No. 26-1503

United States Court of Appeals
For the First Circuit

AMERICAN ACADEMY OF PEDIATRICS, et al.

Plaintiffs-Appellees,

v.

ROBERT F. KENNEDY, JR., et al.

Defendants-Appellants.

On Appeal from the United States District Court for the District of Massachusetts, Boston, Case No. 1:25-cv-11916-BEM

BRIEF OF AMICUS CURIAE GOVERNORS PUBLIC HEALTH ALLIANCE IN SUPPORT OF PLAINTIFFS-APPELLEES

William B. Schultz
ZUCKERMAN SPAEDER LLP
2100 L Street NW, Suite 400
Washington, DC 20037
(202) 778-1800
wschultz@zuckerman.com

Aaron S.J. Zelinsky
(BAR NO. 1218584)
ZUCKERMAN SPAEDER LLP
100 East Pratt Street, Suite 2440
Baltimore, MD 21202
(410) 949-1167
azelinsky@zuckerman.com

Amicus Curiae counsel continued on inside front cover

Julia Spiegel
Emily F. Kirby
Charanya Krishnaswami
Inbar Pe'er*
GOVERNORS ACTION ALLIANCE
2300 N. ST., NW, SUITE 501A
WASHINGTON, D.C. 20037

**Bar admission pending*

Counsel for Amicus Curiae Governors Public Health Alliance

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INTEREST OF AMICUS[1]

Amicus curiae Governors Public Health Alliance (PHA) is a nonpartisan coalition of fifteen governors who collectively represent approximately one third of the American population and who are committed to protecting and advancing the health and wellbeing of people in their respective jurisdictions. PHA member governors include:

- California Governor Gavin Newsom
- Colorado Governor Jared Polis
- Connecticut Governor Ned Lamont
- Delaware Governor Matt Meyer
- Guam Governor Lou Leon Guerrero
- Hawai‘i Governor Josh Green
- Illinois Governor JB Pritzker
- Maryland Governor Wes Moore
- Massachusetts Governor Maura Healey
- New Jersey Governor Mikie Sherrill
- New York Governor Kathy Hochul
- North Carolina Governor Josh Stein
- Oregon Governor Tina Kotek
- Rhode Island Governor Daniel McKee
- Washington Governor Bob Ferguson

[1] Counsel for both parties have consented to the filing of this brief. No party’s counsel authored this brief in whole or in part; no party or party’s counsel contributed money intended to fund the brief’s preparation or submission; and no person other than amicus contributed money intended to fund the brief’s preparation or submission.

Governors formed PHA in October 2025 to work together to protect and strengthen public health in the wake of significant federal changes. As chief executives, PHA's member governors play a central role in ensuring the public health of their states' residents and have direct experience coordinating cross-border outbreak responses, deploying public health emergency powers, and directing their public health agencies. PHA members are on the front lines of responding to the consequences of vaccine misinformation within their states and have witnessed how the erosion of a credible, uniform national immunization standard drives public confusion, fuels vaccine hesitancy, and requires states to unnecessarily expend resources.

These governors and the state public health agencies they lead have historically relied on the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP)'s evidence-based, independent recommendations in a variety of contexts, including in establishing school immunization schedules, framing state vaccine mandates, and structuring public health programs. When ACIP fails to provide state leaders, and the American people, with evidence-based, expert-vetted recommendations, it no longer functions as intended. Residents of these governors' states ultimately bear the consequences of this failure, and state governments must take unexpected and often ad hoc measures in an effort to fill the resulting gap.

Amicus files this brief to inform the Court of the negative multi-state public health impacts of Defendants' actions and to represent the public health interests of one third of the American people, who have, until now, relied on a properly constituted, expert-led ACIP that makes evidence-based recommendations.

SUMMARY OF ARGUMENT

For more than sixty years, the Nation's public health infrastructure has relied on ACIP to supply expert, evidence-based recommendations that guide state health departments, schools, universities, employers, insurers, and providers. States across the country have embedded ACIP's recommendations into their public health frameworks, often through explicit state legislation and regulation. Until June 2025, forty-nine States, three territories, and the District of Columbia incorporated ACIP recommendations by reference though over 600 statutes and regulations, looking to ACIP as the source of evidence-based, nationally recognized standards of care.

States can no longer depend on ACIP as an evidence-based, independent committee nor rely upon its guidance. In June 2025, Secretary Kennedy dismissed all seventeen voting members of ACIP and reconstituted the committee with fifteen new members, "only six of whom appear to have any meaningful experience in vaccines." *Am. Acad. of Pediatrics v. Kennedy*, 823 F.Supp.3d 141, 166 (D. Mass. 2026). The reconstituted ACIP departed from longstanding practice by not grounding its recommendations in the GRADE (Grading of Recommendations

Assessment, Development and Evaluation) and Evidence-to-Recommendations frameworks that had long governed its process. These departures in membership and procedure transformed what had been a credible, science-based process into an unreliable and politicized system, contrary to ACIP's statutory mandate and mission.

Since ACIP's reconstitution, the new committee has issued a series of decisions that depart sharply from decades of settled, evidence-based practice. In September 2025, ACIP recommended against using the combination measles-mumps-rubella-varicella ("MMRV") vaccine for children under four. At the same meeting, ACIP also abandoned the universal recommendation for the COVID-19 vaccination. On December 5, 2025, over the objection of the American Academy of Pediatrics ("AAP") and other professional medical organizations, ACIP voted to rescind the universal hepatitis B birth-dose recommendation. Experts largely credit this standard of care, in place since 1991, with reducing pediatric hepatitis B infections by roughly 99%. *See* Danae Bixler et al., *Progress and Unfinished Business: Hepatitis B in the United States, 1980–2019*, Public Health Reports 1 (2023), https://doi.org/10.1177/00333549231175548. Furthermore, ACIP voted for these changes without the rigorous review of scientific evidence that long governed its recommendations process and against the scientific consensus.

When ACIP compromises national standards by making recommendations not based in scientific evidence, communities across the country suffer. Vaccine

rates drop, reducing herd immunity and making state responses to public health emergencies less effective. Without a properly constituted, expert-led ACIP that makes evidence-based recommendations, states are expending scarce resources to create their own substitutes, forming new regional cooperative bodies, and relying on prior ACIP schedules.

While states are capable of building their own expert advisory councils, doing so is a costly redundancy. Moreover, when states individually determine and adopt potentially incongruent standards, disease—which does not respect borders—becomes more difficult to manage. There is no equivalent substitute for the national-level standard of care guidance that a legitimately constituted, evidence-based ACIP provides.

I. An Unreliable ACIP Impairs State Governors' Ability to Respond Cohesively to Cross-Border Disease Threats.

Effective vaccination campaigns require coordination across state borders. *See* Bianca L. Malcolm, *The Spread Process of Epidemic Influenza in the Continental United States, 1968–2008*, 8 Spatial & Spatiotemporal Epidemiology 35 (2014), https://doi.org/10.1016/j.sste.2014.01.001 (finding that "geographically-close states (<500 miles) showed higher correlations in the start, peak, and end of annual epidemics compared with geographically-distant states"). Credible evidence-based immunization policy is critical to the coordination and efficacy of any multistate response to cross-border disease threats. If some states administer

vaccines that others do not, the ability to achieve herd immunity (when enough people in an area have immunity to a disease so that it no longer spreads easily) is significantly compromised. Consequently, if one state provides vaccines while its neighbor does not, the vaccinating state remains exposed to infection because of its unvaccinated or under-vaccinated neighbors, and the efficacy of the vaccinating states' public health investments are weakened.

For these reasons, states have long relied on ACIP as a central expert authority to recommend uniform standards. As of June 2025, nearly 600 statutes and regulations across forty-nine States, three territories, and the District of Columbia incorporated ACIP recommendations by reference. *See* Ass'n of State & Territorial Health Offs., *Impact of the Advisory Committee on Immunization Practices Recommendations on State Law* (June 23, 2025), https://www.astho.org/topic/resource/impact-of-acip-recommendations-on-state-law. This incorporation was by design, to ensure that states could effectively coordinate their actions and take common steps to combat the shared threat of disease.

When ACIP is not led by experts and does not make evidence-based recommendations, it undermines national uniformity regarding immunization policy. The resulting array of emergency state-level measures has sought to minimize the damage created by Defendants' actions. But emergency measures,

however diligent, do not equal a single, cohesive response. Fragmented, state-by-state measures adopted out of necessity cannot reproduce the compounding benefits that arise when the entire country operates under a consistent, national standard. *See, e.g.*, Mandy K. Cohen et al., *The Essential Role of States in Protecting Immunization Access*, 394 N. Engl. J. Med. 420 (2026), https://doi.org/10.1056/NEJMp2517029 ("Recent federal policy shifts threaten to destabilize an interconnected system of vaccine access, weaken clinical guidance, and undermine public confidence"). As one expert notes, "[w]hen different regions of the country operate under different recommendations, when the message to parents varies by zip code, confusion multiplies and confidence erodes." Jake Scott, *Quiet Dismantling: How "Shared Decision-Making" Weakens Vaccine Policy and Harms Kids*, CIDRAP (Jan. 6, 2026), https://www.cidrap.umn.edu/childhood-vaccines/cidrap-op-ed-quiet-dismantling-how-shared-decision-making-weakens-vaccine-policy.

The result is a coordination problem that states cannot easily solve on their own. So long as ACIP fails to supply a single national standard for immunization policy based on public health considerations, it increases states' exposure to the cross-border spread of preventable disease.

II. An Unreliable ACIP Undermines the Effectiveness of States' Public Health Infrastructure.

Recognizing the need for consistent standards, state legislatures have long enacted laws that expressly incorporate ACIP guidance and recommendations into

state statutory provisions. Governors, through their health agencies, have for decades built regulatory schemes expressly referencing and incorporating ACIP's schedules, including in school immunization schedules, Medicaid coverage mandates, and public health emergency protocols.[2] Undermining ACIP undermines these statutory regimes.

For example, Connecticut, until 2026, defined its then-standard of care for immunization by direct reference to the ACIP schedule and also built its school-and-child-care-entry requirements based on that schedule. *See* Conn. Gen. Stat § 19a-7f(a) ("the standard of care for immunization shall [] be based on a consideration of the recommended schedules" published by ACIP and others); Conn. Gen. Stat. §§ 10-204a(a), (e) (school enrollment); 19a-79 (child care centers). Meanwhile, Delaware required health insurance carriers to fully cover "immunizations for routine use" without any "costs, such as a copayment, coinsurance or deductible,"

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[2] *See* Ass'n of State & Territorial Health Offs., *supra* at 6 (school and healthcare worker immunization schedules); Vanessa C. Forsburg et al., Cong. Rsch. Serv., R48982, *The 2026 Childhood Immunization Schedule* (2026), https://www.congress.gov/crs-product/R48982 (vaccination administration); Jennifer Kates, *ACIP, CDC, and Insurance Coverage of Vaccines in the United States*, KFF (June 13, 2025), https://www.kff.org/other-health/acip-cdc-and-insurance-coverage-of-vaccines-in-the-united-states/ (Medicaid coverage mandates); Kavya Sekar, Cong. Rsch. Serv., IF12317, *The Advisory Committee on Immunization Practices (ACIP)* (updated Dec. 3, 2024), https://www.congress.gov/crs_external_products/IF/PDF/IF12317/IF12317.2.pdf (public health emergency protocols).

so long as the ACIP recommended the vaccine. *See* Del. Code Ann. tit. 18, § 3363 (2025). And Maryland required that vaccinations be "order[ed] and administer[ed] in accordance with" ACIP's schedule and tied pharmacist training requirements to ACIP as well. Md. Code Ann., Health Occ. § 12-508; Md. Code. Regs. 10.34.32.03 (Nov. 20, 2025).

For these states and many others, ACIP had long served as a professional, evidence-based, and independent resource on which they could set state policy and protect their populations from disease through vaccinations. State agencies and legislatures wove ACIP recommendations into their public health infrastructure precisely because those recommendations carried scientific authority and reflected a national standard of care. Once ACIP stopped supplying expert, evidence-based recommendations, state statutes and regulations referencing ACIP also no longer reflected scientific expert consensus, undermining state public health infrastructure.

III. An Unreliable ACIP Costs States Scarce Public Health Resources to Preserve Vaccine Access.

In the absence of an expert-led ACIP that makes evidence-based recommendations, governors have been compelled to develop interim solutions to address eroded vaccine infrastructure. This has taken the form of (A) building new public health bodies in part to coordinate on vaccination policy and access; (B) issuing emergency guidance relying on prior ACIP schedules and professional society recommendations; (C) enacting legislation to delink state public health

infrastructure from ACIP guidance; and (D) expending resources to combat vaccine misinformation that Defendants' actions have fueled. Each of these responses has forced governors to divert scarce public health resources that would otherwise have been spent combatting disease and advancing public health.

A. Governors Have Built New Multistate Public Health Coordinating Bodies Which Must Devote Scarce Resources to Addressing Gaps in Federal Vaccination Policy.

Governors have formed new multistate public health bodies to address a multitude of public health issues, including gaps in federal public health leadership. In the absence of an expert-led ACIP providing evidence-based recommendations, these coordinating bodies have had to expend scarce resources to coordinate vaccination policy across states.

Fifteen governors launched *amicus* Governors' Public Health Alliance (PHA) in October 2025 to support national, gubernatorial-level coordination on a number of public health issues, including healthcare access and disease prevention. PHA's formation followed the earlier creation of regional bodies, including the West Coast Health Alliance (comprised of PHA member states California, Hawai‘i, Oregon, and Washington) and the Northeast Public Health Collaborative (which includes PHA member states Connecticut, Maryland, Massachusetts, New Jersey, New York, and Rhode Island, as well as the city of New York).

However, rather than using their limited resources to collaborate on advancements in public health and combat disease, these bodies have had to expend resources to approximate the uniform vaccine guidance that an expert ACIP once provided states at no cost. For example, both the West Coast Health Alliance and the Northeast Public Health Collaborative have developed and published consensus recommendations and statements on immunization.[3] As a result, capacity these alliances could have devoted to any number of pressing public health problems was instead expended on setting evidence-based, expert-driven vaccination policy, a task for which states have historically relied on ACIP.

B. Governors Have Issued Emergency Provider Guidance to Fill the Gap Left by ACIP's Non-Evidence-Based Recommendations.

States' emergency responses to specific ACIP reversals illustrate the massive disruption these multistate coordinating bodies have been required to address. For example, in September 2025, when the reconstituted ACIP departed from

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[3] *See* West Coast Health Alliance, *Consensus WCHA 2025–2026 Respiratory Virus Season Immunization Recommendations* (Sept. 2025), https://governor.wa.gov/sites/default/files/2025-09/FILE_5257.pdf; NYC Health, *Several Northeastern States and America's Largest City Announce the Northeast Public Health Collaborative* (Sept. 2025), https://www.nyc.gov/site/doh/about/press/pr2025/announce-northeast-public-health-collaborative.page; Northeast Public Health Collaborative, *Recommendations for the 2025-2026 Covid-19 Vaccine* (Sept. 15, 2025), https://www.mass.gov/doc/northeast-public-health-collaborative-recommendations-for-the-2025-2026-covid-19-vaccine/download.

established consensus to recommend against the combination MMRV vaccine (which protects children from measles, mumps, rubella, and chickenpox) for young children, and in December 2025, when it voted to rescind the universal hepatitis B birth-dose recommendation, states had to expend resources issuing their own evidence-based guidance. The Massachusetts Department of Public Health, for example, published MMRV and hepatitis B guidance, directing providers to follow the AAP immunization schedule rather than the reconstituted ACIP's. *See* MA Dept. Pub. Health, *Guidance on Use of the Measles, Mumps, Rubella, Varicella (MMRV) Vaccine in Children Under the Age of Four Years* (Oct. 2025), https://www.mass.gov/doc/measles-mumps-rubella-varicella-mmrv-guidance/download; MA Dept. Pub. Health, *Hepatitis B Vaccine Guidance for Families of Infants and Young Children* (Dec. 2025), https://www.mass.gov/doc/hepatitis-b-vaccine-family-guidance-december-2025/download. New Jersey issued an Executive Directive recommending providers to continue giving every newborn a hepatitis B birth dose within 24 hours of delivery. NJ Dept. Pub. Health, *Acting Health Commissioner Brown Issues Executive Directive Protecting Birth Dose of Hepatitis B Vaccine in New Jersey* (Dec. 5, 2025), https://www.nj.gov/health/news/2025/approved/20251205a.shtml. Rhode Island issued advisories to healthcare professionals and birthing hospitals to the same effect pertaining to hepatitis B and Maryland issued a provider advisory

directing continued administration of the hepatitis B birth dose per the previous standard of care.[4]

These emergency directives provided clarity for providers and ensured continuing vaccine access for families, but required each state to separately issue evidence-based guidance that ACIP once furnished at the national level. An ACIP composed of experts relying on scientific evidence would have eliminated that redundancy and maintained uniformity across the country.

C. Governors Have Worked with State Legislatures and Agencies to Delink Their State Public Health Infrastructure From ACIP.

Beyond these emergency measures, state agencies, governors, and legislatures have worked together to enact legislation delinking their state public health infrastructure from ACIP. *See* KFF, *Reliance on Sources Other Than CDC/ACIP for State Childhood Vaccine Recommendations* (last updated May 4, 2026), https://www.kff.org/other-health/state-indicator/reliance-on-sources-other-than-cdc-acip-for-state-childhood-vaccine-recommendations (noting 29 states and the

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[4] RI Dept. Health, *Rhode Island Response to Hepatitis B Vaccination Vote* (Dec. 11, 2025), https://www.ri.gov/press/view/50177; MD Dept. Health, *Statement from Secretary Seshamani on importance of hepatitis B birth dose for all newborns* (Dec. 5, 2025), https://health.maryland.gov/newsroom/Pages/Statement%20from%20Secretary%20Seshamani%20on%20importance%20of%20hepatitis%20B%20birth%20dose%20for%20all%20newborns.aspx.

District of Columbia rely on sources other than ACIP for state childhood vaccine recommendations). Every PHA member has moved to sever their immunization frameworks from ACIP, whether by statute or executive action.

Many PHA-member states now vest a state official or agency with authority to set immunization standards based on professional medical-society recommendations rather than ACIP. Connecticut, Maryland, and Massachusetts each empowered their public health commissioner to set immunization standards for children and adults on that basis, and to require insurance coverage of the commissioner-recommended vaccines. *See* sH.B. 5044, 2026 Gen. Assemb., Feb. Sess. (Conn. 2026) (enacted as 2026 Conn. Pub. Acts 26-3); S.B. 385, Gen. Assemb., Reg. Sess. (Md. 2026) (enacted as 2026 Md. Laws ch. 8); H. 4761, 194th Gen. Ct. (Mass. 2025–2026) (enacted as 2025 Mass. Acts ch. 73). New Jersey did the same in substance, making its Department of Health the state's primary source for immunization recommendations across insurance coverage, Medicaid, public employee health plans, and other vaccine-related statutes, while requiring the Department to consider federal and major medical society guidance. *See* S. 4894, 221st Leg., Reg. Sess. (N.J. 2024–2025) (enacted as 2026 N.J. Laws ch. 283). Washington likewise delinked its immunization-coverage statute from ACIP and directed its Department of Health to set recommendations in consultation with professional medical organizations, local health organizations, and the West Coast

Health Alliance, while preserving cost-free access to preventive services for residents enrolled in commercial health plans. *See* H.B. 2242, 69th Leg., Reg. Sess. (Wash. 2026) (enacted as 2026 Wash. Laws ch. 13).

Others acted through executive orders. In Illinois, Governor Pritzker issued an executive order, which created a new statewide vaccine access initiative led by the Illinois Department of Public Health. The executive order directed the Department to issue standing orders preserving provider access to COVID-19, flu, RSV, MMR, Hepatitis B, and routine child and adult vaccines and to develop contingency plans to protect the Vaccines for Children program if federal disruptions threaten vaccine supply. It also required state-regulated health insurers to cover Department-recommended vaccines without cost-sharing even where those recommendations depart from ACIP. *See* Ill. Exec. Order No. 2025-04, *Enhancing Access to Life-Saving Vaccines* (Sept. 12, 2025), https://www.illinois.gov/government/executive-orders/executive-order.executive-order-2025-04.2025.html.

Some states, such as New York, required more than one kind of delinking effort in a single legislative package. Through companion bills, New York severed its coverage and school-immunization requirement from ACIP and resolved a scope-of-practice problem that ACIP's deterioration had created. *See* A. 10710, 2025–2026 Leg., Reg. Sess. (N.Y. 2026) (keying vaccine-coverage and school-immunization

requirements to the recommendations of the Commissioner of Health); A. 10711, 2025–2026 Leg., Reg. Sess. (N.Y. 2026) (delinking private insurance-coverage requirements from ACIP). New York's Education Law authorized physicians, nurse practitioners, and pharmacists to prescribe, order, or administer only those vaccines ACIP recommends, so when ACIP abandoned the scientific consensus, that link threatened to strip providers of authority to administer vaccines that remained the standard of care. Correcting it required the state to navigate the legal and political sensitivities that attend any scope-of-practice expansion in New York, and the legislation ultimately permitted pharmacists to administer the COVID-19 vaccine to children ages two to eighteen. Kathy Hochul, Governor, N.Y., *Governor Hochul Signs Two Bills Protecting Vaccine Access for New Yorkers* (May 15, 2026), https://www.governor.ny.gov/news/governor-hochul-signs-two-bills-protecting-vaccine-access-new-yorkers.

Through these varied mechanisms, each of these states spent precious resources—including legislative, gubernatorial, and agency staff time, as well as public health dollars—to ensure continued access to vaccines that should never have been jeopardized. Those are resources that could otherwise have gone to disease surveillance, outbreak response, and advancing public health.

D. Governors Have Expended Resources to Combat Vaccine Misinformation Fueled by Defendants' Actions.

The loss of a trusted federal voice has required the Public Health Alliance's member governors to expend resources on communications and data infrastructure to combat misinformation caused by the Defendants' actions and rebuild trust among residents.

For example, California launched the Public Health Network Innovation Exchange to modernize public health data systems and restore public confidence in science-based guidance. Gavin Newsom, Governor, Cal., *Governor Newsom Announces Top Former CDC Officials to Lead Public Health Innovation, Collaboration* (Dec. 15, 2025), https://www.gov.ca.gov/2025/12/15/governor-newsom-announces-top-former-cdc-officials-to-lead-public-health-innovation-collaboration/. As a part of this initiative, California launched "Project Stethoscope," a communications campaign dedicated to identifying and responding to community-level vaccine questions and misinformation through social-media monitoring and targeted outreach. Massachusetts similarly convened public health leaders to discuss how to counter vaccine misinformation fed by the Defendants' actions. *See* Maura Healey, Governor, Mass., *Ahead of ACIP Meeting, Governor Healey and Public Health Leaders Commit to Protecting Access to Safe, Effective and Life-Saving Childhood Vaccines* (Dec. 4, 2025), https://www.mass.gov/news/ahead-of-

acip-meeting-governor-healey-and-public-health-leaders-commit-to-protecting-access-to-safe-effective-and-life-saving-childhood-vaccines.

These communications and data-collection efforts require funding, staff, and agency attention that states would not have expended had Defendants not radically altered vaccination guidance in defiance of scientific consensus. These actions have fueled public misinformation and doubt, which PHA governors must now expend resources to correct.

CONCLUSION

Uniform, science-based federal vaccination guidance is critical to state public health efforts both within and across states. The federal government's reconstitution of ACIP and departure from evidence-based vaccination policy have significantly increased costs to states and risks to their residents, as well as compromised cross-border public health. No coalition of States, however well-resourced, can reproduce the single national standard of care as protective of public health as ACIP once provided. For these reasons, amicus Governors Public Health Alliance urges this Court to uphold the district court's order.

July 23, 2026

Respectfully submitted,

/s/ Aaron S.J. Zelinsky

William B. Schultz
(Bar No. 1154477)
ZUCKERMAN SPAEDER LLP
2100 L Street NW, Suite 400
Washington, DC 20037
(202) 778-1800
wschultz@zuckerman.com

Aaron S.J. Zelinsky
(Bar No. 1218584)
ZUCKERMAN SPAEDER LLP
100 East Pratt Street, Suite 2440
Baltimore, MD 21202
(410) 949-1167
azelinsky@zuckerman.com

Julia Spiegel
Emily F. Kirby
Charanya Krishnaswami
Inbar Pe'er*
GOVERNORS ACTION ALLIANCE
2300 N. St., NW, Suite 501A
Washington, D.C. 20037

* *Bar admission pending*

Counsel for Amicus Curiae

CERTIFICATE OF COMPLIANCE

1. Pursuant to First Circuit Local Appellate Rule (L.A.R.) 28.3(d), I hereby certify that I, Aaron S.J. Zelinsky, counsel for Amici Curiae, am a member in good standing of the bar of the United States Court of Appeals for the First Circuit.

2. This brief complies with the type-volume requirements of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 3,466 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

3. The brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) and L.A.R. 32.1(c) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman 14-point font.

4. Pursuant to L.A.R. 31.1(c), I hereby certify that the text of the electronic brief is identical to the text in the paper copies, and that it has been scanned for viruses using Aurora Protect Endpoint Defense (f/k/a Cylance) version 3.4.1000.80, and no virus was detected.

July 23, 2026

/s/ Aaron S.J. Zelinsky
Aaron S.J. Zelinsky
Counsel for Amicus Curiae

CERTIFICATE OF SERVICE

I hereby certify that on July 23, 2026, I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the First Circuit by using the CM/ECF system, thereby serving all registered counsel of record.

/s/ Aaron S.J. Zelinsky
Aaron S.J. Zelinsky
Counsel for Amicus Curiae