



August 2020

COVID-19

Brief Update on Initial Federal Response to the Pandemic

Accessible Version

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Abbreviation

BLS	Bureau of Labor Statistics
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
DATA Act	Digital Accountability and Transparency Act of 2014
DHS	Department of Homeland Security
DOT	Department of Transportation
Federal Reserve	Board of Governors of the Federal Reserve System
FMAP	Federal Medical Assistance Percentage
HHS	Department of Health and Human Services
HS	Harmonized Schedule
ICU	intensive care unit
IRS	Internal Revenue Service
NCHS	National Center for Health Statistics
NHSN	National Healthcare Safety Network
OMB	Office of Management and Budget
PPP	Paycheck Protection Program
PUA	Pandemic Unemployment Assistance
SAO	Senior Accountable Official
SBA	Small Business Administration
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
Treasury	Department of the Treasury
UI	unemployment insurance

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Highlights

What GAO Found

In response to the national public health and economic threats caused by COVID-19, four relief laws making appropriations of about \$2.6 trillion had been enacted as of July 31, 2020. Overall, federal obligations and expenditures government-wide of these COVID-19 relief funds totaled \$1.5 trillion and \$1.3 trillion, respectively, as of June 30, 2020. GAO also obtained preliminary data for six major spending areas as of July 31, 2020 (see table).

COVID-19 Relief Appropriations, Obligations, and Expenditures for Six Major Spending Areas, as of July 2020

Spending area	Appropriations ^a (\$ billions)	Preliminary obligations ^b (\$ billions)	Preliminary expenditures ^b (\$ billions)
Business Loan Programs	687.3	538.1	522.2 ^c
Economic Stabilization and Assistance to Distressed Sectors	500.0	30.4	19.2 ^c
Unemployment Insurance	376.4	301.1	296.8
Economic Impact Payments	282.0	273.5	273.5
Public Health and Social Services Emergency Fund	231.7	129.6	95.9
Coronavirus Relief Fund	150.0	149.5	149.5
Total for six spending areas	2,227.4	1,422.2	1,357.0

Source: GAO analysis of data from the Department of the Treasury, USA Spending.gov, and applicable agencies. | GAO-20-708

^aCOVID-19 relief appropriations reflect amounts appropriated under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); and Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020). These data are based on appropriations warrant information provided by the Department of the Treasury as of July 31, 2020. These amounts could increase in the future for programs with indefinite appropriations, which are appropriations that, at the time of enactment, are for an unspecified amount. In addition, this table does not represent transfers of funds that federal agencies may make between appropriation accounts or transfers of funds they may make to other agencies.

^bObligations and expenditures data for July 2020 are based on preliminary data reported by applicable agencies.

^cThese expenditures relate to the loan subsidy costs (the loan's estimated long-term costs to the United States government).

The CARES Act included a provision for GAO to assess the impact of the federal response on public health and the economy. The following are examples of health care and economic indicators that GAO is monitoring.

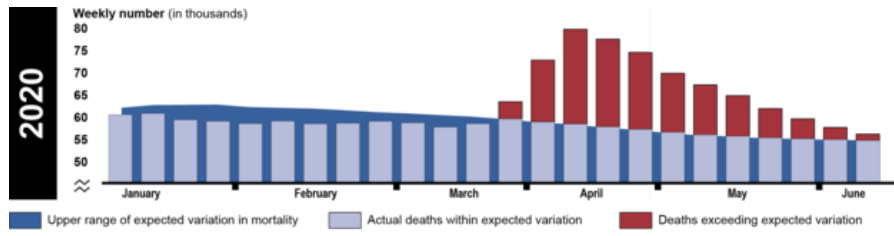
Health care. GAO's indicators are intended to assess the nation's immediate response to COVID-19 as it first took hold, gauge its recovery from the effects of the pandemic over the longer term, and determine the nation's level of preparedness for future pandemics, involving subsequent waves of either COVID-19 or other infectious diseases.

For example, to assess the sufficiency of testing—a potential indicator of the system's response and recovery—GAO suggests monitoring the proportion of tests in a given population that are positive for infection. A higher positivity rate can indicate that testing is not sufficiently widespread to find all cases. That is higher positivity rates can indicate that testing has focused on those most likely to be infected and seeking testing because they have symptoms, and may not be detecting COVID-19 cases among individuals with no symptoms.

Although there is no agreed-upon threshold for the test positivity rate, governments should target low positivity rates. The World Health Organization recommends a test positivity rate threshold of less than 5 percent over a 14-day period. As of August 12, 2020, 12 states and the District of Columbia had met this threshold (38 states had not). Resolve to Save Lives, another organization, recommends a threshold of less than 3 percent over a 7-day period, and 11 states and the District of Columbia had met this threshold (39 states had not) as of August 12, 2020.

GAO also suggests monitoring mortality from all causes compared to historical norms as an indicator of the pandemic's broad effect on health care outcomes. Mortality rates have tended to be consistent from year to year. This allows an estimation of how much mortality rose with the onset of the pandemic, and provides a baseline by which to judge a return to pre-COVID levels. According to Centers for Disease Control and Prevention data, about 125,000 more people died from all causes January 1–June 13 than would normally be expected (see figure).

CDC Data on Higher-Than-Expected Weekly Mortality, January 1 through June 13, 2020

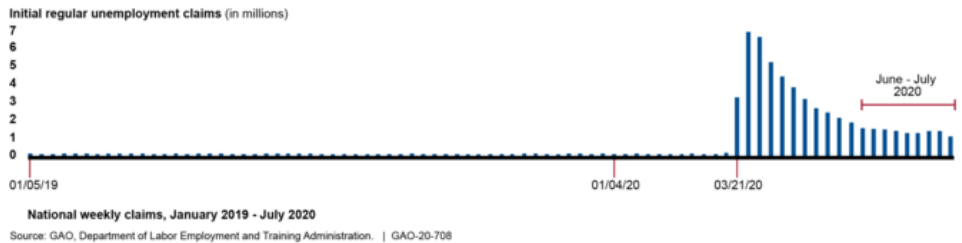


Note: The figure shows the number of deaths from all causes in a given week that exceeded the upper bound threshold of expected deaths calculated by CDC on the basis of variation in mortality experienced in prior years. Changes in the observed numbers of deaths in recent weeks should be interpreted cautiously as this figure relies on provisional data that are generally less complete in recent weeks. Data were accessed on July 16, 2020.

Economy. GAO updated information on a number of indicators to facilitate ongoing and consistent monitoring of areas of the economy supported by the federal pandemic response, in particular the COVID-19 relief laws. These indicators suggest that economic conditions—including for workers, small businesses, and corporations—have improved modestly in recent months but remain much weaker than prior to the pandemic.

In June and July initial regular unemployment insurance (UI) claims filed weekly averaged roughly 1.4 million (see figure), which was six and a half times higher than average weekly claims in 2019, but claims have decreased substantially since mid-March, falling to 971,000 in the week ending August 8, 2020. Increasing infections in some states and orders to once again close or limit certain businesses are likely to pose additional challenges for potentially fragile economic improvements, especially in affected sectors, such as the leisure and hospitality sector.

National Weekly Initial Unemployment Insurance Claims, January 2019–July 2020



Note: See figure 5 in the report.

As GAO reported in June, consistent with the urgency of responding to serious and widespread health issues and economic disruptions, federal agencies gave priority to moving swiftly where possible to distribute funds and implement new programs designed to help small businesses and the newly unemployed, for example. However, such urgency required certain tradeoffs in achieving transparency and accountability goals. To make mid-course corrections, GAO made three recommendations to federal agencies:

- To reduce the potential for duplicate payments from the Paycheck Protection Program (PPP)—a program that provides guaranteed loans through lenders to small businesses—and unemployment insurance, GAO recommended that the Department of Labor (DOL), in consultation with the Small Business Administration (SBA) and the Department of the Treasury (Treasury), immediately provide information to state unemployment agencies that specifically addresses PPP loans, and the risk of improper unemployment insurance payments. DOL issued guidance on August 12, 2020, that, among other things, clarified that individuals working full-time and being paid through PPP are not eligible for UI.
- To recoup economic impact payments totaling more than \$1.6 billion sent to decedents, GAO recommended that the Internal Revenue Service (IRS) consider cost-effective options for notifying ineligible recipients of economic impact payments how to return payments. IRS has taken steps to address this recommendation. According to a Treasury official, nearly 70 percent of the payments sent to decedents have been recovered. However, GAO was unable to verify that amount before finalizing work on this report. GAO is working with Treasury to determine the number of payments sent to decedents that have been recovered. Treasury was considering sending letters to request the return of remaining outstanding payments but has not moved forward with this effort because, according to Treasury, Congress is considering legislation that would clarify or change payment eligibility requirements.
- To reduce the potential for fraud and ensure program integrity, GAO recommended that SBA develop and implement plans to identify and respond to risks in PPP to ensure program integrity, achieve program effectiveness, and address potential fraud. SBA has begun developing oversight plans for PPP but has not yet finalized or implemented them.

In addition, to improve the government's response efforts, GAO suggested three matters for congressional consideration:

- GAO urged Congress to take legislative action to require the Department of Transportation (DOT) to work with relevant agencies and stakeholders, such as HHS, the Department of Homeland Security (DHS), and international organizations, to develop a national aviation-preparedness plan to ensure safeguards are in place to limit the spread of communicable disease threats from abroad, while also minimizing any unnecessary interference with travel and trade. In early July 2020, DOT collaborated with HHS and DHS to issue guidance to airports and airlines for implementing measures to mitigate the public health risks associated with COVID-19, but it has not developed a preparedness plan for future communicable disease threats. DOT has maintained that HHS and DHS should lead such planning efforts as they are responsible for communicable disease response and preparedness planning, respectively. In June 2020, HHS stated that it is not in a position to develop a national aviation-preparedness plan as it does not have primary jurisdiction over the entire aviation sector or the relevant transportation expertise. In May 2020, DHS stated that it had reviewed its existing plans for pandemic preparedness and response activities and determined it is not best situated to develop a national aviation-preparedness plan. Without such a plan, the U.S. will not be as prepared to minimize and quickly respond to future communicable disease events.
- GAO also urged Congress to amend the Social Security Act to explicitly allow the Social Security Administration (SSA) to share its full death data with Treasury for data matching to help prevent payments to ineligible individuals. In June 2020, the Senate passed S.4104, referred to as the Stopping Improper Payments to Deceased People Act. If enacted, the bill would allow SSA to share these data with Treasury's Bureau of the Fiscal Service to avoid paying deceased individuals.
- Finally, GAO urged Congress to use GAO's Federal Medical Assistance Percentage (FMAP) formula for any future changes to the FMAP—the statutory formula according to which the federal government matches states' spending for Medicaid services—during the current or any future economic downturn. Congress has taken no action thus far on this issue.

GAO incorporated technical comments received from the Departments of Labor, Commerce, Health and Human Services, Transportation, and the Treasury; the Federal Reserve; Office of Management and Budget; and Internal Revenue Service. The Small Business Administration commented that GAO did not include information on actions taken and controls related to its loan forgiveness program or its plans for loan reviews. GAO plans to provide more information on these topics in its next CARES Act report.

Why GAO Did This Study

As of August 20, 2020, the U.S. had over 5.5 million cumulative reported cases of COVID-19, and 158,000 reported deaths, according to federal agencies. The country also continues to experience serious economic repercussions and turmoil. Four relief laws, including the CARES Act, were enacted between March and July 2020 to provide appropriations for the response to COVID-19.

The CARES Act includes a provision for GAO to report bimonthly on its ongoing monitoring and oversight efforts related to COVID-19. This second report examines federal spending on the COVID-19 response; indicators for monitoring public health and the economy; and the status of matters for congressional consideration and recommendations from GAO's June 2020 report (GAO-20-625).

GAO reviewed data through June 30, 2020 (the latest available) from USAspending.gov, a government website with data from government agencies. GAO also obtained, directly from the agencies, spending data, as of July 31, 2020, for the six largest spending areas, to the extent available.

To develop the public health indicators, GAO reviewed research and federal guidance. To understand economic developments, GAO reviewed data from federal statistical agencies, the Federal Reserve, and Bloomberg Terminal, as well as economic research.

To update the status of matters for congressional consideration and recommendations, GAO reviewed agency and congressional actions.

Introduction

Congressional Committees

The Coronavirus Disease 2019 (COVID-19) pandemic has resulted in catastrophic loss of life and substantial damage to the global economy, stability, and security. Worldwide there were 22,256,000 reported cases and 782,000 reported deaths due to COVID-19, as of August 20, 2020; within the United States, there were 5,507,000 cumulative reported cases and 158,000 reported deaths.¹ The United States also continues to experience serious economic repercussions and turmoil. As of July 2020, there were about 16.3 million unemployed individuals, compared to nearly 5.9 million individuals at the beginning of the calendar year.²

In response to the far-reaching public health and economic crises, Congress and the administration have taken a series of actions. For example, in March 2020, Congress passed, and the President signed into law, the CARES Act, which provides over \$2 trillion in emergency assistance and health care response for individuals, families, and businesses affected by COVID-19.³

The CARES Act includes a provision for us to conduct monitoring and oversight of the federal government's efforts to prepare for, respond to,

¹ Reported COVID-19 cases include confirmed and probable cases, as of April 14, 2020, if states report probable cases to CDC. According to CDC, the actual number of cases is unknown for a variety of reasons, including that people who have been infected may have not been tested or may have not sought medical care. National Center for Health Statistics (NCHS) provisional death counts include both confirmed and probable or presumed deaths. The counts reported are the total number of deaths received and coded as of the date of analysis and do not represent all deaths that occurred in that period. Provisional counts are incomplete because of the lag in time between when the death occurred and when the death certificate is completed, submitted to NCHS, and processed for reporting purposes. This delay is an average of 1 to 2 weeks and can range from 1 to 8 weeks or more, depending on the jurisdiction, age, and cause of death.

² Bureau of Labor Statistics, Unemployment Level [UNEMPLOY], retrieved from FRED, Federal Reserve Bank of St. Louis, accessed August 7, 2020, <https://fred.stlouisfed.org/series/UNEMPLOY>.

³ Pub. L. No. 116-136, 134 Stat. 281 (2020). As of August 1, 2020, three other relief laws had also been enacted in response to the COVID-19 pandemic: the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020); and Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020). In this report, we refer to these four laws, each of which was enacted as of August 1, 2020, and provides supplemental appropriations for the COVID-19 response, as "COVID-19 relief laws," and the supplemental funding appropriated by these laws as "COVID-19 relief funds." This report does not address the Executive Order on homeowner and renter assistance, or Memoranda on payroll tax deferrals, student loan payment relief, or assistance for lost wages, issued on August 8, 2020.

and recover from the COVID-19 pandemic, including monitoring and oversight of the use of funds made available. ⁴ We are to report on, among other things, the effect of the pandemic on the public health, economy, and public and private institutions.

According to the provision, GAO is to submit bimonthly reports on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic. We issued our first report on June 25, 2020. ⁵ In addition to these bimonthly reports, we will issue other reports that focus on specific aspects of the federal government's efforts to respond to COVID-19. As of August 20, 2020, we had 75 audits underway related to the pandemic examining a variety of issues, including vaccines and therapeutics, COVID-19 testing, small business programs, the Strategic National Stockpile, use of the Defense Production Act, the response of the Department of Veterans Affairs to COVID-19, child welfare and education, worker safety, and homeowner and renter protections. We continue to actively coordinate our audits with other accountability organizations, including the Pandemic Response Accountability Committee, federal inspectors general, and state and local auditors. ⁶

To provide the most up-to-date information on the federal government's initial response from March through July 2020, we are issuing today's report. This report provides information on (1) total appropriated funds as of July 31, 2020, and the latest spending information available; (2) indicators for monitoring the public health system's preparedness for, response to, and recovery from COVID-19, and indicators for key areas of the economy targeted by federal efforts; and (3) the status of recommendations we made to executive agencies and matters for congressional consideration in our June report.

Our September report will provide a comprehensive review of key federal actions to prepare for, respond to, and recover from COVID-19, including actions to address testing, medical supplies, vaccine and therapeutic

⁴ Pub. L. No. 116-136, § 19010, 134 Stat. at 579-81.

⁵ GAO, COVID-19: Opportunities to Improve Federal Response and Recovery Efforts, GAO-20-625 (Washington, D.C.: June 25, 2020).

⁶ The CARES Act created the Pandemic Response Accountability Committee within the Council of the Inspectors General on Integrity and Efficiency to promote transparency and conduct and support oversight of covered funds and the COVID-19 response to (1) prevent and detect fraud, waste, abuse, and mismanagement and (2) mitigate major risks that cut across program and agency boundaries.

development, the Paycheck Protection Program (PPP), and unemployment insurance. Based on the review, the report will include recommendations for federal agencies.

For this report, we obtained a listing of all appropriation warrants issued by the Bureau of the Fiscal Service to the respective federal agencies for the four COVID-19 relief laws.⁷ We compared each appropriation amount to the respective law or other supporting documentation. We determined that the data were sufficiently reliable for our purposes. We analyzed centralized, government-wide data on federal spending for the pandemic from USAspending.gov as of June 30, 2020, the most recent data available. USAspending.gov is a publicly available website that includes detailed data on federal spending for nearly all accounts across the federal government, maintained by the Department of the Treasury (Treasury). We also sought July 31, 2020, spending data from the six areas with the largest appropriations in the four COVID-19 relief laws and present this information to the extent it was available.

To update the indicators that we identified in our June 2020 report and to identify additional indicators for monitoring the public health system's preparedness for, response to, and recovery from COVID-19, we reviewed selected research published in June and July 2020 by organizations with public health and policy researchers who are knowledgeable about the use of COVID-19 data to support decision-making, such as the Harvard Global Health Institute and the Edmond J. Safra Center for Ethics at Harvard, and Resolve to Save Lives. We also reviewed Department of Health and Human Services (HHS) documents, such as HHS's COVID-19 guidance for hospital reporting and the Centers for Disease Control and Prevention's (CDC) guidance on contact tracing workforce and programs.⁸ We assessed the reliability of data on the number of higher than expected deaths from CDC's National Center for Health Statistics, which we intend to use for monitoring and reporting, by reviewing relevant documents and published reports that use these data

⁷ The Bureau of the Fiscal Service issues warrants to federal agencies, which are the official documents that the Department of the Treasury issues upon enactment of an appropriation that reflect the dollar amount authorized to be obligated and expended for the specified purpose and period of availability provided by law.

⁸ Department of Health and Human Services, COVID-19 Guidance for Hospital Reporting and FAQs for Hospitals, Hospital Laboratory, and Acute Care Facility Data Reporting (July 10, 2020) and Centers for Disease Control and Prevention, Health Departments: Interim Guidance on Developing a COVID-19 Case Investigation & Contact Tracing Plan (June 19, 2020).

and obtaining additional information about the data from CDC officials. We found that the data were sufficiently reliable for our purposes. Finally, we interviewed officials from HHS and organizations including the Harvard Global Health Institute and the National Association of County and City Health Officials.

To identify indicators for monitoring the economy, we first reviewed the federal responses to the pandemic, in particular the COVID-19 relief laws, and identified five key provisions intended to support the economy, corresponding to five different areas of the economy: labor markets, households, small business credit markets, corporate credit markets, and markets associated with state and local government finances. We identified these key provisions based on their relative size, in dollars, as well as their potential economic effects. We then identified economic indicators corresponding to those five areas of the economy in order to provide a timely, general sense of how those areas of the economy were performing. In addition, we identified two indicators of the economic condition of the health care sector.

To identify potential indicators, we reviewed a number of sources, including prior GAO work, releases from federal statistical agencies, information from the Board of Governors of the Federal Reserve System (Federal Reserve) and relevant federal agencies responsible for the pandemic response and oversight of the health care system, data available on the Bloomberg Terminal, and input from internal GAO experts. To understand the relative importance of the key factors that could influence economic activity during the pandemic, such as supply and demand, the severity of the pandemic, and the impact of mitigation measures, we have begun to identify and review empirical research on these topics. We assessed the reliability of the data we intend to use for monitoring and reporting on areas of the economy supported by the federal pandemic response, in particular the COVID-19 relief laws. We took a number of steps to determine the reliability of proposed data sources and indicators, including reviewing relevant documentation, reviewing prior GAO work, and interviewing data providers. The quality of some available data and collection methods have been influenced by the COVID-19 pandemic. Nevertheless, we found that, collectively, the indicators were sufficiently reliable to provide a general sense of how these areas of the economy are performing.

To update the status of recommendations made to agencies and matters for congressional consideration made in our June 2020 report, we interviewed agency officials and monitored bills in Congress. We report

the status of relevant bills that had, at a minimum, been reported out of a committee of jurisdiction as of July 2020.

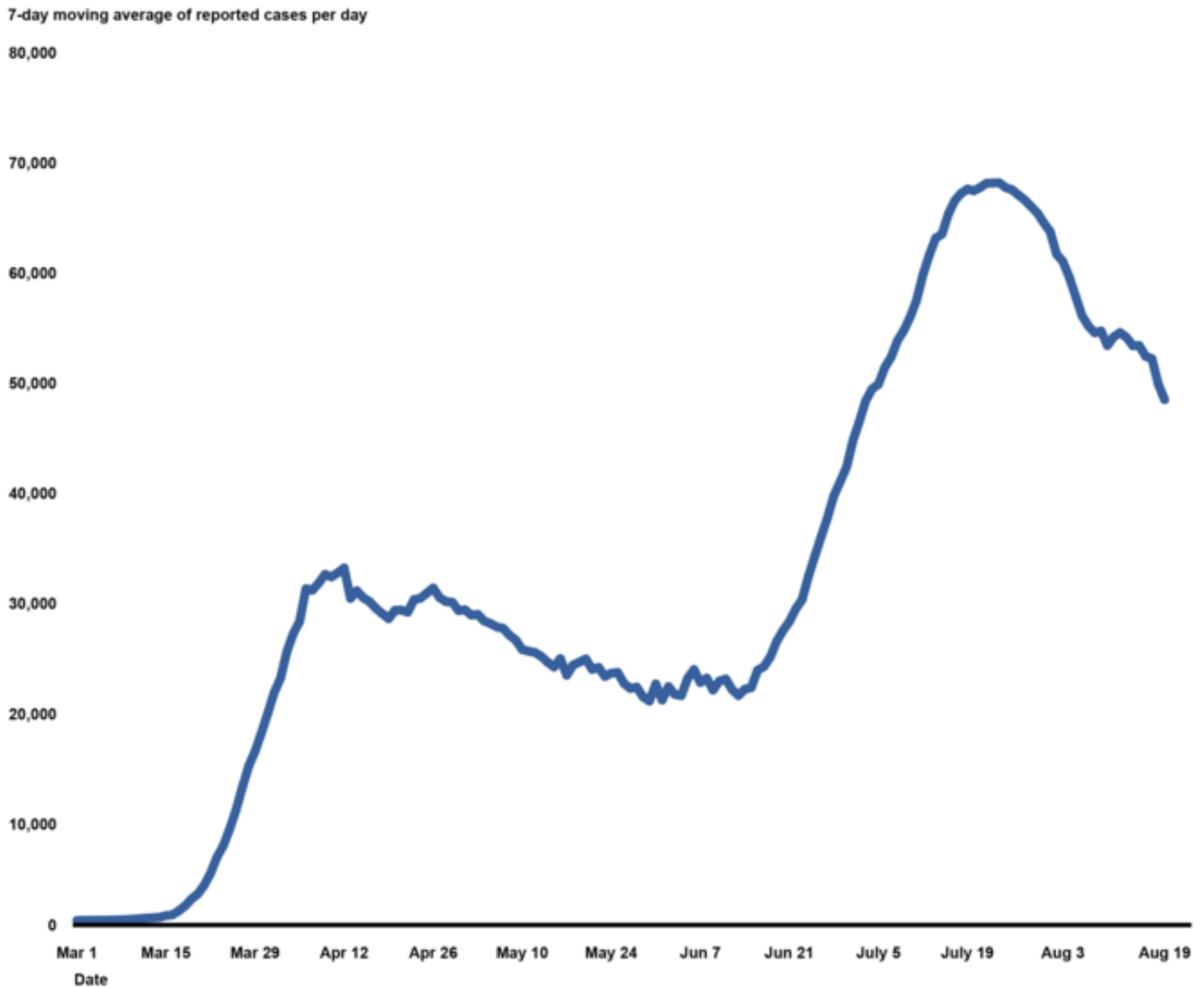
We conducted this performance audit from June 2020 to August 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Since early July, the United States had approximately 50,000 to 65,000 reported new COVID-19 cases per day, on average.⁹ Figure 1 shows the reported U.S. COVID-19 cases per day as a 7-day moving average.

⁹ Cases reported by CDC include both confirmed and probable cases. A confirmed case is defined by meeting confirmatory laboratory evidence for COVID-19, i.e. a positive molecular test. A probable case is defined by one of the following: (1) meeting clinical criteria AND epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19; (2) meeting presumptive laboratory evidence AND either clinical criteria OR epidemiologic evidence; or (3) meeting vital records criteria with no confirmatory laboratory testing performed for COVID-19. For more information on COVID-19 testing, see “Key Health Care and Economic Indicators” section.

Figure 1: Reported COVID-19 Cases per Day in the United States, as of August 20, 2020

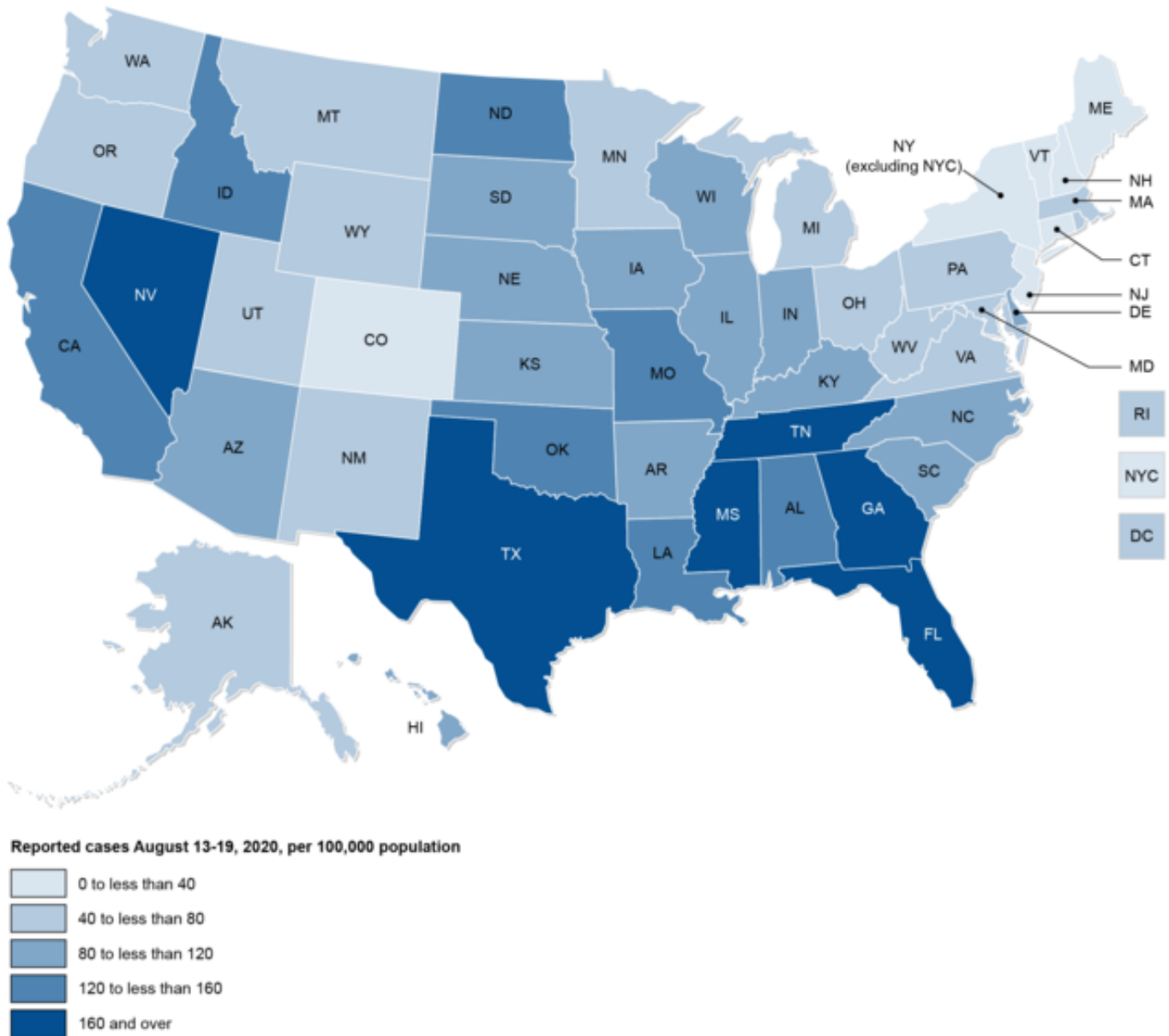


Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data. | GAO-20-708

Note: Reported COVID-19 cases include confirmed and probable cases, as of April 14, 2020, if states report probable cases to CDC. According to CDC, the actual number of cases is unknown for a variety of reasons, including that people who have been infected may have not been tested or may have not sought medical care. The data presented in the figure were last updated on August 20, 2020. The 7-day moving average of new cases (current day plus 6 preceding days divided by 7) was calculated to smooth variations in daily counts.

The total number of cases nationwide, while useful in assessing the magnitude of the outbreak, can mask the severity of the outbreak in certain locations, including locations where the number of cases are increasing (often referred to as hotspots). Since the first case was reported in the United States, the severity and timing of outbreaks have varied across the nation. For example, from late March through early June, some states in the Northeast had higher numbers of reported cases than others. Subsequently, the outbreak slowed in that region while some states in the Southeast and Southwest saw increases in reported cases from late June through July. The number of reported new cases has varied geographically. Figure 2 shows reported cases per 100,000 population by state from August 13 to August 19, the most recent data available at the time of this analysis.

Figure 2: Reported COVID-19 Cases August 13-19, 2020, by State, per 100,000 Population



Source: GAO analysis of Centers for Disease Control and Prevention (CDC) and U.S. Census Bureau data. | GAO-20-708

Note: Reported COVID-19 cases include confirmed and probable cases as of April 14, 2020, if states report probable cases to CDC. According to CDC, the actual number of cases is unknown for a variety of reasons, including that people who have been infected may have not been tested or may have not sought medical care. The data presented in the figure were last updated on August 19, 2020. Rates were calculated using population estimates from U.S. Census Bureau, 2018 American Community Survey 1-Year Estimates, as the number of cases per 100,000 population.

Major Findings

Federal COVID-19 Funding and Spending

As of July 31, 2020, about \$2.6 trillion had been appropriated to fund response and recovery efforts for—as well as to mitigate the public health, economic, and homeland security effects of—COVID-19.¹⁰ The Business Loan Programs, Economic Stabilization and Assistance to Distressed Sectors programs, unemployment insurance, Economic Impact Payments, the Public Health and Social Services Emergency Fund, and the Coronavirus Relief Fund represent \$2.2 trillion, or 85 percent, of the total amounts appropriated.¹¹

As of June 30, 2020, the most recent date for which government-wide information was available, the federal government had obligated a total of \$1.5 trillion and expended \$1.3 trillion of the COVID-19 relief funds as reported by federal agencies on USAspending.gov.¹² The Office of Management and Budget (OMB) directed federal agencies to report obligations and expenditure data on a monthly basis for posting on USAspending.gov, to provide monthly attestations on the financial data, and to certify the data quality on a quarterly basis beginning with the June 2020 reporting period.¹³ As shown in table 1, OMB's prescribed certification time frames are consistent with pre-COVID-19 quarterly reporting. Agencies will provide monthly attestations over their financial

¹⁰ An appropriation provides legal authority for federal agencies to incur obligations and make payments out of the U.S. Treasury for specified purposes.

¹¹ The Small Business Administration's Business Loan Program account includes activity for the Paycheck Protection Program and certain loan subsidies.

¹² An obligation is a definite commitment that creates a legal liability of the U.S. government for the payment of goods and services ordered or received, or a legal duty on the part of the U.S. government that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the U.S. government. An expenditure is the actual spending of money, or an outlay. Expenditures include some estimates, such as estimated subsidy costs for direct loans and loan guarantees. Increased spending in Medicaid is not accounted for in the appropriations provided by the COVID-19 relief laws. USAspending.gov accessed on August 19, 2020.

¹³ Specifically, agencies that received COVID-19 relief funds were directed to report April, May, and June 2020 obligations and expenditures in July 2020, and certify the data quality by August 14, 2020, on USAspending.gov. Office of Management and Budget, Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019, OMB Memorandum M-20-21 (Washington, D.C.: Apr. 10, 2020).

files, and quarterly government-wide spending information as of July 31, 2020, certified in mid-November 2020.

Table 1: Time Frames for Reporting and Certifying COVID-19 Relief Spending Data

Period covered by COVID-19 agency reporting to USAspending.gov	Time frames for agency reporting	Deadline for agencies to certify data reported
April, May, June 2020	July 17–30, 2020	August 14, 2020
July 2020	August 19–28, 2020	November 16, 2020
August 2020	September 18–29, 2020	November 16, 2020
September 2020	October 19–November 16, 2020	November 16, 2020

Source: Fiscal year 2020 Digital Accountability and Transparency Act of 2014 (DATA Act) Monthly Reporting Window Schedule published by the Department of the Treasury. | GAO-20-708

Note: USAspending.gov is a publicly available website that includes detailed data on federal spending for nearly all accounts across the federal government and is maintained by the Department of the Treasury.

Because July 2020 monthly data have not been reported and certified on USAspending.gov, we collected preliminary obligation and expenditure data for the six largest areas, to the extent practicable, as of July 31, 2020. ¹⁴ For these six largest spending areas, agencies estimated obligations totaling \$1.4 trillion and expenditures totaling \$1.4 trillion. Table 2 shows appropriations, obligations, and expenditures of COVID-19 relief funds by these spending areas.

Table 2: COVID-19 Relief Appropriations, Obligations, and Expenditures for the Six Largest Spending Areas, as of May, June, and July 2020

Spending area	Total appropriations (\$ billions) July 31, 2020 ^a	Reported cumulative obligations (\$ billions)			Reported cumulative expenditures (\$ billions)		
		May 2020 ^b	June 2020 ^c	Preliminary July 2020 ^d	May 2020 ^b	June 2020 ^c	Preliminary July 2020 ^d
Business Loan Programs (Small Business Administration)	687.3	528.9	534.4	538.1	9.9	506.3 ^e	522.2 ^e

¹⁴ Obligations and expenditures of COVID-19 relief funds as of July 31, 2020, are required to be reported to USAspending.gov by August 28, 2020, and certified by November 16, 2020.

Letter

Spending area	Total appropriations (\$ billions)	Reported cumulative obligations (\$ billions)			Reported cumulative expenditures (\$ billions)		
	July 31, 2020 ^a	May 2020 ^b	June 2020 ^c	Preliminary July 2020 ^d	May 2020 ^b	June 2020 ^c	Preliminary July 2020 ^d
Economic Stabilization and Assistance to Distressed Sectors (Department of the Treasury)	500.0	22.1	22.2	30.4	2.2	11.2 ^e	19.2 ^e
Unemployment insurance (Department of Labor)	376.4	107.1	202.4	301.1	101.8	197.1	296.8
Economic Impact Payments (Department of the Treasury)	282.0	267.4	270.7	273.5	267.4	270.7	273.5
Public Health and Social Services Emergency Fund (Department of Health and Human Services)	231.7	87.9	110.5	129.6	66.0	79.7	95.9
Coronavirus Relief Fund (Department of the Treasury)	150.0	146.6	149.5	149.5	146.6	149.5	149.5
Total for six spending areas	2,227.4	1,160.1	1,289.7	1,422.2	594.0	1,214.4	1,357.0

Source: GAO analysis of data from the Department of the Treasury, USA Spending.gov, and applicable agencies. | GAO-20-708

^aCOVID-19 relief appropriations reflect amounts appropriated under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. No. 116-123, 134 Stat. 146; Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020); CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); and Paycheck Protection Program and Health Care Enhancement Act, Pub. L. No. 116-139, 134 Stat. 620 (2020). These data are based on appropriations warrant information provided by the Department of the Treasury as of July 31, 2020. These amounts could increase in the future for programs with indefinite appropriations, which are appropriations that, at the time of enactment, are for an unspecified amount. In addition, this table does not represent transfers of funds that federal agencies may make between appropriation accounts or transfers of funds they may make to other agencies.

^bObligations and expenditures data for May 2020 are based on agency-reported data from the Department of the Treasury as of May 31, 2020. Some amounts differ from our June 2020 report (GAO-20-625) because they are based on more current information that has been made available since then.

^cObligations and expenditures data for June 2020 are based on data from USA Spending.gov as of August 19, 2020.

^dObligations and expenditures data for July 2020 are based on preliminary data reported by applicable agencies.

^eThese expenditures relate to the loan subsidy costs (the loan's estimated long-term costs to the United States government).

The following provide information on what has been happening in each of the six programs since our last report:

- **Business Loan Programs.** The Small Business Administration's (SBA) Business Loan Programs received \$687 billion in appropriations and had obligated \$538.1 billion of these funds as of July 31, 2020. SBA's Business Loan Program account includes amounts for the PPP and for subsidies for certain SBA loan programs. Most of the appropriations went to the PPP, which is a loan guarantee program in which loans are guaranteed at 100 percent by SBA, are low-interest (1 percent), and will be fully forgiven if the borrower meets certain conditions. As of July 31, 2020, SBA reported that lenders had made about 5.1 million PPP loans, up from 4.6 million loans as of June 12, 2020.¹⁵ SBA stated that its loan guarantee expenditures were \$522.2 billion as of July 31, 2020, which represents the estimated cost to the federal government to satisfy the loan guarantee obligations to lenders.¹⁶ The amount SBA ultimately spends largely depends on the number of loans actually forgiven. When the loans are forgiven, payments will be made to the lenders.
- **Economic Stabilization and Assistance to Distressed Sectors.** The Economic Stabilization and Assistance to Distressed Sectors programs received \$500 billion in appropriations.¹⁷ Most of these appropriations—about \$454 billion—relate to support for lending facilities administered by the Federal Reserve. Since early June 2020, five additional emergency lending programs (or facilities) supported through CARES Act appropriated funds became operational, resulting in a total of seven CARES Act facilities being operational as of July 31, 2020. As of that date, Treasury had

¹⁵ Totals exclude loans that have been canceled. According to SBA, canceled loans may include, but are not limited to, duplicative loans, loans not closed for any reason, and loans that have been fully paid off.

¹⁶ Under the Federal Credit Reform Act, which is codified, as amended, at 2 U.S.C. §§ 661-661f, federal agencies making a loan guarantee must obligate the subsidy cost, which is the loan's estimated long-term cost to the U.S. government, calculated on a net present value basis at the time when the guaranteed loan is disbursed by the lender. The subsidy cost excludes administrative costs and includes estimates of both payments made by the government, such as to cover loan forgiveness, defaults and delinquencies, and revenues received by the government, such as fees and penalties.

¹⁷ CARES Act. Pub. L. No. 116-136, § 4027, 134 Stat. at 496-97 (codified at 15 U.S.C. § 9061). This provision appropriated \$500 billion for the Exchange Stabilization Fund established under 31 U.S.C. § 5302.

committed \$195 billion, or about 43 percent, of the \$454 billion from the CARES Act available to support the facilities and disbursed \$102.5 billion of that commitment, up from \$55 billion in early June.¹⁸ Most of the \$19.2 billion of expenditures also relate to this program. Budget expenditures related to the lending facilities administered by the Federal Reserve represent the loan subsidy costs (the loan's estimated long-term costs to the United States government) of the facilities to the federal government. The subsidy cost is calculated as the estimated net present value of both cash disbursements made to the facilities and cash received from the facilities when the facilities are terminated. Treasury estimates, on a net present value basis, that cash disbursed to the facilities will exceed the cash received from the facilities by \$18 billion, as of July 31, 2020.

The Economic Stabilization and Assistance to Distressed Sectors program also includes an appropriation of \$46 billion in loans, loan guarantees, and other investments to provide liquidity to the aviation sector and businesses critical to maintaining national security, including non-aviation sector businesses. As of July 2020, Treasury had made one loan for up to \$700 million to a business designated as critical to maintaining national security, and had also signed letters of intent with 10 passenger carriers to provide loans that could total over \$20 billion.

- **Unemployment Insurance.** Between May and July 2020, obligations for regular unemployment insurance increased from \$107.1 billion to \$301.1 billion, and expenditures increased from \$101.8 billion to \$296.8 billion. In May 2020, 9.4 million initial unemployment claims were processed. In July 2020, states processed 6.7 million initial unemployment claims.¹⁹
- **Economic Impact Payments.** Both cumulative obligations and cumulative expenditures for economic impact payments—direct payments to individuals and households to mitigate the effects of the pandemic—increased from \$267.4 billion in May 2020 to \$273.5 billion in July 2020. The vast majority of the 164 million economic impact payments disbursed by Treasury and Internal Revenue Service (IRS) had been disbursed by May 22, 2020.

¹⁸ To implement these facilities, the Federal Reserve is using legal entities known as special purpose vehicles to purchase qualifying assets from or initiate lending to eligible institutions, and Treasury has also made equity investments in the special purpose vehicles with CARES Act funds.

¹⁹ May and June 2020 included 4 weeks, while July 2020 included 5 weeks.

Those who received payments in June and July 2020 were individuals who filed their taxes up until the extended tax filing season deadline of July 15, individuals who previously filed a paper return that IRS was unable to process due to certain functions being shut down during the pandemic, and individuals who did not file taxes but used the IRS's non-filer portal to claim their economic impact payment.²⁰

- **Public Health and Social Services Emergency Fund.** Payments to health care providers for costs related to COVID-19 or lost revenues are one of the activities supported by Public Health and Social Services Emergency Fund appropriations, through what is known as the Provider Relief Fund. Payments to providers totaled \$65.2 billion as of May 31, 2020, and increased to \$92.4 billion by the end of July. After initially making general relief payments to health care providers in April, HHS subsequently began allocating more funding to areas particularly affected by the COVID-19 outbreak, including rural health care facilities, high-impact hospitals (those hospitals with a high rate of COVID-19 inpatient admissions), safety net hospitals, health care providers that participate in Medicaid and the Children's Health Insurance Program, skilled nursing facilities, Indian health care providers, and dental providers.
- **Coronavirus Relief Fund.** As of July 31, 2020, Treasury had received \$150 billion in appropriations and had provided \$149.5 billion in direct assistance to states, localities, tribal governments, the District of Columbia, and U.S. territories to help offset costs of their response to the COVID-19 pandemic. The approximately \$2.9 billion in additional obligations and expenditures since the end of May were payments to tribal governments that Treasury made in June.

Clear and transparent reporting of COVID-19 relief spending data and related information is an important tool for Congress, agency officials, and the public in monitoring and assessing implementation of the COVID-19

²⁰ IRS Notice 2020-23, 2020-18 IRB 742 (Apr. 27, 2020). Notice 2020-23 amplified relief provided in Notice 2020-18 and Notice 2020-20, 2020-15 IRB 590 (Apr. 6, 2020); 2020-16 IRB 660 (Apr. 13, 2020). The Secretary of the Treasury has statutory authority to postpone filing and payment deadlines for taxpayers affected by federally declared disasters. 26 U.S.C. § 7508A. On March 13, 2020, the President instructed the Secretary of the Treasury to provide relief from tax deadlines to Americans who have been adversely affected by the COVID-19 emergency, as appropriate, pursuant to 26 U.S.C. 7508A(a).

relief laws. Toward that end, the CARES Act contains several requirements for federal agencies and nonfederal entities receiving federal awards for the timely reporting of covered funds.²¹ In April 2020, OMB issued guidance to direct agencies and recipients on how to implement CARES Act reporting requirements. This guidance included making some modifications to the existing framework of reporting requirements under the Federal Funding Accountability and Transparency Act of 2006, as amended by the Digital Accountability and Transparency Act of 2014 (DATA Act).²² Among these modifications was the requirement that agencies use predefined codes to designate the funds associated with the appropriations enacted in the COVID-19 relief laws and enable tracking at the award level and as displayed on USAspending.gov.²³

In an effort to help ensure the quality of data reported on USAspending.gov, OMB's DATA Act guidance directs each agency to identify a Senior Accountable Official (SAO) who must provide a quarterly assurance that the agency's internal controls support the reliability and validity of the agency account-level and award-level data.²⁴ OMB and Treasury still require quarterly SAO certifications of data quality. In addition, agencies that receive COVID-19 related funding that are reporting on a monthly basis are also required to provide monthly attestations for their financial files beginning with the June 2020 reporting period. These attestations state that the monthly data followed the agency's normal practices and procedures, and that the SAO will certify the data at the end of the quarter.

Previous work by GAO and agency inspectors general has identified several challenges related to the quality of the data contained on

²¹ Pub. L. No. 116-136, §§ 15010, 15011, 134 Stat. at 533–42.

²² Federal Funding Accountability and Transparency Act of 2006, Pub. L. No. 109-282, 120 Stat. 1186; DATA Act, Pub. L. No. 113-101, 128 Stat. 1146 (reprinted in 31 U.S.C. § 6101 note).

²³ OMB Memorandum M-20-21.

²⁴ Office of Management and Budget, Additional Guidance for DATA Act Implementation: Further Requirements for Reporting and Assuring Data Reliability, OMB Memorandum M-17-04 (Washington, D.C.: Nov. 4, 2016). Specifically, the SAO must certify that the alignment among all submitted files is valid and reliable and that the data from the agency's financial systems are valid and reliable. In addition, agencies are to include information about any data limitations in their SAO certification statements, which are then made publicly available on USAspending.gov.

USAspending.gov. Among these is the need to more fully disclose the limitations of data displayed on USAspending.gov.²⁵ We previously recommended that Treasury disclose known data quality issues and limitations on USAspending.gov.²⁶ Treasury has recently disclosed some data limitations for COVID-19 related spending.²⁷ These disclosures are an important step toward more fully identifying and disclosing known data limitations on USAspending.gov. Systematic expansion of such disclosures across the website could help users of the data better understand potential quality issues with particular data elements and sources, and how to appropriately interpret the data. In the absence of such information, users are unable to consider these differences in their assessment of how to use and understand the data provided. We will continue to monitor this issue and conduct work related to the quality of data reported on USAspending.gov and the related issues of data governance and data use.

Key Health Care and Economic Indicators

As we noted in our June 2020 report, indicators can be powerful tools to assess the federal government's response to the COVID-19 pandemic. GAO's indicators are intended to assess the nation's immediate response to COVID-19 as it first took hold, gauge its recovery from the effects of the pandemic over the longer term, and determine the nation's level of preparedness for future pandemics, involving subsequent waves of either COVID-19 or other infectious diseases.

²⁵ For details on other challenges identified by GAO and agency inspectors general, including data accuracy, completeness, and timeliness, see GAO, DATA Act: Quality of Data Submissions Has Improved but Further Action Is Needed to Disclose Known Data Limitations, GAO-20-75 (Washington, D.C.: Nov. 8, 2019) and DATA Act: OIGs Reported That Quality of Agency-Submitted Data Varied, and Most Recommended Improvements, GAO-20-540 (Washington, D.C.: July 9, 2020).

²⁶ GAO, DATA Act: OMB, Treasury, and Agencies Need to Improve Completeness and Accuracy of Spending Data and Disclose Limitations, GAO-18-138 (Washington, D.C.: Nov. 8, 2017).

²⁷ These disclosures include information from specific federal agencies regarding how reporting issues may impact the accuracy or completeness of COVID-19 data displayed on the site. Examples include timing differences resulting in discrepancies in program totals listed on USAspending.gov when compared to other sources and the lack of information on the geographic distribution of payments for specific programs.

Four Indicators Help to Monitor Areas of the Health Care System's Response and Recovery

To date, we have identified four indicators that can help to monitor the status of the U.S. health care system's response to and recovery from the COVID-19 pandemic, as well as its preparedness for future outbreaks. These indicators are (1) the positivity rate for COVID-19 testing, (2) contact tracing performance, (3) the proportion of intensive care unit (ICU) beds available, and (4) the number of higher than expected deaths from all causes. Given the evolving knowledge about COVID-19, we focused on new information about the potential indicators that we identified in our prior report, such as recommended thresholds for governments to target. We plan to work with the National Academies of Sciences, Engineering, and Medicine (National Academies) to establish approaches for monitoring these and other potential indicators, such as identifying data sources and thresholds as appropriate.

Positivity Rate for COVID-19 Testing

The proportion of COVID-19 viral tests in a given population that are positive for infection (the positivity rate) is one indicator of the sufficiency of testing. Viral tests provide data on ongoing infections, while antibody tests provide data on prevalence of past infections. A higher positivity rate indicates that not enough testing is being conducted to find all cases. That is, a higher rate indicates that testing has been focused on those most likely to be infected and seeking testing because they have symptoms, and may not be detecting COVID-19 cases among individuals with no symptoms. This is important because presymptomatic (infected individuals who will go on to develop symptoms) and asymptomatic individuals can transmit COVID-19.

Although there is no agreed-upon threshold for the test positivity rate for COVID-19, governments should target low positivity rates. Examples of recommended positivity rate levels for COVID-19 include the following:

- In May 2020, the World Health Organization recommended that governments target a test positivity rate of less than 5 percent over a 14-day period. As of August 12, 2020, 12 states and the District of Columbia had met the World Health Organization recommended threshold of less than 5 percent over a 14-day period (38 states did not), according to data reported publicly by

states.²⁸ In June and July 2020, several organizations also included the positivity rate as a key indicator in their new guidance to help governments assess progress in reducing the incidence of COVID-19.²⁹ For example, Resolve to Save Lives recommended that governments target a positivity rate of less than 3 percent based on a 7-day average and that they monitor positivity rates by age and race.³⁰ As of August 12, 2020, 11 states and the District of Columbia had met the threshold of less than 3 percent over a 7-day period (39 states did not), according to data reported publicly by states.³¹

- Similarly, in July 2020, the Harvard Global Health Institute and the Edmond J. Safra Center for Ethics published a framework—developed in collaboration with a network of research, policy, and public health experts—that includes targets for positivity rates that depend on a government’s goal to achieve “mitigation” (i.e., reduce the incidence of COVID-19) or “suppression” (i.e., eliminate the incidence of COVID-19 almost entirely) through the

²⁸ These data were collected from the websites of state/territory public health authorities by the COVID Tracking Project, which is a volunteer organization dedicated to collecting and publishing data concerning the COVID-19 outbreak in the United States. To determine the number of states that met the 5 percent threshold over a 14-day period, we identified states with a positivity rate of less than 5 percent based on a 7-day moving average for two consecutive weeks. A 7-day moving average (current day plus 6 preceding days) is used to smooth expected variation in daily counts of positive cases. An average of less than 7 days may not be representative of the ongoing COVID-19 experience because it does not account for certain fluctuations in the data, such as fewer cases being reported on weekends.

²⁹ See: Bloomberg Philanthropies and the Johns Hopkins Bloomberg School of Public Health, *COVID-19 Management Metrics for Cities: Guide for Mayors and City Leadership* (June 2020); National Academies of Sciences, Engineering, and Medicine 2020, *Evaluating Data Types: A Guide for Decision Makers using Data to Understand the Extent and Spread of COVID-19* (Washington, D.C.: The National Academies Press, June 2020); Resolve to Save Lives and Vital Strategies, *Tracking COVID-19 in the United States From Information Catastrophe to Empowered Communities* (July 2020).

³⁰ Resolve to Save Lives is a public health organization focused on preventing deaths from epidemics, and it is part of Vital Strategies, a global public health organization that works with governments to help address public health challenges such as epidemics.

³¹ These data were collected from the websites of state/territory public health authorities by the COVID Tracking Project. The threshold positivity rate is calculated as an average over the 7-day period.

use of testing, contact tracing, and isolation.³² Harvard officials told us they established these targets based on the World Health Organization's recommendation and positivity rates observed in other countries that have made progress in working toward suppression (e.g., South Korea, Germany). Harvard officials explained that these goals are part of a continuum, with the ultimate goal of suppression, and that governments should work toward a goal that is achievable. For example, governments that are faced with serious outbreaks in their communities should first work toward a goal of mitigation before suppression. Under the framework, it is suggested that governments target a positivity rate of about 10 percent for mitigation or a positivity rate of less than 3 percent for suppression.³³

The extent to which governments can reduce the positivity rate is partly dependent on the available resources to perform testing and contact tracing.³⁴ This is because a more intensive use of testing and contact tracing is needed to identify infected individuals and take steps to help prevent further disease transmission. By helping to reduce disease transmission, more intensive testing and contact tracing may lead to a lower positivity rate over time as more people being tested are less likely to be infected.

As stated in our June 2020 report, we determined that the testing data that CDC reported did not provide sufficiently reliable information on the amount of COVID-19 viral testing occurring over time because the data

³² Harvard officials told us that the goal of developing the framework was to build consensus around key indicators and help policymakers effectively respond to COVID-19. Officials also explained that other strategies should be used concurrently, such as social distancing. See Harvard Global Health Institute and Edmond J. Safra Center for Ethics, Key Metrics for COVID Suppression: A Framework for Policymakers and the Public (July 1, 2020).

³³ Further, the framework provides targets related to the composition of positive COVID-19 cases. For example, the framework recommends that about 60 percent of positive cases should come from individuals who were tested because they were identified through contact tracing (e.g., asymptomatic individuals), compared to individuals who were tested because they were symptomatic.

³⁴ For example, achieving a sufficient level of testing depends, in part, on ensuring that all supplies required to conduct the tests are made available. As noted in our June 2020 report, challenges remain in ensuring adequate COVID-19 testing supplies. In mid-July 2020, the Food and Drug Administration issued the first emergency use authorization for a COVID-19 viral test for use with pooled samples. Pooled samples allow for fewer tests to be run overall, conserving testing resources, including supplies, and potentially allowing more samples to be evaluated faster.

were incomplete and inconsistent. For example, some states were combining viral and antibody tests in their reporting to CDC. However, we also reported that CDC had taken steps to improve the reliability of testing data, and we will continue to review the reliability of these data.³⁵ We plan to work with the National Academies to establish an approach for monitoring this potential indicator, such as an appropriate way to geographically define the positivity rate (e.g., national, state, county).

Contact Tracing Performance

Contact tracing is a critical tool to contain community outbreaks of COVID-19. It is a process in which trained public health officials attempt to limit disease transmission by identifying infected individuals, notifying their “contacts”—all the people they may have transmitted the disease to—and asking infected individuals and their contacts to quarantine, if appropriate.³⁶ After identifying an infected individual, public health officials interview the individual to identify recent contacts. They also ask the individual and their contacts to take containment measures, if appropriate (e.g., a 14-day quarantine for COVID-19) and coordinate any needed care and testing. To be most effective, test turnaround time and time to trace contacts must be rapid. Further, contact tracing must be implemented with other measures, such as social distancing, to effectively limit disease transmission.³⁷ When the level of community spread has become uncontrolled, however, stay-at-home orders combined with other measures may be required, as well as surge levels of testing and contact tracing resources.

In June and July 2020, several organizations recommended that governments track performance indicators for contact tracing to help them

³⁵ CDC is the official federal source for testing data. As an example of CDC’s efforts to improve testing data, on June 4, 2020, HHS issued guidance that, pursuant to its new authority under the CARES Act, requires all laboratories to submit data on viral tests and other tests they perform to diagnose a possible case of COVID-19. Required data include those on point-of-care tests and those that identify whether a viral or antibody test was performed.

³⁶ Digital contact tracing tools can facilitate contact tracing and may reduce the number of contact tracers needed. In addition, digital apps that trace proximity can identify and notify contacts faster, leading to faster quarantine. See GAO, Science & Tech Spotlight: Contact Tracing Apps, GAO-20-666SP (Washington, D.C.: July 28, 2020).

³⁷ See GAO, Science & Tech Spotlight: Social Distancing During Pandemics, GAO-20-545SP (Washington, D.C.: May 13, 2020).

assess the effectiveness of their contact tracing programs and overall progress in reducing the transmission of COVID-19.³⁸ In addition, they recommended several thresholds for governments to target. For example, in July 2020, Resolve to Save Lives recommended that governments monitor on a weekly basis the percentage of new COVID-19 cases that were linked to already-known cases (based on contact tracing data) and that they achieve a target of at least 50 percent. Resolve to Save Lives and other organizations have emphasized the importance of monitoring both contact tracing and testing performance concurrently because contact tracing effectiveness depends on testing turnaround and capacity.

Similarly, CDC issued interim contact tracing guidance for state and local health departments in June 2020, and it states that state and local health departments should regularly collect and monitor performance indicators to assess program outcomes and identify and address issues.³⁹ For example, CDC provides examples of specific measures that health departments may track, such as the number of contacts of infected individuals identified through contact tracing that were subsequently tested for COVID-19. In addition, CDC's guidance states that state and local health departments should consider setting targets for their performance indicators. According to CDC officials, state and local health departments that receive funds are required to report to CDC data on six performance measures related to contact tracing.⁴⁰ For example, CDC officials told us that state and local health departments are to report the proportion of close contacts of infected individuals who are notified within

³⁸ Harvard Global Health Institute and Edmond J. Safra Center for Ethics, Key Metrics for COVID Suppression: A Framework for Policymakers and the Public (July 1, 2020); Bloomberg Philanthropies and the Johns Hopkins Bloomberg School of Public Health, COVID-19 Management Metrics for Cities: Guide for Mayors and City Leadership (June 2020); Resolve to Save Lives and Vital Strategies, Tracking COVID-19 in the United States: From Information Catastrophe to Empowered Communities (July 2020).

³⁹ Centers for Disease Control and Prevention, Health Departments: Interim Guidance on Developing a COVID-19 Case Investigation & Contact Tracing Plan (June 19, 2020).

⁴⁰ According to CDC officials, \$10.25 billion in funds provided under the Paycheck Protection Program and Health Care Enhancement Act were obligated for awards to states, territories, and local jurisdictions through CDC's Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases cooperative agreement to help them expand their testing and contact tracing capacity, among other things.

24 hours of health departments initiating follow up.⁴¹ CDC officials added that close contacts are identified through interviews with infected individuals. CDC officials told us each of the six measures are to be reported on a monthly or quarterly basis, beginning August 14, 2020, and that CDC plans to use the measures to monitor progress in reducing the transmission of COVID-19. There are no national data on contact tracing performance.

As discussed in our June 2020 report, a sufficient contact tracing workforce is critical in responding to a pandemic, such as COVID-19. We also reported that there are no national data on the number of contact tracers. In April 2020, the National Association of City and County Health Officials recommended a benchmark of 30 contact tracers per 100,000 population.⁴² However, association officials told us this was an early estimate and it did not account for variation in state and local needs. The association subsequently worked with George Washington University to develop a workforce estimator that would account for this variation. While other organizations, such as Johns Hopkins Bloomberg School of Public Health and Harvard Global Health Institute and Harvard's Edmond J. Safra Center for Ethics, have recently highlighted the importance of a sufficient contact tracer workforce, they emphasized that the recommended baseline varies among state and local health departments and in relation to changes in the incidence of COVID-19 and local and state testing capabilities. Harvard officials told us that the recommended baseline is a moving target, for example, that would significantly increase with community outbreaks.

CDC has provided funds to help state and local health departments expand their contact tracing capacity, which may include hiring additional contact tracers.⁴³ In addition, to support surge staffing needs in health departments, CDC awarded funds to the CDC Foundation to hire and

⁴¹ The other five measures are (1) number of COVID-19 cases assigned for investigation, per staff person; (2) among COVID-19 cases prioritized for investigation, the proportion interviewed within 24 hours of being reported to staff; (3) number of close contacts of infected individuals assigned for follow up, per contact tracer; (4) among contacts notified by staff, the proportion tested for COVID-19 (at least once within 14 days of notification); and (5) number of new confirmed or probable COVID-19 cases identified among contacts in the contact tracing system (within 14 days of last exposure to the originating COVID-19 case).

⁴² This equates to about 98,460 contact tracers needed to cover the U.S. population.

⁴³ As described earlier, these funds were provided with amounts appropriated under the Paycheck Protection Program and Health Care Enhancement Act.

place public health professionals—including contact tracers—in state, local, territorial, and tribal health departments. As of July 30, 2020, CDC officials told us that the CDC Foundation had hired and placed about 300 such professionals, of which more than half were contact tracers.

Proportion of Intensive Care Unit Beds Available

Tracking the proportion of staffed ICU beds that are available at regular intervals over time offers insight on changes in our health care system's capacity to care for the sickest patients with COVID-19 (i.e., those that may require respiratory support on a ventilator to survive). In addition to COVID-19, the upcoming flu season could increase demand for hospital resources—for example, about 490,000 hospitalizations associated with the flu occurred during the 2018–2019 flu season, according to CDC estimates.⁴⁴ Given that several states reported record increases in the number of new COVID-19 cases in July 2020, and that flu cases will likely increase starting in the fall, the proportion of staffed ICU beds remains an important indicator to monitor.

CDC and several organizations included this indicator in recent reports that included guidance to help inform response decisions at different levels of government and provided different ways to geographically define it (e.g., states, hospital referral regions), and they differed in whether to recommend a threshold.⁴⁵ For example, CDC recommends that states and local jurisdictions monitor the indicator based on a threshold of 70 percent ICU bed occupancy (i.e., 30 percent of its staffed ICU beds are available). That is, an ICU bed occupancy rate of less than 70 percent indicates that a hospital likely has sufficient capacity to accommodate a certain level of additional patients. In comparison, the Bloomberg Philanthropies and Johns Hopkins Bloomberg School of Public Health recommended that cities monitor this indicator by ZIP code but do not specify a threshold.

⁴⁴ The estimated number of flu hospitalizations varies from season to season. Since 2010, CDC estimates that flu has resulted in between 140,000 and 960,000 hospitalizations each year. Ventilators are critical for treating hospitalized flu patients in respiratory failure. A 2017 study estimated that about 20 percent of flu patients treated in ICUs required the use of ventilators.

⁴⁵ Hospital referral regions refer to markets where people generally go to the same hospitals.

One way to present data on ICU bed occupancy is to determine the number of states that met the 70 percent threshold on a given day, and then calculate the average of that daily result over some period of time, such as a week or month. For example, from July 1 to July 7, 2020, a daily average of 39 states met the 70 percent threshold of ICU bed occupancy (i.e., 30 percent or more of their staffed ICU beds were available), according to data from CDC.⁴⁶ We plan to work with the National Academies to further refine this indicator, such as by developing a threshold for ICU bed availability and ways to geographically define it (e.g., national, state, hospital referral region) for the purposes of monitoring.

Since our June 2020 report, HHS revised its guidance for hospitals to report COVID-19 data—including ICU bed availability—in an effort to help coordinate federal reporting and ensure flexibility in data collection. As of July 15, 2020, hospitals are to report these data directly to HHS through TeleTracking, or states may submit these data on behalf of hospitals to HHS Protect.⁴⁷ For ICU bed availability, hospitals are to include in their reports all staffed ICU beds (including overflow and surge ICU beds that are staffed). Prior to July 15, hospitals also had the option to report these data through CDC's National Healthcare Safety Network (NHSN).⁴⁸ According to HHS, this change will help the agency more quickly update the type of data it collects, for example, by adding data elements on the kinds of COVID-19 treatments that are being used.

As of July 20, 2020, under its revised reporting process, HHS provides hospital utilization data—including the proportion of staffed ICU beds that are available within each state—from all participating hospitals on its new

⁴⁶ This metric is based on data that hospitals voluntarily reported to CDC's National Healthcare Safety Network on daily ICU occupancy.

⁴⁷ HHS Protect is a data platform that includes data from hospitals and other sources, such as the Census, and TeleTracking is a system that HHS uses to collect data for input into HHS Protect.

⁴⁸ CDC's National Healthcare Safety Network collects a range of data—including healthcare-associated infections, antibiotic resistance, and antibiotic use—from hospitals and other health care facilities.

HHS Protect Public Data Hub website.⁴⁹ According to data published on July 30, 2020, about 92 percent of hospitals nationally reported at least one data element within the past 7 days, and the percentage of those hospitals reporting varied by state, from about 68 to 100 percent.⁵⁰ However, the percentage of hospitals that are reporting the proportion of ICU beds available on a daily basis is unclear. Prior to the revised reporting process, CDC provided hospital utilization data on its NHSN website, which included only the hospitals that reported through NHSN. We plan to monitor the transition to and implementation of HHS's new data collection and reporting system, such as any effects on transparency.

Higher than Expected Deaths from All Causes

Mortality rates have tended to be consistent from year to year. As stated in our June 2020 report, the number of deaths from all causes during the pandemic compared to historical counts provides a potential indicator of the impact of deaths from COVID-19, as well as the pandemic's broad effect on deaths from other causes. The full effect of COVID-19 goes beyond those infected with the disease. That is, it has affected access and utilization across the continuum of health care services, from primary care visits to emergency treatment of heart attacks, for example. Of particular concern are the potential effects of COVID-19-related disruptions of the health care system on mortality.

Examining higher than expected deaths can also address the imperfect reporting of COVID-19 deaths where the cause of death was unknown or misdiagnosed.⁵¹ Several researchers and professional organizations have recently underscored the importance of monitoring this indicator to

⁴⁹ HHS Protect Public Data Hub displays the percentage of hospitals reporting one or more elements into HHS Protect for the most recent collection date (during the last 7 days). See the Department of Health and Human Services, Percentage of Hospitals Reporting by State, HHS Protect Public Data Hub, accessed July 31, 2020, <https://protect-public.hhs.gov/pages/covid19-module>.

⁵⁰ This estimate of hospital reporting includes data from the 50 states and the District of Columbia. Data from U.S. territories, such as Puerto Rico and American Samoa, were not included but are available from the HHS Protect Public Data Hub.

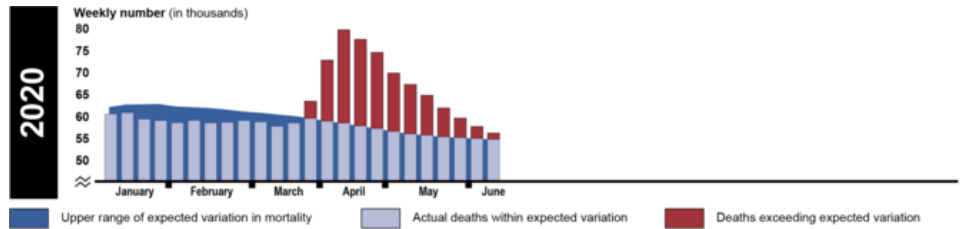
⁵¹ For more information about examining higher than expected deaths during the pandemic, see GAO, COVID-19: Data Quality and Considerations for Modeling and Analysis, GAO-20-635SP (Washington, D.C.: July 30, 2020).

understand the effects of the pandemic on mortality.⁵² Between January 1, 2020, and June 13, 2020, about 125,000 more deaths occurred from all causes than would normally be expected, according to data from CDC's National Center for Health Statistics (see fig. 3).⁵³

⁵² For example, see National Academies of Sciences, Engineering, and Medicine 2020, *Evaluating Data Types: A Guide for Decision Makers using Data to Understand the Extent and Spread of COVID-19*; Steven H Woolf et al., "Excess Deaths From COVID-19 and Other Causes, March-April 2020," *Journal of American Medical Association* (July 1, 2020); and Daniel M. Weinberger et al., "Estimation of Excess Deaths Associated with the COVID-19 Pandemic in the United States, March to May 2020," *Journal of the American Medical Association* (July 1, 2020).

⁵³ This total represents the number of deaths that exceeds the upper bound of normal variation as estimated using CDC's 95 percent confidence interval. See CDC's National Center for Health Statistics webpage on excess deaths for more details on the approach: https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm, accessed on July 16, 2020.

Figure 3: CDC Data on Higher Than Expected Weekly Mortality, January 1 through June 13, 2020



Source: GAO analysis of Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS) data. | GAO-20-708

Notes: The figure shows the number of deaths from all causes in a given week that exceeded the upper bound threshold of expected deaths calculated by CDC on the basis of variation in mortality experienced in prior years. See CDC's National Center for Health Statistics webpage on excess deaths for further details on how CDC estimates this upper bound threshold: https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm, accessed on July 16, 2020. Changes in the observed numbers of deaths in recent weeks should be interpreted cautiously as this figure relies on provisional data that are generally less complete in recent weeks.

The Economy Remains Weak but Indicators Suggest Modest Improvement in Key Areas Supported by the Federal Pandemic Response

The national economy and areas of the economy supported by the federal pandemic response have improved modestly in recent months but remain much weaker than prior to the pandemic. By the end of May 2020, the majority of states had eased the stay-at-home orders and certain restrictions on nonessential businesses that they had introduced at the onset of the pandemic. Contemporaneous gains in employment were driven by individuals returning to work in leisure and hospitality, retail trade, and health care.

Aggregate economic conditions in the United States also improved in June and July based on the Federal Reserve Bank of New York's Weekly Economic Index, which combines high-frequency economic data from a wide range of sources.⁵⁴ Nevertheless, the index suggests a large drop in economic activity relative to a year ago. Similarly, U.S. gross domestic product fell at a 32.9 percent annual rate in the second quarter of 2020,

⁵⁴ Daniel J. Lewis, Karel Mertens, and Jim Stock, "U.S. Economic Activity during the Early Weeks of the SARS-Cov-2 Outbreak," Federal Reserve Bank of New York Staff Report No. 920 (April 2020).

the fastest rate on record, and was 9.5 percent lower than a year ago. As we noted in June, the impact of the pandemic on the economy will reduce federal tax revenues while the fiscal response from the COVID-19 relief laws and heightened demands on federal social programs will increase expenditures.⁵⁵ Federal debt held by the public increased from \$19.8 trillion in May to \$20.6 trillion in July—up over \$3 trillion since February—while 3-month Treasury interest rates increased 3 basis points from 0.13 percent to 0.16 percent from May to June but returned to 0.13 percent in July.⁵⁶

Increasing infections in some states and orders to once again close or limit certain businesses are likely to pose additional challenges for potentially fragile economic improvements, especially in affected sectors, such as the leisure and hospitality sector. More generally, economic activity during the pandemic will evolve based on a complex interaction of supply constraints, patterns of consumer demand, the severity of the pandemic, the effectiveness of mitigation measures, and when and how states and localities reopen—or restrict—various parts of their economies.⁵⁷ Emerging empirical research on these topics, which we plan to monitor and review in greater depth to better understand changes in national and regional economic activity, should provide insight into the relative importance of these various factors and how they interact.⁵⁸

Both imports to and exports from the United States fell in May but rose significantly in June as other areas of the economy continued to recover. Trade in transportation and travel services in June 2020 continued to be substantially below their levels from a year ago. Travel exports in June

⁵⁵ GAO-20-625 .

⁵⁶ A basis point is 1/100th of a percentage point. The 3 month Treasury interest rate is the constant maturity rate from the Federal Reserve's H.15 Selected Interest Rates release.

⁵⁷ The severity of the pandemic is likely to influence the pace of economic activity. Moreover, the nature of social interactions associated with growing economic activity could influence the risk of contagion, suggesting important feedback effects between the economy and the pandemic.

⁵⁸ See for example, Asger Lau Andersen, Emil Toft Hansen, Niels Johannesen, and Adam Sheridan, "Pandemic, Shutdown and Consumer Spending: Lessons from Scandinavian Policy Responses to COVID-19," (2020) and Adam Brzezinski, Guido Deiana, Valentin Kecht and David Van Dijcke, "The COVID-19 Pandemic: Government versus Community Action across the United States," INET Oxford Working Paper No. 2020-06 (2020).

2020, for example, were 73 percent lower than in June 2019. COVID-19-related imports continued to rise in May and June while COVID-19-related exports were roughly constant.⁵⁹ Measures of economic and financial stress in advanced and emerging market economies improved in June relative to May but remained elevated compared to 2019.

Indicators of areas of the economy supported by the federal pandemic response improved in June, but labor market indicators remained far from prepandemic levels (see fig. 4).⁶⁰

⁵⁹ World Customs Organization, HS classification reference for Covid-19 medical supplies, 2nd edition (April 9, 2020). The import and export values are based on Harmonized Schedule (HS) codes at the 6-digit level identified by the World Customs Organization and the World Health Organization. While these are a useful indication of trends in the imports and exports of COVID-19-related products, because HS 6-digit numbers are broad categories that cover more than one product, data at the HS 6-digit level may include a mix of COVID-19-related and non-COVID-19-related products. For this reason, the value reported may overestimate the imports and exports of COVID-19-related products.

⁶⁰ We identified a number of economic indicators to facilitate ongoing and consistent monitoring of areas of the economy supported by the federal pandemic response. These six areas are labor markets, households, small business credit markets, corporate credit markets, markets associated with state and local government finances, and the health care sector. Key aspects of the federal response that are intended to support the economy include Federal Reserve lending facilities, some supported by funds appropriated under the CARES Act to Treasury's Exchange Stabilization Fund; the Paycheck Protection Program; expanded unemployment insurance; recovery rebates; and payments to state, local, and tribal governments. To the extent that federal pandemic responses are effective, we would expect to see improvements in outcomes related to these indicators. However, while trends in these indicators may be suggestive of the effect of provisions of the COVID-19 relief laws over time, those trends will not on their own provide definitive evidence of effectiveness.

Figure 4: Indicators for Areas of the Economy Supported by the Federal Pandemic Response, 2015-2019 and March 2020-July 2020

red, underlined numbers indicate a negative trend

Indicator	Average, 2015-2019	March 2020	April 2020	May 2020	June 2020	July 2020
Initial unemployment insurance claims (weekly average) ^a	244,705	<u>2,666,750</u>	<u>4,667,400</u>	2,288,250	1,499,000	1,333,200
Employment-to-population ratio ^b	60.1	<u>60.0</u>	<u>51.3</u>	52.8	54.6	55.1
Consumer Credit Default Composite Index ^c (not seasonally adjusted)	.91	<u>0.99</u>	0.90	0.78	0.66	N/A
Small Business Health Index ^d (not seasonally adjusted)	90.6	84.05	<u>80.73</u>	83.1	<u>82.8</u>	N/A
Spreads on investment grade corporate bonds ^e	127	<u>238</u>	212	194	153	137
Spreads on municipal bonds ^f	-3	<u>119</u>	<u>144</u>	121	83	74
Changes in state and local government employment	+10,000	<u>-36,000</u>	<u>-959,000</u>	<u>-503,000</u>	+54,000	+274,000
Changes in health care employment	+26,800	<u>-90,100</u>	<u>-1,487,500</u>	+304,000	+351,600	+125,500
Changes in personal spending on health care services (\$ billions) ^g	+\$5	<u>-\$365</u>	<u>-\$530</u>	+\$331	+\$237	N/A

Source: GAO analysis of data from Department of Labor, S&P/Experian, Dun & Bradstreet, Bloomberg and Bureau of Economic Analysis. | GAO-20-708

^aInitial unemployment claim totals include initial regular unemployment claims submitted during the month but may understate emerging unemployment of workers who qualify for the Pandemic Unemployment Assistance (PUA) program. The PUA program generally authorizes up to 39 weeks of unemployment insurance (UI) benefits to individuals not otherwise eligible for UI benefits, such as self-employed and certain gig economy workers, who are unable to work as a result of COVID-19. Claims weeks are included in the month where the majority of the week falls. For example, the weekly average for April 2020 includes the claims week ending May 2.

^bThe employment-to-population ratio represents the number of employed people as a percentage of

the civilian noninstitutional population 16 years and over and is subject to misclassification errors with respect to consistently identifying workers as employed and absent from work or unemployed on temporary layoff.

^cHigher levels of the Consumer Credit Default Composite Index indicate more defaults on consumer loans, including auto loans, bank cards, and mortgages. The Consumer Credit Default Composite Index could be subject to seasonal variation but is not seasonally adjusted.

^dLower levels of the Small Business Health Index indicate higher utilization of credit, delayed payments on credit, and more small business failures. The Small Business Health Index is published under license and permission from Dun & Bradstreet and no commercial use can be made of these data.

^eCorporate bond spreads are option-adjusted spreads on dollar-denominated investment grade corporate bonds and are measured in basis points or 1/100th of a percentage point. Higher spreads reflect higher perceived risk among corporate borrowers by investors.

^fSpreads on municipal bonds are calculated relative to interest rates on Treasury securities based on the Bloomberg-Barclays Municipal Bond Index and are measured in basis points or 1/100th of a percentage point. Higher spreads reflect higher perceived risk among municipal borrowers by investors.

^gExpenditures are in real (inflation-adjusted) dollars using chained (2012) dollars and are seasonally adjusted at annual rates.

Labor markets. The labor market showed some signs of improvement as the employment-to-population ratio increased from a historic low of 51.3 percent in April to 55.1 percent in July.⁶¹ Gains in employment were primarily driven by individuals returning to work in leisure and hospitality, government, and retail trade. However, new state orders to restrict certain business activities in some states may slow growth in employment in impacted industries. Employment levels remain below their prepandemic levels, as the employment-to-population ratio in July was 6 percentage points lower than in February 2020.⁶² Percentage declines in the employment-to-population ratios from February to July were larger for Black and Hispanic workers compared to White workers, and were also larger for those without a bachelor's degree.

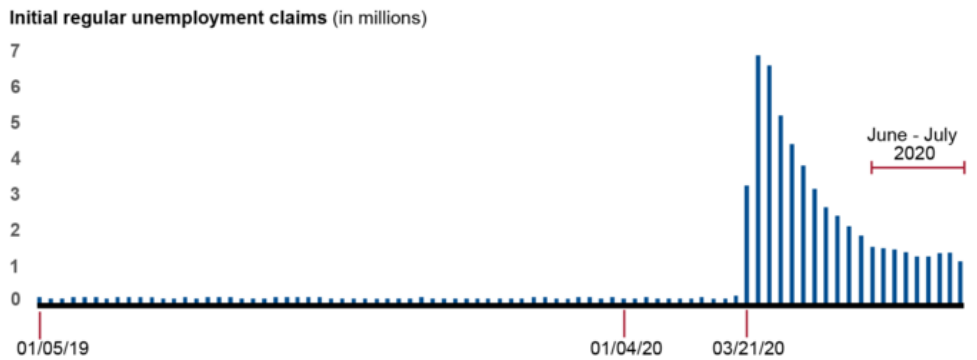
In four states, the employment-to-population ratio was less than 50 percent. Moreover, the number of initial regular unemployment insurance

⁶¹ The employment-to-population ratio represents the number of employed people as a percentage of the civilian noninstitutional population 16 years and over.

⁶² From March through July, employment data from the Bureau of Labor Statistics (BLS) household survey, including the employment-to-population ratio, have been subject to misclassification errors with respect to identifying workers as employed and absent from work or unemployed on temporary layoff consistently. According to BLS, the degree of misclassification error declined considerably in June and July after BLS took steps to improve the reliability of the data after the May employment data were released. While BLS measures employment and labor force statistics in its household survey, it also measures an alternative measure of employment called nonfarm employment in its establishment survey. According to BLS, the establishment survey was not subject to the misclassification error, and employment variables from both data sets indicate increases in employment levels in July. See the "Coronavirus (COVID-19) Impact on June 2020 Establishment and Household Survey Data" in BLS's Employment Situation Summary for more details.

(UI) claims filed weekly in June and July 2020 averaged roughly 1.4 million, which was six and a half times higher than average weekly claims in 2019 (see fig. 5). While the number of initial regular UI claims filed weekly has decreased since March when the pandemic began, falling to 971,000 in the week ending August 8, 2020, the persistently high level of claims indicates that economic disruption from the pandemic and significant stress in some areas of the labor market continue.

Figure 5: National Weekly Initial Regular Unemployment Insurance Claims, January 2019–July 2020



National weekly claims, January 2019 - July 2020.

Source: GAO, Department of Labor Employment and Training Administration. | GAO-20-708

Notes: National initial regular unemployment insurance (UI) claims data are seasonally adjusted and include the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Figure includes data retrieved on August 20, 2020, and covers weekly claims from January 5, 2019, through August 8, 2020. Recent initial UI claims totals may understate emerging unemployment due to capacity issues that may have limited or delayed successful claim filing in many states. Initial unemployment claims totals may also understate emerging unemployment of workers who qualify for the Pandemic Unemployment Assistance (PUA) program, as states have different processes for processing claims under this program since its implementation in May 2020. The PUA program generally authorizes up to 39 weeks of UI benefits to individuals not otherwise eligible for such benefits, such as self-employed and certain gig economy workers, who are unable to work as a result of COVID-19. According to the Department of Labor, in some states, workers eligible for PUA may first submit an UI claim, but in other states, these workers can apply directly for the PUA program, and PUA claims are not counted as initial regular UI claims. Due to outstanding and unresolved data issues specific to the PUA program, this graphic does not include separate initial PUA claims.

Household financial conditions. The Consumer Credit Default Composite Index—a timely measure of households’ ability to make

scheduled payments—continued to improve in June.⁶³ While subindexes for mortgages, auto loans, and bank cards improved in June relative to May, defaults on bank cards remained higher than a year ago. Relatively high bank card defaults could indicate that households are prioritizing payments on some liabilities over others or that households that disproportionately rely on credit cards have experienced more financial hardship since the onset of the pandemic. In addition, preliminary data on households participating in the Supplemental Nutrition Assistance Program (SNAP) rose by about 17 percent in April compared to March—suggesting a significant increase in the demand for food assistance.⁶⁴ Federal Pandemic Unemployment Compensation benefits expired at the end of July, which could influence eligibility for SNAP as well as demand for food assistance.

Small business credit markets. The Small Business Health Index—a timely measure of the financial condition of small businesses—improved in May, but dropped in June. In addition, subcomponents of the index measuring delinquency on certain financial obligations were still on the rise, suggesting that small businesses had increased difficulty making scheduled payments.⁶⁵ As of June 2020, small businesses in the retail and automotive sectors had the largest deterioration in their sector-level

⁶³ The S&P/Experian Consumer Credit Default Composite Index measures the proportion of consumer credit account balances that enter default across auto loans, first and second mortgages, and bank cards each month. Although changes in these indexes over time should provide a general indication of changes in the financial condition of households, forbearance arrangements could affect how delinquencies are reported and therefore the measurement of consumer credit defaults in the near term.

⁶⁴ SNAP (formerly the Food Stamp program) is the largest food assistance program and one of the largest safety net programs in the United States. Historically, the number of households that participate in SNAP has tended to decrease as household financial conditions improve. We report the number of households participating in SNAP based on monthly data reported by the Department of Agriculture's Food and Nutrition Service. Changes in SNAP flexibilities could also influence SNAP participation. These preliminary data may be subject to revision given that some states issued new Pandemic Electronic Benefits Transfer benefits for school-age children through SNAP and therefore may have reported larger-than-actual SNAP participation.

⁶⁵ The Small Business Health Index combines information on the timeliness of payments, failure rates, and utilization of credit of a large sample of active small businesses with fewer than 100 employees. The index tends to increase as economic conditions improve. We report this index and its subcomponents based on Dun and Bradstreet's monthly index for the United States as a whole.

indexes since January, with increases in business failures and growing delinquencies driving the changes.

Corporate credit markets. Spreads on investment grade corporate bonds improved in June and July relative to April and May, suggesting that perceived risk among corporate borrowers has fallen and that access to credit for corporations has improved.⁶⁶

State and local government finances. Spreads on municipal bonds also improved in June and July relative to April and May, suggesting that perceived risk among municipal borrowers has fallen and access to credit for state and local governments has improved.⁶⁷ State and local government employment, another indicator of state and local government finances, improved based on growth in local educational employment.

Monthly change in personal consumption expenditures for health care. The COVID-19 pandemic has taken a severe toll on the health care sector, not only through the sharp rise in demand for services for COVID-19 patients but also through the disruption of services for non-COVID-19 patients. Early in the pandemic, state stay-at-home orders and federal recommendations to postpone nonessential medical procedures contributed to declines in hospital/facility stays and patient visits for non-COVID-related conditions or impairments. States began easing COVID-related restrictions in late April, and by the end of May, most had relaxed or ended stay-at-home orders. Some states began reimposing certain restrictions, such as bar closures, in June or July. This indicator, based on data reported by the Bureau of Economic Analysis, reflects these developments.

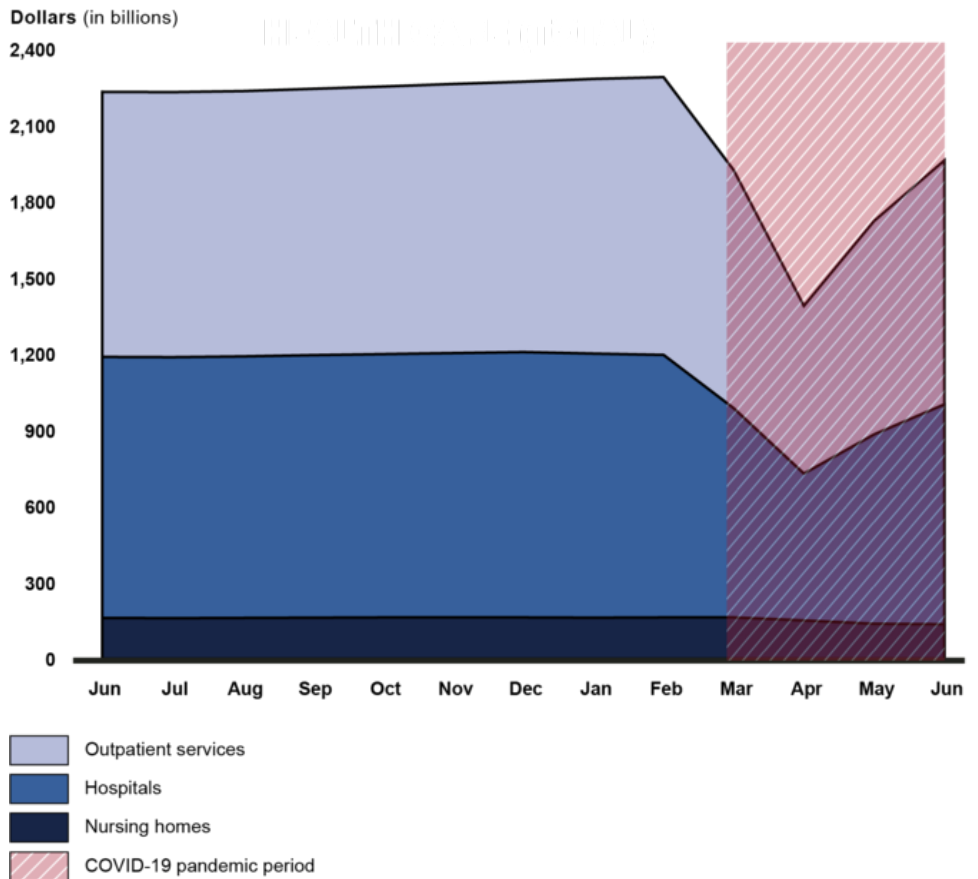
⁶⁶ Spreads on corporate bonds relative to benchmark interest rates (e.g., Treasury interest rates) measure the premium corporate borrowers must pay to compensate lenders for taking on the risk of loss due to default (risk premium) and for foregoing investments in more liquid assets (liquidity premium). We report spreads on aggregations of dollar-denominated investment grade corporate bonds available via Bloomberg.

⁶⁷ Spreads on municipal bonds relative to benchmark interest rates (e.g., Treasury interest rates) incorporate the favorable tax treatment received by municipal debt and may also reflect any premium state and local borrowers pay to compensate lenders for taking on the risk of loss due to default (risk premium) and for tying up their investment funds for a period of time (liquidity premium). We report spreads calculated based on the Bloomberg Barclays Municipal Bond Index. Spreads are calculated using yield to worst, which results in a conservative—that is, lower—estimate of potential returns on callable bonds.

As shown in figure 6, seasonally adjusted real (inflation-adjusted) personal consumption expenditures for health care dropped by \$365 billion (16 percent) between February and March and then another \$530 billion (28 percent) between March and April, with large drops in spending for both outpatient and hospital services.⁶⁸ Personal consumption expenditures for health care rose in May and again in June, with increases in spending for both outpatient and hospital services, but remained well below prepandemic levels. New stay-at-home orders or other measures to address increasing numbers of cases in some areas of the country may slow growth in spending.

⁶⁸ Personal consumption expenditures, a component of gross domestic product, is the value of goods and services purchased by, or on behalf of, U.S. residents.

Figure 6: Real Personal Consumption Expenditures for Health Care, Seasonally Adjusted, June 2019–June 2020



Source: GAO analysis of Bureau of Economic Analysis data. | GAO-20-708

Note: Expenditures are in real (inflation-adjusted) dollars using chained (2012) dollars and are seasonally adjusted at annual rates.

Monthly change in health care employment. As the COVID-19 pandemic spread throughout the United States, and hospital stays and patient visits for non-COVID-related conditions or impairments declined, many health care establishments such as private physician offices curtailed services and laid off staff. Declines in health care employment lagged those in health care spending, with employment declining substantially in April while personal health care expenditures fell sharply the previous month. Even when facing revenue losses, employers may have retained staff for a number of reasons—for example, to avoid the future costs of hiring and training new staff when patient visits resume or, in the case of hospitals, to care for individuals with COVID-19. Financial support provided by the COVID-19 relief laws to assist providers facing

increased health-care-related expenses or lost revenue attributable to COVID-19, known as the Provider Relief Fund, may also have helped some providers retain staff.⁶⁹

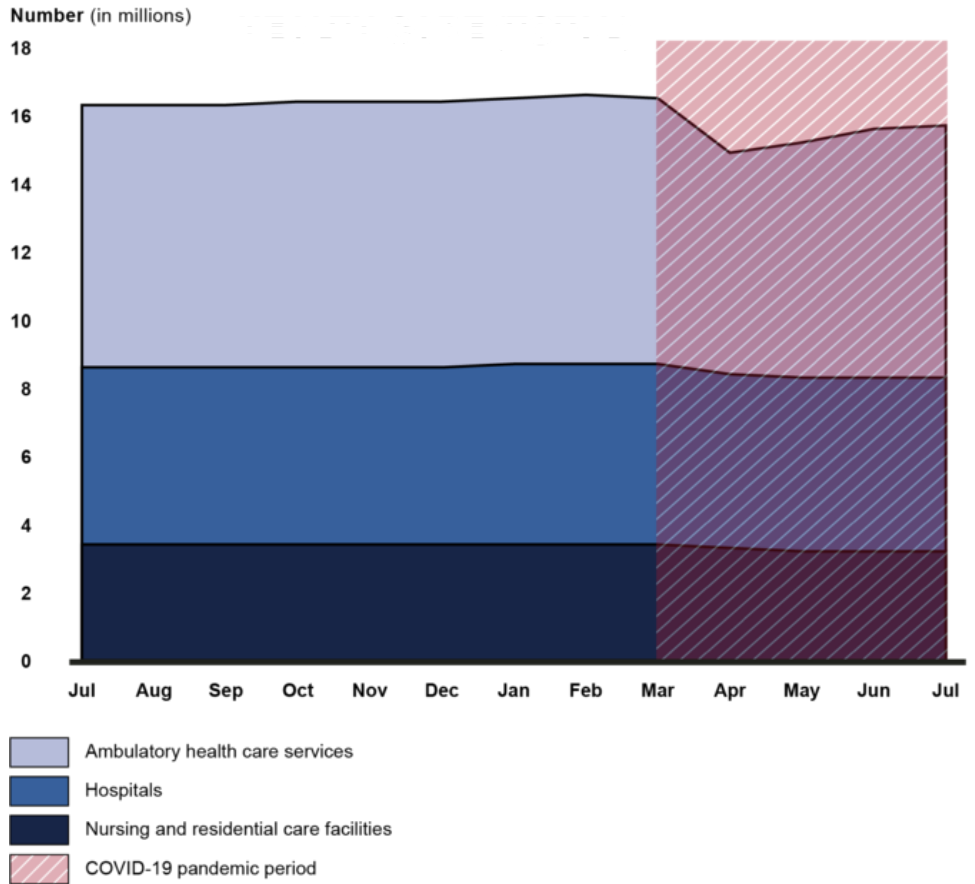
According to data from the Bureau of Labor Statistics (BLS) Current Employment Statistics Survey of establishments, seasonally adjusted employment in the health care sector dropped by almost 1.6 million between February and April 2020, largely due to declines in employment in ambulatory health care establishments—including dentists' offices, which accounted for 35 percent of all job losses in health care during that period (see fig. 7).⁷⁰ BLS data show recovery in health care sector employment in the following 3 months, including in dentists' offices, which regained almost nine in 10 of the jobs lost in March and April.⁷¹ However, employment in this sector was still below prepandemic levels as of July.

⁶⁹ Specifically, the CARES Act appropriated \$100 billion and the Paycheck Protection Program and Health Care Enhancement Act appropriated \$75 billion for the fund. HHS began distributing funds in April.

⁷⁰ Employment in ambulatory health care services fell from 7.9 million in February to 6.5 million in April, while total employment in health care fell from 16.5 million to 14.9 million in this period.

⁷¹ As of August, June and July employment data were preliminary.

Figure 7: Health Care Sector Employment, Seasonally Adjusted, July 2019–July 2020



Source: GAO analysis of Bureau of Labor Statistics data. | GAO-20-708

Note: June and July 2020 data are preliminary.

Status of GAO’s June 2020 Recommendations and Matters for Congressional Consideration

As we reported in June, consistent with the urgency of responding to serious and widespread health issues and economic disruptions, federal agencies gave priority to moving swiftly where possible to distribute funds and implement new programs designed to help small businesses and the newly unemployed, for example. However, such urgency required certain tradeoffs in achieving transparency and accountability goals. To make

Letter

mid-course corrections, GAO made three recommendations to federal agencies:

Recommendations

Unemployment insurance. We recommended that the Secretary of Labor, in consultation with SBA and Treasury, immediately provide information to state unemployment agencies that specifically addresses SBA's PPP loans, and the risk of improper payments associated with these loans. DOL issued guidance on August 12, 2020, that clarified that individuals working full-time and being paid through PPP are not eligible for UI, and that individuals working part-time and being paid through PPP would be subject to certain state policies, including state policies on partial unemployment to determine their eligibility for UI benefits. Further, the guidance clarified that individuals being paid through PPP but not performing any services would similarly be subject to certain provisions of state law, and noted that an individual receiving full compensation would be ineligible for UI.

Economic impact payments. Treasury and IRS sent almost 1.2 million economic impact payments totaling \$1.6 billion to deceased individuals. In June 2020, we recommended that IRS consider cost-effective options for notifying ineligible recipients on how to return payments. IRS agreed with this recommendation. Treasury and IRS have taken steps to implement this recommendation and are considering further actions. Currently, IRS has instructions on its website requesting that individuals voluntarily mail the appropriate economic impact payment amount sent to the decedent or incarcerated individual back to IRS, for both electronic and paper check payments. The envelopes in which paper checks were sent also have a checkbox to indicate if the recipient is deceased, which then could be mailed back to the Bureau of the Fiscal Service. Treasury has also held and canceled payments to decedents along with those that have been returned.

According to a Treasury official, of the \$1.6 billion in economic impact payments sent to decedents, nearly 70 percent have been recovered. However, we were unable to verify that amount by the time we finalized our work on this report. We are working with Treasury to determine the number of payments sent to decedents that have been recovered.

Treasury was considering sending letters to request the return of outstanding checks and the repayment of amounts already paid by direct deposit or by checks that have been cashed. However, Treasury has not moved forward with this effort because, according to Treasury, Congress is currently considering legislation that would clarify or change the

eligibility requirements of the payments, including payments to the deceased and incarcerated.

Paycheck Protection Program. We recommended that the Administrator of the Small Business Administration develop and implement plans to identify and respond to risks in the PPP to ensure program integrity, achieve program effectiveness, and address potential fraud, including in loans of \$2 million or less. As of August 2020, SBA has begun developing oversight plans for the PPP but has not yet finalized or implemented them.

Specifically, SBA is currently working with Treasury to finalize plans for reviewing PPP loans. For example, SBA officials told us that a contractor would use an automated review tool to flag potentially questionable loans over \$2 million and that the contractor would conduct manual reviews of flagged loans. According to SBA officials, SBA would then complete the reviews with a combination of contract and federal staff, and another contractor would perform a quality assurance review on a sample of loans. However, as of August 14, 2020, SBA was still working with Treasury to finalize the specific review procedures its contractors and staff would follow.

Matters for Congressional Consideration

In addition, to improve the government's response efforts, GAO suggested three matters for congressional consideration.

Aviation preparedness. In our June 2020 report, we urged Congress to take legislative action to require the Secretary of Transportation to work with relevant agencies and stakeholders, such as HHS, the Department of Homeland Security (DHS), members of the aviation and public health sectors, and international organizations, to develop a national aviation-preparedness plan to limit the spread of communicable disease threats and minimize travel and trade impacts. We originally made this recommendation to the Department of Transportation (DOT) in December 2015.⁷² As of August 2020, no aviation-preparedness plan had been developed.

⁷² GAO, Air Travel and Communicable Disease: Comprehensive Federal Plan Needed for U.S. Aviation System's Preparedness, GAO-16-127 (Washington, D.C.: Dec. 16, 2015).

Although DOT supports the inclusion of aviation in a comprehensive pandemic preparedness plan, it maintains that other federal agencies should lead such planning efforts. DOT has reiterated that because HHS and DHS are responsible for communicable disease response and preparedness planning, respectively, these departments should lead any efforts to address planning for communicable disease outbreaks, including for transportation.⁷³

However, in May 2020, DHS stated that it had reviewed its existing national, sector, and modal plans for pandemic preparedness and response activities and determined that it is not best situated to develop a national aviation-preparedness plan. It noted that DOT, along with HHS and DHS, would be the appropriate leads. In June 2020, HHS stated that it is not in a position to develop a national aviation-preparedness plan because it does not have primary jurisdiction over the entire aviation sector or the relevant transportation expertise. Also, the National Response Framework—a guide to how the nation responds to all types of disasters and emergencies—identifies DOT as the lead federal agency for coordinating the management of transportation systems and infrastructure during domestic threats or in response to actual or potential incidents.⁷⁴

Several recent developments indicate progress to respond to this recommendation. For example, in May 2020, the House of Representatives passed H.R. 6800, referred to as the HEROES Act, which would require DOT, in coordination with HHS, DHS, and other appropriate federal departments and agencies, to develop a national aviation preparedness plan. The legislation directs the plan to incorporate all elements referenced in the recommendation from our December 2015

⁷³ DOT has pointed to Presidential Policy Directive/PPD-8 as part of its rationale for why other federal agencies should lead an aviation-preparedness plan to respond to communicable disease threats. This directive, published in March 2011, calls for the establishment of a risk-informed National Preparedness Goal to define the capabilities needed to respond to the nation's greatest risks and a National Preparedness System, consisting of an integrated set of guidance, programs, and processes that will enable the nation to meet the goal. The directive states that the Secretary of Homeland Security is responsible for coordinating the domestic all-hazards preparedness efforts of all executive departments and agencies, but that it is not intended to alter or impede the ability of executive departments or agencies to perform their responsibilities under law and other Presidential guidance.

⁷⁴ The National Response Framework includes Emergency Support Functions that describe federal coordinating structures that group resources and capabilities into functional areas most frequently needed in a national response. DOT is the coordinator and primary agency for Emergency Support Function #1 – Transportation.

report. The plan would also be required to provide for an adaptable and scalable framework to help align individual airport and airline plans, as well as improve coordination among appropriate federal, state, and local governments.

In addition, in May 2020, the Senate Committee on Commerce, Science, and Transportation favorably reported S. 3681, Restoring Safety in the Skies Act of 2020. This bill would require HHS, DHS, and DOT to form a joint task force on air travel during and after the COVID-19 public health emergency, and includes a provision for the task force to develop operating procedures to manage future anticipated public health crises affecting air travel. The task force would be focused on COVID-19 and the immediate aftermath of the pandemic, not future communicable disease threats.

In early July 2020, DOT, HHS, and DHS issued guidance to airports and airlines for implementing measures to mitigate the public health risks associated with COVID-19.⁷⁵ Among other things, the document establishes the principles for implementing public health measures in the aviation sector and identifies risk mitigation measures that should be applied for the entire passenger journey in the air transportation system, such as social distancing and contact tracing. While this guidance is a positive step, DOT has not taken action to develop an aviation preparedness plan for future communicable disease threats that incorporates all of the elements referenced in our 2015 report, such as protocols for responding to the threat and coordination among stakeholders. Without such a plan, the United States will not be as prepared to minimize and quickly respond to future communicable disease events.

Full access to death data. In our June 2020 report, we urged Congress to amend the Social Security Act to explicitly allow the Social Security Administration (SSA) to share its full death data with Treasury for data matching to prevent payments to ineligible individuals.

In June 2020, the Senate passed S.4104, referred to as the Stopping Improper Payments to Deceased People Act. If enacted, the bill would

⁷⁵ Departments of Transportation, Homeland Security, and Health and Human Services, Runway to Recovery: The United States Framework for Airlines and Airports to Mitigate the Public Health Risks of Coronavirus (Washington, D.C.: July 2020).

allow SSA to share these data with Treasury's Bureau of Fiscal Service to avoid paying deceased individuals.

Fiscal assistance through Medicaid. In our June 2020 report, we urged Congress to use our Federal Medical Assistance Percentage (FMAP) formula for any future changes to the FMAP—the statutory formula according to which the federal government matches states' spending for Medicaid services—during the current or any future economic downturn. Our past work has found that during economic downturns—when Medicaid enrollment can rise and state economies weaken—the FMAP formula, which is based on each state's per capita income, does not reflect current state economic conditions. In addition, past efforts to provide states with temporary increases in the FMAP were not as timely or responsive as they could have been. No congressional action has been taken to date.

Agency Comments and Our Evaluation

We shared a draft of this report with multiple agencies for review and comment.⁷⁶ Agencies provided the following comments:

Small Business Administration. In an email on August 14, 2020, SBA provided substantive comments on the report. SBA commented that the language in this report on PPP did not mention controls in place during the application process, rules and guidance that the agency had issued, or actions it had taken to create a portal for submitting loan forgiveness applications. SBA also stated that we had not included all of the information provided to us in interviews on its plans for loan reviews. As our goal was to provide a brief overview of actions SBA had taken in response to the recommendation in our June 2020 report that focused on SBA's reviews of approved PPP loans, we did not make any changes to this report. We plan to provide more detailed information on the status of SBA's plans for loan reviews and the loan forgiveness process in our next report on the CARES Act.

Technical comments. The following agencies provided technical comments, which we incorporated as appropriate: Departments of Labor,

⁷⁶ We shared a draft of this report with the Departments of Labor, Commerce, Health and Human Services, Transportation, and the Treasury. We also shared a draft with the Federal Reserve, Small Business Administration, Office of Management and Budget, and Internal Revenue Service.

Commerce, Health and Human Services, Transportation, and the Treasury; the Federal Reserve; Office of Management and Budget; and Internal Revenue Service.

We are sending copies of this report to the appropriate congressional committees, the Director of the Office of Management and Budget, White House Coronavirus Task Force, and other relevant agencies. In addition, the report is available at no charge on the GAO website at <https://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-5500 or dodarog@gao.gov. Questions can also be directed to Kate Siggerud, Chief Operating Officer, at (202) 512-5600, A. Nicole Clowers, Managing Director, Health Care, at (202) 512-7114 or clowersa@gao.gov or Orice Williams Brown, Managing Director, Congressional Relations, at (202) 512-4400 or williamso@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.



Gene L. Dodaro

Comptroller General of the United States

Congressional Addressees

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Chairman
The Honorable Patrick J. Leahy
Vice Chairman
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United States Senate

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The Honorable Bennie Thompson
Chairman
The Honorable Mike D. Rogers
Ranking Member
Committee on Homeland Security
House of Representatives

Letter

The Honorable Carolyn B. Maloney
Chairwoman
The Honorable James R. Comer
Ranking Member
Committee on Oversight and Reform
House of Representatives

Abbreviations

Abbreviation	Description
BLS	Bureau of Labor Statistics
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
DATA Act	Digital Accountability and Transparency Act of 2014
DHS	Department of Homeland Security
DOT	Department of Transportation

Abbreviation	Description
	Federal Reserve Board of Governors of the Federal Reserve System
FMAP	Federal Medical Assistance Percentage
HHS	Department of Health and Human Services
HS	Harmonized Schedule
ICU	intensive care unit
IRS	Internal Revenue Service
NCHS	National Center for Health Statistics
NHSN	National Healthcare Safety Network

Abbreviation	Description
OMB	Office of Management and Budget
PPP	Paycheck Protection Program
PUA	Pandemic Unemployment Assistance
SAO	Senior Accountable Official
SBA	Small Business Administration
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
Treasury	Department of the Treasury

Letter

Abbreviation	Description
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UI	unemployment insurance
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Accessible Data

Data Tables

Accessible Data for CDC Data on Higher-Than-Expected Weekly Mortality, January 1 through June 13, 2020

WEEK ENDING DATE	OBSERVED NUMBER	UPPER BOUND THRESHOLD	EXCESS DEATHS VAL
2020-01-04	60,319	61,891	0
2020-01-11	60,620	62,484	0
2020-01-18	59,193	62,530	0
2020-01-25	58,852	62,594	0
2020-02-01	58,343	62,049	0
2020-02-08	58,901	61,870	0
2020-02-15	58,286	61,709	0
2020-02-22	58,446	61,354	0
2020-02-29	58,852	60,911	0
2020-03-07	58,542	60,635	0
2020-03-14	57,550	60,255	0
2020-03-21	58,309	59,930	0
2020-03-28	59,386	59,377	3,878
2020-04-04	58,726	58,719	13,870
2020-04-11	58,258	58,248	21,270
2020-04-18	57,626	57,611	19,703
2020-04-25	57,044	57,023	17,304
2020-05-02	56,381	56,357	13,271
2020-05-09	55,803	55,780	11,249
2020-05-16	55,516	55,516	9,116
2020-05-23	55,132	55,132	6,595
2020-05-30	54,955	54,955	4,448
2020-06-06	54,755	54,755	2,730
2020-06-13	54,546	54,546	1,458

Accessible Data

**Accessible Data for National Weekly Initial Unemployment Insurance Claims,
January 2019–July 2020**

Week	Claims
1/5/2019	220,000
1/12/2019	216,000
1/19/2019	209,000
1/26/2019	236,000
2/2/2019	230,000
2/9/2019	228,000
2/16/2019	218,000
2/23/2019	224,000
3/2/2019	220,000
3/9/2019	224,000
3/16/2019	219,000
3/23/2019	215,000
3/30/2019	211,000
4/6/2019	203,000
4/13/2019	203,000
4/20/2019	226,000
4/27/2019	230,000
5/4/2019	225,000
5/11/2019	217,000
5/18/2019	213,000
5/25/2019	218,000
6/1/2019	220,000
6/8/2019	220,000
6/15/2019	219,000
6/22/2019	224,000
6/29/2019	222,000
7/6/2019	211,000
7/13/2019	217,000
7/20/2019	211,000
7/27/2019	216,000
8/3/2019	214,000
8/10/2019	218,000
8/17/2019	215,000

Accessible Data

Week	Claims
8/24/2019	215,000
8/31/2019	219,000
9/7/2019	208,000
9/14/2019	211,000
9/21/2019	215,000
9/28/2019	218,000
10/5/2019	212,000
10/12/2019	218,000
10/19/2019	213,000
10/26/2019	217,000
11/2/2019	212,000
11/9/2019	222,000
11/16/2019	223,000
11/23/2019	211,000
11/30/2019	206,000
12/7/2019	237,000
12/14/2019	229,000
12/21/2019	218,000
12/28/2019	220,000
1/4/2020	212,000
1/11/2020	207,000
1/18/2020	220,000
1/25/2020	212,000
2/1/2020	201,000
2/8/2020	204,000
2/15/2020	215,000
2/22/2020	220,000
2/29/2020	217,000
3/7/2020	211,000
3/14/2020	282,000
3/21/2020	3,307,000
3/28/2020	6,867,000
4/4/2020	6,615,000
4/11/2020	5,237,000
4/18/2020	4,442,000
4/25/2020	3,867,000
5/2/2020	3,176,000

Accessible Data

Week	Claims
5/9/2020	2,687,000
5/16/2020	2,446,000
5/23/2020	2,123,000
5/30/2020	1,897,000
6/6/2020	1,566,000
6/13/2020	1,540,000
6/20/2020	1,482,000
6/27/2020	1,408,000
7/4/2020	1,310,000
7/11/2020	1,308,000
7/18/2020	1,422,000
7/25/2020	1,435,000
8/1/2020	1,191,000

Accessible Data for Figure 1: Reported COVID-19 Cases per Day in the United States, as of August 20, 2020

Date	7-day moving average of reported cases per day
3/1/2020	2
3/2/2020	5
3/3/2020	9
3/4/2020	12
3/5/2020	21
3/6/2020	28
3/7/2020	36
3/8/2020	56
3/9/2020	85
3/10/2020	123
3/11/2020	160
3/12/2020	209
3/13/2020	241
3/14/2020	280
3/15/2020	436
3/16/2020	511
3/17/2020	869
3/18/2020	1318
3/19/2020	1941
3/20/2020	2407
3/21/2020	3193
3/22/2020	4276
3/23/2020	5730
3/24/2020	6776
3/25/2020	8285
3/26/2020	10020
3/27/2020	12082
3/28/2020	14010
3/29/2020	15357
3/30/2020	17029
3/31/2020	18807
4/1/2020	20672
4/2/2020	21989

Accessible Data

Date	7-day moving average of reported cases per day
4/3/2020	24403
4/4/2020	26025
4/5/2020	27141
4/6/2020	30113
4/7/2020	29975
4/8/2020	30617
4/9/2020	31412
4/10/2020	31182
4/11/2020	31554
4/12/2020	31994
4/13/2020	29239
4/14/2020	29923
4/15/2020	29298
4/16/2020	28935
4/17/2020	28328
4/18/2020	27847
4/19/2020	27397
4/20/2020	28155
4/21/2020	28170
4/22/2020	27985
4/23/2020	29125
4/24/2020	29249
4/25/2020	29713
4/26/2020	30179
4/27/2020	29308
4/28/2020	28938
4/29/2020	28888
4/30/2020	28123
5/1/2020	28194
5/2/2020	27713
5/3/2020	27785
5/4/2020	27181
5/5/2020	26952
5/6/2020	26646
5/7/2020	26513
5/8/2020	25889
5/9/2020	25441

Accessible Data

Date	7-day moving average of reported cases per day
5/10/2020	24588
5/11/2020	24441
5/12/2020	24321
5/13/2020	23964
5/14/2020	23440
5/15/2020	23009
5/16/2020	23767
5/17/2020	22266
5/18/2020	23177
5/19/2020	23453
5/20/2020	23738
5/21/2020	22785
5/22/2020	22970
5/23/2020	22150
5/24/2020	22444
5/25/2020	22512
5/26/2020	21515
5/27/2020	21061
5/28/2020	21173
5/29/2020	20295
5/30/2020	19913
5/31/2020	21461
6/1/2020	20008
6/2/2020	21226
6/3/2020	20511
6/4/2020	20404
6/5/2020	21963
6/6/2020	22772
6/7/2020	21592
6/8/2020	21993
6/9/2020	19625
6/10/2020	21740
6/11/2020	21910
6/12/2020	20951
6/13/2020	20415
6/14/2020	20992
6/15/2020	21132

Accessible Data

Date	7-day moving average of reported cases per day
6/16/2020	23932
6/17/2020	23041
6/18/2020	23240
6/19/2020	25325
6/20/2020	26317
6/21/2020	27125
6/22/2020	28277
6/23/2020	29185
6/24/2020	31244
6/25/2020	33737
6/26/2020	34836
6/27/2020	36592
6/28/2020	38560
6/29/2020	39849
6/30/2020	41180
7/1/2020	43564
7/2/2020	45299
7/3/2020	47172
7/4/2020	48247
7/5/2020	48672
7/6/2020	50195
7/7/2020	51147
7/8/2020	52634
7/9/2020	53567
7/10/2020	54791
7/11/2020	56318
7/12/2020	58619
7/13/2020	60409
7/14/2020	61933
7/15/2020	62309
7/16/2020	64135
7/17/2020	65339
7/18/2020	66004
7/19/2020	66395
7/20/2020	66240
7/21/2020	66534
7/22/2020	66920

Accessible Data

Date	7-day moving average of reported cases per day
7/23/2020	66945
7/24/2020	66960
7/25/2020	66533
7/26/2020	66332
7/27/2020	65857
7/28/2020	65404
7/29/2020	64808
7/30/2020	64212
7/31/2020	63324
8/1/2020	62519
8/2/2020	60488
8/3/2020	59812
8/4/2020	
8/5/2020	
8/6/2020	
8/7/2020	
8/8/2020	
8/9/2020	
8/10/2020	
8/11/2020	
8/12/2020	
8/13/2020	
8/14/2020	
8/15/2020	
8/16/2020	
8/17/2020	
8/18/2020	
8/19/2020	

Accessible Data for Figure 2: Reported COVID-19 Cases August 13-19, 2020, by State, per 100,000 Population

States (abbr)	Reported cases July 29-August 4, per 100,000 population
AK	97.50
AL	233.05
AR	170.88
AZ	218.50
CA	137.40
CO	59.75
CT	30.20
DC	64.77
DE	59.87
FL	275.73
GA	233.78
HI	49.84
IA	104.27
ID	169.93
IL	83.39
IN	82.58
KS	92.87
KY	87.44
LA	234.53
MA	39.57
MD	104.75
ME	10.24
MI	52.03
MN	86.99
MO	160.57
MS	309.46
MT	87.83
NC	117.43
ND	104.20
NE	107.14
NH	16.14
NJ	31.45
NM	77.69

Accessible Data

States (abbr)	Reported cases July 29-August 4, per 100,000 population
NV	242.78
NY (excluding NYC)	23.21
NYC	23.00
OH	75.16
OK	157.69
OR	54.36
PA	37.25
RI	69.14
SC	207.19
SD	65.29
TN	208.97
TX	195.43
UT	102.43
VA	85.20
VT	3.83
WA	71.58
WI	105.27
WV	50.89
WY	56.77

Accessible Data

Accessible Data for Figure 3: CDC Data on Higher Than Expected Weekly Mortality, January 1 through June 13, 2020

WEEK ENDING DATE	OBSERVED NUMBER	UPPER BOUND THRESHOLD	EXCESS DEATHS VAL
2020-01-04	60,319	61,891	0
2020-01-11	60,620	62,484	0
2020-01-18	59,193	62,530	0
2020-01-25	58,852	62,594	0
2020-02-01	58,343	62,049	0
2020-02-08	58,901	61,870	0
2020-02-15	58,286	61,709	0
2020-02-22	58,446	61,354	0
2020-02-29	58,852	60,911	0
2020-03-07	58,542	60,635	0
2020-03-14	57,550	60,255	0
2020-03-21	58,309	59,930	0
2020-03-28	59,386	59,377	3,878
2020-04-04	58,726	58,719	13,870
2020-04-11	58,258	58,248	21,270
2020-04-18	57,626	57,611	19,703
2020-04-25	57,044	57,023	17,304
2020-05-02	56,381	56,357	13,271
2020-05-09	55,803	55,780	11,249
2020-05-16	55,516	55,516	9,116
2020-05-23	55,132	55,132	6,595
2020-05-30	54,955	54,955	4,448
2020-06-06	54,755	54,755	2,730
2020-06-13	54,546	54,546	1,458

Accessible Data

Accessible Data for Figure 4: Indicators for Areas of the Economy Supported by the Federal Pandemic Response, 2015-2019 and March 2020-July 2020

Indicator	Average, 2015-2019	March 2020	April 2020	May 2020	June 2020	July 2020
Initial unemployment insurance claims (weekly average) ^a	244,05	<u>2,666,750</u>	<u>4,667,400</u>	2,288,250	1,499,000	1,333,200
Employment-to-population ratio ^b	60.1	<u>60.0</u>	<u>51.3</u>	52.8	54.6	55.1
Consumer Credit Default Composite Index ^c (not seasonally adjusted)	.91	<u>0.99</u>	0.90	0.78	0.66	N/A
Small Business Health Index ^d (not seasonally adjusted)	90.6	84.05	<u>80.73</u>	83.1	<u>82.8</u>	N/A
Spreads on investment grade corporate bonds ^e	127	<u>238</u>	212	194	153	137
Spreads on municipal bonds ^f	-3	<u>119</u>	<u>144</u>	121	83	74
Changes in state and local government employment	+10,000	<u>-36,000</u>	<u>-959,000</u>	<u>-503,000</u>	+54,000	+274,000
Changes in health care employment	+26,800	<u>-90,100</u>	<u>-1,487,500</u>	+304,000	+351,600	+125,500
Changes in personal spending on health care services (\$ billions) ^g	+\$5	<u>-\$365</u>	<u>-\$530</u>	+\$331	+\$237	N/A

Accessible Data for Figure 5: National Weekly Initial Regular Unemployment Insurance Claims, January 2019–July 2020

Week	Claims
1/5/2019	220,000
1/12/2019	216,000
1/19/2019	209,000
1/26/2019	236,000
2/2/2019	230,000
2/9/2019	228,000
2/16/2019	218,000
2/23/2019	224,000
3/2/2019	220,000
3/9/2019	224,000
3/16/2019	219,000
3/23/2019	215,000
3/30/2019	211,000
4/6/2019	203,000
4/13/2019	203,000
4/20/2019	226,000
4/27/2019	230,000
5/4/2019	225,000
5/11/2019	217,000
5/18/2019	213,000
5/25/2019	218,000
6/1/2019	220,000
6/8/2019	220,000
6/15/2019	219,000
6/22/2019	224,000
6/29/2019	222,000
7/6/2019	211,000
7/13/2019	217,000
7/20/2019	211,000
7/27/2019	216,000
8/3/2019	214,000
8/10/2019	218,000
8/17/2019	215,000

Accessible Data

Week	Claims
8/24/2019	215,000
8/31/2019	219,000
9/7/2019	208,000
9/14/2019	211,000
9/21/2019	215,000
9/28/2019	218,000
10/5/2019	212,000
10/12/2019	218,000
10/19/2019	213,000
10/26/2019	217,000
11/2/2019	212,000
11/9/2019	222,000
11/16/2019	223,000
11/23/2019	211,000
11/30/2019	206,000
12/7/2019	237,000
12/14/2019	229,000
12/21/2019	218,000
12/28/2019	220,000
1/4/2020	212,000
1/11/2020	207,000
1/18/2020	220,000
1/25/2020	212,000
2/1/2020	201,000
2/8/2020	204,000
2/15/2020	215,000
2/22/2020	220,000
2/29/2020	217,000
3/7/2020	211,000
3/14/2020	282,000
3/21/2020	3,307,000
3/28/2020	6,867,000
4/4/2020	6,615,000
4/11/2020	5,237,000
4/18/2020	4,442,000
4/25/2020	3,867,000
5/2/2020	3,176,000

Accessible Data

Week	Claims
5/9/2020	2,687,000
5/16/2020	2,446,000
5/23/2020	2,123,000
5/30/2020	1,897,000
6/6/2020	1,566,000
6/13/2020	1,540,000
6/20/2020	1,482,000
6/27/2020	1,408,000
7/4/2020	1,310,000
7/11/2020	1,308,000
7/18/2020	1,422,000
7/25/2020	1,435,000
8/1/2020	1,191,000

Accessible Data

Accessible Data for Figure 6: Real Personal Consumption Expenditures for Health Care, Seasonally Adjusted, June 2019–June 2020

Month	Nursing homes	Hospitals	Outpatient services
Jun 2019	161	1027	1043
Jul 2019	160	1027	1043
Aug 2019	161	1029	1044
Sep 2019	162	1033	1048
Oct 2019	163	1036	1053
Nov 2019	163	1040	1059
Dec 2019	163	1044	1064
Jan 2020	162	1039	1081
Feb 2020	163	1033	1093
Mar 2020	163	823	937
Apr 2020	151	578	660
May 2020	138	745	840
Jun 2020	136	865	960

Accessible Data for Figure 7: Health Care Sector Employment, Seasonally Adjusted, July 2019–July 2020

Month	Nursing and residential care facilities	Hospitals	Ambulatory health care services
Jul 2019	3.4	5.2	7.7
Aug 2019	3.4	5.2	7.7
Sep 2019	3.4	5.2	7.7
Oct 2019	3.4	5.2	7.8
Nov 2019	3.4	5.2	7.8
Dec 2019	3.4	5.2	7.8
Jan 2020	3.4	5.3	7.8
Feb 2020	3.4	5.3	7.9
Mar 2020	3.4	5.3	7.8
Apr 2020	3.3	5.1	6.5
May 2020	3.2	5.1	6.9
Jun 2020	3.2	5.1	7.3
Jul 2020	3.2	5.1	7.4

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