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November 2, 2026

The Bureau of the Census

Submitted to: https://www.regulations.gov/commenton/USBC-2026-0628-0001

RE: Docket USBC-2026-0628; Federal Register Number 2026-18481; Proposed Rule: Decennial Census of the Population of Americans; Proposed Residence Criteria and Proposed Regulations for Demographic Questions

To Whom It May Concern,

The American Association for Cancer Research (AACR) is the world's first and largest professional organization dedicated to advancing cancer research and its mission to prevent and cure all cancers. Representing more than 65,000 members, AACR serves as a leading voice for cancer science and evidence-based public policy. Its membership includes laboratory, translational, and clinical researchers, population scientists, other health care professionals, and patient advocates working in many different capacities across the entire cancer continuum in the United States and in 143 countries and territories around the world. AACR works to strengthen the nation's medical research enterprise through advocating for robust and sustained investments in cancer research and medical science and promoting policies that accelerate scientific discovery and improve patient outcomes. AACR champions federal policies that foster innovation, support the cancer research workforce, reduce barriers to scientific progress, and ensure that lifesaving advances reach all patients.

AACR appreciates the opportunity to comment on the Census Bureau's proposed rule, "Decennial Census of the Population of Americans; Proposed Residence Criteria and Proposed Regulations for Demographic Questions." AACR strongly opposes the prohibition on questions about race, ethnicity, and sexual orientation in the decennial census under proposed 15 CFR § 70.2(a). AACR is especially concerned about the potential implications of such restrictions on the collection of demographic data for public health surveillance. In addition, when properly collected, race, ethnicity, and sexual orientation are essential variables for public health research dedicated to understanding how social, environmental, economic, and health care conditions affect disease burden and outcomes across populations. Reliable, representative population data are essential to cancer research efforts, enabling researchers and public health agencies to measure cancer incidence and mortality, identify populations experiencing disproportionate burdens, evaluate interventions, and guide effective use of health care resources.

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AACR urges the Census Bureau to withdraw the proposed prohibition on collecting race, ethnicity, and sexual orientation information through the decennial census short-form questionnaire. The Census Bureau should preserve high-quality, consistent demographic data collection and ensure that confidentiality protections are balanced with the public interest in reliable population statistics.

I. Census Demographic Data is Essential for Public Health Statistics and Research

The Census Bureau's proposed rule emphasizes that the "fundamental purpose" of the decennial census is for counting the population for congressional apportionment and redistricting. However, the proposed rule recognizes that the decennial census "historically have also been used as a vehicle for collecting demographic information about the population of the United States." In fact, the decennial census has collected race and ethnicity data in some form in every census since 1790 and provides a foundational benchmark for the nation's statistical infrastructure. Demographic data collected via the census support population estimates, public health surveillance, epidemiologic research, resource planning, and assessments of health outcomes across geographic areas and demographic groups. The Census Bureau's own Population Estimates Program utilizes decennial census data to provide demographic analysis, including by race, for national, state, and county levels of geography.[1] The Centers for Disease Control and Prevention (CDC) relies on Census Bureau population estimates to calculate U.S. cancer incidence and death rates, including those specific to race, ethnicity, age, and sex groups.[2] Likewise, the National Cancer Institute (NCI) similarly maintains population estimates using Census Bureau data stratified by age, sex, race, and ethnicity through collaboration with the Census Bureau and CDC's National Center for Health Statistics for calculating cancer incidence and mortality rates at the county and census-tract levels.[3]

Overall, numerous statistical frameworks for evaluating U.S. disease incidence, mortality, and morbidity rates depend on accurate census data. Many official, congressionally mandated annual reports of U.S. trends in health statistics such as Health, United States or federal initiatives such as Healthy People 2030 use census population data to report disease incidence and mortality rates for both the total U.S. population and by race and ethnicity, socioeconomic status, or other demographic factors.[4] For cancer statistics, NCI's Surveillance, Epidemiology, and End Results (SEER) program's specialized census-tract database supports calculation of cancer incidence rates by race, ethnicity, sex, age, and geography or other socioeconomic characteristics.[5] Population-based cancer surveillance depends on consistent methods that permit comparisons across time, demographics, and geographic areas and relies on population denominators aligned with Census Bureau population estimates. If the method used to establish race-, ethnicity-, or sexual orientation-specific population

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estimates is altered, it will be incredibly difficult to determine whether future observed changes in cancer incidence or mortality reflect genuine changes in disease burden or changes caused by differing population measurement, classification, or estimation methods.

Comprehensive, accurate data on population composition and understanding trends in cancer incidence and mortality across different demographic groups is also essential in projecting cancer burden and addressing economic implications. Although advances in screening, targeted therapies, and treatment are improving outcomes for some cancers, studies utilizing census data project that the overall cancer burden will continue to grow in the coming decades, largely driven by population aging and demographic shifts, with significant implications for health care capacity, public spending, and long-term economic stability.[6] Reliable projections help policymakers estimate future demand for prevention, screening, treatment, and survivorship services, anticipate health care workforce and infrastructure needs, and evaluate how the burden and cost of cancer may vary among communities. Furthermore, policymakers depend on an accurate understanding of how the population is distributed by race, ethnicity, and other demographic variables to assess the economic consequences of health disparities and inform effective policies to address them. It is estimated that racial and ethnic health inequities imposed an economic burden of approximately $421 billion to $451 billion, equivalent to ~2% of U.S. gross domestic product in 2018, through premature deaths, lost labor productivity, and excess medical care costs.[7] Therefore, the long-term economic strength of the United States depends on census data that includes race, ethnicity, and sexual orientation to anticipate demographic shifts, address economic outcomes, and inform federal policy and budget planning.

In addition, demographic data collected via the decennial census is widely used by cancer researchers for nationwide analyses. High impact, influential research regarding cancer statistics and projections is supported by Census Bureau data.[8,9] Race, ethnicity, and sexual orientation data allow researchers to identify patterns in cancer burden that may be obscured by national or statewide averages. They inform analyses of differences across demographic groups and are necessary to answer fundamental scientific questions such as whether incidence and mortality rates are changing over time or whether certain groups are experiencing higher cancer burden. For example, SEER reports that the age-adjusted U.S. female breast cancer death rate for 2020–2024 was 25.9 deaths per 100,000 among non-Hispanic Black women, compared with 19.1 among non-Hispanic White women.[10] Consistent demographic data that includes race and ethnicity are essential to identify such disparities and inform research directions.

Eliminating race, ethnicity, and sexual orientation questions from the decennial census would therefore remove a core source of population data used by federal agencies and

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to conduct numerous critical analyses. Even if researchers can obtain information from other sources, the loss of such central and trusted data would raise serious questions about the accuracy, comparability, and validation of subsequent population estimates by demographic group.

II. Census Demographic Data Supports the Identification and Reduction of Cancer Health Disparities

Cancer disparities are differences in cancer incidence, mortality, stage at diagnosis, access to screening and treatment, survivorship, and other outcomes among population groups.[11] Understanding these differences is essential to improving cancer prevention and care for the benefit of all Americans. When demographic data are combined with information about socioeconomic conditions, environmental exposures, insurance coverage, and access to health care, researchers can investigate the multiple factors contributing to disparities and identify opportunities for intervention.

Demographic categories in public health data such as race and ethnicity help researchers examine the consequences of differences in lived experiences, social conditions, and access to resources. Race and ethnicity are complex constructs, and race is particularly important for understanding the effects of social and political conditions on health as well as how differences in access to health services, educational opportunities, housing, and other conditions can contribute to disparities in morbidity and mortality.[12] Consistent measurement of such demographic data across populations and over time is necessary to produce meaningful comparisons and identify population-specific health needs. In addition, numerous studies have demonstrated the capacity of race, ethnicity, and sexual orientation demographic data from the census or census-based SEER registry in producing trends and analyses of cancer health disparities that inform policy-based interventions that improve cancer outcomes.[13–17] Removing the ability to reliably measure outcomes by such demographic categories would make cancer disparities harder to identify and address.

The loss of decennial census demographic data on race, ethnicity, and sexual orientation would affect more than cancer disparities research. It would make it harder for federal, state, local, and Tribal public health agencies to assess needs, plan services, and evaluate programs. State and local health departments, cancer centers, and community organizations use census demographic data and population-based analyses to inform catchment areas, screening outreach, prevention programs, service planning, and targeted research and community interventions.[18,19] By linking cancer registry data to census-tract population demographic and socioeconomic information, public health officials can also examine how cancer outcomes relate to additional community-level conditions and identify areas where tailored prevention, screening, diagnostic services, patient navigation, or treatment resources are most needed. These

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efforts are more likely to be effective when population estimates are accurate, demographic classifications are consistent, and the resulting analyses provide evidence that supports practical public health decisions.

The *AACR Cancer Disparities Progress Report 2026* demonstrates the value of sustained cancer disparities research utilizing demographic data. Decades of research have contributed to meaningful progress including a decline in overall cancer mortality among Black men by more than 50% between 1991 and 2024 and a narrowing in the disparity in overall cancer mortality between Black and White populations from 34% higher among Black individuals in 1991 to 9% higher in 2024.[20] Likewise, disparities in cervical cancer mortality between Hispanic and White populations and stomach cancer mortality between Asian or Pacific Islander and White populations have also significantly narrowed.[20] The report also documents substantial disparities that persist, including higher overall cancer mortality among Black and American Indian or Alaska Native populations and pronounced regional differences in cancer burden among American Indian or Alaska Native communities.[20] Likewise, CDC's U.S. Cancer Statistics show that cancer incidence and death rates for common cancers differ between metropolitan and nonmetropolitan counties, with particularly high mortality for some cancers and groups in rural communities.[21] The *AACR Cancer Disparities Progress Report 2026* also documented that overall cancer incidence and mortality rates were higher in rural areas compared to urban areas, with even larger disparities for lung, cervical, and colorectal cancers.[20] Consistent census-based data that includes race, ethnicity, and sexual orientation helps rural health departments, cancer centers, and community organizations with limited resources accurately identify the scale and location of need, assess barriers to screening and treatment, and plan for services tailored to their communities. Reliable race- and ethnicity-specific population estimates are essential to documenting these trends, evaluating progress over time, and identifying which populations continue to face disproportionate burdens across the rural-urban continuum. If the decennial census no longer directly collects race, ethnicity, or sexual orientation data researchers and public health agencies would face greater uncertainty about the reliability and comparability of subgroup population estimates and be unable to readily identify emerging disparities, determine trends, and evaluate the effects of policies and interventions. Maintaining the collection of this data in the census is vital to sustaining advances against cancer and ensuring that those benefits reach all populations.

III. Other Surveys or Records are Incomplete Substitutes

AACR recognizes that proposed rule section 15 CFR § 70.4 would preserve the Census Bureau's authority to collect demographic information, including those on race, ethnicity, and sexual orientation, through the American Community Survey (ACS) and other sources. However, the decennial census and the ACS or other surveys serve different

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purposes, and this provision does not resolve the concerns raised in this comment. The decennial census is a full population enumeration that provides a benchmark for the Census Bureau's annual population estimates, while the ACS is a survey used to produce demographic and social estimates. Continued collection of detailed demographic, socioeconomic, and community factors through the ACS is valuable, but it cannot replace the decennial census as a direct source of population counts by race and ethnicity or sexual orientation that are fundamental to cancer incidence and mortality calculations.

In fact, research has shown that using the ACS as a substitute for the decennial census would severely compromise cancer health disparities research because its sampling design fails to provide the localized, granular denominator data needed to calculate accurate cancer incidence and mortality rates for small, marginalized populations.[22] Cancer disparities are often localized and heavily influenced by neighborhood-level environmental factors as well as concentrated within specific intersectional or small racial and ethnic subgroups. Because the ACS or other surveys rely on a sample rather than a full population count, its data for small geographic units (like census tracts) or smaller demographic cohorts carries a high margin of error, which introduces substantial statistical noise. Therefore, such data is comparatively unreliable, effectively masks true disparities, and renders it impossible to accurately track long-term cancer trends in vulnerable communities or the precise targeting of public health interventions and screening programs.

In addition, administrative records may help fill information gaps, and AACR supports their responsible use where appropriate. However, records collected for tax, benefits, or other administrative purposes are not designed to capture self-identified race and ethnicity or sexual orientation in a standardized manner. Different records may use different categories, lack information for some individuals, or vary in their ability to represent particular populations. A report from the Congressional Budget Office found that census data on race and ethnicity were critical for analyzing income distributions and congressional reporting regarding budgetary and economic conditions.[23] If administrative records become a more important basis for demographic estimates, the Census Bureau should explain how it will assess data completeness, minimize misclassification, document uncertainty, and ensure that population estimates remain comparable across groups, jurisdictions, and time.

The highlighted concerns are especially important for smaller populations and geographic areas. Disparities affecting American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, Asian American, and specific Hispanic or Latino communities can be obscured when categories are combined or data are incomplete. Reliable disaggregated population information helps researchers identify needs that

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may otherwise be hidden within broader estimated national averages built from other data sources.

The proposal does not explain in sufficient detail how the Census Bureau would develop, validate, and reconcile race-, ethnicity-, or sexual orientation-specific population estimates following the elimination of direct questions on the decennial census. Nor does the proposal demonstrate that administrative records or other data sources can fully reproduce the accuracy, consistency, geographic detail, and comparability of direct demographic reporting through a complete enumeration via the census. The Census Bureau should therefore provide a clear technical plan for preserving specific population estimates and demonstrate, with evidence, that any alternative methods will provide data of sufficient quality for public health surveillance and cancer disparities research. It should not assume that the continued availability of the ACS or administrative records eliminates the need for demographic information from the decennial census.

IV. Privacy and Respondent Burden Should Be Addressed Without Sacrificing Data

AACR recognizes the importance of respondent privacy and the need to ensure that census questions are appropriate, understandable, and designed to minimize unnecessary burden. Protecting respondents from disclosure and misuse of information is essential to maintaining trust in the Census Bureau and the integrity of the data it collects. However, the benefits of demographic data for public health and scientific research should be weighed alongside privacy concerns. The proposed rule asserts that removing certain questions could reduce respondent burden and disclosure risks, potentially improve response, and facilitate greater reliance on administrative records. AACR is concerned that this rationale does not adequately account for the downstream consequences of losing direct race, ethnicity, and sexual orientation information from a full population enumeration.

The Census Bureau has established confidentiality protections and statistical disclosure avoidance practices. The agency should continue to strengthen these safeguards and determine how to release useful aggregate statistics while protecting individual responses. The existence of privacy risks does not, by itself, demonstrate that eliminating demographic questions from the decennial census is the most effective or proportionate solution. The proposed rule would significantly change a longstanding source of population data that supports public health surveillance and scientific research. AACR urges the Census Bureau to identify and evaluate alternatives that can meet legitimate privacy and burden-reduction objectives while preserving the quality and utility of specific population information. Potential alternatives include refining question wording, improving privacy communication and disclosure avoidance, and

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validating complementary data sources without eliminating direct collection through the decennial census.

V. AACR Recommendation

Before finalizing the proposed rule, the Census Bureau should explain how it evaluated the consequences for federal agencies and public health data users. The proposal does not provide sufficient detail about the implications for the population estimates used by CDC and NCI to calculate cancer incidence and mortality rates, the ability to maintain comparable statistics across decades, or the potential effects on the identification of cancer disparities. The Census Bureau should consult CDC, NCI, state and Tribal cancer registries, public health agencies, academic researchers, and other affected stakeholders as well as include an assessment of the expected effects on demographic-specific population estimates, cancer incidence and mortality rates, small-area research, time-series comparability, and the evaluation of cancer disparities. The Census Bureau should also evaluate how reduced demographic detail would impair planning for workforce and infrastructure needs, budgetary forecasting, projecting cancer care demands, and economic stability. AACR urges the Census Bureau to evaluate these downstream effects, and provide the technical methods used to do so, before adopting any restriction that would materially change the demographic information available from the decennial census.

In addition, if the Census Bureau suggests administrative records or survey estimates are expected to substitute for decennial demographic information, the Census Bureau should provide a technical plan describing how it will measure effectiveness for population estimates, validate completeness and accuracy, assess misclassification, characterize uncertainty, maintain geographic detail, and ensure comparability across demographic groups.

Given the substantial implications for public health surveillance and cancer disparities research and significant concerns discussed in this comment, AACR recommends that the Census Bureau withdraw proposed § 70.2(a) restrictions on the inclusion of certain demographic questions. The Census Bureau should continue collecting race, ethnicity, and sexual orientation data through the decennial census to preserve an essential, consistent benchmark for population health statistics estimates, public health surveillance, and scientific research. To address any privacy concerns, the Census Bureau should evaluate alternatives that reduce disclosure risks and unnecessary respondent burden without eliminating demographic information essential to cancer surveillance and research and provide that analysis before pursuing any changes to the decennial census.

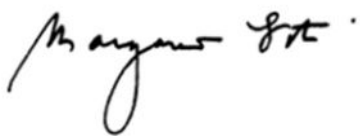
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Conclusion

Accurate, consistent population-level data are indispensable to cancer surveillance, health disparities research, public health planning, and the responsible use of federal resources. The Census Bureau's proposal to prohibit race, ethnicity, and sexual orientation questions in the decennial census risks weakening the demographic foundation on which federal cancer statistics and many population-based studies depend. Although the proposed rule preserves the collection of demographic information through other surveys and records, these would not adequately replace the role of direct demographic information from a complete decennial enumeration. Any final rule should preserve the ability of public health agencies and researchers to measure cancer outcomes by demographic categories including race, ethnicity, and sexual orientation with sufficient accuracy to support evidence-based decision making.

AACR supports efforts to protect respondent confidentiality, reduce unnecessary burden, and maintain an accurate census. Those objectives can and should be pursued without sacrificing data essential to understanding cancer burden, economic and budgetary planning, and improving health outcomes. AACR therefore urges the Census Bureau to withdraw the proposed prohibition on collecting race, ethnicity, and sexual orientation data through the decennial census and preserve the demographic information necessary for rigorous cancer disparities research, effective public health action, and improved outcomes for all Americans. If AACR can provide any additional information or assistance to the Census Bureau, please do not hesitate to contact Jon Retzlaff, Chief Policy Officer and Vice President, Science Policy and Government Affairs, at jon.retzlaff@aacr.org. Thank you again for the opportunity to provide comments on the proposed rule.

Sincerely,



Margaret Foti, PhD, MD (h.c.)

Chief Executive Officer
American Association for Cancer Research

615 Chestnut Street | 17th Floor
Philadelphia, PA 19106-4404
215-440-9300 | 215-440-9313 Fax
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