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UNDERFUNDED AND UNDER STRAIN:

The State of America's Public Health System

Trust for America's Health 25 YEARS

Acknowledgments

Trust for America's Health (TFAH) is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority. For more information, please review TFAH's 2023–2026 Strategic Plan at tfah.org.

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25 Years of Making the Case for a Stronger Public Health System

Since its founding in 2001, Trust for America's Health (TFAH) has worked to make the nation's public health needs visible to policymakers and the public. For more than two decades, TFAH's reports have tracked federal and state investments, identified gaps in the systems that protect communities, and advanced recommendations for building a stronger and more resilient public health infrastructure.

Over that period, the nation has made important progress. Investments have strengthened disease surveillance and laboratories, improved public health data systems, expanded prevention programs, and supported the workforce and partnerships needed to respond to emergencies. These advances demonstrate what sustained public commitment and investment can accomplish.

But TFAH's work has also documented a persistent pattern: public health funding often rises during crises and recedes as the immediate danger passes. Core investments have often failed to keep pace with inflation, population needs, and increasingly complex health threats. As a result, many health departments continue to face workforce shortages, outdated technology, limited surge capacity, and fragmented or inflexible funding.

The developments examined in this report reinforce another lesson from the past 25 years: appropriations are essential, but dollars alone do not determine whether the public health system can function effectively. Operational capacity also depends on skilled staff, institutional knowledge, organizational stability, timely grant administration, technical assistance, modern data systems, and trusted partnerships.

As TFAH marks its 25th anniversary, the task ahead is not simply to preserve individual programs. It is to build and sustain the underlying capacity that allows public health agencies and their partners to protect communities every day—and to respond when the next crisis arrives.

Executive Summary

America's public health system[1]—the network of agencies, programs, laboratories, surveillance systems, and frontline workers that protect the nation from preventable disease and injury—is at an inflection point. Trust for America's Health (TFAH) has published reports tracking public health funding for more than two decades. This report continues that work at an unprecedented moment: following decades of chronic underinvestment, the system absorbed workforce disruptions, funding interruptions, and institutional uncertainty unusual in scale and speed in modern federal public health history, even as the health threats it exists to address continue to grow. The fiscal year (FY) 2027 President's Budget Request now before Congress would, if enacted, further narrow the federal public health mission and reduce its resources. This report examines the structural conditions that shaped the system entering 2025, the disruptions that followed, the limits of the congressional response, and what is at stake in the appropriations decisions ahead.

HOW TO USE THIS REPORT

This report follows a single line of analysis: the public health system entered 2025 with longstanding funding, workforce, and infrastructure vulnerabilities; federal actions then imposed additional disruption; Congress preserved much of the existing system in FY 2026 but could not fully restore lost operating capacity; and the FY 2027 decisions now before Congress will determine whether that erosion continues or begins to reverse. The report is organized around that progression:

THE STRUCTURAL BASELINE explains the chronic underinvestment and temporary funding model that left the system with little margin entering 2025.

DISRUPTION LAYERED ON FRAGILITY documents the workforce, funding, organizational, scientific, and communications disruptions that followed.

NAVIGATING FEDERAL UNCERTAINTY FROM THE FRONT LINES shows how those changes affected state and local health agencies and their community partners.

CONGRESS RESPONDS examines what FY 2026 appropriations preserved, the guardrails Congress added, and the limits of that response.

EXAMPLES OF THE FUNDING-FUNCTION GAP show why a funded program is not necessarily a fully functioning program.

THE ROAD AHEAD analyzes the FY 2027 proposals, the risk of continued erosion even without the deepest proposed cuts, and the capabilities and communities at stake.

RECOMMENDATIONS FOR CONGRESS AND THE ADMINISTRATION presents TFAH's agenda for rebuilding capacity and establishing a more durable public health foundation.

A System Built on a Structural Deficit

In 2024, national health expenditures in the United States totaled $5.3 trillion—$15,474 per person, or 18.0 percent of GDP.[2] By standard international measures, the United States spends more on health, in both per capita and GDP-share terms, than any comparable high-income country. Yet even as life expectancy in the United States reached a record 79.0 years in 2024, it remained 3.7 years below the average of comparable high-income countries.[3] Recent data by race and ethnicity show that the national aggregate also masks wide variation within the United States.[4]

A 2025 study published in *JAMA Internal Medicine* found that avoidable mortality—deaths preventable through effective public health interventions and accessible healthcare—increased in every U.S. state and the District of Columbia between 2009 and 2021, diverging sharply from trends in peer countries. The study found no significant association between state-level healthcare spending and avoidable mortality across U.S. states—a finding consistent with the broader pattern that high healthcare spending alone has not produced population health outcomes comparable to peer nations.[5]

Of the $5.3 trillion the United States spent on health in 2024, only about 3 percent went to government public health activities. Meanwhile, the disease burden that public health investment is designed to address is vastly larger: 90 percent of annual healthcare expenditures go toward care for people with chronic and mental health conditions.

The source of this divergence is structural. In 2024, of the $5.3 trillion spent on health in the United States, only about 3 percent went to government public health activities at the federal, state, and local levels.[6,7] The disease burden that public health investment is designed to address is vastly larger: the Centers for Disease Control and Prevention (CDC) estimates that 90 percent of annual healthcare expenditures go toward care for people with chronic and mental health conditions[8]—yet CDC's allocation for chronic disease prevention and health promotion amounts to roughly three cents for every $100 spent on care for people with those conditions.[9]

Public health investment is predominantly discretionary, competing each year against other domestic priorities. The Prevention and Public Health Fund (PPHF), established under the Affordable Care Act (ACA) as a dedicated mandatory funding stream intended to provide prevention investments with some protection from annual appropriations pressures, has never reached the $2 billion annual level under the ACA's original funding schedule.[10] Under current law, annual PPHF funding ranged from $900 million to $1.0 billion from FY 2016 through FY 2023, before rising to $1.3 billion in FY 2024 and FY 2025 and $1.5 billion in FY 2026—still below the ACA's intended level.[11,12] CDC's allocation from the PPHF rose to approximately $1.4 billion in FY 2026.[13] Successive statutory reductions—many enacted as offsets for other federal priorities—mean that, from FY 2013 through FY 2029, the Fund is projected to receive approximately $12.95 billion less than it would have received under the ACA's original funding schedule.[14]

In nominal terms, CDC's program-level funding grew from approximately $7.3 billion in FY 2016[15] to $9.1 billion in FY 2026[16] —a figure that, taken in isolation, suggests meaningful growth.[17] Adjusted for inflation, however, real funding declined by roughly 7 percent over that period. On a per capita basis, CDC's purchasing power fell from approximately $30.30 per person in FY 2016 to $26.71 in FY 2026 in constant dollars—a real decline of approximately 12 percent

over a decade during which the population grew and demands on the agency intensified.[18]

Public health emergencies have periodically interrupted this pattern but have not resolved it. The COVID-19 pandemic prompted the largest temporary increase in public health funding in modern U.S. history: emergency supplemental appropriations temporarily drove government public health spending to 5.8 percent of total national health expenditures in 2020.[19] By 2024, that figure had reverted to 3.0 percent—essentially back to the pre-pandemic baseline. Each such cycle follows the same logic: a public health emergency reveals the inadequacy of existing infrastructure, emergency appropriations fund immediate response needs and temporary surge capacity, and then, as the acute crisis recedes, funding contracts—leaving the underlying structural deficit unaddressed or deepened.

The evidence for prevention investment is substantial. A 2017 systematic review published in the *Journal of Epidemiology and Community Health* found a median return on investment of approximately 14 to 1 for public health interventions in high-income countries.[20] A 2024 CDC analysis found that routine childhood vaccinations have, for children born during 1994–2023, prevented approximately 508 million cases of illness and more than 1.1 million deaths, generating an estimated $540 billion in direct cost savings and $2.7 trillion in broader societal savings.[21] The gap between that evidence base and the nation's actual investment in prevention is one of the defining features of the U.S. health system.

A System Already Under Strain

Federal investments made during and after the COVID-19 pandemic produced genuine and meaningful advances in public health capacity, including new workforce positions and career pathway programs, expanded laboratory technology, modernized surveillance infrastructure, and the Public Health Infrastructure Grant (PHIG), one of the most significant investments—a flexible, multiyear CDC initiative launched in 2022 that provided billions of dollars to health departments to strengthen workforce, data, and foundational public health capabilities.[22] But as the 2025 disruption period began, that progress rested on a temporary and uneven funding foundation. Some emergency resources had already expired or were approaching expiration; positions created with supplemental funds had not been fully incorporated into regular appropriations; and PHIG's largest component—the five-year workforce investment funded by the American Rescue Plan Act—was time-limited, scheduled to end in November 2027, and had no identified successor funding stream. Other PHIG components, including foundational capabilities and core funding for data modernization, depended on annual appropriations rather than a sustained long-term funding commitment.

A foundational 2021 analysis by the de Beaumont Foundation and the Public Health National Center for Innovations estimated that state and local governmental public health departments needed at least 80,000 additional full-time-equivalent positions—an increase of nearly 80 percent—to deliver a minimum package of public health services.[23] That estimate reflected a baseline structural staffing gap, not a post-pandemic reassessment, and represented a floor, not a measure of total need. The 2024 Public Health Workforce Interests and Needs Survey (PH WINS) found that 71 percent of the current workforce reported at least one symptom of burnout, one in five reported near-constant burnout, and more than half had been at their current agency for five years or less.[24] Among epidemiologists—a specialized and

hard-to-replace segment of the workforce—nearly 3 in 10 planned to leave their agency within the next year.[25] The National Association of County and City Health Officials 2024 Forces of Change survey found that 17 percent of local health departments had already experienced budget cuts in FY 2024 and that 23 percent anticipated cuts in FY 2025,[26] before any new administration actions had taken effect.

What the system lacked entering 2025 was margin: the reserve capacity, flexible resources, and experienced personnel needed to absorb new demands or disruptions without degrading core functions. Its permanent funding base was falling in real terms. Its emergency-era resources were expiring without replacement. Its workforce was strained, with 41 percent of employees having worked in public health for five years or less. The public health system's share of national health expenditures had nearly fully reverted to its pre-pandemic baseline. A system navigating that fiscal transition, without reserve capacity, was—and remains—a system with little buffer against additional disruption.

Workforce, Funding, and Institutional Disruption

Beginning in January 2025, the federal public health system experienced a convergence of workforce reductions, funding disruptions, agency restructuring proposals, and scientific communications interventions that together weakened—or threatened to weaken—federal capacity to administer programs, support grantees, sustain surveillance systems, and respond to emerging health threats.

WORKFORCE

A federal hiring freeze took effect January 20, 2025;[27] after the freeze period, agencies remained subject to a rule generally limiting new hiring to no more than one employee for every four who departed.[28] Roughly 10,000 U.S. Department of Health and Human Services (HHS) employees reportedly applied for deferred resignation, buyouts, or early retirement through voluntary separation programs.[29,30] Beginning in mid-February, termination notices were distributed to thousands of HHS probationary employees,[31] including more than 700 at CDC.[32,33,34,35] On March 27, HHS announced a restructuring plan that called for reducing the department's workforce by approximately 10,000 employees,[36] including an announced gross reduction of roughly 2,400 positions at CDC; layoffs began on April 1.[37] A second wave of approximately 1,300 CDC reduction in force (RIF) notices was issued during the October–November 2025 government shutdown, the longest in U.S. history; about 700 were quickly rescinded, with HHS saying they had been sent in error because of a coding issue. The shutdown-ending legislation later required certain RIF notices to be rescinded and rendered certain shutdown-period RIF actions without force or effect.[38,39,40,41] These losses were not confined to a single office or program; they affected a wide range of CDC and HHS functions. The result was reduced federal capacity to administer grants, provide technical assistance, and respond to urgent field requests from state and local health departments. In at least one documented case, discussed later in this report, the temporary loss of specialized federal capacity affected whether a jurisdiction received federal expertise during an active children's health emergency.[42]

CDC's workforce as of May 2026—9,218 employees—was at its lowest level since FY 2008 and below its pre-pandemic baseline, even as the agency's responsibilities and the demands placed on its public health infrastructure had expanded over the preceding years.

The cumulative toll is documented in Office of Personnel Management (OPM) data. CDC's workforce declined from 12,820 employees at the end of FY 2024 to 9,218 as of May 2026—a net reduction of approximately 3,600 employees, or roughly 28 percent. The agency's May 2026 headcount was its lowest since FY 2008.[43] Workforce losses extended across HHS: the Health Resources and Services Administration (HRSA) declined by approximately 38 percent, the Substance Abuse and Mental Health Services Administration (SAMHSA) by approximately 42 percent, and the Food and Drug Administration by approximately 22 percent.

FUNDING DISRUPTIONS

On March 24, 2025, HHS moved without prior notice to terminate access to or claw back more than $12 billion in federal grants, primarily CDC-administered awards to state and local health departments and other public health organizations.[44] The affected grants had supported infectious disease epidemiology and laboratory capacity, immunization services, disease surveillance, data systems, emergency preparedness, community health worker initiatives, health disparities initiatives, and mental health and substance use services—activities that, in many cases, reflected approved COVID-19 prevention, preparedness, response, and recovery workplans and were not limited to immediate pandemic response. Health departments across the country immediately assessed layoffs, paused active work, and confronted uncertainty about whether they could continue services, contracts, and infrastructure projects already underway.[45] Courts later blocked the challenged terminations for plaintiff jurisdictions, but the relief was plaintiff-specific, leaving jurisdictions not covered by those orders exposed to the loss of previously awarded funds. Separate disruptions affected cardiovascular disease prevention, cancer screening, and emergency preparedness grants as CDC operated for months under short-term funding increments while awaiting full apportionment of its FY 2025 enacted appropriations.[46]

LEADERSHIP AND SCIENTIFIC INTEGRITY

CDC operated without a permanent, Senate-confirmed director for nearly all of 2025 and the first seven months of 2026. The first Senate-confirmed CDC director, confirmed July 29, 2025,[47] was fired on August 27[48]—approximately one month later—after reportedly refusing to approve vaccine recommendations without evidence and to fire career officials without cause.[49] Her departure triggered the resignations of at least four senior CDC leaders. On August 5, 2026, the Senate confirmed Dr. Erica Schwartz as CDC director.[50] In June 2025, the HHS secretary terminated all 17 members of the Advisory Committee on Immunization Practices and replaced them with a new panel, some of whose members had publicly questioned routine vaccination.[51,52,53] Publication of CDC's *Morbidity and Mortality Weekly Report* was paused for two weeks during an early communications freeze,[54,55] and multiple CDC data resources were removed or modified in response to administration directives.[56,57,58]

THE FY 2026 PRESIDENT'S BUDGET REQUEST

Released in May 2025, the administration's FY 2026 budget proposed reducing CDC's program level by more than half,[59,60] eliminating the Prevention and Public Health Fund (PPHF), creating a new Administration for a Healthy America (AHA) that would consolidate several HHS agencies, offices, and programs, and reducing HHS-wide discretionary funding by approximately 25 percent.[61] Had it been enacted, the proposal would have constituted a fundamental reorientation of the federal role in public health—substantially narrower in scope and smaller in scale.

Congress Responds—But Appropriations Alone Could Not Restore Capacity

The Consolidated Appropriations Act, 2026 (P.L. 119-75), enacted February 3, 2026, represented a clear and consequential congressional response to the administration's proposed funding cuts and restructuring, as well as to the funding delays, grant disruptions, and operational instability that had marked the prior year. CDC's program-level funding was maintained at approximately $9.1 billion—essentially flat with FY 2025 and roughly double the administration's FY 2026 request. Congress did not adopt the administration's proposed consolidation of SAMHSA, HRSA, or the Administration for Strategic Preparedness and Response (ASPR), or its proposed elimination of the Prevention and Public Health Fund (PPHF); instead, CDC's allocation from the fund increased from approximately $1.2 billion to $1.4 billion under the fund's statutory schedule.[62] The legislation and accompanying explanatory statement also included several oversight mechanisms: a statutory requirement that HHS support staffing levels necessary to fulfill its statutory responsibilities; a requirement that HHS submit a detailed plan and justification to the appropriations committees and make it publicly available at least 60 days before moving CDC functions to another HHS component;[63,64] direction that HHS consult with the committees before terminating grants and provide at least three days' notice before announcing or providing notice of a grant termination;[65] and directive language governing the timing and conditions of grant disbursements.[66]

What appropriations could not do was restore what had already been lost. By the time P.L. 119-75 was enacted, CDC had sustained a net workforce loss of more than 3,000 employees. The program expertise, institutional knowledge, grant-administration capacity, and established grantee relationships those employees had built departed with them. Real-time outlay data show CDC disbursements running well below prior-year comparable levels: full-year CDC outlays in calendar year 2025 totaled $13.3 billion, a decline of $3.7 billion, or approximately 22 percent, from 2024.[67] Through July 21, 2026, year-to-date outlays were approximately 27 percent below the comparable 2025 level.

Congress appropriated roughly $9.1 billion for CDC in FY 2026. But appropriated dollars cannot automatically restore the staffing, institutional knowledge, and grantee relationships needed to deliver the programs those dollars fund.

The new oversight provisions were tested almost immediately. Six days after P.L. 119-75 was enacted, the administration invoked the new grant-termination notification procedure to announce a new round of CDC grant terminations.[68,69] As of mid-May 2026, the cumulative total of CDC grant terminations under the administration had reached 444 grants and $5.78 billion in unliquidated obligations[70] —funds obligated under existing agreements but not yet paid out. A flat annual appropriation of roughly $9.1 billion does not replace $5.78 billion in terminated multiyear obligations; it maintains the regular annual baseline while previously appropriated supplemental investments are withdrawn, interrupted, or challenged in litigation. Nor is the risk limited to those specific actions. Executive Order 14332 already requires senior appointee pre-issuance review of discretionary grant awards for consistency with agency priorities and the national interest;[71] a proposed Office of Management and Budget rule published in May 2026 would further codify pre-issuance review and broaden agencies' authority to suspend or terminate grants based on policy and priority determinations.[72]

Together, these actions illustrate a central finding of this report: appropriations are necessary, but they do not by themselves determine whether public health programs have the resources, staffing, continuity, and administrative capacity to function.

The report illustrates this funding-function gap through examples involving chronic disease prevention programs that Congress preserved even as CDC capacity was reduced, Project AWARE school mental health grants that remained funded while the SAMHSA staff responsible for administering them were eliminated, and Milwaukee's childhood lead crisis, where CDC could not provide requested field support after the HHS reduction in force eliminated the staff of its lead-poisoning prevention team.

The FY 2027 Proposal: Persistent Direction

The FY 2027 President's Budget Request, released in April 2026, moderates some elements of its predecessor. From a comparably adjusted FY 2026 funding level, the request would reduce HHS discretionary budget authority by $15.8 billion, or 12.5 percent[73]—a smaller reduction than the $31.4 billion, or approximately 25 percent, cut proposed in the prior year's request from a comparably adjusted FY 2025 funding level.[74] The National Institutes of Health would face a less sweeping restructuring, CDC's Global Health account would be preserved at the comparably adjusted FY 2026 level, and ASPR and the Advanced Research Projects Agency for Health (ARPA-H) would be maintained as separate entities. The request also proposes targeted increases for emerging infectious disease surveillance and laboratory capacity, data modernization, food safety, and immunization programs.

On the structural and fiscal priorities of greatest consequence, however, the request holds its course. AHA—the consolidating entity Congress declined to adopt in the FY 2026 appropriations process—is again proposed. The Prevention and Public Health Fund (PPHF) is again proposed for complete elimination. And after accounting for proposed program transfers to AHA and other HHS entities, resources supporting activities historically housed at CDC and the Agency for Toxic Substances and Disease Registry would stand approximately 31 percent below FY 2026 enacted levels. The reductions in specific public health and preparedness program areas are substantial:

- Chronic disease prevention and health promotion activities currently housed at CDC would receive approximately 67 percent less on a functional basis than their FY 2026 enacted levels, with tobacco prevention, heart disease and stroke, diabetes, oral health, and community-based prevention programs eliminated or sharply reduced.
- The Public Health Emergency Preparedness cooperative agreement—the primary federal grant for building state and local preparedness capacity—would be cut from $735 million to $350 million, a reduction of 52 percent.[75]
- Hospital Preparedness Program cooperative-agreement funding—the primary federal funding stream dedicated to healthcare delivery system preparedness and response, including support for healthcare coalitions—would be eliminated,[76] reducing support for hospitals and health systems preparing for disasters, infectious-disease emergencies, cyber incidents, and other events that disrupt care or require coordinated medical surge capacity.
- Domestic HIV prevention and research funding would decline by approximately 78 percent.
- Public Health Infrastructure and Capacity funding—the principal annual CDC appropriation supporting foundational health department capabilities—would fall from $360 million to $260 million, a reduction of approximately 28 percent. That reduction would coincide with the scheduled November 2027 end of the current five-year PHIG award period. With no successor investment of comparable scale identified, health departments face a sharp transition from PHIG's multibillion-dollar investment to a much smaller annual appropriation.

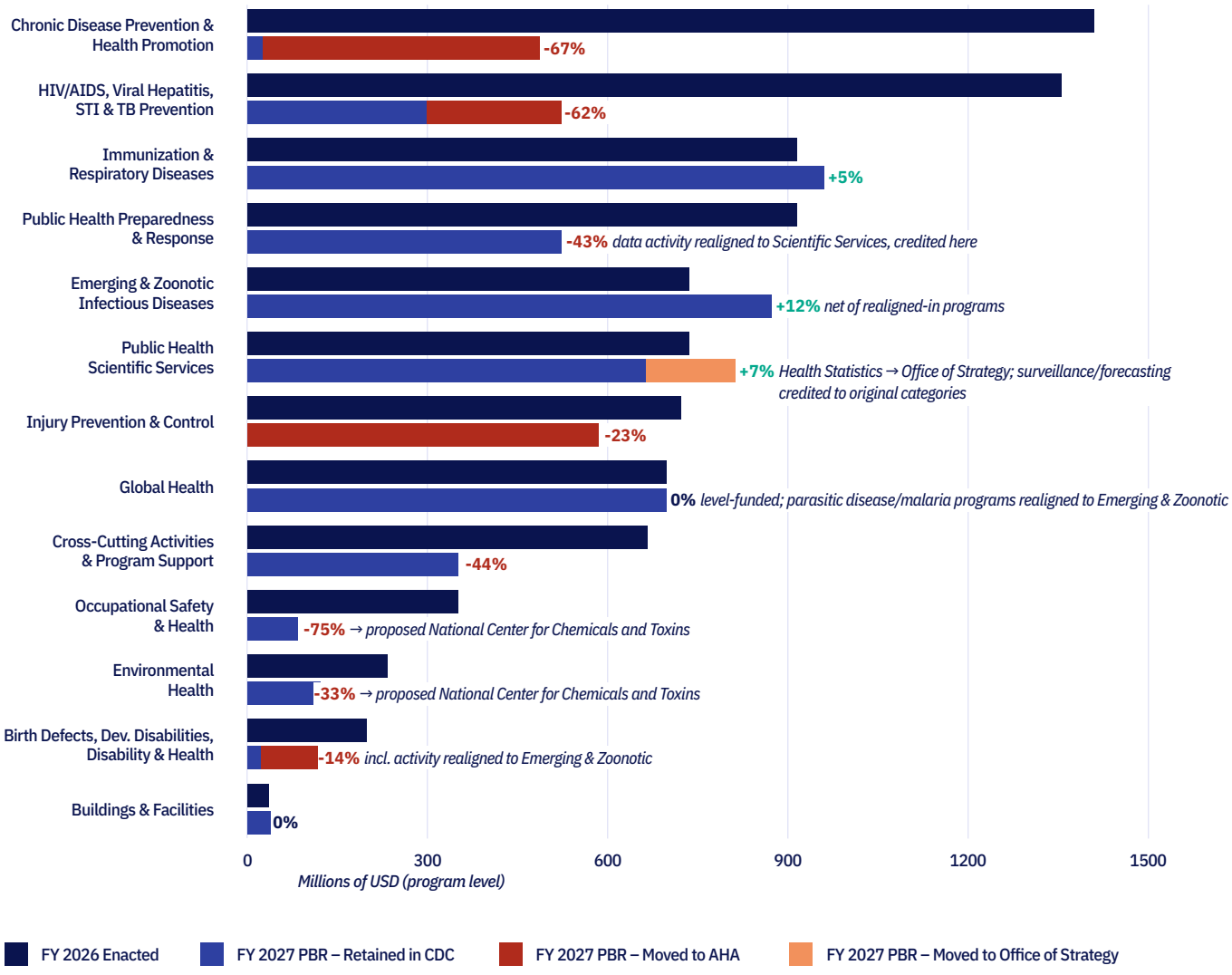
These reductions would occur against a backdrop of rising vaccine-preventable disease activity and declining vaccination coverage, increasing the importance of the immunization, surveillance, laboratory, data, communications, and state-support capacities affected by the proposal. In 2025, the United States recorded 2,289 confirmed measles cases—the highest annual total since 1991—with three deaths.[77,78] As of July 16, 2026, an additional 2,260 cases had been confirmed, bringing the combined total for the two years to 4,549 cases across 46 states and the District of Columbia.[79] Measles, mumps, and rubella (MMR) vaccination coverage among kindergarteners fell to 92.5 percent in 2024–2025, below the approximately 95 percent threshold generally needed for community protection.[80] That national average also masks states, schools, and communities with substantially lower coverage, leaving them especially susceptible to outbreaks. The nation's measles elimination status is scheduled for review by the Pan American Health Organization's Regional Verification Commission for the Elimination of Measles, Rubella, and Congenital Rubella Syndrome.[81] Reported pertussis cases in 2024 reached their highest total in more than a decade.[82]

The fiscal environment for state and local health systems is further complicated by the One Big Beautiful Bill Act (OBBBA), enacted July 4, 2025. According to Congressional Budget Office estimates summarized by the Center on Budget and Policy Priorities, the law's Medicaid provisions would reduce federal Medicaid spending by more than $900 billion over the 2025–2034 period and increase the number of uninsured people by approximately 7.5 million in 2034.[83] Those coverage losses will increase reliance on public health and safety-net infrastructure at the same time that federal investment in that infrastructure remains under sustained pressure. The law also established a $50 billion Rural Health Transformation Program to support rural healthcare delivery from FY 2026 through FY 2030;[84] the program represents a significant new federal investment in rural health, though it is not structured to replace coverage losses or address existing gaps in public health infrastructure and capacity. In addition, OBBBA reduced federal support for the Supplemental Nutrition Assistance Program (SNAP) and terminated new mandatory funding after FY 2025 for the SNAP Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed), eliminating a funding stream that states and implementing partners used to promote healthy eating and physical activity among people with low incomes.[85,86]

The risk the public health system faces is cumulative. Decades of chronic underinvestment preceded a period of disruption that enacted appropriations could only partially offset. The FY 2027 request demonstrates that the policy direction reflected in that disruption persists into the next budget cycle. That tension was already visible in June 2026, when the House Appropriations Committee advanced a bill that retained HHS's existing organizational structure rather than establishing the proposed Administration for a Healthy America but would reduce CDC program-level funding by approximately $1.0 billion from the FY 2026 enacted level.[87,88] Even a scenario in which Congress rejects the deepest proposed cuts would not guarantee reversal of capacity erosion if flat funding fails to keep pace with inflation, hiring remains constrained, administrative mechanisms—including abrupt grant terminations, attempted clawbacks, and delayed apportionments—continue to affect grant administration, and state and local fiscal pressures compound the effects of reduced federal support.

FIGURE 1: CDC Program Funding by Category: FY 2026 Enacted vs. FY 2027 President's Budget

Program level (budget authority plus PPHF and PHS evaluation transfers), in millions of dollars. FY 2026 enacted operating-plan categories are compared with FY 2027 proposed funding for the same functions, tracked to where the request would house them. Because several categories are reorganized, percent changes are functional comparisons, not direct account-to-account comparisons.



Notes: Program level includes budget authority, PPHF transfers, and the Public Health Service evaluation transfer. FY 2026 enacted levels are from the FY 2026 CDC Operating Plan; FY 2027 levels are from the CDC, AHA, and Office of Strategy FY 2027 congressional justifications. Because the FY 2027 request reorganizes several categories, percentages are functional comparisons: categories in the FY 2026 CDC Operating Plan are compared with FY 2027 proposed funding for the same functions wherever the request would house them, and activities moved at equal funding levels show no net change. Health Statistics would move to the Office of Strategy. Parasitic Diseases and Malaria and Surveillance for Emerging Threats to Mothers and Babies would move to Emerging and Zoonotic Infectious Diseases but are credited to Global Health and Birth Defects, Developmental Disabilities, Disability and Health, respectively, at their FY 2026 levels. Ready Response Enterprise Data Integration and forecasting and outbreak-analytics activities would move from Public Health Preparedness and Response to Public Health Scientific Services but are credited to Preparedness at their FY 2026 level. The request would also retain Disease Risk Factor Surveillance within Public Health Scientific Services rather than move it to AHA with the remainder of the chronic-disease portfolio. Because the request does not separately itemize its funding, this analysis treats the full $29.5 million increase in Surveillance, Epidemiology, and Informatics as funding for that activity and credits it to Chronic Disease Prevention and Health Promotion. The funded portions of Environmental Health and Occupational Safety and Health would remain within CDC as part of the proposed National Center for Chemicals and Toxins.

Sources: FY 2026 CDC Operating Plan;[89] FY 2027 Congressional Justifications for CDC,[90] the Administration for a Healthy America,[91] and the HHS Office of Strategy.[92]

Policy Recommendations

To protect the nation's health, economic security, and national security, TFAH recommends that Congress and the administration take action to rebuild and strengthen the public health system. Key recommendations, summarized below and discussed in greater detail later in this report, include:

- Restoring federal health agency staffing, program funding, and operational capacity sufficient to carry out funded programs and statutory responsibilities, including capacity reduced or eliminated in 2025.
- Preserving and strengthening the complementary roles and distinct expertise of CDC, SAMHSA, HRSA, the Administration for Community Living, and other federal agencies with public health responsibilities, and ensuring that any major restructuring proceeds only through a bipartisan, deliberative process with congressional oversight and input from public health stakeholders and partners.
- Providing at least $11.58 billion for CDC in FY 2027, with increases in subsequent years, and maintaining CDC as a national public health agency responsible for detecting, preventing, and mitigating infectious diseases, chronic conditions, and other leading causes of preventable death, illness, and injury.
- Ensuring that appropriated funds are released and spent for their intended purposes; that federal grantmaking remains predictable, transparent, merit-based, and evidence-based, with independent scientific and merit review; and that awards are not suspended or terminated for reasons unrelated to statutory program purposes, recipient performance, or compliance with award terms.
- Enacting full-year appropriations on time, restoring and protecting the Prevention and Public Health Fund, and rejecting new discretionary budget caps that fail to account for inflation, population growth, and evolving health threats.
- Investing in foundational public health infrastructure, including workforce, laboratories, data systems, and sustained funding for such public health capabilities.
- Creating a Health Defense Operations budget designation to protect core health security programs from recurring instability in the annual appropriations process.

SECTION I

The Structural Baseline: Chronic Underinvestment and the Public Health System It Shaped

For more than two decades, Trust for America's Health (TFAH) has published reports tracking public health funding and examining what the nation invests in its public health system and what those investments—and the gaps in them—mean for population health. That work has consistently found that the United States chronically underinvests in the prevention and public health infrastructure that keeps people healthy, and a broader evidence base shows that the consequences are measurable in preventable illness, worse mortality outcomes, and healthcare costs that prevention could have reduced.

SECTION AT A GLANCE

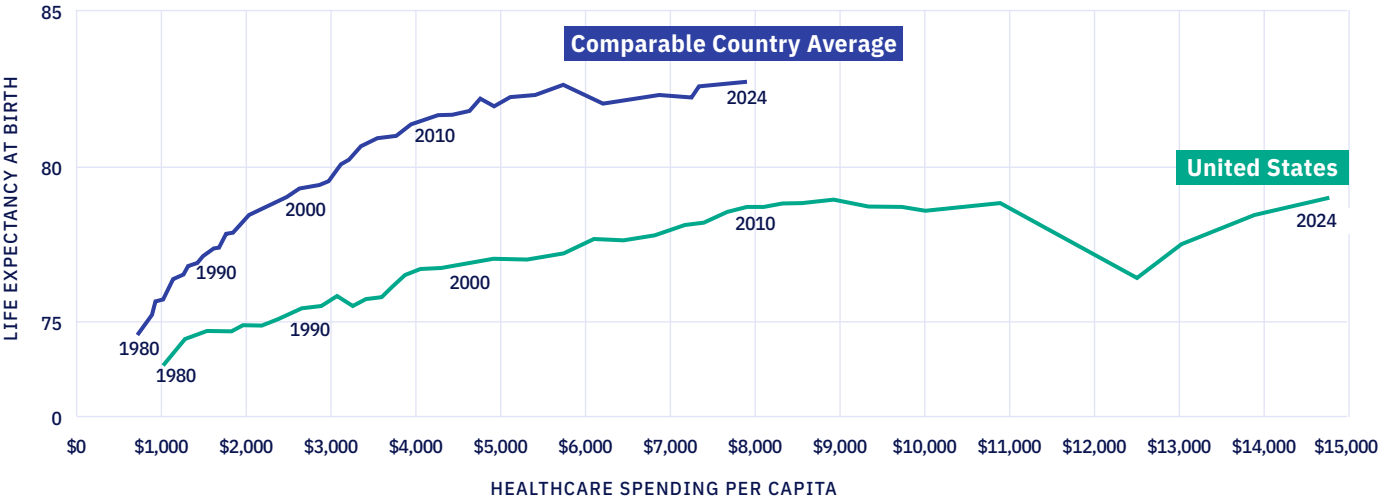
- The United States spends more on health than comparable high-income countries, but directs only a small share of that spending toward governmental public health and prevention. CDC's funding has increased in nominal dollars while declining in inflation-adjusted and per-capita terms.
- Emergency investments have repeatedly expanded public health capacity during crises, only to recede afterward. COVID-era funding produced meaningful advances in workforce, laboratories, surveillance, and data systems, but many of those gains rested on temporary resources.
- Public health infrastructure includes not only grant dollars, but also trained personnel, laboratories, data and surveillance systems, communications, preparedness, grant administration, federal expertise, and longstanding partnerships. Once lost or disrupted, these capabilities cannot be quickly rebuilt.
- By early 2025, temporary funding was expiring, workforce strain was already widespread, and major infrastructure investments lacked identified long-term successors. The system had made progress, but it had little reserve capacity with which to absorb another shock.

This report continues that work at an unprecedented moment. TFAH's 2025 funding report represented a significant departure in approach: the scale and pace of federal executive actions beginning in January 2025—workforce reductions, grant terminations, proposed agency restructurings, and budget proposals that would have significantly cut federal public health investment—required a broader examination of what those actions meant for the agencies, grantees, and communities that depend on federally supported public health infrastructure. This report returns to rigorous program-level funding analysis, now updated through fiscal year (FY) 2026 with the release of the FY 2026 CDC Operating Plan—the annual document in which the Centers for Disease Control and Prevention (CDC) reports its program-level budget allocations for the fiscal year, based on enacted appropriations, statutory requirements, and accompanying congressional direction—while also carrying forward the operational and institutional analysis that contextualizes the funding trends. That context is especially consequential in the wake of a period in which emergency supplemental funding temporarily expanded public health capacity beyond its structural baseline—the latest instance of a boom-and-bust dynamic in which crisis-driven surges in public health investment have repeatedly given way to contraction, leaving the underlying structural deficit intact. Understanding what the numbers mean requires understanding the condition of the system behind them.

The Pattern of Chronic Underinvestment

In 2024, the country spent $5.3 trillion on health—$15,474 per person—a figure representing 18.0 percent of the entire national economy.[93] That is more than any comparable high-income nation spends, both per capita and as a share of GDP. Yet even as life expectancy in the United States reached a record 79.0 years in 2024, it remained 3.7 years below the average of comparable high-income countries.[94] That national aggregate also masks wide variation by race and ethnicity within the United States.[95]

FIGURE 2: Life Expectancy and Healthcare Spending Per Capita, 1980–2024



Notes: Healthcare spending per capita data represent health consumption expenditures per capita. Comparable countries include Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the U.K.

Source: Peterson-KFF Health System Tracker[96]

A 2025 study by researchers at Brown University and Harvard University, published in *JAMA Internal Medicine*, found that avoidable mortality—deaths preventable through effective public health interventions and accessible, high-quality healthcare services—increased in every U.S. state and the District of Columbia between 2009 and 2021, with increases in preventable mortality as the primary driver.[97] The divergence from peer nations was most pronounced in the pre-pandemic period: from 2009 to 2019, avoidable mortality worsened across all U.S. states and the District of Columbia (D.C.) while declining in most peer countries. During the COVID-19 pandemic years (2019–2021), avoidable mortality rose in comparator countries as well, though by considerably less than in the United States. Notably, the study found no statistically significant association between state-level healthcare spending and avoidable mortality across U.S. states—a finding that contrasts sharply with the pattern among high-income peer nations, where higher health spending was significantly associated with lower avoidable mortality.[98]

This divergence reflects a structural feature of how the United States allocates its health dollars: the overwhelming majority flows toward treating disease after it occurs, while a persistently small share is directed toward preventing it. In 2024, of the $5.3 trillion spent on health in the United States, only about 3 percent went to government public health activities. The disease burden that public health investment is designed to address is vastly larger.[99] Chronic diseases—including heart disease, cancer, diabetes, and stroke—are the leading drivers of the nation's annual healthcare costs[100] and the leading causes of illness, disability, and death in the United States.[101] In 2023, more than 194 million U.S. adults reported having at least one of 12 selected chronic conditions.[102]

FIGURE 3: The Imbalance in U.S. Health Spending, Viewed Two Ways

≈$90

of every $100 in U.S. health care spending is for people with chronic and mental health conditions.

≈$3

of every $100 in U.S. national health expenditures is for government public health activities.

These figures show different dimensions of health spending and are not parts of a single accounting breakdown.

A NARROWER DIMENSION OF THAT IMBALANCE:

3¢

CDC funding for chronic disease prevention and health promotion equaled **about 3 cents for every $100 in estimated health care spending** for people with chronic and mental health conditions.

FY 2024 CDC Chronic Disease Prevention and Health Promotion:

$1.434 BILLION

Estimated 2024 health care spending for people with chronic and mental health conditions:

$4.75 TRILLION

Note: The two top-panel measures are separate, overlapping views of health spending—not mutually exclusive categories. The 90 percent figure is a historical estimate applied by CDC to 2024 national health expenditures. The 3¢ comparison juxtaposes FY 2024 CDC funding with calendar-year 2024 national spending.

Sources: CMS National Health Expenditure Accounts (2024); CDC Fast Facts: Health and Economic Costs of Chronic Conditions; CDC FY 2024 Operating Plan; RAND, Multiple Chronic Conditions in the United States (2017).

CDC estimates that 90 percent of the nation's annual healthcare expenditures go toward care for people with chronic and mental health conditions—yet CDC funding for chronic disease prevention and health promotion amounted to about three cents for every $100 spent on such care.[103,104]

That structural imbalance is reflected in the trajectory of federal public health investment more broadly. In nominal terms, CDC's program-level funding—the total resources allocated to the agency across its programs each year—increased from approximately $7.3 billion in FY 2016 to $9.1 billion in FY 2026, a figure that, taken in isolation, suggests meaningful growth. Adjusted for inflation, however, real funding declined over the same period by roughly 7 percent. Expressed on a per capita basis, the erosion is more pronounced: in constant FY 2026 dollars, CDC's purchasing power per person served fell from approximately $30.30 in FY 2016 to $26.71 in FY 2026, a real decline of approximately 12 percent over a decade during which the population grew, health threats multiplied, and demands on the agency intensified.

The Prevention and Public Health Fund (PPHF)—established under the Affordable Care Act (ACA) as a dedicated mandatory funding stream intended to give public health investment a measure of protection from annual appropriations pressures and, under the ACA's original schedule, to grow to $2 billion per year by FY 2015[105]—has only partially offset this erosion. Although the PPHF provides mandatory funding, Congress allocates those funds to specific federal programs through the annual appropriations process. Under current law, annual PPHF funding ranged from $900 million to $1.0 billion from FY 2016 through FY 2023, before rising to $1.3 billion in FY 2024 and FY 2025 and $1.525 billion in FY 2026—still below the ACA's intended level.[106,107]

CDC's allocation from the Fund increased from approximately $1.2 billion in FY 2024[108] and FY 2025[109] to approximately $1.4 billion in FY 2026.[110] Successive statutory reductions from the ACA's original trajectory—many of which were enacted as offsets for other mandatory spending, including other federal healthcare priorities[111]—have produced a cumulative gap projected to reach approximately $12.95 billion between the Fund's original schedule and enacted and scheduled funding levels from FY 2013 through FY 2029.[112] Throughout this period, the PPHF represented a substantial share of CDC's total program level, reaching roughly 15 percent in FY 2026[113]—large enough to make it a structural component of the agency's base budget, meaning that shortfalls in the Fund affect core operations.

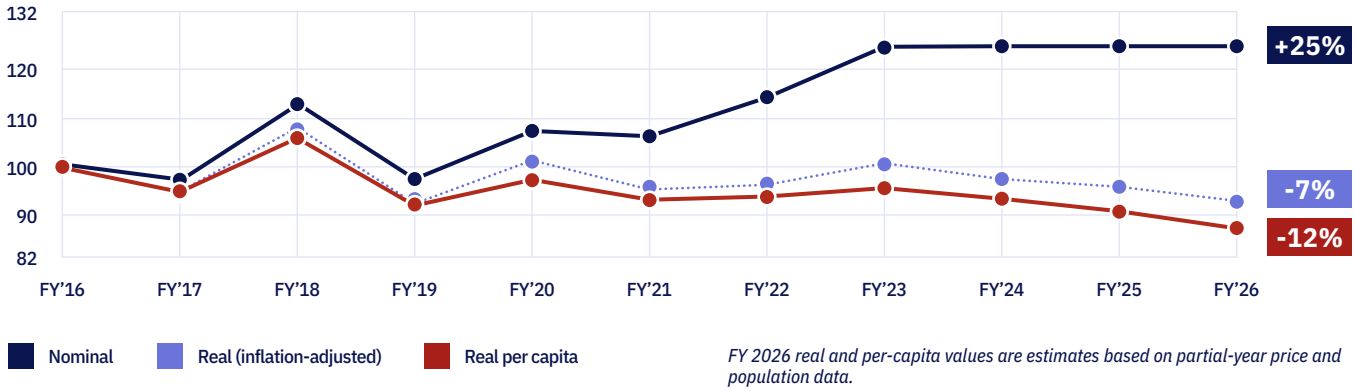
Emergency resources, by definition, arrive after the inadequacy of existing infrastructure has already been demonstrated. They are a response to the consequences of underinvestment, not a substitute for preventing those consequences in the first place.

The PPHF's history reflects one dimension of chronic underinvestment—the erosion of dedicated prevention funding during stable periods. But the broader pattern of public health financing has an additional and compounding feature: crisis-driven surges in investment that temporarily obscure the structural deficit before giving way to contraction, leaving the underlying problem intact. The COVID-19 pandemic produced the most dramatic recent instance of this dynamic—the boom-and-bust cycle of crisis-driven investment. The pattern is consistent: a public health emergency reveals the inadequacy of existing infrastructure, emergency supplemental appropriations are enacted, health officials race to expand capacity amid a fast-moving crisis, and then—as the acute crisis recedes—funding contracts, often below pre-crisis levels in real terms. Similar cycles played out following the September 11 attacks and the 2001 anthrax mailings, H1N1 in 2009, Ebola in 2014, and Zika in 2016. Each time, emergency resources addressed an immediate need without resolving the structural deficit that the emergency had exposed. Emergency resources, by definition, arrive after the inadequacy of existing infrastructure has already been demonstrated—often at significant cost in lives, economic disruption, and system strain. They are a response to the consequences of underinvestment, not a substitute for preventing those consequences in the first place.

FIGURE 4: Public Health Funding Trends Across Three Key Measures

CDC Program-Level Funding, FY 2016–FY 2026

Indexed: FY 2016 = 100 · Endpoint values shown at right

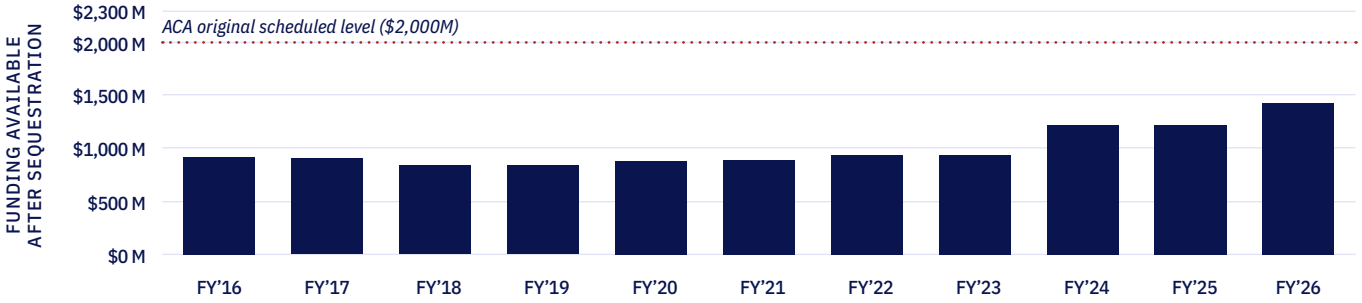


Nominal · Real (inflation-adjusted) · Real per capita

FY 2026 real and per-capita values are estimates based on partial-year price and population data.

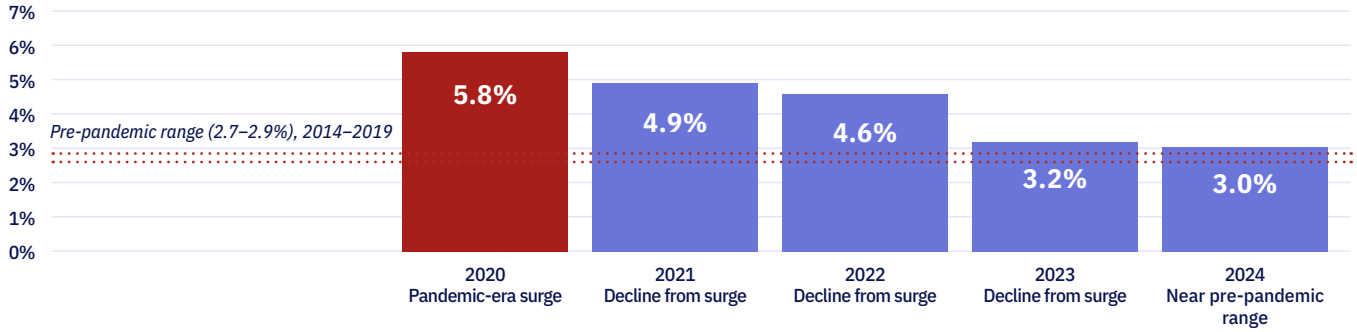
Prevention and Public Health Fund: Funding Available vs. ACA Original Scheduled Level

Dollars in millions · The ACA originally scheduled $2 billion annually beginning in FY 2015; the dashed line shows that original schedule, not current-law funding levels.



Government Public Health Activities As A Share Of National Health Expenditures

Percent of national health expenditures



Notes: Chart 1 indexes each series to FY 2016 = 100. Program level includes CDC budget authority, Prevention and Public Health Fund transfers, and Public Health Service evaluation transfers. For historical years, the series uses comparably adjusted prior-year amounts reported in subsequent CDC operating plans when available. FY 2026 real and per-capita values are estimates based on partial-year price and population data. Chart 2 bars show PPHF funding available after sequestration; the dashed line shows the ACA's original $2 billion annual schedule, not current-law funding levels. Chart 3 figures are calculated from CMS National Health Expenditure Accounts; the pre-pandemic range is approximate.

Sources: CDC Congressional Justifications and Operating Plans; U.S. Census Bureau resident-population estimates; Bureau of Economic Analysis GDP price index; CMS National Health Expenditure Accounts; Affordable Care Act §4002; TFAH analysis.

The surge of emergency funding during the COVID-19 pandemic far exceeded that provided during any prior public health emergency, reflecting the extraordinary scale and severity of the pandemic. In 2020, emergency supplemental appropriations helped drive government public health spending to 5.8 percent of total national health expenditures[114]—roughly double its pre-pandemic share. The funding supported the immediate pandemic response while also financing investments in the public health workforce, laboratory capacity, disease surveillance, data systems, and other foundational capabilities with value beyond the acute emergency. But as emergency funds expired, legislative rescissions canceled billions in unobligated balances—including funds available for public health workforce, surveillance, data, and other infrastructure-related activities—and annual appropriations returned to their pre-pandemic trajectory. The public health share of national health expenditures reverted correspondingly: to 4.9 percent in 2021, 4.6 percent in 2022, 3.2 percent in 2023, and 3.0 percent in 2024—nearly back to the pre-pandemic baseline.[115] The pandemic era demonstrated that the nation is capable of investing in public health at a greater scale when a crisis demands it. What it did not produce was a durable change in the underlying commitment. CDC made this case directly to Congress in July 2024, in testimony that described the structural challenge plainly:[116]

The investments made by Congress have allowed CDC to make important progress towards readiness and response capabilities, but there is more work to do. Decades of underinvestment in public health have left major gaps in the ecosystem that do not meet the need for rapid, data-driven action both for critical day-to-day activities and for public health emergencies. … We have been able to use [supplemental] funds to support critical activities, including national programs for wastewater surveillance and genomic sequencing. … Lack of support for these critical efforts threatens to erase the progress we made over the past few years and will leave the public health system less prepared to face future disease threats. Supplemental funding in an emergency is always critical for responding to urgent needs but is emblematic of the historic trend to fund public health needs only when there are dire, high-profile challenges, creating a boom-or-bust cycle with steep fiscal cliffs that require jurisdictions to dismantle programs the public has come to expect, only to scramble to restart them for the next emergency. After an emergency, this often leaves [CDC]—and the state, local, tribal, and territorial partners CDC funds—with no sustained source of funding to create a stronger, more resilient public health system that is ready to face future health crises. For further progress to be made at CDC and in states and localities, increased and sustained investments are critical to better connect public health and healthcare data; hire a workforce that isn't only temporary in an emergency; support a national laboratory network; and create a level of readiness to respond to urgent public health challenges.

The mechanism that produces and perpetuates chronic underinvestment in federal public health is structural. Unlike Medicare and Medicaid, which are primarily funded through mandatory spending rather than annual discretionary appropriations, most federal public health programs depend on annual discretionary funding and must compete each year with other domestic priorities. The PPHF was designed specifically to establish a dedicated mandatory funding stream for prevention. That the Fund has nonetheless consistently fallen short of the ACA's original funding schedule—through successive statutory reductions, often enacted as offsets for other federal spending priorities—illustrates the structural disadvantage facing dedicated prevention funding: even a mandatory funding stream designed to give public health investment protection from ordinary discretionary appropriations pressures has proved vulnerable to competing legislative priorities.

Beyond improving health outcomes—the primary purpose of public health investment—the economic returns are well documented and substantial. A 2017 systematic review of public health interventions in high-income countries, published in the *Journal of Epidemiology and Community Health*, found a median

return on investment of approximately 14 to 1—meaning that for every dollar invested, public health interventions generated about $14 in benefits to the health system and wider economy.[117] The evidence on specific programs is consistent with that finding. For example, routine childhood immunization is among the most thoroughly studied public health investments in the United States: a 2024 CDC analysis found that routine childhood vaccinations in the United States have, for children born during 1994–2023, prevented approximately 508 million cases of illness and more than 1.1 million deaths, generating an estimated $540 billion in direct cost savings and $2.7 trillion in broader societal savings.[118] These benefits were assessed in the context of the Vaccines for Children program, which provides vaccines at no cost to children whose families might not otherwise be able to afford them.

The economic logic underlying public health's return on investment is straightforward. Most public health interventions work by preventing a health event—an illness, a hospitalization, a premature death—that would otherwise generate substantial costs. Treating a heart attack in an emergency department, managing the long-term complications of uncontrolled diabetes, providing rehabilitation following a stroke, or caring for a child hospitalized with a vaccine-preventable illness each requires significant clinical resources. Preventing those events through population-level interventions—controlling hypertension, improving nutrition environments, expanding access to preventive screenings, and maintaining high immunization coverage—eliminates not just the immediate treatment cost but the downstream cascade of care that serious illness typically generates. Because the cost of clinical treatment is almost always far higher than the cost of the prevention that would have made it unnecessary, even modestly effective prevention programs tend to produce favorable economic returns. The calculus becomes still more favorable when prevention's broader economic effects are counted: a healthier workforce is more productive; children who do not suffer developmental harm from lead exposure or preventable illness can reach higher levels of educational and economic attainment; and communities with lower rates of chronic disease place less strain on publicly financed healthcare programs. Public health investment does not merely substitute a cheaper intervention for an expensive one; it reduces the total burden of illness that the entire healthcare system—and the economy that supports it—must absorb.

FIGURE 5: Why Effective Public Health Prevention Produces Economic Returns

Prevention reduces costly health events and the downstream burden they create.

WITH PREVENTION

1. **Public health investment**
   Vaccines, screening and early detection, lead prevention, hypertension control, nutrition, and healthy environments
2. **Health event prevented**
   Illness, hospitalization, or premature death averted
3. **Immediate medical costs avoided**
   Emergency care, acute treatment, and hospital costs never incurred
4. **Downstream cascade of care avoided**
   Fewer complications, follow-up visits, rehabilitation, and long-term management needs
5. **Broader economic gains**
   - Healthier workforce and higher productivity
   - For some interventions, better educational and long-term economic outcomes
   - Reduced spending pressure on publicly financed health programs

RESULT: Effective prevention can cost far less than the illness and treatment it helps avert.

WITHOUT PREVENTION

1. **Health event occurs**
   Heart attack, stroke, uncontrolled diabetes complications, or vaccine-preventable illness
2. **Immediate treatment costs**
   Emergency department care, hospitalization, and acute intervention
3. **Downstream cascade of care**
   Complications, follow-up care, rehabilitation, and chronic management
4. **Broader economic burden**
   - Lost productivity and earnings
   - For some childhood harms, poorer educational and long-term economic outcomes
   - Greater pressure on health systems and public programs

RESULT: Treatment costs and economic losses accumulate.

THE CORE LOGIC: Public health investment does not simply shift spending from treatment to prevention. By preventing illness or reducing its severity, it reduces the total burden of disease that the healthcare system—and the economy that supports it—must absorb.

Note: The pathways illustrate how effective preventive interventions can generate health and economic benefits. Returns vary by intervention; some interventions produce net savings, while others improve health at an additional but cost-effective level of spending.

The gap between the evidence base and actual investment decisions is illustrated with particular clarity by tobacco prevention. Rigorous analyses find that investments in tobacco prevention—including state tobacco-control programs that work to prevent youth smoking, reduce secondhand smoke exposure, and help people quit—produce significant savings in averted treatment costs.[119,120] Nevertheless, in FY 2024, states collectively spent an estimated $728.6 million on tobacco prevention and cessation programs while collecting an estimated $25.9 billion in tobacco settlement payments and taxes—meaning that roughly 2.8 percent of tobacco revenue was directed toward tobacco prevention.[121] A majority of states were spending less than 25 percent of the level CDC recommends for effective tobacco prevention; 19 states were spending less than 10 percent of the recommended level.[122]

High healthcare spending has not substituted for public health investment. The United States has built a system designed primarily around treating injury and disease, while the investment required to prevent those outcomes has remained chronically insufficient.

The value of public health investment is visible in the historical record: CDC's landmark series on public health achievements in the 20th century found that the average lifespan of persons in the United States lengthened by more than 30 years between 1900 and 1999, and the series attributed 25 of those years to advances in public health.[123] The consequences of chronic underinvestment are equally visible in more recent health outcomes data. The Commonwealth Fund's 2024 international comparison ranked the United States last overall among 10 comparable high-income nations, with the highest rates of preventable and treatable deaths.[124] Research has identified four preventable causes—cardiovascular disease, drug overdose, firearm deaths, including homicide and suicide, and motor vehicle crashes—as major contributors to the life-expectancy gap between the United States and comparable countries.[125] Each is amenable to evidence-based public health prevention strategies. A 2017 analysis estimated that nationwide implementation of 25 rigorously studied, evidence-based primary prevention protocols—including smoking-prevention programs, influenza and HPV vaccination, school-based obesity prevention, and hand-washing promotion—could have averted more than 15 percent of all U.S. deaths in 2010. Approximately two-thirds of the estimated averted deaths would have been from cardiovascular disease or cancer, underscoring the substantial gap between current outcomes and what evidence-based prevention could achieve.[126]

The evidence on prevention's potential—in lives saved, illness averted, and costs avoided—is substantial and consistent. The gap between that evidence and the nation's actual investment in prevention is equally well-documented. High healthcare spending has not substituted for public health investment; the outcomes data make that clear. The result is a system designed primarily around the treatment of injury and disease, in which the investment required to prevent such outcomes has remained chronically insufficient.

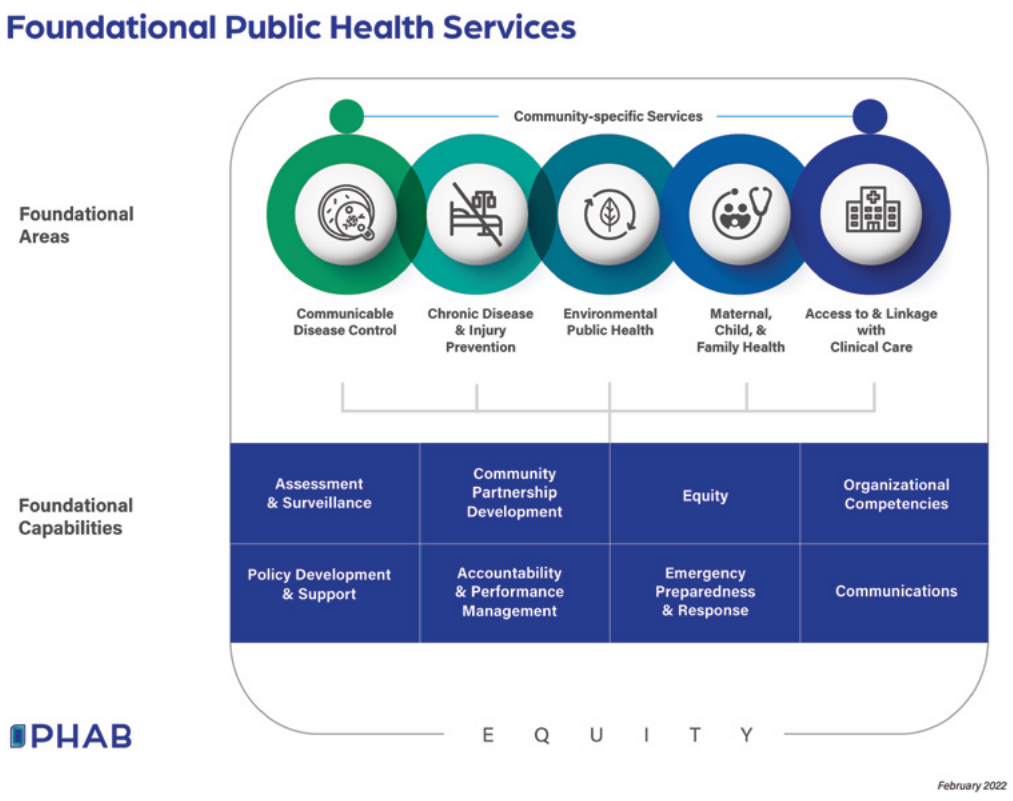
The pandemic era demonstrated that the nation is capable of investing in public health at a greater scale when a crisis demands it. What it did not produce was a durable change in the underlying commitment.

What Public Health Infrastructure Means

In public health, "infrastructure" encompasses a wide range of interconnected capabilities—disease surveillance, emergency response, chronic disease prevention, and environmental health protection—many of which operate outside public view and become most visible when they fail. The term therefore requires more careful definition than its everyday usage might suggest.

The Foundational Public Health Services framework—stewarded by the Public Health Accreditation Board and most recently updated in 2022—defines the minimum package of public health capabilities and programs that every community should be able to rely on, encompassing both cross-cutting functional capacities such as assessment, surveillance, communications, and policy development, and specific foundational program areas such as communicable disease control and environmental health.[127] For purposes of tracking public health spending, the Centers for Medicare & Medicaid Services (CMS) defines government public health activities to encompass population-wide services, including epidemiologic surveillance, immunization and vaccination programs, disease prevention, and the operation of public health laboratories.[128] These definitions share a common logic: public health infrastructure is not a single program or agency but a system of interconnected components that must function continuously—not only in declared emergencies—to protect the public's health. These include workforce, laboratories, surveillance and data systems, emergency preparedness capacity, and the federal scientific expertise, grant administration capacity, and technical assistance that support state, local, tribal, and territorial public health agencies in carrying out their responsibilities.

FIGURE 6: Foundational Public Health Services



The federal government's role in that system is irreplaceable. CDC is the nation's principal public health agency—the primary source of epidemiological expertise, laboratory science, disease surveillance, program development, and technical assistance that state, local, tribal, and territorial public health agencies draw on to serve their communities. But CDC does not primarily deliver public health services directly; it funds others to deliver them. Approximately 80 percent of CDC's domestic budget flows to external partners, including states, localities, tribes, tribal organizations, territories, healthcare systems, and community organizations.[129] That figure has significant implications for how reductions in CDC's budget translate into real-world effects: a cut to CDC's funding is, in practice, primarily a reduction in the resources available to the network of programs and personnel—at public health agencies, community-based organizations, healthcare systems, and other partners—that deliver public health services to communities across the country.

That network was already understaffed before any of the disruptions this report documents. A foundational 2021 analysis by the de Beaumont Foundation and the Public Health National Center for Innovations—*Staffing Up*—found that state and local governmental public health departments need a minimum of 80,000 additional full-time equivalent positions, an increase of nearly 80 percent,[130] to provide a minimum package of public health services. Approximately 54,000 of those positions were needed at local health departments—a 70 percent increase—and 26,000 at state agencies, with the greatest unmet need concentrated in smaller local departments serving fewer than 100,000 people.[131] The analysis was based on pre-COVID-19 data and did not include workforce needs for U.S. territories and freely associated states or Tribal Nations. The 80,000-position gap is therefore a pre-pandemic floor, not a current estimate, and it represents the minimum needed to provide a basic package of public health services—not the capacity required to respond effectively to emergencies or address the full range of community health needs.

Approximately 80 percent of CDC's domestic budget flows to external partners, including states, localities, tribes, tribal organizations, territories, healthcare systems, and community organizations. A cut to CDC's funding is, in practice, primarily a reduction in the resources available to the network of programs and personnel that health departments across the country rely on to deliver public health services.

The most recent nationally representative picture of the workforce comes from the 2024 Public Health Workforce Interests and Needs Survey (PH WINS), the fourth administration of a survey conducted by the de Beaumont Foundation and the Association of State and Territorial Health Officials. The survey received responses from nearly 57,000 employees representing 48 state health agencies and more than 1,100 local health departments in 49 states.[132] The findings, released in 2025, describe a workforce that remained committed but was carrying significant strain. Seventy-one percent of respondents reported experiencing at least one symptom of burnout; one in five reported near-constant burnout.[133] More than half of workers had been at their current agency for five years or less, and 41 percent had been working in public health for five years or less[134]—indicating a workforce in which accumulated institutional knowledge was concentrated in a relatively small share of more experienced employees. Epidemiologists—among the hardest-to-replace members of the public health workforce—were particularly likely to report departure plans: nearly 3 in 10 planned to leave their agency within the next year, and more than 1 in 5 intended to leave public health entirely.[135]

For purposes of this report, "public health infrastructure" refers to the people, systems, and operational capacities that enable public health agencies to carry out foundational public health services. This framing draws on the Foundational Public Health Services framework and related work in the field, while emphasizing the capacities most relevant to the funding

and operational disruptions documented in this report: workforce, laboratories, surveillance and data systems, communications and public information capacity, emergency preparedness capacity, and the federal scientific expertise, grant administration capacity, and technical assistance that support state, local, tribal, and territorial public health agencies.

Each of these components carries specific vulnerabilities that help explain why the stakes of the investments and disinvestments documented in this report are so high.

WORKFORCE is foundational. Public health work is knowledge-intensive and credentialed. Epidemiologists, laboratorians, environmental health specialists, health educators, and public health nurses require years of training and field experience. Replacing a senior epidemiologist, for example, may require recruiting from a constrained talent pool, navigating lengthy hiring processes, and then developing a new team member who has credentials but who may not yet have the institutional knowledge, community relationships, and jurisdictional expertise that the departing professional carried.

LABORATORIES are the diagnostic backbone of the public health system—the facilities that identify novel pathogens, characterize outbreaks, test environmental samples, and produce the data that support public health decisions. As CDC told Congress in July 2024, a high-functioning and effective national laboratory system—one that includes CDC working closely with state and local public health and clinical laboratories—is critical for providing timely and actionable data to protect public health, particularly at the onset of emergency responses and testing surges; and maintaining that capacity requires consistent attention and investment across all laboratory systems, encompassing quality, safety, informatics, workforce, and response readiness.[136] That sustained investment has been difficult to secure. Governmental laboratory infrastructure is expensive to build and maintain, requires continuous quality assurance, and depends on

specialized staff whose recruitment and retention are perennially challenged by compensation competition from clinical and private-sector laboratories. The Association of Public Health Laboratories has documented these pressures across its membership: insufficient sustained funding and workforce instability are among the most common challenges facing public health laboratories nationwide, including a pattern of departures that erodes the institutional knowledge—of processes, procedures, and partner relationships—that effective laboratory response depends on.[137] Laboratories in rural and geographically dispersed states face compounding disadvantages, operating with limited resources far from major population centers and with little margin to absorb funding disruptions.[138] The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases cooperative agreement—the primary CDC mechanism for supporting state, local, and territorial infectious disease epidemiology and laboratory capacity[139]—was substantially supplemented during the COVID-19 pandemic[140,141,142] with emergency funds that have since expired or been unexpectedly terminated before planned work was complete, leaving many laboratories navigating a return toward pre-pandemic resource levels even as demands on the system have not receded.[143]

SURVEILLANCE AND DATA SYSTEMS are the means by which the public health system detects and monitors health threats. Without functioning disease surveillance, emerging threats go undetected; without modern, interoperable data infrastructure, the lag between a health event and a public health response can cost lives. CDC's Data Modernization Initiative—established in 2019 with its first dedicated funding appropriated for FY 2020—was designed as a multiyear effort to move the nation's fragmented and often paper-based public health data and surveillance infrastructure toward interoperable, near-real-time electronic data exchange and address a recognized, long-standing gap.[144] A 2024 analysis by The Pew

Charitable Trusts found wide variation across states in the policies and practices governing how clinical data reach public health agencies, with major staffing, information technology, and funding constraints persisting alongside meaningful progress toward automated electronic reporting[145]—underscoring that data system fragility is not only a federal problem but a structural feature of the national system as a whole. Real progress on modernization was underway as of 2024—but it remained incomplete and at risk.

EMERGENCY PREPAREDNESS CAPACITY encompasses more than response plans and medical stockpiles. It includes the trained personnel, practiced coordination systems, and established relationships between agencies—at the federal, state, and local levels—that allow an effective response when a threat materializes. Two federal grant programs form the financial backbone of that capacity: the Public Health Emergency Preparedness (PHEP) cooperative agreement, administered by CDC, which funds state and local health department preparedness activities; and the Hospital Preparedness Program (HPP), administered by the Administration for Strategic Preparedness and Response (ASPR) within the Department of Health and Human Services, which funds healthcare system readiness for public health emergencies. PHEP supports thousands of positions across state, local, and territorial health departments,[146] and CDC's Public Health Preparedness and Response team responds each year to hundreds of requests for information and technical assistance from state, tribal, local, and territorial health departments[147]—each representing an established relationship and reservoir of knowledge that cannot be reconstituted on short notice.

GRANT ADMINISTRATION CAPACITY is among the least visible components of public health infrastructure, but it is the connective tissue of the federal-to-state and local funding relationship. The federal public health funding system operates primarily through cooperative agreements and grants, and administering that system effectively—issuing awards on schedule, processing payments, providing technical assistance, monitoring performance, and supporting grantee compliance—requires dedicated, experienced staff at the federal level. When that capacity is strained or reduced, the effects propagate outward: grantees experience delays, programs miss implementation windows, and the effective value of appropriated funds diminishes, even when the dollar amounts are unchanged.

TECHNICAL ASSISTANCE is one mechanism by which state, local, tribal, and territorial health departments draw on CDC and other federal expertise as a shared national resource. That expertise matters not only for implementation, but also because no health department can maintain specialized in-house capacity for every disease, condition, exposure, injury, or emerging threat it may need to address. Federal agencies provide specialized depth that state and local agencies rely on precisely because some needs are too infrequent or technically complex to staff locally. When CDC program office staffing levels decrease, so does the agency's capacity to provide implementation guidance, respond to field questions, assist with program design, support quality improvement, and deploy specialized expertise when jurisdictions request help. Epidemic-assistance investigations (Epi-Aids) illustrate this function: they allow state, local, tribal, territorial, and other public health authorities to request rapid, short-term assistance from CDC's Epidemic Intelligence Service officers and other subject matter experts for urgent public health problems, including both infectious and noninfectious threats.[148] For many health departments operating with constrained in-house capacity, federal technical assistance is not a supplement to local capacity—it is a prerequisite for effective program implementation and response.

The need for specialized implementation support extends beyond program-specific guidance to the

technical work of modernizing public health systems themselves. For example, the Public Health Data Modernization Implementation Center Program was established specifically to help public health agencies adopt current health IT standards and expand participation in data exchange networks.[149,150,151] The program's existence reflects a recognition that funding for technology is only one part of modernization: agencies also need sustained expert support to translate funding into functional infrastructure. That implementation capacity is itself a component of infrastructure, and one that is rarely reflected in appropriations figures.

COMMUNICATIONS & PUBLIC INFORMATION CAPACITY is also a core component of public health infrastructure. Public health agencies must be able to issue timely alerts, translate scientific findings into actionable guidance for clinicians and the public, explain changing risk, and respond to false or misleading claims that can undermine health-protective action. Those functions depend on trained communications staff, trusted messengers, established relationships with healthcare providers and community partners, and the institutional credibility built through consistent, evidence-based communication over time. Trust is itself an infrastructure asset: agencies that have built a record of accurate, transparent, and timely communication are better positioned to deliver credible guidance during emergencies. When communications capacity is reduced or scientific messaging is delayed, inconsistent, or politicized, the consequences are operational: clinicians may lack timely guidance, communities may receive unclear or conflicting information, and public trust—essential to vaccination, outbreak response, emergency preparedness, and other public health functions—can erode.

These components share one critical characteristic: once degraded, they cannot be quickly restored. The epidemiologist who departs takes with them the knowledge of local disease patterns, community relationships, and response protocols that years of field work produced. The surveillance data series that lapses loses its longitudinal integrity—and much of its value for trend analysis, outbreak investigation, and policy evaluation. The partnerships among federal, state, local, territorial, and tribal agencies, and between those agencies and the community organizations they work with and through, are built over years and cannot be rapidly reconstituted once lost or disrupted.

The federal government has demonstrated, through its own program design, that it understands this dynamic. CDC's Public Health Infrastructure Grant (PHIG)—a historically large and flexible federal investment in foundational public health infrastructure—had awarded more than $5 billion as of December 2025 over a five-year grant period running from December 2022 through November 2027.[152,153] That total included approximately $4.7 billion for 107 health departments and $382 million for three national public health partners.[154] The grant's multiyear structure and its focus on workforce, foundational capabilities, and data modernization reflect the premise that rebuilding public health infrastructure requires sustained, cross-cutting investment. That recognition makes the program's fiscal trajectory a consequential open question in federal public health policy. PHIG's largest component—the $3 billion, five-year workforce investment funded through the American Rescue Plan Act—rests on one-time supplemental funding and runs through November 2027. Other PHIG components depend on annual appropriations to varying degrees, including foundational capabilities and core funding for data modernization. Public Health Infrastructure and Capacity was funded at approximately $360 million in FY 2026.[155] The issue, therefore, is not whether federal infrastructure support disappears entirely, but whether annual funding will be sustained and expanded enough to prevent a sharp drop-off as time-limited grant funding expires. It is also far from the only uncertainty facing federal public health infrastructure.

FIGURE 7: Seven Mutually Reinforcing Components – Disruption in Any One Can Affect the Whole

WORKFORCE

Many public health roles require specialized training and field experience.

VULNERABILITY
Departing staff carry institutional knowledge and community relationships that credentials alone cannot replace.

SURVEILLANCE AND DATA SYSTEMS

Disease surveillance and interoperable data infrastructure allow emerging threats to be detected and responses mounted in time.

VULNERABILITY
Data continuity is essential; gaps in collection erode the longitudinal value needed for trend analysis, outbreak investigation, and policy evaluation.

GRANT ADMINISTRATION CAPACITY

Administering federal grants requires experienced staff to issue awards, process payments, monitor performance, and support grantee compliance.

VULNERABILITY
When staffing is strained, resulting delays can cause programs to miss implementation windows even when appropriated funding is unchanged.

COMMUNICATIONS

Public health communicators translate complex and evolving information into clear, timely, and accessible guidance that helps people understand risks, take protective action, and connect with services.

VULNERABILITY
Effective communication depends on skilled staff, trusted messengers, established channels, multilingual capacity, and coordination across agencies and communities. Once credibility or reach is lost, it can be difficult to restore—especially during a crisis.

LABORATORIES

Public health laboratories identify novel pathogens, characterize outbreaks, and produce the data that drive public health decisions.

VULNERABILITY
Specialized staff are difficult to recruit and retain, and laboratory systems require sustained investment to maintain readiness between emergencies.

EMERGENCY PREPAREDNESS CAPACITY

Effective emergency response depends on trained personnel, practiced coordination systems, and established interagency relationships.

VULNERABILITY
These systems and relationships require sustained investment; they cannot be reconstituted on short notice after disruption.

TECHNICAL ASSISTANCE

Federal technical expertise supports state and local practice through implementation guidance, field support, and quality improvement.

VULNERABILITY
For health departments with constrained in-house capacity, federal technical assistance can be essential to effective implementation.

SHARED VULNERABILITY

Once degraded, these capacities cannot be quickly restored.

Lost staff, gaps in data collection, weakened federal-state-local relationships, disrupted community partnerships, reduced communications capacity, and eroded public trust can have lasting effects that may take years to repair or rebuild—and communities and public health systems bear the costs in the meantime.

The Fragility Entering 2025

The documented disruptions did not strike a healthy, robust system at full capacity. They struck a system that was already carrying significant structural vulnerabilities—navigating a difficult fiscal transition, managing the expiration of temporary resources on which real capacity had been built, and doing so without a meaningful margin to absorb additional stress.

The COVID-19 pandemic produced a temporary surge of federal investment in public health capacity. Emergency supplemental appropriations funded major expansions in workforce, laboratory capability, disease surveillance, immunization infrastructure, and data modernization.[156] State and local health departments hired thousands of new employees, many of them in temporary, term-limited, grant-funded, or contract-supported positions.[157,158] CDC expanded existing cooperative agreements and established new ones, developed new programs, and supported new data systems that had not previously existed. Some of that investment was designed explicitly to address long-standing structural deficits rather than serve immediate pandemic needs—most notably the PHIG, funded through the American Rescue Plan Act (ARPA) and later annual appropriations, which directed resources toward workforce, foundational capabilities, and data modernization at health departments that had been chronically underfunded long before the pandemic began,[159] and CDC's broader Data Modernization Initiative, which sought to modernize the agency's own data infrastructure and that of its partners.[160] That investment represented genuine and meaningful progress.

But that progress was built, in significant part, on a temporary foundation. The workforce hired with COVID-19 emergency funds depended on continued federal funding that was never guaranteed. CDC's Advanced Molecular Detection program, which uses cutting-edge genomic technology to identify and track pathogens,[161] had a base annual appropriation of around $40 million, yet received more than $1.7 billion in supplemental funding; as a result, a substantial share of its pandemic-era scale depended on temporary funds.[162,163] PHIG runs through November 2027,[164] and as of early 2025, health departments were in year three of the five-year award, with no confirmed successor funding. State and local fiscal recovery funds made available through ARPA carried an obligation deadline of December 31, 2024.[165] The COVID-era investments had not solved the structural problem. They had layered temporary capacity onto a chronically underfunded base—and that temporary layer was already in the process of being shed as 2025 began.

That temporary layer included investments in the nonfederal workforce pipeline. Public Health AmeriCorps, launched as a CDC-AmeriCorps partnership with ARPA funding, was designed to expand near-term public health capacity while creating pathways into the field for future workers, including people who came from, or had lived experience in, the communities they served.[166,167] Members served in health departments, community-based organizations, clinics, and other local settings—including in rural areas, tribal communities, and other communities facing persistent public health workforce and access challenges—supporting activities such as health education, disease prevention, outreach, navigation, and emergency response. The program illustrates how time-limited emergency resources can expand current capacity and build future career pathways for the workforce—but also leave both vulnerable when those resources are not replaced with sustained funding.

The Fiscal Responsibility Act of 2023 (FRA) accelerated the contraction. The FRA rescinded an estimated $13.2 billion in unobligated COVID-19 and American Rescue Plan public health funding from HHS accounts,[168,169] including the Public Health and Social Services Emergency Fund, CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health

(NIH), and the Food and Drug Administration (FDA). At CDC, the rescissions affected more than $950 million for vaccine distribution and confidence, roughly $450 million for Disease Intervention Specialist activities, and approximately $300 million for global health activities.[170,171] The rescissions affected funding available to support ongoing response and infrastructure activities. The FRA also imposed discretionary spending caps for FY 2024 and FY 2025,[172] directly constraining the room available for public health appropriations at precisely the moment when emergency funds were winding down and no replacement investment had been identified. By the time FY 2025 began, state and local health departments were navigating significant fiscal cliffs: COVID-era positions going unfilled or being eliminated, supplemental-funded programs winding down, and infrastructure grants past their midpoints with no successors announced.

FY 2025 provided no relief. The government operated under a series of short-term continuing resolutions from October 2024 until March 15, 2025, when a full-year continuing resolution (P.L. 119-4) was enacted that held most programs, including CDC, at FY 2024 funding levels for the remainder of the fiscal year.[173] There was no new investment to replace the expiring emergency resources, and the appropriations environment left little room for increases even where political will existed.

The workforce data made the preexisting stress visible. The National Association of County and City Health Officials' 2024 Forces of Change survey, which tracks conditions and trends at local health departments nationwide, found that 17 percent of local health departments had already experienced budget cuts in FY 2024 and that 23 percent anticipated cuts in FY 2025[174]—predating the new administration's actions and reflecting the structural pressures of expiring funds and flat appropriations. The 2024 PH WINS survey captured a workforce experiencing widespread burnout, substantial turnover risk among critical specialties, and relatively short institutional tenure—more than half of employees had worked at their current agency for five years or less[175]—leaving agencies vulnerable to further disruption. A *Health Affairs* study found that among state and local public health workers age 35 or younger and those with less than five years of experience, departure rates from 2017 to 2021 were 74 percent and 77 percent, respectively.[176] High turnover among early-career workers, combined with projected cumulative departures well exceeding the rate of new hiring, left the workforce pipeline unable to offset the loss of experienced staff.[177]

The picture entering 2025 was mixed. Investment during and following the pandemic produced real improvements in laboratory technology, surveillance systems, workforce training, and data infrastructure. PHIG represented a genuine shift in how the federal government conceptualized and supported foundational public health capacity. The accurate characterization is partial and precarious progress—genuine advances built on a temporary funding basis, not yet consolidated into durable infrastructure, and increasingly at risk as the funding that supported them wound down.

What the system lacked entering 2025 was margin. Its permanent funding base was falling in real terms. Its emergency-era resources were expiring or winding down without comparable permanent replacement. Its workforce was strained. Its flagship infrastructure grant had just under three years remaining, with no successor identified. And, as documented earlier, public health spending by federal, state, and local governments had nearly returned to its pre-pandemic share of total national health expenditures. Federal public health investment, following the emergency surge, returned to the same structural baseline that had characterized the preceding decade.

A system at that baseline, without reserve capacity and in the middle of a fiscal transition, was a system with no buffer against disruption.

What the system lacked, entering 2025, was margin.

FIGURE 8: Pandemic-Era Public Health Funding: Major Investments, Expirations, and Rescissions

Chronological timeline showing major pandemic-era public health investments, a program launch, funding or emergency end points, and a rescission.

2020

ENACTED
March 6, 2020 · P.L. 116-123

Coronavirus Preparedness and Response Supplemental Appropriations Act
The act provides approximately $8.3B overall. CDC receives $2.2B, including no less than $950M for grants and cooperative agreements supporting state, local, territorial, and Tribal surveillance, epidemiology, laboratory capacity, and other preparedness and response activities.

ENACTED
March 27, 2020 · P.L. 116-136

Coronavirus Aid, Relief, and Economic Security (CARES) Act
Approximately $2.2T total; CDC receives $4.3B. CDC uses $631M of CARES Act funding to expand the existing Epidemiology and Laboratory Capacity (ELC) cooperative agreement across 64 jurisdictions.

ENACTED
April 24, 2020 · P.L. 116-139

Paycheck Protection Program and Health Care Enhancement Act
CDC receives $1B; HHS also provides $10.25B through CDC's Epidemiology and Laboratory Capacity cooperative agreement to support testing, contact tracing, surveillance, laboratory expansion, and related response capacity.

ENACTED
December 27, 2020 · P.L. 116-260, Division M

Consolidated Appropriations Act, 2021 / Coronavirus Response and Relief Supplemental Appropriations Act
CDC receives $8.75B for COVID-19 vaccine planning, distribution, administration, and monitoring, available for obligation through September 30, 2024. HHS also provides $19.11B through ELC for testing, contact tracing, disease investigation, and enhanced surveillance.

2021

ENACTED
March 11, 2021 · P.L. 117-2

American Rescue Plan Act (ARPA)
Approximately $1.9T total. Includes $7.66B to establish, expand, and sustain the public health workforce, of which CDC later uses $3B for PHIG's workforce component; $1.75B for genomic sequencing, analytics, and disease surveillance; and $350B for State and Local Fiscal Recovery Funds.

2022

MILESTONE
December 1, 2022 · Grant period: Dec. 2022–Nov. 2027

Public Health Infrastructure Grant (PHIG) – Awards Begin
Five-year grant begins for 107 health departments and three national public health partners. As of December 2025, CDC had awarded more than $5B in total—including more than $4.6B to health departments and more than $382M to national partners—for workforce, foundational capabilities, and data modernization.

2023

EXPIRATION
April 10/May 11, 2023

COVID National Emergency and Federal Public Health Emergency End
Congress terminates the national emergency on April 10. The separate Section 319 federal public health emergency expires at the end of May 11. Some emergency authorities and administrative flexibilities end or begin winding down, with timing varying by program.

RESCISSION
June 3, 2023 · P.L. 118-5

Fiscal Responsibility Act of 2023
Rescinds approximately $13.2B in unobligated balances from selected HHS public-health accounts—including CDC, the Public Health and Social Services Emergency Fund, NIH, HRSA, FDA, and medical-supply accounts—within approximately $27.1B in rescissions governmentwide. The law also establishes discretionary spending caps for FY 2024 and FY 2025.

2024

EXPIRATION
July 31, 2024

ELC Advanced Molecular Detection Sequencing and Analytics Supplement Ends
A pandemic-era ELC supplemental award supporting genomic sequencing and analytics reaches the end of its project period. ARPA's $1.75B appropriation for genomic sequencing and pathogen surveillance was available until expended; the Advanced Molecular Detection (AMD) program itself continued with annual base funding.

EXPIRATION
September 30, 2024

CRRSA Vaccine Appropriation Reaches End of Availability
The $8.75B CDC vaccine appropriation provided in Division M was available for obligation through September 30, 2024.

EXPIRATION
December 31, 2024

ARPA State and Local Fiscal Recovery Funds – Obligation Deadline
Recipients were required to obligate their shares of the $350B State and Local Fiscal Recovery Funds program by December 31, 2024. Public health workforce, facility, and program investments supported through SLFRF were subject to that deadline. Most obligated funds must be expended by December 31, 2026.

Sources: Congress.gov and Congressional Research Service; CDC; Congressional Budget Office; U.S. Department of Health and Human Services; U.S. Department of the Treasury.

Disruption Layered on Fragility: Administration Actions Beginning in 2025

Beginning in January 2025, the federal public health system experienced a convergence of workforce reductions, grant terminations, agency restructuring proposals, disruptions to CDC's scientific advisory and communications functions, and a budget request that together materially reduced—or proposed to reduce—federal public health capacity and altered the terms on which that capacity had to be assessed. These actions and proposals—pursued primarily through executive and administrative channels, without prior congressional authorization in several cases, and while legal challenges were pending in others—affected whether federal agencies retained the staff, organizational structure, scientific integrity, and operational stability needed to administer programs, support grantees, sustain surveillance systems, and respond to emerging health threats. This section documents those actions: what was done, when, through what mechanism, and with what consequences for the agencies, programs, and jurisdictions that depend on federally supported public health infrastructure.

SECTION AT A GLANCE

- Beginning in January 2025, hiring restrictions, voluntary departures, probationary removals, reductions in force, and continued attrition substantially reduced staffing across federal health agencies. CDC's workforce contracted below its pre-pandemic baseline, while HRSA, SAMHSA, FDA, and other agencies also sustained significant losses.
- Abrupt grant terminations and pauses, delayed apportionments, and restrictions affecting awarded or appropriated funds destabilized state and local health departments, behavioral health providers, community organizations, and other grantees that had built staffing, contracts, and multiyear workplans around federal support.
- Proposed agency reorganizations and changes affecting CDC's leadership, scientific advisory processes, data resources, and public communications added institutional uncertainty to the workforce and funding disruptions already underway.
- The FY 2026 President's Budget Request sought to translate this direction into a permanent fiscal and organizational structure through deep funding reductions, elimination of the Prevention and Public Health Fund, creation of the Administration for a Healthy America, and a substantially smaller and narrower CDC.
- Courts, Congress, and the administration itself reversed or limited some actions. Those reversals did not automatically restore departed expertise, interrupted work, strained partner relationships, or confidence in the continuity of federal support.

Workforce Disruption

The disruption to the federal public health workforce unfolded in overlapping waves across 2025 and into 2026, with each wave compounding the effects of earlier actions.

HIRING FREEZE AND REPLACEMENT LIMITS

On January 20, 2025, the administration issued a presidential memorandum freezing most civilian federal hiring.[178] The freeze applied across HHS, including CDC, and was extended through October 15, 2025.[179,180] The freeze was paired with broader replacement limits established in Executive Order 14210: after the hiring freeze and implementation of the administration's hiring plan, agencies were directed to hire no more than one employee for every four employees who departed federal service, with exceptions for certain functions.[181] April 2025 guidance reiterated how that ratio would apply once the freeze expired.[182] On October 15, 2025, the administration imposed a new ongoing hiring-control process requiring agency strategic hiring committees and annual staffing plans.[183] The practical consequence was cumulative: routine departures through retirements, resignations, and transfers generally could not be replaced without exemption or approval, converting normal turnover into a persistent mechanism of capacity reduction. Even where Congress maintained program funding at stable levels, federal public health agencies were losing staff they could not readily replace.

DEFERRED RESIGNATION AND VOLUNTARY SEPARATION PROGRAMS

In late January 2025, the Office of Personnel Management (OPM) launched a government-wide deferred resignation program—commonly referred to as the "Fork in the Road" program[184,185]—offering eligible federal employees the option to resign effective September 30, 2025, while retaining pay and benefits and, in many cases, being placed on paid administrative leave.[186] The response at HHS was significant: approximately 10,000 HHS employees—roughly 12 percent of the department's workforce—departed or were expected to depart through deferred resignation, voluntary early retirement, or buyout payments.[187,188] At CDC specifically, more than 400 employees entered paid-leave status through the deferred resignation program; more than 500 retired, a majority through the agency's voluntary early retirement offer; and approximately 180 accepted Voluntary Separation Incentive Payments, according to June 2025 reporting based on CDC presentation materials.[189]

Though departures through these programs were nominally voluntary, they took place in the context of impending layoffs, announced organizational restructuring, and sustained institutional uncertainty. The practical effect was a rapid loss of institutional knowledge and program continuity across HHS.

PROBATIONARY EMPLOYEE REMOVALS

Beginning in mid-February 2025, HHS distributed termination notices to probationary and trial-period employees—staff in their first one to two years of federal service or those recently promoted to new positions.[190] By March 13, 2025, approximately 3,248 such notices had been issued across HHS.[191] At CDC, approximately 750 employees in probationary status received termination notices, including fellows from training programs that deploy public health professionals to state and local health departments.[192,193,194] In February and March 2025, a series of court orders temporarily halted aspects of the probationary-employee removals and required

numerous federal agencies to reinstate thousands of affected workers pending further litigation. At HHS, which identified more than 3,000 affected probationary employees, many reinstated workers remained or were placed on paid administrative leave.[195,196,197] On April 8, 2025, the Supreme Court stayed a lower court's reinstatement order[198,199] and the U.S. Court of Appeals for the Fourth Circuit issued a similar ruling the following day,[200,201] clearing the way for agencies to proceed with probationary terminations in many cases. The probationary removals were significant not only for their immediate effect on agency headcount but because they disproportionately affected early-career professionals and training program fellows—part of the pipeline through which CDC develops and deploys public health expertise to state and local health departments.

SPRING 2025 REDUCTIONS IN FORCE

On March 27, 2025, HHS formally announced a reduction in force (RIF) as part of a broader departmental restructuring plan.[202] Beginning April 1, 2025, HHS implemented RIF actions eliminating approximately 10,000 positions department-wide.[203] At CDC, approximately 2,400 RIF notices were issued.[204] Program areas affected included disease surveillance, epidemiology, occupational health, injury prevention, tobacco prevention, lead poisoning prevention, specialized laboratory functions, and administrative and operational support functions.[205] In some cases, the reductions eliminated entire offices or branches, at least initially, leaving funded program areas without the specialized staff needed to administer grants, provide technical assistance, maintain surveillance and data systems, and support state and local implementation. For example, CDC's National Center for Injury Prevention and Control lost more than 200 staff.[206] Combined with the approximately 10,000 employees who had exited through voluntary departure programs, the total announced HHS workforce reduction approached 20,000 employees—from approximately 82,000 toward a stated target of 62,000.

PARTIAL REINSTATEMENTS

Not all RIF actions held. By mid-June, for example, approximately 800 of the roughly 2,400 CDC RIF notices had reportedly been rescinded.[207] Reinstated staff included teams working in HIV and sexually transmitted infection prevention, environmental health, lead-poisoning prevention, and global health. However, partial reinstatements did not erase the disruption already sustained. Program teams had already been disbanded, departing staff had left with their institutional knowledge and partner relationships, and state and local partners had experienced extended uncertainty about whether federal programs and technical assistance would continue.

THE CASE OF NIOSH

The National Institute for Occupational Safety and Health (NIOSH) was among the CDC components most severely affected by the RIF actions. NIOSH is CDC's primary occupational safety and health research institute, with responsibilities that include research, surveillance, technical assistance, and recommendations related to workplace injury and illness prevention, including for miners, firefighters, healthcare workers, agricultural workers, and others in hazardous occupations. Initial RIF actions reportedly affected most of NIOSH's workforce, with estimates ranging from roughly 850 to about 1,000 employees—roughly nine in 10 NIOSH staff.[208,209] The cuts threatened highly specialized federal capacity related to mining safety, firefighter health, respirator certification and personal protective technology, occupational disease surveillance, and long-running worker health research.

HHS later reversed course following sustained opposition from lawmakers of both parties, labor organizations, occupational health groups, mine safety advocates, and others. In spring 2025, more than 300 NIOSH employees were reinstated, according to reporting at the time;[210,211] in January 2026, HHS

rescinded the remaining NIOSH RIF notices and reinstated all NIOSH employees who had received layoff notices.[212] But these events illustrate a broader point about the 2025 workforce disruption: specialized public health capacity can be destabilized quickly, while restoration is slower and incomplete. Even when layoff notices are later rescinded, staff may have retired or taken other jobs, research and surveillance activities may have been interrupted, and partners may have lost confidence and trust in the continuity of federal support.

OCTOBER 2025 WORKFORCE ACTIONS

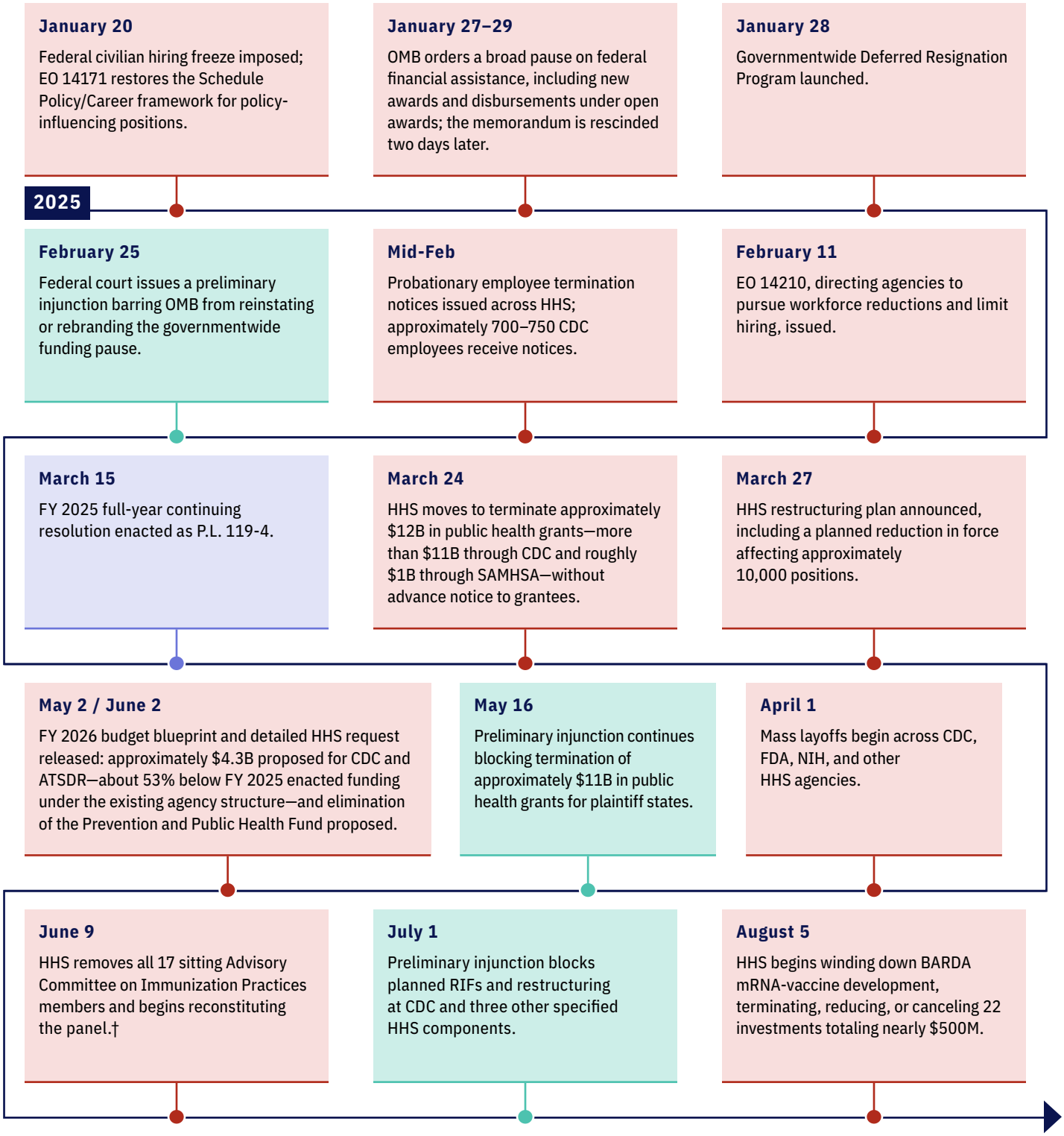
The workforce disruption did not end in spring 2025. The federal government entered a shutdown on October 1, 2025, and the lapse in appropriations lasted 42 days, ending after a reopening measure was signed late on November 12, 2025.[213] During the shutdown, HHS issued a further round of approximately 1,300 RIF notices to CDC employees, framed as shutdown-related. Approximately 700 notices were rescinded within about 24 hours, with HHS attributing the over-issuance to data discrepancies, processing errors, or a coding error. Approximately 600 notices initially remained in effect.[214,215,216] Federal litigation followed, with a court finding the shutdown-related RIFs likely unlawful; some affected employees were placed on paid administrative leave while legal proceedings continued.[217] Among those caught in the sequence of notices and rescissions were members of CDC's *Morbidity and Mortality Weekly Report* publication team, Epidemic Intelligence Service officers, and staff supporting the agency's response to the active measles outbreak.[218]

The October 2025 RIFs were ultimately reversed by statute. The continuing resolution enacted on November 12, 2025, included a provision specifying that any RIF initiated by an executive agency between October 1 and the date of enactment "shall have no force or effect," requiring agencies to rescind notices and restore affected employees to their September 30 employment status with back pay.[219] The law also prohibited new reductions in force through January 30, 2026.[220]

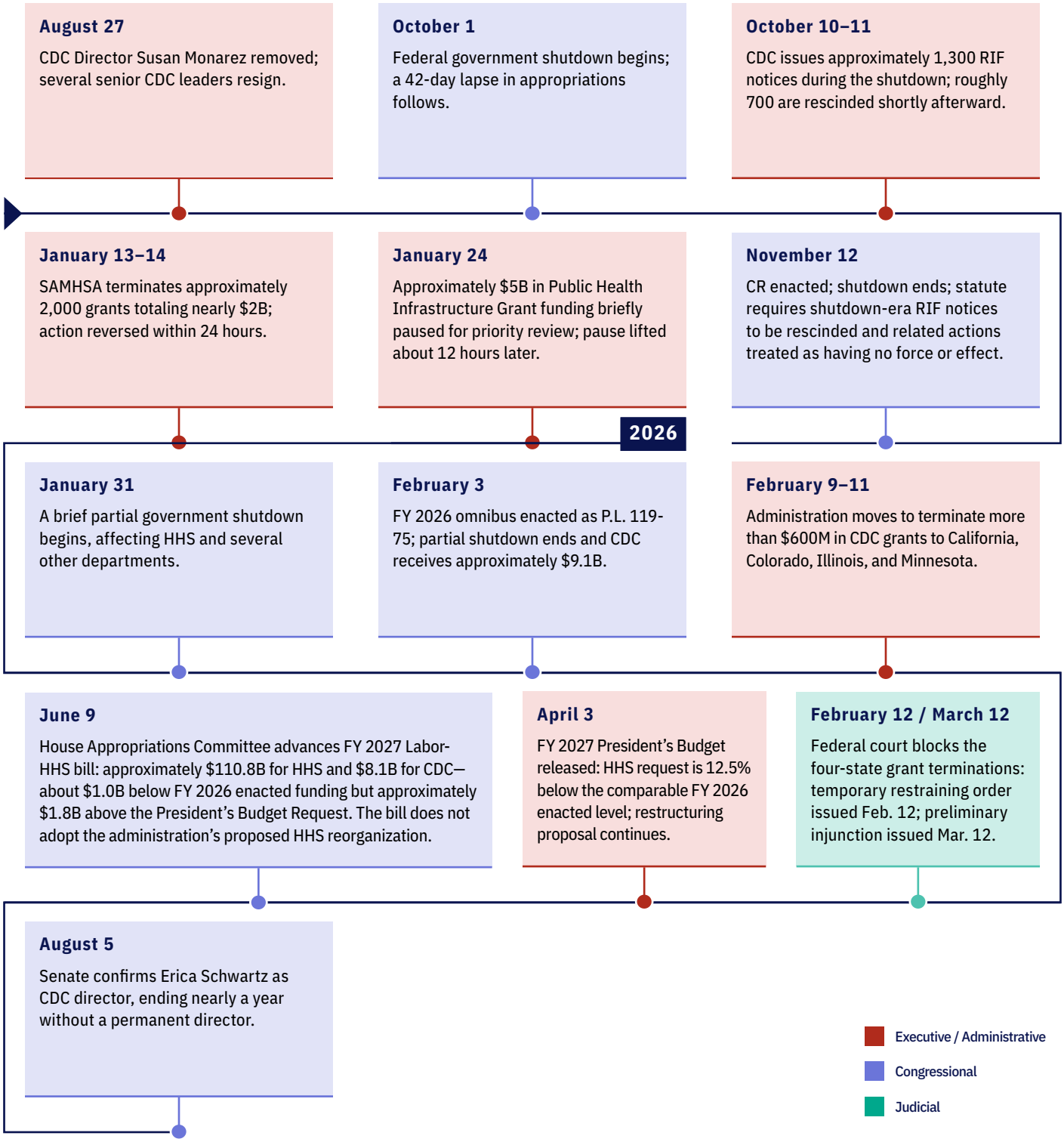
The shutdown itself interrupted agency operations for 42 days at a period when CDC's capacity was already substantially reduced, adding further uncertainty to grant administration and program activities at a critical juncture in the fiscal year.

FIGURE 9: Major Federal Actions Affecting Public Health Funding and Infrastructure

January 2025–August 2026



† Included as a disruption to scientific advisory infrastructure.



Sources: White House and OMB; OPM; HHS; CDC; Congress.gov, GovInfo, and congressional committee materials; federal court orders and state attorney general materials; AP; Reuters; TFAH analysis.

NET WORKFORCE REDUCTION

Data from the federal government's own personnel systems make it possible to quantify the net workforce contraction over the period encompassing the hiring freeze, voluntary separation programs, probationary removals, and RIF actions described above. Data from OPM—the federal agency responsible for overseeing the civilian federal workforce—drawn from monthly snapshots of active employees and last updated as of May 2026, document the scale of that contraction.

Viewed against the longer arc, CDC's workforce grew substantially from the eve of the pandemic through FY 2024, rising from 10,487 employees at the end of FY 2019 to 12,820 at the end of FY 2024.[221] That increase coincided with—and was supported in part by—the demands of the COVID-19 response and emergency supplemental appropriations, but it also occurred as CDC supported broader responsibilities and investments, including drug-overdose prevention and surveillance, public health data modernization, laboratory and surveillance capacity, and outbreak forecasting and analytics through the Center for Forecasting and Outbreak Analytics. The May 2026 level of 9,218 employees represents a reversal of that growth and more: CDC's workforce was not only well below its FY 2024 peak but at its lowest level since FY 2008.[222] In net terms, workforce losses since January 2025 erased the preceding expansion and contracted the agency below its pre-pandemic baseline, even as CDC's responsibilities and the expectations placed on its infrastructure had expanded over the preceding years.

The reduction unfolded in two phases. From the end of FY 2024 through the end of FY 2025—a period encompassing the hiring freeze, the probationary removals, the voluntary separation programs, and the spring 2025 RIFs and their partial reinstatements, but predating the October 2025 shutdown-era actions—CDC declined from 12,820 to 10,223 employees, a loss of approximately 2,600 positions, or roughly 20 percent of its workforce. From the end of FY 2025 through May 2026—reflecting continued attrition under ongoing hiring limits and any separations not restored—the agency lost approximately 1,000 additional employees, declining from 10,223 to 9,218. The cumulative reduction from the end of FY 2024 through May 2026 was approximately 3,600 employees, or roughly 28 percent of CDC's pre-disruption workforce.

The contraction extended well beyond CDC. Several other HHS agencies whose work is central to public health also lost substantial shares of their workforces over the same period. HRSA—the Health Resources and Services Administration, which funds community health centers, the National Health Service Corps, and maternal and child health programs—declined from 2,689 employees at the end of FY 2024 to 1,668 as of May 2026, a reduction of approximately 38 percent. The Substance Abuse and Mental Health Services Administration (SAMHSA), the primary federal agency for behavioral health programs, declined from 916 to 527 employees—a reduction of approximately 42 percent. FDA, which regulates the safety of drugs, vaccines, medical devices, and the food supply—declined from 20,912 employees at the end of FY 2024 to 16,261 as of May 2026, a reduction of approximately 22 percent.[223]

TABLE 1: Workforce Change at HHS and Selected HHS Agencies, September 2024–May 2026

Civilian employee headcount

AGENCY	SEPT. 30, 2024	MAY 31, 2026	NET CHANGE	PERCENT CHANGE
Department of Health and Human Services (HHS), Total	92,620	73,186	–19,434	–21%
Centers for Disease Control and Prevention (CDC)	12,820	9,218	–3,602	–28%
Food and Drug Administration (FDA)	20,912	16,261	–4,651	–22%
Health Resources and Services Administration (HRSA)	2,689	1,668	–1,021	–38%
Substance Abuse and Mental Health Services Administration (SAMHSA)	916	527	–389	–42%
SELECTED-AGENCY TOTAL	**37,337**	**27,674**	**–9,663**	**–26%**

Note: Figures are as of September 30, 2024 (the end of FY 2024) and May 31, 2026. Counts represent active civilian employees in pay or non-pay status and are headcounts, not full-time equivalents. Net changes reflect all changes in employment—including hiring, retirements, resignations, transfers, and other separations—and should not be interpreted as counts of layoffs. The selected-agency subtotal is included within, rather than additional to, the HHS total.

Source: U.S. Office of Personnel Management, Federal Workforce Data, Employment (EHRI Status), September 2024 and May 2026.

The practical effect of these reductions was a loss of operating capacity. Fewer program officers, scientists, grant managers, epidemiologists, laboratorians, and technical experts meant less capacity to issue awards on time, process payments, answer grantee questions, provide implementation guidance, review data, support outbreak investigations, and respond when jurisdictions requested specialized help. For state and local health departments, that federal capacity is often the mechanism through which appropriated dollars become functioning programs: grants are awarded, technical assistance is provided, problems are resolved, and specialized expertise reaches the field. When that capacity is reduced, the effects can be felt even in programs Congress continues to fund.

These figures carry important caveats. OPM data capture headcounts of active employees and therefore may include employees on paid administrative leave, even if they were not performing regular duties. The data also may not fully reflect the precise timing of reinstatements, litigation-related status changes, or effective working capacity. Nevertheless, the data represent the most authoritative available accounting of net federal workforce headcount changes—and they document a substantial reduction in staffing capacity. Underlying that reduction is a loss of program expertise, institutional memory, and established partner relationships concentrated in the staff who departed—capacity that cannot be quickly rebuilt.

The disruption also creates a longer-term recruitment and retention challenge: uncertainty about agency missions, staffing levels, leadership, scientific independence, and grant administration may make HHS and its public health agencies less attractive to the scientists, program officers, grant managers, communicators, and technical experts needed to rebuild and sustain capacity.

LEADERSHIP INSTABILITY

Workforce disruption extended to CDC's senior leadership, compounding operational challenges throughout the agency.

The agency entered 2025 under acting leadership while a permanent director was sought. The administration's first nominee, former Florida Representative Dr. David Weldon, had his nomination withdrawn and his Senate confirmation hearing canceled shortly before it was scheduled to begin.[224,225] Dr. Susan Monarez, who had served as acting director earlier in 2025, was confirmed by the Senate on July 29, 2025[226]—the first Senate-confirmed CDC director under a 2023 law requiring Senate confirmation for the position.[227] Less than a month later, on August 27, 2025, she was fired.[228] The White House described her as not aligned with the president's agenda. In Senate testimony, Dr. Monarez stated that she was fired after refusing to approve vaccine recommendations without evidence and to fire career officials without cause, actions she characterized as inconsistent with her oath of office and public service ethics.[229]

Dr. Monarez's firing triggered the resignations of at least four senior CDC leaders, including the agency's chief medical officer and deputy director and the directors of the National Center for Emerging and Zoonotic Infectious Diseases, the National Center for Immunization and Respiratory Diseases, and the Office of Public Health Data, Surveillance, and Technology.[230] The agency subsequently operated under a succession of acting leaders. In February 2026, NIH Director Jay Bhattacharya was designated to perform the delegable duties of the CDC director while also continuing to lead NIH.[231]

Leadership instability extended beyond the CDC director's office. Reporting in spring 2026 described multiple senior CDC leadership posts as vacant or filled on an acting basis,[232] while NIH was also operating with acting leadership across many of its institutes and centers.[233]

SAMHSA, too, was operating without a Senate-confirmed assistant secretary.[234] These gaps matter because senior leaders do not merely set policy direction; they make programmatic decisions, resolve cross-agency disputes, communicate with state and local partners, and provide the internal authority needed to maintain continuity during emergencies and periods of organizational change.

From August 27, 2025, to August 5, 2026, CDC was led by acting officials rather than a Senate-confirmed director.

On April 16, 2026, the administration nominated Dr. Erica Schwartz—a board-certified preventive medicine physician, retired rear admiral in the U.S. Public Health Service Commissioned Corps, and former deputy surgeon general during President Donald Trump's first term—to serve as CDC director. On August 5, the Senate confirmed Dr. Schwartz. She now serves as CDC director and administrator of the Agency for Toxic Substances and Disease Registry.[235,236]

The period of leadership instability preceding Dr. Schwartz's confirmation contributed to uncertainty over the agency's strategic direction, low staff morale, disruptions in communication, and diminished continuity in CDC's public voice. These strains persisted during active public health emergencies, including major measles outbreaks, the May 2026 Andes virus outbreak aboard the M/V Hondius, and the spring 2026 Ebola outbreak in the Democratic Republic of the Congo and Uganda. State and local partners faced added uncertainty about decisions, guidance, and program continuity when leadership authority at the federal level was in flux, and a less visible federal public health voice placed greater pressure on state and local officials to communicate with the media and the public during evolving health events.

EXECUTIVE ORDERS AFFECTING AGENCY OPERATIONS AND WORKFORCE

Several executive orders issued during 2025 established the policy and administrative framework within which HHS's workforce, operational, and grant-management changes were carried out.

EO 14151, ***Ending Radical and Wasteful Government DEI Programs and Preferencing***, signed January 20, 2025, directed the Office of Management and Budget (OMB), OPM, and the Attorney General to coordinate the termination of federal diversity, equity, and inclusion (DEI) and diversity, equity, inclusion, and accessibility (DEIA) mandates, policies, programs, preferences, and activities.[237] The order further directed agency heads, within 60 days and to the maximum extent allowed by law, to terminate DEI, DEIA, and "environmental justice" offices and positions; "equity action plans," "equity" actions, initiatives, or programs, and "equity-related" grants or contracts; and DEI or DEIA performance requirements for employees, contractors, or grantees. It also required agencies to inventory DEI, DEIA, and environmental justice positions, programs, budgets, contractors, and grantees. For public health agencies, the order had operational relevance because many programs use health equity, disparities-reduction, accessibility, and environmental justice frameworks to identify populations at elevated risk, target prevention resources, and assess whether federally supported programs are reaching communities with the greatest need. The order therefore created or intensified review and compliance demands, as well as uncertainty for programs, staff, grantees, and community partners whose work was connected to health equity, environmental justice, or disparities-reduction activities.

EO 14171, ***Restoring Accountability to Policy-Influencing Positions Within the Federal Workforce***, signed January 20, 2025, reinstated and amended the former Schedule F framework, renaming it Schedule Policy/Career—an excepted-service category for certain career positions of a confidential, policy-determining, policy-making, or policy-advocating character.[238] OPM implemented the order through a final rule published on February 6, 2026, that took effect on March 9, 2026.[239] Employees whose positions are placed in Schedule Policy/Career are excluded from standard statutory procedures governing performance-based and adverse actions, including related Merit Systems Protection Board appeal rights. They are also excluded from the statutory process for bringing prohibited-personnel-practice claims, including whistleblower-retaliation claims, to the Office of Special Counsel; agencies are instead required to establish and enforce internal policies prohibiting those practices.[240,241] OPM estimated that approximately 50,000 positions government-wide could ultimately be placed in Schedule Policy/Career. On June 3, 2026, EO 14410 placed an initial group of approximately 8,000 positions in the new category.[242,243] Legal challenges to EO 14171, OPM's implementing rule, and the June 2026 implementation order remained pending as of mid-July 2026.[244,245,246]

EO 14210, ***Implementing the President's "Department of Government Efficiency" Workforce Optimization Initiative,*** signed February 11, 2025, provided the administrative framework under which HHS developed and executed its reorganization and RIF plans. The order directed agencies to prepare for large-scale RIFs, reduce workforce size, identify for

reduction or elimination non-statutorily required offices and positions, and develop a workforce-reduction plan requiring no more than one hire for every four departures, subject to exemptions and implementation details.[247]

EO 14332, ***Improving Oversight of Federal Grantmaking***,[248] signed August 7, 2025, extended this framework to federal grantmaking. The order directed agencies to establish senior-appointee review processes for new funding opportunity announcements and discretionary awards to ensure consistency with agency priorities and the national interest. It also directed OMB to revise the Uniform Guidance to require discretionary grants to permit termination for convenience, including when an award no longer advances agency priorities or the national interest, and directed agencies to revise existing discretionary grant terms, to the maximum extent permitted by law, to permit or clarify that such termination is allowed. For public health grantees, including health departments and community partners operating multiyear awards, these provisions could increase uncertainty about whether funds already awarded and incorporated into staffing, contracts, and workplans will remain available for the duration of the award period. Even when funds are ultimately continued, the possibility of mid-award termination based on changing agency priorities can make it harder for grantees to hire, contract, plan, and sustain work with confidence.

Two deregulatory orders—**EO 14192**, ***Unleashing Prosperity Through Deregulation***, signed January 31, 2025,[249] and **EO 14219**, ***Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Deregulatory Initiative***, signed February 19, 2025[250]—directed agencies to identify at least 10 existing regulations for repeal whenever proposing or promulgating a new regulation and to review existing regulations to identify those considered legally vulnerable, inconsistent with administration policy, insufficiently justified by their public benefits, or unduly burdensome to small businesses and private enterprise. EO 14192 established the 10-for-1 identification requirement; EO 14219 directed the legal-vulnerability and policy-consistency review. These requirements created new review, compliance, and administrative obligations for HHS agencies at a time when their staff capacity was already being reduced, placing additional demands on organizations simultaneously absorbing significant workforce losses.

Note on scope: The executive actions documented here are those that most directly affected core public health funding, infrastructure, workforce, and grant operations. The Trump Administration has also issued numerous additional executive orders with significant but separate public health implications.[251] These actions have real consequences for population health and health equity, particularly for historically marginalized communities, but they operate primarily through pathways other than the public health funding and infrastructure channels that are the focus of this report. For a comprehensive tracker of executive orders and their public health implications, see the Network for Public Health Law's "The Public Health Impact of the 2025 Federal Executive Orders" resource.[252]

Funding Disruption

The workforce disruptions were accompanied by a parallel set of funding disruptions that abruptly altered the operating assumptions under which state and local health departments had been working. Programs that grantees had built multiyear plans around—with staff hired, contracts in place, and work already underway—were suddenly at risk of cancellation, clawback, or indefinite pause.

GRANT TERMINATIONS AND PAUSES

While workforce disruptions primarily affected federal agencies that administer public health grants, many of the funding disruptions affected grantees—the state and local health departments, behavioral health providers, community-based organizations, and other public health organizations that use federal grant funding to operate. Approximately 80 percent of CDC's domestic budget flows to external partners through grants and cooperative agreements;[253] disruptions to that funding relationship can translate quickly into operational consequences at the state, local, tribal, territorial, and community levels, even when Congress has appropriated funds. Since March 2025, a recurring pattern of grant terminations, clawbacks, and pauses affected billions of dollars in awards that grantees had, in many cases, already incorporated into staffing plans, infrastructure projects, and multiyear program commitments. In practice, these disruptions affected whether health departments, community-based organizations, and other community partners could retain staff, continue contracts, operate clinics, maintain surveillance and data projects, and plan multiyear public health work with confidence.

MARCH 2025 COVID-ERA GRANT TERMINATIONS

On March 24, 2025, without advance notice to grantees, HHS began terminating approximately $12.4 billion in remaining federal grant and cooperative-agreement funding for state and local health departments and other public health partners.[254] Approximately $11.4 billion involved CDC-administered grants to state and local health departments and other health organizations, primarily under the Epidemiology and Laboratory Capacity cooperative agreements, which had supported infectious disease epidemiology and laboratory capacity at state, local, and territorial health departments, along with grants supporting immunization services, community health workers, health disparities initiatives, and other infectious disease programs.[255] An additional approximately $1 billion in SAMHSA grants for mental health and substance use services was terminated in the same action.

HHS stated that the grants were being terminated because "the COVID-19 pandemic is over, and HHS will no longer waste billions of taxpayer dollars responding to a non-existent pandemic that Americans moved on from years ago."[256] While the terminated funds originated in pandemic-era appropriations—including the CARES Act, ARPA, and other COVID-related laws—many approved activities had shifted into a post-emergency response and recovery phase, supporting health department services, infrastructure, and capacity that had been strained or expanded during the pandemic. HHS had approved continued use of some awards into 2026 or 2027 for these efforts. Congress had rescinded roughly $27 billion in unobligated pandemic-era funds in 2023 but had not rescinded the awarded grants at issue here, which had already been committed to specific recipients and were actively supporting ongoing public health activities.[257] The affected grants supported broader public health infrastructure and services, including data systems, laboratory capacity, disease surveillance, workforce development, immunization infrastructure, emergency preparedness, and mental health and substance use services.[258] Health departments had spent time and resources building programs, services, staffing, contracts, and infrastructure that depended on

continued funding to remain operational; termination notices arrived while many of those activities were still underway, disrupting midstream work that agencies and community partners had planned around approved awards.

The state- and local-level consequences were immediate and concrete, affecting staffing, clinic operations, outbreak surveillance, immunization infrastructure, laboratory capacity, data systems, and preparedness activities:

- Minnesota reported approximately $226 million in terminated funding and issued layoff and separation notices to 170 state health department employees.[259,260]
- North Carolina reported $100 million in cuts and 80 job losses, with reporting indicating that funding for the state's NC Immunization Registry was among the affected programs.[261,262]
- Illinois reported $125 million in terminated funding affecting its Department of Public Health and 97 local health departments, with consequences for laboratory capacity, infectious disease tracking, H5N1 and measles surveillance, vaccination efforts, and preparedness.[263]
- Texas faced an estimated $550 million to more than $700 million at risk across state and local public health programs.[264] In Lubbock, terminated grant funding had been supporting staff directly involved in the measles response, including vaccination, phone support, and patient testing;[265] in Dallas County, officials canceled 50 vaccination events or clinics, including school-based measles vaccination efforts, as the state was experiencing a measles outbreak.[266]
- New York City reported more than $100 million in affected funding,[267] and New Jersey reported more than $350 million affecting the state departments of health and human services, spanning public health and behavioral health programs.[268]
- Washington state reported that more than $130 million in public health funding for its Department of Health had been terminated, including funding supporting disease surveillance, data systems, immunization programs, and outbreak response.[269,270]

Across these jurisdictions, the common experience was not merely a budget shortfall to be absorbed over time: it was a sudden withdrawal of funds already committed and supporting work in progress, forcing health departments to assess layoffs, pause activities, communicate uncertainty to contractors and community partners, and plan for the possibility that major federal funding streams—incorporated into multiyear operational plans—might not continue.[271]

Twenty-three states and the District of Columbia filed suit against HHS on April 1, 2025, challenging the grant terminations in the U.S. District Court for the District of Rhode Island.[272] On May 16, 2025, a district judge issued a preliminary injunction blocking the terminations for plaintiff states, finding that the plaintiffs were likely to succeed on the merits and that the terminations would cause serious harm.[273] A separate lawsuit was filed by Harris County, Texas; Columbus, Ohio; the Metropolitan Government of Nashville and Davidson County, Tennessee; Kansas City, Missouri; the American Federation of State, County, and Municipal Employees; and the AFL-CIO challenging HHS's termination of public health grants.[274] Courts blocked terminations for plaintiffs while litigation proceeded, but the announced clawbacks had already produced disruption. Health departments across the country—including in jurisdictions with no guarantee of legal protection—had assessed potential layoffs, paused work, and communicated uncertainty to partners during the weeks before any injunctive relief arrived. Because the relief was plaintiff-specific, jurisdictions not covered by those orders remained exposed to the loss of previously awarded funds.

JANUARY 2026 SAMHSA AND PUBLIC HEALTH INFRASTRUCTURE GRANT (PHIG) DISRUPTIONS

On the evening of January 13, 2026, SAMHSA issued mass termination notices for discretionary grants supporting behavioral health programs. Reporting indicated that the cancellations would have affected

more than 2,000 grants, with some estimates as high as 2,706 to 2,800 grants, totaling roughly $1.9 billion to $2 billion—about one-quarter or more of SAMHSA's overall budget.[275,276] SAMHSA career staff were reportedly unaware of the cancellations, which had not been coordinated internally. The termination letters stated that the affected grants no longer aligned with agency priorities.[277] The affected programs spanned behavioral health services, including opioid addiction treatment, overdose prevention, naloxone distribution, suicide prevention, school mental health programs, peer recovery support, trauma care for children, services for pregnant women, outreach to unhoused people, and workforce development.[278,279,280] Notably, the termination notices were issued just over a month after the bipartisan SUPPORT for Patients and Communities Reauthorization Act of 2025 was enacted, reauthorizing SAMHSA's core substance use disorder and mental health programs through FY 2030.[281]

The terminations were reversed within about 24 hours after strong opposition from lawmakers, behavioral health and public health organizations, and affected providers, including a January 14 letter signed by 100 House members urging HHS to rescind the terminations.[282] Affected organizations later received written notice that their awards would remain active under their original terms and conditions.[283]

Later that month, HHS briefly paused activities funded through CDC's Public Health Infrastructure Grant program.[284] Grantees received unexpected notices stating that PHIG-funded activities were paused while HHS reviewed them to ensure alignment with administration and agency priorities. The notices arrived as state and local health departments across much of the country were preparing for a major winter storm. HHS confirmed hours later that the pause had been lifted.[285] PHIG awards have supported core public health capacity, including staffing, modern data systems, basic health department operations, training and technical assistance, program evaluation, and public communications.[286]

Even though the SAMHSA terminations were quickly reversed and the PHIG pause was brief, the episodes created immediate uncertainty for grantees and program partners whose active awards supported school mental health, overdose prevention, suicide prevention, public health staffing, data modernization, and core health department operations.

The SAMHSA terminations and PHIG pause were distinct situations involving different agencies and programs, but both illustrated a common source of instability: funds that had already been awarded and incorporated into multiyear program and staffing plans could still be interrupted abruptly, with little or no advance notice and without clear program-specific explanation.

FEBRUARY 2026: TERMINATION OF GRANTS TO FOUR STATES

In February 2026, the administration moved to terminate or cut approximately $600 million in CDC-administered public health grants for four states—California, Colorado, Illinois, and Minnesota—indicating that the grants were "inconsistent with agency priorities."[287] The affected grants included public health infrastructure funding, including PHIG-related awards, as well as grants supporting disease-outbreak tracking, HIV and sexually transmitted infection prevention, public health data collection, and efforts focused on communities experiencing health disparities.[288] Notably, some of the affected funding streams had just been funded in the FY 2026 HHS appropriations law, which President Trump signed on February 3, 2026; Congress had also increased Public Health Infrastructure and Capacity funding by $10 million in that law.[289,290]

The four states sued in the U.S. District Court for the Northern District of Illinois, arguing that the cuts were unlawful and politically retaliatory and imposed retroactive conditions on federal funds already awarded.[291] On February 12, 2026, the court issued a temporary restraining order blocking implementation of the challenged grant-termination directives while

the litigation proceeded.[292] On March 12, the court granted a preliminary injunction in part, continuing to bar federal officials from implementing guidance or directives targeting the plaintiff states for the cessation of HHS- or CDC-awarded payments.[293]

In the days before the February 12 temporary restraining order, the affected states had no guarantee that legal relief would arrive and had to begin assessing continuity for PHIG-supported staff positions, data systems, and grant-funded programs before any legal protection was in place.

FY 2025 APPORTIONMENT AND FUNDING DELAYS

Beyond the March 2025 grant terminations, CDC also experienced disruption in the administration of its regular FY 2025 funding. Congress enacted CDC's full-year FY 2025 appropriation through a continuing resolution signed on March 15, 2025,[294] but CDC reportedly did not receive full access to those funds on the usual schedule after enactment. Instead, the agency operated for months under 30-day funding increments while awaiting full apportionment from OMB.[295]

These delays affected more than internal CDC budgeting. Because CDC could not issue notices of award until funds were apportioned and available for obligation, delayed apportionment reportedly prevented the agency from issuing notices of award to state and local health departments for critical public health programs, including cardiovascular disease prevention, breast and cervical cancer screening, and emergency preparedness grants.[296] Without notices of award, grantees could not be certain they would be reimbursed for ongoing work, forcing some to choose between continuing activities at financial risk or slowing, suspending, or reducing program operations.

CDC also faced restrictions or freezes affecting selected program funds. Reporting in August 2025 found that, even after CDC received its full FY 2025 apportionment, OMB continued to freeze specific CDC program budget lines, including youth-violence prevention, firearm-injury prevention and research, diabetes, chronic kidney disease, and tobacco-use programs, while awards for other programs had been delayed.[297,298] CDC later moved to release some delayed funds, including funding for rape and domestic-violence prevention and the full amount expected for the Overdose Data to Action program. NPR reported that the overdose funding had previously been withheld.[299]

Taken together, the FY 2025 funding environment illustrated a core principle: the amount Congress appropriates is necessary but not sufficient for actual program delivery. Appropriated funds must be apportioned, obligated, awarded, and disbursed on a predictable schedule. When any step in that chain is delayed or disrupted—whether through deliberate administrative action, capacity constraints, or organizational uncertainty—the effective value of those appropriations diminishes, even if the enacted dollar amounts remain unchanged.

Structural Disruption

Concurrent with the workforce and funding disruptions described above, the administration announced and began advancing plans to fundamentally reorganize HHS and its component agencies. The reorganization plan introduced a second layer of uncertainty that compounded the operational disruptions already underway: state and local partners, grantees, and program staff were navigating not only immediate personnel and funding shocks but also the prospect that the agencies and program offices they worked with might not continue to exist in their current form.

MARCH 2025 HHS RESTRUCTURING PLAN

On March 27, 2025, HHS Secretary Robert F. Kennedy Jr. announced a comprehensive restructuring of the department, consistent with the administration's broader workforce-reduction initiative under EO 14210 and without prior congressional authorization for the proposed reorganization.[300,301] The plan had four principal structural elements.

First, consolidation from 28 divisions to 15—a fundamental reduction in the number of distinct agency components within HHS, each with its own leadership, statutory authorities, program expertise, and established relationships with grantees and state and local partners.[302]

Second, reduction of HHS regional offices from 10 to 5.[303] The regional offices are important points of contact through which HHS maintains working relationships with state and local agencies across the country; consolidating them reduced the geographic reach and density of those relationships.

Third, creation of the Administration for a Healthy America (AHA)—a proposed new administrative entity that HHS said would consolidate the Office of the Assistant Secretary for Health, HRSA, SAMHSA, the Agency for Toxic Substances and Disease Registry (ATSDR), and the National Institute for Occupational Safety and Health. HHS stated that AHA would coordinate chronic care and disease prevention programs and include divisions focused on primary care, maternal and child health, mental health, environmental health, HIV/AIDS, and workforce.[304,305]

Fourth, the proposal—further clarified by the FY 2026 budget request—would eliminate ASPR as a standalone HHS operating division and split its functions among other entities. Under the FY 2026 budget proposal, the Biomedical Advanced Research and Development Authority, Project BioShield, the Pandemic Influenza program, and the Strategic National Stockpile would transfer to the new Assistant Secretary for a Healthy Future; Health Care Readiness and Recovery, Preparedness and Response Innovation, and the National Disaster Medical System would shift to CDC; and ASPR's Hospital Preparedness Program—the primary source of federal funding for healthcare preparedness and response—would be eliminated.[306] The practical significance of this fragmentation would be that a congressionally established, integrated federal preparedness and response structure[307] would be broken apart, with core functions dispersed across a significantly restructured CDC and a newly proposed HHS office, while other preparedness programs would be eliminated.

The Agency for Healthcare Research and Quality (AHRQ) and the Office of the Assistant Secretary for Planning and Evaluation were proposed for merger into a new Office of Strategy.[308] The Administration for Community Living was proposed for dissolution, with its programs redistributed among a new Administration for Children, Families, and Communities, the Office of the Assistant Secretary for Planning and Evaluation, and the Centers for Medicare & Medicaid Services.[309]

FIGURE 10: FY 2026 President's Budget Would Have Reshaped the FY 2025 HHS Structure

FY 2025 HHS STRUCTURE (AGENCIES AND OFFICES)	
Administration for Children and Families (ACF)	Centers for Medicare & Medicaid Services (CMS)
Administration for Community Living (ACL)	Departmental Appeals Board (DAB)
Advanced Research Projects Agency for Health (ARPA-H)	Food and Drug Administration (FDA)
Administration for Strategic Preparedness and Response (ASPR)	Health Resources and Services Administration (HRSA)
Agency for Healthcare Research and Quality (AHRQ)	Immediate Office of the Secretary (IOS)
Assistant Secretary for Technology Policy / Office of the National Coordinator for Health IT (ASTP/ONC)	Indian Health Service (IHS)
Agency for Toxic Substances and Disease Registry (ATSDR)	National Institutes of Health (NIH)
Assistant Secretary for Administration (ASA)	Office for Civil Rights (OCR)
Assistant Secretary for Financial Resources (ASFR)	Office of Global Affairs (OGA)
Assistant Secretary for Health / Office of the Assistant Secretary for Health (ASH/OASH)	Office of Inspector General (OIG)
Assistant Secretary for Legislation (ASL)	Office of Intergovernmental and External Affairs (IEA)
Assistant Secretary for Planning and Evaluation (ASPE)	Office of Medicare Hearings and Appeals (OMHA)
Assistant Secretary for Public Affairs (ASPA)	Office of the General Counsel (OGC)
Center for Faith-Based and Neighborhood Partnerships (Faith Center)	Office of the Secretary
Centers for Disease Control and Prevention (CDC)	Substance Abuse and Mental Health Services Administration (SAMHSA)

FY 2026 PRESIDENT'S BUDGET REORGANIZATION PROPOSAL

new	**Administration for a Healthy America (AHA)** Combines OASH and the Office of the Surgeon General, most functions of HRSA and SAMHSA, NIEHS from NIH, and selected CDC functions in injury prevention and control; occupational safety and health; environmental health; birth defects, developmental disabilities, disability and health; and CDC's Ending the HIV Epidemic Initiative activities, plus the Alzheimer's disease program.	modified	**Centers for Disease Control and Prevention (CDC)** Establishes a Center for Preparedness and Response; receives the National Disaster Medical System, Preparedness and Response Innovation, and Health Care Readiness and Recovery from ASPR; transfers selected chronic disease, injury, occupational health, environmental health, birth-defects, and HIV functions to AHA; transfers NCHS to the Office of Strategy.
new	**Administration for Children, Families, and Communities (ACFC)** Combines the Administration for Children and Families and the Administration for Community Living.	modified	**National Institutes of Health (NIH)** Restructures NIH's institutes and centers into eight; transfers NIEHS to AHA; would eliminate NINR, NCCIH, the Fogarty International Center, and NIMHD.
new	**Office of Strategy** Combines ASPE, AHRQ, the National Center for Health Statistics from CDC, and the Office of Research Integrity from OASH.	modified	**Assistant Secretary for Administration (ASA)** Would lose the Office of the Chief Information Officer to the new Office of the Chief Technology Officer.
new	**Assistant Secretary for a Healthy Future (ASHF)** Combines ARPA-H with selected ASPR preparedness and medical-countermeasure functions, including BARDA, Project BioShield, pandemic influenza, the Strategic National Stockpile, and ASPR program management.	modified	**Centers for Medicare & Medicaid Services (CMS)** Would receive the 340B Drug Pricing Program from HRSA.
new	**Assistant Secretary for Enforcement (ASE)** Combines the Office for Civil Rights, Office of Medicare Hearings and Appeals, Departmental Appeals Board, and Office for Human Research Protections.	retained	**Agency for Toxic Substances and Disease Registry (ATSDR)**
new	**Assistant Secretary for Consumer Product Safety (ASCPS)** Would incorporate the independent Consumer Product Safety Commission into HHS within the Office of the Secretary.	retained	**Assistant Secretary for Financial Resources (ASFR)**
new	**Office of the Assistant Secretary for External Affairs** Combines the Office of Global Affairs, Assistant Secretary for Legislation, Office of Intergovernmental and External Affairs, Assistant Secretary for Public Affairs, and the Faith Center.	retained	**Food and Drug Administration (FDA)**
new	**Office of the Chief Technology Officer (CTO)** Would consolidate ASTP/ONC—including its internal Office of the Chief Technology Officer—with OCIO and the departmental cybersecurity program into a department-level technology office.	retained	**Immediate Office of the Secretary (IOS)**
		retained	**Indian Health Service (IHS)**
		retained	**Office of Inspector General (OIG)**
		retained	**Office of the General Counsel (OGC)**
		retained	**Office of the Secretary**

Note: This figure compares the FY 2025 HHS organizational structure with the reorganization proposed in the FY 2026 President's Budget. Congress did not adopt the proposed structure in FY 2026 appropriations.

Sources: HHS FY 2026 Budget in Brief; FY 2026 Departmental Management Congressional Justification; FY 2026 CDC Congressional Justification.

IMPLEMENTATION, LITIGATION, AND PARTIAL EXECUTION

Implementation of the restructuring was soon challenged in federal court. On May 5, 2025, 19 states and the District of Columbia filed suit in the U.S. District Court for the District of Rhode Island in *New York v. Kennedy*, arguing that HHS's March 27, 2025, restructuring directive violated the Administrative Procedure Act, the Appropriations Clause, and separation-of-powers principles, in part because the executive branch may not unilaterally dismantle agencies and programs that Congress created and funded.[310] On July 1, 2025, the court issued a preliminary injunction blocking implementation or enforcement of the planned RIFs and sub-agency restructuring; the injunction was later clarified to cover CDC, FDA's Center for Tobacco Products, the Office of Head Start, and the Office of the Assistant Secretary for Planning and Evaluation.[311] The First Circuit declined to stay the injunction on September 17, 2025, finding the government unlikely to succeed on appeal.[312,313]

The legal landscape was not uniform. The Supreme Court stayed a separate lower-court injunction in *Trump v. AFGE* on July 8, 2025—allowing broader workforce-reduction planning under EO 14210 to proceed without resolving the legality of specific agency reorganization plans.[314,315] The result was a fragmented environment in which some restructuring actions were blocked while others proceeded, creating sustained uncertainty for agencies, grantees, and state and local partners about the structure and authority of the federal agencies they relied on. Legal uncertainty was itself a form of operational disruption: state and local health departments and grantees could not plan reliably around agency structures whose status was in active litigation.

CDC'S SCIENTIFIC ADVISORY AND COMMUNICATIONS FUNCTIONS

The disruption extended to CDC's scientific advisory and communications infrastructure in ways that affected how the agency performs core scientific work—distinct from, but related to, the organizational restructuring described above.

In June 2025, the HHS secretary terminated the appointments of all 17 members of the Advisory Committee on Immunization Practices (ACIP) and replaced them with a new panel, some of whose members had publicly questioned or opposed aspects of routine vaccination.[316,317,318] ACIP's recommendations carry clinical, legal, and insurance coverage implications well beyond CDC's own programs: once adopted by CDC, they become official CDC policy, inform federal immunization schedules, influence many state immunization policies and requirements, and help determine vaccine coverage across major insurance programs.[319,320,321,322] Changes to the composition and orientation of ACIP therefore have practical implications for how core CDC vaccine guidance is formulated and whether that guidance is regarded as grounded in an independent scientific process.

A coalition of medical professional societies and public health organizations, including the American Academy of Pediatrics, challenged the ACIP reconstitution in federal court.[323] On March 16, 2026, a U.S. district judge in Massachusetts issued a preliminary injunction blocking key elements of the reconstituted ACIP's actions, finding that several appointments to the committee likely violated federal requirements for advisory committees and staying votes taken by those appointees while litigation proceeded.[324]

CDC's scientific communications were also affected. The *Morbidity and Mortality Weekly Report*—CDC's principal publication for reporting disease trends, outbreak investigations, and public health findings—paused publication for two weeks during the administration's early public-communications freeze before resuming amid reported new layers of HHS review, including political-appointee review of federal health agency communications.[325,326]

Workforce reductions also affected the policy, clearance, and communications functions that support CDC's scientific voice. Reporting during 2025 described cuts to communications and policy offices across the agency, as well as disruptions to offices involved in reviewing and clearing CDC scientific reports and informational products.[327,328,329] These functions are

often less visible than disease-specific programs, but they are part of the infrastructure that allows CDC to translate scientific work into timely guidance, public communication, and usable information for health departments, clinicians, policymakers, and the public.

CDC's data-publication and public-information functions were also affected. In early 2025, CDC webpages and datasets were removed or modified in response to administration directives, including resources related to HIV, LGBTQ+ youth health, contraception, and youth risk behavior data.[330,331,332]

Later, in November 2025, CDC's vaccine/autism webpage was revised at the direction of the HHS secretary,[333] without standard scientific signoff,[334,335] to cast doubt on CDC's longstanding conclusion that vaccines do not cause autism. Together, these actions affected both the public availability of CDC surveillance and program data and the content of CDC scientific communications, raising concerns about the continued independence and reliability of federal public health information.

FY 2026 President's Budget Request

In May 2025, the administration released its FY 2026 President's Budget Request, which formalized the structural direction its previous actions had already begun to establish.[336]

HHS-WIDE REDUCTION

The budget proposed $94.7 billion in discretionary budget authority for HHS—a reduction of approximately 25 percent from the FY 2025 enacted level.[337,338] The request was aligned with the administration's planned HHS reorganization and reflected the proposed consolidation from 28 divisions to 15.[339] The scale of the proposed reduction—the equivalent of eliminating nearly one dollar in four from the department's discretionary budget—was extraordinary in modern HHS budget history.

CDC AND ATSDR

The budget proposed a program level of $4.3 billion for CDC and ATSDR—a reduction of approximately 53 percent from the FY 2025 program level of approximately $9.25 billion.[340,341,342] The proposed CDC and ATSDR workforce would have been reduced to 7,571 full-time equivalents, compared with an FY 2024 actual of 13,242.[343]

The proposed budget would have transformed CDC from a broad national public health institution—encompassing infectious disease, chronic disease prevention, environmental health, injury prevention, occupational health, and global health—into a substantially smaller agency focused more narrowly on selected infectious disease, preparedness, and infrastructure functions. Major parts of the agency's chronic disease, injury, environmental health, occupational health, and global health portfolios would have been eliminated, narrowed, or transferred to the proposed AHA or other HHS entities.

PROPOSED ELIMINATION OF THE PREVENTION AND PUBLIC HEALTH FUND

The budget proposed the complete elimination of the Prevention and Public Health Fund.[344] The PPHF has functioned as a structural component of CDC's annual program-level funding—accounting for approximately 15 percent of CDC's FY 2026 program level, which includes PPHF and PHS Evaluation transfers but excludes separately accounted mandatory programs—and supports prevention activities across all 50 states, the District of Columbia, U.S. territories, and freely associated states.[345,346] Eliminating the PPHF would remove a dedicated mandatory funding stream that has, despite falling short of its originally authorized levels, provided a measure of structural support for public health investment outside the annual discretionary appropriations cycle. Because PPHF resources are embedded across multiple CDC program lines, the fund's elimination would have cascading program-specific effects well beyond what the top-line dollar figure suggests. One of the clearest state-facing losses would be the Preventive Health and Health Services Block Grant—funded exclusively through the PPHF under current law—which provides flexible resources that states, territories, tribes, and freely associated states use to tailor prevention activities to their needs and priorities.[347]

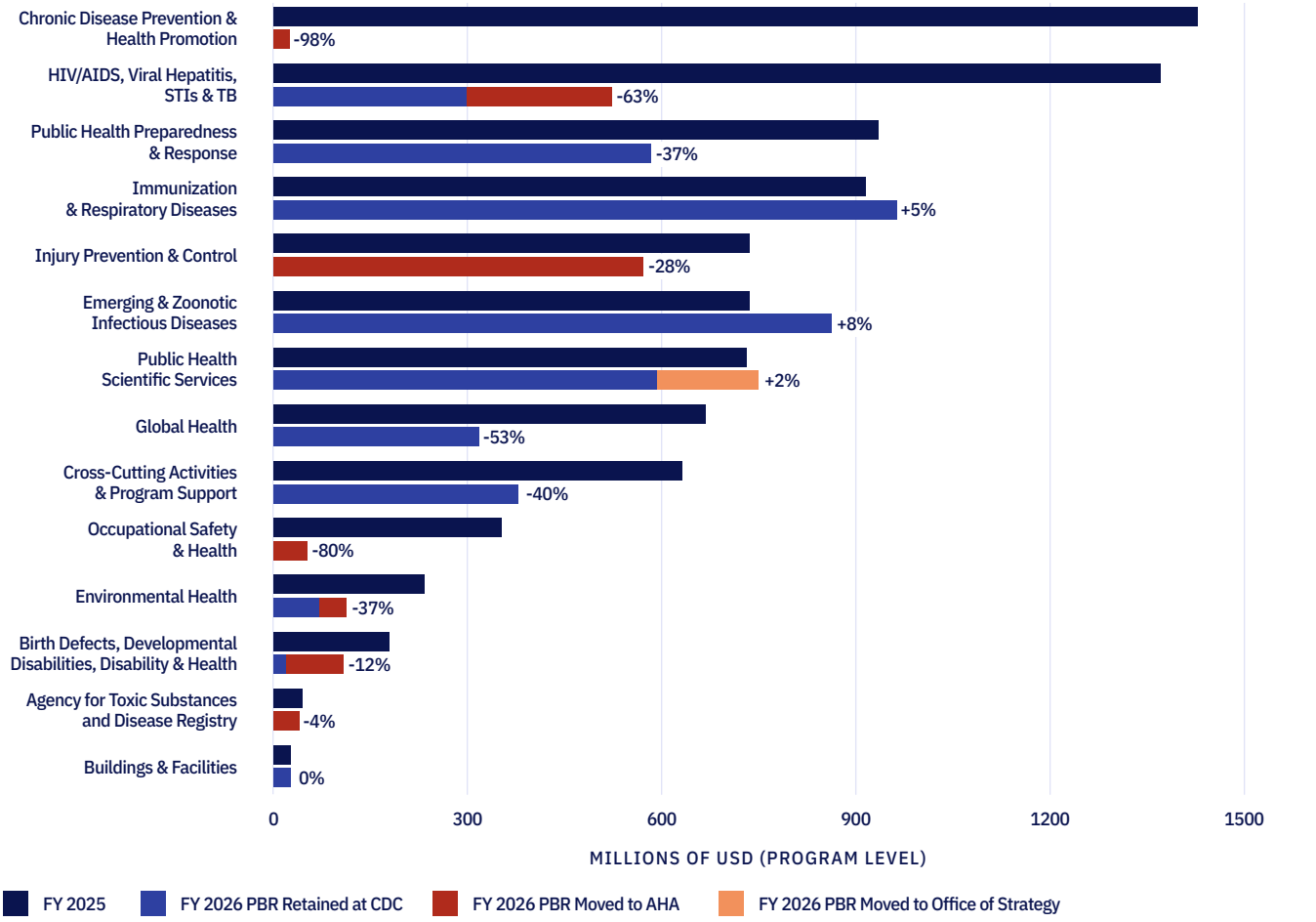
CHRONIC DISEASE, INJURY, AND ENVIRONMENTAL HEALTH PROGRAMS

The FY 2026 President's Budget proposed the near-elimination of CDC's chronic disease prevention functions.[348] The National Center for Chronic Disease Prevention and Health Promotion—which addresses major causes of illness, disability, and death in the United States and received approximately $1.43 billion in FY 2025[349]—would have been nearly entirely eliminated, with only selected functions proposed for transfer to the AHA.[350] Programs proposed for termination[351] or near-elimination included the Division of Nutrition, Physical Activity, and Obesity, which received $58.4 million in FY 2025[352] and supports evidence-based strategies to improve nutrition, increase physical activity, and address obesity; the Office on Smoking and Health, funded at $246.5 million in FY

2025,[353] which has supported state tobacco-control programs and helped achieve the lowest recorded level of youth tobacco use in 25 years;[354] programs addressing heart disease, stroke, diabetes, and cancer prevention—conditions that collectively account for about half of all deaths in the United States each year;[355] the Racial and Ethnic Approaches to Community Health program; the Healthy Schools program; and programs addressing upstream drivers of health.

The budget also proposed the near-elimination of injury prevention functions from CDC's portfolio, which received approximately $761 million in FY 2025,[356] with selected functions proposed for transfer to AHA. NIOSH-related occupational safety and health functions and selected environmental health functions, including lead-poisoning prevention, were proposed for transfer to AHA, while many other CDC environmental health activities were proposed for elimination.

FIGURE 11: President's FY 2026 Budget Proposed Deep CDC Cuts, With Limited Funding Shifted Elsewhere



Note: FY 2025 baseline amounts reflect the FY 2025 Final levels reported in the FY 2026 CDC Operating Plan and the FY 2025 Enacted ATSDR level reported in the FY 2026 ATSDR Congressional Justification. Percentages are functional comparisons: each FY 2025 program category is compared with FY 2026 President's Budget funding for the same functions wherever the request would house them. Funding shifted to the proposed Administration for a Healthy America or the Office of Strategy is shown within the corresponding FY 2025 originating category by destination. Intra-CDC realignments are credited to their FY 2025 originating categories: Surveillance for Emerging Threats to Mothers and Babies to Birth Defects, Developmental Disabilities, Disability and Health; Parasitic Diseases and Malaria and Global Public Health Protection to Global Health; RREDI/forecasting and outbreak analytics to Public Health Preparedness and Response; and Environmental Health Laboratory and Environmental Health Threats Prevention to Environmental Health. Functions proposed for transfer into CDC from ASPR are excluded because they were not part of the FY 2025 CDC baseline.

Sources: FY 2026 CDC Operating Plan, FY 2025 Final column; FY 2026 ATSDR Congressional Justification, FY 2025 Enacted level; FY 2026 CDC Congressional Justification Detail Table; FY 2026 HHS Budget in Brief; TFAH analysis.

Taken together, the proposed FY 2026 budget would have reduced direct CDC and ATSDR program-level funding by more than half. Tracking FY 2025 CDC and ATSDR functions to wherever the proposal would have housed them, including AHA and the Office of Strategy, those functions would have received approximately $5.50 billion—about $3.75 billion, or 41 percent, below FY 2025 levels.

What the Budget Request Represented

The FY 2026 request, taken together, represented the administration's attempt to translate its operational actions into a permanent fiscal and organizational framework: workforce losses already executed were embedded in proposed full-time-equivalent tables; the structural reorganization already announced was formalized through proposed funding architecture; and the same retrenchment reflected in earlier grant terminations appeared in proposed program-level eliminations. Had it been enacted as proposed, the request would have constituted a fundamental reorientation of the federal government's role in public health—narrower in scope and substantially smaller in scale.

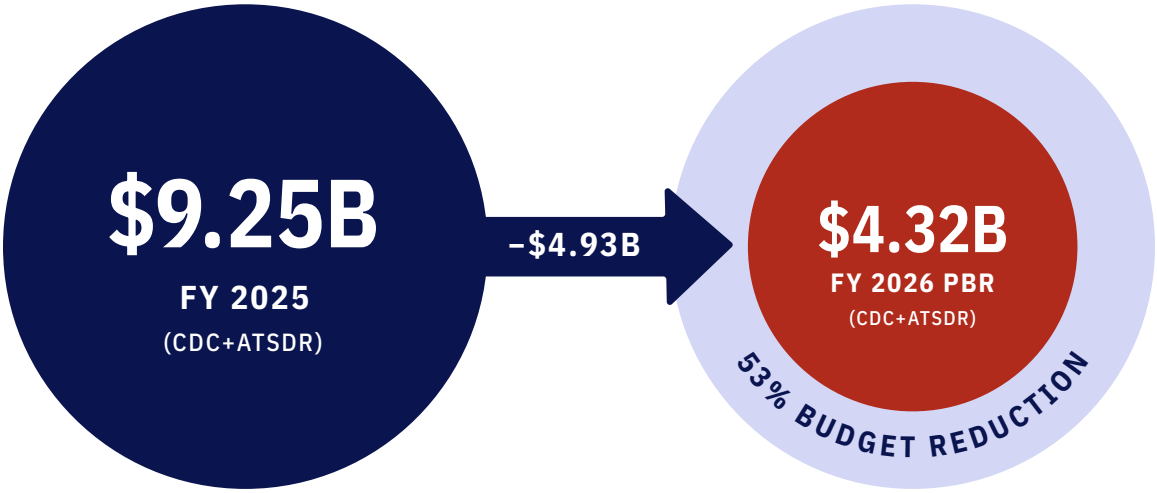
The proposals were not enacted. The Consolidated Appropriations Act, 2026 (P.L. 119-75), signed February 3, 2026, provided CDC a program level of approximately $9.15 billion—essentially flat with FY 2025 and more than double the administration's proposed amount.[357, 358, 359]

Congress's FY 2026 appropriations decisions mattered significantly: they rejected many of the deepest proposed cuts and preserved core agency structures. But congressional action could not undo every consequence of what had already occurred. By the time the FY 2026 omnibus was enacted, CDC and its partner agencies had already lost thousands of staff members, experienced more than a year of leadership instability, disrupted established grant relationships with state and local health departments, and imposed prolonged operational uncertainty on partners that depended on federal funding, technical assistance, and program continuity.

The question facing the nation is not only how much Congress appropriates. It is what the public health system's actual capacity to function is after more than a year of workforce losses, funding disruptions, and structural uncertainty that enacted appropriations alone cannot repair.

FIGURE 12: President's FY 2026 Budget Proposed a 53% Cut to CDC and ATSDR

Combined program-level funding would have fallen by $4.93 billion, reflecting both proposed cuts and transfers of functions to other HHS entities.



Note: Figures are combined CDC and ATSDR discretionary program-level funding. The FY 2026 PBR amount reflects the proposed HHS reorganization, including funding shifted from CDC to the Administration for a Healthy America and the Office of Strategy and approximately $99 million in selected ASPR functions shifted into CDC. The $4.93 billion decline therefore combines proposed cuts and organizational transfers and is not the amount eliminated from HHS.

Sources: FY 2026 CDC Operating Plan; FY 2026 CDC and ATSDR Congressional Justifications; FY 2026 HHS Budget in Brief; TFAH analysis.

NAVIGATING FEDERAL UNCERTAINTY FROM THE FRONT LINES
A CONVERSATION WITH DANIEL EDNEY, M.D., FACP, FASAM

State Health Officer
Mississippi State Department of Health

President-Elect
Association of State and Territorial Health Officials

Q: Could you start by describing the Mississippi State Department of Health—its mission, priorities, and the degree to which federal funding supports your ability to carry out that work?

The Mississippi State Department of Health is celebrating 150 years of public health in Mississippi starting in January of next year. The mission of the department is to protect and advance the health, well-being, and safety of everyone in Mississippi—with no exceptions. That's all 2.9 million of us. We're one of the very few entities that touches every life, every day. We emphasize the importance of public health as a core function of government to remind our elected officials that what we do is critically important in serving the people of Mississippi.

When I took office four years ago, we were about 80 percent funded by federal dollars, which was very dangerous. That's an exceedingly high ratio of federal to state funding. We're a small state, so our budget runs about $500 million or so a year. Four years ago, 80 percent of that was federal. Now it's about 65 percent. But that's not from federal cuts; that's from the state doing better. We have the ability to generate revenue as a centralized agency, so we were actually generating more revenue ourselves than we received through the state appropriation. My goal is to get us down to 55 percent of our budget being federally funded through improved efforts on the state side.

Q: Looking back at the period from early 2025 through today, what has this period looked like from where you sit in Jackson?

All of our federal partners are extremely important. In my four years as state health officer, the federal relationship has been largely unidirectional. It has involved very heavy-handed directives coming from Atlanta and Washington rather than cooperative efforts. The best example was the DOGE cuts. We lost $230 million. Those funds weren't budgeted. Their loss didn't slam our budget, but it slammed our work.

The so-called COVID rescissions were done very impulsively and irrationally, with no thought given to what the impact would be. No one ever asked us, "What are you doing with these funds?" We were doing what we were supposed to be doing: preparing for the next pandemic and rebuilding our infrastructure, which the recent pandemic decimated. A big part of that preparation was the data modernization that we're all working on and simply having a better-prepared public health system so it can respond better than we did the last time.

That just pulled the rug out from under us. It made as much sense as building half of your house and then shutting down construction without having any walls or a roof. It was an utter waste of money because there was so much we had begun investing in that we couldn't finish.

That was not partnership. I'm of the mind that the public health agenda of the state of Mississippi is better determined by Mississippians than by federal project officers. The more discretion the states on the front lines are given, and the closer we can get to communities as we make these important decisions, the more effectively and efficiently the money will be used. Then give us some opportunity to braid and blend funding.

Q: Beyond the dollar amounts in grant awards, federal health agencies provide technical assistance, scientific guidance, laboratory services, data infrastructure, and subject matter expertise that states rely on to do their work. Have you experienced changes in that dimension of the partnership? What does it look like when a familiar federal contact or source of expertise is no longer available?

Relationships matter. The best time to develop a relationship is before the crisis happens. When you have that relationship, it makes working through a crisis easier—rather than talking on the phone for the first time with people you've never spoken to before.

We're very grateful for our federal partnerships, and some do a better job than others. HRSA is an outstanding partner with us on rural health issues. The folks at EPA Region 4 know us; we talk to them all the time. There aren't that many state or territorial health officials, so I think CDC leadership should know every one of us.

We don't have the ability to do Biosafety Level 4 laboratory testing. With all of the crazy, rare bugs, the states don't have enough volume to do that on a day-to-day basis in our public health laboratories. We need CDC's expertise and laboratory testing, especially for unusual or challenging outbreaks, like the measles outbreaks in Texas, Utah, and South Carolina.

We need CDC's epidemiologic expertise. We need that technical expertise on hantavirus. We don't deal with that in Mississippi, but I had to be prepared in case there had been travelers involved. We can't defend Mississippi against Ebola by ourselves. It takes partnerships with CDC, but CDC can't be on the front lines in Jackson, Mississippi, so we have to work together.

It hurts public health in Mississippi when we can't immediately pivot to our federal experts for help when we need it. A great example was the blackout period during the transition between presidential administrations. We were disconnected from the federal government, and I just thought, "Well, Lord, I hope nothing happens where we need CDC during this."

Q: In August 2025, MSDH declared a public health emergency over Mississippi's infant mortality rate—the highest the state had recorded in more than a decade. Addressing that crisis depends in part on federal support from agencies such as CDC and HRSA. What has this period of federal uncertainty meant for that work specifically?

The emergency was based on an explosion in African American infant mortality. It was a drastic jump that was so worrisome on top of an already bad number. I brought together everyone throughout the agency to understand whether they were doing anything related to infant mortality and what investments we were making in maternal health.

We reconstructed our home-visitation program into a new model using community health workers. Our experts were telling us that safe-sleep issues were killing way too many of our babies, especially in the high-risk, low-income homes that were most affected. We got cribs and Pack 'n Plays to our high-risk homes, along with teaching families and grandparents about safe sleep. We had federal funding available to help us.

Later, one of my team members said, "Well, we used to give out cribs."

I said, "Well, why did we stop?"

She said, "The federal grant went away."

I just shook my head. It brought home to me that we need to determine the public health policies and programs that Mississippi needs, and then we will use every federal, state-appropriated, and discretionary dollar we can to make them happen. But we cannot base our programs on whether federal funding is available. Now, if federal funds go away, the cribs aren't going away. These changes are making an impact. They're teaching us a lesson.

Q: Much of Mississippi's federal public health funding flows through your department to local health departments and community organizations. When federal funding is disrupted at the state level, how does that affect the partners downstream who depend on MSDH as an intermediary?

I shared with our congressional delegation that the folks who were hit the hardest by the DOGE rescissions were community-based partners. It really hurt the trust we had built with partners because we had contracts and subgrants in place related to all this funding that was rescinded.

We had work orders, and millions of dollars were going out to community-based organizations with relatively small budgets that had applied for and received awards and had begun their work. Then we had to issue stop-work orders because the federal funds were pulled. Now nobody wants to enter into contracts with us because they don't know whether the money will be rescinded.

It was not catastrophic, but it negatively affected our work and severely affected our partnerships. It decimated our community health worker efforts, which we're slowly rebuilding with Rural Health Transformation grant funds. The smarter thing would have been to leave those initial grants alone and let them mature so the work that had already started could be completed.

Q: As ASTHO's President-Elect, you hear from state health officers across the country. Are there patterns you're seeing in how this period has played out across states?

We've all been trying to work through these changes together, just in our different ways. The blue states had challenges and were knocked back on their heels, but their funding got turned back on. The red states are used to more funding challenges, especially my colleagues in the Southeast, but we have a different attitude about it.

We all work in the same political climate, but we do it successfully. When we go to the Capitol, we're appreciated, respected, and listened to. It doesn't mean they give us everything we ask for, but they voice their appreciation frequently, and that goes a long way.

The most important thing I have to defend is not our funding, but trust in public health. And we've been very successful with that. We navigated the pandemic without losing trust or abusing public health authority, and we were seen as trusted subject matter experts by our elected officials and the community at large. That has made it easier to request funding for specific issues.

Q: The President's FY 2027 budget proposes significant reductions to CDC and other federal public health programs. What would those cuts mean in practice—for your department, the communities you serve, and communities across the country?

It was counterintuitive to me that an administration that's trying to make us healthy again would eliminate the Prevention and Public Health Fund or eliminate the Office on Smoking and Health at CDC.

No one has asked us at the state level, "If you need to trim 15 percent from the budget, what would be the wisest way to do it, and how would it affect the community?" I'm not opposed to some thoughtful reorganization, but I think what has also been extremely expensive is the drastic reduction in the federal workforce without a whole lot of planning, thought, or preparation. Those of us who are used to managing large workforces know that workforce adjustments need to be done thoughtfully.

I suspect there will be cuts. I can't predict which of the proposed cuts will be honored, but I'm very worried about any cuts to the Title V Maternal and Child Health Services Block Grant. We have the investment in our federally qualified health centers through HRSA. The WIC program is absolutely necessary, so cutting WIC across the board in a less-than-thoughtful manner is going to hurt women, infants, and children, which I don't think any of us in the United States wants to do.

I think our HIV funding is at risk, right as we are making historic improvements in reducing the incidence and prevalence of HIV and bringing the largest number of people into care that I think we ever have.

"When CDC is hurting, that hurts public health in Mississippi."

—Daniel Edney, M.D., FACP, FASAM
State Health Officer, Mississippi State Department of Health

Q: What would you most want members of Congress—and the public—to understand about what federal public health investment makes possible and what is genuinely at risk right now?

When I talk to our congressional delegation, I share that CDC is our closest federal partner. We also have a lot of work in the HRSA space and some work with SAMHSA, but mostly CDC. Then I remind them that 80 percent of CDC's funding flows out to states and localities.

I know there was a lot of appetite to punish CDC. Having endured the pandemic, first as a practitioner at the bedside and then coming to the State Department of Health right in the middle of it, I know there are things that could have been done better. But everybody's heart was in the right place.

You cannot decimate CDC and then think it's going to work well. It is an extremely important federal agency that has now been decapitated and is just floundering. When CDC is hurting, that hurts public health in Mississippi.

The stability in public health has occurred because state and local agencies have held it together. The folks at CDC are doing the best they can in this situation. We love and respect them, and we need them. What I've been communicating to our federal delegation is the importance of CDC and the good work it does for Mississippians. It is the best example for us in terms of our federal partners.

If I'm getting direct funding from Congress without CDC, I can keep doing a lot of what we do, but I can't keep doing everything we do. Also, a lot of people don't understand how many different federal partners we work with every day. For us to keep the water safe in this state, we have to have EPA. For us to keep the milk supply and dairy products safe and to manage the WIC program, we have to have USDA.

Q: Is there anything we have not discussed that you think is important for readers—especially policymakers—to understand about this moment for state public health agencies?

How do you survive challenging budget times? I knew we had to do better at generating revenue ourselves. I knew the area where we were getting practically no funding was the private sector—and who in the world wants to donate to a state agency?

I was able to get the legislature to enact a trust for public health in Mississippi and have it funded in a blended fashion. There are appropriated tax dollars, discretionary public health dollars, and private donations beginning to come into the trust. It's a true endowment that earns interest and can't be used for any other purpose. We work only off the interest. That gave me a different revenue stream.

I love the thought that, even after I'm long gone, some of the work we've instituted during this time will still be working to save moms and babies.

The pendulum is swinging, and it's going to swing back. In our state, funding is going to be more stable than I think our federal funding will be. Rather than just preaching doom and gloom about it all, I think it's best that we respond to where we are in the current climate. Keep advocating for the importance of our work. Demonstrate excellence. As we demonstrate excellence and good stewardship, the funding will come.

And, you know, I think we're going to have some lean times for a few years, but then I think the pendulum will come back, and that'll be okay. It's just going to be the role of all of us who are currently state health officials to navigate the waters. We can do it, though. It'll be all right.

This interview was conducted in June 2026 and has been lightly edited for length and clarity.

NAVIGATING FEDERAL UNCERTAINTY FROM THE FRONT LINES
A CONVERSATION WITH MICHELLE TAYLOR, M.D., DR.P.H., M.P.A.

Commissioner
Baltimore City Health Department

Chair
Big Cities Health Coalition

Q: Could you start by describing the Baltimore City Health Department—its mission, priorities, and the degree to which federal funding supports your ability to carry out that work?

The Baltimore City Health Department is a larger local health department, with 700-plus employees across administration and four divisions: Youth Wellness and Community Health, Population Health, Public Behavioral Health, and Aging. The mission is to protect health, eliminate disparities, and enhance the well-being of everyone in our community through education, coordination, advocacy, and direct service delivery. Our vision is an equitable, just, and well Baltimore, where everyone has the opportunity to be healthy and to thrive.

We rely heavily on federal funding, with about 38 percent of our $200 million budget coming from federal grants or federal pass-through funding from the state health department. Much of this funding supports core services and public health infrastructure. Historically, the federal government has consistently funded bread-and-butter public health, as well as innovative new projects. That is the role of the federal government: to support essential services, as well as invest in projects that may not reap rewards for 10 to 15 years but will have significant benefits when they do.

The federal funding that the Baltimore City Health Department receives is concentrated in specific areas of work, and that's not uncommon for local health departments. For example, in FY 2026, $91.5 million was allocated to services for older adults in Baltimore City. Of that amount, a little over $86 million came from federal funds. Because federal funding isn't evenly distributed across areas in the health department, we are heavily dependent on it in some areas but less dependent in others.

Q: Before the changes that began in early 2025, how would you describe the Baltimore City Health Department's relationship with CDC and the broader federal public health infrastructure? What did that partnership make possible that Baltimore could not readily replicate on its own?

The Baltimore City Health Department's relationship with CDC in early 2025 and before was strong, as it was for many local health departments. We hosted CDC Masters Fellows and Prevention Health Fellows, which was invaluable. They did tremendous work in adolescent and reproductive health, preventing substance-exposed pregnancy, and improving health literacy. We've seen major successes here with Baltimore City's Ryan White program as a result of our partnerships with CDC. The program has always been a leader in innovation and practice across the state, and Baltimore was one of the early pioneers in harm reduction, mainly because of skyrocketing HIV rates decades ago. Baltimore now has a new HIV infection rate commensurate with the state of Maryland, and many of those living with HIV are older adults who have stayed connected to treatment. We continue to receive and utilize funds from the Public Health Infrastructure Grant to revitalize our workforce, expand educational opportunities, provide training, and update our systems. The funds have been

transformative, and that has been the case both here in Baltimore City and in my previous role in Shelby County, Tennessee.

Normally in public health, if we knew a cut was coming, we would have six months to a year to prepare for that cut. We would be informed super early. We would have time to cross-train our workforce. We would have time to find other positions for people and to prepare the community for cuts that were coming. In this new environment, we get notice to change our work plan, or else. The funding is cut, and you're scrambling to figure out: Can I keep the workforce on the payroll that was funded by this program? Can I keep these services going without these funds? It's chaotic, and it makes the work a lot harder. When we're not sure where our funding will come from in the next three to five years, it means we cannot plan for future expansion of services. It means that our attention is split. Instead of focusing solely on the health of our residents, we must also prepare for overnight losses of funding. We're having to become much more efficient in the way we do business while also holding our collective breath to see what the next shock to the system might be.

Q: Federal funding that supports Baltimore's public health work reaches your department both through direct federal grants and through the Maryland Department of Health. Much of your work also depends on partnerships with community-based organizations, health care providers, schools, shelters, and other local entities. When federal funding, guidance, technical support, or grant administration becomes uncertain upstream, how does that affect the Baltimore City Health Department and the partners who depend on it as a funder, convener, and source of public health expertise?

One thing about community partnerships that we rely on is the trust that we've built over the years. Community partnerships can be dicey at times because sometimes we go for the same funding. But in Baltimore City, I have been impressed by the level of partnership and the understanding that everybody's resources are required to do this work. Organizations ask the health department to help with applications or to be partners.

We are still working to act as a primary convener because the way that we get through this time is together. While we're looked at as a source of public health expertise, our ability to fund ongoing work is diminished. And our partners know that. Because of the loss of teen pregnancy prevention funding, city schools will not receive an education program that they thought they would have for another two years. The Baltimore City Health Department continues to convene local hospitals, opioid-associated disease prevention and outreach programs, and federally qualified health centers to ensure that we are working collaboratively to make the best use of our funding and improve the health of our public. We know that we continue to act as a convener, but it's not just us as a local health department. Everybody in the system is feeling this and realizing that we have to be honest brokers and partners with each other to get this work done.

Our residents have felt the impact of this changing funding landscape. They know that they may not continue to receive the types of services they've come to expect from the health department. They hear about it on the news. Ultimately, this makes it even more difficult to gain the trust of residents who may be in vulnerable situations or have historically struggled to access services. The last thing you want to do is start something in a community—or have something that's been in a community for years—and then have to abruptly cut it off.

Q: One theme we are exploring is that appropriated funding levels alone do not fully capture whether public health agencies have the capacity to function effectively. Does that resonate with your experience at the local level? What has changed for your department that may not be visible in the grant award amounts?

Public health has been consistently underfunded over the years. We are asked to accomplish more with less

and have been asked to do that for decades. The creation of Public Health Infrastructure Grant funds was one of the first times public health was given flexible dollars to do the type of work we needed to do, at a scale that allowed us to operate at the level we needed. Now, the question is whether we can function effectively with much less funding than we have traditionally had. Funding may appear in the budget line, but everybody who leads a local or state health department, along with all their staff, understands that in the current environment, just because it's on a line in a funding document doesn't mean it's going to stay there. We've had some very honest conversations with our staff about that.

We're trying to figure out how to effectively, safely, and responsibly use AI and data to automate certain activities that may not require as much funding but will help us continue to get the work done. We're learning from the lessons of COVID, including good and not-so-good examples of communication, to let people know that we're not perfect, but that the public health message and the advocates who carry that message are important. The messengers may change based on who the population is. We're also looking at aging populations and systems. What does it mean that our population in the United States is older than it's ever been? We have to know how to reach older adults to make sure that they have a good quality of life, and if we reach them intergenerationally, we're reaching those younger generations as well. Those are challenges that we are facing, but they also present unique opportunities to do things a bit differently, a bit more efficiently, and to really turn the chaos that we're seeing in the system on its head.

Q: Baltimore has made progress in reducing overdose deaths, even as overdose mortality remains a serious public health crisis for the city. You have also identified overdose prevention as a major priority. How does federal public health support help make that work possible, and what has this period of federal change and uncertainty meant for those efforts specifically?

Most of the Baltimore City Health Department's funding for the overdose crisis response is from the city's Opioid Restitution Fund under the mayor's office. This is a fund that was established using settlement dollars from litigation regarding the involvement of pharmaceutical companies in the opioid crisis. The mayor issued an executive order requiring a strategic plan and a two-year needs assessment. This funding from the mayor's office has been essential in supporting our work to address overdose mortality in Baltimore City, including a new division of public behavioral health within the health department. We ask ourselves what program sustainability looks like and how federal uncertainty may impact long-term planning. It's encouraging that, no matter what the uncertainty is on the federal side, Baltimore City has these settlement funds and has decided to use them responsibly and to respond to community voice, both in real time and over the long term. We have a Restitution Advisory Board of residents with lived experience with substance use disorder or who work in that space, and they are informing the rules for this next set of RFPs. That does not happen everywhere. I really do believe that we're going to continue to see significant reductions in overdose mortality and a healthier community in the long term because people are making smart fiscal decisions with community voice at the top of the list.

Q: Beyond the dollar amounts in grant awards, federal health agencies provide technical assistance, scientific guidance, laboratory support, data infrastructure, and subject matter expertise that local health departments rely on to do their work. Have you experienced changes in that dimension of the partnership? What does it look like when a familiar federal contact or source of expertise is no longer available?

We have traditionally depended on the federal government for lab support, for subject matter expertise, and for leadership on national public health issues, such as air quality emergencies, cyclosporiasis

messaging, and childhood vaccines. Recently, insufficient federal leadership has required state and local agencies to assume greater responsibility within their own jurisdictions. While we are capable of this, I can say from both a military and local perspective that the lack of leadership complicates coordinated responses, an area where federal leadership is most effective. Organizations such as the Northeastern Public Health Collaborative have strengthened connections among states and cities nationwide to address major public health issues and share information on changes in national funding.

When the federal government started layoffs, the CDC COVID disparities grant project officer changed several times. Our staff would email the project officer they thought they were working with, get no answer, and then eventually hear that someone else was the officer. It made it more challenging to close out our grants. Technical assistance and guidance on fulfilling requirements for federal grants may change mid-funding cycle. It's gotten to the point where, no matter which public health partner I'm talking to, if one entity gets an email that says we have five days to do something, we're all emailing one another, saying, "I got this. Did you get it? Check Grant Solutions, check your other websites, make sure that you didn't get the same letter." We're partnering to try to manage the chaos.

Q: Through your role as Board Chair of the Big Cities Health Coalition and your connections across the local public health community, are there patterns you are seeing in how this period has played out for urban health departments across the country? Are local agencies experiencing similar challenges even when the details differ from place to place?

A lot of local agencies have networks, and those networks existed before the type of chaos that we've seen for the last year and a half. We are really leaning on each other to make sure that everybody has the same information. A good example would be with hantavirus. Through our regional contacts, we were notified that there was a chance some passengers might have to come to this region because of where we sit geographically. Everybody in this region, from a public health or health system standpoint, was on calls together to make sure that if any passengers had to be brought here, everybody was aware and prepared to push out messages to the public. We were prepared regionally because we were communicating. Our federal partners have done as much as they can to help, while making sure that they can give us as much information as they're allowed to give.

These agencies—federal, state, and local—have been coordinating for years. When our federal partners aren't saying something that we would be accustomed to getting in their messaging, that's a message too. It tells us at the state and local level that since they're not answering this question in the way we would normally expect, let's get together and figure out what else we would normally do in this situation. It really is about filling in some of those coordination gaps. Is this something we should have to do? No. It puts everybody in danger from a health standpoint. But what I can tell you is that coordination is still happening because you have a lot of dedicated people who want to make sure that we are minimizing threats in the way we have been trained to do and in the way we have been accustomed to minimizing them throughout the years.

Q: The President's FY 2027 budget proposes significant reductions to CDC and other federal public health programs. What would those cuts mean in practice—for your department, for the communities you serve in Baltimore, and for local public health agencies across the country?

You may not see the changes right away, and everything will look the same at first. But we're already asking ourselves: Can we do the same amount of work with less? Will we have to cut positions or potentially leave vacancies unfilled? Will we hold back from applying for new projects because we're so focused on maintaining services? Based on the kind of cuts being proposed, we will have to be vigilant for increased rates of STDs and STIs, which we're already seeing.

We've seen a 246 percent increase in babies born with congenital syphilis because they were infected while they were being carried by their mothers. We will see an increased need for support among vulnerable pregnant people, higher rates of teen pregnancy, greater challenges in vaccination, increases in suicide or depression among LGBTQ+ community members, poor outbreak tracking in general, and more emergency room visits among those who are uninsured or underinsured, especially those who may be undocumented or no longer able to access insurance due to changes in Medicaid.

While public health agencies across the nation will try to stem the tide, changes at the federal level will undercut the public's health for decades to come. This is not hyperbole. The changes being proposed to Medicaid alone are going to be devastating to population health and to our health systems, which will be charged with dealing with more people showing up in emergency departments because they don't have adequate coverage or coverage at all. And some of those changes have already been passed. Starting October 1, H.R. 1 will restrict Medicaid coverage for some noncitizens, including many refugees and asylees. Then, starting January 1, new work-related requirements will take effect for some adults who rely on Medicaid. So yes, things are happening in the background to try to mitigate that, but we are going to feel the stress of that soon.

Q: What would you most want members of Congress—and the public—to understand about what federal public health investment makes possible at the local level, and what is genuinely at risk right now?

In 2009, Baltimore City had one of the worst rates of infant mortality in the country: 13.5 infant deaths per 1,000 live births. Black babies were five times more likely to die than white babies. The city came together and took a public health approach to address this issue. By 2021, Baltimore City had achieved the lowest infant mortality rate in the city's history: 7.5 infant deaths per 1,000 live births. Now, Baltimore City travels the nation educating other jurisdictions about how they can do the same. We host graduation parties for the babies and parents who complete our programs. These parents may not have been with us without public health intervention and public health funding. Better yet, think about the classrooms of kindergartners we would never have seen if infant mortality rates had remained at their 2009 levels.

In 2008, Baltimore City had a new HIV diagnosis rate more than three times higher than the state average. The Baltimore City Health Department introduced an innovative idea for the time—a syringe service program to reduce unintentional infection and increase education. And now Baltimore City's new HIV diagnosis rates are commensurate with the state. We've been able to watch a disease that killed thousands become a chronic illness for our residents living with HIV.

And that's what we stand to lose. Sometimes people say, "That's Baltimore City, but it's happening in other places." No. I led a local health department in a city where the investment levels were not the same. When I left Shelby County, Tennessee, the county and the surrounding area for our Grant Area were number two in the nation for new HIV infections in 2023. You can track, by jurisdiction, the level of investment—local, state, federal—and what these different jurisdictions have been able to do based on that investment. People will say, "Oh, it's choice, it's culture." Sure. But that investment in true evidence-based public health is palpable, and the evidence is there every single day.

Q: Is there anything else you'd like to add?

Public health has done hard things before. This is not new. I can imagine the folks in the 19th century dealing with yellow fever. Those public health professionals, whether they were calling themselves that or not at the time, were trying to figure out just how to keep so many people from dying from these epidemics. We figured it out. We will get through this challenging period. And I really do believe that we will be better on the other side because we will know what needs to be rebuilt and how to rebuild it better.

This interview was conducted in July 2026 and has been lightly edited for length and clarity.

Congress Responds—What FY 2026 Appropriations Did and Did Not Resolve

The FY 2026 appropriations process produced a clear and consequential result: Congress rejected the administration's proposed cuts to federal public health funding, did not adopt the proposed consolidation of several major public health agencies into a new organizational structure, and enacted several provisions designed to constrain the kinds of disruptions documented in the preceding section.[360,361,362] The final legislation—the Consolidated Appropriations Act, 2026 (P.L. 119-75), enacted February 3, 2026, as part of a broader appropriations package[363,364]—funded HHS at a level substantially above the administration's request and included new statutory and report language responsive to grant termination, staffing, payment-disbursement, and reorganization practices that had affected public health operations during 2025.

SECTION AT A GLANCE

- Congress rejected the administration's proposed FY 2026 restructuring and deepest public health cuts. It funded HHS substantially above the President's request, maintained CDC, SAMHSA, HRSA, and ASPR as distinct entities, preserved the Prevention and Public Health Fund, and kept CDC's overall program level approximately flat.
- Congress also added new guardrails addressing staffing, movement of CDC functions, grant terminations, payment delays, and program-level spending. These provisions reflected serious concern about how appropriated funds and public health programs had been administered during 2025.
- The response came only after a prolonged shutdown, temporary funding, and a second brief lapse in appropriations—conditions that themselves disrupted agency and grantee operations.
- Appropriations established funding and congressional direction, but they could not immediately restore lost personnel, institutional knowledge, technical-assistance relationships, or grant-administration capacity. Nor did the new procedures prevent every subsequent grant termination or delay.
- FY 2026 therefore represented a consequential rejection of the deepest proposed cuts, but not a recovery of the system's pre-disruption operating capacity. Appropriated dollars are necessary; whether they produce functioning programs depends on staffing, timely execution, stable administration, and sustained congressional oversight.

That response was meaningful and should not be minimized. But it was also incomplete, as subsequent months would underscore. Whether appropriated dollars translate into actual public health capacity depends on a set of factors—staffing levels, grant execution, operational continuity, and institutional knowledge—that this legislation sought to protect and stabilize but could not by itself restore.

The Path to FY 2026 Enacted Funding

The road to full-year FY 2026 appropriations for HHS ran through a 42-day government shutdown, a continuing resolution (CR), and a brief partial shutdown before concluding on February 3, 2026—more than four months into the fiscal year. That path matters for understanding what the appropriations ultimately achieved, because the funding process itself was a source of operational disruption well before full-year funding took effect.

OCTOBER 2025 SHUTDOWN

When Congress failed to enact full-year appropriations or a CR before the start of the fiscal year, a funding lapse commenced on October 1, 2025. The shutdown that followed lasted 42 days—ending November 12, 2025—making it the longest government shutdown in U.S. history.[365]

The contingency plans pointed to substantial potential consequences for public health operations. Under the September 2025 version of its FY 2026 contingency staffing plan, HHS expected to furlough roughly 41 percent of its workforce.[366,367,368] For CDC specifically, the implications were sharper: under the agency's own contingency plan, approximately two-thirds of CDC and ATSDR staff would not be retained,[369,370] leaving only those whose work qualified as exempt under existing carryover or other available funding, or as excepted for the protection of human life or property or by necessary implication. The operational consequences that CDC catalogued in its contingency plan included the suspension of grant funding announcements, which compressed application timelines for state and local health departments; the suspension of ongoing applied public health research; delays in disease surveillance reports; and the unavailability of CDC scientific and medical experts for guidance to state and local health departments on programs including opioid overdose prevention, HIV prevention, and diabetes prevention.[371] HHS's plan noted that CDC's public communication function would be "hampered" during a lapse.[372,373]

The timing of the lapse amplified its effects. The shutdown began at the very start of the fiscal year, when agencies would ordinarily begin implementing annual funding decisions and preparing new grant activity. For many state and local health departments that rely heavily on federal grants, the October 1 timing introduced uncertainty about the availability and timing of funds at the moment annual planning would otherwise commence.

The shutdown also carried a workforce dimension that distinguished it from prior episodes. On September 24, 2025—one week before the lapse began—the White House OMB circulated a memo to Cabinet secretaries directing agencies to consider using a potential shutdown as an "opportunity to consider Reduction in Force (RIF) notices for all employees in programs, projects, or activities" whose discretionary funding would lapse on October 1, lacked another available funding source, and were "not consistent with the President's priorities."[374,375] That memo introduced a level of workforce uncertainty—the possibility that shutdown-related furloughs could be accompanied by or followed by permanent separations—that represented a departure from the historical practice under which such furloughs were generally understood as temporary and reversible.

NOVEMBER 2025 CONTINUING RESOLUTION

The shutdown concluded on November 12, 2025, when the president signed P.L. 119-37. Division A of the law provided continuing appropriations through January 30, 2026, for HHS and other departments and agencies whose full-year FY 2026 appropriations had not yet been enacted, generally at the rates and under the authorities and conditions provided in the FY 2025 appropriations law.[376,377]

The CR restored operational authority but did not resolve the underlying full-year appropriations questions. By the time P.L. 119-37 was enacted, both congressional chambers' appropriations committees had reported their respective versions of the full-year FY 2026 Labor, Health and Human Services, and Education appropriations bill.[378,379] Both the House and Senate committee bills maintained the existing federal health agency structure and did not establish the administration's proposed AHA, although they differed substantially in their funding priorities. Both also departed from the administration's deepest proposed reductions to CDC and other health agencies.[380,381,382] The House bill, however, still proposed substantial public health cuts, including a significant reduction to CDC.[383] The broad direction of the congressional response was therefore visible but not fully settled: appropriators were not prepared to enact the administration's full reorganization proposal or its deepest funding cuts, but the chambers still differed over funding levels and programmatic reductions.

What remained unresolved through the CR period were the specific enacted levels, the particular oversight provisions, and the details of the final agreement.[384] For agencies, grantees, and state and local health departments, the practical constraints of temporary funding were real: under a CR, agencies generally faced limits on making full-year grant awards, initiating new multiyear funding cycles, and planning or obligating funds with the certainty that annual appropriations provide.[385]

FINAL ENACTMENT

When the CR expired at the end of January 30, 2026, full-year appropriations for HHS and several other departments and agencies had not yet been enacted, triggering a second, brief funding lapse.[386] The lapse ended on February 3, when the president signed a package containing five full-year appropriations bills. Full-year funding for the Department of Homeland Security had been set aside for separate negotiations, with the department instead funded under a short-term extension.[387] On January 30, the Senate passed the five-bill package by a vote of 71 to 29.[388,389] The House approved the measure on February 3 by a vote of 217 to 214,[390] and the president signed the Consolidated Appropriations Act, 2026, later that same day,[391,392] ending the funding lapse and resolving HHS funding levels for the remainder of the fiscal year.

The vote margins warrant attention. The Senate's 71-to-29 margin reflected bipartisan support. The House vote of 217 to 214 was considerably narrower, but it was sufficient to send the legislation to the president for signature and secure full-year HHS appropriations.

Congress funded HHS substantially above the administration's FY 2026 budget request and declined to adopt the proposed restructuring of major public health agencies. But whether appropriated dollars translate into actual public health capacity depends on a set of factors—staffing levels, grant execution, operational continuity, and institutional knowledge—that legislation can direct and constrain but cannot independently supply.

FY 2026 Enacted Funding Levels

The funding levels enacted in P.L. 119-75 represent Congress's clearest statutory statement of its federal public health funding priorities for FY 2026. Against an administration request that proposed restructuring or eliminating several major federal health agencies and public health functions and reducing HHS discretionary funding by nearly 25 percent,[393,394] Congress largely preserved the existing agency structure and funded most major agencies and programs much closer to their FY 2025 levels than to the administration's request.

HHS-WIDE

The FY 2026 enacted level for HHS-wide discretionary budget authority was $126.6 billion on the existing HHS organizational basis[395]—effectively flat compared with FY 2025 on the same basis,[396] and approximately $32 billion, or 34 percent, more than the $94.7 billion requested in the FY 2026 President's Budget.[397]

CDC

At the program level—the measure CDC uses to capture its discretionary operating resources, including budget authority, PPHF transfers, and Public Health Service evaluation transfers—CDC received $9.1 billion for FY 2026.[398] For practical purposes, CDC's enacted funding was essentially flat year over year, declining by $19.1 million, or about 0.2 percent, from FY 2025.

Within the program-level total, appropriators made targeted adjustments. Public Health Infrastructure and Capacity grants—the primary mechanism for direct federal support to state and local health department capacity—received a $10 million increase to $360 million;[399] Public Health Data Modernization received a $10 million increase to $185 million;[400] and Emerging and Zoonotic Infectious Diseases grew by $21 million.[401] On the other side of the ledger, Public Health Preparedness and Response declined by $25 million to $913 million, driven by a reduction in the Ready Response Enterprise Data Integration Platform/ Forecasting and Outbreak Analytics line, while the PHEP cooperative agreement itself remained flat.[402] The Social Determinants of Health line, funded at $6 million in FY 2025, was eliminated.[403]

The enacted CDC program level contrasts sharply with what the administration proposed. The FY 2026 President's Budget requested a combined CDC and ATSDR discretionary program level of approximately $4.3 billion—roughly 53 percent below the FY 2026 enacted level.[404] That proposed reduction reflected both the administration's proposed elimination of the PPHF and the proposed transfer, consolidation, or elimination of selected CDC program areas and functions, including parts of injury prevention, environmental health, and occupational safety and health, within the proposed AHA structure.[405] Congress did not adopt that proposed structure and instead provided CDC with a resource level close to its FY 2025 baseline.

SAMHSA, HRSA, AND ASPR

SAMHSA received $7.4 billion, roughly level with FY 2025.[406,407,408] The administration's FY 2026 budget request had proposed absorbing SAMHSA into the new AHA. Congress instead maintained SAMHSA as a separate operating division with dedicated appropriations. Key components included approximately $1.0 billion for the Community Mental Health Services Block Grant, $2.0 billion for the Substance Use Prevention, Treatment, and Recovery Services Block Grant, $1.6 billion for State Opioid Response Grants, and $535 million for 988 and Behavioral Health Crisis Services.[409]

HRSA was similarly maintained as a separate operating division. The administration's FY 2026 budget had proposed folding HRSA into AHA alongside SAMHSA.[410] The enacted level of approximately $8.95 billion

included approximately $1.9 billion for the Health Centers program and $130 million for the National Health Service Corps, among other programs.[411]

ASPR received $3.69 billion and was maintained as an independent entity.[412] The enacted level included $1.1 billion for the Biomedical Advanced Research and Development Authority, $850 million for Project BioShield, and $1.0 billion for the Strategic National Stockpile.[413] The administration's proposed reorganization would have eliminated ASPR as a distinct entity, transferring selected functions to a new Office of the Assistant Secretary for a Healthy Future and others to CDC.[414] Congress instead funded ASPR as a separate entity under the existing program structure.

THE PREVENTION AND PUBLIC HEALTH FUND

The administration's FY 2026 President's Budget proposed eliminating the PPHF—the dedicated mandatory funding stream established by the ACA to support sustained investment in public health and prevention. Congress declined that proposal and allowed the PPHF's current-law level to rise from $1.3 billion in FY 2025 to $1.5 billion in FY 2026.[415,416] CDC's allocation from the PPHF increased from $1.2 billion to $1.4 billion, partially offsetting the reduction in CDC's discretionary budget authority and resulting in the near-flat total program level noted above.[417]

Structural and Oversight Provisions

The enacted legislation went beyond funding levels in ways that signal the scope of congressional concern about executive administration of public health programs.[418] Appropriators used the FY 2026 Labor, Health and Human Services, and Education appropriations bill to address not only how much money agencies would have, but whether that money would be administered consistently with congressional intent.[419,420,421] Several of the provisions that follow were responsive to the kinds of disruptions documented in 2025, including grant terminations, payment delays, staffing reductions, and proposed reorganizations.

ADMINISTRATION FOR A HEALTHY AMERICA

The administration's FY 2026 reorganization proposal was premised on the creation of the AHA, which would have consolidated several existing HHS divisions and program areas into a single new entity.[422,423] P.L. 119-75 did not adopt or fund the proposed AHA structure. Instead, Congress appropriated dedicated funds through the existing HHS operating-division structure, including separate appropriations for HRSA, SAMHSA, CDC, and ASPR—entities that the administration's broader reorganization proposal would have consolidated, absorbed, or substantially reconfigured.[424]

Congress's rejection of AHA did not appear as an explicit statutory prohibition on creating the entity. Congress acted primarily through appropriations: funding the existing agencies and not adopting the proposed replacement structure. That approach made clear that FY 2026 funds were being provided through the existing appropriations framework, not through AHA. Whether and how the administration could pursue elements of the reorganization through other administrative mechanisms remained a separate legal and oversight question—one that Congress addressed in part through a 60-day notification requirement for certain reorganizations.[425]

60-DAY REORGANIZATION NOTIFICATION REQUIREMENT

Enacted as statutory text in P.L. 119-75, the legislation requires the HHS secretary to submit a detailed plan and justification to the congressional appropriations committees—and to make that plan publicly available—not less than 60 days before initiating any reorganization that would move CDC functions to another HHS component.[426,427] The requirement applies to CDC functions funded under the enacted appropriations. The provision does not require

affirmative congressional approval of a reorganization, but it does require advance disclosure and creates a period for congressional and public review before such restructuring is initiated.

STAFFING LEVELS REQUIREMENT

The legislation enacted a staffing requirement in statutory text: "The Department of Health and Human Services shall support staffing levels necessary to fulfill its statutory responsibilities including carrying out programs, projects, and activities funded in this title of this Act in a timely manner."[428,429,430] This language, applicable to HHS as a department,[431] was responsive to the 2025 workforce reductions that raised concerns that programs could be funded but lacked sufficient staff to execute at prior-year levels. Similar language was included for the U.S. Department of Education.[432,433]

GRANT TERMINATION NOTIFICATION

The legislation requires HHS, along with the Departments of Labor and Education and the Corporation for National and Community Service, to notify the House and Senate Appropriations Committees not less than three full business days before announcing or providing notice of the termination or non-continuation of any grant, including a short description of the reason for the action.[434] This requirement was enacted in statutory text, not expressed solely in accompanying report language, and establishes a minimum advance-notice procedure for FY 2026 grant terminations and non-continuations.

GRANT DISBURSEMENT REQUIREMENTS

Report language accompanying the legislation addressed the pace at which appropriated funds flow to grantees through the department's Payment Management System (PMS),[435] the administrative mechanism through which HHS provides services for disbursement, grant monitoring, reporting, and cash management.[436] The language directs HHS to provide advance notification to the appropriations committees before implementing any restrictions that would delay PMS disbursements; directs HHS to ensure that disbursements are processed within five business days except under extraordinary circumstances; and directs HHS to brief the committees on the circumstances justifying any delay exceeding five business days.[437,438] These provisions responded to concerns about grant disbursement delays and restrictions during 2025. The grant termination notification requirement and the PMS disbursement provisions are distinct mechanisms addressing different stages of the grant lifecycle.

PROGRAM-LEVEL SPENDING REQUIREMENTS

The enacted legislation and accompanying explanatory statement used CDC program-area funding tables as an implementation and accountability tool.[439,440] Section 236 gave the budget activities and amounts in those tables statutory effect by providing that funds made available under the listed CDC headings "shall be for the budget activities, and in the amounts specified in the table under each such heading" in the explanatory statement.[441] The explanatory statement also directed agencies not to reallocate resources or reorganize activities except as provided and identified funding for individual programs and activities in detailed tables. For CDC, this meant that Congress established program-level spending requirements below the broad account level, reducing—but not eliminating—the executive branch's discretion to shift funds among CDC program areas without satisfying applicable transfer, reprogramming, and congressional-notification requirements.[442] This mechanism reinforced Congress's decision to fund the existing CDC program structure rather than the administration's proposed consolidation or elimination of selected program areas, while leaving unresolved whether funded program lines would have sufficient staffing and operating capacity to function as intended.

FIGURE 13: Selected FY 2026 Congressional Oversight Provisions for HHS

The enacted law and accompanying explanatory statement establish requirements and congressional directives for staffing, reorganizations, grants, disbursements, and the use of appropriated funds.

STATUTORY PROVISIONS *(enacted in law)*

1. **60-day public plan for CDC function transfers**
   Before initiating a reorganization that would move CDC functions to another HHS component, relative to how those functions are funded under the act, HHS must submit a detailed plan and justification to the House and Senate Appropriations Committees and make it public at least 60 days in advance.

2. **HHS staffing requirement**
   HHS must support staffing levels necessary to fulfill its statutory responsibilities and carry out programs, projects, and activities funded in the act in a timely manner.

3. **Notice before grant terminations**
   HHS must notify the House and Senate Appropriations Committees at least three full business days before announcing or providing notice of a grant termination or non-continuation and include a short description of the reason.

4. **Operating plan and reprogramming controls**
   Agencies funded by the act must submit an FY 2026 operating plan within 45 days. Covered reprogramming—including creating or eliminating programs, relocating or reorganizing offices, and reorganizing activities—requires committee consultation 15 days in advance and written notice 10 days in advance.

5. **Binding CDC program-level funding allocations**
   Section 236 gives statutory effect to the detailed CDC funding tables. Funds under 12 CDC appropriations headings must be used for the budget activities and in the amounts specified in the explanatory statement.

EXPLANATORY STATEMENT AND REPORT LANGUAGE *(congressional direction; not statutory text)*

6. **Payment Management System disbursement directives**
   The explanatory statement directs HHS to notify the committees before imposing restrictions that would delay Payment Management System disbursements, process disbursements within five business days except under extraordinary circumstances, and brief the committees about delays longer than five business days.

Sources: Consolidated Appropriations Act, 2026, Pub. L. 119-75, div. B, §§ 236, 239, 514, 516, and 524; explanatory statement accompanying div. B.

What Appropriations Could Not Do

In its FY 2026 appropriations law, Congress provided substantially more funding than the administration requested, preserved the existing appropriations structure for major HHS public health agencies and programs, and enacted new oversight mechanisms responsive to the disruptions documented in 2025. That response was real and consequential.

What the subsequent months have illustrated, however, are the limits of what appropriations alone can accomplish. The core difficulty is structural: appropriations establish legal authority and congressional direction to use funds for specified purposes. What they do not directly supply is the staffing, organizational capacity, operational continuity, and grant execution needed to convert that authority into actual public health services. Each link in that chain depends on executive-branch implementation: Congress can direct, fund, and constrain that implementation, but program delivery still depends on whether agencies have the people, systems, leadership, and operating capacity to carry it out.

THE OUTLAY GAP

One partial way to track whether appropriated funds are translating into public health capacity is to examine actual disbursements—the cash the federal government transfers to grantees and other recipients. The Hamilton Project's analysis of daily U.S. Treasury statements provides a real-time record of CDC outlays:[443] actual cash disbursements from CDC accounts, regardless of whether the underlying budget authority came from regular annual appropriations, mandatory funding, or prior supplemental appropriations, reported in nominal dollars.

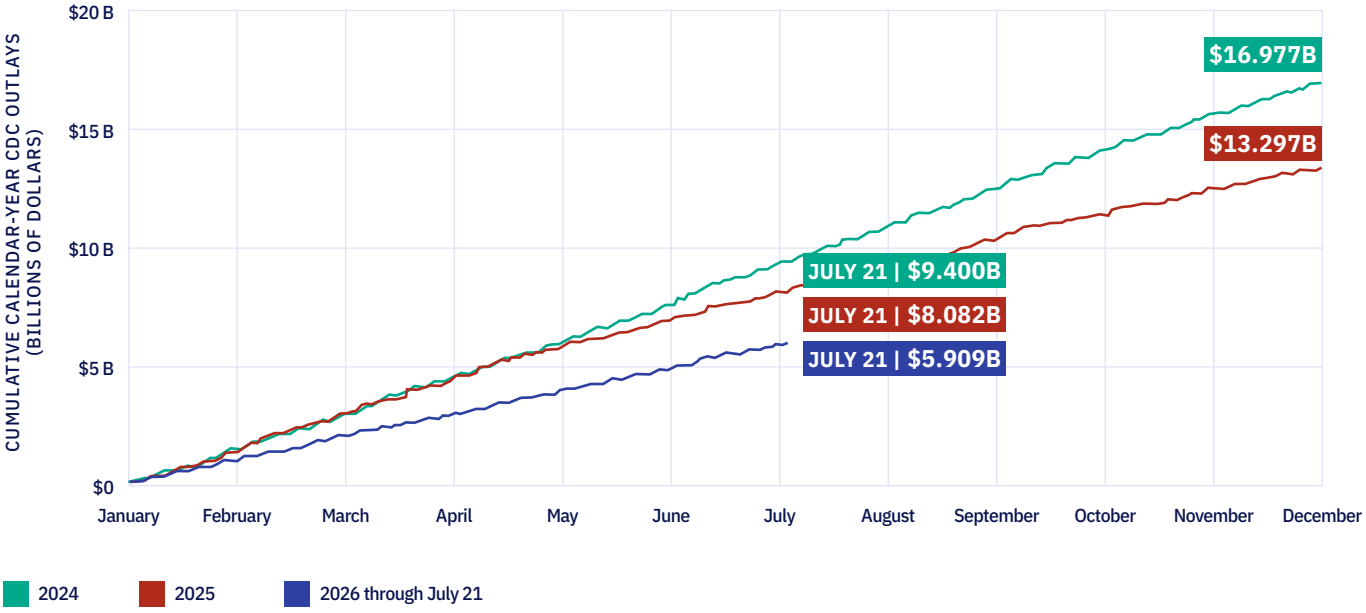
The data reveal a pattern that warrants careful interpretation. CDC outlays in calendar years 2021 and 2022—$20.3 billion and $22.4 billion, respectively—were elevated well above the levels implied by annual appropriations alone.[444] Several factors contribute to the normal gap between annual appropriation levels and annual outlays: CDC regularly receives appropriations with multiyear availability, meaning funds appropriated in prior fiscal years can produce outlays as grantees draw down awards over their performance periods; and mandatory funding streams, including the PPHF, flow through CDC accounts alongside discretionary appropriations. But the dominant driver of the 2021–2022 elevation was likely the drawdown of multiyear COVID-era supplemental appropriations—congressionally authorized investments in public health capacity that flowed to grantees on top of regular annual funding under grants awarded in prior years. The subsequent decline from the 2022 peak through calendar year 2024, when outlays totaled $17.0 billion[445] despite an annual CDC program level of approximately $9.2 billion,[446] likely reflects the continuing maturation of those supplemental grant awards as grantees completed their performance periods.

The declines in 2025 and 2026 are sharper than the preceding trend and coincide with several documented disruptions to federal public health grant operations. Full-year CDC outlays in calendar year 2025 totaled $13.3 billion—a decline of $3.7 billion, or approximately 22 percent, from calendar year 2024.[447] Monthly data within 2025 show the pattern clearly. Outlays ran roughly comparable to 2024 levels through February 2025. A modest divergence began in March and widened later in the year,[448] following the administration's announcement of large-scale COVID-era grant terminations. October and November 2025 were among the lowest monthly outlay figures of the year, with November the lowest,[449] corresponding to the government shutdown period.

Through July 21, 2026, CDC outlays totaled $5.9 billion year-to-date.[450] The year-over-year comparison is striking: the 2026 pace was approximately 27 percent below the comparable 2025 figure of $8.1 billion and approximately 37 percent below the comparable 2024 figure of $9.4 billion.[451]

FIGURE 14: CDC Outlays Fell Below 2024 Levels in 2025 and Declined Further in 2026

Through July 21, cumulative 2026 outlays were 27% below 2025 and 37% below 2024.



Note: Lines show cumulative calendar-year cash outlays recorded by the U.S. Treasury under the "HHS - Centers for Disease Control (CDC)" category. Values are nominal. The 2024 and 2025 lines cover full calendar years; the 2026 line runs through July 21, 2026. Outlays reflect cash disbursements rather than obligations, grant awards, appropriations, or total program funding. The data show changes in the timing and volume of cash spending but do not by themselves establish why those changes occurred.

Source: The Hamilton Project analysis of U.S. Department of the Treasury Daily Treasury Statement data; TFAH calculations.[452]

The relevant comparison for state and local health departments is not only whether regular annual appropriations are flowing at their baseline rate, but whether total disbursements are sufficient to maintain the programs, staffing, contracts, services, and infrastructure those funds support. Congress appropriated FY 2026 annual funds, but it had also previously appropriated multiyear supplemental funds that, for many grants, were expected to continue supporting work beyond the year in which the funds were first enacted. The administration's 2025 grant terminations and related funding disruptions reduced or disrupted that payment pipeline, subject to ongoing litigation. A flat annual appropriation does not replace those supplemental investments; it maintains the baseline while prior temporary capacity is withdrawn or interrupted.

These data do not, by themselves, establish the cause or causes of the decline. Outlay timing is affected by multiple factors—grant-cycle calendars, accounting classifications, liquidation of prior-year obligations, supplemental funding runoff, and the sequence of the appropriations process itself. What the data show is that CDC outlays through mid-2026 are running well below prior-year comparable levels despite a roughly flat annual appropriation—a pattern that warrants attention as the fiscal year progresses and that enacted funding levels alone cannot fully explain.

POST-ENACTMENT GRANT TERMINATIONS

The administration's response to P.L. 119-75 in the days immediately following enactment illustrates the limits of the new oversight provisions. The legislation had been signed for six days when, on February 9, 2026, the

administration notified Congress of impending CDC grant terminations,[453,454] apparently invoking the new three-business-day notification procedure.

As of mid-May 2026, the Congressional Research Service reported that HHS had terminated 444 CDC grants totaling $5.78 billion in unliquidated obligations[455] —funds that had been obligated under existing grant agreements but that had not yet been outlaid. Absent termination or other legal restriction, those funds could have been drawn down by grantees for allowable costs over the relevant performance periods. The termination of those agreements sought to end grantees' access to funds that had remained available under the original awards, subject to litigation and any subsequent reversals or court orders. In practice, the notification requirement appeared to operate as a procedural threshold—a step the administration could take before proceeding—rather than as a substantive constraint on the terminations themselves.

This pattern connects directly to the outlay data, though the data do not establish causation by themselves. The year-over-year decline in CDC disbursements in the early months of 2026 is consistent with both the natural exhaustion of the COVID supplemental pipeline and the termination or disruption of prior-year grant agreements that had kept congressionally appropriated funds flowing to grantees. A flat FY 2026 annual appropriation of roughly $9.2 billion does not replace $5.78 billion in terminated or disrupted multiyear obligations; it maintains the regular annual baseline while prior-year supplemental investments are withdrawn, interrupted, or litigated.

EXECUTIVE GRANTMAKING FRAMEWORK

A further constraint on the effectiveness of enacted appropriations predates P.L. 119-75 and was not displaced by its provisions. Executive Order 14332, signed on August 7, 2025, imposed new requirements for discretionary federal grantmaking.[456] The order requires senior appointee review and approval of funding opportunity announcements and pre-issuance review of discretionary awards; specifies that peer review recommendations remain advisory and may not be routinely deferred to or treated as de facto binding; and directs OMB and federal agencies to require discretionary grants to permit termination for convenience, including when an award no longer advances agency priorities or the national interest.[457] The order was in effect when P.L. 119-75 was enacted. Appropriations legislation provides funding and direction for programs, but it does not automatically supersede executive-branch administrative procedures governing how grants are awarded and administered—and P.L. 119-75 did not appear to displace this grantmaking framework.

OMB subsequently proposed revisions to the government-wide regulations governing federal financial assistance that would further formalize this framework. Published in May 2026, the proposed rule would require pre-issuance review of discretionary awards by senior appointees, specify that peer review recommendations remain advisory and may not be routinely deferred to, and permit discretionary awards to be terminated when an agency determines that they no longer effectuate program goals, federal agency priorities, or the national interest.[458] If finalized, the rule would move many of the same grantmaking requirements into government-wide regulation and could increase the risk that appropriated public health funds are delayed, conditioned, or terminated for reasons unrelated to recipient performance or compliance with award terms.

By June 2026, there was evidence that these requirements were affecting both the timing and terms of grantmaking. A June 19, 2026 NOTUS investigation, based on internal documents, public records, and interviews with current and former HHS employees and grant recipients, reported that the department's review process had delayed the posting of about 30 CDC funding opportunities totaling approximately $728 million and more than half of approximately

$700 million in SAMHSA opportunities projected for FY 2026. After HHS began releasing some notices, NOTUS reported that approximately $630 million in CDC opportunities and $286 million in SAMHSA opportunities remained pending. HHS characterized the process as the standard review and approval process and said it would release the remaining FY 2026 notices once finalized.[459] Separately, HHS confirmed that recipients of a June CDC directive had been instructed to review their work plans for alignment with departmental priorities; the directive itself was not explicitly tied to funding.[460] Several recent CDC funding announcements also required recipients to demonstrate ongoing compliance with CDC priorities and stated that failure to meaningfully align funded activities could result in corrective action, additional reporting requirements, or other enforcement action consistent with federal grant regulations and award terms.[461,462] Together, these developments illustrate how administrative review can shape both when funding opportunities are made available and the conditions governing resulting awards, even when Congress has appropriated funds for the underlying programs.

LIMITS OF THE STAFFING PROVISION

The statutory requirement that HHS "support staffing levels necessary to fulfill its statutory responsibilities"[463,464] was a meaningful legislative response to the 2025 workforce reductions. The provision, however, leaves several implementation questions unresolved. It establishes no numerical staffing floor or specific criteria for determining the staffing levels necessary to meet particular statutory responsibilities. Nor does it address the use of contractors in relation to federal staffing or establish specific operational timelines or performance benchmarks for activities such as issuing grants, maintaining surveillance systems, providing technical assistance to grantees, or responding to emerging health threats. At the same time, it creates a statutory standard against which HHS implementation can be assessed through congressional oversight, future appropriations language, and, potentially, litigation. How the provision is interpreted, implemented, and enforced will determine its practical effect.

Beyond the question of enforcement, appropriations language cannot restore what departed with the staff losses at CDC in 2025: the institutional knowledge, programmatic relationships, and organizational continuity that experienced staff carry. Experienced program officers hold detailed knowledge of grantee portfolios, surveillance network structures, and technical assistance relationships that cannot be reconstituted quickly through new hires or contractor arrangements. Senior scientific and epidemiological leadership turnover in 2025, including the period of interim leadership following turnover in the CDC director role, represented a loss of coordinating capacity that funding could not immediately restore. The programs appropriated in P.L. 119-75 remain funded; the institutional capacity to administer them is a separate and more difficult question.

LIMITS OF THE OVERSIGHT PROVISIONS

The oversight provisions enacted or incorporated through P.L. 119-75—the grant termination notification requirement, the 60-day CDC reorganization requirement, the staffing language, the program-level funding tables, and the PMS disbursement language[465]—created procedural requirements, transparency obligations, and accountability mechanisms aimed at constraining the kinds of disruptions documented in 2025. Some were enacted as statutory text; others appeared in the joint explanatory statement that guides implementation of the appropriations agreement. That distinction matters because statutory provisions are legally binding, while directives contained in joint explanatory statements—though important expressions of congressional intent and traditionally treated as guiding implementation—may have more limited enforceability, particularly if funding is

later continued through a CR that does not clearly incorporate them.

Their practical effect, however, depends on two conditions that cannot be assumed. First, executive implementation: as the administration's post-enactment effort to terminate more than $600 million in CDC grants illustrates, advance-notification requirements can create procedural thresholds without, by themselves, prohibiting the contemplated action.[466,467] Second, congressional will to enforce: the staffing provisions and briefing requirements create accountability mechanisms whose effectiveness depends on congressional follow-through—oversight hearings, formal inquiries, and sustained attention to whether the provisions are being observed. Litigation has provided a partial check; for example, in February 2026, a federal court temporarily blocked more than $600 million in CDC grant terminations affecting four states.[468] But court orders address particular disputes rather than establishing ongoing systemic compliance with the appropriations act's broader intent.

The January 2026 SAMHSA grant terminations are instructive in this regard. On December 1, 2025—approximately six weeks before the terminations—the president had signed the bipartisan SUPPORT for Patients and Communities Reauthorization Act of 2025 into law, extending key substance-use-disorder prevention, treatment, and recovery programs through FY 2030.[469,470] While the FY 2026 CR was still in effect—and before the oversight provisions of P.L. 119-75 had been enacted—SAMHSA reportedly terminated as many as 2,800 grants totaling approximately $2 billion,[471,472] then reversed the terminations within a day.[473] The episode illustrated a dynamic that the new oversight provisions may not fully resolve: funding authorized and appropriated by Congress does not, by itself, ensure that funds will be administered and disbursed without disruption.

FUNDING-FUNCTION GAP

Congress's FY 2026 response should be assessed on two dimensions. On the first—the scale of the proposed cuts rejected and the existing federal public health agency structure preserved—the congressional response was consequential. Federal public health funding and agency architecture look materially different than they would have under the administration's FY 2026 proposals, and that difference has real significance for the programs and people those agencies serve.

On the second dimension—whether appropriated funds are translating into functional public health capacity—the picture is less fully resolved. Real-time outlay data raise questions about disbursement that enacted funding levels alone cannot answer. Post-enactment grant terminations have disrupted access to billions of dollars in previously appropriated funds that had been in the grantee payment pipeline. Oversight provisions were tested within days of enactment and have not prevented all post-enactment disruptions. And the workforce, institutional knowledge, and operational continuity that programs require to function effectively cannot be restored by a budget line.

The resulting gap—or potential gap—between what Congress appropriated and what the public health system has the capacity to deliver, between funded programs and functional programs, is critical to understand.

Examples of the Funding-Function Gap

Some of the clearest cases of the funding-function gap in 2025 and 2026 involved programs for which Congress maintained or increased funding, but executive-branch workforce and organizational changes reduced or disrupted the federal capacity needed to administer and support them.

Across chronic disease prevention, school mental health, and childhood lead-poisoning response, lawmakers continued or increased appropriations, and states, school districts, and local health departments built services and staffing around the expectation of federal support. In these cases, the central disruption was not that Congress eliminated the line item. It was that the administration removed or sharply reduced the federal staffing capacity needed to administer grants, provide technical assistance, and help turn annual appropriations into functioning programs—through reductions in force, administrative leave, and related reorganizations that diminished or, in some cases, functionally eliminated key teams at CDC and SAMHSA. The line items survived, but the operating capacity behind them was reduced, disrupted, or temporarily severed.

SECTION AT A GLANCE

Some of the clearest examples of the funding-function gap involve programs for which Congress maintained or increased appropriations while federal staffing and operating capacity were sharply reduced or interrupted. In chronic disease prevention, school mental health, and childhood lead-poisoning response, appropriations remained in place or increased while the federal staffing and operating capacity behind the programs was sharply reduced or interrupted.

The examples that follow show three ways this gap can emerge:

- **CDC chronic disease programs remained funded while federal teams responsible for grants, surveillance, technical assistance, and implementation support were reduced.**
- **Project AWARE grants remained funded, but SAMHSA lost much of the staff responsible for administering the program, and the awards were later abruptly terminated and restored.**
- **During Milwaukee's childhood lead emergency, CDC initially could not provide requested field assistance after the HHS reduction in force eliminated the staff of its specialized lead-poisoning prevention team.**

Together, these cases demonstrate that an appropriation is not self-executing. Programs also require experienced staff, functioning grant administration, technical expertise, organizational continuity, and the capacity to respond when communities need help.

CHRONIC DISEASE AT CDC: FUNDED PROGRAMS, REDUCED CAPACITY TO RUN THEM

CDC's chronic disease portfolio illustrates the funding-function gap: major program lines remained funded, while the federal capacity needed to administer and support them was sharply reduced.

In the FY 2026 appropriations process, Congress declined to follow the administration's proposal to eliminate or transfer major functions of CDC's National Center for Chronic Disease Prevention and Health Promotion—the center responsible for addressing many of the leading causes of illness, disability, and death in the United States. The FY 2026 CDC Operating Plan, the agency's blueprint for distributing enacted appropriations across programs, continued funding for tobacco prevention and control at $246.5 million, the Division of Nutrition, Physical Activity, and Obesity at $54.3 million, and oral health at $21.25 million.[474] Lawmakers went further on dementia, increasing the CDC Alzheimer's program by $2 million, to $41.5 million.[475] On paper, much of the chronic disease portfolio Congress chose to preserve remained funded.

The workforce that runs it did not. On April 1, 2025, HHS issued RIF notices to roughly one-third of the staff at the center.[476,477,478] The reductions affected entire offices, divisions, and branches, including staff associated with the Office on Smoking and Health, the Division of Oral Health, and the Division of Population Health, along with staff in reproductive health and other units. In practical terms, those actions left several funded program areas without the federal teams that had administered grants, provided technical assistance, maintained surveillance and data systems, and supported state and local implementation. The losses fell unevenly across functions that states cannot easily replace. The Office on Smoking and Health administered the only federal program providing tobacco-control funding across all 50 states, the District of Columbia, and U.S. territories, while also providing technical assistance to state and territorial health departments. It supported national surveillance tracking tobacco use among young people and adults and ran the Tips From Former Smokers campaign, which CDC estimates helped more than 1 million adults quit smoking during 2012–2018, prevented approximately 129,000 early deaths, and saved an estimated $7.3 billion in smoking-related healthcare costs.[479,480,481,482] The Division of Oral Health had been CDC's home for guidance on community water fluoridation and dental infection control.[483] And although Congress had unanimously passed legislation reauthorizing the BOLD Infrastructure for Alzheimer's Act in late 2024,[484] staff supporting the BOLD program and CDC's Healthy Brain Initiative were placed on administrative leave on April 1, 2025.[485]

For grantees, appropriated dollars could remain available even as the federal partner responsible for administering and supporting the work was sharply reduced. State tobacco-control programs faced months of uncertainty before FY 2025 funding began to be released;[486] by then, the federal staffing capacity that had helped guide quitlines, support and analyze surveillance data, and coordinate the national campaign had been eliminated or sharply reduced.[487] Where Congress preserved a program but the administration eliminated or reorganized the division that housed it, surviving units have had to absorb the work—stretching already-reduced staff and curtailing the technical assistance, grantee convenings and coordination, and data analysis that help turn an appropriation into a functioning program. The effect compounds over time and is uneven: long-established efforts with substantial state-level capacity, such as tobacco control, can operate on momentum for a period, while newer or more specialized programs are more exposed.

The stakeholders closest to these programs described the gap in similar terms. The Campaign for Tobacco-Free Kids warned that the Office on Smoking and Health "provides critical financial and technical assistance to every state," and that recent progress "is at risk unless states step up their efforts and Congress

restores funding for the CDC's tobacco control program."[488] UsAgainstAlzheimer's stated the funding-function gap precisely: in January 2026, it thanked Congress for increasing the CDC Alzheimer's program by $2 million while urging the administration "to restore the staffing capacity and expertise needed for CDC to fully carry out the work under the BOLD Infrastructure for Alzheimer's Act."[489]

The FY 2027 President's Budget proposes eliminating many of the chronic disease programs Congress preserved in FY 2026: tobacco prevention and control, nutrition, physical activity and obesity, oral health, and numerous other chronic disease lines are proposed for elimination, while the Alzheimer's program would be reduced. The request would move much of the portfolio from a funded-but-diminished operating posture toward proposed program elimination or further reduction.[490,491,492]

This year's report documents recent policy decisions, related structural changes, and their effects across key public health agencies within the U.S. Department of Health and Human Services. TFAH sought to understand dynamics across specific HHS programs beginning in spring 2025, resulting in the creation of the Public Health Programs Monitor (PHPM). This effort tracks federal health-promoting programs and operational activities across HHS and offers insight into how federal decisions have shaped programs and community health since fiscal year 2025. The initiative includes an interactive dashboard documenting proposed or actual funding reductions to federal health-promoting programs, as well as proposed reorganization efforts. The PHPM also provides analysis and narratives that help explain trends that data alone cannot capture, including how programs operate amid funding and staffing changes. To view additional programs that have experienced proposed changes, visit www.tfah.org/initiatives/phpm/.

PROJECT AWARE: FUNDED GRANTS, REDUCED CAPACITY TO ADMINISTER THEM

Project AWARE shows what can happen when Congress funds a grant program, but the administration reduces the federal staffing capacity needed to administer it—and SAMHSA later terminates and restores the awards themselves.

Over the past decade, data show that the mental health of children and youth in the United States has worsened. According to CDC's 2023 Youth Risk Behavior Survey, nearly 40 percent of high school students reported persistent sadness or hopelessness, 20 percent seriously considered attempting suicide, and nearly 10 percent attempted suicide.[493] CDC also documented recent increases in school violence indicators: from 2021 to 2023, the share of high school students reporting that they were bullied at school rose from 15 percent to 19 percent, and the share reporting that they were threatened or injured with a weapon at school rose from 7 percent to 9 percent.[494]

Project AWARE (Advancing Wellness and Resiliency in Education) is a school-based mental health grant program administered by SAMHSA.[495] Created in the wake of the 2012 Sandy Hook Elementary School shooting, Project AWARE supports school districts, universities, health agencies, and state education departments in identifying students who need mental healthcare, expanding access to school- and community-based services, and training teachers and school staff to recognize and respond to mental health needs.[496,497,498] SAMHSA funded 139 Project AWARE continuation grants in FY 2024 and 120 in FY 2025, including awards supported by base budget authority and the Bipartisan Safer Communities Act.[499] The program was funded at about $120.4 million in FY 2025 and $140.0 million in FY 2026,[500] supporting multiyear grants that districts build staffing and services around. Having operated for more than a decade, the program has continued across administrations and has drawn support

from members of both parties, while many state and local education leaders have built school mental health programs around it. For example, in 2024, Montana's then–state superintendent, Elsie Arntzen, described her state's Project AWARE awards as a reflection of her "Montana Hope" initiative, noting that "nearly one-third of our students say that their mental health was poor most of the time or always."[501]

In 2025, SAMHSA's workforce was reduced sharply.[502] Hundreds of staff were laid off, including most of the Center for Mental Health Services staff responsible for youth mental health programs.[503,504] The RIF reportedly eliminated the SAMHSA employees who oversaw Project AWARE, leaving no one to provide policy guidance, technical assistance, or timely disbursement of funds.[505] The erosion of staff expertise extended beyond Project AWARE, with youth mental health programs especially affected.[506] The grant lines remained; the people who turned them into functioning programs did not.

Then the awards themselves were terminated and restored. In mid-January 2026, SAMHSA sent termination notices to grantees stating that their awards had been terminated.[507] Within about 24 hours—after lawmakers opposed the terminations and advocates, grantees, and mental health and addiction organizations warned that abruptly ending already-awarded grants would force layoffs and threaten care—the administration reversed course, restoring nearly $2 billion in grants.[508,509,510] The reversal did not immediately reach every grantee: as of the next day, some districts had not received official notice that their awards had been restored, leaving the status of their programs uncertain.[511,512]

For grantees, the instability had direct operational consequences. Project AWARE grants support multiyear staffing, school-community partnerships, screening and referral systems, training for educators and school staff, and contracts with community mental health partners. The loss of SAMHSA staff responsible for overseeing the program reduced federal capacity to provide guidance, technical assistance, and timely grant administration; the subsequent termination and reversal of awards created uncertainty about whether districts should retain staff, continue contracts, and keep services operating. In FY 2025, through the end of Q3, Project AWARE grantees screened more than 275,000 children and youth for mental health-related concerns and referred more than 66,000 to mental health and related services; over the full fiscal year, grantees provided prevention or mental health-promotion training to more than 140,000 individuals.[513] Those results depended on a federal-grantee partnership whose federal staffing and administrative capacity had been sharply reduced.

In Manchester, New Hampshire, district leaders scrambled after receiving notice that the district's Project AWARE funding would be terminated—funding that supported eight positions and mental health services that the district described as critical.[514] In September 2025, the Concord, New Hampshire, school district was awaiting confirmation of approximately $2.5 million in annual continuation funding under two multiyear SAMHSA grants expected to provide roughly $11 million over five years. District officials described uncertainty surrounding services supported by the grants, including a partnership with Riverbend Community Mental Health Center and the Project AWARE youth mental-health program. SAMHSA subsequently confirmed that the funding would continue, but only after weeks of uncertainty and district contingency planning. In the 2023–2024 school year, the Riverbend partnership referred 86 students to school-based counseling and connected 25 to community services; in Project AWARE's first year, the grant funded a new middle school advisory program and small-group interventions for 375 students.[515]

The FY 2027 President's Budget proposes $120.5 million for Project AWARE—$19.5 million below the FY 2026 enacted level—and would place the program within the proposed AHA,[516] a consolidation Congress has not approved and whose operational details remain unsettled.

CHILDHOOD LEAD POISONING PREVENTION: A CRISIS MEETS REDUCED FEDERAL CAPACITY

In the spring of 2025, a city in the middle of a childhood lead emergency asked CDC for help and was told the agency could not support the request after the HHS reduction in force eliminated the staff of CDC's childhood lead-poisoning prevention team.

Congress had not eliminated funding for childhood lead poisoning prevention. The federal program line remained funded, and the administration's own FY 2026 budget later proposed $56 million for the Childhood Lead Poisoning Prevention Program and Lead Exposure Registry.[517] What CDC lost at the moment of Milwaukee's crisis was not a statutory program or an appropriated line item. It was people.

Beginning in early 2025, the Milwaukee Health Department, working with Milwaukee Public Schools, identified lead-based paint and lead-dust hazards in buildings constructed before 1978, when the federal government banned consumer uses of lead-based paint.[518,519,520,521] Multiple schools closed,[522] and the district faced the task of assessing about 100 aging school buildings[523,524] and managing the resulting inspections, remediation, clearance testing, and student follow-up across a system serving more than 60,000 students.[525,526] On March 26, 2025, the Milwaukee Health Department and the Wisconsin State Health Department formally requested a CDC Epi-Aid[527,528]—a short-term deployment of federal experts to investigate an urgent public health problem and help local officials make rapid decisions to contain it.

On April 1, 2025, the HHS RIFs eliminated the staff of CDC's childhood lead-poisoning prevention team—the Childhood Lead Poisoning Prevention and Surveillance Branch within the National Center for Environmental Health.[529,530] Two days later, Milwaukee's request was denied. "I sincerely regret to inform you that due to the complete loss of our Lead Program, we will be unable to support you with this," wrote Dr. Aaron Bernstein, director of the National Center for Environmental Health and ATSDR, to city officials on April 3.[531] Milwaukee Health Commissioner Mike Totoraitis described the denial as extraordinary.[532]

The capacity Milwaukee lost was specialized and not locally replaceable. The federal team would have helped the city develop a testing and triage strategy that applied lead-specific epidemiological expertise to detect exposure patterns that local officials might miss. "At this point, we don't have any contacts at the CDC for childhood lead poisoning," Totoraitis said in April 2025. "It's a pretty stark moment for us in the department to not have someone to reach out to federally." The lost CDC experts, he noted, "see lead issues at a much larger scale than we do normally here in Milwaukee."[533]

Some CDC staff involved in childhood lead poisoning prevention were reinstated in June 2025,[534,535] and CDC later resumed technical engagement with Milwaukee, including through a fall 2025 grant of nearly $400,000 to support expanded school-based lead screening and a CDC site visit in February 2026.[536] The gap between Milwaukee's March 2025 request and the resumption of federal support nonetheless left the city navigating a children's health emergency without the federal epidemiological support it had requested at a critical juncture. Milwaukee, after expanding local screening and response efforts, completed lead-paint stabilization work in the 99 schools identified as needing intervention after roughly 10 months of work.[537] But the episode illustrates the fragility the funding-function gap creates: an avoidable gap in response to a children's health emergency, produced not by a funding cut but by the removal of a small, specialized team at the moment it was most needed. The program's future remains unsettled: the FY 2026 budget proposed relocating childhood lead poisoning prevention to the proposed AHA,[538] while the FY 2027 budget would keep it within CDC but reorganize it under the proposed National Center for Chemicals and Toxins.[539]

FIGURE 15: The Funding–Function Gap

Why enacted funding does not by itself ensure a fully functioning public health program

Congress Appropriates Funds	Federal Operating Capacity Helps Turn Funding Into Action	States, Localities, Schools, And Community Partners Often Deliver Services
A program line or grant account is funded.	■ Grant administration ■ Award and payment processing ■ Technical assistance ■ Subject-matter expertise ■ Surveillance, data, and laboratory support ■ Field response when jurisdictions need help	■ Hire and retain staff ■ Maintain contracts and partnerships ■ Operate clinics and prevention programs ■ Run surveillance and data systems ■ Provide school mental health and outbreak response

When the middle step is disrupted, an appropriation may remain in place while delivery capacity weakens in practice.

Delayed awards or payments	Reduced technical assistance	Uncertain or disrupted grantee operations	Less responsive support during emergencies

Documented Examples, 2025–2026

Program or Funding Line	Enacted Funding / Funding Status	What Happened to Federal Operating Capacity	Operational Consequence	Primary Authority
Chronic disease prevention at CDC	FY 2025 → FY 2026 enacted: Tobacco remained at $246.5M; Oral Health increased from $20.25M to $21.25M; and Alzheimer's Disease increased from $39.5M to $41.5M.	The April 1, 2025 RIF initially reduced the National Center for Chronic Disease Prevention and Health Promotion by about one-third and eliminated the Office on Smoking and Health and Division of Oral Health, among other units.	The funding lines remained, but staffing and federal capacity for grantee support, technical assistance, surveillance, and related subject-matter expertise were reduced.	FY 2026 CDC Operating Plan; Politico reporting on the April 2025 RIF.
Project AWARE school mental health grants	FY 2025 final: $120.374M. Project AWARE continued under an FY 2026 continuing resolution when SAMHSA issued the Jan. 13 termination notices; full-year FY 2026 appropriations later provided $140.001M.	Most SAMHSA staff responsible for youth mental health programs were let go in 2025. On Jan. 13, 2026, SAMHSA terminated Project AWARE and other grants; the administration reversed the terminations about a day later.	Grantees faced immediate uncertainty about staffing, contracts, planned activities, and continuity of school mental health services; some had not received confirmation of the reversal by Jan. 15.	FY 2027 AHA Congressional Justification; STAT; Education Week.
Milwaukee childhood lead crisis	CDC's Childhood Lead Poisoning Prevention line remained funded at $51.0M in FY 2025 and FY 2026.	On Mar. 26, 2025, Milwaukee and Wisconsin health officials jointly requested CDC Epi-Aid assistance. The April 1 RIF eliminated the Childhood Lead Poisoning Prevention and Surveillance Branch, and CDC subsequently denied the request because it lacked the specialized staff to support it.	The requested federal field assistance was unavailable during an active school lead crisis after the specialized branch was eliminated.	FY 2026 CDC Operating Plan; Wisconsin Public Radio; congressional correspondence concerning Milwaukee's Epi-Aid request.

TAKEAWAY: A funded line item does not by itself ensure full program delivery when federal capacity to administer, support, or respond is reduced or eliminated.

Source: Based on documented events. Selected sources: FY 2026 CDC Operating Plan; FY 2027 Administration for a Healthy America Congressional Justification, Project AWARE section, reporting FY 2025 final and FY 2026 enacted funding for this legacy SAMHSA program; Politico; STAT; Education Week; Wisconsin Public Radio; and congressional correspondence concerning Milwaukee's Epi-Aid request.

SECTION IV

The Road Ahead—FY 2027 Proposals and What Is at Stake

The public health system entered 2025 already vulnerable after decades of underinvestment. It then encountered a period of workforce disruption, funding interruptions, and institutional uncertainty unusual in scale and speed in modern federal public health history. In the FY 2026 appropriations process, Congress rejected the administration's proposed cuts and preserved the existing federal agency structure—but appropriations, by themselves, could not restore the operational capacity that the preceding year had weakened.

SECTION AT A GLANCE

- The FY 2027 President's Budget Request moderates several elements of the prior year's proposal, but preserves its central direction: a smaller federal public health footprint, creation of the Administration for a Healthy America, elimination of the Prevention and Public Health Fund, and a narrower and reorganized CDC.
- The proposal is selective rather than uniform. It would maintain or increase selected investments in infectious disease surveillance, laboratory science, data modernization, immunization, food safety, and global health, while substantially reducing broad-based chronic disease and injury prevention, state and local preparedness, foundational infrastructure, domestic HIV prevention, and several environmental and occupational health functions.
- Moving programs to a different agency would not necessarily preserve them. In several major areas, the proposed transfers would be accompanied by significant reductions in the total resources available for the underlying functions.
- The risk is not limited to enactment of the president's request. Continued flat funding, inflation, hiring constraints, grant-administration disruptions, and new fiscal pressures on states and safety-net systems could produce further erosion even if Congress again rejects the deepest cuts.
- At stake are the systems that sustain vaccination and outbreak control, emergency readiness, environmental and workplace protections, public health data, chronic disease and injury prevention, and the capacity of less-resourced communities to respond to health threats. These systems are also important to national and economic security.

The FY 2027 President's Budget Request is the next iteration of the policy direction this report has documented. It is, in several respects, a more moderate proposal than its predecessor. But it preserves the core structural vision—a consolidated HHS, a narrowed CDC, the elimination of the PPHF, and reduced investment in broad-based prevention, state and local preparedness, and several environmental and occupational health functions—that Congress declined to adopt a year earlier. Understanding what the FY 2027 request would mean for the public health system, and what is at stake in the appropriations process that will determine its fate, requires understanding both the ways it departs from the FY 2026 proposal and the ways it does not.

The FY 2027 President's Budget Request

In April 2026, the administration released its FY 2027 President's Budget Request.[540] In some respects, the HHS and CDC portions of the request moderate the most sweeping elements of the FY 2026 proposal. But their fundamental direction remains continuous with the FY 2026 request that Congress declined to adopt: a smaller federal public health footprint, a consolidated HHS organizational structure, elimination of the PPHF, and a narrowed CDC.

The FY 2027 budget proposes $111.1 billion in HHS discretionary budget authority—a reduction of approximately $15.8 billion, or 12.5 percent, from FY 2026 enacted levels.[541] That is a substantial proposed reduction, but it is considerably smaller than the FY 2026 request, which would have reduced HHS discretionary funding by $31.4 billion, or approximately 25 percent, from FY 2025 levels.[542]

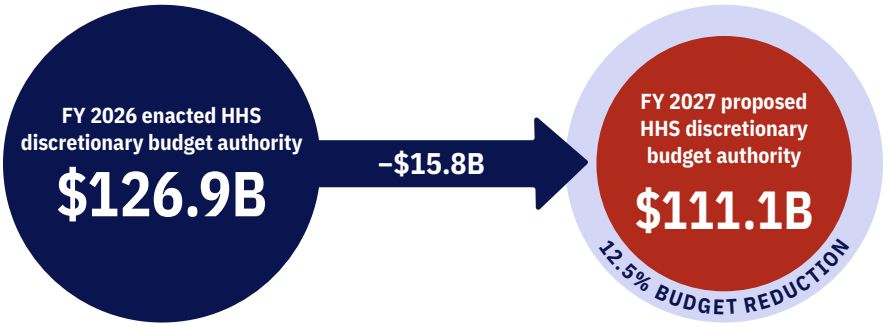
For CDC, the FY 2027 budget requests $5.5 billion in discretionary program-level funding.[543] Against CDC's FY 2026 enacted program level of approximately $9.1 billion under the current organizational structure,[544] this represents a reduction of approximately 40 percent. That figure requires important qualification. The administration's FY 2027 proposal would move several programs now housed at CDC to other parts of HHS, primarily to the proposed AHA, with Health Statistics realigned to the Office of Strategy.[545] On the administration's own comparably adjusted display—which restates the FY 2026 enacted baseline to reflect the programs and activities proposed to be housed within CDC under the FY 2027 reorganization—the program level would decline by $1.2 billion, or approximately 18 percent.[546]

Both comparisons are useful, but they answer different questions. The unadjusted comparison shows the net change in CDC's agency-level program funding under the current and proposed organizational structures, including the effects of programs moving both out of and into CDC. The comparably adjusted comparison restates the FY 2026 baseline to reflect all programs and activities proposed to be housed within CDC under the administration's reorganization, providing a like-for-like comparison for the proposed CDC structure. That adjusted comparison is internally consistent, but it does not capture reductions to functions currently housed at CDC that would be transferred elsewhere within HHS; several major transferred programs would receive substantially less funding under the proposed structure than they receive in FY 2026.[547]

The budget would reduce resources supporting functions currently housed at CDC and ATSDR through a combination of lower funding for activities retained within CDC and the movement of selected activities to AHA and the Office of Strategy. Of the $4.44 billion gross reduction in funding retained within CDC for historically CDC and ATSDR functions, $1.59 billion would be provided for activities shifted to those other entities, offsetting about 36 percent of the reduction.

FIGURE 16: FY 2027 Budget Proposes a Smaller HHS Cut Than the FY 2026 Request—but Still a Major CDC Retrenchment

Key Takeaways From the FY 2027 HHS and CDC Budget Proposals



FOR COMPARISON:

the FY 2026 request would have cut HHS by **$31.4B (–24.9%)** from FY 2025 levels.

The FY 2027 proposed cut remains substantial but is about half as large as the reduction proposed a year earlier.

HOW TO INTERPRET THE CDC PROPOSAL

The FY 2027 request would reduce CDC funding, but part of the apparent reduction would reflect proposed transfers to other HHS entities. Three complementary views show the organizational and functional effects.

1 — FY 2026 CDC + ATSDR Footprint vs. Proposed FY 2027 CDC

FY 2026 enacted discretionary program level

$9.23B

↓

FY 2027 requested discretionary program level

$5.48B

–$3.74B (–41%)

2 — FY 2027 CDC Footprint, Comparably Adjusted

Administration's like-for-like CDC Comparison:

–$1.23B

(-18%)

3 — FY 2026 CDC/ATSDR-Origin Activities, Tracked After Transfers

Reduction in resources retained within CDC for these activities	**–$4.44B**
Resources shifted to AHA and the Office of Strategy	**+$1.59B**
Resources still supporting FY 2026 CDC/ATSDR-origin activities	**$6.37B**

Net Change vs. FY 2026

–$2.86B

(–31%)

BOTTOM LINE: The proposal would reduce resources supporting FY 2026 CDC/ATSDR-origin activities by $2.86 billion, or 31%. About $1.59 billion would continue elsewhere in HHS under the proposed Administration for a Healthy America and Office of Strategy, offsetting just over a third of the reduction in resources retained within CDC.

Notes: HHS figures are discretionary budget authority. CDC figures are discretionary program level, which may include budget authority and transfers from the Prevention and Public Health Fund and the PHS Evaluation Set-Aside. The CDC/ATSDR-origin analysis tracks those resources across their proposed FY 2027 destinations. Figures may not sum due to rounding.

Note: FY 2026 CDC program-level funding included $1.398 billion from the Prevention and Public Health Fund. The FY 2027 request proposes no PPHF transfer, although some activities previously supported through the fund would receive replacement budget authority or PHS Evaluation funding.

Sources: FY 2026 CDC Operating Plan; FY 2026 and FY 2027 HHS Budget in Briefs; FY 2027 CDC, Administration for a Healthy America, and Office of Strategy Congressional Justifications; TFAH analysis. [549,550,551,552,553,554]

Altogether, resources supporting activities historically housed at CDC and ATSDR would total approximately $6.37 billion—$2.86 billion, or 31 percent, below the FY 2026 level.[548]

In short, the proposal would cut CDC and ATSDR appropriations by nearly half, then restore more than a third of the lost dollars by relocating selected programs to two newly proposed divisions.

THE PROPOSED ADMINISTRATION FOR A HEALTHY AMERICA

The FY 2027 budget again proposes establishing the AHA—the same consolidating entity proposed in the FY 2026 request that Congress declined to adopt. Under the FY 2027 proposal, AHA would combine the Office of the Assistant Secretary for Health, HRSA, SAMHSA, and several CDC centers and program areas, including chronic disease prevention and health promotion, injury prevention and control, birth defects/developmental disabilities/disability and health, and domestic HIV prevention activities.[555] AHA's proposed total program level is $17.5 billion, a decrease of $8.6 billion, or approximately 33 percent, from the comparably adjusted FY 2026 level for the programs it would encompass.[556]

The reduction is concentrated in primary care and several major program areas proposed for consolidation within AHA, including chronic disease prevention, HIV/AIDS, the health workforce, behavioral health, and maternal and child health. Some of the apparent decline also reflects expiring mandatory Health Centers funding and the absence of FY 2026 congressionally directed project funding, rather than reductions to ongoing discretionary programs alone.[557] For this report, the CDC-related reductions are especially significant because they show that the proposed transfer to AHA would not simply relocate public health functions within HHS. In several major areas, it would also substantially reduce the resources available for those functions.

Chronic disease prevention and health promotion activities funded at approximately $1.43 billion at CDC in FY 2026[558] would receive approximately $478 million across AHA and CDC under the FY 2027 request—about $448 million through AHA and an estimated $29.5 million for Disease Risk Factor Surveillance retained within CDC[559]—a reduction of roughly $955 million, or about 67 percent. Under the proposal, retained funding would be concentrated in Cancer Prevention and Control and Alzheimer's Disease, while most other chronic disease and health promotion activities would be eliminated. Examples include federal support for work to prevent tobacco use, improve nutrition and physical activity, prevent diabetes and heart disease, support oral health, advance school health, fund Prevention Research Centers, and support community-based programs such as REACH that work to reduce racial and ethnic health disparities.[560]

Injury prevention and control programs currently housed at CDC are proposed at approximately $588 million under AHA, a reduction of approximately $173 million,[561,562] or about 23 percent. The proposal would eliminate several CDC-supported efforts that help communities prevent injuries and deaths, including work to prevent youth violence and firearm injury, reduce childhood trauma and adverse childhood experiences, prevent falls among older adults, prevent drownings, support injury prevention research, and help state and local partners identify and respond to the leading causes of injury in their communities.[563]

Domestic HIV/AIDS Prevention and Research funding currently housed at CDC would decline from approximately $1.01 billion to $220 million—a reduction of about $794 million, or 78 percent.[564,565] The remaining $220 million would support discrete activities formerly carried out by CDC in support of the Ending the HIV Epidemic in the U.S. (EHE) initiative. In practical terms, the proposal would preserve that targeted initiative while eliminating dedicated funding for much of CDC's broader HIV prevention work outside EHE, including support for testing, surveillance, prevention services, and state and local health department efforts across the country. More broadly, KFF estimates that the FY 2027 request would reduce domestic HIV funding across federal programs by approximately $1.6 billion, or 35 percent, from FY 2026 levels.[566]

Birth defects, developmental disabilities, disability, and health activities are funded at approximately $205 million at CDC in FY 2026.[567] Most of the portfolio would move to AHA, while the $23 million Surveillance for Emerging Threats to Mothers and Babies program would be realigned elsewhere within CDC,[568] producing a comparably adjusted AHA baseline of approximately $182 million.[569] The FY 2027 AHA request provides approximately $154 million for these activities, a reduction of about $28 million,[570] or 16 percent, from the comparable FY 2026 baseline. These programs support work such as tracking birth defects and developmental disabilities, monitoring autism and other child developmental conditions, supporting early hearing detection, improving health for people with disabilities, and addressing conditions such as fetal alcohol syndrome, muscular dystrophy, Tourette syndrome, fragile X syndrome, spina bifida, and blood disorders.

PROPOSED ELIMINATION OF THE PREVENTION AND PUBLIC HEALTH FUND

The FY 2027 request proposes the complete elimination of the PPHF. In FY 2026, CDC's PPHF allocation totaled approximately $1.4 billion—roughly 15 percent of the agency's total enacted program level—supporting prevention activities across every state and territory, as well as localities, tribal communities, and other partners.[571]

The FY 2027 budget proposes replacing the PPHF financing within the Immunization and Respiratory Diseases account with discretionary budget authority.[572] In FY 2026, the PPHF provided approximately $596 million of the account's $913 million total, with approximately $317 million provided through regular budget authority.[573] Under the FY 2027 request, the account would receive approximately $963 million entirely through budget authority—a nominal increase of $50 million. That substitution would maintain and modestly increase the account's dollar total, but it would remove PPHF's dedicated mandatory funding stream and shift the full account into the annual discretionary appropriations process.

That distinction matters. The PPHF was established to provide dedicated funding for prevention and public health outside the annual discretionary appropriations process—the same process whose year-to-year pressures and competing priorities have contributed to the documented chronic underinvestment in public health. Converting the immunization account from PPHF-supported funding to discretionary budget authority does not reduce the account in the FY 2027 request; it changes the funding structure and exposes the account more fully to future appropriations-cycle pressures. In a 2019 analysis, the Association of Immunization Managers reported that PPHF accounted for nearly half of federal funding allocated for state, local, and territorial immunization program activities,[574] illustrating the extent to which core immunization infrastructure had come to rely on that dedicated funding stream.

Outside immunization, the consequences of eliminating PPHF vary by program area. Some PPHF-supported lines would receive replacement budget authority, at least in whole or in part. Others would be reduced, eliminated, or transferred and restructured under other parts of the proposed HHS reorganization. The largest clear loss within CDC's remaining structure is in CDC-Wide Activities and Program Support, which received $250 million in PPHF in FY 2026, including $160 million for the Preventive Health and Health Services Block Grant.[575] The block grant, funded exclusively through PPHF, provides flexible resources to state and local health departments for prevention activities tailored to local needs. The FY 2027 request proposes eliminating the block grant entirely and cuts CDC-Wide Activities overall from approximately $647 million to $362 million;[576] the disappearance of PPHF accounts for most of that decline.

PPHF has also provided substantial support across CDC's broader prevention portfolio, including tobacco prevention, heart disease and stroke, diabetes, and environmental health programs such as childhood lead poisoning prevention.[577] For some programs, the FY 2027 request would replace PPHF support with discretionary budget authority; for others, PPHF elimination would

coincide with separate proposed reductions, program eliminations, or organizational transfers accompanied by lower funding.[578] The result is not a simple one-for-one funding loss across every line, but a broader weakening of the dedicated prevention-financing structure that has helped sustain CDC prevention activities across annual appropriations cycles.

NEW IN FY 2027: THE PROPOSED NATIONAL CENTER FOR CHEMICALS AND TOXINS

The FY 2027 request includes a major structural element absent from the FY 2026 proposal: the creation of a new National Center for Chemicals and Toxins within CDC. The proposed center would consolidate ATSDR, NIH's National Institute of Environmental Health Sciences, FDA's National Center for Toxicological Research, and selected programs and funding lines from CDC's National Center for Environmental Health and National Institute for Occupational Safety and Health.[579] The proposed center's budget is approximately $1.0 billion, about $718 million below the comparably adjusted FY 2026 level for the programs and activities it would encompass.[580] This consolidation would not fully preserve the environmental health, occupational health, toxicology, and related scientific capacity currently housed across CDC and other federal health agencies. At the same time the budget proposes creating the new center, it also proposes eliminating several programs that help communities prepare for climate-related health risks, track environmental health threats, prevent asthma, train occupational health professionals, and conduct workplace safety and health research.[581]

PROPOSED TARGETED INCREASES FOR CDC

Within a substantially reduced CDC request, the FY 2027 budget proposes targeted increases in areas the administration identifies as priorities: $50 million for Immunization and Respiratory Diseases; $45 million for the Biothreat Radar Initiative, comprising increases for Travel and Port Health Protection and Advanced Molecular Detection, whose funding would rise from $43 million to $66 million; $33 million for food safety, including faster outbreak detection and research on micro- and nanoplastics; approximately $28 million for emerging infectious diseases; $22 million for antimicrobial resistance; and $65 million for public health data modernization, measured against a comparably adjusted baseline that incorporates related forecasting and response-data activities. The request also shows a $30 million increase for Surveillance, Epidemiology, and Informatics, although that comparison is affected by the proposed realignment of Disease Risk Factor Surveillance into the CDC line.[582]

These increases are focused on detecting threats early, responding to infectious diseases, strengthening laboratory capacity, and improving public health data. They reflect a coherent, but narrow, set of priorities and should be understood alongside the same budget's broader proposed reductions in prevention, preparedness, occupational health, and environmental health capacity.

Comparing the FY 2026 and FY 2027 Proposals

Considered together, the FY 2026 and FY 2027 budget requests describe a policy direction rather than a one-time proposal. The FY 2027 request moderated several elements of the FY 2026 proposal, including in some high-profile areas that had drawn congressional or stakeholder concern. But it maintained the same basic structural and fiscal direction: consolidation of HHS functions, creation of AHA, elimination of the PPHF, a smaller and reorganized CDC, and reduced investment in several broad-based prevention and preparedness functions.

WHERE THE FY 2027 REQUEST MODERATES THE FY 2026 APPROACH

The most significant moderation is in the overall scale of the proposed reductions. The FY 2026 request proposed cutting HHS discretionary funding by approximately $31.4 billion, or roughly 25 percent, from FY 2025 enacted levels.[583] The FY 2027 request proposes a reduction of approximately $15.8 billion, or 12.5 percent, from FY 2026 enacted levels.[584] At NIH, where the FY 2026 request proposed a sweeping restructuring of the agency's institutes and centers, the FY 2027 proposal is less sweeping: it preserves more of NIH's existing structure while proposing targeted consolidations, selected eliminations, and a smaller, though still substantial, funding reduction.[585] CDC's proposed funding level is higher in the FY 2027 request than it was in the FY 2026 proposal.[586,587] Global health remains within CDC at FY 2026 enacted levels, rather than being proposed for transfer or reduction.[588,589] However, recent reporting indicates that implementation decisions outside the budget tables could still substantially alter CDC's role in global health by shifting greater control over funding and program decisions to the State Department and moving CDC technical assistance toward a more transactional, fee-for-service model.[590] ASPR and the Advanced Research Projects Agency for Health (ARPA-H) are maintained as separate entities.[591] The FY 2027 budget also presents a more explicit argument for preparedness investment by highlighting the Strategic National Stockpile and the Biothreat Radar Initiative, even as it proposes deep cuts to the PHEP cooperative agreement.[592]

WHERE THE FY 2027 REQUEST MAINTAINS THE FY 2026 PROPOSAL'S CORE DIRECTION

On the structural elements of greatest consequence for the federal public health architecture, substantial continuity with the FY 2026 proposal remains the dominant pattern. The AHA—the consolidating entity Congress declined to adopt in the FY 2026 appropriations process—is proposed again, with the same basic organizational logic: combining OASH, HRSA, SAMHSA, and several CDC program areas into a single new entity with a substantially reduced combined budget. The PPHF is again proposed for complete elimination. CDC is again proposed below FY 2026 enacted levels. And although the FY 2027 request preserves a broader CDC role than the FY 2026 proposal did, both requests move in the same general direction: away from CDC as a broad national public health institution encompassing infectious disease, chronic disease, injury, environmental health, and occupational health, and toward a more narrowly defined agency centered on infectious disease surveillance, preparedness, laboratory capacity, and data infrastructure.

Other recurring elements also show continuity between the two requests. Both requests would consolidate some targeted funding streams into broader grants with more state discretion. The clearest example is behavioral health: both proposals would combine the Community Mental Health Services Block Grant, the Substance Use Prevention, Treatment, and Recovery Support Services Block Grant, and State Opioid Response program into a new Behavioral Health Innovation Block Grant.[593,594]

Within CDC, the FY 2027 request also proposes consolidating separate viral hepatitis, STI, tuberculosis, and infectious disease/opioid funding lines into a single Hepatitis, STI, and Tuberculosis Prevention Grant.[595]

Both requests would move CDC's health statistics function—the work that produces national data on births, deaths, life expectancy, causes of death, healthcare use, and other core measures of the nation's health—out of CDC and into the HHS Office of Strategy,[596,597] potentially separating a core public health data function from the agency most responsible for disease surveillance, population health monitoring, and public health response.

Both requests also propose eliminating the Preventive Health and Health Services Block Grant,[598,599] one of CDC's most flexible funding streams for state and local prevention work, and reducing Public Health Infrastructure and Capacity grants,[600,601] which help health departments maintain basic capabilities such as workforce, data systems, communications, performance improvement, and emergency-ready operations.

Compared with the FY 2026 proposal, the FY 2027 request is less sweeping in several respects: the overall HHS reduction is smaller, NIH faces a less severe cut and less sweeping restructuring, CDC is larger than it would have been under the FY 2026 request, global health remains within CDC, and ASPR and ARPA-H are maintained as separate entities. But on several central structural and fiscal priorities, the FY 2027 request largely holds its course: AHA creation, PPHF elimination, a smaller and reorganized CDC, and reduced investment in chronic disease prevention and state and local preparedness grants. The result is a budget that advances the same underlying theory of change: a consolidated HHS; a smaller CDC focused primarily on infectious disease surveillance, early threat detection, laboratory capacity, data systems, and food safety; and reduced federal investment in broad-based prevention, preparedness grants to states and localities, and environmental and occupational health capacity. The persistence of the AHA proposal in the FY 2027 request—notwithstanding Congress's decision in the FY 2026 appropriations process to fund the existing agency structure rather than the proposed replacement—illustrates the point most directly.

TABLE 2: HHS Discretionary Budget Authority Crosswalk, FY 2025–FY 2027

Dollars in millions. A crosswalk from FY 2025 final funding to the FY 2026 President's Budget Request (PBR), FY 2026 enacted funding, and the FY 2027 PBR.

AGENCY/DIVISION	FY 2025 FINAL	FY 2026 PBR	FY 2026 ENACTED	FY 2027 PBR
Agencies proposed for consolidation into new HHS entities				
Health Resources & Services Administration (HRSA)	8,020	→ AHA	8,948	→ AHA
Substance Abuse & Mental Health Services Admin. (SAMHSA)	7,392	→ AHA	7,294	→ AHA
Administration for a Healthy America (AHA)[1]	—	**14,058**	—	**14,673**
Administration for Children & Families (ACF)	34,025	→ ACFC	33,026	→ ACFC
Administration for Community Living (ACL)	2,489	→ ACFC	2,509	→ ACFC
Administration for Children, Families & Communities (ACFC)[1]	—	**29,331**	—	**28,680**
Other divisions, offices, and reconciliation lines				
Centers for Disease Control & Prevention (CDC), excl. ATSDR2	7,937	4,038	7,706	5,202
Agency for Toxic Substances & Disease Registry (ATSDR)[2]	82	78	80	78
National Institutes of Health (NIH)[3]	45,463	27,506	45,861	41,164
Food and Drug Administration (FDA)[3]	3,576	3,167	3,426	3,306
Indian Health Service (IHS)	7,482	7,909	7,985	9,094
Strategic Preparedness & Response (ASPR; FY 2026 PBR = ASHF)[4]	3,628	3,672	3,693	3,337
Centers for Medicare & Medicaid Services (CMS), program mgmt.	4,125	3,464	4,125	3,700
Agency for Healthcare Research & Quality (AHRQ)[5]	369	→ *Office of Strategy*	345	→ *Office of Strategy*
Advanced Research Projects Agency for Health (ARPA-H)[6]	1,500	→ ASHF	1,500	945
Office of Strategy[7]	—	240	—	240
All other HHS discretionary (residual)	1,966	1,955	1,961	1,819
Total, discretionary budget authority (before NEF)	**128,054**	**95,418**	**128,459**	**112,238**
less: Nonrecurring Expenses Fund cancellation/rescissions	(1,471)	(750)	(1,826)	(1,176)
Discretionary budget authority (after NEF)[8]	**126,583**	**94,668**	**126,633**	**111,062**
less: one-time rescissions	(13,249)	(8,685)	(14,340)	(21,519)
Revised, discretionary budget authority	**113,334**	**85,983**	**112,293**	**89,543**

Note: Dollars in millions; discretionary budget authority. FY 2025 final and FY 2026 enacted columns reflect HHS's existing organizational structure; FY 2025 final figures include required and permissive transfers. President's Budget Request (PBR) columns reflect the administration's proposed reorganizations. Congress did not adopt the FY 2026 request's reorganization in P.L. 119-75, and the FY 2027 request's reorganization remains pending. Because the columns span different organizational structures, each column shows either a proposed consolidated entity or its component agencies, but not both; "→" denotes an agency whose funding is consolidated elsewhere in that column. Agency rows sum to the gross total shown.

1. *The Administration for a Healthy America (AHA) and the Administration for Children, Families, and Communities (ACFC) are proposed entities with no enacted counterpart. AHA would consolidate the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Office of the Assistant Secretary for Health, and several CDC programs—and, under the FY 2026 PBR, the National Institute of Environmental Health Sciences; see note 3. Its scope therefore extends beyond HRSA and SAMHSA alone, and the AHA figure should not be read as the sum of the two agency rows shown above it. ACFC would consolidate the Administration for Children and Families and the Administration for Community Living.*
2. *CDC is shown excluding the Agency for Toxic Substances and Disease Registry (ATSDR) in all columns, with ATSDR on a separate line; HHS's published CDC figure combines the two. In the FY 2027 PBR, ATSDR would be realigned into a new CDC National Center for Chemicals and Toxins (NCCT); the FY 2026 PBR did not propose the NCCT structure.*
3. *The PBR columns differ structurally from the enacted columns, and the two requests also differ from each other. In the FY 2026 PBR, the National Institute of Environmental Health Sciences (NIEHS) was proposed for consolidation into AHA. In the FY 2027 PBR, NIEHS—from NIH—and the National Center for Toxicological Research—from FDA—are proposed for realignment into CDC's NCCT. The FY 2026 NIH figure is net of the proposed NIEHS transfer to AHA; the FY 2027 NIH and FDA figures are net of the proposed transfers of NIEHS and the National Center for Toxicological Research to CDC. Year-over-year changes for CDC, NIH, and FDA across the enacted and proposed columns therefore are not pure funding changes.*
4. *The FY 2026 PBR proposed an "Assistant Secretary for a Healthy Future" (ASHF) combining ARPA-H with selected functions formerly housed in the Administration for Strategic Preparedness and Response; the $3,672 million shown is the total for ASHF. Selected other ASPR functions were proposed for transfer to CDC, while others were proposed for elimination. The FY 2027 PBR reestablishes ASPR and ARPA-H as standalone divisions.*
5. *The Agency for Healthcare Research and Quality is proposed for consolidation; the healthcare-research functions retained in each request would move to the new Office of Strategy (see note 7).*
6. *In the FY 2026 PBR, ARPA-H—funded at $945 million—was included within ASHF rather than shown as a standalone division. The FY 2027 PBR reestablishes ARPA-H as its own division.*
7. *The Office of Strategy is a proposed office appearing only in the PBR columns, but its composition differs between the two requests. Under the FY 2026 PBR, it would combine the healthcare-research functions retained from AHRQ, CDC's National Center for Health Statistics, the Assistant Secretary for Planning and Evaluation, and the Office of Research Integrity; that request proposed eliminating digital healthcare and patient-centered outcomes research. Under the FY 2027 PBR, it would combine retained AHRQ healthcare-research functions, NCHS, and ASPE; the Office of Research Integrity would instead be consolidated into the proposed Assistant Secretary for Civil Rights and Appeals, while the Office of Strategy's program level would include a mandatory transfer from the Patient-Centered Outcomes Research Trust Fund. The $240 million shown in each PBR column is discretionary budget authority only and excludes PHS Evaluation and mandatory funding.*
8. *The discretionary budget-authority totals after the NEF adjustment—$94.7 billion for the FY 2026 PBR and $111.1 billion for the FY 2027 PBR—correspond to the figures cited in HHS's budget overviews. The gross total immediately above is the sum of the agency rows before the Nonrecurring Expenses Fund cancellation or rescissions. Topline reductions cited elsewhere in this report use the comparably adjusted baselines that HHS presents with each PBR to account for proposed funding and organizational realignments. For the FY 2027 PBR, HHS compares the $111.062 billion request with a comparably adjusted FY 2026 baseline of $126.911 billion, yielding a reduction of $15.849 billion, or 12.5 percent. The existing-structure FY 2026 total shown in this crosswalk is $126.633 billion; the $278 million difference reflects funding outside HHS that the proposal would transfer into the department, including the Drug-Free Communities and anti-doping programs and the Consumer Product Safety Commission. Similarly, HHS evaluated the FY 2026 PBR against an FY 2025 baseline adjusted to that request's different proposed structure. Reductions calculated directly from the existing-structure totals in this crosswalk therefore differ slightly from the comparably adjusted reductions cited elsewhere.*

"All other HHS discretionary" reconciles the named agencies to the HHS discretionary total. Its composition varies by column and includes General Departmental Management; civil-rights and Medicare-appeals functions or their proposed successor offices; the Office of Inspector General; the Office of the Chief Information Officer; discretionary healthcare fraud and abuse control funding; the Commissioned Corps health-benefits accrual; and, in the PBR columns, the proposed Assistant Secretary for Consumer Product Safety, reflecting the proposed transfer of the independent Consumer Product Safety Commission into HHS. It also includes other applicable small or one-time lines, such as the closeout cost proposed in the FY 2026 PBR.

NIH figures are budget authority and include 21st Century Cures Act allocations. HHS reports an FY 2026 enacted NIH program level of approximately $47.5 billion, higher than the $45.861 billion in budget authority shown in the table.

Sources: U.S. Department of Health and Human Services, FY 2026 and FY 2027 Budgets in Brief; Centers for Disease Control and Prevention, FY 2026 and FY 2027 Congressional Justifications; Administration for a Healthy America, FY 2027 Congressional Justification; HHS Departmental Management, FY 2027 Congressional Justification; FY 2026 CDC Operating Plan; Consolidated Appropriations Act, 2026 (P.L. 119-75).

What the FY 2027 Request Would Mean for CDC

The FY 2027 President's Budget Request does not propose a uniform contraction of CDC. Read carefully, it proposes a reorientation—and the distinction matters for understanding what would be lost and what would be preserved.

On a functional basis, several CDC-originating program areas would see meaningful funding increases under the FY 2027 request. Emerging and zoonotic infectious diseases would increase by 12 percent, net of realigned programs;[602,603] public health scientific services—reflecting an expansion of public health data modernization—would increase by 7 percent;[604,605,606] and the Immunization and Respiratory Diseases account would increase nominally by 5 percent.[607,608,609] The request also preserves CDC's Global Health account at the comparably adjusted FY 2026 level, maintaining CDC's role in global HIV/AIDS, tuberculosis, immunization, polio eradication, disease detection, and global health protection.[610,611,612] Together, these funding choices suggest the CDC-originating public health priorities the administration is prepared to sustain: early detection and response for infectious threats, laboratory and data infrastructure, immunization, and selected global disease-control and health-security functions.

The rest of the picture is considerably different. Public Health Preparedness and Response would decline by 43 percent on a functional basis—a reduction driven primarily by the proposed cut to the PHEP cooperative agreement from $735 million to $350 million, a decrease of $385 million, or more than half.[613,614,615] PHEP provides direct funding to 62 state, local, and territorial jurisdictions and supports the front-line preparedness workforce—including epidemiologists, laboratorians, emergency operations staff, and other personnel—that jurisdictions rely on for emergency readiness and response.[616] The $735 million FY 2026 enacted level was itself already below the $1 billion level TFAH and other public health organizations have identified as necessary for nationwide health emergency readiness.[617] The proposed $350 million for PHEP would be just 35 percent of the recommended $1 billion level.

The proposed reduction to PHEP also occurs against the backdrop of a broader shift in federal preparedness policy. Executive Order 14239, signed in March 2025, declared that preparedness is "most effectively owned and managed at the State, local, and even individual levels" and called for state and local governments and individuals to play a more active role in national resilience and preparedness.[618] Yet the FY 2027 request would cut by more than half the core CDC cooperative agreement through which jurisdictions receive public health preparedness funding, creating a clear tension between greater state and local responsibility and reduced federal support for fulfilling it.

Cross-cutting activities and program support—the account that funds direct grants to more than 100 state, local, and territorial health departments for foundational public health infrastructure, as well as tribal public health programs—would fall by 44 percent.[619,620] That reduction is especially important because Public Health Infrastructure and Capacity funding is not disease-specific. It is one of the federal government's principal tools for helping health departments maintain cross-cutting capacity: workforce, data systems, organizational infrastructure, emergency-ready operations, communications, and other foundational capabilities that multiple public health programs depend on. CDC acknowledges in its FY 2027 budget request an estimated $4.5 billion annual gap in foundational public health capabilities nationwide, while the administration simultaneously proposes to reduce Public Health Infrastructure and Capacity funding—the primary federal investment in closing that gap—by $100 million.[621]

The administration's own budget documents acknowledge a $4.5 billion gap in foundational public health capabilities—while proposing to cut the grant designed to close it.

The proposed National Center for Chemicals and Toxins illustrates the same mixed pattern. Rather than moving CDC's environmental and occupational-health functions

outside the agency, as the FY 2026 request proposed, the FY 2027 request would consolidate selected CDC functions with environmental-health and toxicology programs from elsewhere in HHS within a new CDC center. But the center would be funded approximately 41 percent below the combined FY 2026 level of the programs it would encompass.[622] Within that structure, Occupational Safety and Health would decline by 75 percent from FY 2026 levels, and Environmental Health would decline by 33 percent.[623] In practical terms, the proposal would keep within CDC a consolidated portfolio spanning chemicals and toxins, environmental health, and occupational health, while substantially reducing federal capacity across several environmental- and workplace-health functions.

Among program areas currently housed at CDC and proposed largely for transfer to AHA, the funding reductions are especially large. Chronic Disease Prevention and Health Promotion—the program area that addresses many of the leading causes of death and disability in the United States and conditions that drive a large share of national healthcare spending—would decline by approximately 67 percent on a functional basis relative to FY 2026 enacted levels.[624,625,626,627] The reduction is highly uneven: the request preserves Cancer Prevention and Control at the FY 2026 level, retains Disease Risk Factor Surveillance within CDC, and continues Alzheimer's Disease funding at a reduced level, while eliminating most other existing chronic disease prevention program lines, including tobacco prevention, heart disease and stroke, diabetes, oral health, Safe Motherhood/Infant Health, and community-based prevention programs.

HIV/AIDS, viral hepatitis, STI, and tuberculosis prevention programs would fall by approximately 62 percent, with most CDC domestic HIV prevention and research funding eliminated or restructured and $220 million continuing under AHA for Ending the HIV Epidemic activities formerly carried out by CDC.[628] Injury prevention and control would decline by 23 percent.[629,630,631] These are not organizational reclassifications in which existing funding simply follows programs to a new administrative home; they are substantial proposed reductions in the total resources available for programs that collectively address major contributors to preventable illness and death.

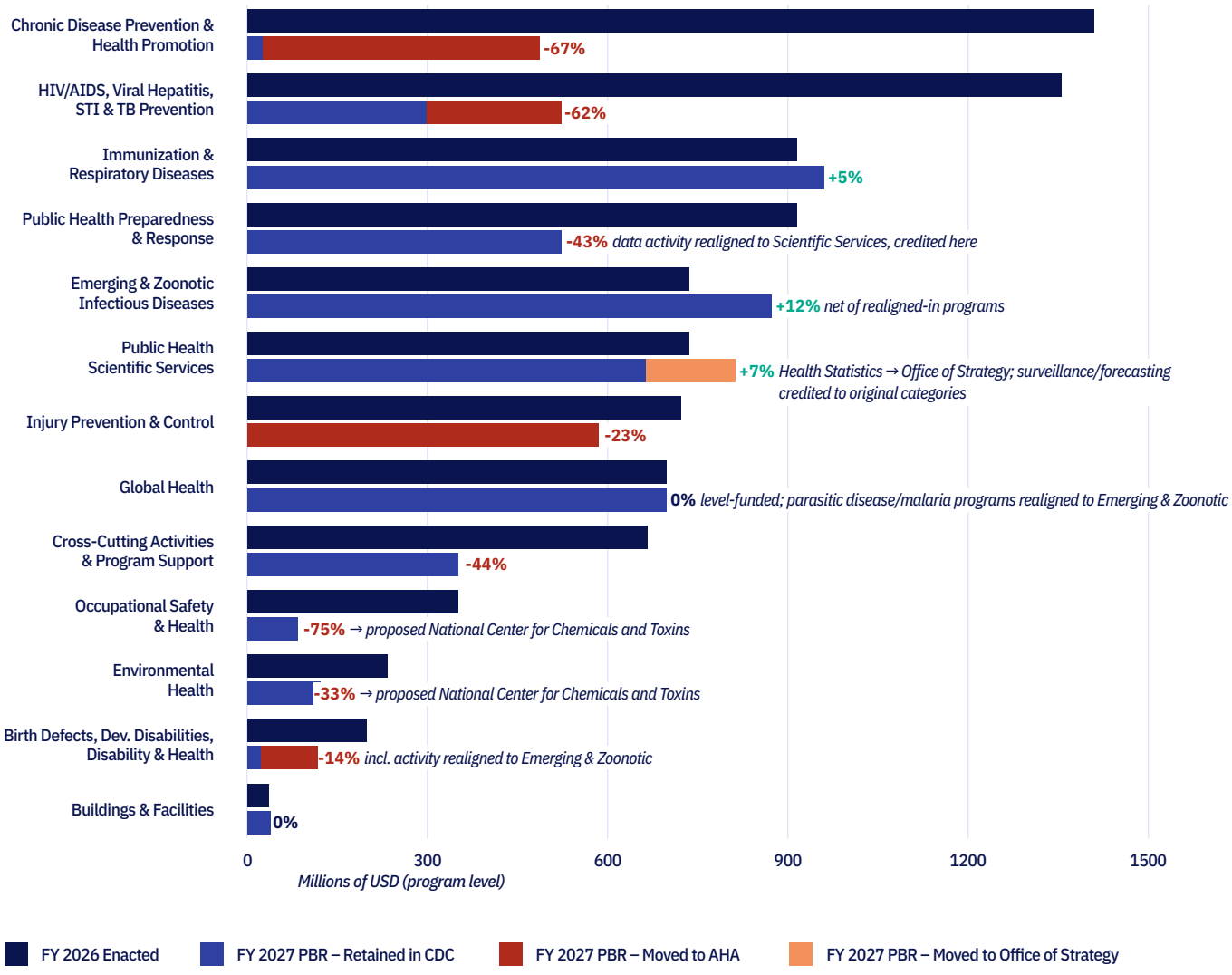
A federal public health agency reoriented away from chronic disease prevention, injury prevention, preparedness, and environmental and occupational health would not merely be a smaller version of the existing institution; it would have weaker capacity in core public health functions.

The FY 2027 request combines targeted increases or level funding in some CDC functions with substantial reductions or eliminations in others. The administration is proposing to maintain and in some cases strengthen federal capacity for infectious disease surveillance, early threat detection, laboratory science, data infrastructure, immunization, and selected global disease-control and health-security functions. Taken together, those priorities emphasize the functions most analogous to a national early-warning and response system for biological threats. It is proposing to substantially reduce or eliminate federal capacity for chronic disease prevention, injury prevention, public health preparedness grants, occupational health, and environmental health functions that address disease and injury burdens across the population on a continuous basis, not only during declared emergencies.

Whether that trade-off reflects sound public health policy depends on a prior question: whether the functions proposed for reduction or elimination are secondary to the federal public health mission, or whether they are—like the infectious disease and surveillance functions being prioritized—core to it. The chronic disease burden, injury burden, preparedness infrastructure, occupational injury and illness, and environmental exposures addressed by the programs proposed for the deepest cuts are not marginal public health concerns. They include leading causes of preventable morbidity, mortality, and healthcare cost, as well as core infrastructure needed to prevent, detect, and respond to health threats. A federal public health agency reoriented away from them would not merely be a smaller version of the existing institution; it would have weaker capacity in core public health functions.

FIGURE 17: CDC Program Funding by Category: FY 2026 Enacted vs. FY 2027 President's Budget

Program level (budget authority plus PPHF and PHS evaluation transfers), in millions of dollars. FY 2026 enacted operating-plan categories are compared with FY 2027 proposed funding for the same functions, tracked to where the request would house them. Because several categories are reorganized, percent changes are functional comparisons, not direct account-to-account comparisons.



Notes: Program level includes budget authority, PPHF transfers, and the Public Health Service evaluation transfer. FY 2026 enacted levels are from the FY 2026 CDC Operating Plan; FY 2027 levels are from the CDC, AHA, and Office of Strategy FY 2027 congressional justifications. Because the FY 2027 request reorganizes several categories, percentages are functional comparisons: categories in the FY 2026 CDC Operating Plan are compared with FY 2027 proposed funding for the same functions wherever the request would house them, and activities moved at equal funding levels show no net change. Health Statistics would move to the Office of Strategy. Parasitic Diseases and Malaria and Surveillance for Emerging Threats to Mothers and Babies would move to Emerging and Zoonotic Infectious Diseases but are credited to Global Health and Birth Defects, Developmental Disabilities, Disability and Health, respectively, at their FY 2026 levels. Ready Response Enterprise Data Integration and forecasting and outbreak-analytics activities would move from Public Health Preparedness and Response to Public Health Scientific Services but are credited to Preparedness at their FY 2026 level. The request would also retain Disease Risk Factor Surveillance within Public Health Scientific Services rather than move it to AHA with the remainder of the chronic-disease portfolio. Because the request does not separately itemize its funding, this analysis treats the full $29.5 million increase in Surveillance, Epidemiology, and Informatics as funding for that activity and credits it to Chronic Disease Prevention and Health Promotion. The funded portions of Environmental Health and Occupational Safety and Health would remain within CDC as part of the proposed National Center for Chemicals and Toxins.

Sources: FY 2026 CDC Operating Plan;[632] FY 2027 Congressional Justifications for CDC,[633] the Administration for a Healthy America,[634] and the HHS Office of Strategy.[635]

Ongoing Risks to Public Health Capacity

Congress's response to the FY 2026 President's Budget Request was consequential. The Consolidated Appropriations Act, 2026 kept CDC program-level funding roughly flat relative to FY 2025 enacted levels; left SAMHSA, HRSA, and ASPR in place as independent agencies; and declined to create or fund the AHA as a new operating division—rejecting most of the proposed structural reorganization while adding new oversight provisions related to reorganization notification, workforce levels, and grant administration. That outcome represented a clear and important affirmation of Congress's authority over the organizational and fiscal architecture of the federal public health system.

That outcome does not, however, establish that the system is now on a stable footing—for reasons that are simultaneously retrospective and prospective.

THE FY 2026 BASELINE IS NOT A RECOVERY

FY 2026 enacted funding levels represent a rejection of the administration's proposed cuts, not a restoration of the system's pre-disruption operational capacity. As of May 2026, CDC employment had fallen by approximately 3,600 from FY 2024 levels—a reduction of roughly 28 percent.[636] The program expertise, institutional knowledge, grant administration capacity, and established grantee relationships that those employees carried departed with them. Outlay data show CDC disbursements running well below prior-year comparable levels through mid-2026,[637] a pattern consistent with reduced operational capacity and documented grant termination activity. A flat annual appropriation of roughly $9.1 billion funds much of the same nominal program structure as before;[638] it does not automatically reconstruct the staffing, systems, and relationships needed to administer those programs. Appropriated dollars are a necessary but not sufficient condition for public health capacity.

Appropriated dollars are a necessary but not sufficient condition for public health capacity.

THE FY 2027 REQUEST DEMONSTRATES PERSISTENCE OF DIRECTION

The FY 2027 budget request makes clear that the policy direction documented in this report was not foreclosed by one appropriations outcome. Many of the same core structural and fiscal proposals—AHA, PPHF elimination, a narrowed CDC, and deep preparedness cuts—return in the FY 2027 request. Under this pattern, each appropriations cycle requires active congressional decision-making to preserve the existing federal public health architecture and sustain core program investments; the FY 2026 outcome does not, by itself, guarantee the continuation of existing agencies or programs at existing levels.

Initial congressional action on the FY 2027 request illustrates that distinction. On June 9, 2026, the House Appropriations Committee approved the FY 2027 Labor-HHS appropriations bill.[639] The committee retained HHS's existing organizational structure rather than establishing the proposed AHA or implementing the administration's other major reorganization proposals, noting that the authorizing committees had not yet considered every proposal. On the CDC program-level basis used in this report—which excludes mandatory funding under the Energy Employees Occupational Illness Compensation Program Act—the bill would provide approximately $8.1 billion, about $1.0 billion below the FY 2026 enacted level, while continuing approximately $1.4 billion in Prevention and Public Health Fund transfers to CDC. It would increase selected investments in public health infrastructure, data modernization, and the Public Health Emergency Preparedness cooperative agreement, while eliminating the Preventive Health and Health Services Block Grant and reducing or eliminating other public health programs.[640] The proposal therefore illustrates that congressional rejection of the administration's proposed restructuring does not necessarily mean preservation of the FY 2026 funding baseline.

THE FLAT-FUNDING SCENARIO

Even in the absence of the administration's deepest proposed cuts, flat funding for FY 2027 would not be a neutral outcome for the public health system. In real, inflation-adjusted terms, level nominal funding represents continued erosion of purchasing power—a pattern that has characterized federal public health investment for much of the past decade. The workforce losses already sustained do not reverse automatically as new fiscal years begin; rebuilding them requires sustained hiring, which remains constrained by federal hiring controls. And documented administrative mechanisms—grant terminations, delayed apportionment, restrictions on disbursement, and the executive grantmaking framework established under Executive Order 14332—remain potential points of disruption regardless of enacted appropriation levels. Appropriated funds that are delayed, restricted, or terminated before reaching grantees do not provide the public health capacity they are nominally intended to support. A flat appropriation that is administered differently than in prior years can produce meaningfully different real-world outcomes.

RECONCILIATION PRESSURES

The fiscal environment in which state and local health systems operate was materially altered by enactment of the One Big Beautiful Bill Act (OBBBA) (Public Law 119-21) on July 4, 2025.[641] The Congressional Budget Office (CBO) estimated that the law would reduce federal Medicaid spending by approximately $911 billion over the FY 2025–2034 period, a reduction that policy analysts have described as the largest Medicaid cut in the program's history.[642] CBO estimated that the law's health provisions would increase the number of uninsured people by about 10 million by 2034, including approximately 7.5 million people becoming uninsured because of Medicaid provisions.[643] A RAND analysis estimated that the OBBBA provisions it studied would reduce state Medicaid funds by approximately $665 billion from 2025 through 2034, including an aggregate reduction of approximately $86 billion in state general funds.[644]

The public health implications are direct. Individuals who lose coverage do not cease to have healthcare needs; evidence shows that uninsured people are more likely to delay or forgo needed care because of cost, and Medicaid coverage losses would disproportionately

affect safety-net providers that serve high shares of low-income and Medicaid patients.[645,646] State governments facing large reductions in federal Medicaid support will also face new fiscal and operational pressures, limiting their ability in some cases to supplement federal public health investment or backfill gaps in services. The coverage losses and fiscal pressures resulting from the law will increase demand on public health and safety-net infrastructure at the same time that federal investment in that infrastructure remains under sustained pressure. Rural communities face particular compound risk: analyses of the OBBBA's Medicaid provisions and related health-coverage reductions have identified hundreds of rural hospitals at risk of closure, conversion, or service reductions, in communities where hospitals often serve as primary safety-net providers and alternatives are limited.[647,648]

The OBBBA also included a significant countervailing investment in rural health: the $50 billion Rural Health Transformation Program, a CMS-administered funding stream for states to support rural healthcare delivery transformation from FY 2026 through FY 2030.[649] The program may support activities such as provider payments, workforce recruitment and retention, health information technology, technical assistance, behavioral health services, chronic disease management, innovative care models, and efforts to "right size" rural healthcare delivery systems. Although the program may help states and rural providers respond to some of these challenges, it is not structured to replace coverage losses from the law's Medicaid changes or to address existing gaps in governmental public health infrastructure and capacity.[650,651,652]

The reconciliation law also placed new pressure on nutrition assistance, with implications for public health and state budgets. OBBBA expanded Supplemental Nutrition Assistance Program (SNAP) work requirements, restricted eligibility for some lawfully present noncitizens, reduced or constrained benefits for many households, and changed the program's federal-state financing structure.[653] CBO estimated that the work-requirement provisions alone would reduce SNAP participation by roughly 2.4 million people in an average month over the 2025–2034 period,[654] while other provisions would reduce monthly benefits for many remaining households. In addition, the OBBBA ended required federal funding for the SNAP Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed) after the FY 2025 grant allocation, under Section 10107 of the law, eliminating a federal funding stream through which states and local partners had delivered nutrition education and physical activity programming to eligible low-income individuals and communities as a community-level obesity prevention and chronic disease prevention strategy.[655,656,657] The law also shifts new costs to states by generally requiring states with SNAP payment error rates of 6 percent or higher to pay 5 to 15 percent of benefit costs beginning in FY 2028,[658] subject to delayed implementation for certain states, and by increasing the state share of SNAP administrative costs from 50 percent to 75 percent beginning in FY 2027.[659,660] These changes could increase food insecurity, force states to absorb new costs, reduce access, or shift resources away from other health and human services priorities.[661]

THE CUMULATIVE DYNAMIC

The risk the public health system faces is not reducible to any single budget outcome. It is a cumulative dynamic: chronic structural underfunding, temporarily masked by COVID-era emergency investment, preceded a period of workforce disruption, institutional uncertainty, and funding interruption that enacted appropriations could only partially offset. The FY 2027 request shows that the policy direction reflected in many of those actions and proposals has persisted into the next budget cycle. If enacted, the request would accelerate the erosion of public health operating capacity. But even if Congress again rejects the deepest proposed cuts, capacity could continue to deteriorate if flat funding fails to keep pace with inflation, workforce rebuilding remains constrained by hiring controls, grant administration continues to be shaped by executive-branch mechanisms that appropriations cannot fully control, and reconciliation-

related pressures on state and local health systems compound the effects of constrained federal public health support. The risk is not only that Congress might adopt the FY 2027 request. It is also that rejecting the deepest cuts may not be sufficient to reverse slower capacity loss if flat funding, cumulative attrition, administrative disruption, and sustained uncertainty about the future structure of federal public health agencies continue.

The risk is not only that Congress might adopt the FY 2027 request. It is also that rejecting the deepest cuts may not be sufficient to reverse slower erosion of capacity if flat funding, cumulative attrition, administrative disruption, and sustained uncertainty about the future structure of federal public health agencies continue.

What Is at Stake

The funding decisions before Congress in the FY 2027 appropriations cycle will have significant consequences for public health capabilities, programs, and the populations they serve. The public health system as it now stands—and as it would look after the proposed budget, or after a flat-funded continuation without capacity restoration—is a system progressively less able to meet demands that recent outbreaks, chronic disease trends, environmental hazards, and preparedness gaps show are already testing it.

VACCINE-PREVENTABLE DISEASE AND IMMUNIZATION INFRASTRUCTURE

As of July 16, 2026, CDC had recorded 2,289 confirmed measles cases in 2025—the highest annual total since 1991—across 48 outbreaks,[662] with three deaths: two unvaccinated school-aged children in Texas and one unvaccinated adult in New Mexico.[663] An additional 2,260 cases had been confirmed in 2026, including 2,245 reported by 44 jurisdictions and 15 among international visitors; no measles deaths had been reported in 2026. Together, the two years accounted for 4,549 confirmed cases, with resident cases reported across 46 states and the District of Columbia.[664] In each year, 93 percent of cases occurred among people who were unvaccinated or whose vaccination status was unknown.[665]

Measles, mumps, and rubella (MMR) vaccination coverage among kindergarteners fell from 95.2 percent in the 2019–2020 school year to 92.5 percent in 2024–2025—below the 95 percent coverage level CDC identifies as needed for community protection against measles.[666] The United States' measles elimination status—maintained continuously since 2000—is under formal review.[667]

Pertussis also rebounded sharply after the pandemic. CDC recorded 43,321 cases in 2024—the highest annual total since 2012—and 28,783 provisional cases in 2025,[668] with 16 reported deaths, including 10 among infants younger than one year.[669] As of CDC's July 10, 2026 update, preliminary reports indicated fewer cases than at the same point in 2025.[670] Still, the sustained burden during 2024 and 2025 underscores the continuing importance of strong immunization, disease-surveillance, laboratory, and outbreak-response capacity.

Vaccine-preventable diseases are resurging in the United States at the same time that vaccination coverage has declined and measles elimination status is at risk. Those trends make immunization infrastructure more important, not less. The state and local programs, federal technical support, cooperative agreements, surveillance systems, outbreak-response capacity, and public communication

Editor's note: The measles data above reflect information available as of July 16, 2026. Since this report was finalized, CDC reported 2,777 confirmed U.S. measles cases as of August 20, surpassing the full-year 2025 total.

functions that sustain vaccination coverage are also the infrastructure needed to prevent isolated cases from becoming larger outbreaks. Because the same immunization infrastructure supports both routine vaccination and outbreak response, increased outbreak activity can place additional demands on already limited routine vaccination capacity. The FY 2027 budget's proposed elimination of the PPHF[671] is therefore not a marginal budget adjustment. Although the request would nominally increase the Immunization and Respiratory Diseases account, it would replace PPHF's dedicated mandatory funding with discretionary budget authority, removing a funding source designed to support sustained prevention investment at the precise moment when vaccine-preventable disease threats are increasing.

PREPAREDNESS CAPACITY

The PHEP cooperative agreement is the main federal public health preparedness grant for building and sustaining state, local, and territorial health department capacity—the trained personnel, practiced response systems, and established interagency relationships that allow effective response when a health threat materializes. The FY 2027 request would reduce PHEP funding from $735 million to $350 million, a cut of $385 million, or 52 percent.[672] States and localities dependent on PHEP funding would likely face decisions about which preparedness functions to sustain and which to scale back or eliminate. Academic Centers for Public Health Preparedness, which support the training pipeline for preparedness professionals, would receive no funding under the proposal.[673] The Infectious Disease Rapid Response Reserve Fund, which provides flexible resources for responses to emerging outbreaks, would receive no new budget authority.[674]

The FY 2027 request would also eliminate the Hospital Preparedness Program (HPP) cooperative agreements,[675] the primary federal funding stream dedicated to healthcare delivery system preparedness and response.[676] Administered by the Administration for Strategic Preparedness and Response (ASPR) and funded at $240 million in FY 2026,[677] HPP provides funding and guidance to 62 recipients—including all states, territories, freely associated states, the District of Columbia, Chicago, New York City, and Los Angeles County—to support healthcare coalitions: geographically defined networks of public and private healthcare and response organizations that prepare for and respond to disasters and emergencies that exceed day-to-day healthcare capacity.[678,679] Under the FY 2027 request, HPP cooperative agreement funding would fall to zero. Cutting PHEP while eliminating HPP would reduce federal support on both sides of the preparedness system: the public health infrastructure that identifies and manages threats and the healthcare delivery infrastructure that must continue operating when those threats disrupt care.

The preparedness capacity supported by these investments cannot be replaced simply by shifting dollars from unrelated programs. The epidemiological expertise, practiced coordination protocols, and established relationships among federal, state, and local agencies that effective emergency response requires are built over years and cannot be rapidly reconstructed once allowed to atrophy. As prior public health emergencies have demonstrated, the costs of inadequate readiness are measured in lives, economic disruption, and overwhelmed health systems.[680,681,682] TFAH's companion preparedness analysis, *Ready or Not 2026*, found that at least 12 states had already reduced public health funding in FY 2025, before the full impact of federal funding disruptions had been absorbed, underscoring that federal reductions would compound state-level constraints rather than be reliably offset by them.[683]

ENVIRONMENTAL AND OCCUPATIONAL HEALTH

The FY 2027 request would create a new National Center for Chemicals and Toxins within CDC, consolidating environmental health, occupational safety and health, toxicology, chemical-exposure, and related research functions currently housed across NCEH, NIOSH, ATSDR, NIEHS, and FDA's National

Center for Toxicological Research. Organizational consolidation of programs addressing overlapping subject matter can, in principle, improve coordination and reduce duplication. But the proposed center's budget would be substantially below the combined FY 2026 levels of the programs it would encompass, with several activities eliminated or reduced. Proposed eliminations include, among others, the Climate and Health program, the Environmental and Health Outcome Tracking Network, occupational health Education and Research Centers, and the National Occupational Research Agenda.[684] The question the proposal raises is whether the proposed center would preserve the substantive capabilities of the programs it incorporates—and the proposed funding levels and program eliminations suggest it would not. Environmental health monitoring, climate and health research, and occupational safety research and surveillance address health threats that continue regardless of whether federal capacity to track and respond to them is reduced.

DATA AND ANALYTIC INFRASTRUCTURE

The FY 2027 request proposes increases for public health data modernization and the Advanced Molecular Detection program[685]—investments in the surveillance, laboratory, and analytic infrastructure that supports outbreak detection, genomic characterization of pathogens, and public health decision-making. These are meaningful proposed investments in core CDC functions. Their value, however, depends on the broader ecosystem in which they operate: the state and local surveillance systems that generate data flowing into national networks, the public health laboratories that collect and process specimens, and the program staff and cooperative agreements that sustain the partnerships through which federal analytical capacity reaches state and local practice. The value of those investments also depends on sufficient state and local capacity—including workforce, laboratory systems, and cooperative agreements—to participate in the national data infrastructure.

THE UNEQUAL DISTRIBUTION OF CONSEQUENCES

The consequences of reduced federal public health capacity are not evenly distributed. Federally supported public health infrastructure helps reduce differences in capacity across jurisdictions with widely varying fiscal resources. Through cooperative agreements, grants, technical assistance, and national scientific support, federal investment helps states and localities maintain capabilities—such as epidemiological expertise, laboratory services, surveillance systems, and prevention programs—that no jurisdiction could fully replace on its own, with the greatest relative impact falling on communities and jurisdictions with the least fiscal and operational margin.

Program areas proposed for elimination or significant reduction—including HIV prevention, injury prevention, chronic disease prevention, and environmental health monitoring—often serve communities with elevated disease burdens and limited access to alternative sources of care. The coverage losses resulting from OBBBA are expected to fall heavily on low-income adults who gained coverage through Medicaid expansion[686] and on states and communities more dependent on federal Medicaid and Marketplace support.[687] Those coverage losses are likely to increase reliance on safety-net and public health services at the same time that federal support for public health infrastructure is under pressure. Rural communities may face particular strain because public health agencies, clinics, hospitals, and community-based organizations often operate with lean staffing, fewer alternative providers, longer travel distances, and less local fiscal capacity to replace lost federal support. The reduction in federally supported public health capacity documented in this report therefore risks widening existing disparities in health outcomes—between well-resourced and under-resourced jurisdictions, between urban and rural communities, and across racial, ethnic, and socio-economic lines.

A public health system that is less able to prevent illness generates a healthcare system that must treat more of it—at substantially greater cost.

NATIONAL AND ECONOMIC SECURITY

Public health infrastructure is a national security asset. The workforce, laboratories, surveillance systems, and partnerships among federal, state, local, tribal, and territorial public health agencies that serve routine public health functions are the same capabilities that underlie the nation's capacity to detect, characterize, and respond to biological threats—whether naturally occurring, accidentally released, or deliberately introduced.[688,689] A biosurveillance system that can detect an emerging pathogen provides limited protection if the public health system that must investigate, contain, and respond to what it detects lacks the workforce, laboratory capacity, and partner relationships to do so effectively. Proposals that increase investment in threat detection while reducing the broader preparedness and response infrastructure on which detection's value depends raise a basic policy question: whether the budget's detection investments are matched by the response capacity needed to act on what they find.

The economic logic of prevention investment is grounded in the same patterns documented throughout this report. People with chronic and mental health conditions account for an estimated 90 percent of the nation's annual healthcare expenditures, and chronic diseases—including heart disease, cancer, diabetes, and stroke—are among the leading drivers of illness, disability, death, and healthcare costs.[690] They are central to the CDC prevention portfolio proposed for reduction or transfer under the FY 2027 budget.

Reductions in prevention investment do not reduce the burden of chronic disease; they shift its costs downstream to emergency departments, hospitals, long-term care systems, taxpayers, employers, and families. Systematic analysis of public health interventions in high-income countries found a median return on investment of approximately 14 to 1.[691] A public health system that is less able to prevent illness generates a healthcare system that must treat more of it—at substantially greater cost.

A SYSTEM UNDER SUSTAINED PRESSURE

The public health system described in this report—chronically underfunded before 2025, destabilized by workforce reductions, funding disruptions, and institutional uncertainty during 2025 and 2026, and now facing a budget proposal that would further narrow its mission and reduce its resources—is a system whose capacity to fulfill its core purpose has been materially diminished. The threats that system exists to address have not diminished correspondingly. Measles outbreaks, elevated pertussis activity, ongoing H5N1 and pandemic influenza risk, antimicrobial resistance, foodborne and waterborne threats, environmental and occupational hazards, and a chronic disease burden that remains high by peer-country standards continue to place demands on an infrastructure whose capacity to meet them has contracted. The FY 2027 appropriations process will determine, in significant part, whether the trajectory of the past two years continues or whether the investments needed to arrest and begin reversing it are made.

SECTION V

Recommendations for Congress and the Administration

The public health system—comprising governmental and nongovernmental entities that work together to protect communities from preventable disease and injury—needs a baseline of resources, connectivity, workforce, and structures to function effectively. The interconnectedness of our nation's public health enterprise means instability in federal funding, workforce, and infrastructure puts the health of every community at risk.

TFAH'S ACTION AGENDA

TFAH's recommendations are designed to rebuild public health capacity after the disruptions of 2025 and 2026 while establishing a more stable foundation for the future:

- **Restore federal health agency operating capacity.** Rebuild staffing, expertise, grant administration, technical assistance, and other operational capacity needed to carry out funded programs and statutory responsibilities.
- **Preserve complementary federal capabilities.** Preserve and strengthen the distinct roles of CDC, SAMHSA, HRSA, the Administration for Community Living, ASPR, and other federal health agencies. Any major restructuring should proceed only through a bipartisan, deliberative process with congressional oversight and stakeholder input.
- **Strengthen CDC as a comprehensive national public health agency.** Provide at least $11.58 billion for CDC in FY 2027, followed by sustained increases, and preserve its responsibilities across infectious disease, chronic disease, injury prevention, environmental and occupational health, preparedness, and foundational infrastructure.
- **Ensure that appropriated funds are spent as intended.** Release funds promptly and prevent awards from being delayed or terminated for reasons unrelated to statutory purposes, performance, or compliance.
- **Provide durable and predictable financing.** Enact full-year appropriations on time, restore and protect the Prevention and Public Health Fund, and reject new discretionary funding caps that hinder public health modernization and readiness for evolving health threats.
- **Invest in foundational infrastructure and health security.** Sustain workforce, laboratory, epidemiology, data-modernization, and cross-cutting health department capacity, and create a Health Defense Operations budget designation for programs central to the nation's health, economic, and national security.

To protect the nation's health, economic security, and national security, TFAH recommends that Congress and the administration take the following actions for FY 2027 and beyond. These recommendations address urgent challenges currently facing the public health system.

- **Congress and the administration should restore federal health agency staffing, program funding, and operational capacity sufficient to carry out funded programs and statutory responsibilities, including capacity reduced or eliminated in 2025.** The rapid elimination of federal programs and loss of expertise across HHS are harming the public's health and public health capabilities nationwide. HHS should also report to Congress on how it is complying with the Consolidated Appropriations Act, 2026 provision requiring the Department to maintain staffing levels necessary to carry out all funded programs and agency functions.
- **Congress and the administration should preserve and strengthen the structure and capabilities of federal health agencies, which have specific, complementary, and distinct roles and expertise in protecting the nation's health.** Proposals to fundamentally alter CDC, SAMHSA, HRSA, the Administration for Community Living, and other federal public health agencies risk serious disruptions in the detection and prevention of disease and in the delivery of services and other supports to communities.
- **Congress, in collaboration with federal agencies and outside experts and partners, should lead a bipartisan, deliberative process for reviewing proposals for federal health agency restructuring or the development of new agencies.** The administration should provide a comprehensive plan to Congress on its proposals to restructure federal agencies before moving forward, including plans to ensure essential public health services for all communities. To inform the process, relevant congressional committees should hold listening sessions and hearings with governmental and nongovernmental components of the public health, healthcare, patient, and scientific ecosystem to ensure federal agencies can support the health protection needs of all communities.
- **Congress and the administration should strengthen CDC as a national, comprehensive public health agency with clear responsibilities for detecting, preventing, and mitigating infectious diseases, chronic conditions, and other leading causes of preventable death, illness, and injury.** To fulfill its role in protecting the health of the American people and supporting state and local efforts to do the same, Congress should provide at least $11.58 billion for CDC in FY 2027, with increases to follow.
- **Federal agencies must spend all funds appropriated by Congress, as required by law, and the Office of Management and Budget (OMB) should release full-year funds to agencies soon after passage of appropriations legislation.** Impounding, delaying, freezing, or terminating public health funding that has been passed into law leaves every community at risk, weakens the economy, and disrupts research. Even temporary funding delays can cause health departments and nonprofit organizations to end programs and lose staff. Congress should require OMB to provide funding by particular deadlines and ensure that federal agencies expend all money as directed.
- **Federal agencies should uphold predictable, transparent, merit-based, and evidence-based processes for awarding and administering federal grants and cooperative agreements.** Congress should prohibit policies that politicize grantmaking decisions, undermine independent scientific and merit review, or permit awards to be suspended or terminated for reasons unrelated to statutory program purposes, recipient performance, or compliance with award terms.
- **Congress should enact full-year appropriations bills for HHS and its agencies and operating divisions.** Continuing resolutions, short-term funding, government shutdowns, and across-the-board cuts are all deeply harmful to public health and scientific research. They prevent the efficient and effective use of taxpayer dollars and hinder the hiring and retention of skilled workers.

- **Congress and the administration should implement evidence-based processes to identify inefficiencies and enhance the effectiveness of federal public health services, such as improving the efficiency of federal fund disbursement, program evaluation and data collection, and enabling flexibility when needed.**
- **Congress should restore the Prevention and Public Health Fund and prevent future cuts.** PPHF has made critical investments in every state, such as expanding vaccine access through CDC's Immunization Program, building laboratory capacity, and preventing chronic disease. In its first 15 fiscal years, FY 2010 through FY 2024, the Prevention Fund provided more than $13.5 billion for prevention and public health programs, supporting work in every state and territory, including grants to state and local governments, tribal organizations, and community-based and other nonprofit organizations. Successive statutory reductions have left the PPHF scheduled to receive $12.95 billion less over FY 2013 through FY 2029 than under the ACA's original funding schedule. Congress should restore and protect the Fund and not use it as an offset in future legislation.
- **Congress should reject new discretionary budgetary caps.** Inadequate overall health funding constrained by arbitrary caps fails to account for inflation, new public health threats, and population growth.
- **Congress should ensure continuous improvement of the nation's public health infrastructure, capabilities, and essential services, including workforce, laboratories, and data systems at all levels.** Congress should enact legislation such as the Public Health Infrastructure Saves Lives Act, which would provide sustained funding for the Public Health Infrastructure Program, which, in turn, is strengthening the nation's public health system to address 21st-century health threats and opportunities. This investment is vital to ensuring that health departments have more effective emergency responses, faster disease detection, and continuous progress toward preventing chronic diseases. In the interim, Congress should provide robust annual appropriations for public health infrastructure, data modernization, and epidemiology and laboratory capacity, most of which supports foundational capabilities across the country.
- **Congress should create a Health Defense Operations budget designation to exempt health defense programs central to health security from annual discretionary budget allocations, ensuring that these critical activities receive the sustainable resources necessary to protect Americans' health, economic, and national security.** Budget caps and competing priorities within the nondefense discretionary budget category continue to constrain annual discretionary appropriations, undermining the sustained investment that medium- and long-term health defense requires.

Endnotes

1. In this report, the public health system refers primarily to the governmental public health enterprise: federal, state, local, tribal, and territorial agencies; the workforce, funding, data systems, laboratories, grantmaking, technical assistance, and emergency-response capacities that support them; and the community, healthcare, academic, and other partners through which public health programs are often implemented.
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18. TFAH analysis of CDC program-level funding from CDC operating plans and congressional justifications, FY 2016–FY 2026. Inflation adjustment uses U.S. Bureau of Economic Analysis's National Income and Product Accounts Table 1.1.4, "Price Indexes for Gross Domestic Product"; population adjustment uses U.S. Census Bureau resident population estimates. Figures are expressed in constant FY 2026 dollars and calculated on a fiscal-year basis.
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548. Figures in this paragraph compare the FY 2026–enacted CDC and ATSDR program level with the FY 2027 President's Budget Request, tracking each FY 2026 program to where the FY 2027 request would house it. All figures are at the program level—budget authority plus Prevention and Public Health Fund and Public Health Service evaluation transfers—and are stated in nominal dollars.

The FY 2026 baseline is $9.23 billion: a CDC program level of $9,147,633,000, as reported in the FY 2026 CDC Operating Plan, plus $79.8 million in separately funded ATSDR resources. In FY 2027, ATSDR is proposed for realignment into CDC's new National Center for Chemicals and Toxins, so its proposed $78 million is included within the FY 2027 CDC program level.

The FY 2027 funding requested through CDC for functions historically housed at CDC or ATSDR is $4.78 billion. This figure is derived by subtracting from the $5,484,825,000 CDC program level the three activities proposed for movement into CDC from elsewhere: the National Institute of Environmental Health Sciences, $594,086,000; NIEHS Superfund-Related Activities, $51,814,000; and the National Center for Toxicological Research, $56,307,000. The resulting $4,782,618,000 is $4,444,815,000, or approximately 48 percent, below the FY 2026 CDC-and-ATSDR baseline.

FY 2027 funding requested outside CDC for functions currently housed there totals $1,585,485,000: $1,410,188,000 through AHA and $175,297,000 through the Office of Strategy. This funding offsets approximately 36 percent of the $4.44 billion reduction in resources provided through CDC. Altogether, the proposal would provide approximately $6.37 billion for functions historically housed at CDC and ATSDR—$2.86 billion, or 31 percent, below the FY 2026 baseline.

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609. The percentage changes for these three program areas reflect a functional comparison rather than a direct account-to-account comparison: each FY 2026 program area, as defined in the FY 2026 CDC Operating Plan, is compared with the FY 2027 President's Budget Request for the same functions, wherever the request proposes to house them. Programs realigned between accounts are credited to their originating program area and are assumed to be funded at their FY 2026 levels, so a program that moves without a change in funding registers as no change rather than as a cut to one account and an offsetting increase to another. All figures are at the program level (budget authority plus Prevention and Public Health Fund and Public Health Service evaluation transfers) and are stated in nominal dollars. The three increases are derived as follows.

    Emerging and Zoonotic Infectious Diseases was funded at $781.3 million in FY 2026. The FY 2027 request for the account is $927.8 million, but that total includes $52 million realigned from other program areas—$29 million for Parasitic Diseases and Malaria, credited here to Global Health, and $23 million for Surveillance for Emerging Threats to Mothers and Babies, credited here to Birth Defects, Developmental Disabilities, Disability and Health. Excluding those realigned-in funds, FY 2027 funding for the account's own programs is approximately $875.8 million, an increase of about 12 percent from FY 2026.

    Public health scientific services was funded at $767.5 million in FY 2026. The FY 2027 CDC account would receive $704.6 million, but that total includes activities realigned from other program areas and credited here to their FY 2026 origins: approximately $30 million in forecasting and data-modernization activities from Public Health Preparedness and Response, and Disease Risk Factor Surveillance, which the request would retain within CDC rather than transfer to AHA with the remainder of the chronic disease portfolio. Because the request does not separately itemize funding for Disease Risk Factor Surveillance, this analysis treats the full $29.5 million increase in Surveillance, Epidemiology, and Informatics as funding for that incoming activity. Excluding both realignments leaves approximately $645.1 million for the account's own functions. Separately, the Health Statistics function—funded at approximately $175.3 million—would move to the HHS Office of Strategy. Counting the account's own functions and the relocated Health Statistics function together, FY 2027 funding would total approximately $820.4 million, an increase of about 7 percent from FY 2026. The increase is driven by expanded funding for public health data modernization through a PHS Evaluation Transfer, partly offset by a reduction in Health Statistics.

    Immunization and Respiratory Diseases is a direct account-to-account comparison, unaffected by realignments: $913.3 million in FY 2026 and $963.3 million in FY 2027, an increase of about 5 percent from FY 2026. Because this figure is nominal, it does not account for inflation.

610. Centers for Disease Control and Prevention. "FY 2026 Operating Plan." U.S. Department of Health and Human Services, 2026. https://www.cdc.gov/budget/documents/fy2026/FY-2026-CDC-Operating-Plan.pdf. Accessed July 6, 2026.

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612. CDC's FY 2027 request for the Global Health account is $663.843 million, level with the comparably adjusted FY 2026 level of $663.843 million—a change of zero. "Comparably adjusted" refers to the FY 2026 figure restated to reflect the request's proposed realignment of Parasitic Diseases and Malaria into the Emerging Infectious Diseases line; on the unadjusted FY 2026 CDC Operating Plan basis, the Global Health account was approximately $692.8 million, and the roughly $29 million difference is the Parasitic Diseases and Malaria work, which remains within CDC but in a different account. On this comparable basis, every program line within the account is held flat from FY 2026 to FY 2027.

613. Centers for Disease Control and Prevention. "FY 2026 Operating Plan." U.S. Department of Health and Human Services, 2026. https://www.cdc.gov/budget/documents/fy2026/FY-2026-CDC-Operating-Plan.pdf. Accessed July 6, 2026.

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615. The 43 percent figure is calculated on a functional basis, rather than as a direct account-to-account comparison. In the FY 2026 CDC Operating Plan, Public Health Preparedness and Response was funded at approximately $913.2 million. In the FY 2027 request, the Public Health Preparedness and Response account is funded at $489.0 million. However, the FY 2027 request proposes to move the Ready Response Enterprise Data Integration Platform and Forecasting and Outbreak Analytics activities from Public Health Preparedness and Response into Public Health Data Modernization within Public Health Scientific Services. For this functional comparison, those data and forecasting activities are credited back to Public Health Preparedness and Response at their FY 2026 level of approximately $30.0 million, producing a comparable FY 2027 total of approximately $519.0 million. The resulting change is a decline of approximately 43 percent ($519.0 million ÷ $913.2 million - 1 = -43.2 percent).

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621. Ibid.

622. Ibid.

623. The proposed National Center for Chemicals and Toxins would consolidate, within CDC, the National Center for Environmental Health (NCEH), the National Institute for Occupational Safety and Health (NIOSH), and ATSDR, together with the National Institute of Environmental Health Sciences (NIEHS, formerly of NIH) and the National Center for Toxicological Research (NCTR, formerly of FDA). The FY 2027 request for the consolidated center is $1,034.757 million, compared with a combined FY 2026 program level of $1,752.287 million for the same programs—a reduction of $717.530 million, or about 41 percent (on a budget-authority basis, excluding the $51 million in Prevention and Public Health Fund support the programs received in FY 2026, the reduction is $666.530 million, or about 39 percent). The decline is distributed across every component: NIEHS, $913.979 million to $594.086 million (-35 percent); NIEHS Superfund activities, $77.100 million to $51.814 million (-33 percent); NCTR, $71.758 million to $56.307 million (-22 percent); ATSDR, $79.800 million to $78.000 million (-2 percent); NIOSH, $366.800 million to $92.200 million (-75 percent); and NCEH, $242.850 million to $162.350 million (-33 percent). These six lines sum to the center totals in both years ($913.979 million + $77.100 million + $71.758 million + $79.800 million + $366.800 million + $242.850 million = $1,752.287 million in FY 2026; $594.086 million + $51.814 million + $56.307 million + $78.000 million + $92.200 million + $162.350 million = $1,034.757 million in FY 2027).

    The occupational safety and health figure ($92.200 million ÷ $366.800 million - 1 = -74.9 percent) and the environmental health figure ($162.350 million ÷ $242.850 million - 1 = -33.1 percent) are derived rather than published as center-level totals: the FY 2027 request does not break out NCEH and NIOSH as discrete subtotals within the consolidated center. The NIOSH figure of $92.2 million and the NCEH figure of $162.35 million are the sum of their respective FY 2027 program lines. All figures are stated in nominal dollars.

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628. The 62 percent figure is calculated as a functional comparison that tracks CDC-originating HIV/AIDS, Viral Hepatitis, STI, and Tuberculosis Prevention activities to their proposed FY 2027 funding source. In the FY 2026 CDC Operating Plan, the HIV/AIDS, Viral Hepatitis, STI, and TB Prevention account was funded at $1.4 billion, including $1.0 billion for Domestic HIV/AIDS Prevention and Research and $370.3 million for viral hepatitis, STI, tuberculosis, and infectious diseases/opioid-related activities. In the FY 2027 request, the viral hepatitis, STI, and tuberculosis activities that remain at CDC are consolidated into a $300.0 million Hepatitis, STI, and Tuberculosis Prevention Grant, while $220.0 million for Ending the HIV Epidemic activities formerly carried out by CDC is proposed under AHA. The comparable FY 2027 total is therefore $520.0 million, a decrease of $864.1 million, or approximately 62 percent ($520.0 million ÷ $1,384.1 million - 1 = -62.4 percent). Within that total, CDC-originating Domestic HIV/AIDS Prevention and Research funding would fall from $1.0137 billion in FY 2026 to $220.0 million in FY 2027, a decrease of $793.7 million, or approximately 78 percent. Figures are program-level amounts and are stated in nominal dollars.

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