Public Health Service Agencies: Overview and Funding

Amalia K. Corby-Edwards, Coordinator
Analyst in Public Health and Epidemiology

C. Stephen Redhead, Coordinator
Specialist in Health Policy

November 12, 2013

Congressional Research Service
7-5700
www.crs.gov
R43304

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

Within the Department of Health and Human Services (HHS), eight agencies are designated components of the U.S. Public Health Service (PHS): (1) the Agency for Healthcare Research and Quality (AHRQ), (2) the Agency for Toxic Substances and Disease Registry (ATSDR), (3) the Centers for Disease Control and Prevention (CDC), (4) the Food and Drug Administration (FDA), (5) the Health Resources and Services Administration (HRSA), (6) the Indian Health Service (IHS), (7) the National Institutes of Health (NIH), and (8) the Substance Abuse and Mental Health Services Administration (SAMHSA). This report gives a brief overview of each agency and summarizes its funding for FY2010 through FY2013, as well as its FY2014 budget request.

The total amount of funding available to the agencies (i.e., total program level) includes discretionary budget authority provided in annual appropriations acts—plus additional funding from other sources, including user fees and collections from third-party payers—and mandatory funding. Mandatory funding for PHS agencies is provided in laws other than annual appropriations acts, notably the Patient Protection and Affordable Care Act (ACA, P.L. 111-148). Five of the PHS agencies are funded through the Labor, Health and Human Services, and Education (Labor-HHS-ED) appropriations act, and those agencies are subject to the PHS Program Evaluation Set-Aside. Set-aside funds are distributed to evaluate program implementation and effectiveness based on amounts approved by appropriators.

AHRQ and NIH are primarily research agencies. AHRQ conducts and supports health services research to improve the quality of health care. NIH conducts and supports basic, clinical, and translational biomedical and behavioral research. Three PHS agencies—IHS, HRSA, and SAMHSA—provide health care services or help fund systems that do so. IHS supports a health care delivery system for American Indians and Alaska Natives. HRSA funds programs and systems to improve access to health care among the uninsured and medically underserved. SAMHSA funds mental health and substance abuse prevention and treatment services. CDC and ATSDR coordinate and support a variety of population-based programs to prevent and control disease, injury, and disability. FDA regulates drugs, medical devices, food, dietary supplements, and tobacco products.

In 2011, Congress and the President enacted the Budget Control Act (BCA, P.L. 112-25) in response to concerns about the growth in the federal deficit. The BCA established limits on overall discretionary spending and triggered annual across-the-board spending reductions—a process known as sequestration—beginning in FY2013. These deficit-reduction measures have also affected PHS agency discretionary and mandatory funding. For FY2013, each agency's post-sequester total program level funding was as follows:

- AHRQ, which is funded by PHS set-aside and mandatory transfers: $429 million, which is $24 million (5.9%) above the FY2012 amount.
- NIH, which is almost entirely funded by discretionary appropriations: $29.151 billion, which is $1.709 billion (5.5%) below the FY2012 amount.
- IHS, which is funded by a combination of discretionary appropriations, mandatory appropriations, and collections: $5.258 billion, which is $160 million (3.0%) below the FY2012 amount.

- HRSA, which is funded by a combination of discretionary appropriations, ACA mandatory appropriations, PHS set-aside funds, and user fees: $8.1 billion, which is $105 million (1.3%) below the FY2012 amount.
- SAMHSA, which is funded largely by discretionary appropriations, also receives some PHS evaluation funds: $3.355 billion, which is $214 million (6.0%) below the FY2012 level.
- CDC (including ATSDR), which is funded by a combination of discretionary appropriations and mandatory appropriations: $10.258 billion, which is $935 million (8.4%) below the FY2012 level.
- FDA receives an increasing proportion of its funding from industry user fees, and also receives discretionary appropriations: $4.031 billion, which is $199 million (5.1%) above the FY2012 amount.

Contents

Figures

Tables

Appendixes

Contacts

Introduction

The Department of Health and Human Services (HHS) has designated eight of its 11 operating divisions (agencies) as components of the U.S. Public Health Service (PHS). The PHS agencies are: (1) the Agency for Healthcare Research and Quality (AHRQ), (2) the Agency for Toxic Substances and Disease Registry (ATSDR), (3) the Centers for Disease Control and Prevention (CDC), (4) the Food and Drug Administration (FDA), (5) the Health Resources and Services Administration (HRSA), (6) the Indian Health Service (IHS), (7) the National Institutes of Health (NIH), and (8) the Substance Abuse and Mental Health Services Administration (SAMHSA).[1]

Collectively, the PHS agencies provide and support essential public health services. Individually, the missions of the PHS agencies vary. With the exception of FDA, the agencies have limited regulatory responsibilities. Two of them, NIH and AHRQ, are primarily research agencies. NIH conducts and supports basic, clinical, and translational medical research. AHRQ conducts and supports research on the quality and effectiveness of health care services and systems.

Three of the other agencies—IHS, HRSA, and SAMHSA—provide health care services or help support systems that deliver such services. IHS supports a health care delivery system for American Indians and Alaska Natives. Health services are provided directly by the IHS, as well as through tribally contracted and operated health programs, and through services purchased from private providers. HRSA funds programs and systems to improve access to health care among low-income populations, pregnant women and children, persons living with HIV/AIDS, rural and frontier populations, and others who are medically underserved. SAMHSA funds community-based mental health and substance abuse prevention and treatment services.

CDC is a public health agency that develops and supports community-based and population-wide programs and systems, such as disease surveillance and education programs, for a full spectrum of acute and chronic diseases and injuries, including public health emergencies and bioterrorism. ATSDR, headed by the CDC director, is tasked with identifying potential public health effects from exposure to hazardous substances. Finally, FDA is primarily a regulatory agency, whose mission is to ensure the safety of foods, dietary supplements, and cosmetics, and the safety and effectiveness of drugs, vaccines, medical devices, and other health products.

The programs and activities of five of the PHS agencies—AHRQ, CDC, HRSA, NIH, and SAMHSA—are mostly authorized under the Public Health Service Act (PHSA).[2] While some of FDA's regulatory activities are also authorized under the PHSA, the agency and its programs largely derive their statutory authority from the Federal Food, Drug, and Cosmetic Act

[1] HHS also includes three human services agencies that are not part of the Public Health Service: (1) the Administration for Children and Families (ACF); (2) the Administration for Community Living (ACL), which was created in April 2012 by consolidating the Administration on Aging (AoA), the HHS Office on Disability, and ACF's Administration on Developmental Disability; and (3) the Centers for Medicare & Medicaid Services (CMS). Departmental leadership is provided by the Office of the Secretary, which is comprised of various subdivisions including the Assistant Secretary for Preparedness and Response (ASPR), the Assistant Secretary for Health (ASH), the Office of the Surgeon General, the Office for Civil Rights (OCR), the Office of the Inspector General (OIG), and the Office of the National Coordinator for Health Information Technology (ONC). For more information on HHS and links to the PHS agency websites, see http://www.hhs.gov/.

[2] 42 U.S.C. §§201 et seq.

(FFDCA).[3] HRSA's maternal and child health programs are authorized in the Social Security Act (SSA);[4] and many of the IHS programs and services are authorized by the Indian Health Care Improvement Act.[5] ATSDR was created by the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA, the "Superfund" law).[6]

Overview of PHS Agency Funding

The main source of funding for each PHS agency is the discretionary budget authority it receives through the annual appropriations process.[7] AHRQ, CDC, HRSA, NIH, and SAMHSA are funded through the Departments of Labor, Health and Human Services, Education, and Related Agencies (Labor-HHS-ED) appropriations act. Funding for ATSDR and IHS is provided through the Department of the Interior, Environment, and Related Agencies (Interior/Environment) appropriations act. FDA gets its funding through the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies (Agriculture) appropriations act.[8]

In addition to the discretionary funding that is provided by the annual appropriations acts, PHS agencies may also receive funds from the PHS Program Evaluation Set-Aside, mandatory appropriations, supplemental appropriations, user fees, and collections from third-party payers. As discussed briefly below, and in more detail in the relevant sections later in the report, these additional sources of funding are a substantial component of the budget of several PHS agencies.

PHS Agency FY2013 Funding At-a-Glance

Agency for Healthcare Research and Quality (AHRQ)

For FY2013, AHRQ's post-sequester program level is $429 million, which is $24 million (5.9%) above the FY2012 amount. See **Table 2**.

Centers for Disease Control and Prevention (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR)

For FY2013, CDC's post-sequester discretionary budget authority (including ATSDR) is $5.509 billion, within its total program level of $10.258 billion. Relative to FY2012, CDC/ATSDR's discretionary budget authority decreased by 3.9% and overall program level decreased by 8.4%. See **Table 3**.

Food and Drug Administration (FDA)

For FY2013, FDA's post-sequester program level is $4.031 billion, which includes $2.386 billion in discretionary funding and $1.645 billion in user fees. Relative to FY2012, these amounts represent a 4.8% decrease in discretionary

[3] 21 U.S.C. §§301 et seq.

[4] SSA Title V, 42 U.S.C. §§701 et seq.

[5] 25 U.S.C. §§1601 et seq.

[6] 42 U.S.C. §9604(i).

[7] Budget authority is the authority provided in federal law to incur financial obligations that will result in immediate or future expenditures, or outlays, of federal funds. Such obligations include contracts for the purchase of supplies and services, liabilities for salaries and wages, and awarding grants. Appropriations are the most common form of budget authority. Discretionary budget authority represents funding that is provided in and controlled by the annual appropriations acts.

[8] For an overview of each of these three appropriations acts, see CRS Report CRS Report R43236, *Labor, Health and Human Services, and Education (L-HHS-ED): FY2014 Appropriations*, coordinated by Karen E. Lynch; CRS Report R42525, *Interior, Environment, and Related Agencies: FY2013 Appropriations*, coordinated by Carol Hardy Vincent; and CRS Report R42596, *Agriculture and Related Agencies: FY2013 Appropriations*, by Jim Monke.

budget authority and a 24.0% increase in user fees. See **Table 4**.

Health Resources and Services Administration (HRSA)

For FY2013, HRSA's post-sequester discretionary budget authority is $5.863 billion, within its total program level of $8.100 billion. Relative to FY2012, HRSA's discretionary budget authority decreased by 5.7%, and its total program level decreased by 1.3%. See **Table 5**.

Indian Health Service (IHS)

For FY2013, IHS's post-sequester discretionary budget authority is $4.131 billion, within its program level funding of $5.258 billion. Relative to FY2012, IHS's discretionary budget authority decreased by 4.1%, and its total program level decreased by 3.0%. See **Table 6**.

National Institutes of Health (NIH)

For FY2013, NIH's post-sequester program level is $29.151 billion, within its discretionary budget authority of $29.001 billion. Relative to FY2012, both NIH's program level and discretionary budget authority decreased by 5.5%. See **Table 7**.

Substance Abuse and Mental Health Services Administration (SAMHSA)

For FY2013, SAMHSA's post-sequester program level is $3.355 billion, within its discretionary budget authority of $3.211 billion. Relative to FY2012, SAMHSA's program level decreased by 6.0% and its discretionary budget authority decreased by 4.1%. See **Table 8**.

PHS Program Evaluation Set-Aside

The five PHS agencies funded through the Labor-HHS-ED appropriations act are subject to the PHS Program Evaluation Set-Aside ("set-aside"), which is a unique feature of HHS appropriations, authorized by Section 241 of the PHSA. This provision authorizes the HHS Secretary, with the approval of appropriators, to use a portion of the funds appropriated for PHSA programs to evaluate their implementation and effectiveness. Under this authority, the appropriations of a number of HHS agencies and offices are subject to a budget "tap." The tapped funds are redistributed within the department for evaluation and other specific purposes. Although the PHSA limits the set-aside to no more than 1% of program appropriations, in recent years the annual Labor-HHS-ED appropriations act has specified a higher maximum amount of set-aside funds. The FY2012 Labor-HHS-ED appropriations act capped the set-aside at 2.5%,[9] an amount that was continued in FY2013 by the Full-Year Continuing Appropriations Act.[10] For FY2014, the President's budget proposes increasing the set-aside to 3.0%.

Following passage of the annual Labor-HHS-ED appropriations act, the HHS Budget Office calculates the amount of set-aside funds to be tapped from the various donor agencies and offices. It then allocates those funds to recipient agencies and programs, including offices within the Office of the Secretary, based on the amounts specified in the appropriations act.[11] In FY2012, four PHS agencies—CDC, HRSA, NIH, and SAMHSA—together donated almost all (98%) of the set-aside funds.[12] These agencies also were recipients of set-aside funds. A fifth PHS

[9] P.L. 112-74, Division F, Section 205, 125 Stat. 1082.

[10] P.L. 113-6, Division F, 127 Stat. 412.

[11] For further details, see Chapter I of HHS, Office of the Assistant Secretary for Planning and Evaluation, "Evaluation: Performance Improvement 2009," Washington, DC, 2010, pp. 6-8, http://aspe.hhs.gov/pic/perfimp/2009/report.pdf.

[12] HHS, "Use of Public Health Service Set-Aside Authority for Fiscal Year 2012, Report to Congress." Most of the funds appropriated for CDC, HRSA, NIH, and SAMHSA are subject to the PHS evaluation tap. Exceptions, by HHS convention, normally include funds appropriated for certain block grants administered by those agencies (targeting (continued...)

agency—AHRQ—is also an important recipient of funding. In recent years, AHRQ has not received a discretionary appropriation and has been largely supported by the set-aside funds and other transfers it receives (see **Table 2**).

Supplemental Appropriations

In February 2009, the American Reinvestment and Recovery Act (Recovery Act, or ARRA) provided $15.100 billion in supplemental FY2009 discretionary appropriations to the five PHS agencies that receive annual discretionary appropriations through the Labor-HHS-ED appropriations act.[13] Details of the allocation of those funds are provided in **Appendix A**. Almost all of the ARRA appropriations were designated as two-year funds, available for obligation through the end of FY2010.

Mandatory Appropriations

Although the bulk of PHS agency funding is provided by discretionary appropriations, agencies also receive mandatory funding from other sources.[14] The Patient Protection and Affordable Care Act (ACA)[15] included numerous provisions financed with appropriations that provide billions of dollars of mandatory (or direct) spending to support new and existing grant programs and other activities.[16]

Several of those ACA provisions appropriated funds for specified programs and activities within the PHS agencies. These appropriations are itemized and included in the funding tables later in this report. ACA also established three multibillion dollar trust funds to support programs and activities within the PHS agencies (see text box).

(...continued)

prevention, substance abuse, and mental health), for program management activities, and for buildings and facilities. It also includes funds appropriated for some programs not authorized by the PHSA, such as HRSA's maternal and child health block grant.

[13] P.L. 111-5, 123 Stat. 115. The PHS agency appropriations were included in Title VIII (Labor-HHS-ED) of Division A of ARRA. In addition to these discretionary appropriations, ARRA included several HHS mandatory spending provisions. For example, ARRA temporarily increased federal payments to states under the Medicaid and the Temporary Assistance for Needy Families (TANF) programs. ARRA also incorporated the Health Information Technology for Economic and Clinical Health (HITECH) Act, which established multibillion dollar incentive programs under Medicare and Medicaid to encourage hospitals and physicians to adopt and use interoperable electronic health record technology. For more information, see CRS Report R40537, *American Recovery and Reinvestment Act of 2009 (P.L. 111-5): Summary and Legislative History*, by Clinton T. Brass et al.

[14] Mandatory spending, also known as direct spending, refers to outlays from budget authority that is provided in laws other than annual appropriations acts. Mandatory spending includes spending on entitlement programs.

[15] ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended multiple health care and revenue provisions in ACA. A number of other subsequently enacted laws have made more targeted changes to specific ACA provisions. All references to ACA in this report refer to the law as amended.

[16] For a complete list and discussion of all the appropriations in ACA, including details of the obligation of these funds, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead.

Trust Funds Established in the Affordable Care Act

The **Community Health Center Fund (CHCF)**, for which ACA provided a total of $11.000 billion in annual appropriations over the five-year period FY2011-FY2015, is helping support the federal health center program and the National Health Service Corps (NHSC), both administered by HRSA.[17] The contribution of CHCF funds to HRSA's budget is discussed in more detail in the HRSA section of this report. A table summarizing each fiscal year's CHCF appropriation and the allocation of funds appears in **Appendix B**.

The **Prevention and Public Health Fund (PPHF)**, for which ACA provided a permanent annual appropriation, is intended to support prevention, wellness, and other public health programs and activities.[18] The Middle Class Tax Relief and Job Creation Act of 2012 reduced ACA's annual appropriations to the PPHF over the period FY2013-FY2021 by a total of $6.250 billion.[19] To date, CDC has received the majority of PPHF funds, while AHRQ, HRSA, and SAMHSA have received smaller amounts. In FY2013, almost half of the PPHF funds were transferred by the Secretary of HHS to CMS to support ACA implementation. The contribution of PPHF funds to CDC's budget is discussed in more detail in the CDC section of this report. A broader analysis of the allocation of PPHF funding is provided in **Appendix C.**

The **Patient-Centered Outcomes Research Trust Fund (PCORTF)** is supporting comparative effectiveness research over a 10-year period (FY2010-FY2019) with a mix of appropriations, some of which are offset by revenue from a fee imposed on health plans, and transfers from the Medicare Part A and Part B trust funds.[20] A portion of the PCORTF is allocated for AHRQ. More information on the PCORTF, including the appropriation and transfer formulas, is provided in **Appendix D.**

HRSA, CDC, and IHS receive mandatory funds from other sources as well. Family-to-Family Health Information Centers at HRSA have been funded by a series of mandatory appropriations since FY2007. CDC receives Medicaid funding to support the Vaccines for Children program. Both IHS and NIH receive mandatory funds for diabetes programs. These and other mandatory appropriations are reflected in the agency-specific tables in this report.

User Fees

Several PHS agencies assess user fees on third parties to help fund their programs and activities. User fees collected by CDC, HRSA, and SAMHSA represent a relatively small portion of each agency's overall budget.[21] In comparison, the user fees that FDA collects help finance a broad range of the agency's regulatory activities and account for a substantial and growing percentage of the agency's budget. It has been 20 years since the Prescription Drug User Fee Act (PDUFA)[22] established the first user fee program at FDA. Since PDUFA's enactment, Congress has established several other FDA user fee programs. These programs were created to provide FDA with additional resources that allow it to hire more personnel and expedite the process of reviewing and approving new product applications. User fees also support information technology infrastructure. FDA's user fee programs now support the agency's regulation of prescription drugs, animal drugs, medical devices, and tobacco products, among other activities. The amount of user fees that FDA collects under these programs has increased steadily since PDUFA, both in absolute terms and as a share of FDA's overall budget. For FY2013, user fees

[17] ACA Section 10503(a)-(b).

[18] ACA Section 4002.

[19] P.L. 112-96, Section 3205, 126 Stat. 194.

[20] ACA Section 6301(d)-(e).

[21] Details on user fees for CDC, HRSA, and SAMHSA are provided in the respective agency-specific sections in this report.

[22] P.L. 102-571.

accounted for almost 41% of the FDA overall budget. More discussion of user fees is provided in the FDA section and in **Appendix E** of this report.

Collections

IHS supplements its discretionary appropriations with third-party collections from public and private payers. Most of these funds come from Medicare and Medicaid, which reimburse IHS for services provided to American Indians and Alaska Natives enrolled in these programs at facilities operated by the IHS and tribes. IHS also collects reimbursements from private health insurers. IHS collections (and reimbursements) are reflected in **Table 6** of this report.

Transfer Authority

In addition to the funding mechanisms described above, agencies may gain or lose funding through the transfer of budget authority from one appropriations account to another. Generally, budget authority may be transferred between accounts only as specifically authorized by law. A provision in the annual L-HHS-ED appropriations act gives the HHS Secretary the authority to transfer up to 1% of the funds in any given account. However, the transfer authority stipulates that a recipient account may not be increased by more than 3%. It also requires that congressional appropriators be notified in advance of any transfer.[23]

The HHS Secretary has made extensive use of this transfer authority in FY2013 as part of a broader effort to provide CMS with funding to implement ACA.[24] NIH was the primary source of the funds transferred in FY2013, while among the PHS agencies, CDC, HRSA, and SAMHSA were recipients of those transfers.

PHS Agency Funding: FY2010-FY2013

Since FY2010, Congress has taken a number of steps through the annual appropriations process and the enactment of deficit-reduction legislation to reduce federal discretionary spending. Lawmakers agreed to cuts in discretionary spending for a broad range of agencies and programs as part of negotiations to complete the FY2011 appropriations process and avert a government shutdown. In the following two appropriations cycles—FY2012 and FY2013—Congress further reduced funding for many appropriations accounts (see text box). These actions have had a significant impact on PHS agency funding.

Labor-HHS-ED Annual Appropriations (FY2011-FY2013)

FY2011

Title VIII of the Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10, Division B) provided Labor-HHS-ED funding generally at FY2010 levels, but with numerous spending reductions for specified agencies and programs. P.L.

[23] The HHS Secretary's transfer authority was included as Section 206 of the FY2012 Labor-HHS-ED appropriations act (P.L. 112-74, Division F). It remained in effect for FY2013 under the Full-Year Continuing Appropriations Act, 2013 (P.L. 113-6, Division F).

[24] For more discussion of ACA implementation funding, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

112-10 also applied a 0.2% across-the-board rescission to all accounts (including Labor-HHS-ED) with the exception of the Department of Defense and certain funds related to the global war on terrorism or designated as emergency.

FY2012

Division F of the Consolidated Appropriations Act, 2012 (P.L. 112-74) provided regular appropriations for Labor-HHS-ED for FY2012. P.L. 112-74 also applied a 0.189% across-the-board rescission to all Labor-HHS-ED appropriations accounts. FY2012 funding levels for the PHS agencies that receive discretionary funding through the Labor-HHS-ED appropriations act generally were below FY2011 amounts.

FY2013

Title V of the Full-Year Continuing Appropriations Act, 2013 (P.L. 113-6, Division F) provided Labor-HHS-ED funding generally at FY2012 levels, but with some spending adjustments—reductions and increases—for specified programs. Pursuant to Sec. 3004 in Division G of P.L. 113-6, the Office of Management and Budget applied a 0.2% across-the-board rescission to all nonsecurity appropriations accounts, including Labor-HHS-ED.

In 2011, Congress and the President enacted the Budget Control Act (BCA)[25] in response to concerns about the growth in the federal deficit. The BCA established limits on overall discretionary spending and triggered annual across-the-board spending reductions—a process known as sequestration—beginning in FY2013. These deficit-reduction measures have also affected PHS agency discretionary and mandatory funding.

Discretionary Spending Limits and Sequestration[26]

The BCA amended the Balanced Budget and Emergency Deficit Control Act (BBEDCA, P.L. 99-177) by establishing two budget enforcement mechanisms to reduce the federal deficit over the 10-year period FY2012 through FY2021 by at least $2.1 trillion. First, the BCA established enforceable limits, or caps, on discretionary spending for each of FY2012 through FY2021. The Congressional Budget Office (CBO) estimated that adhering to the discretionary spending caps, which grow by approximately 2% each year, would reduce federal spending by about $0.9 trillion over that period, compared to the projected level of spending if annual discretionary appropriations were to grow at the rate of inflation.

Second, the BCA created a Joint Committee on Deficit Reduction (Joint Committee) and instructed it to develop legislation to reduce the federal deficit. The law gave Congress and the President until January 15, 2012, to enact a Joint Committee bill to reduce the federal deficit by an amount greater than $1.2 trillion over the period FY2012-FY2021. If Congress and the President failed to meet that deadline then automatic annual spending reductions would be triggered for each of FY2013 through FY2021. The spending reductions would be achieved through a combination of sequestration (i.e., an across-the-board cancellation of budgetary resources) and lowering the BCA-imposed discretionary spending caps.

On November 21, 2012, the co-chairs of the Joint Committee announced that the group had been unable to reach agreement on a legislative proposal to cut the deficit and would not be submitting a bill to Congress. Thus, on March 1, 2013, the President ordered the FY2013 spending reductions, pursuant to the BBEDCA, as amended by the BCA. The FY2013 sequestration order was the first of a series of automatic annual spending reductions under the BCA that are required

[25] P.L. 112-25, 125 Stat. 240.

[26] This section of the report is drawn largely from CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

each fiscal year through FY2021. On April 10, 2013, the day the President released the FY2014 budget, he ordered the FY2014 spending reductions.

The law specifies that each year's spending reductions must cut a total of $109.333 billion from nonexempt budget accounts. That amount is equally divided between defense and nondefense spending, each of which is subject to a $54.667 billion annual cut. PHS agency spending belongs in the nondefense category. Importantly, the American Taxpayer Relief Act of 2012 (ATRA) reduced the FY2013 cuts by $24 billion, which means that both defense and nondefense spending were subject to $12 billion less in cuts in FY2013 (i.e., $42.667 billion, instead of $54.667 billion). The annual spending reductions in each spending category—defense and nondefense—are further divided proportionately between discretionary spending and nonexempt mandatory (i.e., direct) spending.

The Office of Management and Budget (OMB) is responsible for calculating the percentages and amounts by which mandatory and discretionary spending are required to be reduced annually in both the defense and the nondefense categories. OMB also is responsible for applying the BBEDCA's sequestration exemptions and special rules.[27] Importantly, while direct spending reductions are executed each year by a sequestration of all nonexempt accounts, discretionary spending reductions are achieved through sequestration only in FY2013. In each of the remaining fiscal years (i.e., FY2014-FY2021), discretionary spending reductions are achieved by lowering the BCA-imposed discretionary spending caps for defense and nondefense spending by the total dollar amount of the reduction.

For FY2013, OMB calculated that sequestration would reduce nonexempt nondefense mandatory spending by 5.1% and reduce nonexempt nondefense discretionary spending by 5.0%.[28] For FY2014, OMB calculated that sequestration would reduce nonexempt nondefense mandatory spending by 7.2%.[29] As noted above, the reduction in defense and nondefense discretionary spending for FY2014 is achieved through a reduction in the spending caps (see **Table 1**).

Generally, PHS agency mandatory spending (and FY2013 discretionary spending) is fully sequestrable at the appropriate rate for nondefense spending, with two important exceptions. Funding for the Vaccines for Children program, administered by CDC, is transferred from Medicaid and is fully exempt from sequestration.[30] In addition, the BBEDCA sequestration rules include a 2% limit on cuts in spending on community health centers, migrant health centers, and IHS. However, OMB concluded in its analysis of the statute that these rules apply only to mandatory spending reductions and not to cuts in discretionary spending. Thus, reductions in CHCF (mandatory) funding for community health centers and migrant health centers are capped at 2%, whereas FY2013 discretionary spending on health centers is fully sequestrable at the rate

[27] For an overview of the sequestration exemptions and special rules in BBEDCA Sections. 255 and 256, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

[28] U.S. Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013*, March 1, 2013, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf.

[29] U.S. Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2014*, April 10, 2013 (Corrected version, May 20, 2013), http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy14_preview_and_joint_committee_reductions_reports_05202013.pdf.

[30] Medicaid is exempt from sequestration. For more information, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

applicable to nonexempt nondefense spending. Similarly, cuts to IHS's mandatory spending are capped at 2%, while the agency's FY2013 discretionary appropriations are fully sequestrable. See **Table 1**.

Table 1. Impact of BCA Annual Spending Reductions on PHS Agency Funding

FY2013-FY2014

Program	Percent Reduction	
	FY2013	FY2014
Mandatory Spending		
Nonexempt programs	5.1%	7.2%
Community health centers, migrant health centers, IHS	2.0%	2.0%
Discretionary Spending		
Nonexempt programs	5.0%[a]	NA[b]

Source: OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013, March 1, 2013; OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2014, May 20, 2013.

a. The FY2013 sequestration order on March 1, 2013, occurred prior to enactment of full-year appropriations for FY2013. Pursuant to the BBEDCA, OMB calculated the percentage reduction for discretionary spending (i.e., 5.0%) based on the annualized funding levels under the six-month FY2013 continuing resolution (CR) that was in effect at the time. The FY2013 CR generally funded discretionary programs at their FY2012 levels plus 0.612%. OMB applied the 5.0% to the annualized funding levels in the CR to determine the dollar amount reduction for each nonexempt discretionary account. However, the Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6), which was enacted on March 26, 2013, generally provided funding at levels slightly below the annualized amounts in the six-month CR. OMB, however, did not recalculate the percentage reduction for discretionary spending. Instead, pursuant to the BBEDCA, it applied the dollar amount reductions calculated based on the six-month CR to the marginally lower final FY2013 levels. Thus, the actual percentage reduction was slightly more than 5.0%.

b. As noted in the text, the FY2014 reduction in discretionary spending (defense and nondefense) is achieved through a reduction in the BCA-imposed discretionary spending caps, rather than through sequestration.

Congress has yet to complete legislative action on any of the regular appropriations bills for FY2014. The government is currently operating under the Continuing Appropriations Act, 2014 (P.L. 113-46), which provides appropriations through January 15, 2014. Generally, P.L. 113-46 provides funding at FY2013 post-sequestration spending levels. This report will be updated with information on PHS agency funding for FY2014 when full-year appropriations measures are enacted.

Report Outline

The remainder of this report is divided into seven sections, one for each PHS agency. ATSDR and its budget are included in the discussion of CDC. Each section includes (1) an overview of the

agency's statutory authority and principal activities; (2) a summary of agency funding over the period FY2010-FY2013; and (3) highlights of the agency's FY2014 budget request. This material is accompanied by a detailed five-year funding table showing the FY2010-FY2013 funding levels and the FY2014 budget request for the agency's budget accounts and for selected programs and activities within those accounts. The amounts in the funding tables in this report are taken from the PHS agencies' budget justification documents for FY2012-FY2014 and the FY2013 operating plans that were submitted to the appropriations committees.[31] *The funding figures for FY2013 reflect the Joint Committee sequestration of nonexempt mandatory and discretionary spending. The funding figures for FY2014 are based on the FY2014 President's Budget Request. As such, they do not reflect the sequestration of nonexempt mandatory spending.*

Each funding table shows the program level amounts for all the major budget items, which are summed to give the agency's total program level. At the bottom of the table, any user fees, PHS evaluation set-aside funds, ACA funds, and other nondiscretionary funds are subtracted from the program level to show the agency's discretionary budget authority. Most tables include one or more non-add entries (italicized and in parentheses) either to highlight the funding for specific programs within a larger budget line or, in some instances, to indicate the allocation of user fees or ACA funds.

It is important to note that, by convention, HHS budget tables show only the amount of set-aside funds received. They do not subtract the amount of the evaluation tap from donor agencies' appropriations. The impact of this practice on the presentation of agencies' budgets is particularly significant in the case of NIH, whose appropriation is larger than the appropriations of all the other PHS agencies combined. NIH is the largest donor of set-aside funds, and one of the smallest recipients. In FY2012, for example, NIH contributed $709 million in set-aside funds, which is not reflected in the agency's funding table. It received $8 million, which is allocated for the National Library of Medicine (see **Table 7**) and included as part of the NIH's overall program level.[32]

Agency for Healthcare Research and Quality (AHRQ)

Agency Overview

AHRQ is the federal agency charged with supporting research designed to improve the quality of health care; increase the efficiency of its delivery; and broaden access to health services. Specific research efforts in furtherance of these goals include those aimed at reducing the costs of care, promoting patient safety, and improving health care services, organization, and financing. These efforts include a focus on dissemination of research findings to health care providers, payers, and consumers, among others. In addition, the agency collects data on health care expenditures and utilization through the Medical Expenditure Panel Surveys (MEPS) and Healthcare Cost and Utilization Project (HCUP).

[31] The HHS congressional budget justifications and the FY2013 operating plans for all the HHS operating divisions are available at http://www.hhs.gov/budget/.

[32] HHS, "Use of Public Health Service Set-Aside Authority for Fiscal Year 2012, Report to Congress."

AHRQ has evolved from a succession of agencies concerned with fostering health services research and health care technology assessment. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) added a new PHSA Title IX and established the Agency for Health Care Policy and Research (AHCPR), a successor agency to the former National Center for Health Services Research and Health Care Technology Assessment (NCHSR). AHCPR was reauthorized in 1992 (P.L. 102-410). On December 6, 1999, President Clinton signed the Healthcare Research and Quality Act of 1999 (P.L. 106-129), which renamed AHCPR as the Agency for Healthcare Research and Quality (AHRQ) and reauthorized it through FY2005.[33] Since 2005, Congress has not reauthorized the agency. Despite the expired authorization, AHRQ has continued to receive funds. Since FY2010, AHRQ has received its entire budget from the PHS evaluation set-aside and other transfers. The set-aside funds are included in the agency's overall program level amount but are not counted as appropriated funds; thus, the agency's discretionary budget authority shows up as zero in the table. Additional funds are provided from the Patient-Centered Outcomes Research Trust Fund (PCORTF) and the Prevention and Public Health Fund (PPHF), both established by ACA and described in **Appendix C** and **Appendix D** of this report, respectively.

The AHRQ budget is organized according to three program areas: (1) Healthcare Costs, Quality and Outcomes (HCQO) Research; (2) the Medical Expenditure Panel Surveys (MEPS); and (3) program support. HCQO research focuses on six priority areas, summarized in the text box below.

Healthcare Costs, Quality and Outcomes (HCQO) Research Areas

Health Information Technology (HIT). Research evaluating HIT and its impact on the quality and efficiency of health care.

General Patient Safety Research. Research on reducing and preventing medical errors, with a focus on health care-associated infections (HAIs).

Patient-Centered Health Research. Research comparing the effectiveness of different treatment options (previously referred to as comparative effectiveness research).

Research Innovations. Research on quality of health care that spans multiple priority areas including, for example, the annual National Healthcare Quality and National Healthcare Disparities Reports.

Value. Research and projects supporting value in health care, focusing on reducing cost and improving quality.

Prevention/Care Management. Research on improving the delivery of primary care and preventive services.

FY2010-FY2013 Funding

As shown in **Table 2**, AHRQ's total program level increased by $27 million (6.7%) between FY2010 and FY2013, from $403 million to $429 million. This overall growth was the result of increasing ACA fund transfers during this time, which offset a decrease in evaluation set-aside funding for the agency of $32 million (8.0%). Between FY2010 and FY2013, total transfers from the PPHF and the PCORTF to the agency increased from $6 million to $64 million. During FY2011 and FY2012, transfers from the PPHF increased but returned in FY2013 to a level close to the FY2010 level, while PCORTF transfers increased steadily (according to statutory requirements). The total program level for the agency for FY2013 includes $365 million in evaluation set-aside funding and a total of $64 million in transfers from ACA funds ($6 million from PPHF and $58 million from PCORTF).

[33] See the AHRQ website at http://www.ahrq.gov.

Notable shifts in program area funding levels between FY2010 and FY2013 include the changing level for Patient-Centered Health Research, which increased by $47 million during this period, as a result of the fund transfers from PCORTF. In addition, funding for General Patient Safety Research decreased between FY2010 and FY2013 by $24 million. Funds transferred from the PPHF have supported an increase in funding for prevention and care management activities over this period, and have been used in part to fund the activities of the U.S. Preventive Services Task Force (USPSTF).

FY2014 President's Budget Request

For FY2014, the President is requesting a total program level of $434 million for AHRQ; this would be comprised of both funds from the PHS evaluation set-aside ($334 million) and a transfer from PCORTF ($100 million), and would represent an increase of about $4 million (1.0%) from the AHRQ Sequestration Operating Plan for FY2013. This would continue the trend of decreasing PHS evaluation set-aside funding being offset by increasing ACA fund transfers. In addition, under the President's request, no transfer of funds would be made from the PPHF for the first time since the establishment of that fund (FY2010). Under the President's request, most of the program areas under HCQO would receive decreases in their funding, with the exception of Patient-Centered Health Research, which would receive an increase of $32 million as a result of the increased PCORTF transfer.

Table 2 presents AHRQ funding from FY2010 through the FY2014 President's Budget request. Overall program level funding is shown in **bold** for HCQO, MEPS, and program support. Additional details are provided for research areas and sources of funding (transfers). Program level funding for HCQO, MEPS, and Program Support is summed and presented as total program level. Transfers are subtracted from the total program level to show the discretionary budget authority (i.e., discretionary appropriation as provided by Congress) at the bottom of the table. In AHRQ's case, in the years specified in the table, the agency was solely funded by set-aside funds and transfers. Thus, the discretionary budget authority is "0". For a detailed discussion of the funding concepts noted in the table, see the discussions in **Appendix C**, **Appendix D**, and "PHS Program Evaluation Set-Aside" in this report.

Table 2. Agency for Healthcare Research and Quality (AHRQ)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 request
Health Costs, Quality and Outcomes (HCQO) Research	**276**	**266**	**272**	**300**	**301**
Health Information Technology	28	28	26	26	26
General Patient Safety Research	91	66	66	67	63
Patient-Centered Health Research	21	29	41	68	100
PCORTF Transfer (non-add)	—	*(8)*	*(24)*	*(58)*	*(100)*
Research Innovations[a]	112	112	108	111	89
Value Research	4	4	4	4	3
Prevention/Care Management	21	28	28	26	21
PPHF Transfer (non-add)	*(6)*	*(12)*	*(12)*	*(6)*	—
Medical Expenditure Panel Surveys (MEPS)	**59**	**59**	**59**	**61**	**64**
Program Support	**68**	**68**	**74**	**68**	**69**
Total, Program Level	**403**	**392**	**405**	**429**	**434**

Program or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 request
Less Funds From Other Sources					
PHS Evaluation Funds	397	372	369	365	334
PCORTF Transfers	—	8	24	58	100
PPHF Transfers	6	12	12	6	—
Total, Discretionary Budget Authority	**0**	**0**	**0**	**0**	**0**

Sources: The amounts for FY2010, FY2011, and FY2014 are taken from the FY2012, FY2013, and FY2014 congressional budget justification documents. Funding amounts for FY2012 and FY2013 are taken from: "Sequestration Operating Plan for Fiscal Year 2013: Agency for Healthcare Research and Quality," May 2013. These documents are available at http://www.hhs.gov/budget/. Funding amounts for FY2013 reflect sequestration.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

a. Formerly "Crosscutting Activities."

Centers for Disease Control and Prevention (CDC)

Agency Overview

According to CDC, its mission is "[c]ollaborating to create the expertise, information, and tools that people and communities need to protect their health—through health promotion, prevention of disease, injury and disability, and preparedness for new health threats."[34] CDC is organized into a number of centers, institutes, and offices, some focused on specific public health challenges (e.g., injury prevention), others on general public health capabilities (e.g., surveillance and laboratory services).[35] The Agency for Toxic Substances and Disease Registry (ATSDR) is headed by the CDC Director and is discussed in this section.

Many CDC activities are not specifically authorized but are based in broad, permanent authorities in the PHSA.[36] Four CDC operating divisions are explicitly authorized. The National Institute for Occupational Safety and Health (NIOSH) was permanently authorized by the Occupational Safety and Health Act of 1970.[37] The National Center on Birth Defects and Developmental Disabilities (NCBDDD) was established in PHSA Section 317C by the Children's Health Act of 2000.[38] The National Center for Health Statistics (NCHS) was established in PHSA Section 306 by the Health Services Research, Health Statistics, and Medical Libraries Act of 1974.[39] ATSDR was established by the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA, the "Superfund" law).[40]

[34] See the CDC website at http://www.cdc.gov/about/organization/mission.htm.

[35] Information about CDC's organization is available at http://www.cdc.gov/about/organization/cio.htm.

[36] For example, PHSA Section 301 authorizes the Secretary of HHS to conduct research and investigations as necessary to control disease, and Section 317 authorizes the Secretary to award grants to states for preventive health programs.

[37] 29 U.S.C. §671.

[38] 42 U.S.C. §247b-4.

[39] 42 U.S.C. §242k.

[40] 42 U.S.C. §9604(i). Authorizations of appropriations for NCBDDD, NCHS, and ATSDR have expired, but the programs continue to receive annual appropriations.

CDC provides financial and technical assistance to state, local, municipal, tribal, and foreign governments, and to academic and non-profit entities. Nearly 85% of the agency's funding is spent on grants and contracts.[41] CDC has few regulatory responsibilities.

Most CDC programs are funded through the Labor-HHS-ED appropriations act; ATSDR is funded separately through the Interior/Environment appropriations act. **Table 3** presents funding levels for CDC programs for FY2010 through the FY2014 request. In addition to annual discretionary appropriations, program level amounts for recent years include funds from the following four mandatory appropriations: (1) the Vaccines for Children (VFC) program;[42] (2) NIOSH activities to support the Energy Employees Occupational Illness Compensation Program (EEOICPA);[43] (3) the World Trade Center (WTC) Health Program;[44] and (4) appropriations provided under ACA, principally through the PPHF.[45] CDC also receives annual funds through the PHS evaluation set-aside and authorized user fees, and may also receive funding through supplemental appropriations and other transfers.

FY2010-FY2013 Funding

Overall, CDC's discretionary budget authority decreased from FY2010 to FY2013. The CDC/ATSDR program level increased from FY2010 through FY2012 then decreased to below the FY2010 level for FY2013. The decrease for FY2013 was due somewhat to sequestration, but in larger part to a decrease in the amount of funds transferred from the PPHF. Sequestration reduced the FY2013 program level by $293 million compared with the FY2012 level.[46] Additionally, the PPHF transfer for FY2013 was $346 million less than for FY2012.

Most CDC accounts—including EEOICPA and WTC mandatory funds—were subject to sequestration for FY2013. VFC funds, which are transferred from the Medicaid program, are exempt. The PPHF is also subject to sequestration, which was applied to FY2013 PPHF funds before they were distributed. However, the decreased availability of FY2013 PPHF funds for CDC (and other PHS agencies) was due mainly to a large one-time PPHF distribution to CMS for enrollment activities for ACA-mandated health insurance exchanges, rather than to sequestration. **Appendix C** in this report provides more information about PPHF distributions for FY2013.

In order to blunt the effects of the decreased CDC FY2013 program level, the HHS Secretary used transfer authority provided in annual appropriations for a one-time net transfer of $79 million to CDC from other HHS accounts, principally at NIH.[47]

[41] See CDC, Procurements and Grants, http://www.cdc.gov/about/business/funding.htm.

[42] See CDC, Vaccines for Children Program, http://www.cdc.gov/vaccines/programs/vfc/index.html.

[43] See CDC, EEOICPA, "Frequently Asked Questions," http://www.cdc.gov/niosh/ocas/faqsact.html.

[44] See CRS Report R41292, *Comparison of the World Trade Center Medical Monitoring and Treatment Program and the World Trade Center Health Program Created by Title I of P.L. 111-347, the James Zadroga 9/11 Health and Compensation Act of 2010*, by Scott D. Szymendera and Sarah A. Lister.

[45] CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead. See more information about the PPHF in **Appendix C** of this report.

[46] CDC Office of the Chief Operating Officer, June 13, 2013.

[47] CDC Office of the Chief Operating Officer, June 13, 2013. See also John Reichard, "HHS to Use $454 Million From Prevention Fund for Health Insurance Enrollment," *CQ HealthBeat*, April 15, 2013.

FY2014 President's Budget Request

For FY2014, the Administration requests $5.217 billion in budget authority, $220 million (4%) less than the FY2013 post-sequester amount. The Administration proposes, however, to increase the agency's program level by using transfers from the PPHF ($755 million) and the evaluation tap ($618 million). This increase, which would be almost $1 billion more than the FY2013 level, reflects increases in these transfers, as well as an increase of $686 million in an estimated transfer to the Vaccines for Children program. As with several previous years, the Administration proposes to eliminate the Preventive Health and Health Services block grant for FY2014, stating that PPHF funds serve the same purpose.[48]

CDC's FY2014 budget presentation includes a plan to implement a "Working Capital Fund," a revolving fund to be used by agency programs to "pay for" the agency's centralized services, such as human resources and procurement. These services have received direct appropriations in the past.[49] In order to implement the new fund, the Administration proposes to apply certain business services funds previously assigned to the Cross-cutting Activities and Program Support account across programmatic accounts instead. The effect would be to further increase program levels, above the FY2013 levels, for most of the recipient accounts. However, the FY2013 amounts provided in the agency's operating plan and displayed in **Table 3** were not adjusted to reflect this realignment of funds, and are therefore not comparable to the FY2014 requested amounts.

Table 3 presents CDC/ATSDR funding from FY2010 through the FY2014 President's Budget request. Overall program level funding is shown in **bold** for CDC programs. Discretionary budget authority (BA), mandatory funds, and other sources of funding, including transfers, are provided for each program. Funding for select projects is also presented; these are displayed as non-adds under the appropriate program. Overall program level funding is summed and presented as total program level. Transfers, user fees, and mandatory funds are subtracted from the total program level to show the discretionary budget authority (i.e., discretionary appropriation as provided by Congress) at the bottom of the table. For a detailed discussion of the funding concepts noted in the table, see the discussions in **Appendix C** and "PHS Program Evaluation Set-Aside" in this report.

Table 3. Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances and Disease Registry (ATSDR)

(Dollars in millions)

Program or Activity	FY2010	FY2011	FY2012	FY2013[a]	FY2014 request[b]
Immunization and Respiratory Diseases	**721**	**748**	**779**	**679**	**754**
BA	708	479	576	563[a]	669
PHS Evaluation Funds	13	13	13	13	13
PPHF Transfer	0	100	190	91	72
PHSSEF Transfer	0	156	0	12	0

[48] See, for example, "Program Decreases and Eliminations" in FY2014 CDC congressional budget justification, p. 13.

[49] Ibid, p. 16.

Program or Activity	FY2010	FY2011	FY2012	FY2013[a]	FY2014 request[b]
HIV/AIDS, Viral Hepatitis, STI and TB	**1,119**	**1,116**	**1,110**	**1,048**	**1,177**
BA	1,088	1,116	1,100	1,045[a]	1,174
PHS Evaluation Funds	0	0	0	4	3
PPHF Transfer	30	0	10	0	0
Emerging & Zoonotic Infectious Diseases	**281**	**304**	**304**	**291**	**432**
BA	261	252	252	247[a]	381
PPHF Transfer	20	52	52	44	52
Chronic Disease Prevention and Health Promotion	**924**	**1,075**	**1,167**	**973**	**1,036**
BA	865	774	756	740[a]	620
PPHF Transfer	59	301	411	233	416
ACA Community Transformation Grants (non-add)	*(0)*	*(0)*	*(226)*	*(146)*	*(0)*
Birth Defects, Developmental Disabilities, Disability and Health	**144**	**136**	**137**	**130**	**142**
BA	144	136	137	130	67
PPHF Transfer	0	0	0	0	75
Environmental Health	**181**	**170**	**140**	**123**	**155**
BA	181	135	105	103[a]	126
PPHF Transfer	0	35	35	21	29
Injury Prevention and Control	**149**	**144**	**138**	**131**	**182**
BA	149	144	138	131	177
PHS Evaluation Funds	0	0	0	0	5
Public Health Scientific Services	**441**	**468**	**462**	**443**	**539**
BA	161	148	144	144[a]	144
PHS Evaluation Funds	248	248	248	248	325
PPHF Transfer	32	72	70	52	70
Occupational Safety and Health[c]	**430**	**442**	**536**	**573**	**568**
BA	283	224	182	172	0
PHS Evaluation Funds	92	92	111	111	272
Energy Employees Compensation Program	55	55	55	51	55
World Trade Center Health Program[d]	0	71	188	239	241
Global Health	**354**	**340**	**348**	**329**	**393**
Public Health Preparedness and Response	**1,522**	**1,415**	**1,329**	**1,232**	**1,334**
BA	1,522	1,337	1,299	1,232	1,334
PPHF Transfer	0	10	0	0	0
PHSSEF Transfer	0	69	30	0	0

Program or Activity	FY2010	FY2011	FY2012	FY2013[a]	FY2014 request[b]
Crosscutting Activities and Program Support[e]	**730[e]**	**605**	**659**	**624**	**173**
BA	680	564	618	601[a]	131
Prevention Block Grant (non-add)	*(100)*	*(80)*	*(80)*	*(75)*	*(0)*
PPHF Transfer	50	41	41	23	41
ATSDR	**77**	**77**	**76**	**72**	**76**
Other ACA Transfers	**48[g]**	**0**	**0**	**0**	**0**
User Fees	**2**	**2**	**2**	**2**	**2**
Vaccines for Children[f]	**3,761**	**3,953**	**4,006**	**3,607**	**4,293**
Total, CDC/ATSDR Program Level	**10,884**	**10,995**	**11,193**	**10,258[a]**	**11,257**
Less Funds From Other Sources					
PHSSEF Transfers	0	225	30	12	0
PHS Evaluation Funds	352	352	371	375	618
PPHF Transfers	192	611	809	463	755
Other ACA Transfers	48[g]	0	0	0	0
User Fees	2	2	2	2	2
Other Mandatory Funds	3,816	4,079	4,249	3,897	4,589
Total, CDC/ATSDR Discretionary Budget Authority	**6,474**	**5,726**	**5,732**	**5,509[a]**	**5,293**
Less ATSDR Discretionary Budget Authority	**77**	**77**	**76**	**72**	**76**
Total, CDC Discretionary Budget Authority	**6,397**	**5,649**	**5,656**	**5,437**	**5,217**

Sources: The amounts for FY2010, FY2011, FY2012, and FY2014 are taken from the CDC congressional budget justifications for FY2012 and FY2014. Funding amounts for FY2013 reflect sequestration and are taken from the FY2013 operating plan, http://www.cdc.gov/fmo/index.html; CDC Office of the Chief Operating Officer, June 13, 2013.

Notes: Individual amounts may not add to subtotals or totals due to rounding. PHSSEF is the Public Health and Social Services Emergency Fund, a fund used by appropriators to provide the Secretary with ongoing or one-time emergency funding, such as for the response to influenza epidemics. STI is sexually transmitted infection.

a. In addition, budget authority for FY2013 includes a one-time net transfer of $79 million in total from other HHS agencies, pursuant to the HHS Secretary's transfer authority (Sec. 206, general provision in HHS annual appropriations acts), distributed to the following CDC accounts: Immunization and Respiratory Diseases; HIV/AIDS, Viral Hepatitis, STI, and TB Prevention; Emerging and Zoonotic Infectious Diseases; Chronic Disease Prevention and Health Promotion; Environmental Health; Public Health Scientific Services; and Cross-cutting Activities and Program Support. CDC Office of the Chief Operating Officer, June 13, 2013.

b. Most BA and program level amounts requested for FY2014 reflect a proposed realignment of funds from certain business services in the Cross-cutting Activities and Program Support account into other accounts, in order to implement the Working Capital Fund, discussed in the text of this report. As a result, most amounts requested for FY2014 are not comparable to amounts for previous fiscal years.

c. Program levels for Occupational Safety and Health include Energy Employees and World Trade Center mandatory program funds.

d. Beginning July 1, 2011 (i.e., for the final quarter of FY2011), the World Trade Center Program, previously funded through discretionary appropriations, was replaced by a mandatory program. Amounts presented are estimates. Although FY2013 funds are subject to sequestration, because these funds exceed estimated obligations, the sequester will not affect FY2013 obligations. The reduced amount will be reflected in amounts available for the program in FY2015. CDC Office of the Chief Operating Officer, June 13, 2013.

e. Amounts for FY2010 include amounts previously designated as Public Health Leadership and Support, Business Services Support, Buildings and Facilities, and Preventive Health and Health Services Block Grant.

f. The Vaccines for Children (VFC) program provides free pediatric vaccines to doctors who serve eligible (generally low-income) children. VFC is funded entirely as an entitlement through federal Medicaid appropriations and is exempt from sequestration. Amounts for FY2012 through FY2014 are estimates.

g. Amount reflects $25 million for a childhood obesity demonstration project, http://www.cdc.gov/obesity/childhood/researchproject.html, and $23 million for an asbestos health screening program in Libby, Montana.

Food and Drug Administration (FDA)

Agency Overview

FDA regulates the safety of human foods, dietary supplements, cosmetics, and animal foods; the safety and effectiveness of human drugs, biological products (e.g., vaccines), medical devices, radiation-emitting products, and animal drugs; and the manufacture, marketing, and distribution of tobacco products.[50]

Seven centers within FDA represent the broad program areas for which the agency has responsibility: the Center for Biologics Evaluation and Research (CBER), the Center for Devices and Radiological Health (CDRH), the Center for Drug Evaluation and Research (CDER), the Center for Food Safety and Applied Nutrition (CFSAN), the Center for Veterinary Medicine (CVM), the National Center for Toxicological Research (NCTR), and the Center for Tobacco Products (CTP). Several offices have agency-wide responsibilities.

The Federal Food, Drug, and Cosmetic Act (FFDCA) is the principal source of FDA's statutory authority.[51] FDA is also responsible for administering certain provisions in other laws, most notably the PHSA.[52] Although the FDA's authorizing committees in Congress are the committees with jurisdiction over public health issues—the Senate Committee on Health, Education, Labor, and Pensions, and the House Committee on Energy and Commerce—FDA's assignment within the appropriations committees reflects its origin as part of the Department of Agriculture. The Senate and House appropriations subcommittees on Agriculture, Rural Development, FDA, and Related Agencies have jurisdiction over FDA's budget, even though the agency has been part of various federal health agencies (HHS and its predecessors) since 1940.

[50] See the FDA website at http://www.fda.gov.

[51] 21 U.S.C. §§301 et seq.

[52] PHSA Section 351 (21 U.S.C. §262) authorizes the regulation of biological products and states that FFDCA requirements apply to biological products licensed under the PHSA. A listing of other laws containing provisions for which FDA is responsible is at http://www.fda.gov/RegulatoryInformation/Legislation/default.htm.

FDA's budget has two funding streams: annual appropriations (i.e., discretionary budget authority) and industry user fees.[53] In FDA's annual appropriation, Congress sets both the total amount of appropriated funds and the level of user fees to be collected that year. Appropriated funds are largely for the Salaries and Expenses account, with a much smaller amount for the Buildings and Facilities account. Several different user fees, which accounted for 41% of FDA's total FY2013 program level,[54] contribute only to the Salaries and Expenses account.

The largest and oldest FDA user fee that is linked to a specific program was first authorized by the Prescription Drug User Fee Act (PDUFA, P.L. 102-571) in 1992. **Appendix E** presents the authorizing legislation for current FDA user fees, sorted by the dollar amount they contribute to the FY2013 budget. After PDUFA, Congress added user fee authorities regarding medical devices, animal drugs, animal generic drugs, tobacco products, priority review, food reinspection, food recall, voluntary qualified food importer, and, most recently, generic drugs and biosimilars. Several indefinite authorities apply to fees for mammography inspection, color additive certification, and export certification.[55]

FY2010-FY2013 Funding

From FY2010 to FY2013, Congress increased FDA's discretionary budget authority (annual appropriations) by less than one percent (0.7%). However, because of a 120% increase in user fee revenue the total program level for FDA increased 29% over that period. Between the FY2012 actual appropriations and the FY2013 Sequestration Operating Plan, discretionary budget authority decreased 5% while user fees increased 24%, yielding an overall total program level increase of 5%. During FY2013, collections from each continuing user fee program increased and two new user fee programs took effect. Between FY2010 and FY2013, the proportion of the agency's budget that came from user fees increased from 30% to 41%.

FDA statutory responsibilities have increased since FY2010, and new user fees do not cover all the new activities. The Food and Drug Administration Amendments Act of 2007 (P.L. 110-85), the Food Safety Modernization Act (FSMA, P.L. 111-353), and the Food and Drug Administration Safety and Innovation Act (FDASIA, P.L. 112-144) added requirements concerning food, drug, biologics, and device regulation.[56]

---

[53] For additional information on the history of the FDA budget, see CRS Report RL34334, *The Food and Drug Administration: Budget and Statutory History, FY1980-FY2007*, coordinated by Judith A. Johnson.

[54] CRS calculation from FDA, "Food and Drug Administration Sequestration Operating Plan [for FY2013]," http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/BudgetReports/UCM352114.pdf.

[55] User fees provide varying proportions of funding for several FDA programs. For example, the agency's tobacco regulatory activities are entirely supported through user fees paid by tobacco product manufacturers and importers. In FY2013, PDUFA revenues account for 63.1% of the human drugs program budget; fees provide 36.8% of the biologics budget, 22.9% of the devices and radiological health budget, 18.6% of the animal drugs and feeds budget, and 2.0% of the foods budget. **Appendix E** of this report presents additional detail.

[56] See, for example, statement of Margaret A. Hamburg, Commissioner of Food and Drugs, FDA, before the House Committee on Appropriations, Subcommittee on Agriculture, Rural Development, Food and Drug Administration, and Related Agencies, "President's Fiscal year 2014 Budget Request for the FDA," April 26, 2013; and Stephen Grossman, "Funding Cutbacks at FDA: A Sequester Primer," *FDA Matters*, March 7, 2013. For details of the additional responsibilities, see CRS Report RL34465, *FDA Amendments Act of 2007 (P.L. 110-85)*, by Susan Thaul; CRS Report R40443, *The FDA Food Safety Modernization Act (P.L. 111-353)*, coordinated by Renée Johnson; and CRS Report R42680, *The Food and Drug Administration Safety and Innovation Act (FDASIA, P.L. 112-144)*, coordinated by Susan Thaul.

FY2014 President's Budget Request

The President requested a FY2014 FDA total program level of $4.654 billion, which is the sum of budget authority and user fees. As is customary, the total request included some new fees that Congress has not yet authorized. Without those proposed fees, which the appropriators cannot include in the FY2014 bill unless Congress and the President enact them into law, the total program level request is $4.384 billion, 8.8% higher than the FY2013 Sequestration Operating Plan. The request includes $2.558 billion in budget authority and $1.827 billion in authorized user fees, 7.2% and 11.0% above FY2013 levels respectively.

The Office of Management and Budget (OMB) has interpreted the Budget Control Act of 2011 (BCA, P.L. 112-25), which governs sequestration action, as requiring that user fees be included in the sequestrable base along with directly appropriated budget authority.[57] The FDA Commissioner estimated that FDA would lose about $83 million in user fees in FY2013.[58] The FFDCA sections authorizing FDA user fees for drugs and medical devices limit the use of fee revenue to specified agency activities. Because the sequestered user fee collections may not be used for other purposes, they remain untouchable in the FDA account. The FDA Commissioner, some Members of Congress, industry, and others have urged that fees be exempted from sequestration.[59] Their attempts have not altered the FY2013 sequester. Members of the House and Senate appropriations subcommittees working on a FY2014 bill have stated their intentions to work together to find a way to avoid fee sequestering for that year.[60]

Table 4 presents FDA funding from FY2010 through the FY2014 President's Budget request. Overall program level funding is shown in **bold** for FDA program areas.[61] Discretionary budget authority (BA) and user fees (fees) are provided for each program area. At the bottom of the table, overall program level funding is summed and presented as total program level. User fees are then subtracted from the total program level to show the discretionary budget authority (i.e., discretionary appropriation as provided by Congress). For a detailed list of user fee authorizations, see the discussions in **Appendix E** of this report.

[57] Office of Management and Budget (OMB), *OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013*, March 1, 2013, http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf.

[58] Remarks by Margaret A. Hamburg, Commissioner of Food and Drugs, 2013 FDLI Annual Conference, Washington, DC, April 23, 2013.

[59] See, for example, CQ Congressional Transcripts, "Senate Appropriations Subcommittee on Agriculture, Rural Development, FDA, and Related Agencies Holds Hearing on President Obama's Fiscal 2014 Budget Proposal for the Food and Drug Administration," April 18, 2013; Alliance for a Stronger FDA, "Advocacy at a Glance," June 14, 2013 http://strengthenfda.org/2013/06/14/advocacy-at-a-glance-90/; and Nanci Bompey, "House Appropriators Hold Off On FDA User Fee Sequestration Exemption," *FDA Week*, June 14, 2014.

[60] Nanci Bompey, "House Appropriators Hold Off On FDA User Fee Sequestration Exemption," *FDA Week*, June 14, 2014. Representative Lance, along with bipartisan co-sponsors, on July 18, 2013, introduced H.R. 2725, the Food and Drug Administration Safety over Sequestration Act of 2013 to amend the BCA to exempt from sequestration certain FDA user fees.

[61] Funding for a product-specific program, such as Foods or Human Drugs, includes funding for the program center (e.g., Center for Food Safety and Applied Nutrition or the Center for Drug Evaluation and Research) and the related activities of the Office of Regulatory Affairs.

Table 4. Food and Drug Administration (FDA)

(Dollars in Millions)

Program area	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Foods	**783**	**836**	**883**	**813**	**1107**
BA					
	783	836	866	797	883
Fees					
	—	—	17	17	224
Human drugs	**884**	**950**	**979**	**1,187**	**1,292**
BA					
	462	478	478	439	466
Fees					
	421	472	501	748	826
Biologics	**291**	**302**	**329**	**308**	**338**
BA					
	206	212	212	195	211
Fees					
	86	90	117	113	127
Animal drugs and feeds	**154**	**159**	**166**	**155**	**191**
BA					
	134	139	138	126	142
Fees					
	20	20	28	29	49
Devices and radiological health	**370**	**379**	**376**	**384**	**435**
BA					
	314	322	323	296	321
Fees					
	57	56	53	88	115
Tobacco products	**64**	**136**	**455**	**459**	**501**
BA					
	—	—	—	—	—
Fees					
	64	136	455	459	501
Toxicological research	**59**	**61**	**60**	**55**	**60**
BA					
	59	61	60	55	60
Fees					
	—	—	—	—	—
Headquarters/Commissioner's Office	**178**	**187**	**223**	**251**	**298**

Program area	FY2010	FY2011	FY2012	FY2013	FY2014 Request
BA					
	141	150	154	160	173
Fees					
	37	37	69	91	125
GSA rent	**178**	**178**	**205**	**199**	**228**
BA					
	145	151	161	150	162
Fees					
	32	27	45	49	66
Other rent and rent-related activities[a]	**124**	**129**	**132**	**157**	**183**
BA					
	103	100	106	118	133
Fees					
	21	30	26	40	50
Export and color certification funds	**10**	**11**	**11**	**12**	**12**
BA					
	—	—	—	—	—
Fees					
	10	11	11	12	12
Buildings & Facilities	**22**	**13**	**9**	**5**	**9**
BA					
	22[b]	13	9	5	9
Fees					
	0	0	0	0	0
Food and drug safety[c]	**—**	**—**	**—**	**46**	**0**
BA					
	—	—	—	46	0
Fees					
	—	—	—	0	0
Total, Program Level	**3,118**	**3,339**	**3,832**	**4,031**	**4,654[d]**
Less Funds From Other Sources					
User Fees					
	748	879	1,326	1,645	2,096[d]
Total, Discretionary Budget Authority	**2,369**	**2,460**	**2,506**	**2,386**	**2,558**

Sources: The amounts for FY2010, FY2011, FY2012, and FY2014 are taken from the FY2012, FY2013, and FY2014 congressional budget justification documents. Funding amounts for FY2013 reflect sequestration and are taken from the FDA FY2013 Sequestration Operation Plan. These documents are available at http://www.hhs.gov/budget/.

Notes: Consistent with the Administration and congressional committee formats, each program area includes funding designated for the responsible FDA center (e.g., the Center for Drug Evaluation and Research or the Center for Food Safety and Applied Nutrition) and the portion of effort budgeted for the agency-wide Office of Regulatory Affairs to commit to that area. It also apportions user fee revenue across the program areas as indicated in the Administration's request (e.g., 90% of the animal drug user fee revenue is designated for the animal drugs and feeds program, with the rest going to headquarters and Office of the Commissioner, GSA rent, and other rent and rent-related activities categories).

a. Other rent and rent-related activities include White Oak consolidation.

b. The FY2010 Buildings & Facilities appropriation included about $7 million for the National Center for Natural Products Research, as directed by the Committee on Appropriations.

c. The FY2013 Sequestration Operating Plan notes food safety and drug safety items that had not been included in the program-level appropriations.

d. The President's FY2014 request includes $1.827 billion in user fees from currently authorized programs (prescription drug, tobacco product, generic drug, medical device, animal drug, biosimilars, mammography quality, food reinspection, food recall, color certification, animal generic drug, and export certification) plus $269 million in proposed user fees (medical product reinspection, international courier, food establishment registration, food imports, cosmetics, and food contact notification) that would require authorizing legislation to implement. Without those proposed fees, the President's total program level request is $4.384 billion.

Health Resources and Services Administration (HRSA)

Agency Overview

HRSA is the federal agency charged with improving access to health care for those who are uninsured, isolated, or medically vulnerable. The agency currently awards funding to more than 3,000 grantees, including community-based organizations; colleges and universities; hospitals; state, local, and tribal governments; and private entities to support health services projects.[62] HRSA also administers the health centers program, which provides grants to non-profit entities that provide primary care services to people who experience financial, geographic, cultural, or other barriers to health care.[63]

HRSA is organized into six bureaus and ten offices as outlined in the text box below. Some focus on specific populations or health care issues, while others provide technical assistance to HRSA's regional offices.[64]

[62] See also HRSA's website at http://www.hrsa.gov.

[63] For more information, see CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

[64] See also HRSA's website at http://www.hrsa.gov.

HRSA Bureaus

The **Bureau of Primary Health Care** administers the Health Centers program, which aims to provide access to primary care for individuals who are low-income, uninsured, or living where health care is scarce. Title III of the PHSA authorizes the Health Centers Program; the Free Clinics Medical Malpractice program; and the National Hansen's Disease Program, which are administered by the bureau. The bureau also administers mandatory ACA funding for School Based-Health Centers and Community Health Centers.

The **Bureau of Clinician Recruitment and Service** administers several health workforce programs. These programs recruit clinicians from diverse backgrounds to provide services in underserved communities and areas with critical health care provider shortages. They include the National Health Service Corps, nursing student scholarship and loan repayment programs, and the Faculty Loan Repayment Program. Titles III, VII, and VIII of the PHSA authorize programs in this bureau.

The **Bureau of Health Professions** administers a number of programs for health professions training and development of diversity and cultural competence in the health workforce. These programs include the Oral Health Training Program, Nursing Workforce Diversity Program, Children's Hospitals Graduate Medical Education Program, and the Scholarships for Disadvantaged Students Program. The Bureau of Health Professions also administers the National Practitioner and Healthcare Integrity Protection Data Banks and the National Center for Health Workforce Analysis. Titles III, VII, and VIII of the PHSA authorize programs in this bureau.

The **Maternal and Child Health Bureau** administers the Maternal and Child Health Block Grant[65] and other programs that support the infrastructure for maternal and child health services, including the Maternal, Infant, and Early Childhood Home Visiting Program that was authorized and funded by ACA. These programs are authorized in the Social Security Act (SSA). This bureau also administers Healthy Start, newborn hearing screening, autism, and other programs authorized under the PHSA.

The **HIV/AIDS Bureau** administers the Ryan White HIV/AIDS program, which is the largest discretionary grant program within HRSA and is focused on HIV/AIDS care. The Ryan White HIV/AIDS program administers grant programs that provide early intervention, minority, and family services. It also administers the AIDS Drug Assistance Program (ADAP). Title XXVI of the PHSA authorizes the Ryan White HIV/AIDS programs.

The **Healthcare Systems Bureau** provides national leadership and direction in targeted areas, such as organ and bone marrow transplantation, poison control centers, and others. Titles III and XII of the PHSA authorize programs in the Healthcare Systems Bureau.

As noted above, the majority of HRSA's programs are authorized in the PHSA and the SSA. Additionally, Section 427(e) of the Federal Mine Safety and Health Amendments Act (P.L. 95-164) authorizes the Black Lung Program, which supports clinics that provide services to retired coal miners and others.

FY2010-FY2013 Funding

As shown in **Table 5**, HRSA's discretionary budget authority from FY2010 to FY2013 decreased by 22% from $7.492 billion to $5.863 billion. However, HRSA's total program level increased from $8.067 billion in FY2010 to $9.666 billion in FY2011, and then decreased to $8.100 billion in FY2013. These fluctuations are largely due to changes in the amount of ACA mandatory funds provided to HRSA over this period, including the Community Health Center Fund (CHCF), which provided funding to support the federal health center program and the National Health Service Corps.

Program level funding for the health centers program (see Primary Care Bureau in **Table 5**) increased by $756 million, from $2.253 billion in FY2010 to $3.009 billion in FY2013. ACA

[65] For more information, see CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*, by Amalia K. Corby-Edwards.

mandatory appropriations provided an increasing proportion of health center funding over this time period, increasing from $1 billion in FY2011 to $1.465 billion in FY2013 (see **Appendix A**). Other ACA funding for this bureau includes $1.5 billion for health center construction, and four years of funding totaling $200 million for the School-Based Health Centers program.

Overall, funding for health workforce programs has decreased by $247 million, from $1.248 million in FY2010 to $1.001 billion in FY2013. The FY2012 appropriations law eliminated discretionary funding for the National Health Service Corps. However, the program continues to receive mandatory CHCF funding (see **Appendix B**).

Funding for maternal and child health programs at HRSA increased from $984 million in FY2010 to $1.192 billion in FY2013. This increase was largely due to mandatory funds for the Maternal, Infant, and Early Childhood Home Visiting program which were appropriated under ACA. Those funds increased incrementally from $100 million in FY2010 to $380 million in FY2013. Funding for the Maternal and Child Health Block Grant decreased from $661 million in FY2010 to $605 million in FY2013. Family to Family Health Information Centers, which were appropriated $5 million for each of FY2010 through FY2012 in ACA, were reauthorized and appropriated $5 million for FY2013 under the American Taxpayer Relief Act (ATRA) of 2012.[66]

With the exception of the FY2013 sequester, funding for the Ryan White HIV/AIDS program has risen steadily.[67] The FY2012 appropriation provided a total of $2.248 billion in discretionary funds for the Ryan White HIV/AIDS program, an increase of about $77 million over FY2010. The increase was targeted to the AIDS Drug Assistance Program (ADAP). Congress has also provided $25 million in evaluation set-aside funds for the program.

The Healthcare Systems Bureau received a one-time appropriation of $100 million in FY2010 for hospital construction grants under ACA Section 10502. FY2010 was also the final year of funding for the State Health Access Grant Program, which received $74 million that year. Funding for HRSA's cord blood, organ transplantation, and cell transplantation programs remained relatively flat since FY2010. Federal funding for Poison Control Centers decreased from $29 million in FY2010 to $17 million in FY2013.

Rural health funding decreased from $185 million in FY2010 to $131 million in FY2013, largely due to the elimination of funding for the Delta Health Initiative and the Denali Project. Also of note in this time period is the elimination of congressional projects (also known as "earmarks") in the FY2011 appropriations process. Congressional projects were funded at $337 million in FY2010.

FY2014 President's Budget Request

The President's Budget for FY2014 requests $9.043 billion in program level funding for HRSA. This amount includes $6.022 billion in discretionary budget authority, $2.962 billion in mandatory ACA funding (including PPHF transfers), plus additional evaluation set-aside funds and user fees.

[66] P.L. 112-240.

[67] See CRS Report RL33279, *The Ryan White HIV/AIDS Program*, by Judith A. Johnson for more information on this program.

Absent further congressional action, HRSA will continue to receive mandatory appropriations provided in ACA. However, as noted earlier, for FY2013 onward these appropriations will be subject to sequestration.[68] Specifically, mandatory ACA funding for the Health Centers program will increase from $1.5 billion ($1.465 billion post-sequester) in FY2013 to $2.2 billion in FY2014. The Maternal, Infant, and Early Childhood Home Visiting program will receive its final ACA-authorized mandatory appropriation of $400 million in FY2014.[69] The National Health Service Corps mandatory appropriation will increase from $300 million ($285 million post-sequester) in FY2013 to $305 million in FY2014. Although $5 million in annual mandatory funding for Family-to-Family Health Information Centers in ACA ended in FY2012, ATRA extended funding for the program through FY2013, appropriating $5 million. No funds are requested for FY2014.

The Administration requests decreased funding of $88 million for Children's Hospital Graduate Medical Education (GME) payments, which were funded at $251 million in FY2013. Increased funds are requested for Family Planning ($327 million), Pediatric Loan Repayment ($5 million), and Ryan White HIV/AIDS ($2.412 billion). The Administration also proposes a transfer of $57 million in PPHF funds to HRSA to support Poison Control Centers, Universal Newborn Hearing Screening, Heritable Disorders, Alzheimer's prevention, and Public Health Workforce Development. Lastly, the Administration proposes to transfer the Health Education Assistance Loan program to the Department of Education, and to eliminate the Rural Access to Emergency Devices program.

Table 5 presents HRSA funding from FY2010 through the FY2014 President's Budget request. Funding in the table is shown in **bold** for each major budget account, several of which correspond to specific HRSA bureaus. The Bureaus of Health Professions and Clinician Recruitment and Service are combined under the title "Health Workforce," in keeping with their presentation in the HRSA congressional budget justifications. Overall program level funding is summed and presented as total program level. Transfers, user fees, and mandatory funds are subtracted from the total program level to show the discretionary budget authority (i.e., discretionary appropriation as provided by Congress) at the bottom of the table. For a detailed discussion of the funding concepts noted in the table, see the discussions in **Appendix B**, **Appendix C**, and "PHS Program Evaluation Set-Aside" in this report.

Table 5. Health Resources and Services Administration (HRSA)

(Dollars in Millions)

Bureau or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Primary Care	**2,253**	**4,149**	**2,835**	**3,009**	**3,785**
Health Centers					
	2,141	2,481	2,672	2,856	3,672

[68] As of the date of this report, post-sequester funding for FY2014 mandatory programs has not yet been released by OMB.

[69] The President has proposed to extend and expand the home visiting program beyond the $1.5 billion that was provided under ACA.

Bureau or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
CHCF Transfer (non-add)					
	—	*(1,000)*	*(1,200)*	*(1,465)*	*(2,200)*
Health Center Tort Claims	44	100	95	89	*95*
School Based Health Centers (ACA Sec. 4101(a))					
	50	50	50	48	—
Health Center Construction (ACA Sec. 10503(c))					
	—	1,500	—	—	—
Hansen's Disease Center	16	16	16	15	16
Payment to Hawaii	2	2	2	2	2
Health Workforce	**1,248**	**1,359**	**1,085**	**1,001**	**884**
National Health Service Corps					
	141	315	295	285	305
CHCF Transfer (non-add)					
	—	*(290)*	*(295)*	*(285)*	*(305)*
Advanced Education Nursing	95	95	84	79	84
Training for Diversity	95	95	85	80	70
Health Care Workforce Assessment	3	3	3	3	5
Primary Care Training and Enhancement	237	39	39	37	51
PPHF Transfer (non-add)	*(198)*	—	—	—	—
Oral Health Training	33	33	32	31	32
Interdisciplinary, Community-Based Linkages	72	72	61	60	39
PPHF Transfer (non-add)	*(0)*	*(0)*	*(10)*	*(0)*	*(0)*
Public Health Workforce/Prev. Medicine	30	30	45	8	8
PPHF Transfer (non-add)	*(21)*	*(20)*	*(25)*	—	—
Nursing Workforce Development	196	150	148	140	168
PPHF Transfer (non-add)	*(47)*	—	—	—	—
Children's Hospital GME	317	268	265	251	88
Pediatric Loan Repayment	—	—	—	—	5
Patient Navigator Outreach	5	5	0	0	0
GME Payments for Teaching Health Centers (ACA Sec. 5508(c))					
	—	230	—	—	—
National Practitioner Data Bank (User Fees)					
	20	20	28	27	28
Healthcare Integrity Data Bank (User Fees)	4	4	—	—	—
Maternal and Child Health	**984**	**1,128**	**1,208**	**1,192**	**1,253**
Maternal and Child Health Block Grant	661	656	639	605	639

Bureau or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Early Childhood Home Visiting (ACA Sec. 2951)					
	100	250	350	380	400
Autism and Other Dev. Disorders	48	48	47	45	*47*
Traumatic Brain Injury	10	10	10	9	*10*
Sickle Cell Demonstration	5	5	5	4	*5*
Universal Newborn Hearing Screening	19	19	19	18	*0*
PPHF Transfer (non-add)	—	—	—	—	*(19)*
Emergency Medical Services for Children	21	21	21	20	*21*
Healthy Start	105	104	104	98	*104*
Heritable Disorders	10	10	10	9	*0*
PPHF Transfer (non-add)	—	—	—	—	*(10)*
Family-to-Family Health Information Centers (ACA Sec. 5507; ATRA Sec. 624)					
	5	5	5	5	—
Ryan White HIV/AIDS	**2,312**	**2,337**	**2,392**	**2,248**	**2,412**
Emergency Relief—Part A	678	673	666	624	666
Comprehensive Care—Part B	1,277	1,308	1,361	1,288	1,371
Early Intervention—Part C	206	206	215	194	225
Children, Youth, Women, and Families—Part D	78	77	77	72	77
AIDS Education and Training Centers—Part F	35	35	35	32	35
Dental Reimbursement Program—Part F	14	14	13	13	13
PHS Evaluation Funds	25	25	25	25	25
Health Care Systems	**267**	**87**	**83**	**78**	**91**
Organ Transplantation	26	25	24	23	26
National Cord Blood Inventory	12	12	12	11	12
C.W. Bill Young Cell Transplantation	24	23	23	22	23
Poison Control Centers	29	22	19	17	19
PPHF Transfer (non-add)	—	—	—	—	*(19)*
340b Drug Pricing	2	5	4	4	4
340b Drug Pricing Program (User Fees)	—	—	—	—	*6*
Health Center Infrastructure (ACA Sec. 10502)					
	100	—	—	—	—
State Health Access Grants	74	0	0	0	0
Rural Health	**185**	**138**	**138**	**131**	**122**
Rural Health Policy Development	10	10	10	9	10
Rural Health Outreach Grants	56	56	56	52	56
Rural Access to Emergency Devices	3	1	1	2	0

Bureau or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Rural Hospital Flexibility Grants	41	41	41	38	26
State Offices of Rural Health	10	10	10	9	10
Radiation Exposure Screening	2	2	2	2	2
Black Lung	7	7	7	7	7
Telehealth	12	12	12	11	12
Denali Project	10	—	—	—	—
Congressional Projects	**337**	—	—	—	—
Program Management	**147**	**162**	**160**	**151**	**162**
Family Planning	**317**	**299**	**294**	**278**	**327**
Healthy Weight Collaborative, PPHF	**5**	**—**	**—**	**—**	**—**
Vaccine Injury Compensation, Administration	**7**	**6**	**6**	**6**	**6**
Health Education Assistance Loans (HEAL)	**4**	**4**	**3**	**3**	—
Total, Program Level	**8,067**	**9,666**	**8,205**	**8,100**	**9,043**
Less Funds From Other Sources					
PHS Evaluation Funds	25	25	25	25	25
User Fees	24	24	28	27	32
PPHF Transfers	271	20	37	2	57
Other Mandatory Funds	255	3,325	1,900	2184	2,905
Total, Discretionary Budget Authority	**7,492**	**6,272**	**6,215**	**5,863**	**6,022**

Sources: The amounts for FY2010, FY2011, FY2012, and FY2014 are taken from the FY2012, FY2013, and FY2014 congressional budget justification documents. Funding amounts for FY2013 reflect sequestration and are taken from the HRSA FY2013 Sequestration Operation Plan. These documents are available at http://www.hhs.gov/budget/. The sequestered mandatory funding levels for FY2013 were obtained directly from the agency.

Note: Individual amounts may not add to subtotals or totals due to rounding.

Indian Health Service (IHS)

Agency Overview

IHS provides health care for approximately 2.2 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[70] IHS provides services to members of 566 federally recognized tribes either directly or through facilities and programs operated by Indian Tribes or

[70] U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, p. CJ-142, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf..

Tribal Organizations through self-determination contracts and self-governance compacts authorized in the Indian Self-Determination and Education Assistance Act (ISDEAA).[71]

The Snyder Act of 1921[72] provides general statutory authority for IHS.[73] In addition, specific IHS programs are authorized by two acts: the Indian Sanitation Facilities Act of 1959[74] and the Indian Health Care Improvement Act (IHCIA).[75] The Indian Sanitation Facilities Act authorizes the IHS to construct sanitation facilities for Indian communities and homes, and IHCIA authorizes programs such as urban health, health professions recruitment, and substance abuse and mental health treatment, and permits IHS to receive reimbursements from Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), and third-party insurers.

Unlike most other PHS agencies, IHS receives its appropriations through the Interior/ Environment appropriations act, not the Labor-HHS-ED appropriations act. IHS is also not subject to the PHS Program Evaluation Set-Aside.

FY2010-FY2013 Funding

Funding for the IHS had increased from FY2010 through FY2012, but with the sequester, FY2013 funding levels were below FY2012 funding levels. Specifically, from FY2010 to FY2012 the IHS appropriation increased by $254 million (5.9%), from $4.052 billion to $4.306 billion. The majority of this increase was used to fund additional clinical services, including providing additional funding for purchased/referred care. This program was previously referred to as the contract health service (CHS) program. It funds the purchase of essential health services from local and community health care providers when IHS cannot provide medical care and specific services through its own system. In general, funding has not allowed the program to meet all requests, so IHS prioritizes payments based on relative medical need and denies other requests. Decreasing the number of denied requests has been a priority,[76] and funding for this program increased between FY2010 and FY2012.[77] Funding increases were also used to provide additional funding for contract support costs (CSCs). CSC funding is provided to tribes to help pay the costs of administering IHS-funded programs under self-determination contracts or self-

[71] P.L. 93-638; 25 U.S.C. §450 et seq.

[72] P.L. 67-85, as amended; 25 U.S.C. §13.

[73] The Snyder Act established this authority as part of the Bureau of Indian Affairs within the Department of the Interior. The Transfer Act of 1954 (P.L. 83-568) transferred this authority to the U.S. Surgeon General within the then Department of Health, Education, and Welfare (now the Department of Health and Human Services).

[74] P.L. 86-121; 42 U.S.C. §2004a.

[75] P.L. 94-437, as amended; 25 U.S.C. §§1601 et seq., and 42 U.S.C. §§1395qq and 1396j (and amending other sections). This act was permanently reauthorized as part of ACA. Changes made by the reauthorization are summarized in CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*, by Elayne J. Heisler.

[76] The IHS FY2014 budget justification notes that improving the program is a top Tribal priority; see U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, p. CJ-142, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf. The Senate Committee on Indian Affairs has also held hearings on this program and noted that IHS should work to reduce the number of denials. See U.S. Congress, Senate Committee on Indian Affairs, *Access to Contract Health Services in Indian Country*, 110th Cong., 2nd sess., June 26, 2008, S.Hrg.110-519 (Washington: GPO, 2008).

[77] See, for example, U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2011 Indian Health Service Justification of Estimates*, p. CJ-95, http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS%20FY%202011%20Congressional%20Justification.pdf.

governance compacts authorized by ISDEAA.[78] CSC funding pays for the costs that tribes incur for such items as financial management, accounting, training, and program start-up. Shortfalls in funding for the CSC program have resulted in reduced services or decreased administrative efficiency for tribes with contracts and compacts.[79]

Under the FY2013 sequestration operating plan, IHS's budget authority was $175 million less than for FY2012. This decrease was initially unexpected because, as noted in the introductory section of this report, the BBEDCA sequestration rules include a 2% limit on cuts to IHS.[80] However, OMB determined that the 2% limit only applied to IHS's mandatory funding. The agency's discretionary appropriation was fully sequestrable.[81] While the IHS FY2013 appropriation was above the FY2012 funding level, the sequester reduced that amount to below the FY2012 level. Although IHS predicted that it would collect more in reimbursements in FY2013 than it did in FY2012—an expected additional $19 million in collections—that increase would not be sufficient to offset the amount reduced under the sequester.

FY2014 President's Budget Request

The FY2014 President's Budget would increase funding for IHS above both the FY2013 and FY2012 operating levels. Specifically, it would increase funding for clinical services by $322 million; this includes an additional $100 million expected from increased collections. IHS would use this clinical services budget increase to provide additional funds for purchased/referred care and for preventive health services such as public health nursing and health education activities.

IHS, as a result of ACA's implementation, is expecting increased reimbursements from collections from Medicare, Medicaid, CHIP, and other third-party insurers for services provided at IHS-funded facilities. Specifically, IHS is expecting that collections will increase by approximately $100 million because additional IHS-beneficiaries will be eligible for Medicaid[82] and because some will enroll in private insurance offered through the exchanges established by the ACA.[83] Although not included in the IHS collections totals, IHS is to also receive collections

[78] 25 U.S.C. §450 et seq.

[79] See U.S. General Accounting Office, *Indian Self-Determination Act: Shortfalls in Indian Contract Support Costs Need to Be Addressed*, GAO/RCED-99-150, June 1999, http://www.gao.gov/archive/1999/rc99150.pdf.

[80] For example, see Rob Carpiccioso, "A Miscalculation on the Sequester Has Already Harmed Indian Health," *Indian Country*, March 11, 2013, http://indiancountrytodaymedianetwork.com/2013/03/11/miscalculation-sequester-has-already-harmed-indian-health-148110.

[81] See CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

[82] This would only occur in states where the Medicaid program is expanded. See CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

[83] IHS beneficiaries are exempt from the ACA requirement to have insurance coverage; however, ACA included provisions that would make it easier for IHS beneficiaries to participate in a health insurance plan through the exchanges. Specifically, IHS beneficiaries have a special enrollment period for health insurance plans offered through the exchanges and, if their incomes are not more than 300% of the federal poverty level, are exempt from cost-sharing when enrolled in a plan offered through an exchange. In addition, IHS beneficiaries, like the general population, are eligible for income-determined subsidies to purchase insurance. A recent GAO report examined potential effects of ACA on Medicaid and private insurance among American Indians and Alaska Natives. See U.S. Government Accountability Office, *Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment*, 13-553, September 5, 2013, http://www.gao.gov/products/GAO-13-553. See also CRS Report R41152, *Indian Health Care: Impact of the* (continued...)

from the Department of Veterans Affairs (VA).[84] The agency estimates that it will receive $52 million in FY2014, but notes that this amount is uncertain because IHS only recently obtained authority to bill the VA, and reimbursement agreements are not fully implemented.[85]

The FY2014 President's Budget would also increase funding for CSCs. A 2012 Supreme Court decision in *Salazar v. Ramah Navajo*[86] found that lack of sufficient appropriations does not release the federal government from its obligation to provide adequate contract support costs.[87] IHS reports that it will work with Indian Tribes and Tribal Organizations to determine appropriate CSC levels and to balance CSC priorities with any offsets in funding for direct health care services for IHS beneficiaries.

Table 6 shows IHS funding for FY2010 through the FY2014 President's Budget request. The table includes funding under IHS's discretionary budget authority, as well as mandatory appropriations for the Special Diabetes Program for Indians[88] and funds that IHS receives from renting staff quarters and from collections from Medicare, Medicaid, CHIP, and other third-party insurers for services provided at IHS-funded facilities. Overall funding for Clinical and Preventive Services, Other Health Services, and Health Facilities is shown in **bold**. Program level funding is presented in the respective categories. Overall program level funding is summed and presented as total program level. Collections, Rental of Staff Quarters, and mandatory funds are subtracted from the total program level to show the discretionary budget authority (i.e., discretionary appropriation as provided by Congress) at the bottom of the table.

Table 6. Indian Health Service (IHS)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Clinical and Preventive Services	**4,139**	**4,171**	**4,335**	**4,230**	**4,564**
Clinical Services	3,845[a]	3,877[b]	4,038[c]	3,940[d]	4,262[e]
Purchased/Referred Care (non-add)[f]	*(779)*	*(780)*	*(844)*	*(801)*	*(879)*
Preventive Health	144	144	147	143	152
Special Diabetes Program for Indians[g]	150	150	150	147	150
Other Health Services	**560**	**559**	**636**	**603**	**642**

(...continued)

Affordable Care Act (ACA), by Elayne J. Heisler.

[84] IHS does not specify why the VA collections are not included as part of its general collection totals. It is possible that these funds may be omitted because they are a new collection type and IHS does not yet have information on how these funds will be used by IHS-funded facilities.

[85] See U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2014 Indian Health Service Justification of Estimates*, p. CJ-142, http://www.ihs.gov/BudgetFormulation/documents/FY2014BudgetJustification.pdf.

[86] *Salazar v. Ramah Navajo*, No. 11-551, slip op. (June 18, 2012), available at http://www.supremecourt.gov/opinions/11pdf/11-551.pdf.

[87] CRS Report WSLG119, *Supreme Court Holds the Government Liable for Contract Support Costs in Indian Self-Determination Contracts Even When Congress Fails to Appropriate Adequate Funds*, by Jane M. Smith.

[88] P.L. 110-275, Section 303, 122 Stat. 2594; and P.L. 111-309, Section 112, 124 Stat. 3289.

Program or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Urban Health Projects	43	43	43	41	43
Indian Health Professions	41	41	41	38	41
Tribal Management/Self-Governance	9	9	9	8	9
Direct Operations	69	69	72	68	72
Contract Support Costs	398	398	471	448	477
Health Facilities	**401**	**411**	**448**	**426**	**456**
Maintenance and Improvement	60[h]	60[h]	61[i]	59[i]	61[j]
Sanitation Facilities Construction	96	96	80	75	80
Health Care Facilities Construction	29	39	85	77	85
Facilities/Environmental Health Support	193	193	199	194	207
Medical Equipment	23	23	23	21	23
Total, Program Level	**5,100**	**5,140**	**5,418**	**5,258**	**5,662**
Less Funds from Other Sources					
Collections	891	915	954	974	1,074
Rental of Staff Quarters	6	6	8	8	8
Special Diabetes Program for Indians[f]	150	150	150	147	150
Total, Discretionary Budget Authority	**4,052**	**4,069**	**4,306**	**4,131**	**4,431**

Sources: The amounts for FY2010, FY2011, FY2012, and FY2014 are taken from the FY2012, FY2013, and FY2014 congressional budget justification documents. Funding amounts for FY2013 reflect sequestration and are taken from the IHS FY2013 Sequestration Operation Plan. These documents are available at http://www.hhs.gov/budget/.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

a. Includes $891 million received in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

b. Includes $915 million received in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

c. Includes $954 million received in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

d. Includes $974 million that IHS estimates it will receive in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

e. Includes $1,074 million that IHS estimates it will receive in collections from Medicare, Medicaid, CHIP, private insurance, and other programs.

f. This was previously referred to as "Contract Health Services."

g. These are appropriated funds made available to IHS for the Special Diabetes Program for Indians authorized by PHSA Sec. 330C.

h. Includes $6 million that IHS received from rental of staff quarters.

i. Includes $8 million that IHS received from rental of staff quarters.

j. Includes $8 million that IHS estimates the agency will receive from rental of staff quarters.

National Institutes of Health (NIH)

Agency Overview

NIH is the primary agency of the federal government charged with performing and supporting biomedical and behavioral research. Its activities cover a wide range of basic, clinical, and translational research, as well as research training and health information collection and dissemination. The agency is organized into 27 research institutes and centers, headed by the NIH Director. The Office of the Director (OD) sets overall policy for NIH and coordinates the programs and activities of all NIH components, particularly in areas of research that involve multiple institutes. The institutes and centers (collectively called ICs) focus on particular diseases, areas of human health and development, or aspects of research support. Each IC plans and manages its own research programs in coordination with the Office of the Director.

The bulk of NIH's budget, about 83%, goes out to the extramural research community through grants, contracts, and other awards. The funding supports research performed by more than 300,000 non-federal scientists and technical personnel who work at more than 2,500 universities, hospitals, medical schools, and other research institutions around the country and abroad.[89] A smaller proportion of the budget, about 11%, supports the intramural research programs of the NIH institutes and centers, funding research performed by NIH scientists and non-employee trainees in the NIH laboratories and Clinical Center. The remaining 6% funds various research management, support, and facilities' needs.

NIH derives its statutory authority from the PHSA. Title III, Section 301 of the PHSA grants the Secretary of HHS broad permanent authority to conduct and sponsor research. In addition, Title IV, "National Research Institutes," authorizes in greater detail various activities, functions, and responsibilities of the NIH Director and the institutes and centers. All of the ICs are covered by specific provisions in the PHSA, but they vary considerably in the amount of detail included in the statutory language. There are few time-and-dollar authorization levels specified for individual activities. Congress authorized a significant reorganization of IC responsibilities in the FY2012 Consolidated Appropriations Act (P.L. 112-74, Division F) by creating a new National Center for Advancing Translational Sciences (NCATS) and dissolving the National Center for Research Resources (NCRR). Activities relating to translational sciences from NCRR and many other ICs were consolidated in NCATS, and NCRR's other programs were moved to several other ICs and OD.

As shown in **Table 7**, the annual Labor-HHS-ED appropriations act provides separate appropriations to 24 of the ICs, the OD, and the Buildings and Facilities account. NIH receives additional funds from the Interior/Environment appropriations act and from a mandatory appropriation for type 1 diabetes research.

[89] U.S. Department of Health and Human Services, *FY2014 Budget in Brief*, April 10, 2013, p. 34, http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

FY2010-FY2013 Funding

In program level funding, the FY2010 total of $31.243 billion for NIH was higher than funding in each of the three following years. Program level funding declined by $317 million (1.0%) from FY2010 to FY2011 under the full-year continuing resolution (P.L. 112-10). Funding further decreased by $66 million (0.2%) to $30.860 billion in FY2012. Under the FY2013 operating plan (after sequestration and transfers), program level funding was $1.709 billion (5.5%) lower than FY2012.[90]

The ICs have shared about equally in the increases and decreases each year. A few programs that were moved in the NCATS/NCRR reorganization have received additional emphasis, and an HHS initiative on Alzheimer's disease research has brought additional funding to the National Institute on Aging (NIA). In FY2013, the initial enacted appropriation in P.L. 113-6 gave NIH a slight increase over FY2012 by adding funding for the OD. The March 2013 sequestration, however, reduced each NIH account by about 5%, and an HHS transfer under the Secretary's authority resulted in a further reduction of $173 million (about 0.55% from each IC and a larger amount from OD).

The main funding mechanism for supporting extramural research is research project grants (RPGs), which are competitive, peer-reviewed, and largely investigator-initiated. In FY2012, NIH supported a total of 36,259 RPGs, including 8,986 in the "new and competing awards" category. The NIH FY2013 operating plan predicts spending 6.0% less on 34,902 RPGs (3.7% fewer), including 8,283 competing awards, a decrease of 703 competing grants (7.8% fewer).[91]

FY2014 President's Budget Request[92]

The FY2014 President's Budget requests a program level total of $31.331 billion for NIH, $471 million (1.5%) more than the comparable FY2012 amount of $30.860 billion and an increase of $2.180 billion (7.5%) above the FY2013 level of $29.151 billion. Most of the institutes and ICs would receive increases in the request compared to FY2013, with selected exceptions reflecting program priorities and new initiatives. For example, about $40 million is requested for the recently-announced BRAIN initiative (Brain Research through Application of Innovative Neurotechnologies) to develop new tools for study of complex brain functions.

The FY2014 budget request for NCATS is $666 million, an increase of $124 million (23%) over its FY2013 budget. NIH estimates it will increase its overall spending on Alzheimer's disease (AD) research in FY2014 by about 12% from FY2012. The request for the National Institute on Aging is $153 million (15%) above FY2013. The National Library of Medicine (NLM) would receive an increase in the request for its data-handling responsibilities, but the increase is smaller

[90] The FY2010 and FY2011 appropriations included about $300 million each that did not remain with NIH. Funds for the U.S. contribution to the Global Fund to Fight AIDS, Tuberculosis, and Malaria were appropriated to NIH (in the account for NIAID, the National Institute of Allergy and Infectious Diseases) but were then transferred to non-HHS agencies that manage overseas assistance programs. Since FY2012 Congress has appropriated Global Fund money directly to the relevant agencies.

[91] For further information, see NIH, "Fact Sheet: Impact of Sequestration on the National Institutes of Health," news release, June 3, 2013, http://www.nih.gov/news/health/jun2013/nih-03.htm.

[92] For additional details, see the NIH section of CRS Report R43086, *Federal Research and Development Funding: FY2014*, coordinated by John F. Sargent Jr.

than it would appear from **Table 7**. For several years, all the ICs have transferred funds from their appropriations to NLM to help cover some shared expenses (for example, in FY2012 the transfers totaled over $27 million). The request proposes that those funds be directly appropriated to NLM.

Table 7 shows funding for NIH accounts for FY2010 through the FY2014 request. FY2012 was the first year in which the NCATS/NCRR reorganization took effect. Program level funding from all accounts is summed and presented as total program level. Mandatory funds and transfers are subtracted from the total program level to show the discretionary budget authority (i.e., discretionary appropriation as provided by Congress) at the bottom of the table. For more information on the PHS Evaluation Set-Aside transfer, see that section in the front matter of this report.[93]

Table 7. National Institutes of Health (NIH)

(Dollars in Millions)

Institutes and Centers (ICs)	FY2010[a]	FY2011[b]	FY2012[c]	FY2013	FY2014 Request
Cancer (NCI)	5,098	5,059	5,067	4,779	5,126
Heart/Lung/Blood (NHLBI)	3,094	3,070	3,076	2,901	3,099
Dental/Craniofacial Research (NIDCR)	413	410	410	387	412
Diabetes/Digestive/Kidney (NIDDK)[d]	1,959	1,942	1,945	1,836	1,962
Neurological Disorders/Stroke (NINDS)	1,634	1,622	1,625	1,532	1,643
Allergy/Infectious Diseases (NIAID)[e]	4,815	4,776	4,486	4,231	4,579
General Medical Sciences (NIGMS)	2,048	2,034	2,428	2,291	2,401
Child Health/Human Development (NICHD)	1,327	1,318	1,320	1,245	1,339
Eye (NEI)	706	701	702	662	699
Environmental Health Sciences (NIEHS), L-HHS appropriation	695	684	685	646	691
NIEHS, Interior/Environment[f]	79	79	79	75	79
Aging (NIA)	1,108	1,100	1,121	1,040	1,193
Arthritis/Musculoskeletal/Skin (NIAMS)	538	534	535	505	541
Deafness/Communication Disorders (NIDCD)	418	415	416	392	423
Nursing Research (NINR)	145	144	145	136	146
Alcohol Abuse/Alcoholism (NIAAA)	462	458	459	433	464
Drug Abuse (NIDA)	1,067	1,051	1,052	993	1,072
Mental Health (NIMH)[g]	1,494	1,477	1,479	1,395	1,466
Human Genome Research (NHGRI)	524	511	513	483	517
Biomedical Imaging/Bioengineering (NIBIB)	316	314	338	319	339

[93] For further background on NIH, see CRS Report R41705, *The National Institutes of Health (NIH): Organization, Funding, and Congressional Issues*, by Judith A. Johnson and Pamela W. Smith, and for current funding information, see the NIH section of CRS Report R43086, *Federal Research and Development Funding: FY2014* , coordinated by John F. Sargent Jr.

Institutes and Centers (ICs)	FY2010[a]	FY2011[b]	FY2012[c]	FY2013	FY2014 Request
Complementary/Alternative Med (NCCAM)	129	128	128	121	129
Minority Health/Health Disparities (NIMHD)	211	210	276	260	283
Fogarty International Center (FIC)	70	69	70	66	73
[former] Ctr for Research Resources (NCRR)	1,267	1,258	—	—	—
Advancing Translational Sciences (NCATS)	—	—	575	542	666
National Library of Medicine (NLM)[h]	349	345	346	326	390
Office of Director (OD)	1,177	1,167	1,459	1,436	1,473
Buildings & Facilities (B&F)	100	50	125	118	126
Total, Program Level	**31,243**	**30,926**	**30,860**	**29,151**	**31,331**
Less Funds From Other Sources					
PHS Evaluation Funds (NLM)	8	8	8	8	8
Type 1 Diabetes Research (NIDDK)[d]	150	150	150	142	150
Total, Discretionary Budget Authority	**31,084**	**30,767**	**30,702**	**29,001**	**31,173**

Sources: Funding amounts for FY2010 are taken from the NIH FY2012 congressional budget justification. Amounts for FY2011 are from the FY2013 justification. Amounts for FY2012 and the FY2014 request are from the FY2014 justification, available (along with older years) at http://officeofbudget.od.nih.gov/. Funding amounts for FY2013 reflect sequestration and are from the NIH Sequestration Operating Plan, available at http://officeofbudget.od.nih.gov/pdfs/FY14/POST%20ONLINE_NIH.pdf.

Notes: FY2010 through FY2013 IC and NLM amounts are not comparable to FY2014 as they do not reflect transfers from ICs to NLM. FY2010 and FY2011 are not adjusted for comparability for the NCATS/NCRR reorganization. Totals may differ from the sum of the components due to rounding.

a. FY2010 reflects real transfer of $1 million from HHS Office of the Secretary to NIMH, $4.6 million transfer to HRSA Ryan White program (Secretary's authority), and transfers among ICs for the Genes, Environment, and Health Initiative (NIH Director's authority).

b. FY2011 reflects real transfer of almost $1 million from HHS Office of the Secretary to NIMH for the Interagency Autism Coordinating Committee.

c. FY2012 reflects Secretary's transfer of $8.727 million to HRSA for Ryan White AIDS and Secretary's net transfer of $18.273 million for Alzheimer's disease research to NIA from other ICs.

d. NIDDK program level includes mandatory funds for type 1 diabetes research appropriated in PHSA Sec. 330B (provided by P.L. 110-275, P.L. 111-309, and P.L. 112-240). Funds have been appropriated through FY2014.

e. FY2010 and FY2011 amounts include funds appropriated to NIAID for transfer to the Global Fund to Fight AIDS, Tuberculosis, and Malaria ($300 million in FY2010 and $297.3 million in FY2011, see footnote 88 in text). BioShield transfer of $304 million provided in FY2010 was not provided under the FY2011 appropriation.

f. This is a separate account in the Interior/Environment appropriations act for NIEHS research activities related to Superfund.

g. The FY2014 request proposes shifting a $27 million program on HIV/AIDS behavioral health research from NIMH to NIAID.

h. NLM program level includes $8.2 million transferred from PHS Evaluation Funds each year.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Agency Overview

SAMHSA is the lead federal agency for increasing access to behavioral health services.[94] It supports community-based mental health and substance abuse treatment and prevention services through formula grants to the states and U.S. territories and through numerous competitive grant programs to states, territories, tribal organizations, local communities, and private entities. Under SAMHSA' s charitable choice provisions, religious organizations are eligible to receive funding in order to provide substance abuse services without altering their religious character. The agency also collects information on the incidence and prevalence of mental illness and substance abuse at the national and state levels.

SAMHSA and most of its programs and activities are authorized under PHSA Title V. However, the agency's two largest programs, the Substance Abuse Prevention and Treatment (SAPT) block grant and the Community Mental Health Services (CMHS) block grant, which together accounted for 64% of SAMHSA's program-level funding in FY2013, are separately authorized under PHSA Title XIX, Part B.

Under PHSA Title V, SAMHSA is organized into three centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). Each center has general statutory authority, called Programs of Regional and National Significance (PRNS), under which it has established grant programs for states and communities to address their important substance abuse and mental health needs. PRNS authorizes each center to fund projects that (1) translate promising new research findings to community-based prevention and treatment services; (2) provide training and technical assistance; and (3) target resources to increase service capacity where it is most needed. In addition, PHSA Title V authorizes a number of specific grant programs, referred to as categorical grants. The PHSA also directs SAMHSA to conduct data collection and analysis activities related to mental health and substance abuse; for example, SAMHSA administers the National Survey on Drug Use and Health (an annual survey that collects information about substance use and related health topics) and publishes analyses of the survey data.

Most SAMHSA programs are administered by one of the three centers and focus on mental health, substance abuse treatment, or substance abuse prevention. Some programs receive support from more than one center; for example, CMHS and CSAT both support SAMHSA's Behavioral Health Treatment Court Collaboratives. Additional activities that fall outside the three centers (e.g., collecting information on the incidence and prevalence of mental illness and substance abuse) are categorized under health surveillance and program support.

[94] Unless otherwise noted, information in this section is summarized from CRS Report R41477, *Substance Abuse and Mental Health Services Administration (SAMHSA): Agency Overview and Reauthorization Issues*, by C. Stephen Redhead.

Congress has not taken up comprehensive legislation to reauthorize SAMHSA since 2000, when the agency and its programs were last reauthorized as part of the Children's Health Act.[95] However, Congress has added some new authorities to Title V and otherwise expanded SAMHSA's programs and activities in the past decade. Although authorizations of appropriations for most of SAMHSA's grant programs expired at the end of FY2003, many of these programs continue to receive annual appropriations.

FY2010-FY2013 Funding

From FY2010 through FY2013, SAMHSA's program-level funding decreased from $3.583 billion to $3.355 billion (a change of $228 million, or 6.4%); SAMHSA's budget authority, excluding PHS evaluation set-aside funds and PPHF transfers, decreased from $3.431 billion in FY2010 to $3.211 billion in FY2013 (a change of $220 million, or 6.4%).

In the Consolidated Appropriations Act, 2012 (P.L. 112-74) and the accompanying conference report,[96] Congress rejected changes SAMHSA proposed to its budget structure in the FY2012 budget request. Among other proposed changes, the FY2012 budget request would have combined most of the existing PRNS in the three centers into a single account for Innovation and Emerging Issues. Congress directed that future budget requests reflect the structure of the three centers, as well as an account labeled Health Surveillance and Program Support to fund "program support and cross-cutting activities that supplement activities funded under [the three centers, and] to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public awareness and technical assistance activities."[97] SAMHSA's FY2013 and FY2014 budget requests have reflected the structure requested by Congress in P.L. 112-74.

FY2014 President's Budget Request

The FY2014 request would return SAMHSA's budget authority ($3.348 billion) and program-level funding ($3.572 billion) to approximately the FY2012 amounts (with less than 0.1% difference). Relative to SAMSHA's FY2012 budget, the FY2014 request would decrease funding for CSAT (by $75 million) and CSAP (by $10 million) and increase funding for CMHS (by $40 million) and health surveillance and program support (by $49 million). The proposed decrease in CSAT funding reflects a reduction in CSAT's PRNS funding (by $94 million) that is partially offset by an increase in CSAT's block grant funding (by $20 million). The proposed decrease in CSAP funding reflects a reduction in CSAP's PRNS funding (by $10 million). The proposed increase in CMHS funding reflects an increase in CMHS's PRNS funding (by $40 million). The proposed increase in health surveillance and program support funding primarily reflects an increase in funding for agency-wide initiatives (by $51 million).

Table 8 presents SAMHSA funding from FY2010 through the FY2014 President's Budget request. Overall program level funding is shown in **bold** for each major budget account. Discretionary budget authority, mandatory funds, user fees, and other sources of funding including transfers are provided. Overall program level funding for each account is summed and

[95] P.L. 106-310, Titles XXXI-XXXIV.

[96] H.Rept. 112-331.

[97] P.L. 112-74; 125 Stat. 1074.

presented as total program level. Transfers, user fees, and mandatory funds are subtracted from the total program level to show the agency's discretionary budget authority (i.e., discretionary appropriation as provided by Congress) at the bottom of the table. For a detailed discussion of the funding concepts noted in the table, see the discussions in **Appendix C** and "PHS Program Evaluation Set-Aside" in this report.

Table 8. Substance Abuse and Mental Health Services Administration (SAMHSA)

(Dollars in Millions)

Program or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
Center for Mental Health Services (CMHS)	**1,005**	**1,022**	**999**	**915**	**1,039**
Mental Health Block Grant	421	420	460	437	460
PHS Evaluation Funds (non-add)	*(21)*	*(21)*	*(21)*	*(21)*	*(21)*
Programs of Regional and National Significance	361	384	321	271	361
PPHF Transfer (non-add)	*(20)*	*(45)*	*(45)*	—	*(28)*
Children's Mental Health Services	121	118	117	111	117
PATH Homeless Formula Grant	65	65	65	61	65
Protection & Advocacy Formula Grant	36	36	36	34	36
Center for Substance Abuse Treatment (CSAT)	**2,253**	**1,871**	**2,230**	**2,115**	**2,155**
Substance Abuse Block Grant (SAPT)	1,799	1,783	1,800	1,710	1,820
PHS Evaluation Funds (non-add)	*(79)*	*(79)*	*(79)*	*(79)*	*(72)*
Programs of Regional and National Significance	452	429	429	405	335
PHS Evaluation Funds (non-add)	*(9)*	*(2)*	*(2)*	*(2)*	—
PPHF Transfer (non-add)	—	*(2)*	*(29)*	—	*30*
Prescription Drug Monitoring (NASPER)[a]	2	—	—	—	—
Center for Substance Abuse Prevention (CSAP)	**202**	**186**	**186**	**176**	**176**
Programs of Regional and National Significance	202	186	186	176	176
Health Surveillance and Program Support	**102**	**177**	**154**	**149**	**203**
Health Surveillance and Program Support	102	171	124	123	120
PHS Evaluation Funds (non-add)	*(23)*	*(29)*	*(27)*	*(27)*	*(45)*
PPHF Transfer (non-add)	—	*(25)*	*(18)*	*(15)*	—
Public Awareness and Support	—	—	14	14	14

Program or Activity	FY2010	FY2011	FY2012	FY2013	FY2014 Request
PHS Evaluation Funds (non-add)	—	—	—	—	*(14)*
Performance and Quality Information Systems	—	—	13	9	13
PHS Evaluation Funds (non-add)	—	—	—	—	*(13)*
Agency-Wide Initiatives	—	5	3	3	54
Data Request and Publications User Fees[b]	—	—	—	—	2
St. Elizabeths Hospital[c]	1	—	—	—	—
Total, Program Level	**3,583**	**3,599**	**3,569**	**3,355**	**3,572**
Less Funds From Other Sources					
PHS Evaluation Funds	132	132	130	130	165
PPHF Transfers	20	88	92	15	58
Data Request and Publications User Fees	—	—	—	—	2
Total, Discretionary Budget Authority	**3,431**	**3,380**	**3,347**	**3,211**	**3,348**

Sources: The amounts for FY2010, FY2011, FY2012, and FY2014 are taken from the FY2012, FY2013, and FY2014 congressional budget justification documents. Funding amounts for FY2013 reflect sequestration and are taken from the SAMHSA FY2013 Sequestration Operation Plan. These documents are available at http://www.hhs.gov/budget/.

Notes: Individual amounts may not add to subtotals or totals due to rounding.

a. The FY2011 full-year continuing resolution (P.L. 112-10) prohibited the funding of grants originally authorized under the National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER, P.L. 109-60) and first funded in FY2009. These grants have not been funded since FY2010. See CRS Report R42593, *Prescription Drug Monitoring Programs*, by Kristin Finklea, Erin Bagalman, and Lisa N. Sacco.

b. SAMHSA has requested authority to seek $1.5 million in Data Request and Publications User Fees, which would be collected for extraordinary requests that SAMHSA would not otherwise be able to fulfill using existing resources.

c. Upon the transfer of the West Campus of St. Elizabeths Hospital from HHS to the General Services Administration (GSA) in 2004, HHS and GSA signed a Memorandum of Agreement that required (among other things) HHS to pay for remediation (clean-up) of hazardous substances found on the site after the date of transfer. Funding for this purpose has not been needed since FY2010.

Appendix A. American Recovery and Reinvestment Act (ARRA): FY2009 Supplemental Appropriations

Through ARRA, Congress appropriated a total of $22.4 billion in supplemental FY2009 discretionary appropriations for health and human services programs administered by HHS. Of that total amount, $15.1 billion was provided directly to, or allocated for, programs and activities administered by, the PHS agencies (see text box below).[98] Generally, the discretionary funds appropriated under ARRA were intended to be time-limited. In most instances the funding was to remain available for obligation through the end of FY2010 (i.e., September 30, 2010). To date, essentially all the ARRA discretionary funds provided to HHS have been obligated.[99]

ARRA: FY2009 Supplemental Discretionary Appropriations for PHS Programs

Agency for Healthcare Research and Quality (AHRQ): $1.1 billion

These funds were used to support comparative effectiveness research (now called patient-centered outcomes research). Of the total amount: $300 million was administered by AHRQ; $400 million was transferred to NIH; and the remaining $400 million was allocated at the discretion of the HHS Secretary and used primarily to develop the infrastructure for comparative effectiveness research.

Health Resources and Services Administration (HRSA): $2.5 billion

These funds were used to support HRSA programs as follows: $1.5 billion for health center construction, renovation, equipment, and health information technology (HIT); $500 million to support new health center delivery sites and service areas and expand services at existing sites; $300 million for the National Health Service Corps; and $200 million for HRSA's health workforce programs.

Indian Health Service (IHS): $500 million

These funds were used to support the following IHS facility and infrastructure projects: $227 million for health facilities construction; $100 million for maintenance and improvement; $85 million for HIT activities; $68 million for sanitation facilities construction; and $20 million for health equipment, including HIT. [Note: IHS received an additional $90 million in ARRA discretionary funds from the Environmental Protection Agency for sanitation facilities construction.]

National Institutes of Health (NIH): $10 billion

These funds were used to support NIH activities as follows: $8.2 billion for intramural and extramural scientific research; $1.3 billion for extramural research facility construction, renovation, and equipment; and $500 million for the construction, repair, and improvement of NIH's facilities. NIH also received a transfer of $400 million from AHRQ for comparative effectiveness research (see above).

Prevention and Wellness Fund: $1 billion

These funds were used as follows: $300 million for CDC's immunization program; $50 million for CDC and CMS to support state and local efforts to reduce health care-associated infections; and $650 million for CDC to support an evidence-based clinical and community-based prevention and wellness program—Communities Putting Prevention to Work (CPPW)—focused on increasing levels of physical activity, improving nutrition, reducing obesity rates, and decreasing smoking prevalence and exposure to secondhand smoke.

[98] P.L. 111-5, 123 Stat. 115. The HHS appropriations were included in Title VIII (Labor-HHS-ED) of Division A of ARRA. In addition to these discretionary appropriations, ARRA included several HHS mandatory spending provisions. For more information, see CRS Report R40537, *American Recovery and Reinvestment Act of 2009 (P.L. 111-5): Summary and Legislative History*, by Clinton T. Brass et al.

[99] HHS maintains a Recovery Act website at http://www.hhs.gov/recovery/. It includes detailed implementation plans for all the ARRA-funded programs, up-to-date information on ARRA obligations and outlays (by state), and links to the Recovery Act websites maintained by individual HHS agencies.

Appendix B. Community Health Center Fund

ACA Section 10503 established a Community Health Center Fund (CHCF) to provide supplemental funding for health center operations and the National Health Service Corps (NHSC). The law provided annual appropriations to the CHCF totaling $11 billion over the five-year period of FY2011 through FY2015. Despite the title of the fund, which only refers to community health centers, the CHCF supports funding for four types of health centers: community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing. ACA Section 10503 also included a separate appropriation of $1.5 billion, available for the period FY2011 through FY2015, for health center construction and renovation. These funds are separate from the CHCF and are not included in **Table B-1**.

ACA also included a provision that required that the CHCF be used to increase funding for the health centers program and the NHSC above FY2008 funding levels. P.L. 112-10, which provided full year appropriations for FY2011, eliminated this requirement for FY2011, thus allowing CHCF funds to be used to either supplement or replace annual appropriations for health centers and the NHSC. FY2011, FY2012, and FY2013 annual appropriations for health centers and the NHSC were below the FY2008 funding level. This is also the case under the FY2014 President's Budget request. In addition, since FY2012, the NHSC has not received annual discretionary appropriations. Similarly, the FY2014 President's Budget request would also eliminate the program's annual discretionary appropriations. Instead, in each of these years, funds from the CHCF made up—or, in the case of FY2014, would make up—the entirety of the NHSC's budget. **Table B-1** summarizes the amounts appropriated to the CHCF and the allocation of funds for each of the five fiscal years.

CHCF funds for community and migrant health centers were reduced by 2% for FY2013 under the BCA sequester; the remaining funds (those for other health center types and for the NHSC) were reduced at 5.1%, the percentage that OMB determined would apply to mandatory funds.[100]

Table B-1. Community Health Center Fund, FY2011-FY2015

(Dollars in Millions)

Program	FY2011	FY2012	FY2013	FY2014	FY2015	Total
Health Center Program	1,000	1,200	1,500[a]	2,200	3,600	9,500
National Health Service Corps	290	295	300[b]	305	310	1,500
Total	**1,290**	**1,495**	**1,800**	**2,505**	**3,910**	**11,000**

Source: Patient Protection and Affordable Care Act of (ACA; P.L. 111-148, as amended).

a. This amount was reduced to $1,465 million by sequestration.

b. This amount was reduced to $285 million by sequestration.

[100] Discretionary funds for the health center program were reduced by 5% for FY2013. For more information, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar. For information on the OMB report see *OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013,* March 1, 2013: http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/fy13ombjcsequestrationreport.pdf.

Appendix C. Prevention and Public Health Fund (PPHF)

The Patient Protection and Affordable Care Act (ACA) established the Prevention and Public Health Fund (PPHF) and provided it with a permanent annual appropriation.[101] PPHF funds are to be transferred by the HHS Secretary for prevention, wellness, and public health activities.

ACA appropriated increasing amounts to the PPHF for FY2010 through FY2014, and $2 billion per fiscal year in perpetuity thereafter. In February 2012, through the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96, Section 3205), Congress amended the PPHF authority, decreasing the appropriated amounts from FY2013 through FY2021 as part of a package of offsets to partly cover the costs of the law. (These costs included, among other things, extending certain unemployment and Medicare programs.) Original appropriations to the PPHF in ACA and current-law amounts are presented in **Table C-1**. Note that PPHF amounts for FY2013 through FY2021 are subject to sequestration under the Budget Control Act (BCA, P.L. 112-25).[102]

Table C-1. PPHF Appropriations Under ACA and Current Law

(Dollars in Millions)

Fiscal Year	Total Appropriation	
	ACA (P.L. 111-148)	Current Law[a]
2010	500	500
2011	750	750
2012	1,000	1,000
2013	1,250	949[b]
2014	1,500	1,000[c]
2015	2,000	1,000[c]
2016	2,000	1,000[c]
2017	2,000	1,000[c]
2018	2,000	1,250[c]
2019	2,000	1,250[c]
2020	2,000	1,500[c]
2021	2,000	1,500[c]
2022 and each subsequent FY	2,000	2,000

Source: Prepared by Congressional Research Service.

a. ACA, as amended by P.L. 112-96, the Middle Class Tax Relief and Job Creation Act of 2012, Sec. 3205.

[101] ACA Section 4002; 42 U.S.C. §300u-11.

[102] CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

b. Reflects reduction to $1 billion under P.L. 112-96, and cancellation of 5.1% ($51 million) of FY2013 budgetary resources under Budget Control Act (BCA) sequestration for nonexempt nondefense mandatory programs, as of March 1, 2013. For background on BCA sequestration, see CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

c. Amounts through FY2021 are subject to BCA sequestration in amounts determined by the White House Office of Management and Budget (OMB).

PPHF funds are available to the HHS Secretary on October 1 of each year, when each new fiscal year begins. As a result, the Administration's annual budget proposals for the PPHF reflect not the Administration's request for the funds, but rather its intended distribution and use of the funds. The distribution of PPHF funds to various HHS agencies for FY2010 through the FY2014 President's budget proposal is presented in **Table C-2**. Further details regarding PPHF distributions to AHRQ, CDC, HRSA, and SAMHSA are provided in the respective agency budget tables in the body of this report.[103]

Table C-2. PPHF Transfers to HHS Agencies, FY2010-FY2014

(Dollars in Millions)

Agency	FY2010	FY2011	FY2012	FY2013[a]	FY2014 Proposal[b]	Agency Total, FY10-FY14	Agency Total (%), FY10-FY14
AHRQ	6	12	12	7	0	36	0.9
AoA/ACL	0	0	20	9	25	54	1.3
CDC	192	611	809	463	755	2,830	67.4
CMS	0	0	0	454[c]	0	454[c]	10.8
HRSA	271	20	37	2	57	387	9.2
OS	12	19	30	0	105	166	4.0
SAMHSA	20	88	92	15	58	273	6.5
Total	**500**	**750**	**1,000**	**949**	**1,000**	**4,199**	**100.0**

Sources: Prepared by Congressional Research Service based on HHS agency congressional budget justifications for FY2012 through FY2014, http://www.hhs.gov/budget/; and HHS, "Prevention and Public Health Fund," funding distribution tables, http://www.hhs.gov/open/recordsandreports/prevention/index.html.

Notes: Individual amounts may not add to totals due to rounding. Acronyms are as follows: AHRQ is the Agency for Healthcare Research and Quality, AoA is the Administration on Aging, ACL is the Administration for Community Living, CDC is the Centers for Disease Control and Prevention, CMS is the Centers for Medicare & Medicaid Services, HRSA is the Health Resources and Services Administration, OS is the Office of the HHS Secretary, and SAMHSA is the Substance Abuse and Mental Health Services Administration.

a. Amounts reflect cancellation of $51 million in budgetary resources under FY2013 sequestration.

b. Distribution proposed by the Administration. This is not a budget request, as PPHF funds have already been appropriated. Amounts do not reflect FY2014 sequestration that may be required under current law.

c. According to HHS, funds are for "Health Insurance Enrollment Support" for implementation of insurance exchanges under ACA, "[t]o invest in health insurance enrollment support specifically through activities that will assist with eligibility determinations which are in need of intervention and activities to make people aware of insurance options and enrollment assistance available to them."

Scope of PPHF-Funded Activities

[103] See also references to the PPHF in text and tables in CRS Report RL33880, *Funding for the Older Americans Act and Other Aging Services Programs*, by Angela Napili and Kirsten J. Colello.

The terms "prevention," "wellness," and "public health activities," which describe allowable PPHF-funded activities, are not defined in the PHSA, ACA, or elsewhere in federal law. ACA was not accompanied by committee reports in either chamber. Finally, HHS has not published regulations, guidance, or other information to clarify the department's views about the types of activities that are within scope for PPHF funding.[104]

HHS recently published an annual report to Congress on PPHF spending for FY2012, as required by law.[105] The report notes spending (typically through grants or contracts) on the following types of activities, among others: (1) *community prevention activities* to improve health and reduce chronic disease risk factors, to reduce tobacco use, and to improve fitness and reduce obesity; (2) *clinical prevention activities* to improve access to important preventive services and definitive care for a variety of health needs; (3) *behavioral health* screening and integration with primary care; (4) *public health infrastructure*, workforce, and training; and (5) *public health research* and data collection. As shown in **Table C-2**, more than two-thirds of PPHF funds have been distributed to CDC.

Members of Congress hold a variety of views about the PPHF.[106] The Fund's proponents often support an expanded view of the role of public health in addressing so-called social or non-medical determinants of health, such as behavior, socioeconomic status, and the environment.[107] They see the PPHF as a means to enable communities to expand their public health efforts in order to control the chronic disease burdens that affect them. Others have objected to this approach; some criticize the use of the PPHF for public works projects such as playgrounds and bike lanes, while others charge that a federal role in behavior modification is inappropriate and intrusive.

In April 2013, HHS announced its intention to transfer $454 million—almost half of the $949 million available for FY2013—to the Centers for Medicare & Medicaid Services (CMS) to help pay for ongoing ACA implementation activities, including the establishment of the federally facilitated exchanges, as well as consumer education and outreach.[108] Congress did not provide CMS with the additional discretionary funding that it requested for ACA implementation in FY2013. The plan to transfer PPHF funds to CMS was criticized by supporters of the Fund.[109] As shown in **Table C-2**, each HHS agency that received a PPHF transfer in FY2012 received substantially less from the PPHF for FY2013, largely as a result of the transfer to CMS.

---

[104] For more information about federal prevention activities and how they may be defined, see Government Accountability Office, *Available Information on Federal Spending, Cost Savings, and International Comparisons Has Limitations*, GAO-13-49, December 6, 2012, http://gao.gov/products/GAO-13-49.

[105] HHS, "The Affordable Care Act and the Prevention and Public Health Fund: Report to Congress for FY2012," undated, http://www.hhs.gov/open/recordsandreports/prevention/fy2012_aca_rpt_to_congress.pdf.

[106] Unless otherwise noted, information in this paragraph is drawn from: Michael Kranish, "In Health Bill, Billions for Parks, Paths," *The Boston Globe*, July 9, 2009; John Reichard, "Whither the Overhaul Law's Prevention Fund?," *CQ HealthBeat News*, January 6, 2011; and Jennifer Haberkorn, "The Prevention and Public Health Fund," *Health Affairs*, Health Policy Brief, February 23, 2012. In the 112th Congress, the House passed H.R. 1217, a bill to repeal the PPHF. A similar bill, H.R. 1099, has been introduced in the House in the 113th Congress. Comparable bills have not advanced in the Senate.

[107] For more information, see Michele J. Orza, *High Hopes: Public Health Approaches to Reducing the Need for Health Care*, National Health Policy Forum, September 27, 2010, http://www.nhpf.org/library/details.cfm/2833.

[108] Rachana Dixit, "HHS Sets Aside $454 Million In Prevention Funds For Insurance Enrollment Support," *InsideHealthPolicy,* April 16, 2013.

[109] John Reichard, "HHS Draws $304 Million from Prevention Fund to Enroll Uninsured," *CQ HealthBeat News*, April 12, 2013.

Relationship to Annual Appropriations

In some cases, the Secretary has used, or proposed to use, PPHF funds to augment funds from annual discretionary appropriations. For example, for FY2013, the Administration proposed using the PPHF to fund almost the entire budget of the CDC Center on Birth Defects and Developmental Disabilities.[110] If PPHF funds were to become unavailable, appropriators would face a need to provide additional regular appropriations in order to sustain programmatic activities.[111]

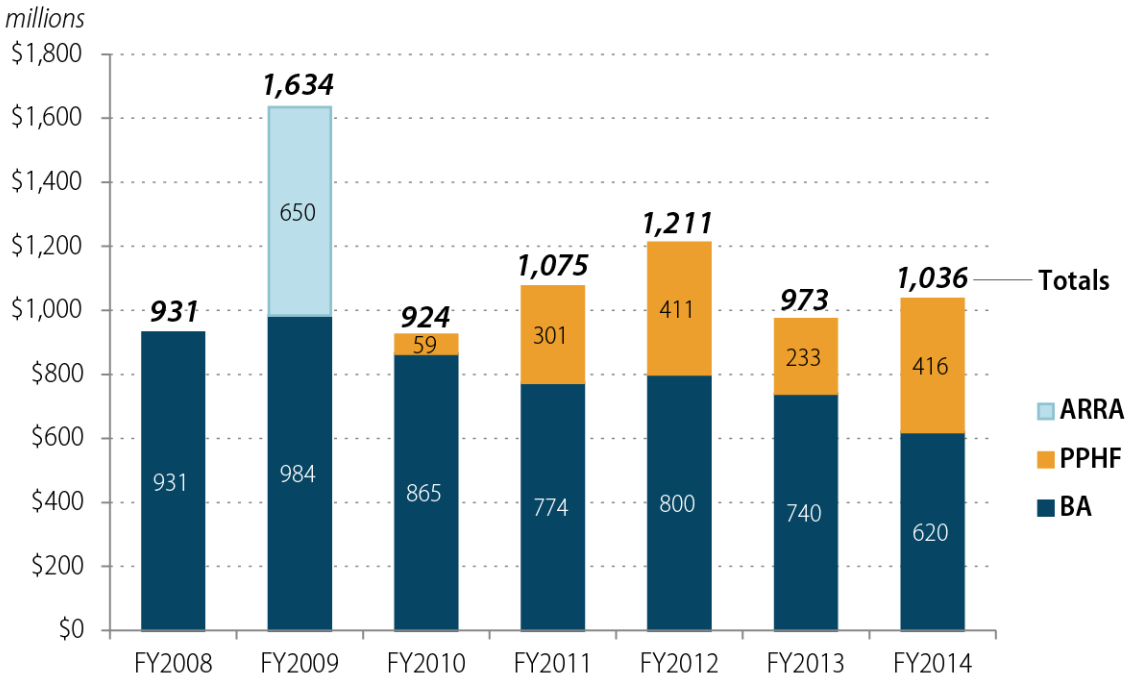
Recent funding trends for the CDC Chronic Disease Prevention and Health Promotion account illustrate this point. This account has received sizeable PPHF distributions since funds first became available for FY2010. As shown in **Figure C-1**, budget authority for the account decreased overall from FY2009 (before PPHF funds were available) through the FY2014 request. However, the program level increased from FY2010 through FY2012, due to the increasing transfers of PPHF funds. The program level then decreased for FY2013. This was due in part to the decrease in budget authority (BA) as a result of rescission and sequestration, but in larger part to the reduced PPHF transfer that, as discussed above, resulted from the large PPHF transfer to CMS. Ultimately, the CMS transfer had a greater effect on the operating budget for CDC Chronic Disease Prevention and Health Promotion activities than did sequestration.

[110] CDC, *Justification of Estimates for Congressional Committees*, FY2013, February, 2012, p. 153, http://www.cdc.gov/fmo.

[111] John Reichard, "Advocates: CDC, Other Agencies Face Big Cuts Fast if Prevention Fund Ends," *CQ HealthBeat*, June 18, 2012.

Figure C-1. Funding for CDC Chronic Disease Prevention and Health Promotion, FY2008-FY2014

Dollars in millions



Sources: Prepared by Congressional Research Service from CDC, *Justification of Estimates for Congressional Committees*, FY2013, p. 120, and FY2014, p. 138, and CDC FY2013 operating plan, all at http://www.cdc.gov/fmo; and CDC Office of the Chief Operating Officer, June 13, 2013.

Notes: Column totals are program levels. Amounts for FY2008 and FY2009 have not been made comparable to subsequent years which reflect a FY2010 budget realignment. FY2012 and FY2013 amounts have been made comparable to FY2014 to reflect a planned budget realignment for the Working Capital Fund. ARRA is the American Recovery and Reinvestment Act of 2009. (See CRS Report R40181, *Selected Health Funding in the American Recovery and Reinvestment Act of 2009*, coordinated by C. Stephen Redhead.) PPHF is the ACA Prevention and Public Health Fund. BA is budget authority. The BA amount presented for FY2013 reflects cancellation of $38.1 million due to sequestration, and addition of $22.7 million through a one-time transfer from other HHS agencies, under the HHS Secretary's general transfer authority.

Appendix D. Patient-Centered Outcomes Research Trust Fund

ACA Section 6301(e) established the Patient-Centered Outcomes Research Trust Fund (PCORTF) to receive funds to support comparative clinical effectiveness research (CER) and dissemination of its results at both HHS and the Patient-Centered Outcomes Research Institute (PCORI).[112] Sources of monies to PCORTF include (1) annual appropriations; (2) fees on health insurance and self-insured plans; and (3) transfers from the Medicare Part A and Part B Trust Funds.

Specifically, ACA appropriated funds to PCORTF for FY2010 through FY2019, in the following amounts: (1) $10 million for FY2010; (2) $50 million for FY2011; and (3) $150 million for each of FY2012 through FY2019. In addition, for each of FY2013 through 2019, ACA appropriated an amount equivalent to the net revenues from a new fee that the law imposes on health insurance policies and self-insured plans. For policy/plan years ending during FY2013, the fee equals $1 multiplied by the number of covered lives; for policy/plan years ending during each subsequent fiscal year through FY2019, the fee equals $2 multiplied by the number of covered lives. Finally, transfers to PCORTF from the Medicare Part A and Part B trust funds are calculated by multiplying the average number of individuals entitled to benefits under Medicare Part A, or enrolled in Medicare Part B, by $1 (for FY2013) and by $2 (for each of fiscal years 2014 through 2019).

For each of FY2011 through FY2019, ACA requires 80% of the PCORTF funds to be made available to PCORI, and 20% of the PCORTF funds to be transferred to the HHS Secretary for carrying out PHSA Section 937.[113] Of the total amount transferred to HHS, 80% is to be distributed to AHRQ. **Table D-1** presents the amounts distributed from PCORTF to PCORI and transferred to HHS in FY2010 through FY2013 and the estimated amounts for FY2014.

Table D-1. PCORTF Distribution, FY2010-FY2014

(Dollars in Millions)

Funding Recipient	FY2010	FY2011	FY2012	FY2013 (estimated)	FY2014 (estimated)
PCORI	10	40	120	304	498
Transfer to HHS	—	10	30	76	125
AHRQ (non-add)	—	8	24	61	100
HHS Secretary (non-add)	—	2	6	15	25
Total		**50**	**150**	**380**	**623**

Sources: Office of Management and Budget, *Fiscal Year 2013, Appendix, Budget of the U.S. Government*; and *Fiscal Year 2014, Appendix, Budget of the U.S. Government.*

[112] ACA Section 6301(e), adding new Internal Revenue Code Section 9511. PCORI (established in ACA Section 6301(a), adding new SSA Section 1181) is a non-governmental body authorized by Congress to evaluate existing research and to conduct original research examining the relative health outcomes, clinical effectiveness, and appropriateness of different medical treatments.

[113] ACA Section 6301(b) adds a new PHSA Section 937 requiring the broad dissemination of CER results published by PCORI.

Appendix E. FDA User Fee Authorizations

Table E-1. FDA User Fee Authorizations and FY2013 Amounts

(in order of FY2013 anticipated revenue in Sequestration Operating Plan)

User fee	Initial authorizing legislation and year	Amount in FY2013 ($ in millions)
Prescription drug	Prescription Drug User Fee Act (PDUFA), 1992 (P.L. 102-300)	683
Tobacco product	Family Smoking Prevention and Tobacco Control Act, 2009 (P.L. 111-31)	480
Generic drug	Food and Drug Administration Safety and Innovation Act (FDASIA), 2012 (P.L. 112-144)	284
Medical device	Medical Device User Fee and Modernization Act (MDUFMA), 2002 (P.L. 107-250)	93
Animal drug	Animal Drug User Fee Act (ADUFA), 2003 (P.L. 108-130)	23
Biosimilars	Food and Drug Administration Safety and Innovation Act (FDASIA), 2012 (P.L. 112-144)	19
Mammography	Mammography Quality Standards Act (MQSA), 1992 (P.L. 102-539)	18
Food reinspection	Food Safety Modernization Act (FSMA), 2011 (P.L. 111-353)	15
Food recall	Food Safety Modernization Act (FSMA), 2011 (P.L. 111-353)	12
Color certification	Color Additive Amendments of 1960 (P.L. 86-618)	7
Animal generic drug	Animal Generic Drug User Fee Act (AGDUFA), 2008 (P.L. 110-316)	6
Export certification	FDA Export Reform and Enhancement Act of 1996 [for medical products] (P.L. 104-134); Food Safety Modernization Act (FSMA), 2011 [for foods] (P.L. 111-353)	5
Priority review with voucher[a]	Food and Drug Administration Amendments Act (FDAAA), 2007 (P.L. 110-85)	0
Voluntary qualified importer (VQIP)[b]	Food Safety Modernization Act (FSMA), 2011 (P.L. 111-353)	0
Total		**645**

Source: Prepared by Congressional Research Service.

a. The appropriations act for FY2009 was the first to authorize priority review user fees to be assessed when a sponsor submitted an application using a priority review voucher that FDA had issued after it approved an New Drug Application (from the same or another sponsor) for a tropical disease. Congress added a second opportunity for a priority review voucher in return for an approved NDA for a rare pediatric disease. FDA collected a priority review fee only once, in 2012.

b. No appropriations have yet been authorized for VQIP.

Author Contact Information

Amalia K. Corby-Edwards, Coordinator
Analyst in Public Health and Epidemiology
acorbyedwards@crs.loc.gov, 7-0423

C. Stephen Redhead, Coordinator
Specialist in Health Policy
credhead@crs.loc.gov, 7-2261

Erin Bagalman
Analyst in Health Policy
ebagalman@crs.loc.gov, 7-5345

Elayne J. Heisler
Analyst in Health Services
eheisler@crs.loc.gov, 7-4453

Sarah A. Lister
Specialist in Public Health and Epidemiology
slister@crs.loc.gov, 7-7320

Amanda K. Sarata
Specialist in Health Policy
asarata@crs.loc.gov, 7-7641

Pamela W. Smith
Analyst in Biomedical Policy
psmith@crs.loc.gov, 7-7048

Susan Thaul
Specialist in Drug Safety and Effectiveness
sthaul@crs.loc.gov, 7-0562