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Overview of COVID-19 LHHS Supplemental Appropriations: FY2020 and FY2021

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SUMMARY

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Overview of COVID-19 LHHS Supplemental Appropriations: FY2020 and FY2021

The legislative response to the global pandemic of Coronavirus Disease 2019 (COVID-19) has included the enactment of laws to provide authorities and supplemental funding to prevent, prepare for, and respond to the pandemic. This report focuses on supplemental FY2020 and FY2021 discretionary appropriations provided to programs and activities traditionally funded by the Departments of Labor, Health and Human Services, and Education, and Related Agencies (LHHS) appropriations bill. For a discussion of those appropriations for FY2020 only, see CRS Report R46353, *COVID-19: Overview of FY2020 LHHS Supplemental Appropriations*.

As of the date of this report, LHHS supplemental discretionary appropriations for COVID-19 response have been provided in five separate supplemental appropriations measures (four for FY2020 and one for FY2021):

- Title III, Division A, of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), enacted on March 6, 2020, provided approximately $6.4 billion in supplemental LHHS funds.
- Title V, Division A, of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), enacted on March 18, 2020, provided $1.25 billion in supplemental LHHS funds.
- Title VIII, Division B, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), enacted on March 27, 2020, provided $172.1 billion in supplemental LHHS funds.
- Title I, Division B, of the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139), enacted on April 24, 2020, provided $100 billion in supplemental LHHS funds.
- Title III, Division M, of the Consolidated Appropriations Act, 2021 (FY2021 CAA, P.L. 116-260), enacted on December 27, 2020, provided $154.9 billion in supplemental LHHS funds.

In total, LHHS received roughly $435 billion in supplemental discretionary appropriations from these COVID-19 response measures. These supplemental funds are *in addition to* roughly $195 billion in regular FY2020 LHHS discretionary appropriations enacted in P.L. 116-94 prior to these supplemental appropriations measures, and $200 billion in regular FY2021 LHHS discretionary appropriations enacted in Division H of the FY2021 CAA. Unlike the annual discretionary appropriations, however, these additional funds were designated as an "emergency requirement" and thus were effectively exempted from otherwise applicable budget enforcement requirements (such as the statutory discretionary spending limits). Overall, the COVID-19 supplemental funds increased FY2020 LHHS discretionary appropriations by approximately 143%, and FY2021 LHHS discretionary appropriations by approximately 77%.

The Department of Health and Human Services (HHS) received funding in all five COVID-19 supplemental appropriations acts. The Department of Education (ED) received funding in the third and fifth supplementals, while the Department of Labor (DOL) and entities funded under the "Related Agencies" heading received funding in the third supplemental only. In total, HHS received $321 billion, or 73.8% of all COVID-19 LHHS supplemental appropriations. ED received the second-largest share at $113 billion, or 26.0%. DOL and Related Agencies (as a whole) received approximately 0.1% apiece of the LHHS COVID-19 supplemental funds.

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Introduction

The pandemic of Coronavirus Disease 2019 (COVID-19), the worst U.S. public health emergency in more than a century, has elicited extraordinary effort across all levels of government and sectors of society. Federal response efforts have included the enactment of laws to provide authorities and supplemental funding to prevent, prepare for, and respond to the pandemic. This report focuses on supplemental FY2020 and FY2021 discretionary appropriations provided to programs and activities traditionally funded by the Departments of Labor, Health and Human Services, and Education, and Related Agencies (LHHS) appropriations bill.[3] For a discussion of those appropriations for FY2020 only, see CRS Report R46353, *COVID-19: Overview of FY2020 LHHS Supplemental Appropriations*.

Scope of the LHHS Appropriations Act

- the Department of Labor;
- most agencies at the Department of Health and Human Services, except for the Food and Drug Administration (FDA, funded through the Agriculture appropriations bill), the Indian Health Service (IHS, funded through the Interior-Environment appropriations bill), and the Agency for Toxic Substances and Disease Registry (ATSDR, funded through the Interior-Environment appropriations bill);[1]
- the Department of Education; and
- more than a dozen related agencies, including the Social Security Administration, the Corporation for National and Community Service, the Corporation for Public Broadcasting, the Institute of Museum and Library Services, the National Labor Relations Board, and the Railroad Retirement Board.[2]

As of the date of this report, LHHS supplemental discretionary appropriations for COVID-19 response have been provided in five separate supplemental appropriations measures (four for FY2020 and one for FY2021):

- Title III, Division A, of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), enacted on March 6, 2020, provided $6.4 billion in supplemental LHHS funds.
- Title V, Division A, of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127), enacted on March 18, 2020, provided $1.25 billion in supplemental LHHS funds.
- Title VIII, Division B, of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136), enacted on March 27, 2020, provided $172.1 billion in supplemental LHHS funds.
- Title I, Division B, of the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA, P.L. 116-139), enacted on April 24, 2020, provided $100 billion in supplemental LHHS funds.

[1] COVID-19-related supplemental funding appropriated to the FDA and IHS is not discussed in this report. For information on the IHS supplemental funding, see CRS Insight IN11333, *COVID-19 and the Indian Health Service*.

[2] For a detailed description of the scope of the LHHS appropriations act and a summary of FY2020 appropriations, see CRS Report R46492, *Labor, Health and Human Services, and Education: FY2020 Appropriations*. For a summary of FY2021 appropriations, see CRS Report R46457, *Status of FY2021 Labor, Health and Human Services, and Education Appropriations: In Brief*.

[3] Appropriations acts both provide and control *discretionary spending*. While appropriations acts may also provide some mandatory spending (often referred to as *appropriated mandatory spending*), this spending generally is not the focus of appropriations decision-making because it is controlled elsewhere (in authorizing laws). Consequently, the focus of this report is only the discretionary spending provided by the COVID-19 supplemental appropriations acts.

- Title III, Division M, of the Consolidated Appropriations Act, 2021 (FY2021 CAA, P.L. 116-260), enacted on December 27, 2020, provided $154.9 billion in supplemental LHHS funds.

In total, LHHS has received roughly $435 billion in supplemental discretionary appropriations from these COVID-19 response measures.[4] These funds are *in addition to* roughly $195 billion in *regular* FY2020 LHHS discretionary appropriations enacted in P.L. 116-94 prior to these supplemental appropriations measures, and $200 billion in regular FY2021 LHHS discretionary appropriations enacted in Division H of the FY2021 CAA.[5] Unlike the regular discretionary appropriations, however, these additional supplemental funds were designated as an "emergency requirement" and thus were effectively exempted from otherwise applicable budget enforcement requirements (such as the statutory discretionary spending limits).[6] Overall, the COVID-19 supplemental funds have increased FY2020 LHHS discretionary appropriations by approximately 143%, and FY2021 LHHS discretionary appropriations by approximately 77%.[7]

COVID-19-Related Funding Elsewhere

Several of the laws noted above include divisions that provided regular annual appropriations (both mandatory and discretionary) for LHHS accounts and activities. These regular annual funds are not included in this report, as they were not appropriated to prevent, prepare for, or respond to COVID-19. In addition, several of these laws contained mandatory appropriations to certain LHHS-related accounts for COVID-19 response. These mandatory appropriations were provided in divisions of law considered to be authorizing legislation, not appropriations acts. As such, these mandatory funds are beyond the scope of this report. Mandatory funds provided for COVID-19-related activities in the American Rescue Plan Act (P.L. 117-2) are excluded from this report for the same reason.

[4] This total was calculated by the Congressional Research Service based on amounts specified for supplemental appropriations in the applicable division of each COVID-19 response measure listed above. This total excludes funds provided to LHHS agencies and activities in other divisions of these laws, including emergency-designated funds provided in regular appropriations acts and mandatory appropriations. In addition, this total also excludes a supplemental appropriation of $210 million for the Department of Labor that was provided in Title IX of the United States-Mexico-Canada Agreement (USMCA) Supplemental Appropriations Act, 2019 (P.L. 116-113). These are excluded because they were not provided to prevent, prepare for, or respond to the COVID-19 pandemic.

[5] For consistency, these amounts (like the amount shown for COVID-19 supplemental appropriations) are based on total funds provided in the acts, not total funds available for the fiscal year. In addition, these amounts have not been adjusted for certain scorekeeping conventions of the Congressional Budget Office. For FY2020, this amount is drawn from the explanatory statement accompanying the FY2020 LHHS omnibus (P.L. 116-94), available in the *Congressional Record*, daily edition, vol. 165, no. 204, Book III (December 17, 2019), p. H11159. For FY2021, this amount is drawn from the explanatory statement accompanying the FY2021 CAA (P.L. 116-260), available in the *Congressional Record*, daily edition, vol. 166, no. 218, Book IV (December 21, 2020), p. H8710. Note that in addition to annual discretionary appropriations, the vast majority of LHHS funding in both of these appropriations laws is mandatory spending for certain programs and activities. As previously noted, mandatory appropriations are generally beyond the scope of this report.

[6] For further information about the emergency requirements designation, see CRS Report R45778, *Exceptions to the Budget Control Act's Discretionary Spending Limits*.

[7] For further information on FY2020 and FY2021 regular LHHS appropriations, see CRS Report R46492, *Labor, Health and Human Services, and Education: FY2020 Appropriations*, and CRS Report R46457, *Status of FY2021 Labor, Health and Human Services, and Education Appropriations: In Brief*.

Legislative History

The relevant legislative history of each of the five enacted laws containing LHHS supplemental appropriations is detailed below.

FY2020

P.L. 116-123 (H.R. 6074), Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020

In the weeks leading up to the supplemental appropriations action in Congress, Alex Azar, the Secretary of the U.S. Department of Health and Human Services (HHS), took administrative steps to allocate existing funding to COVID-19 response efforts. These included issuing a determination on January 25, 2020, allowing the allotment of $105 million from the Infectious Diseases Rapid Response Reserve Fund (IDRRRF).[8] He also reportedly informed Congress on February 2 that he would potentially exercise his authority to transfer $136 million in existing funds within HHS to increase the budgetary resources of several operating divisions and offices that were tasked with COVID-19 response.[9] In response, the Chair of the House Appropriations Committee, Representative Nita Lowey, and the Chair of the LHHS Subcommittee, Representative Rosa DeLauro, sent the Secretary a letter expressing concern that budgetary resources available to HHS at that time would not be sufficient.[10]

On February 24, 2020, the Trump Administration sent Congress a request for supplemental appropriations of $1.25 billion for the Public Health and Social Services Emergency Fund (PHSSEF) at HHS.[11] The request letter included a number of other proposals, largely but not exclusively related to re-purposing existing funds toward response efforts. All told, the Administration estimated needing to allocate approximately $2.5 billion toward COVID-19 response efforts. (For the most part, amounts for other LHHS aspects of the request generally were unspecified in the publicly released request letter.)[12]

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[8] CQ Newsmaker Transcripts, "Health and Human Services Secretary Azar Holds News Conference on Coronavirus," January 28, 2020, https://plus.cq.com/doc/newsmakertranscripts-5822133?8&searchId=XGVQS7c5. Authority for the IDRRRF, administered by the Director of the Centers for Disease Control and Prevention (CDC), is codified at 42 U.S.C. 247d-4a.

[9] Yasmeen Abutaleb and Erica Werner, "HHS Notifies Congress that It May Tap Millions of Additional Dollars for Coronavirus Response," *Washington Post*, February 3, 2020, https://www.washingtonpost.com/health/2020/02/03/hhs-notifies-congress-it-may-tap-millions-additional-dollars-coronavirus-response/. For additional background on early funding steps taken by the Administration, see CRS Insight IN11212, *Another Coronavirus Emerges: U.S. Domestic Response to 2019-nCoV*; and CRS Report R46219, *Overview of U.S. Domestic Response to Coronavirus Disease 2019 (COVID-19)*.

[10] Letter from Representative Nita M. Lowey, Chair, House Appropriations Committee, and Representative Rosa DeLauro, Chair, LHHS Subcommittee, to Alex Azar, HHS Secretary, February 4, 2020, https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/Lowey-DeLauro%20Ltr%20-%20Azar%20-%202.4.20.pdf).

[11] The PHSSEF is an account used by the HHS Secretary for one-time or short-term funding such as emergency supplemental appropriations, and for some ongoing public health preparedness activities.

[12] Letter from Russell T. Vought, Acting Director, Office of Management and Budget (OMB), to Vice President Michael Pence, February 24, 2020, https://www.whitehouse.gov/wp-content/uploads/2020/02/Coronavirus-Supplemental-Request-Letter-Final.pdf.

Several days after the Administration's request, the Chair of the House Appropriations Committee introduced H.R. 6074 on March 4, 2020. The measure passed the House that same day by a vote of 415-2, passed the Senate on March 5 by a vote of 96-1, and was signed into law (P.L. 116-123) on March 6.[13]

According to the Congressional Budget Office (CBO), P.L. 116-123 provided a total of $7.8 billion in supplemental appropriations in Division A, of which roughly $6.4 billion (about 83%) was for LHHS accounts and activities.[14] (Division B contained authorization provisions related to certain LHHS programs and activities—providing the HHS Secretary authority to temporarily waive or modify the application of certain Medicare requirements with respect to telehealth services.[15] The mandatory spending budgetary effects of these provisions are outside the scope of this report.)

P.L. 116-127 (H.R. 6201), Families First Coronavirus Response Act (FFCRA)

A second COVID-19 response measure was developed by Congress and the Administration soon after the first was enacted. Initially, H.R. 6201 was introduced by the Chair of the House Appropriations Committee on March 11, 2020.[16] The House amended and passed the measure by a vote of 363-40 on March 14, but further alterations to the final legislative package were negotiated over the next two days.[17] On March 16, the House (by unanimous consent) considered and agreed to a resolution (H.Res. 904) that directed the Clerk to make changes to the legislation when preparing the final, official version of the House-passed bill (*engrossment*). The engrossed version was sent to the Senate and ultimately passed without amendment by a vote of 90-8 on March 18. President Trump signed the bill into law (P.L. 116-127) the same day.[18]

Division A of P.L. 116-127 was estimated by CBO to provide a total of $2.5 billion in supplemental appropriations, of which $1.25 billion (approximately 51%) was for LHHS accounts and activities.[19] (Other divisions of the act contained authorization provisions that in some cases relate to LHHS programs and activities—for instance, provisions providing a 6.2% increase to the federal matching assistance percentage for Medicaid and certain other programs.[20] The mandatory spending budgetary effects of such provisions are outside scope of this report.)

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[13] A summary of provisions is provided in CRS Report R46285, *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123): First Coronavirus Supplemental*.

[14] Congressional Budget Office (CBO), *Discretionary Spending Under Division A, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020*, March 4, 2020, https://www.cbo.gov/system/files/2020-03/hr6074.pdf.

[15] For further information, see CRS Report R46239, *Telehealth and Telemedicine: Frequently Asked Questions*.

[16] For a summary of the measure, see House Appropriations Committee, H.R. 6201, *FAMILIES FIRST CORONAVIRUS RESPONSE ACT, Title-By-Title Summary*, March 11, 2020, https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/Families%20First%20Summary%20FINAL.pdf.

[17] For background, see John Bresnahan and Marianne Levine, "Senate to take up coronavirus package after House passes revised bill," *Politico*, March 16, 2020, https://www.politico.com/news/2020/03/16/senate-coronavirus-emergency-package-131465. See also "DIRECTING THE CLERK OF THE HOUSE OF REPRESENTATIVES TO MAKE CORRECTIONS IN THE ENGROSSMENT OF H.R. 6201," *Congressional Record*, daily edition, vol. 166, no. 50 (March 16, 2020), pp. H1698-H1707.

[18] CRS Reports on FFCRA are available on Congress.gov at https://www.congress.gov/bill/116th-congress/house-bill/6201.

[19] CBO, *Preliminary Estimate of the Effects of* H.R. 6201, *the Families First Coronavirus Response Act*, April 2, 2020, p. 18, https://www.cbo.gov/system/files/2020-04/HR6201.pdf.

[20] See Division F, Section 6008 of the Families First Coronavirus Response Act (P.L. 116-127). For background on the federal matching assistance percentage for Medicaid, see CRS Report R43847, *Medicaid's Federal Medical Assistance*

P.L. 116-136 (H.R. 748), Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

On March 17, 2020, the Administration released a second request for FY2020 supplemental appropriations of $45.8 billion for COVID-19 response, of which $11.1 billion was for LHHS accounts and activities.[21]

Over the next several days, Congress and the Administration negotiated the scope and scale of this legislative response, which was expected to involve authorities and additional funding for numerous programs across the federal government. The legislative vehicle that was ultimately chosen for this package was H.R. 748, an unrelated measure that had been passed previously by the House.[22] Prior to when a deal was reached between Congress and the Administration, the Senate voted on March 22 (47-47) and March 23 (49-46) not to invoke cloture on the motion to proceed to H.R. 748.[23] The measure was ultimately laid before the Senate by unanimous consent and passed with a substitute amendment by a vote of 96-0 on March 25. The House subsequently took up the Senate amendment on March 27, and agreed to it by a voice vote. The bill was signed into law (P.L. 116-136) by President Trump that same day.[24]

According to CBO, P.L. 116-136 provided about $330 billion in supplemental appropriations in Division B, of which $172.1 billion (approximately 57%) was for LHHS accounts and activities.[25] (Division A contained authorization provisions that in some cases relate to LHHS programs and activities—for instance, $1.320 billion in mandatory funds for the HRSA health centers program.[26] The mandatory spending budgetary effects of such provisions are outside the scope of this report.)

Percentage (FMAP). For information on FMAP increases, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*. See also CRS Insight IN11297, *Federal Medical Assistance Percentage (FMAP) Increase for Title IV-E Foster Care and Permanency Payments*.

[21] With regard to LHHS, the letter also explained that the Administration was seeking to amend its FY2021 budget request for CDC and NIH to provide them additional budgetary resources and authorities. Letter from Russell T. Vought, Acting Director, Office of Management and Budget (OMB), to Vice President Michael Pence, March 17, 2020, https://www.whitehouse.gov/wp-content/uploads/2020/03/Letter-regarding-additional-funding-to-support-the-United-States-response-to-COVID-19-3.17.2020.pdf.

[22] Prior to when H.R. 748 was determined to be the vehicle for the third COVID-19 response measure, the Senate Majority Leader, Senator McConnell, introduced a proposal on March 19, 2020, that did not include supplemental appropriations (S. 3548). Four days later, on March 23, 2020, the House Appropriations Committee Chair introduced a proposal (H.R. 6379) that did include supplemental appropriations (including for LHHS).

[23] The Senate Appropriations Committee released a summary of the supplemental appropriations in the measure (Senate Appropriations Committee, *$340 Billion Surge in Emergency Funding to Combat Coronavirus Outbreak*, March 25, 2020, https://www.appropriations.senate.gov/imo/media/doc/Coronavirus%20Supplemental%20Appropriations%20Summary_FINAL.pdf.)

[24] CRS reports on the CARES Act are available on Congress.gov at https://www.congress.gov/bill/116th-congress/house-bill/748 and https://www.congress.gov/bill/116th-congress/senate-bill/3548.

[25] The total amount of supplemental appropriations in Division B is from CBO, *Preliminary Estimate of the Effects of* H.R. 748, *the CARES Act*, P.L. 116-136, April 16, 2020, p. 35, https://www.cbo.gov/system/files/2020-04/hr748.pdf. The total amount of LHHS supplemental appropriations in Division B was calculated by CRS (see Table 2 of this report).

[26] See Title III, Division A, Section 3211 of the CARES Act (P.L. 116-136). For background on the HRSA health centers program, see CRS Report R43937, *Federal Health Centers: An Overview*.

P.L. 116-139 (H.R. 266), Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA)

About three weeks after the enactment of the CARES Act, Congress and President Trump came to an agreement that, among other provisions, provided additional supplemental appropriations to HHS for the Provider Relief Fund and to support COVID-19 testing. The legislative vehicle that was used for the agreement was H.R. 266, an unrelated appropriations bill that had been passed previously by the House. On April 21, 2020, the measure was laid before the Senate by unanimous consent and passed with a substitute amendment by voice vote. The House adopted the Senate version of the proposal on April 23 by a vote of 388-5.[27] President Trump signed the bill into law (P.L. 116-139) the following day.[28]

According to CBO, P.L. 116-139 provided $162.1 billion in supplemental appropriations in Division B, of which $100 billion (approximately 62%) was for LHHS.[29] (Division A contained no provisions related to LHHS programs and activities. The mandatory spending budgetary effects of the authorization provisions in Division A are outside the scope of this report.)

FY2021

P.L. 116-260 (H.R. 133), Consolidated Appropriations Act, 2021 (FY2021 CAA)

While annual appropriations for FY2021 were under discussion during the summer and fall of 2020, Congress and President Trump considered whether any additional COVID-19 response funding should be enacted in separate supplemental appropriations measures or packaged with the FY2021 annual funding. In addition, policymakers had the option of making further COVID-19 response funding subject to the limit on FY2021 nondefense discretionary spending, or providing that funding instead as emergency appropriations (effectively exempt from that limit).[30] Ultimately, additional FY2021 appropriations for COVID-19 relief were enacted as part of the FY2021 CAA. (Regular FY2021 LHHS annual appropriations were provided in Division H; emergency supplemental funding was provided in Division M.) On December 21, 2020, the final version of the FY2021 CAA was approved by the House. (The vote to approve the portion that contained Division M was 359-53.[31]) The measure was approved by the Senate (92-6) later that same day, and signed into law (P.L. 116-260) by President Trump on December 27.

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[27] House Committee on Appropriations, H.R. 622, Paycheck Protection Program and Health Care Enhancement Act Division B – Additional Emergency Appropriations for Coronavirus Response, April 21, 2020, https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/Interim%20Emergency%20Package%20Funds%20Hospitals%2C%20Health%20Workers%20and%20Testing.pdf.

[28] See CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief*.

[29] CBO, CBO Estimate for H.R. 266, the Paycheck Protection Program and Health Care Enhancement Act as Passed by the Senate on April 21, 2020, April 22, 2020, https://www.cbo.gov/system/files/2020-04/hr266.pdf.

[30] Prior to the enactment of full-year FY2021 LHHS funding, COVID-19-related LHHS provisions were proposed in several different appropriations measures for FY2021, including the House-passed full-year LHHS bill (Division E, H.R. 7617), a supplemental appropriations package (Division A, H.R. 925), and the FY2021 continuing resolution (Division A, P.L. 116-159). While in some cases the budgetary effects of the COVID-19-related provisions were designated as an emergency requirement, that was not the case universally.

[31] The special rule, H.Res. 1271, provided for the consideration of an amendment consisting of the FY2021 CAA (as contained in House Rules Committee Print 116-68) to the Senate amendment to H.R. 133. H.Res. 1271 also provided for the House to adopt the amendment in two votes: the first on Divisions B, C, E, and F; and the second on the remaining divisions. The House adopted Divisions B, C, E, and F by a vote of 327-85, and adopted the remaining divisions by a vote of 359-53. The subsequent motion that the House agree to the Senate amendment with an

According to CBO, P.L. 116-260 provided about $184.3 billion in supplemental appropriations in Division M, of which $155 billion (approximately 84%) was for LHHS accounts and activities.[32] The discretionary and mandatory funding in the other divisions of the FY2021 CAA is outside the scope of this report. (Divisions A-L contained full-year appropriations for all 12 annual appropriations acts.[33] Additional COVID-19 response provisions were enacted in Division N—for instance, $175 million for nutrition services under the Older Americans Act [Sec. 731]—but Division N is considered to be authorizing legislation and, thus, the funding in that division was classified as mandatory spending.[34] Divisions O-FF of the FY2021 CAA contained miscellaneous authorizing provisions that are also beyond the scope of this report.[35])

Funding Overview

As previously mentioned, LHHS has received in total roughly $435 billion in supplemental discretionary appropriations from the COVID-19 response measures (**Table 1**). HHS received funding in all five supplemental appropriations acts, whereas the Department of Education (ED) received funding in only the third and fifth supplementals. The Department of Labor (DOL) and entities funded under the Related Agencies (RAs) heading received funding in only the third supplemental.

HHS received the vast majority of all LHHS COVID-19 supplemental funds—$321 billion, or 73.8%. ED received the second-largest share—$113 billion, or 26.0%. DOL and RAs (as a whole) received approximately 0.1% apiece.

The remainder of this report provides highlights for HHS, DOL, ED, and RAs, and includes a detailed table (**Table 2**) organized by department or agency and by account, program, or activity.

Table 1. Summary of FY2020 and FY2021 LHHS Supplemental Appropriations for COVID-19 Response

(Budget authority in millions of dollars)

	FY2020				FY2021	
	P.L. 116-123 (Div. A)	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)	P.L. 116-260 (Div. M)	Total
DOL	—	—	360	—	—	360
HHS	6,436[a]	1,250	140,389	100,000	72,945	321,020
ED	—	—	30,925	—	82,000	112,925

amendment was agreed to without objection.

[32] The total amount of supplemental appropriations in Division M is from CBO, *Discretionary Spending Under Division M, the Coronavirus Response and Relief Supplemental Appropriations Act, 2021*, December 22, 2020, p. 1, https://www.cbo.gov/publication/56916. The total amount of LHHS supplemental appropriations in Title III of Division M was calculated by CRS (see Table 2 of this report), and does not include funding appropriated in Title III to the Food and Drug Administration (FDA) Salaries and Expenses account, as this funding is generally not under the purview of the LHHS appropriations act.

[33] Full-year LHHS appropriations were enacted in Division H.

[34] For further information, see CBO, H.R. 133, Estimate for Division N—Additional Coronavirus Response and Relief Consolidated Appropriations Act, 2021, January 14, 2021, https://www.cbo.gov/publication/56961.

[35] For further information, see CBO, H.R. 133, *Estimate for Divisions O-FF, Consolidated Appropriations Act, 2021*, January 14, 2021, https://www.cbo.gov/publication/56962.

	FY2020				FY2021	
	P.L. 116-123 (Div. A)	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)	P.L. 116-260 (Div. M)	Total
Related	—	—	430	—	—	430
Total:	**6,436**	**1,250**	**172,104**	**100,000**	**154,945**	**434,735**

Source: Compiled by CRS from amounts specified in P.L. 116-123 (Title III, Division A), P.L. 116-127 (Title V, Division A), P.L. 116-136 (Title VIII, Division B), P.L. 116-139 (Title I, Division B), and P.L. 116-260 (Title III, Division M). This report does not include funding appropriated in Title III (P.L. 116-260, Division M) to the Food and Drug Administration (FDA) Salaries and Expenses account, as this funding is generally not under the purview of the LHHS appropriations act. Funds provided in other titles and divisions of these laws are beyond the scope of this report and are excluded from the table. (For instance, the table does not include the $1.320 billion in mandatory funds for the HRSA health centers program provided in Title III, Division A, Section 3211 of P.L. 116-136.)

Note: All funds are designated as an emergency requirement.

a. $300 million of these funds (appropriated to the Public Health and Social Services Emergency Fund at HHS) are contingent upon future HHS actions.

Department of Labor

The majority of DOL funds ($345 million)—all provided in the third measure—were for dislocated worker assistance through activities authorized by the Workforce Innovation and Opportunity Act (WIOA). Specifically, the DOL funds were for the WIOA National Reserve, which provides National Dislocated Worker Grants (NDWGs) to states and localities to assist with worker dislocation resulting from natural disasters and mass layoffs. These funds were generally expected to address workforce-related effects of the COVID-19 pandemic.[36]

Department of Health and Human Services

The majority of HHS funds (87%) in the supplemental appropriations measures have been appropriated to the Public Health and Social Services Emergency Fund (PHSSEF). The PHSSEF account is used by the HHS Secretary for one-time or short-term funding, such as emergency supplemental appropriations, and for some ongoing public health preparedness activities including those of the Office of the HHS Assistant Secretary for Preparedness and Response (ASPR).

Accounts at the Centers for Disease Control and Prevention (CDC) and the Administration for Children and Families (ACF) each received approximately 5% of the supplemental HHS appropriations provided in the COVID-19 response measures. Remaining funds were provided in smaller amounts to the National Institutes of Health (NIH), the Administration for Community Living (ACL), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Medicare and Medicaid Services (CMS).

Although the funds in **Table 2** are displayed as appropriated, readers should note that the first, third, fourth, and fifth COVID-19 supplemental appropriations acts authorized HHS to transfer funds made available in these acts, provided the transfers are made to prevent, prepare for, and respond to the pandemic. (This broad authority giving HHS *discretion* over certain transfers is in addition to provisions in these three measures that *direct* HHS to make specific transfers.) The

[36] For additional information on programs and activities authorized by WIOA, see CRS Report R44252, *The Workforce Innovation and Opportunity Act and the One-Stop Delivery System*.

first measure broadly allowed for HHS to transfer funds among accounts at CDC, NIH, and PHSSEF. The third measure allowed for transfers among amounts at CDC, PHSSEF, ACF, ACL, and NIH. The fourth measure allowed for transfers among accounts at CDC, NIH, PHSSEF, and the FDA, but limited the amounts available for such transfers (e.g., it excluded from this authority $75 billion provided to the PHSSEF for the "Provider Relief Fund"). The fifth measure allowed for transfers among accounts at CDC, NIH, PHSSEF, ACF, and SAMHSA, but also limited the amounts available for such transfers (e.g., it excluded from this authority $22.4 billion provided to the PHSSEF for COVID-19 testing, contact tracing, surveillance, containment, and mitigation). The acts require HHS to notify the House and the Senate appropriations committees 10 days in advance of such transfers.

Public Health and Social Services Emergency Fund (PHSSEF)

The PHSSEF received about $280 billion in funding across the five measures. This accounts for 64% of all LHHS funds provided in the acts and 87% of the HHS funds in the LHHS titles of the bills.[37] These PHSSEF funds may support various activities, including health care surge capacity and the development and purchase of medical countermeasures, including vaccines. In general, PHSSEF supplemental funding has been provided for four main sets of activities.

Medical Countermeasures and Surge Capacity: The first, third, and fifth measures each provided funding to support (1) the development, manufacturing, and in some cases federal purchase of COVID-19 medical countermeasures, such as diagnostic tests, treatments, vaccines, and medical supplies, and (2) other response activities such as for healthcare workforce and surge capacity. In total, approximately $53.4 billion has been provided for these activities. Note that the bills also specify that some of these funds are to be transferred elsewhere (e.g., to other federal agencies for the care of persons under federal quarantine) or reserved for specific purposes or activities (e.g., provided to grantees of the Hospital Preparedness Program). These activities may be carried out by various ASPR components, especially the Biomedical Advanced Research and Development Authority (BARDA) for countermeasure development and procurement.[38]

COVID-19 Testing for the Uninsured: The second supplemental measure included $1 billion to provide reimbursements for COVID-19 testing and related services for persons who are uninsured. In addition, the fourth measure specified that up to $1 billion out of the amounts appropriated for broader COVID-19 testing purposes (discussed below) may be used to cover the costs of testing for the uninsured. The program is administered by HRSA.[39]

Provider Relief Fund: The third, fourth, and fifth supplemental measures each provided funding for a "Provider Relief Fund" to assist health care providers and facilities affected by the COVID-19 pandemic.[40] These funds are intended to reimburse eligible health care providers for health care-related expenses or lost revenues that are attributable to the pandemic. The measures define

[37] For further information on PHSSEF funds in the supplemental measures, see CRS Report R46285, *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123): First Coronavirus Supplemental*; CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*; CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief*; and CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[38] For information on the ASPR activities, see HHS, ASPR, "COVID-19: 2019 Novel Coronavirus Disease," https://www.phe.gov/emergency/events/COVID19/Pages/default.aspx.

[39] HRSA, "COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured," https://www.hrsa.gov/CovidUninsuredClaim.

[40] For more information on the PRF, see HHS, "CARES Act Provider Relief Fund," April 22, 2020, https://www.hhs.gov/provider-relief/index.html.

eligible providers broadly as any that provide "diagnoses, testing, or care for individuals with possible or actual cases of COVID-19." In total, $178 billion has been appropriated for the Provider Relief Fund.[41] This program also is administered by HRSA.

COVID-19 Testing, Surveillance, and Contact Tracing: The fourth and fifth supplemental measures provided $47.4 billion to augment national capacity for COVID-19 containment, including expanded testing capacity, and workforce and technical capacity for disease surveillance and contact tracing. The fourth measure directed HHS to reserve some of these funds for specific purposes (e.g., not less than $11 billion is for states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes). In addition, the bill specified that certain funds are to be transferred to other agencies and accounts (e.g., $22 million is to be transferred to the FDA for diagnostic, serological, antigen, and other tests). The fifth measure provided a total of $22.4 billion and provided that funds shall be for states, localities, territories, and tribal entities.[42]

In addition to the activities specified above, PHSSEF appropriations in the first, third, fourth, and fifth supplemental measures called for some portion of the funds to be transferred to other agencies or accounts for particular activities. For instance, some PHSSEF funds are required to be transferred to the HRSA for health centers, rural health, the Ryan White HIV/AIDS program, and health care systems.[43]

Other HHS Funding

Further public health-related funding for preparedness and response was appropriated to the CDC ($15.3 billion) and NIH ($3.0 billion) in the first, third, and fifth supplemental measures. In addition, the fourth measure explicitly directed certain PHSSEF appropriations to be transferred to CDC and NIH for COVID-19 response activities. When accounting for these transfers, total funding directed to the CDC would come to not less than $16.3 billion and total funding directed to NIH would come to not less than $4.8 billion.[44] Much of the CDC funding in the first, third, and fourth measures was intended, among other things, to support grants, or cooperative agreements to states, localities, tribes and other entities, for public health activities (e.g., surveillance, infection control, diagnostics, laboratory support, and epidemiology), as well as for global disease detection and modernization of public health data collection. The funds may also

[41] For further information about these appropriations, see CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief*, and HHS news releases at https://www.hhs.gov/about/news/index.html.

[42] Of the total, $790 million is designated to be transferred to IHS, and a separate amount of not less than $2.5 billion is for "strategies for improving testing capabilities and other purposes … in high-risk and underserved populations, including racial and ethnic minority populations and rural communities as well as identifying best practices for states and public health officials to use for contact tracing in high-risk and underserved populations, including racial and ethnic minority populations and rural communities."

[43] For further background on HRSA and these activities, see, for example, CRS Report R44054, *Health Resources and Services Administration (HRSA) Funding: Fact Sheet*; CRS Report R46239, *Telehealth and Telemedicine: Frequently Asked Questions*; and CRS Insight IN11238, *Coronavirus Disease 2019 (COVID-19) Poses Challenges for the U.S. Blood Supply*. For further background on other transfers that were directed from the PHSSEF, see CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*.

[44] P.L. 116-139 directed HHS to transfer $1 billion to the CDC-Wide Activities and Program Support account for various activities including workforce supports necessary to expand and improve COVID-19 testing. In addition, P.L. 116-139 directed HHS to transfer not less than $1.8 billion to NIH to support activities related to COVID-19 testing. This includes at least $306 million for the National Cancer Institute, at least $500 million for the National Institute of Biomedical Imaging and Bioengineering, and at least $1 billion for the Office of the Director, for specified activities.

be used to support public outreach campaigns, and provide guidance to physicians, health care workers, and others. The $8.75 billion for CDC in the fifth measure was specifically designated for activities related to the national vaccine distribution program. Most of the NIH funding was provided to several institutes to support basic scientific research as well as research on potential vaccines, therapeutics, and diagnostics related to COVID-19.[45] In the fourth and fifth measures, a total of not less than $1.9 billion of funding directed to NIH was designated specifically for research and development related to diagnostic tests.

SAMHSA received a total of $4.7 billion in the third and fifth measures.[46] The bulk of this funding was for SAMHSA's two main block grants ($1.65 billion apiece): the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG).[47] Other funding was allocated to the Certified Community Behavioral Health Clinic (CCBHC) grant program (not less than $850 million), emergency substance abuse or mental health needs (not less than $340 million), and suicide prevention (not less than $100 million).

CMS received $200 million in the third measure. At least half of this appropriation was to be spent on additional infection control surveys for federally certified facilities with populations vulnerable to severe illness from COVID-19.[48]

ACF received $16.5 billion in the third and fifth measures. These funds were directed to a number of human services programs. This funding was largely for the Child Care and Development Block Grant, which received $13.5 billion to provide continued assistance to child care providers in the event of decreased enrollment or program closures. These funds may also be used to support child care facilities that are open and operating, including those providing care for the children of essential workers.[49] Several other ACF programs received funding, including the Community Services Block Grant ($1 billion), Head Start ($1 billion), and the Low Income Home Energy Assistance Program (LIHEAP, $900 million).[50]

[45] For background on NIH funding, see CRS Report R43341, *National Institutes of Health (NIH) Funding: FY1995-FY2021*. For further information on the NIH, see CRS Report R41705, *The National Institutes of Health (NIH): Background and Congressional Issues*.

[46] Of this amount, not less than $140 million was to be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes.

[47] The SABG and MHBG are SAMHSA's two largest grant programs and distribute funds to states, the District of Columbia, and territories according to a statutory formula (see PHSA Title XIX). For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

[48] For background, see CMS, "Coronavirus: Updates for State Surveyors and Accrediting Organizations," https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus.

[49] For further information, see CRS Report R46324, *COVID-19: Child Care and Development Block Grant (CCDBG) Supplemental Appropriations in the CARES Act*.

[50] For background on these programs, see CRS Report RL32872, *Community Services Block Grants (CSBG): Background and Funding*; CRS In Focus IF11008, *Head Start: Overview and Current Issues*; and CRS Report RL31865, *LIHEAP: Program and Funding*.

ACL received a total of $1.3 billion in the second and third response measures.[51] The majority of this funding ($720 million) was spread across a variety of activities that the agency undertakes to provide meals to seniors.[52]

Department of Education

Almost all of the $112.9 billion in supplemental ED appropriations—which was provided in the third[53] and fifth measures—was for the Education Stabilization Fund (ESF). The ESF is composed of three emergency relief funds: (1) a Governor's Emergency Education Relief (GEER) Fund (§18002), (2) an Elementary and Secondary School Emergency Relief (ESSER) Fund (§18003),[54] and (3) a Higher Education Emergency Relief Fund (HEERF) (§18004).[55] The third measure provided a total of $30.750 billion for the ESF.[56] The fifth measure provided a total of $81.9 billion for the ESF.[57]

The GEER Fund may be used to provide emergency support through grants to local educational agencies (LEAs) that the state educational agency (SEA) or governor determines to have been the most significantly impacted by COVID-19. Emergency support may also be provided through grants to institutions of higher education (IHEs) serving students within the state that the governor determines to have been the most significantly impacted by COVID-19. A governor may also choose to provide emergency support to any other IHE, LEA, or education-related entity within the state that he or she deems "essential for carrying out emergency educational services" to students for a broad array of purposes ranging from any activity authorized under various federal education laws to the provision of child care and early childhood education, social and emotional support, and the protection of education-related jobs.

Funds from the ESSER Fund are to be awarded to states based on their relative shares of grants awarded under Title I-A of the Elementary and Secondary Education Act (ESEA), as amended. SEAs are required to provide at least 90% of the funds to LEAs to be used for myriad purposes such as any activity authorized under various federal education laws (e.g., ESEA), coordination of preparedness and response to the COVID-19 pandemic, technology acquisition, mental health, and activities related to summer learning. Funds retained by the SEA must be used for emergency needs, as determined by the SEA, to address issues in response to the COVID-19 pandemic and for program administration.

The HEERF is to distribute funds to IHEs to address needs directly related to the COVID-19 pandemic, including, but not limited to, transitioning courses to distance education and grant aid

[51] In Title VII of Division N, P.L. 116-260 also provided $175.0 million to Aging and Disability Services Programs in mandatory supplemental funding for nutrition services. Of this total, $168 million is for congregate and home-delivered nutrition services and $7 million is for nutrition services to Native Americans. Because it was provided as mandatory spending, this funding is not included in the budgetary figures in this report.

[52] For more information, see CRS Report R43414, *Older Americans Act: Overview and Funding*.

[53] For further information about ED appropriations provided in the third measure, see CRS Report R46378, *CARES Act Education Stabilization Fund: Background and Analysis*.

[54] For more information about emergency assistance for elementary and secondary education related to COVID-19, see CRS In Focus IF11509, *CARES Act Elementary and Secondary Education Provisions*.

[55] For more information about emergency assistance related to COVID-19 for IHEs, see CRS In Focus IF11497, *CARES Act Higher Education Provisions*.

[56] The bill specified that these funds are to remain available through September 30, 2021.

[57] The bill specified that these funds are to remain available through September 30, 2022.

to students for their educational costs such as food, housing, course materials, health care, and child care.[58]

Related Agencies

The Social Security Administration (SSA) received the largest amount of COVID-19 supplemental funding ($300 million) among the related agencies. These funds were provided to the SSA Limitation on Administrative Expenses account to support the salaries and benefits of all SSA employees affected as a result of office closures. The funds are also to be used for costs associated with telework, phone, and communication services for employees; for overtime costs and supplies; and for processing disability and retirement benefit workloads and backlogs.

Detailed LHHS Programs and Activities Supplemental Amounts

Table 2 displays funding directed to LHHS programs and activities, as enacted, across the five COVID-19 supplemental appropriations acts. It is organized by department or agency and by account, program, or activity. The table also indicates a number of cases in which appropriations language reserved funds within a particular account for specific programs or activities, or directed that funds be transferred to other accounts. It makes note of instances in which these reservations are for not less than (NLT) or not more than (NMT) a certain dollar amount. *In cases where the bill text calls for transfers, funds are shown in the account to which they were appropriated, not in the account to which they are to be transferred.*

[58] The fifth supplemental shifted $100 million appropriated for Safe Schools and Citizenship in the CARES Act to HEERF.

Table 2. FY2020 and FY2021 LHHS Supplemental Appropriations for COVID-19 Response

(Budget authority in millions of dollars)

Department and Agency, Account, or Program	FY2020				FY2021	Total
	P.L. 116-123 (Div. A)[a]	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)[b]	P.L. 116-260 (Div. M)	
DOL Subtotal	—	—	360	—	—	360
Training and Employment Services: Dislocated Worker Assistance National Reserve	—	—	345	—	—	345
Departmental Management	—	—	15[c]	—	—	15
Transfer to OIG	—	—	*(1)*	—	—	*(1)*
HHS Subtotal	**6,436[d]**	**1,250**	**140,389[e]**	**100,000[f]**	**72,945[g]**	**321,020**
Centers for Disease Control and Prevention (CDC)	**2,200**	**—**	**4,300**	**—**	**8,750**	**15,250**
CDC-Wide Program Activities and Support	2,200	—	4,300	—	8,750	15,250
NLT for states, territories, localities, or tribal entities[h]	*(950)[i]*	—	*(1,500)[j]*	—	*(4,500)[k]*	*(6,590)*
Transfer to Infectious Disease Rapid Response Reserve Fund (IDRRRF)	*(300)*	—	*(300)*	—	—	*(600)*
NLT for global disease detection and response	*(300)*	—	*(500)*	—	—	*(800)*
NLT for health data surveillance modernization	—	—	*(500)*	—	—	*(500)*
National Institutes of Health (NIH)	**836**	**—**	**945**	**—**	**1,250**	**3,031**
National Heart, Lung, and Blood Institute	—	—	103	—	—	103
National Institute of Allergy and Infectious Diseases	836	—	706	—	—	1,542
NLT transfer to National Institute of Environmental Sciences	*(10)*	—	—	—	—	*(10)*
NLT for vaccine and infectious disease research facilities	—	—	*(156)*	—	—	*(156)*
National Institute of Biomedical Imaging and Bioengineering	—	—	60	—	—	60
National Library of Medicine	—	—	10	—	—	10
National Center for Advancing Translational Sciences	—	—	36	—	—	36
Office of the Director	—	—	30	—	1,250	1,280

Department and Agency, Account, or Program	FY2020				FY2021	
	P.L. 116-123 (Div. A)[a]	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)[b]	P.L. 116-260 (Div. M)	Total
Research and clinical trials related to long-term studies of COVID-19	—	—	—	—	*(1,150)*	*(1,150)*
NLT Rapid Acceleration of Diagnostics	—	—	—	—	*(100)*	*(100)*
Substance Abuse and Mental Health Services Administration (SAMHSA)	**—**	**—**	**425**	**—**	**4,250**	**4,675**
Health Surveillance and Program Support	—	—	425[l]	—	4,250[m]	4,675
NLT for Certified Community Behavioral Health Clinics	—	—	*(250)*	—	*(600)*	*(850)*
NLT for suicide prevention	—	—	*(50)*	—	*(50)*	*(100)*
NLT for emergency response grants for substance abuse and mental health	—	—	*(100)*[n]	—	*(240)*	*(340)*
Substance Abuse and Prevention Treatment Block Grant	—	—	—	—	1,650	1,650
Project AWARE	—	—	—	—	50	50
National Child Traumatic Stress Network	—	—	—	—	10	10
Community Mental Health Services Block Grant	—	—	—	—	1,650	1,650
Centers for Medicare & Medicaid Services (CMS)	**—**	**—**	**200**	**—**	**—**	**200**
Program Management	—	—	200	—	—	200
NLT for survey and certification for infection control	—	—	*(100)*	—	—	*(100)*
Administration for Children and Families (ACF)	**—**	**—**	**6,274**	**—**	**10,250**	**16,524**
Low Income Home Energy Assistance Program	—	—	900	—	—	900
Child Care and Development Block Grant	—	—	3,500	—	10,000	13,500
NMT reservation for federal administrative expenses	—	—	—	—	*(15)*	*(15)*
Children and Families Services Programs	—	—	1,874	—	250	2,124
Community Services Block Grant	—	—	*(1,000)*	—	—	*(1,000)*
Head Start	—	—	*(750)*	—	*(250)*	*(1,000)*
Domestic Violence Hotline	—	—	*(2)*	—	—	*(2)*

Department and Agency, Account, or Program	FY2020				FY2021	Total
	P.L. 116-123 (Div. A)[a]	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)[b]	P.L. 116-260 (Div. M)	
Family Violence Prevention and Services Grants	—	—	*(45)*	—	—	*(45)*
Runaway and Homeless Youth	—	—	*(25)*	—	—	*(25)*
Child Welfare Services	—	—	*(45)*	—	—	*(45)*
Federal Administration	—	—	*(7)*	—	—	*(7)*
Administration for Community Living (ACL)	**—**	**250**	**955**	**—**	**100[o]**	**1,305**
Aging and Disabilities Services	—	250	955	—	100	1,205
Supportive Services	—	—	*(200)*	—	—	*(200)*
Congregate and Home-Delivered Nutrition Services	—	*(240)[p]*	*(480)*	—	—	*(720)*
Nutrition Services to Native Americans	—	*(10)*	*(20)*	—	—	*(30)*
Family Caregivers	—	—	*(100)*	—	—	*(100)*
Elder Rights Protection Activities	—	—	*(20)*	—	—	*(20)*
Aging and Disability Resource Centers	—	—	*(50)*	—	—	*(50)*
Centers for Independent Living	—	—	*(85)*	—	—	*(85)*
Elder Justice	—	—	—	—	*(100)[q]*	*(100)*
Office of the Secretary	**3,400[r]**	**1,000[s]**	**127,290[t]**	**100,000[u]**	**48,345[v]**	**280,035**
Public Health and Social Services Emergency Fund (PHSSEF)	3,400[r]	1,000[s]	127,290[t]	100,000[u]	48,345[v]	280,035
NMT transfer to HHS OIG	*(2)[w]*	—	*(4)[w]*	*(6)[w]*	*(2)[w]*	*(14)*
Testing for the Uninsured	—	*(1,000)*	—	—[x]	—	*(1,000)*
Transfers to HRSA (Ryan White, Rural Health, and Health Care Systems)	—	—	*(275)[y]*	—	—	*(275)*
Provider Relief Fund	—	—	*(100,000)*	*(75,000)*	*(3,000)*	*(178,000)*
Medical Countermeasures and Surge Capacity	*(3,400)[r]*	—	*(27,015)*	—	*(22,945)*	*(53,360)*
Transfer to HRSA (Health Centers)	*(100)*	—	—	—	—	*(100)*

Department and Agency, Account, or Program	FY2020				FY2021	
	P.L. 116-123 (Div. A)[a]	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)[b]	P.L. 116-260 (Div. M)	Total
NMT for Strategic National Stockpile	—	—	*(16,000)*	—	*(3,250)*	*(19,250)*
NLT for Hospital Preparedness Program grantees or subgrantees	—	—	*(250)*	—	—	*(250)*
NLT for Biomedical Advanced Research & Development Authority (BARDA)	—	—	*(3,500)*	—	—	*(3,500)*
BARDA	—	—	—	—	*(19,695)*	*(19,695)*
NMT transfer to other federal agencies for care of persons under federal quarantine	—	—	*(289)*	—	—	*(289)*
National Academies Study	—	—	*(2)*	—	—	*(2)*
COVID-19 Testing, Surveillance, and Contact Tracing	—	—	—[z]	*(25,000)*	*(22,400)*	*(47,400)*
NLT for grants to states, localities, territories, and tribal entities	—	—	—	*(11,000)*[aa]	—[bb]	*(11,000)*
NLT transfer to CDC-Wide Activities and Program Support	—	—	—	*(1,000)*	—	*(1,000)*
NLT transfer to NIH National Cancer Institute	—	—	—	*(306)*	—	*(306)*
NLT transfer to NIH National Institute of Biomedical Imaging and Bioengineering	—	—	—	*(500)*	—	*(500)*
NLT transfer to NIH Office of the Director	—	—	—	*(1,000)*	—	*(1,000)*
NLT for BARDA	—	—	—	*(1,000)*	—	*(1,000)*
Transfer to FDA (Salaries and Expenses)	—	—	—	*(22)*	—	*(22)*
Transfer to HRSA (Health Centers)	—	—	—	*(600)*[cc]	—	*(600)*
Rural Health Clinics	—	—	—	*(225)*	—	*(225)*
NMT Testing for the Uninsured	—	—	—	*(1,000)*[x]	—	*(1,000)*
IHS Transfer	—	—	—	—	*(790)*	*(790)*
NLT improving testing and contract tracing high-risk and underserved populations	—	—	—	—	*(2,500)*	*(2,500)*
ED Subtotal	**—**	**—**	**30,925**	**—**	**82,000**	**112,925**
Education Stabilization Fund	—	—	30,750[dd]	—	81,880[ee]	112,630
Safe Schools and Citizenship	—	—	100[ff]	—	—	100

Department and Agency, Account, or Program	FY2020				FY2021	Total
	P.L. 116-123 (Div. A)[a]	P.L. 116-127 (Div. A)	P.L. 116-136 (Div. B)	P.L. 116-139 (Div. B)[b]	P.L. 116-260 (Div. M)	
Gallaudet University	—	—	7	—	11	18
Student Aid Administration	—	—	40	—	30	70
Howard University	—	—	13	—	20	33
National Technical Institute for the Deaf	—	—	—	—	11	11
Institute of Education Sciences	—	—	—	—	28	28
Program Administration	—	—	8	—	15	23
OIG	—	—	7	—	5	12
Related Agencies Subtotal	**—**	**—**	**430**	**—**	**—**	**430**
Corporation for Public Broadcasting	—	—	75	—	—	75
Institute of Museum and Library Services	—	—	50	—	—	50
Railroad Retirement Board	—	—	5	—	—	5
Social Security Administration	—	—	300	—	—	300
LHHS Total	**6,436**	**1,250**	**172,104**	**100,000**	**154,945**	**434,735**

Source: Compiled by CRS from amounts specified in P.L. 116-123 (Title III, Division A), P.L. 116-127 (Title V, Division A), P.L. 116-136 (Title VIII, Division B), P.L. 116-139 (Title I, Division B), and P.L. 116-260 (Title III, Division M). This report does not include funding appropriated in Title III (P.L. 116-260, Division M) to the Food and Drug Administration (FDA) Salaries and Expenses account, as this funding is generally not under the purview of the LHHS appropriations act. Funds provided in other titles and divisions of these laws are beyond the scope of this report and are excluded from the table. (For instance, the table does not include the $1.320 billion in mandatory funds for the HRSA health centers program provided in Title III, Division A, Section 3211 of P.L. 116-136).

Notes: OIG = Office of the Inspector General. NLT = Not Less Than. NMT = Not More Than. All funds are designated as an emergency requirement. Amounts in parenthesis and italics are non-adds. The table displays funds in the accounts in which they were appropriated. The table makes note of a number of cases in which the appropriations language reserved funds within a particular account for specific programs or activities, or directed that funds be transferred to other accounts. *When the bill text calls for transfers, funds are shown in the account to which they were appropriated, not in the account to which they are to be transferred.*

a. For further information, see CRS Report R46285, *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123): First Coronavirus Supplemental.*

b. For further information, see CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief.*

c. DOL may transfer funds from this appropriation to the accounts for Employee Benefits Security Administration, Wage and Hour Division, Occupational Safety and Health Administration, and Employment and Training Administration—Program Administration.

d. HHS may transfer nearly all the funds appropriated to it in Title III, Division A of P.L. 116-123 among accounts at CDC, NIH, or PHSSEF, provided the transfers are made to prevent, prepare for, and respond to the COVID-19 pandemic, domestically or internationally (see §304). HHS is to notify the House and the Senate appropriations committees 10 days in advance of such a transfer.

e. HHS may transfer nearly all the funds appropriated to it in Title VIII, Division B of P.L. 116-136 among accounts at CDC, PHSSEF, ACF, ACL, and NIH, provided the transfers are made to prevent, prepare for, and respond to the COVID-19 pandemic, domestically or internationally (see §18111). HHS is to notify the House and the Senate appropriations committees 10 days in advance of such a transfer.

f. HHS may transfer certain funds appropriated to it in Title I, Division B of P.L. 116-139 among accounts at CDC, NIH, PHSSEF, and the FDA, provided the transfers are made to prevent, prepare for, and respond to the COVID-19 pandemic (see §102). (This transfer authority does not apply to the $75 billion for the Provider Relief Fund or to the $11 billion in COVID-19 testing capabilities funds for grants to states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or related providers.) HHS is to notify the House and the Senate appropriations committees 10 days in advance of such a transfer.

g. HHS may transfer certain funds appropriated to it in Title III, Division M of P.L. 116-260 among accounts at CDC, NIH, PHSSEF, ACF, and SAMHSA. (This transfer authority does not apply to the $22.4 billion provided to the PHSSEF for COVID-19 testing, contact tracing, surveillance, containment, and mitigation.) HHS is to notify the House and the Senate appropriations committees 10 days in advance of such a transfer.

h. This appropriation was directed for vaccine-related activities, specifically for "activities to plan, prepare for, promote, distribute, administer, monitor, and track coronavirus vaccines to ensure broad-based distribution, access, and vaccine coverage."

i. Of the total appropriated, not less than $40 million shall be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

j. Of the total appropriated, not less than $125 million shall be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

k. Of the total appropriated, not less than $300 million shall be allocated to serving high-risk and underserved populations, including racial and ethnic minority populations and rural communities. In addition, $210 million was to be transferred to the Indian Health Service.

l. Of the total appropriated, not less than $15 million shall be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes.

m. Of the total appropriated, not less $125 million shall be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes.

n. SAMHSA ultimately allocated $110 million for these emergency response grants. HHS, SAMHSA, Grants/Grant Announcements/Emergency Grants to Address Mental and Substance Use Disorders During COVID-19, April 1, 2020, https://www.samhsa.gov/grants/grant-announcements/fg-20-006.

o. P.L. 116-260 (Title VII, Division N) also provided $175.0 million to Aging and Disability Services Programs in mandatory supplemental funding for nutrition services. Of this total, $168 million is for congregate and home-delivered nutrition services and $7 million is for nutrition services to Native Americans.

p. Of this total, $80 million is for congregate nutrition and $160 million is for home-delivered nutrition.

q. This funding is for authorized activities under Title XX, Subtitle B—Elder Justice of the Social Security Act. Of this total, not less than $50 million is for grants to states to enhance Adult Protective Services.

r. The total shown in this table includes $300 million in appropriations contingent upon future HHS actions. Of the total appropriated to the PHSSEF, up to $2 million is to be transferred to the HHS OIG.

s. To provide reimbursements for COVID-19 testing and related services for persons who are uninsured.

t. Provided in distinct appropriations broadly focused on medical countermeasures and surge capacity ($27 billion), health care provider reimbursement (the Provider Relief Fund, $100 billion), and HRSA transfers ($275 million). Of the total appropriated to the PHSSEF, up to $4 million is to be transferred to the HHS OIG.

u. Provided in distinct appropriations broadly focused on health care provider reimbursement (the Provider Relief Fund, $75 billion) and COVID-19 testing, surveillance, and contact tracing ($25 billion). Of the total appropriated to the PHSSEF, up to $6 million is to be transferred to the HHS OIG.

v. Provided in distinct appropriations broadly focused on health care provider reimbursement (the Provider Relief Fund, $3 billion), medical countermeasures and surge capacity ($23 billion), COVID-19 testing, surveillance, and contact tracing ($22 billion). Of the total appropriated to the PHSSEF, up to $2 million is to be transferred to the HHS OIG.

w. The transfers to the HHS OIG are specified in general provisions (not more than $2 million per Title III, Division A, Section 306 of P.L. 116-123, not more than $4 million per Title VIII, Division B, Section 8113 of P.L. 116-136, not more than $6 million per Title I, Division B, Section 103 of P.L. 116-139), and not more than $2 million per Title III, Division M, Section 305 of P.L. 116-260. The amounts transferred to the HHS OIG may come from any funds appropriated to the PHSSEF in the respective appropriations acts. The HHS OIG funds are for oversight of all activities supported with funds appropriated to HHS to prevent, prepare for, and respond to the COVID-19 pandemic (not just funds appropriated to the PHSSEF).

x. P.L. 116-123 did not provide a distinct appropriation for testing for the uninsured, but it specified that up to $1 billion out of the $25 billion appropriated for COVID-19 testing, surveillance, and contact tracing may be used for this purpose.

y. Of the total to be transferred to HRSA, $90 million is for the Ryan White HIV/AIDS program, $180 million is for rural health programs (of which not less than $15 million is for tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes), and $5 million is for health care systems.

z. P.L. 116-136 did not provide a distinct appropriation for these activities, but it did allow for PHSSEF appropriations to be used for "other preparedness and response activities." At the HHS Secretary's discretion, this may include testing, surveillance, and/or contact tracing, among other things.

aa. From this total, not less than $750 million shall be allocated, in coordination with the Director of the Indian Health Service (IHS), to tribes, tribal organizations, urban Indian health organizations, or related entities.

bb. P.L. 116-260 directed that these funds shall be for "states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes" and may be awarded as grants or cooperative agreements.

cc. P.L. 116-139 specified that these funds may be awarded to Federally Qualified Health Centers under Section 330 of the Public Health Service Act and to entities that are eligible for but not currently receiving such funds (i.e., Federally Qualified Health Center "look-alikes").

dd. P.L. 116-136 specified that the bulk of this funding was to be distributed between three different funds: Governor's Emergency Education Relief (GEER) Fund ($3.0 billion), Elementary and Secondary Education Emergency Relief (ESEER) Fund ($13.2 billion), and Higher Education Emergency Relief (HEER) Fund ($14.0 billion) (amounts distributed to each fund as calculated by CRS).

ee. P.L. 116-260 specified that the bulk of this funding was to be distributed between three different funds: GEER Fund ($4.1 billion), ESSER Fund ($54.3 billion), and HEERF ($22.7 billion) (amounts distributed to each fund as calculated by CRS).

ff. The fifth supplemental shifted the $100 million appropriated for Safe Schools and Citizenship in the CARES Act to HEERF.

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