

An Advocate's Guide to Vaccine Access: Understanding Federal, State and Local Levers for Immunization Policy

Introduction

As attacks on vaccine access mount at the federal, state and local levels, health care advocates have an urgent role to play in protecting health in our schools and communities. Ensuring that all children, regardless of ZIP code or background, can easily access the vaccines they need without financial barriers is not only a question of health, but also a question of whether our health care system is affordable and can continue to function.

Vaccines prevent outbreaks and keep hospital beds open for the patients who need them, keep families out of emergency rooms, and hold down costs across the health care system. For example, routine childhood immunization for people born in 2009 is projected to save \$13.5 billion in direct health care costs and \$68.8 billion in total societal costs.¹ At a time when families are struggling with rising health coverage premiums and out-of-pocket costs, few cost containment strategies deliver that kind of impact.

Whether focusing on health care costs, coverage, community health, health access or affordability, health advocates should consider vaccine policy core to their work, not a side issue belonging to public health specialists. Vaccine advocacy spans every level of government. Federal advisory bodies set the recommendations that drive insurance coverage, states set school entry requirements and exemption rules, and localities run the clinics and outreach that turn policy into shots in arms. Advocates who understand how each layer operates are the ones positioned to defend evidence-based immunization policy and to strengthen and expand it.

Sounding the alarm on declining U.S. vaccination rates

In the United States alone, it is estimated that, between 1994 and 2023, vaccines prevented more than 508 million cases of illness, 32 million hospitalizations and 1 million children's deaths.² Yet for the last several years, U.S. vaccination rates have notably and alarmingly declined, threatening to undo one of the greatest achievements in public health history. Kindergarten vaccination rates for measles, mumps and rubella (MMR) and diphtheria, tetanus and pertussis (DTaP) have fallen from about 95% before the COVID-19 pandemic to 92.5% and 92.1%, respectively in 2025.³

The consequences are dire: 39 states report MMR vaccination rates below the 95% threshold needed for community protection,⁴ contributing to the reemergence of measles outbreaks across the country and the highest number of measles infection in the U.S. in 35 years.⁵

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The number of children entering school without their full set of recommended vaccines increased in 36 states and Washington, D.C. between 2024 and 2025, with 17 states now reporting exemption rates exceeding 5% (compared with the national average of 3.3% in 2024).⁶ These declines burden an already strained health care system, deepen existing inequities and leave vulnerable populations exposed to preventable disease. Vaccine myths and falsehoods are fueling distrust, and anti-vaccine activists are working at every level of government to dismantle the protections that keep communities safe.

Defending and expanding vaccine access requires urgent, coordinated action at the federal, state and local levels. While federal vaccine policy often dominates public debate, vaccine access and regulations are primarily determined at the state level — creating a patchwork of immunization requirements, exemption policies and workplace rules that combine to impact public health. The evidence is clear: States that limit exemptions to vaccination requirements to those needed for medical reasons have higher vaccination rates and fewer outbreaks.⁷

Federal vaccine oversight lays the foundation

The federal government plays a limited but foundational role in vaccine policy and access through two key agencies within the U.S. Department of Health and Human Services (HHS): the Food and Drug Administration (FDA), which authorizes vaccines for use, and the Centers for Disease Control and Prevention (CDC), which determines how they are deployed. Together, their decisions cascade through every level of the health care system.

Food and Drug Administration (FDA)

The FDA is the federal agency responsible for authorizing vaccines for use in the United States. The FDA regulates prescription drugs that come to market, with responsibility for reviewing clinical trial data and authorizing new vaccines, drawing on independent scientific review from the Vaccines and Related Biological Products Advisory Committee (VRBPAC).⁸ VRBPAC's recommendations are advisory, not binding, and its meetings are open to the public for comment.⁹

Centers for Disease Control and Prevention (CDC)

Once the FDA approves a vaccine, the CDC determines how it should be used to reduce vaccine-preventable illness.¹⁰ The CDC's Advisory Committee on Immunization Practices (ACIP) reviews the evidence and recommends whether and how a vaccine should be added to the official immunization schedule, which the CDC director then adopts.

ACIP only issues recommendations, not mandates — yet those recommendations are critical to ensure coverage and access because almost all insurers are required to cover vaccines recommended by ACIP/CDC **at no cost sharing** to the consumer.¹¹ Some of these vaccination requirements go back decades, while others are recent victories of health advocates, including the Affordable Care Act and the Inflation Reduction Act:

- **Private/employer-sponsored plans:** Under Public Health Service Act Section 2713 (42 U.S.C. §300gg-13) of the Affordable Care Act (ACA), non-grandfathered private health insurance plans must cover vaccines recommended by ACIP.¹²
- **Medicare:** Medicare Part B covers specific vaccines without cost sharing, including those for pneumococcal disease, hepatitis B, influenza and COVID-19.¹³ Through the Inflation Reduction Act, Medicare Part D is required to cover ACIP-recommended vaccines not covered by Medicare Part B.¹⁴
- **Medicaid:** For adults enrolled in Medicaid, the Inflation Reduction Act requires Medicaid to cover adult vaccinations. For children, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requires all vaccines recommended by ACIP be covered, and any vaccines not recommended by ACIP must be covered if deemed medically necessary.¹⁵
- **Vaccines for Children Program:** Children enrolled in Medicaid, along with children who are uninsured, underinsured or who are American Indian or Alaska Native, receive ACIP-recommended vaccines through the Vaccines for Children Program. The program was established through the Social Security Act and amended by the Omnibus Budget Reconciliation Act.¹⁶

Section 317 Immunization Program

Authorized under the Public Health Service Act, Section 317 is the primary federal funding stream that keeps state and local vaccination infrastructure running — supporting immunization program coordination across all 50 states, the District of Columbia and U.S. territories; vaccine purchasing for uninsured adults; and outbreak surveillance and response.¹⁷

For advocates, Section 317 funding is the line most directly tied to whether state and local health departments have the capacity to maintain vaccination rates and respond to outbreaks, which is why protecting and growing it in annual appropriations is one of the clearest, most concrete asks available at the federal level.

Dismantling Federal Vaccine Programs: The Undermining of ACIP

Since taking the helm at HHS, Secretary Robert F. Kennedy Jr. has taken a series of actions to undermine long-held federal agency processes for vaccine recommendations.

In June 2025, Kennedy dismissed all 17 sitting ACIP members and replaced them with appointees who had publicly promoted anti-vaccine claims. The reconstituted committee made significant changes: removing thimerosal from vaccines, downgrading COVID-19 and MMRV recommendations, and eliminating the recommended universal hepatitis B birth dose — a policy credited with a 99% drop in pediatric hepatitis B infections since 1991. In January 2026, Kennedy directed the CDC to cut the childhood vaccination

schedule from 17 disease preventions to 11, bypassing ACIP entirely.

A lawsuit brought by the American Academy of Pediatrics and other medical and public health groups resulted in these changes being suspended pending further legal action, and as of this printing, ACIP still lacks a quorum to be able to meet to discuss future recommendations.* In August 2026, President Donald Trump issued Executive Order 14407, “Delivering Gold Standard Childhood Vaccine Recommendations for Americans,” bypassing ACIP and issuing new childhood immunization recommendations that, if adopted, would further reduce vaccine access.*

* Source: [Executive Order 14420](#)

Federal advocacy opportunities

Recent executive orders and HHS rulemaking have reshaped vaccine policy in ways that health advocates must actively confront. Advocates have an important role to play in pushing back on misinformation, building a factual record and laying the rationale for future policy reversal.

There are a variety of ways that health advocates can engage in setting and defending sound federal vaccine policy:

Congressional oversight

- Encourage Congress, particularly key committees with jurisdiction over FDA and CDC, to conduct oversight of VRBPAC and ACIP processes — safeguarding independence, ensuring scientific integrity and upholding Federal Advisory Committee Act requirements for transparency and public engagement.¹⁸

- Find ways (including letters, public events and candidate questionnaires) to get Congress members from both parties on the record about these policy changes, which can help constrain the administration.
- Advocate for congressional appropriations committees to increase and protect immunization funding in annual appropriations bills.

Public comments

- Submit written comments before VRBPAC and ACIP advisory committee meetings. Notably, comments submitted during public rulemaking can become part of the evidentiary record that later supports legal challenges.
- Consider attending public advisory committee meetings and sign up to provide oral public comment. These are powerful opportunities to represent patient, clinical and advocacy perspectives.

Coalitions, communications and storytelling

- Partner with local, state and national patient advocacy organizations and medical associations to amplify pro-vaccine evidence and patient stories to FDA and CDC leadership directly, or through earned and digital media to increase education and awareness.
- Mobilize state health departments, community organizations and public health organizations to document the impact of funding levels on local programs and coordinate on opportunities to provide public testimony and written or oral comments for advisory committee meetings.
- Leverage outbreak data, vaccination coverage surveys and case studies to make the case for robust federal funding, including for the Section 317 program, in traditional and social media, and other public communications.

States have broad jurisdiction over vaccine access

While the federal framework is important, states are the primary battleground for vaccine access.¹⁹ Through legislation, regulation and administrative action, states can set vaccination requirements and coverage mandates, determine who is authorized to administer vaccines, and create enforcement mechanisms, making states a critical target for advocacy.

Historically, states have directly referenced ACIP recommendations when determining vaccine access, but in the wake of recent changes to ACIP membership and its decision-making process, states are increasingly turning to recommendations from medical societies and other science-based and well-respected health organizations to guide requirements.²⁰

State legislative authority

State legislatures establish the legal framework governing vaccine access.²¹ Key areas of state legislative authority include:

- **Vaccination requirements and enforcement:** States establish immunization requirements for school-aged children, daycare facilities, colleges and universities, health care workers, and patients/residents of licensed health care facilities, and states determine how these requirements are enforced through exclusion policies, fines and reporting obligations.²²
- **Exemptions:** All states allow for medical exemptions from vaccination requirements, and some states allow for religious and philosophical (nonmedical) exemptions.²³
- **Payer coverage:** While federal laws set the floor for vaccine insurance coverage, states can require coverage beyond those minimums, including for state-regulated plans.²⁴ Notably, states cannot regulate self-insured employer plans, which does often exempt many workers at large employers, although many administrators of such plans do align with state requirements.²⁵
- **Scope of practice:** States determine which health care providers — pharmacists and other nonphysician providers — may administer vaccines, directly shaping how easy or difficult it is for people to get vaccinated close to home.²⁶
- **Vaccine procurement programs:** Some states participate in universal purchase programs, buying vaccines in bulk for all children to lower costs and expand access.²⁷

Rising Rates of Illness With Increase of Nonmedical Vaccine Exemptions

The expansion of nonmedical exemptions has had measurable and serious public health consequences. For example, prior to 2023, Mississippi was one of six states without religious exemptions to vaccination requirements and maintained one of the highest rates of childhood vaccination in the country. In 2023, a judge reversed a 1979 state Supreme Court ruling that found religious exemptions to vaccination requirements unconstitutional.

Mississippi began allowing religious exemptions in the 2023-2024 school year. In the two academic years since the introduction of religious exemptions, Mississippi kindergarten vaccination rates fell from 99% to 97%,²⁸ and whooping cough infections have climbed resulting in the death of the first baby in the state in 13 years.²⁹

Colorado Makes Vaccines More Accessible

In September 2025, Gov. Jared Polis directed Colorado state agencies to ensure statewide access to updated COVID-19 vaccines, prompting the Colorado Department of Public Health and Environment to issue Public Health Order 25-01 along with a companion standing order. Together, these orders allow Coloradans aged 6 months and older to receive updated COVID-19 vaccines at participating pharmacies and providers without an individual prescription. The order also directed the Colorado Department of Public Health and Environment to provide clear guidance to providers, pharmacists and the public on vaccine safety and efficacy; work across state agencies to remove barriers to vaccination; and coordinate with the state Medicaid agency on how federal coverage decisions affect public insurance in Colorado.³⁰

State administrative action

Beyond the legislature, state agencies can take administrative action to expand vaccine access without waiting for legislative approval.

Several states have used administrative authority to proactively expand immunization access, with particular benefit for marginalized and underserved populations. Recent examples include Colorado, Hawaii, Maine, New York, Vermont and Washington, which have used rulemaking, guidance and executive action to expand vaccinator scope, streamline coverage and increase outreach.

- **Standing orders:** Standing orders allow nurses, pharmacists and other nonphysician health care professionals to assess, prescribe and administer vaccinations per a protocol.³¹ States can reduce barriers to access and increase uptake in vaccines by implementing and expanding standing orders for certain vaccines.³²
- **Interstate alliances:** States can form interstate alliances to share resources and strengthen their collective response. These alliances enable states to pool lab testing capacity, increase purchasing power to negotiate vaccine discounts, and coordinate data sharing and surveillance efforts.³³ There are three main voluntary state coalitions coordinating vaccine policy independent of the federal government, formed in a wave starting in September 2025 (Table 1, page 8).

Table 1. Interstate Alliances

Voluntary state alliances	Description
West Coast Health Alliance (WCHA)	This coalition was formed among California, Hawaii, Oregon and Washington to coordinate public health guidelines separate from the CDC, including safeguarding access to vaccines.
Northeast Public Health Collaborative	This collaborative includes Connecticut, Delaware, Maine, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, Vermont and New York City, with interjurisdictional working groups covering public health emergency preparedness and response, vaccine recommendations and purchasing, data collection and analysis, infectious disease, epidemiology, and laboratory capacity.
Governors Public Health Alliance (GPHA)	This coalition includes 14 states plus Guam, representing roughly one-third of the U.S. population. Member states share strategies for preserving vaccine access — including standing orders that counteract federal guidance changes — while also developing policy toolkits and coordinating on bulk vaccine procurement and supply chain resilience.

- **Payor coverage:** States can leverage executive orders to protect and expand vaccine access across multiple domains. For example, in October 2025, Gov. Kathy Hochul extended an executive order in New York that ensured all New Yorkers could receive the COVID-19 vaccine without a prescription regardless of changes made by ACIP.³⁴
- **Source of recommendation:** States can use administrative authority to mandate that agencies align their recommendations with trusted medical societies instead of or in addition to ACIP.³⁵

State advocacy opportunities

As in federal advocacy, state policymaking offers ample opportunities to engage — sharing personal and professional stories, writing formal comment letters, and delivering oral and written testimony to legislators, governors and other state officials.

Legislative

- **Advance pro-access bills.** For example:
 - **Enshrining access protections for vulnerable populations:** Advocate for legislation that ensures access for vulnerable population that reduce barriers to vaccination, like cost. In 2025, Illinois codified vaccine access protections into state law, pairing it with the state-funded Illinois Vaccine Access Program, which lets local health departments directly order and provide certain vaccines at no cost to residents who lack other access.
 - **Expanding scope of practice:** Advocate for legislation that expands pharmacist and other licensed health care professionals' authority to administer all vaccines recommended by ACIP, the American Academy of Pediatrics and other leading agencies.³⁶ Utah recently amended the state's Pharmacy Practice Act to allow pharmacists to provide vaccinations.³⁷
 - **Strengthening data collection:** Advocate for laws requiring all vaccine doses to be recorded in an immunization information system for both children and adults.³⁸ Virginia passed such legislation in recent years, providing a model for other states.³⁹
- **Oppose harmful bills.** For example:
 - **Prioritizing parental rights, medical freedom and mandate bans:** Oppose bills that focus on medical freedom over population health and allow for bans against mandates during a public health emergency. Arizona's governor, Governor Hobbs vetoed the Arizona Medical Freedom Act, a bill designed to prohibit businesses, governments and schools from requiring any "medical intervention," including vaccines.⁴⁰
 - **Expanding exemptions, including for school entry requirements:** Oppose bills that allow for more school entry requirements exemptions. In 2025, Florida proposed allowing for "conscience exemptions" that would allow students to bypass vaccination requirements if they conflicts with the parents' conscience.⁴¹
 - **Reducing access to mRNA vaccines:** Oppose bills that limit access to certain types of vaccines. Most recently, these bills have targeted mRNA vaccines. South Carolina attempted to prohibit health care professionals in South Carolina from administering synthetic mRNA therapies, like the COVID-19 vaccine.⁴²

Administrative

- **Engage with agencies:** Build relationships with state health departments and insurance commissioners to proactively advance pro-access administrative policies.

- **Build coalition:** Bring a broad and diverse set of stakeholders from a spectrum of experiences, including industry and community groups, to weigh in with the agency.
- **Pursue sub regulatory guidance:** Advocate for administrative guidance that decouples state immunization requirements from a static CDC schedule and instead defers to independent medical organizations, such as the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians, ensuring flexibility as federal guidance narrows. **A majority of states have already taken this approach for childhood vaccine recommendations generally, primarily through health department guidance and advisories rather than legislation.⁴³ Advocates seeking to extend this model specifically to school immunization requirements may need a legislative vehicle authorizing state health boards to consider these same medical society recommendations, as several states have already enacted.⁴⁴**

Localities are key to vaccine access

Local governments and institutions serve as the front line of vaccine access and public health infrastructure. While they operate within the frameworks established at the federal and state levels, local actors are the most direct point of contact for patients, families and communities, and they are critical partners for advocacy.

Local health departments

Local health departments are the primary operational arm of vaccine delivery in most communities, often at the city, county or regional level. Their core immunization functions include:⁴⁵

- **Data and surveillance:** Tracking immunization records and managing immunization information systems, monitoring for outbreaks in real time.
- **Outreach and education:** Educating families and providers on vaccine recommendations and exemption implications.
- **Direct service delivery:** Operating vaccination clinics, including school located vaccination events and community-based pop-up clinics, administering Vaccines for Children Program vaccines for eligible children and uninsured adults.
- **Accountability:** Providing site visits and audits to ensure safe storage and handling.

When local health departments are under-resourced or undermined, as in states like Louisiana, which was explicitly directed not to engage in proactive vaccine outreach, the consequences for community vaccination coverage are immediate and measurable.⁴⁶ Since the directive, Louisiana saw the highest whooping cough outbreak in 35 years, resulting in the death of two children.⁴⁷

School boards and school administrators

Schools are among the most powerful leverage points for vaccination coverage because they interact with the vast majority of children and families and serve the following functions:

- Enforcing compliance with state vaccination requirements for enrolled students, including managing exemption documentation.
- Tracking and reporting immunization rates to state health agencies, which provides critical surveillance data on vaccination coverage gaps.
- Maintaining accountability mechanisms for noncompliant students, including exclusion from school during outbreaks and follow-up with families of under-vaccinated students.

Despite their power, school administrators frequently report reluctance to serve as compliance enforcers, and compliance rates vary widely even within the same state. Proactive and supportive approaches, rather than purely punitive enforcement, tend to be more effective and sustainable.

Local advocacy opportunities

Unlike federal and state advocacy efforts, which tend to follow similar protocols, local advocacy tactics vary widely by community — though local health departments and school systems remain consistently important points of engagement.

Health departments

- **Partnerships on education and outreach:** Work with local health departments to co-develop and distribute culturally competent and multilingual vaccine education materials for parents, providers and schools.
- **School-located vaccination clinics:** Partner with local health departments, local pharmacies and community health centers to host vaccination clinics at schools before and after the start of the school year, removing logistical barriers to access.

School boards and administrators

- **Engagement with school boards:** Present data on local vaccination coverage and exemption rates to school boards and urge them to maintain or strengthen compliance and accountability mechanisms.
- **Proactive equity-centered approaches:** Advocate for school policies that emphasize access, such as on-site vaccination clinics, mobile vaccination units visiting schools and coordination with health departments, rather than relying solely on exclusion as an enforcement tool.

- **Data and tracking:** Encourage school districts to actively use immunization information system data to identify pockets of under-vaccination and proactively target outreach and resources.
- **Community campaigns:** Work with school districts and local health departments to conduct annual vaccination drives, leveraging back-to-school periods as key moments for targeted engagement.
- **State funding for school-based programs:** Advocate for state allocation of funds specifically for school-based immunization support, including staffing and clinic infrastructure.

Conclusion

Vaccine policy is the patchwork product of hundreds of choices made across federal agencies, state legislatures, local health departments and school boards. When the FDA authorizes a vaccine, when ACIP recommendations shape insurance coverage, when a state expands or restricts who can administer a shot, when a school district decides whether to run a pop-up clinic — each of these moments is an opportunity to protect and expand access, or a risk that quietly erodes access.

For advocates focused on health access and health care costs, vaccines are one of the clearest returns on investment to help lower health care spending. Routine childhood immunization for a single birth year is projected to save tens of billions of dollars in direct health care costs alone, and tens of billions more in broader societal costs, such as savings from fewer emergency room visits, fewer hospitalizations and lower premiums for everyone. Every time a state broadens exemption policy, restricts who can administer a vaccine or lets local health department capacity erode, it risks our broader public health. But that decision is also a cost driver, shifting expenses onto an already overburdened system, and ultimately to families who are already struggling with rising premiums and out-of-pocket costs.

The advocates who understand how each of these levers work are the ones best positioned to defend the progress already made — and to build a stronger, more affordable, more equitable health care system for the future.

Endnotes

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