chemotherapy, radiation, and ultimately a bone marrow transplant—completely erasing her immune system.

Once Tara was able to be vaccinated again, it took months for her to rebuild immunity. Even then, her doctors made one thing clear: she could only start kindergarten if the school's vaccination rate was high enough to keep her safe. Unfortunately, it wasn't. After an extensive review of vaccination records, the head of school met personally with families who had chosen not to vaccinate, explaining how those decisions affected children like Tara. Because of these efforts, Tara was finally able to start kindergarten that October.

The decision not to vaccinate doesn't just affect one child, it affects entire communities, especially children whose lives depend on the protection others provide. According to the CDC vaccination coverage of at least 95% is needed to achieve community immunity against highly contagious diseases like measles and protect those who cannot be fully protected on their own.[27]

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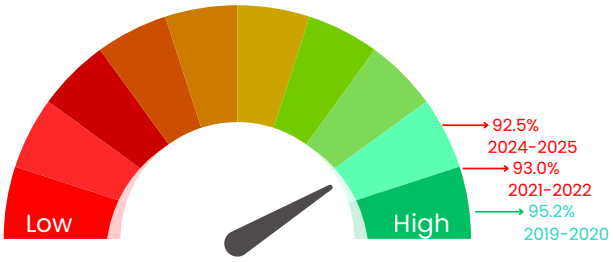
4. Community Immunity and Importance of School Policies Around Vaccines

4.1 Community Immunity and School Settings

High vaccination rates in school settings play a critical role in protecting community health. Children spend a significant portion of their day in close contact with one another in classrooms, cafeterias, playgrounds, and buses. These shared spaces are essential for learning, social development, and growth, but they also create opportunities for infectious diseases to spread quickly. Maintaining high levels of community immunity in school settings helps reduce the likelihood of outbreaks, protecting not only students but also teachers, staff, family members, and others in the broader community.

Since 2020, the vaccination rates among kindergarten students have steadily decreased. During the 2024-2025 school year, vaccination coverage for measles, mumps, and rubella (MMR); diphtheria, tetanus, and pertussis (DTaP); polio; and varicella vaccines decreased among kindergartners. MMR vaccination coverage was just 92.5%, well below the 95% threshold needed to prevent transmission of measles virus.[276]

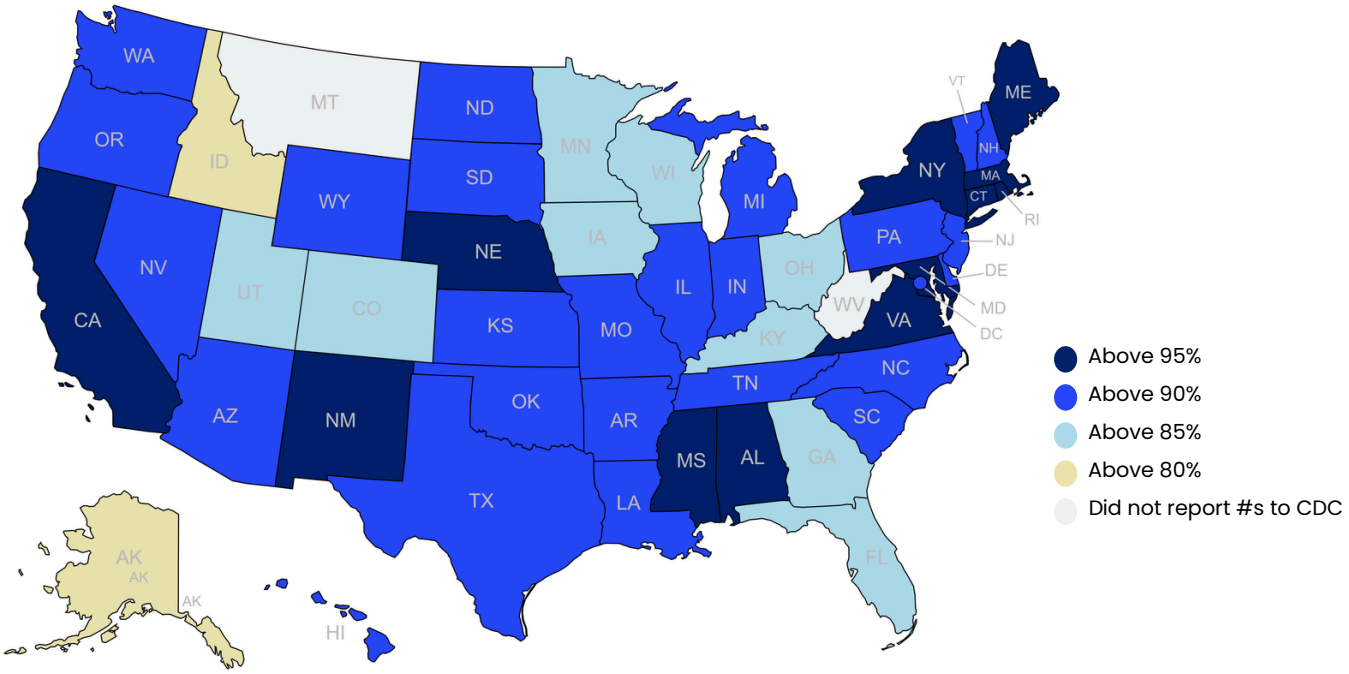
Figure 7: Decline in Kindergarten Vaccination Rates, 2019-2025[27]



During the 2024-2025 school year, vaccination coverage among kindergartners in the U.S. **decreased** for **all reported vaccines** from the year before.[27]

Map 2: Kindergarten Vaccination Rates, 2024-2025[27]

Kindergarten vaccination rates need to reach the threshold of 95% to be considered adequate to achieve community immunity to protect people from communicable diseases.[27] Only 12 states have vaccination rates over 95%, according to 2024-2025 data.



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4.2 Rising Rates of Exemptions to School Entry Vaccination Requirements

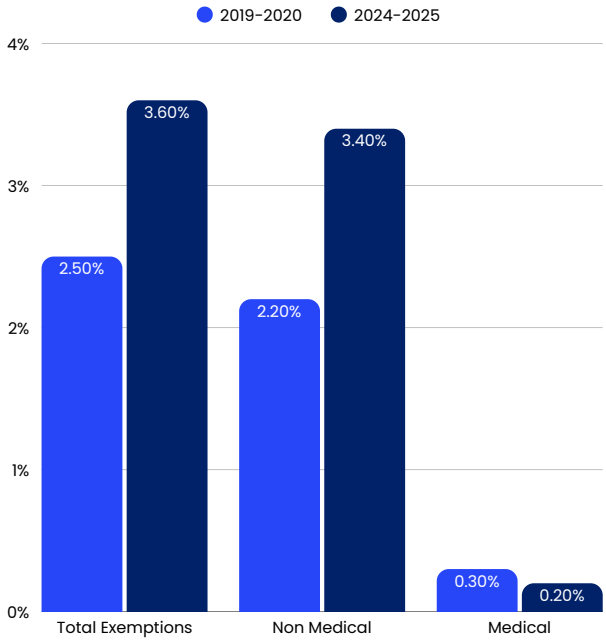
School-entry vaccination requirements have long been a cornerstone of U.S. public health policy and are among the most effective tools for achieving and maintaining high vaccination coverage.[2] They have contributed to dramatic declines in serious childhood diseases such as measles, polio, and diphtheria. States and local jurisdictions determine which vaccines are required for school attendance and establish rules for exemptions, documentation, and provisional enrollment. Since the early 1980s, all 50 states and the District of Columbia have required certain vaccinations for students attending public schools, with most laws also applying to private schools and, in some cases, homeschools.[39] Every state permits medical exemptions for children who cannot be safely vaccinated due to underlying health conditions, and most also allow nonmedical exemptions, typically for religious or, in some states, personal or philosophical reasons. The availability and ease of obtaining exemptions vary by state, contributing to differences in vaccination coverage and localized vulnerability to outbreaks.

Since the COVID-19 pandemic, some states have enacted policies that make it easier to obtain medical exemptions. In the 2024–2025 school year, 17 states reported that more than 5% of kindergarteners claimed a vaccine exemption.[27] Kindergarten vaccination rates need to reach the threshold of 95% to be considered adequate to achieve community immunity to protect people from communicable diseases.[27] Exemption rates larger than 5% make it difficult for a state to reach the target, even if all non-exempt children receive their vaccinations. Nonmedical exemptions to school-based childhood vaccination requirements are associated with lower vaccination coverage and increased risk of outbreaks.[40]

Figure 8: Rising Childhood Vaccine Exemption Rates[27]

National vaccine exemption rates reached a record 3.6% in 2024–2025, up from 2.5% in 2019–2020.

Growth in nonmedical exemptions drove the increase, while medical exemptions decreased. **Nonmedical exemptions** to school-based childhood vaccination requirements are **associated with lower vaccination coverage and increased risk of outbreaks.**[41,42]



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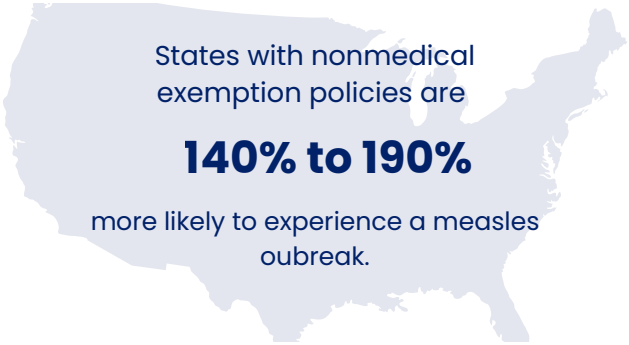
4.3 Impact of Nonmedical Exemptions to School Entry Policies on Disease Outbreaks

Parts of the U.S. are experiencing a resurgence of measles, a highly contagious disease once considered eliminated due to widespread use of the MMR vaccine. This resurgence coincides with efforts in some states to expand nonmedical exemptions from childhood vaccination requirements for school entry. Research shows that higher exemption rates are associated with increased outbreak risk: a 2017 study found that states with easier nonmedical exemption policies were 140% to 190% more likely to experience a measles outbreak, while making more stringent nonmedical exemption policies could reduce outbreak size by approximately half.[43]

Declines in childhood vaccination coverage pose a direct risk to cancer patients and their families, many of whom are immunocompromised and rely on high vaccination coverage in their communities for protection. A 2025 Journal of the American Medical Association modeling study[44] found that, at current U.S. vaccination levels, measles could once again spread continuously within the U.S. within two decades, resulting in an estimated 851,300 cases over 25 years. The same model projected that significant reductions in coverage across childhood vaccines would lead to millions of additional cases of measles, rubella, poliomyelitis, and diphtheria, with broad public health implications for U.S. children and families.

Figure 9: How Vaccine Exemption Policies Influence Measles Outbreak Risk and Size[43]



More stringent nonmedical vaccine exemptions could reduce the size of measles outbreaks **by approximately 50%.**

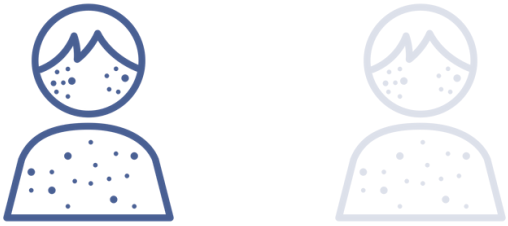


Figure 10: Reduction in Cervical Cancer Incidence in Jurisdictions with HPV School-Entry Vaccination Requirements[45]

Three of the four jurisdictions with the **greatest declines in cervical cancer incidence** between 2000–2005 and 2016–2021—each exceeding 50%—have **HPV vaccination requirements for school entry.**

HPV Vaccination Coverage (Girls 13–17, 2022)*

State	HPV Vaccination Rate	HPV School-Entry Requirement
Rhode Island	93.3%	✓
Hawaii	88.6%	✓
District of Columbia	88.0%	✓
Michigan	82.5%	✗

*Vaccination coverage is defined as receipt of at least one dose of the HPV vaccine, not up-to-date coverage

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Map 3: School Vaccine Exemptions

States with the highest rates of nonmedical vaccine exemptions from 2021 to 2024 were Arizona, Idaho, Oregon, Utah, and Wisconsin. In contrast, states that prohibit nonmedical exemptions—California, Connecticut, Maine, and New York—report very low exemption rates.[46]

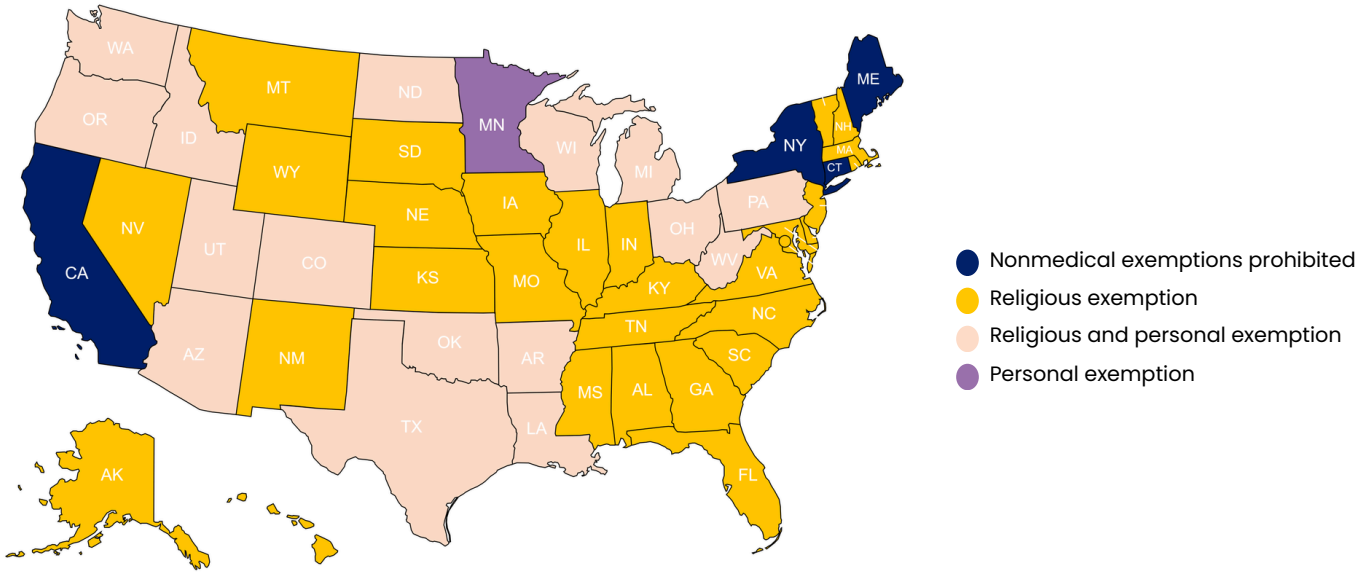
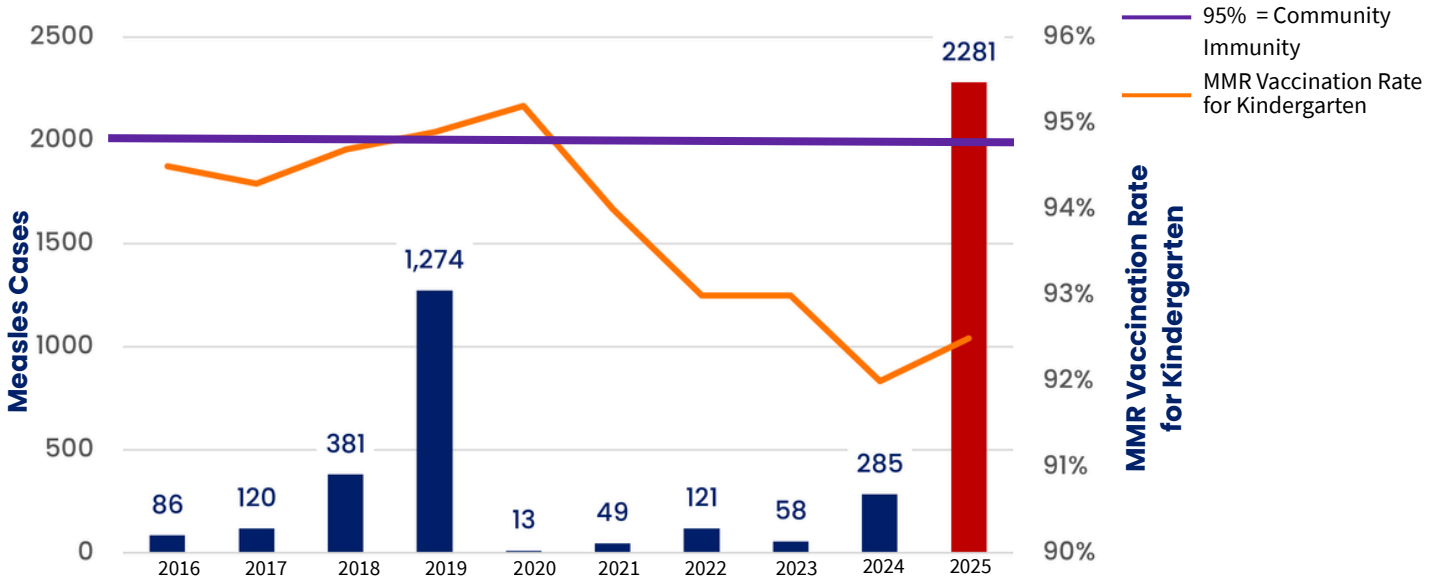


Figure 11: U.S. Measles Cases and MMR Vaccination Coverage, 2016-2025[27,47]

Measles cases rose sharply in 2019 during the largest U.S. outbreak in nearly three decades, largely driven by sustained transmission in undervaccinated communities. Cases declined during the COVID-19 pandemic but have begun to rise again as routine vaccination coverage has fallen, with a sharp increase observed in 2025. The U.S. reported more measles cases in 2025 than were recorded in the previous five years combined.



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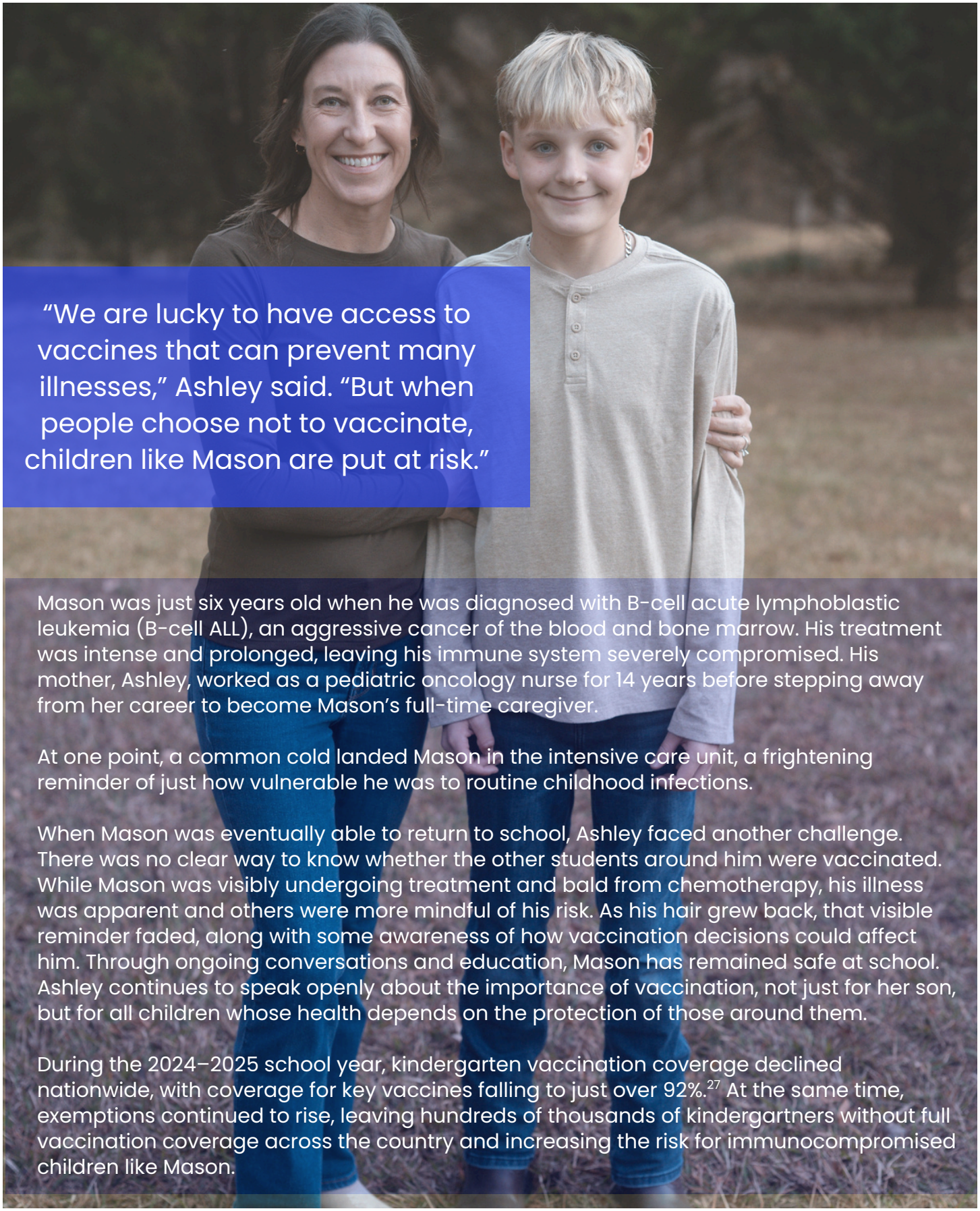

"We are lucky to have access to vaccines that can prevent many illnesses," Ashley said. "But when people choose not to vaccinate, children like Mason are put at risk."

Mason was just six years old when he was diagnosed with B-cell acute lymphoblastic leukemia (B-cell ALL), an aggressive cancer of the blood and bone marrow. His treatment was intense and prolonged, leaving his immune system severely compromised. His mother, Ashley, worked as a pediatric oncology nurse for 14 years before stepping away from her career to become Mason's full-time caregiver.

At one point, a common cold landed Mason in the intensive care unit, a frightening reminder of just how vulnerable he was to routine childhood infections.

When Mason was eventually able to return to school, Ashley faced another challenge. There was no clear way to know whether the other students around him were vaccinated. While Mason was visibly undergoing treatment and bald from chemotherapy, his illness was apparent and others were more mindful of his risk. As his hair grew back, that visible reminder faded, along with some awareness of how vaccination decisions could affect him. Through ongoing conversations and education, Mason has remained safe at school. Ashley continues to speak openly about the importance of vaccination, not just for her son, but for all children whose health depends on the protection of those around them.

During the 2024–2025 school year, kindergarten vaccination coverage declined nationwide, with coverage for key vaccines falling to just over 92%.[27] At the same time, exemptions continued to rise, leaving hundreds of thousands of kindergartners without full vaccination coverage across the country and increasing the risk for immunocompromised children like Mason.

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4.4 State Policies Limiting Access to Vaccines

In recent years, there has been an increase in state legislation framed as "medical freedom" or expanded parental rights.[22,48] These proposals often seek to broaden nonmedical exemptions to school-entry vaccination requirements, limit enforcement of existing requirements, restrict the use or availability of certain vaccine technologies, including mRNA-based vaccines, and reduce the authority of state and local officials to implement vaccination policies.[22,48]

While often framed as individual choice, vaccination policy is about community protection. When vaccination rates decline, children undergoing cancer treatment—who often cannot be fully vaccinated—face greater risk of infectious disease (see Tara's story (page 17) and Mason's story (page 22)). Cancer patients understand this, and strongly support school-entry vaccination requirements and oppose policies that limit access to certain vaccines.

Box 6: Potential Impact of "Medical Freedom" Policies

Medical freedom policies can lower vaccination coverage, weaken community immunity, and increase risk for immunocompromised individuals who cannot be fully vaccinated, including cancer patients and survivors.

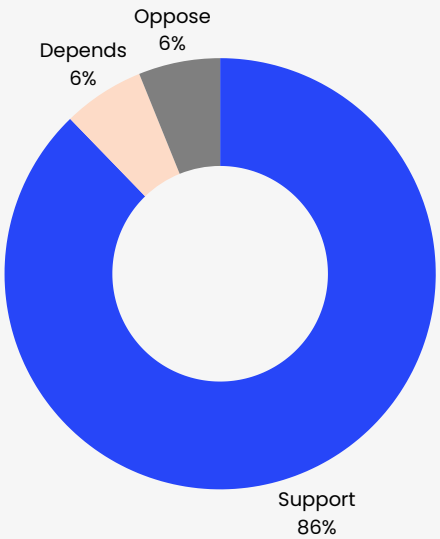
These policies often seek to:

- Expand nonmedical exemptions
- Limit enforcement of school-entry requirements
- Restrict certain vaccine technologies
- Reduce state and local public health authority over vaccines

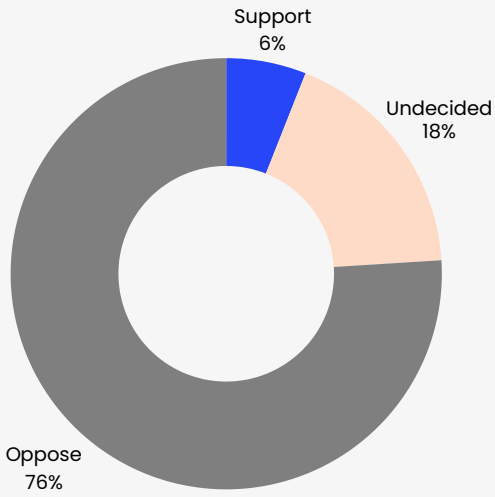
Survivor Views:
Opinions on School Vaccination Requirements and Limiting Vaccine Access Among Cancer Survivors[13]

For cancer patients and survivors, maintaining strong vaccination policies and preserving access to vaccines is critical to protecting themselves and their communities. A strong majority of cancer patients and survivors support school-entry vaccination requirements (86%). Just 6% oppose school entry requirements, while another 6% say their position depends on the vaccine. Cancer patients and survivors also overwhelmingly oppose states limiting access to certain vaccines, with 76% opposed.

Support for School-Entry Requirement



Support for States Eliminating Access to Certain Vaccines



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5. ACS CAN Supports Vaccine Policies that Protect the Cancer Community

5.1 ACS CAN Policy Positions on Vaccines

ACS CAN supports fact-based vaccine policies that **reduce the cancer burden and protect those affected by cancer** through increased access and uptake of vaccines that prevent viruses that lead to cancer, treat cancer by boosting the immune system, and protect cancer patients and their families by maximizing community immunity. These policies include:

- **Evidence-based efforts to achieve the highest possible HPV vaccination rates,** consistent with American Cancer Society HPV Vaccination Guidelines, to prevent cervical and other HPV-related cancers.
- **Coverage without cost sharing for vaccines** recommended by entities that develop guidelines through an evidence-based, scientifically independent process.
- **School vaccination requirements for all children** that are grounded in evidence-based recommendations, limit nonmedical exemptions, include strong enforcement mechanisms, and ensure that exemptions are granted only when medically necessary.
- **Policies that expand the authority of pharmacists to administer vaccines** to both children and adults.
- **Policies that ensure access to vaccines** that are licensed, approved, or authorized by the FDA or are available through an approved FDA investigational new drug application.

ACS CAN opposes policies that limit access to vaccines or weaken public health protections for cancer patients and their families, including policies that:

- **Restrict access to vaccines that could prevent and treat cancer**, including vaccines based on mRNA technology. Several mRNA-based cancer treatment vaccines have shown promise in clinical trials, and limiting these technologies risks putting emerging cancer treatments out of reach for patients.
- Preempt or restrict the **authority of local communities to enact public health and safety laws** that are stronger than state law.
- Limit the **ability of employers and organizations to establish vaccine policies or other safeguards** that protect public health and safeguard individuals with cancer.

Vaccines remain one of the most effective tools for preventing serious illness and protecting medically vulnerable populations, including people in the cancer community such as patients, survivors, and their families. Maintaining strong childhood immunization policies and high vaccination coverage is essential to reducing the spread of vaccine-preventable diseases and protecting these populations.

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