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Pandemic and All-Hazards Preparedness Act: An Overview

In 2006, the Pandemic and All-Hazards Preparedness Act (PAHPA; P.L. 109-417) authorized a suite of programs and authorities within the Department of Health and Human Services (HHS) to focus on public health emergency preparedness and response. Congress has reauthorized PAHPA twice, in 2013 (P.L. 113-5) and in 2019 (P.L. 116-22), both times with changes prompted by preceding public health emergencies. Many existing PAHPA provisions expired in September 2023. Congress has temporarily extended several provisions until September 30, 2025 (P.L. 119-4) and previously deliberated a reauthorization.

Two HHS agencies administer most PAHPA-authorized programs: (1) the Administration for Strategic Preparedness and Response (ASPR), which leads the nation's public health and medical response to emergencies, and (2) the Centers for Disease Control and Prevention (CDC), a leading agency for disease control and prevention and for addressing public health threats. The Trump Administration has proposed significant changes to PAHPA-authorized programs in its FY2026 budget by proposing to eliminate certain ASPR programs and to move other ASPR programs to the CDC and to a new Assistant Secretary for a Healthy Future. Certain proposals may require statutory changes to take effect.

What Is Public Health Emergency Management?

Many types of emergencies involve a *public health* and *medical* response component. To illustrate, during a natural disaster, public health agencies might monitor associated health effects while medical responders coordinate emergency medical services. Alternately, some types of emergencies, such as certain emerging infectious disease outbreaks or bioterrorism events, have a primary impact on human health. Public health emergency management involves a set of specific capabilities tailored to health threats, for example, detection capabilities to identify and monitor new health threats; systems to rapidly develop, regulate, and distribute medical products to address health threats (e.g., vaccines, treatments); policies and systems to manage surges in demand for medical care and supplies; potential use of quarantine and isolation authorities; and leadership and communication functions focused on health.

Under the National Response Framework (NRF), HHS coordinates the public health and medical aspects of federal emergency response. As with U.S. emergency management generally, state, local, tribal, and territorial (SLTT) governments are to lead public health emergency preparedness and response efforts in their communities. Federal agencies generally assist when SLTT communities are overwhelmed, need additional expertise and/or federal assets, or when an emergency spans many jurisdictions and prompts a coordinated federally led response. HHS agencies have programs and authorities tailored to the unique needs and challenges posed by public health emergencies—many authorized in PAHPA.

PAHPA: An Overview

Though PAHPA has changed throughout its history, the law has generally focused on a set of policy categories. The following highlights some key provisions within each category:

Leadership, strategy, and planning. In 2006, PAHPA statutorily established that HHS is to lead federal public health and medical response under the NRF. The law also reauthorized and renamed the position of the Assistant Secretary for Preparedness and Response to serve as principal advisor for HHS emergency response. PAHPA required the quadrennial publication of the National Health Security Strategy (NHSS), wherein HHS anticipates health emergency challenges and its planned approach.

SLTT emergency capacity. PAHPA has reauthorized two grant programs focused on supporting SLTT public health and medical emergency response capacity: (1) the CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement and (2) the ASPR's Hospital Preparedness Program (HPP). In addition, PAHPA has included related authorities. For example, the 2013 law amended the public health emergency (PHE) declaration authority (Public Health Service Act, PHSA §319) to allow for temporary assignment of some state and local personnel during PHEs.

Medical countermeasures. PAHPA has included a suite of programs and authorities aimed at enabling the development, regulation, availability, and distribution of *medical countermeasures* (MCMs). MCMs are medical products that may be used to mitigate, treat, prevent, or diagnose conditions associated with emerging infectious diseases or chemical, biological, radiological, or nuclear (CBRN) agents. For example, the 2006 law established the Biomedical Advanced Research and Development Authority (BARDA) within ASPR to focus on MCM late-stage development, manufacturing, and purchase. In addition, the 2013 law added a title focused on FDA authorities and activities related to MCMs.

Medical response programs. PAHPA authorizes several ASPR medical response programs, such as the National Disaster Medical System, which provides medical personnel, equipment, and other support when requested by states. In addition, the Strategic National Stockpile (SNS) consists of medical products and ancillary supplies that can be deployed to SLTT jurisdictions. The SNS includes products tailored to specific health threats (e.g., smallpox

vaccines) and general medical supplies (e.g., personal protective equipment).

Infectious disease and biothreat programs. PAHPA has formally authorized biosurveillance and laboratory capabilities to detect and monitor health threats, as well as a national situational awareness network to integrate data on health threats and emergencies from state-level systems. In addition, PAHPA has reauthorized several CDC infectious disease programs, such as the Epidemiology and Laboratory Capacity grant program (which predated PAHPA).

Support for at at-risk populations. PAHPA has included provisions aimed at protecting at-risk individuals during PHEs, for example, authorizations for national advisory committees focused on protecting children, seniors, and individuals with disabilities respectively.

Most, but not all, provisions in PAHPA have amended the Public Health Service Act (PHSA), especially PHSA Titles III and XXVIII. Several provisions amended the Federal Food, Drug, and Cosmetic Act (FFDCA).

Expiring and Expired Provisions

Many provisions from the 2019 reauthorization expired in September 2023 or earlier. For the most part, these were authorizations of discretionary appropriations. Congress continued to fund several of these programs (e.g., PHEP, HPP) in FY2024 (P.L. 118-47). The FY2025 Continuing Resolution (P.L. 119-4) appropriated most HHS funding at FY2024 levels, though the precise FY2025 allocations for certain PAHPA-authorized programs remain unclear.

Some PAHPA provisions effectively expire at certain sunset dates. These include, for example, the authority for temporary reassignment of certain state and local personnel during declared PHEs and authorizations for several national advisory committees for at-risk populations. Most recently, P.L. 119-4 temporarily extended seven provisions, setting sunset dates of September 30, 2025.

Brief Legislative History

Congress and the executive branch established public health emergency authorities and programs prior to PAHPA. For example, a version of the federal PHE declaration authority in PHSA Section 319 dates back to 1983 (P.L. 98-49). As another example, CDC was established administratively in 1946 to help respond to disease outbreaks. Thus, when PAHPA was enacted in 2006, HHS already had many existing public health emergency programs and authorities.

PAHPA built upon two earlier laws that addressed HHS public health emergency policy and programs in 2000 (P.L. 106-505) and 2002 (P.L. 107-188). Several developments led to the 2006 law (summarized in S.Rept. 109-319). First, the entire federal homeland security and emergency management system saw transformations following the 9/11 terrorist attacks and 2005 hurricane season. Key reforms included the establishment of the Department of Homeland Security and the NRF to better centralize and coordinate federal emergency response. PAHPA helped formalize HHS's role within this broader federal response framework. Second, concerns about a potential avian influenza pandemic in 2005 prompted many assessments of U.S. public health emergency preparedness and capacity, which found that SLTT public health departments were unprepared to quickly detect and respond to potentially deadly infectious disease outbreaks.

As noted, PAHPA was reauthorized twice with incident-related modifications. In 2013, the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA; P.L. 113-5) was preceded by the H1N1 influenza pandemic in 2010, which primarily affected children. The law therefore included several new provisions aimed at meeting pediatric medical needs during emergencies, among other changes. In 2019, the Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAIA; P.L. 116-22) was preceded by outbreaks of Ebola virus (2014-2015, before and after) and Zika virus (2015-2017), and thus included provisions aimed at infectious disease threats, including newly incorporated reauthorizations of several CDC infectious disease programs.

While not a full PAHPA reauthorization, the PREVENT Pandemics Act (P.L. 117-328, Division FF, Title II) enacted in 2022 amended several provisions included in prior PAHPA reauthorizations and included new authorizations for public health emergency programs. The COVID-19 pandemic had raised many challenges, such as those related to emergency coordination, supply chains, and data systems. In response, HHS agencies had established new capabilities as funded by COVID-19 supplemental appropriations, for example, CDC's outbreak forecasting programs and ASPR's supply chain programs. ASPR's role within HHS was also elevated. The PREVENT Pandemics Act codified some of these new programs in law.

Consideration of Reauthorization

In the 118th Congress, committees passed multiyear PAHPA reauthorizations. The Senate committee-reported bill (S. 2333) would have addressed diverse issues, including, but not limited to, drug shortages, vaccine injury compensation, and laboratory biosafety and biosecurity. The House committee took a narrower approach in two committee-passed bills for CDC (H.R. 4420) and for ASPR (H.R. 4421). These bills mostly proposed reauthorized prior PAHPA programs for four years with some new planning, oversight, and reporting requirements. Congressional debate centered on the appropriate scope of topics for PAHPA reauthorization. For example, House committee majority leaders did not consider FDA drug shortage issues in scope during the bills' markups. In December 2024, introduced text for a FY2025 continuing resolution (CR) included PAHPA reauthorization language (H.R. 10445) reflecting aspects of the House and Senate committee bills. Ultimately, the PAHPA reauthorization was not included in the final enacted December 2024 CR text (P.L. 118-158).

In light of FY2026 proposals to eliminate or restructure certain PAHPA-authorized programs and the agencies that administer them, the 119th Congress faces whether to adopt these proposals and whether to revisit PAHPA amid current and future health threats.

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