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Health Equity and Disparities During the COVID-19 Pandemic: Brief Overview of the Federal Role

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Introduction

According to the U.S. Centers for Disease Control and Prevention (CDC), “[h]ealth equity’ means that everyone has the opportunity to be as healthy as possible.”¹ The COVID-19 pandemic is a catastrophic public health emergency, challenging responders not merely to minimize overall deaths and serious illnesses as best they can, but to assure that the burdens of this emergency are borne equitably across different segments of society.

Inequities, or health disparities, may arise among different racial and ethnic groups, among those of different ages, and among those with preexisting illnesses. Disparities may also be seen across certain socio-demographic and environmental characteristics such as income, educational attainment, and place of residence. These latter factors are often referred to as social determinants of health.²

The U.S. doctrine of federalism, which places states and territories in the lead for most exercises of public health authority (e.g., rationing of limited services and supplies), may further complicate an equitable pandemic response. Non-uniform application of social distancing and masking requirements, business closures, and vaccine prioritization schemes may have facilitated each jurisdiction’s best approach to an equitable response. Anecdotal reports suggest that health disparities have persisted throughout the pandemic, though they have varied between jurisdictions and changed over time.

This CRS Report presents (1) several definitions of potential disparity populations in general and emergency management contexts; (2) selected health disparities documented during the pandemic; (3) selected key federal laws and policies that address health equity in general and during the pandemic; and (4) selected issues involving federalism, disparities data, and competing priorities.

Populations of Interest and Definitions

During the COVID-19 pandemic, certain definitions have been used to identify populations at disproportionate risk for, or experiencing, poor health indicators such as hospitalization and death, or indicators of limited access to services such as testing and vaccination. Some terms define groups that are protected by law from discriminatory actions. Others terms are used for specific administrative purposes such as emergency planning. These definitions overlap to various degrees. They show the many considerations that pandemic planners have had to consider, and the potential for the needs of all these individuals collectively to exceed finite response resources. Broader discussion of federal laws and programs germane to the pandemic response follows later in this report.

Protected Classes Under the Civil Rights Act: The Civil Rights Act of 1964 addresses discrimination based on the grounds of race, color, religion, national origin, or sex in numerous contexts.³ The act and its applicability in preventing health disparities in general and during the COVID-19 pandemic is discussed further below.

¹ Centers for Disease Control and Prevention (CDC), “COVID-19 Racial and Ethnic Health Disparities,” <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html>.

² CDC, “Social Determinants of Health: Know What Affects Health,” <https://www.cdc.gov/socialdeterminants/index.htm>.

³ CRS Report R46534, *The Civil Rights Act of 1964: An Overview*, by Christine J. Back.

Individuals with Disabilities: For the purposes of federal disability nondiscrimination laws—such as the Americans with Disabilities Act (ADA), Section 503 of the Rehabilitation Act of 1973, and Section 188 of the Workforce Innovation and Opportunity Act—a person with a disability is typically defined as someone who (1) has a physical or mental impairment that substantially limits one or more “major life activities,” (2) has a record of such an impairment, or (3) is regarded as having such an impairment.⁴ These acts and their applicability in preventing health disparities in general and during the COVID-19 pandemic are discussed further below.

Health Disparity Populations: The Centers for Disease Control and Prevention (CDC) defines health disparities as “differences in health outcomes and their causes among groups of people.”⁵

In establishing the National Center on Minority Health and Health Disparities (now an Institute, NIMHHD⁶) in the National Institutes of Health (NIH), Congress provided the following definition.

[A] population is a health disparity population if, as determined by the Director of the [NIMHHD] after consultation with the Director of the Agency for Healthcare Research and Quality, there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the health status of the general population.⁷

Populations with Access and Functional Needs: As a discipline, emergency management uses definitions of populations for which additional considerations may be needed in planning and response, to avoid disparate outcomes. These populations have been variously termed “special needs populations”; “at-risk” individuals or populations; individuals with “access and functional needs” (AFN); and similar phrasings.

In particular, the Federal Emergency Management Agency (FEMA) refers to AFN as follows.

Access and functional needs refers to persons who may have additional needs before, during and after an incident in functional areas, including but not limited to: maintaining health, independence, communication, transportation, support, services, self-determination, and medical care. Individuals in need of additional response assistance may include those who have disabilities; live in institutionalized settings; are older adults; are children; are from diverse cultures; have limited English proficiency or are non-English speaking; or are transportation disadvantaged.⁸

In the context of public health emergency management, Congress provided the following definition of at-risk individuals.

For the purpose of [the Public Health Service Act], the term “at-risk individuals” means children, pregnant women, senior citizens and other individuals who have access or functional needs in the event of a public health emergency, as determined by the Secretary.⁹

However, HHS often refers to the FEMA AFN definition in its emergency policy documents.

⁴ U.S. Department of Labor, “How Does the Federal Government Define ‘Disability?’,” <https://www.dol.gov/agencies/odep/publications/faqs/general#3>.

⁵ Centers for Disease Control and Prevention (CDC), *Strategies for Reducing Health Disparities, 2016*, <https://www.cdc.gov/minorityhealth/strategies2016/index.html>.

⁶ National Institutes of Health (NIH), National Institute on Minority Health and Health Disparities (NIMHHD), <https://www.nimhd.nih.gov/>.

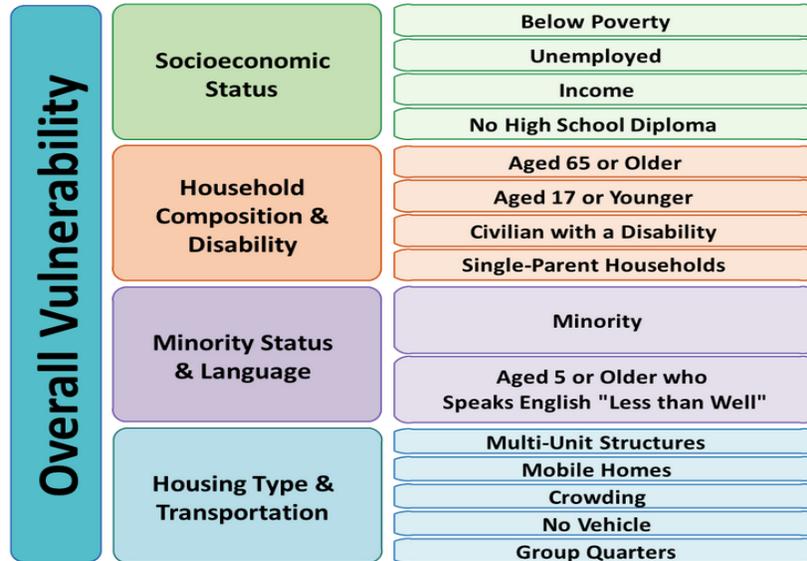
⁷ The Minority Health and Health Disparities Research and Education Act of 2000 (P.L. 106-525), as amended.

⁸ Federal Emergency Management Agency (FEMA), *National Response Framework*, p. 5, FN 11.

⁹ Public Health Service Act (PHSA) §2802(b)(4)(B); 42 U.S.C. §300hh-1(b)(4)(B).

The CDC/ATSDR Social Vulnerability Index: In response to the COVID-19 pandemic, CDC recommended that states, territories, and cities use a specific metric, the Social Vulnerability Index (SVI), to identify populations that could be at greater risk of unequal access to COVID-19 vaccination. The SVI assigns percentile rankings for 15 U.S. Census (American Community Survey) variables for each U.S. census tract, to help identify communities that may need support before, during, or after disasters.¹⁰ The variables are shown in **Figure 1**.

Figure 1. CDC/ATSDR Social Vulnerability Index Measures
Measures Derived from the American Community Survey (ACS)



Source: CDC, “CDC/ATSDR Social Vulnerability Index,” <https://www.atsdr.cdc.gov/placeandhealth/svi/>.

Notes: Current (2018) SVI data are available for all 50 states, the District of Columbia, and Puerto Rico. Unranked data are available for some tribal census tracts.

As the pandemic unfolded, additional populations were identified as having poorer outcomes, or lagging in access to or utilization of medical interventions. These populations have included, among others, individuals who are obese,¹¹ rural populations,¹² younger adults,¹³ and individuals with certain religious or political affiliations.¹⁴ Where feasible, HHS and/or state, local, territorial, and tribal (SLTT) health authorities have attempted to address these disparities.

¹⁰ CDC, “CDC/ATSDR Social Vulnerability Index,” <https://www.atsdr.cdc.gov/placeandhealth/svi/>.

¹¹ CDC, “People with Certain Medical Conditions,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>.

¹² Bhavini Patel Murthy et al. “Disparities in COVID-19 Vaccination Coverage Between Urban and Rural Counties—United States, December 14, 2020–April 10, 2021,” *MMWR*, vol. 70, May 21, 2021, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7020e3.htm>.

¹³ Jill Diesel et al., “COVID-19 Vaccination Coverage Among Adults—United States, December 14, 2020–May 22, 2021,” *MMWR*, vol. 70, June 25, 2021, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7025e1.htm>.

¹⁴ Ariel Fridman, Rachel Gershon, and Ayelet Gneezy, “COVID-19 and Vaccine Hesitancy: A Longitudinal Study,” *PLOS ONE*, April 16, 2021, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0250123>.

Disparities During the COVID-19 Pandemic

Throughout the COVID-19 pandemic, certain groups have experienced more severe health effects from COVID-19 infection, and/or more difficulty accessing pandemic-related health services. These groups include rural populations, racial and ethnic minorities, the elderly, and low-income communities, among others.

Health Outcomes

Numerous analyses have shown that many non-White individuals—specifically Hispanic, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Black Americans—have been over-represented in COVID-19 incidence.¹⁵ At different times during the pandemic, many racial and ethnic minority populations have been more likely to experience severe morbidity or mortality, or to be hospitalized due to COVID-19, than their White peers.¹⁶ According to the CDC, “race and ethnicity are risk markers for other underlying conditions that affect health including socioeconomic status, access to healthcare, and exposure to the virus related to occupation, e.g., frontline, essential, and critical infrastructure workers.”¹⁷

People living in rural areas have experienced higher COVID-19 death rates than those in metropolitan areas.¹⁸ Underlying health factors and poorer access to health care services and health insurance may underpin this disparity.¹⁹ In addition, adults older than 65 years of age have experienced higher COVID-19 death rates than their younger peers.²⁰ The higher prevalence of chronic conditions (e.g., kidney and lung diseases, diabetes and heart conditions) may make severe illness or death more likely with COVID-19 infection in this group.²¹

Access to Testing

Equitable access to reliable and convenient COVID-19 testing has been a concern throughout the pandemic. The term “testing desert” was coined to note areas where access to testing is particularly difficult due to distance or other factors. One study found that 64% of rural U.S. counties lacked a single COVID-19 testing site, leaving about 20.7 million rural residents in

¹⁵ Samuel Raine et al., “Racial and Ethnic Disparities in COVID-19 Outcomes: Social Determination of Health,” *International Journal of Environmental Research and Public Health*, vol. 17, no. 21, p. 8115, November, 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7663309/>.

¹⁶ CDC, “COVID Data Tracker: Health Equity Data,” <https://covid.cdc.gov/covid-data-tracker/#health-equity-data>.

¹⁷ CDC, “Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity,” updated July 16, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.

¹⁸ CDC, “Trends in COVID-19 Cases and Deaths in the United States, by County-Level Population Factors,” https://covid.cdc.gov/covid-data-tracker/#pop-factors_totaldeaths.

¹⁹ CDC, “COVID-19: Rural Communities,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/other-at-risk-populations/rural-communities.html>.

²⁰ CDC, “Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC,” <https://covid.cdc.gov/covid-data-tracker/#demographics>.

²¹ CDC, “COVID Data Tracker: Older Adults,” <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>.

testing deserts.²² Testing deserts have been found to be in more rural or lower-income areas, and racial and ethnic minority communities are disproportionately located in these testing deserts.²³

To date, only seven states and the District of Columbia report race and ethnicity data regarding testing.²⁴ Other jurisdictions report race and ethnicity data only for positive cases of COVID-19. This data limitation has stunted further analysis of disparities in access to COVID-19 testing.²⁵

Access to Vaccines

The Kaiser Family Foundation has conducted surveys on public perception and attitudes about receiving a COVID-19 vaccine, revealing variations in vaccine hesitancy.²⁶ For example, survey results for June 2021 showed the following percentages of persons who responded they would “definitely not” get the vaccine:

- 15% of White adults, 10% of Hispanic adults, and 9% of Black adults.
- 23% of Republicans, 16% of Independents, and 2% of Democrats.
- 24% of rural residents, 15% of suburban residents, and 8% of urban residents.²⁷

Initially, a limited initial supply of COVID-19 vaccine led to a phased roll-out, intended to target populations at higher risk of contracting COVID-19, or of facing serious health outcomes as a result of infection. CDC published a prioritization scheme, but individual jurisdictions had the authority to identify their own priority groups for vaccine receipt based on their individual populations. (See “Federalism,” below.) In March 2021, President Biden announced that all Americans would be eligible for COVID-19 vaccines by May 1, 2021, ending the phased approach for vaccine administration.²⁸

Studies have shown that racial and ethnic disparities were present during the early vaccine roll-out. For example, Black and Hispanic individuals had lower vaccination rates than Whites as of early March, 2021.²⁹ Furthermore, in the first 2.5 months of the vaccination program, highly vulnerable counties as indicated by the CDC’s Social Vulnerability Index had lower COVID-19

²² Surgo Ventures, “New Surgo Analysis Identifies Highly Vulnerable Rural Communities as COVID-19 Testing Deserts,” <https://surgoventures.org/portfolio/action-areas/new-surgo-analysis-identifies-highly-vulnerable-rural-communities-as-covid-19-testing-deserts>.

²³ Caitlin Owens and Andrew Witherspoon, “People of Color Have Less Access to Coronavirus Testing,” *Axios*, June 23, 2020, <https://www.axios.com/minorities-coronavirus-testing-9a6397e4-a7e7-4077-bad2-bbd77fe5d1c2.html>.

²⁴ Johns Hopkins Coronavirus Research Center, “Racial Data Transparency,” Updated March 12, 2021, <https://coronavirus.jhu.edu/data/racial-data-transparency>.

²⁵ For more information on COVID-19 testing see CRS Report R46481, *COVID-19 Testing: Frequently Asked Questions*, coordinated by Amanda K. Sarata and Elayne J. Heisler.

²⁶ Kaiser Family Foundation, “Does The Public Want to Get a COVID-19 Vaccine? When?” KFF COVID-19 Vaccine Monitor, https://www.kff.org/coronavirus-covid-19/dashboard/kff-covid-19-vaccine-monitor-dashboard/?gclid=CjwKCAjw3pWDBhB3EiwAV1c5rBvWtdyhDn05CJL_gpX9POugpYrS10F1-0BnbrZsen5pn5usAtzm7hoC-DcQAvD_BwE.

²⁷ *Ibid.* For most of the groups shown, the percentage of respondents saying they would “definitely not” get the vaccine has remained steady since the survey began in December 2020.

²⁸ The White House, “Fact Sheet: President Biden to Announce All Americans to be Eligible for Vaccinations by May 1, Puts the Nation on a Path to Get Closer to Normal by July 4th,” March 11, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/11/fact-sheet-president-biden-to-announce-all-americans-to-be-eligible-for-vaccinations-by-may-1-puts-the-nation-on-a-path-to-get-closer-to-normal-by-july-4th/>.

²⁹ Amy Schoenfeld Walker et al., “Pandemic’s Racial Disparities Persist in Vaccine Rollout,” *New York Times*, March 5, 2021, <https://www.nytimes.com/interactive/2021/03/05/us/vaccine-racial-disparities.html>.

vaccine coverage than less vulnerable jurisdictions.³⁰ In addition, as of April, 2021, COVID-19 vaccine coverage was lower in rural counties than in urban, and more residents of rural counties had to travel to nonadjacent counties to receive a vaccine than did residents of urban counties.³¹

Selected Federal Laws and Policies to Address Health Disparities

Various standing authorities, entities, and policies were in place before the onset of the COVID-19 pandemic to protect against discrimination in disaster preparedness and response during public health emergencies. Additional authorities, entities, and policies were developed specifically in response to the pandemic. Both are discussed below.

Authorities, Entities, and Policies That Pre-Dated the Pandemic

The **Civil Rights Act (CRA)**, the **Rehabilitation Act**, and other antidiscrimination laws prohibit discrimination against specific groups. Under Title VI of the CRA, federally funded programs and activities may not discriminate in providing access or benefits because of race, color, religion, or national origin. The law bars intentional discrimination based on these characteristics; in some circumstances, applicable regulations also bar methods of administration that would have a disproportionate, unjustified, and adverse impact based on these characteristics.³² Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any programs and activities receiving financial assistance from federal agencies.³³ These antidiscrimination protections remain in effect during disasters and public health emergencies.

Stafford Act: The Robert T. Stafford Disaster Relief and Emergency Assistance (Stafford) Act, Section 308, ensures that all regulations issued by the President in response to a major disaster are “accomplished in an equitable and impartial manner, without discrimination on the grounds of race, color, religion, nationality, sex, age, disability, English proficiency, or economic status.”³⁴ These protections are applicable to the COVID-19 pandemic response, as either emergency or major disaster declarations related to the pandemic have been in effect since March 13, 2020.³⁵ FEMA regulations implementing Section 308 generally require compliance with the agency’s regulations implementing Title VI of the CRA and the Age Discrimination Act of 1975.³⁶

Homeland Security Act: The Homeland Security Act established the Homeland Security Grant Program, which funds a variety of preparedness and response activities for SLTT jurisdictions.³⁷ Recipients of these grants are directed to develop their programs and activities, “in a manner that

³⁰ Melilo, Gianna. “Disparities in COVID-19 Vaccine Rates Tarnish Swift US Rollout,” *American Journal of Managed Care*, April 1, 2021, ajmc.com/view/disparities-in-covid-19-vaccine-rates-tarnish-swift-us-rollout.

³¹ CDC, “Disparities in COVID-19 Vaccination Coverage Between Urban and Rural Counties—United States, December 14, 2020—April 10, 2021,” *MMWR*, May 21, 2021, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7020e3.htm>.

³² P.L. 88-352, 78 Stat. 241; 42 U.S.C. §2000d. For more information see HHS, Office of Civil Rights, “Civil Rights Protections Prohibiting Race, Color and National Origin Discrimination During COVID-19: Application of Title VI of the Civil Rights Act of 1964,” July 20, 2020, <https://www.hhs.gov/sites/default/files/title-vi-bulletin.pdf?language=es>.

³³ P.L. 114-95, as amended; 29 U.S.C. §794.

³⁴ P.L. 100-707, as amended; 42 U.S.C. §5152.

³⁵ Federal Emergency Management Agency, “COVID-19 Disaster Declarations,” <https://www.fema.gov/disasters/coronavirus/disaster-declarations>.

³⁶ 44 C.F.R. §206.11 (citing 44 C.F.R. Part 7).

³⁷ P.L. 116-283, as amended, §2002; 6 U.S.C. §603.

respects and ensures the protection of civil rights for protected populations.”³⁸ DHS Standard Terms and Conditions for federal financial assistance includes a larger list of civil rights provisions that apply.³⁹ In addition, regulations prohibit discrimination on the basis of race, color, national origin, sex, religion, and disability in connection with programs and activities receiving federal financial assistance from the Department of Homeland Security (DHS).⁴⁰

Patient Protection and Affordable Care Act: Section 1557 of the act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in any health program or activity which receives funding from the U.S. Department of Health and Human Services (HHS).⁴¹ As measures to combat the COVID-19 pandemic have been significantly funded by HHS, these regulations would apply.

Social Security Act: Section 508 of the act prohibits discrimination on the basis of age, race, color, national origin, disability, sex (gender), or religion in the Maternal and Child Health Services Block Grant.⁴²

Public Health Service Act (PHSA): Section 319-C1 of the act requires that entities eligible for the Public Health Emergency Preparedness (PHEP) grant submit to HHS an All-Hazards Public Health Emergency Preparedness and Response Plan that includes, among other elements, “preparedness and response strategies and capabilities that take into account the medical and public health needs of at-risk individuals in the event of a public health emergency.”⁴³ Various other sections of the act include program-specific provisions that prohibit discrimination.⁴⁴ According to the HHS Grants Policy Statement (2007),⁴⁵ all HHS grant recipients are required to adhere to several statutes and policies that prohibit various forms of discrimination and apply to any program or activity that receives federal funding.⁴⁶

HHS Office of Civil Rights (OCR): OCR enforces civil rights laws on behalf of HHS.⁴⁷ In March, 2020, OCR released a bulletin restating its commitment to upholding the legal standing authorities mentioned above.⁴⁸ It also provided actionable steps to assist partners in ensuring equitable access to COVID-19 information, resources, and response activities.

³⁸ DHS, *Notice of Funding Opportunity (NOFO), Fiscal Year 2021 Homeland Security Grant Program*, 2020, pp. 48-49, https://www.fema.gov/sites/default/files/documents/FEMA_FY2021-HSGP-NOFO_02-19-21.pdf.

³⁹ DHS, *Fiscal Year 2021 DHS Standard Terms and Conditions Version 11.4*, February 17, 2021, https://www.dhs.gov/sites/default/files/publications/fy_2021_dhs_standard_terms_and_conditions_version_11.4_dated_02-17-2021.pdf.

⁴⁰ 6 C.F.R. §§15.1 - 21.21.

⁴¹ P.L. 111-148, as amended; 42 U.S.C. §18116. See HHS Office of Civil Rights (OCR), “Section 1557 of the Patient Protection and Affordable Care Act,” <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>.

⁴² 42 U.S.C. §708.

⁴³ 42 U.S.C. §247d-3a(b)(2)(A)(iii). A definition for “at-risk” individuals is provided at 42 U.S.C. §300hh-1(b)(4)(B).

⁴⁴ See for example 42 U.S.C. §290cc-33, 42 U.S.C. §300w-7, and 42 U.S.C. §300x-57.

⁴⁵ <https://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf>.

⁴⁶ See generally, P.L. 94-135, <https://www.govinfo.gov/content/pkg/STATUTE-89/pdf/STATUTE-89-Pg713.pdf#page=16>; P.L. 88-352, 78 Stat. 241, <https://www.govinfo.gov/content/pkg/COMPS-342/pdf/COMPS-342.pdf>; P.L. 92-318, <https://www.govinfo.gov/content/pkg/STATUTE-86/pdf/STATUTE-86-Pg235.pdf>; P.L. 93-112; and 45 C.F.R. Part 80.

⁴⁷ HHS Office of Civil Rights (OCR), “About Us,” <https://www.hhs.gov/ocr/about-us/index.html>; and “Laws Enforced by OCR,” <https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html>.

⁴⁸ HHS Office of Civil Rights (OCR), “Bulletin: Civil Rights, HIPAA, and the Coronavirus Disease 2019 (COVID-19),” March 28, 2020, <https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf>.

HHS Office of Minority Health (OMH): OMH develops health policies and programs intended to eliminate health disparities.⁴⁹ The office works in conjunction with other HHS agencies to address the impact of COVID-19 on racial and ethnic minority communities.⁵⁰

Authorities, Entities, and Policies Specific to the Pandemic

To date, Congress has passed and President Donald J. Trump or President Joseph R. Biden has signed six laws that provide, among other things, funding for the public health and medical response to the COVID-19 pandemic. These laws are

- The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123);
- The Families First Coronavirus Response Act, 2020 (P.L. 116-127), Division A;
- The Coronavirus Aid, Relief, and Economic Security Act, 2020 (the “CARES Act”) (P.L. 116-136);
- The Paycheck Protection Program and Health Care Enhancement Act, 2020 (P.L. 116-139);
- The Consolidated Appropriations Act, 2021 (P.L. 116-260), Division M (the Coronavirus Response and Relief Supplemental Appropriations Act of 2021); and
- The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2).⁵¹

The Paycheck Protection Program and Health Care Enhancement Act, Division B, Title I appropriated \$75 billion for the Public Health and Social Services Emergency Fund (PHSSEF), provided that the HHS Secretary shall report to Congress on a strategic testing plan that “address[es] disparities on all communities.”

The Consolidated Appropriations Act of 2021, Division M, Title III states that not less than \$300 million of the \$8.75 billion made available for “CDC-Wide Activities and Program Support” is directed for “high-risk and underserved populations, including racial and ethnic minority populations and rural communities,” and communication efforts to reach these populations. Furthermore, of the nearly \$23 billion available to the PHSSEF for pandemic response domestically and internationally, \$2.5 billion is designated for improving testing capabilities, contact tracing, and other purposes for high-risk and underserved populations, including racial and ethnic minorities and rural populations.

ARPA Section 2206 appropriated \$852 million to the Corporation for National and Community Service, \$620 million of which was to be used to adjust funding to prioritize entities that serve communities disproportionately impacted by the pandemic.⁵² ARPA also appropriated \$7.7 billion dollars for public health departments for costs related to workforce development⁵³ and another

⁴⁹ HHS, Office of Minority Health, <https://www.minorityhealth.hhs.gov/>.

⁵⁰ For more information regarding actions taken by these other HHS agencies to address equity in the COVID-19 response see OMH, “HHS Offices of Minority Health COVID-19 Initiatives and Resources,” May 5, 2021, <https://minorityhealth.hhs.gov/omh/Content.aspx?ID=18514&lvl=2&lvlid=12>.

⁵¹ See CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress*, coordinated by Kavya Sekar; and CRS Report R46834, *American Rescue Plan Act of 2021 (P.L. 117-2): Public Health, Medical Supply Chain, Health Services, and Related Provisions*, coordinated by Johnathan H. Duff and Kavya Sekar.

⁵² American Rescue Plan Act of 2021 §2206.

⁵³ American Rescue Plan Act of 2021 §2501.

\$7.7 billion for community health centers in part for pandemic response; for both of these amounts, Congress emphasized providing support in medically underserved areas.⁵⁴

Executive Order 13995 and the COVID-19 Health Equity Task Force: Executive Order 13995, “Ensuring an Equitable Pandemic Response and Recovery,” issued on January 21, 2021, directed the establishment of the COVID-19 Health Equity Task Force, and required coordination of government-wide COVID-19 response activities in order to prevent health inequities.⁵⁵

The COVID-19 Health Equity Task Force was established in the HHS Office of Minority Health. According to its charter, the Task Force provides specific recommendations to the President regarding resource allocation, distribution of relief funding, communications strategies, and other matters to mitigate health inequities caused or exacerbated by the COVID-19 pandemic, including racism, xenophobia, and intolerance against Asian Americans and Pacific Islanders in the United States.⁵⁶

Executive Order 13995 also commented on the need for better information about health disparities, saying

The lack of complete data, disaggregated by race and ethnicity, on COVID-19 infection, hospitalization, and mortality rates, as well as underlying health and social vulnerabilities, has further hampered efforts to ensure an equitable pandemic response. Other communities, often obscured in the data, are also disproportionately affected by COVID-19, including sexual and gender minority groups, those living with disabilities, and those living at the margins of our economy. Observed inequities in rural and Tribal communities, territories, and other geographically isolated communities require a place-based approach to data collection and the response. Despite increased State and local efforts to address these inequities, COVID-19’s disparate impact on communities of color and other underserved populations remains unrelenting.⁵⁷

The Order directed the Task Force to develop recommendations to address these data shortfalls. (See also “Data Gaps” below.)

FEMA Civil Rights Advisory Group (CRAG⁵⁸): FEMA established the Civil Rights Advisory Group on January 29, 2021, “to help ensure equity in the allocation of scarce resources, including to ensure that Community Vaccine Centers (CVCs) in the Federal pilot program are located in areas that help serve historically disenfranchised and vulnerable populations.”⁵⁹

CDC COVID-19 Response Health Equity Strategy: In July 2020 CDC released a strategy outlining how organizations could reduce disparities in health outcomes from the pandemic, and improve equity in response efforts.⁶⁰ The strategy called for broad measures such as evidence-

⁵⁴ American Rescue Plan Act of 2021 §2501.

⁵⁵ Executive Order 13995, “Ensuring an Equitable Pandemic Response and Recovery,” 86 *Federal Register* 7193-7196, January 21, 2021, <https://www.govinfo.gov/content/pkg/FR-2021-01-26/pdf/2021-01852.pdf>.

⁵⁶ HHS, Office of Minority Health, “About COVID-19 Health Equity Task Force,” with link to Charter, <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=100>.

⁵⁷ Executive Order 13995, “Ensuring an Equitable Pandemic Response and Recovery,” 86 *Federal Register* 7193-7196, January 21, 2021, <https://www.govinfo.gov/content/pkg/FR-2021-01-26/pdf/2021-01852.pdf>.

⁵⁸ CRS Report R46715, *FEMA Assistance for Vaccine Administration and Distribution: In Brief*, by Erica A. Lee and Kavya Sekar.

⁵⁹ FEMA, *FEMA Civil Rights Summits 2020: After Action Report*, April 2021, Version 2.0, p. 3, https://www.fema.gov/sites/default/files/documents/fema_civil-rights-summits-2020-after-action-report.pdf.

⁶⁰ CDC, “CDC COVID-19 Response Health Equity Strategy: Accelerating Progress Towards Reducing COVID-19 Disparities and Achieving Health Equity,” July 2020, available at <https://www.cdc.gov/coronavirus/2019-ncov/>

based policies to address equities, and greater use of preventive measures such as testing and contact tracing, assigning specific actions and timelines to meet these measures. The Government Accountability Office (GAO) analyzed the strategy and offered a number of recommendations to CDC, including to (1) determine whether it had the authority to require jurisdictions to report relevant race and ethnicity information; (2) involve relevant stakeholders to ensure comprehensive collection of demographic data; and (3) ensure that it had the ability to assess the long-term health outcomes of individuals with COVID-19.⁶¹

Addressing Health Equity in COVID-19 Vaccination Planning: Initial funding to SLTT for COVID-19 vaccination program planning was provided by CDC. Mentions of inequity and plans to mitigate it were generally present in grant guidance and other technical assistance documents.⁶² However, in April 2021, CDC announced \$3.15 billion from the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 (P.L. 116-260) and ARPA to make awards to 64 immunization program grantees specifically to address inequities in vaccine administration. In its guidance, CDC identified the following groups for special attention by grantees: (1) racial and ethnic minority groups, specifically Non-Hispanic American Indian; Alaska Native; Non-Hispanic Black; and Hispanic; (2) those living in communities with a high social vulnerability index; (3) those living in rural communities; (4) individuals with disabilities; (5) those who are homebound or isolated; (6) those who are underinsured or uninsured; (7) those who are immigrants and/or refugees; and (8) those with transportation limitations.⁶³

Selected Issues for Congress

Federalism

Initial demand for COVID-19 vaccines exceeded supply. CDC adopted recommendations of its Advisory Committee on Immunization Practices (ACIP) to prioritize certain populations. (See **Figure 2**.) These individuals included seniors and others at increased risk for contracting or suffering severe complications from COVID-19 infection; and essential workers, whose ranks disproportionately include racial and ethnic minorities.

To date, all COVID-19 vaccines in the United States have been federally purchased, which may allow the federal government more authority in directing the use of this product. Providers who have agreed to administer COVID-19 vaccines have been required to sign and adhere to a “Provider Agreement” that specifies, among other provisions, that providers would attempt to vaccinate only those individuals who were eligible to receive the vaccine according to priority groups outlined by either CDC or the state or territory’s governor or other relevant public health authority.⁶⁴ In some instances, the HHS secretary directed health care providers to vaccinate

downloads/community/CDC-Strategy.pdf.

⁶¹ U.S. Government Accountability Office, *Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention*, GAO-21-265, January 2021, p. 297, <https://www.gao.gov/assets/gao-21-265.pdf>.

⁶² CDC, “COVID-19 Vaccination Program Interim Operational Guidance Jurisdiction Operations,” October 29, 2020, p. 15, https://www.cdc.gov/vaccines/imz-managers/downloads/Covid-19-Vaccination-Program-Interim_Playbook.pdf; and CDC, “Vaccine with Confidence,” December 6, 2020, <https://www.cdc.gov/vaccines/covid-19/downloads/vaccinate-with-confidence.pdf>.

⁶³ CDC, “COVID-19 Vaccination Supplement 4 (April 2021): Funding Equity and Prioritizing Populations Disproportionately Affected by COVID-19,” April 2021, p. 3, <https://www.cdc.gov/vaccines/covid-19/covid19-vaccination-guidance.html>.

⁶⁴ CDC, “CDC COVID-19 Vaccination Program Provider Requirements and Support,” <https://www.cdc.gov/vaccines/>

identified priority groups utilizing this same provider agreement.⁶⁵ During the initial phase of COVID-19 vaccine distribution, vaccine was allocated to state and territorial health departments, which then distributed the vaccine according to the jurisdiction’s prioritization scheme.⁶⁶

Figure 2. Initial ACIP Recommendations for COVID-19 Vaccine Allocation

December 22, 2020

Phase	Recommended Groups	Total Persons in Group (millions)	Unique Persons, Group (millions)	Unique Persons, Phase (millions)
1a	Healthcare personnel	21	21	24
	LTCF residents	3	3	
1b	Frontline essential workers	30	30	49
	Persons 75 years or older	21	19	
1c	Persons 65-74 years	32	28	129
	Persons <65 with risk factors	110	81	
	Rest of essential workers	57	20	
2	All others age 16 or older	All remaining	All remaining	All remaining

Source: Kathleen et al., “The Advisory Committee on Immunization Practices’ Updated Interim Recommendation for Allocation of COVID-19 Vaccine—United States, December 2020,” *MMWR*, vol. 69, December 22, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm>.

Notes: Groups 1b and 1c are highlighted per discussion in text.

The ACIP recommendations were intended as guidance to SLTT leaders.⁶⁷ Under the principle of federalism, U.S. state legislatures and governors are generally afforded the flexibility to determine state policy regarding matters of health care and public health, unless federal powers are implicated. This flexibility led to a patchwork of different COVID-19 vaccine prioritization schemes, often placing younger seniors (i.e., between 65 and 74 years old) ahead of essential workers in priority (see red highlighted rows, **Figure 2.**) This patchwork approach led the Government Accountability Office (GAO) to comment that these differences in designation of vaccine priority groups may have contributed to appearances of inequity.⁶⁸

The principle of federalism affords SLTT leaders deference in responding to the health care needs of their varied jurisdictions. The lack of strong federal direction for COVID-19 vaccine usage, however, may have contributed to disparities among populations receiving the vaccine. Congress

covid-19/vaccination-provider-support.html.

⁶⁵ HHS, “Secretarial Directive for Prioritization of COVID-19 Vaccines and Administration for Certain Educational and Child Care Workers,” issued by then-Acting HHS Secretary Norris Cochran, March 2, 2021, <https://www.hhs.gov/sites/default/files/secretarial-directive-prioritization-covid-19-vaccines.pdf>.

⁶⁶ HHS, “COVID-19 Vaccine Distribution: The Process,” <https://www.hhs.gov/coronavirus/covid-19-vaccines/distribution/index.html>.

⁶⁷ HHS, *Answers to National Governors Association Questions*, October 30, 2020, <https://www.hhs.gov/sites/default/files/national-governors-association-questions-on-vaccine-distribution-planning.pdf>.

⁶⁸ U.S. Government Accountability Office, *Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention*, GAO-21-265, January 2021, p. 111, <https://www.gao.gov/assets/gao-21-265.pdf>.

may wish to consider whether certain incentives, or a stronger exercise of federal authority in the allowable uses of federal funding assistance, could better assure equity in response to public health emergencies in the future.

Data Gaps

Health data, especially those collected during a public health emergency, are often incomplete in identifying race, ethnicity, disability, and other characteristics that may demonstrate disparities.⁶⁹ The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, Section 4302) required HHS to establish data collection standards for race, ethnicity, sex, primary language, and disability status, to be used, to the extent practicable, in all HHS-supported or conducted population health surveys.⁷⁰ However, individuals are not required to self-report this information, and often don't. In addition, much public health data collection occurs at the SLTT level. SLTT agencies, the collectors and “owners” of many types of public health data, may not report data they have to CDC or make it publicly available. In some cases jurisdictional privacy and other laws may impede data sharing.

During the COVID-19 pandemic, the federal government imposed its own data reporting requirements on health care entities for testing and vaccination data, which include demographic data reporting.⁷¹ Despite the federal requirements, a substantial portion of CDC-published data related to cases and vaccinations is missing information on race/ethnicity.⁷² Additional barriers to good quality disparities data have included reporting burdens for health care professionals, a lack of relevant data-sharing agreements, and infrastructure gaps that impede data sharing.

Proposals to improve collection of data on individual demographic characteristics include broader use of the ACA data standards; use of incentives to states and providers;⁷³ continued efforts to modernize, standardize, and integrate data infrastructure, including through CDC's Data Modernization Initiative and related efforts;⁷⁴ and various private and academic efforts to compile existing data.⁷⁵ (See also “Executive Order 13995 and the COVID-19 Health Equity Task Force” in “Authorities, Entities, and Policies Specific to the Pandemic” above.)

⁶⁹ Katie Palmer, “A New Tool Puts Health Disparity Data in the Public's Hands,” *STAT*, May 26, 2021, <https://www.statnews.com/2021/05/26/health-equity-tracker-disparities-data-covid19/>.

⁷⁰ HHS, Office of the Assistant Secretary for Evaluation and Planning (ASPE), “HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status,” October 30, 2011, <https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0>.

⁷¹ See for example HHS, “COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115,” January 8, 2020, <https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf>; and CDC, “CDC COVID-19 Vaccination Program Provider Requirements and Support,” <https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html>.

⁷² CDC, “Demographic Trends of COVID-19 Cases and Deaths in the US Reported to CDC,” last updated July 27, 2021, and “Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States,” <https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic>.

⁷³ See for example Andrea Thoumi, Hemi Tewarson, and Kate Johnson, *Prioritizing Equity for COVID-19 Vaccinations: Promising Practices from States to Reduce Racial and Ethnic Disparities*, Duke-Margolis Center for Health Policy and National Governors Association Center for Best Practices, March 2021, <https://www.nga.org/center/publications/prioritizing-equity-in-covid-19-vaccinations/>.

⁷⁴ See “Data Modernization” in CRS Report R46588, *Tracking COVID-19: U.S. Public Health Surveillance and Data*, by Kavya Sekar and Angela Napili.

⁷⁵ See for example Katie Palmer, “A New Tool Puts Health Disparity Data in the Public's Hands,” *STAT*, May 26, 2021, <https://www.statnews.com/2021/05/26/health-equity-tracker-disparities-data-covid19/>.

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