CORONAVIRUS PREPAREDNESS AND RESPONSE

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

MARCH 11–12, 2020

(A TWO DAY HEARING)

Serial No. 116–96

Printed for the use of the Committee on Oversight and Reform

Available on: *http://www.govinfo.gov*, *oversight.house.gov* or *docs.house.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

40–428 PDF WASHINGTON : 2020

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CORONAVIRUS PREPAREDNESS AND RESPONSE (Day 1)

Wednesday, March 11, 2020

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM
Washington, DC.

The committee met, pursuant to notice, at 9:33 a.m., in room 2154, Rayburn Office Building, Hon. Carolyn Maloney,

[chairwoman of the committee] presiding.

Present: Representatives Maloney, Lynch, Cooper, Connolly, Krishnamoorthi, Raskin, Rouda, Khanna, Plasket, Welch, Wasserman Schultz, Haaland, Pressley, Kelly, Sarbanes, Gomez, Jordan, Foxx, Massie, Hice, Grothman, Comer, Green, Norman, Cloud, Roy, Keller, Steube, Armstrong, and Higgins.

Chairwoman MALONEY. The Committee will come to order. Without objection, the Chair is authorized to declare a recess of the Committee at any time. I want to inform members that we have a change in schedule. As we explained in the hearing memo, we were planning to do opening statements from 9:30 a.m. to 10 a.m. and testimony and questions from 10 a.m. to 1 p.m.

This morning, we were informed that President Trump and Vice President Pence have called our witnesses to an emergency meeting at the White House. We don't know the details, just that it is extremely urgent. Now the witnesses have to leave at 11:45 a.m. In light of this sudden change, we are going to significantly reduce opening statements. Instead of doing 30 minutes, we will do 10 so we can get right to questions.

For the witnesses, we have your written statements so please keep your oral statements as brief as possible. At 11:45 p.m., we will recess the hearing and we will work with the agencies to determine when the witnesses can return. With that, I recognize myself for a few remarks. I want to thank everyone for being here for this extremely important hearing. Let me say at the outset that our thoughts go out to everyone who is sick or in isolation, including two members of our very own Committee, our colleagues Representative Meadows and Representative Gosar, who cannot be here to participate in today's hearing. We are now in the middle of a global health crisis. Our response as a Nation must be swift, it must be coordinated, and it must be based on science and the facts. That is what we all want on a bipartisan basis.

Unfortunately, when we look at the last three months objectively, it is clear that strategic errors and a failure of leadership impaired

our Nation's ability to respond to this outbreak. This in turn endangers us all. Let's start with testing. The Trump Administration's testing for the Coronavirus has been severely inadequate, plagued by missteps and resulted in substantial deficiency in our ability to determine who may be infected. Yesterday, Director Redfield testified that CDC has tested about 4,900 people.

By comparison, South Korea tested more than 66,000 people with just one—within just one week of its first case of community transmission. South Korea has now tested more than 196,000 people but we are not anywhere close to that. They started conducting drive-thru testing, but people here in the United States can't even get tested by their own doctors. This is the United States of America. We are supposed to be leading the world. Instead, we are trailing far behind. How did South Korea test so many people so quickly, but we didn't even test a fraction of that number? Why did it take so long?

We must do better. Unfortunately, these delays have been systemic. Just last week, the Trump Administration promised to deliver a million tests by the end of the week, but it did not even come close. On Sunday, they admitted that they delivered only 75,000 tests. That is more than 900,000 tests short. And this was their own stated goal to the American people. Now, the Trump Administration is saying that they have distributed 1 million tests and will be distributing 4 million by the end of this week, but that is difficult to believe given their record. We need facts, we need information, and we need it quickly. If we don't have testing, we don't know the full scope of the problem.

And if we don't test people, then you have no idea how many people are infected. We don't even know where community transmission is happening. We don't know where to direct resources. We are operating in the dark. My question is whether the Administration and President Trump is exacerbating the crisis by downplaying it? Over and over again, we have heard blatant misstatements that consistently diminish this crisis and negatively affect our preparations and response.

Last week, President Trump said and I quote, "anybody that needs a test gets a test." He said the tests are beautiful. He was absolutely wrong. My constituents are telling me they can't get tested. The same is true of President Trump's top adviser Larry Kudlow who made this incredible statement two weeks ago and I quote, "we have contained this. I won't say are tight, but pretty close to airtight. The business side, the economic side. I don't think it is going to be an economic tragedy at all.

The numbers are saying the U.S. is holding up nicely." He could not have been more wrong. The stock market just had one of the worst weeks in history with the single biggest point drop of all time in history. The President and his aides may think they are helping with political spin and happy talk, but the American people want the truth. We need the facts. We need accurate information. The CDC has now reported more than 647 cases across 36 states, but according to experts at John Hopkins and others, the real number is far higher.

My home state of New York has 173 confirmed cases, and every Member of Congress is worried about their constituents. As we pro-

ceed this morning, I would like to recognize several of our Subcommittee chairman for their tremendous leadership. This is truly a team effort. Chairman Lynch of the Security Subcommittee held a hearing last week on our Nation's biodefense capacity and he paved the way for today's hearing. Chairman Krishnamoorthy of the Economic and Consumer Policy Subcommittee has been focused on the effects of this crisis on consumers. And Chairman Connolly of the Government Operations Subcommittee has been working with states and localities on the front lines of our response efforts.

I now recognize our distinguished Ranking Member. I would like express my regret that he is moving to chair yet another Committee. Ranking Member Jordan.

Mr. JORDAN. Thank you, Madam Chair. Thank you to our witnesses for being here today and for all your hard work to ensure the safety of the American public and combat the spread of this Coronavirus. We recognize that your task is ongoing. I hope today's discussion will be as efficient as possible so you can get back to work doing the important work that you are doing to help combat this.

I also want to express my condolences to the Americans who have lost loved ones, as the Chair indicated earlier, from the Coronavirus and we pray for those families. We must continue to support the Trump Administration and its work to protect the health and safety of the American people. As Vice President Pence has reiterated and I hope our experts will explain today, the risk to the American people of contracting the Coronavirus remains low.

Even still, as the outbreak continues, it is important for all Americans to follow the best practices to maintain good hygiene. No. 1, you can protect yourself and your family by practicing proper hand washing techniques and washing your hands often. Second, avoid crowds as much as possible and stay home if you are in fact sick. And third, we can protect ourselves from the virus like we do other viruses, for instance, cover your coughs and sneezes, avoid close contact with those who are sick, and clean and disinfect your home frequently. All good common-sense protocols and procedures that we should be implementing.

These steps are common sense. They make sense and they help prevent the spread of the virus. The risk to Americans remains low in large part due to the leadership and early action of the Administration and his team, many of whom are here with us today. When the threats started to emerge from China, which is ground zero for this virus, President Trump recognized the importance of limiting the exposure from those who had traveled there to the American people. That decisive action brought our public health professionals important time to get a head start in preparing for the virus here at home. Since that time, we have seen clusters of community spread. In other words, instances where people have become sick without traveling to affected areas in the world.

There are important steps we can all take to prevent community spread. Those who are experiencing the Coronavirus in their communities can also take steps to limit the spread of this virus. Today, I look forward to our experts offering some specific recommendations on how people can minimize the spread of the Coronavirus. Also want to commend President Trump and Vice

President Pence for safely repatriating the passengers from The Diamond Princess cruise ship in California. Their leadership drew praise from California Governor Newsom.

I also want to commend the American pharmaceutical industry for working to deliver results to fight this virus. The innovation that drives our economy also helps to advance innovations in public health. As HHS Secretary Azar has explained, our pharmaceutical industry has been developing test kits to distribute around the country. The Vice President explained yesterday that over 1 million test kits have been sent out to date. I hope we can learn more about the efforts to increase the number of these test kits that are going to be deployed. We should also understand that an increase in test kits will inevitably show an increase in positive cases around the country.

Last, I want to say that often times in this Committee, we disagree vigorously on many hot-button issues. We don't always see eye-to-eye on matters of oversight. But on this issue, I think we should all work together for the health and well-being of every American. We should not play politics with the Coronavirus. We should not use it as a reason to advance partisan objectives.

Now is the time for us to come together under President Trump's leadership and work to help all Americans. With that, I would like to thank our witnesses again for their work. We are grateful to you and your teams. Please relay our gratitude back to the people who work for you, and work for our country, and work for the American citizens. Madam Chair, I yield back.

Chairwoman MALONEY. Thank you very much, and I would like to begin by introducing our witnesses today. Dr. Anthony Fauci is the Director of the National Institute of Allergy and Infectious Diseases at the National Institute of Health. He has served well over four Presidents. He is truly America's doctor. We are honored to have you testifying today. Thank you for coming.

Dr. Robert Kadlec is the Assistant Secretary for Preparedness and Response a the Department of Health and Human Services. Thank you for coming. And Dr. Robert Redfield is the Director of the Center for Disease Control and Prevention. Thank you for being here today. And Dr. Terry M. Rauch is the Acting Deputy Assistant Secretary of Defense for Health Readiness, Policy and Oversight at the Department of Defense. Thank you for being here.

Mr. Chris Currie is the Director of Emergency Management and National Preparedness for the Government Accountability Office. Thank you for being here.

I will begin by swearing-in the witnesses. And if you will, all please rise and raise your right hand. Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth so help you God?

[Witnesses sworn.]

Chairwoman MALONEY. Let the record show that they answered in the affirmative. Thank you and please be seated. The microphones are very sensitive so speak directly in them and bring them closer to you. Without objection, your written testimony will be part of the record. Thank you all for being here. We appreciate your service. And with that, Dr. Fauci, you are now recognized to provide your testimony.

STATEMENT OF DR. ANTHONY FAUCI, DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTE OF HEALTH

Dr. FAUCI. Thank you very much, Chairwoman Maloney, Ranking Member Jordan, and members of the Committee. Thank you for calling this hearing and thank you for giving me the opportunity to speak to you for a few minutes on the role of the NIH and the research involved in addressing the 2009 novel Coronavirus.

The NIH is involved, as you know, in understanding the pathogenesis of how these viruses work, but also in developing countermeasures. Given the limited time, I would like to have my remarks confined to two aspects. One is the development of vaccines, what is the realistic expectations. And the other is the development of countermeasures in the form of therapeutics.

With regard to vaccines, as I have mentioned publicly many times, we were able to very quickly go from an understanding of what this virus was, to what the genetic sequence was, to actually developing a vaccine. But there is a lot of confusion about developing a vaccine. In the next, I would say, four weeks or so, we will go into what is called a Phase 1 clinical trial to determine if one of the candidates, and there are more than one candidate, there are probably at least 10 or so that are various stages of development.

The one that we have been talking about is one that involves a platform called messenger RNA but it really serves as a prototype for other types of vaccines that are simultaneously being developed. Getting it into Phase 1 in a matter of months is the quickest that anyone has ever done literally in the history of vaccinology. However, the process of developing a vaccine is one that is not that quick. So, we go into Phase 1. It will take about three months to determine if it is safe.

That will bring us three or four months down the pike and then you go into an important phase called Phase 2 to determine if it works. Since this is a vaccine, you don't want to give it to normal, healthy people with the possibility that A, it will hurt them, and B, that it will not work.

So, the phase of determining if it works is critical. That will take at least another eight months or so. So, when you have heard me say we would not have vaccine that would even be ready to start to deploy for a year to a year and a half, that is the timeframe. Now anyone who thinks they are going to go more quickly than that, I believe, will be cutting corners. That would be detrimental.

What does that tell us? It tells us now the next month, the next several months, we are going to have to rely on public health measures to contain this outbreak. So, let me—and I will be happy to answer questions later. Let me just go on quickly to therapy. The timeline for therapy is a little bit different. The reason it is different is that you are giving this candidate therapy to someone who is already ill.

So, the idea of risks and how quickly you determine if and when it works, is much more quickly than giving a lot of vaccine to normal people and determine if you protect them. There are a couple of candidates that are now already in clinical trial. Some of them in China and some of them right here in the United States, particularly in some of the trials that are being done in some of our

clinical centers including the University of Nebraska. It is likely that we will know if they work in the next several months.

I am hoping that we do get a positive signal. If we do, then we may, and I underline may so that it doesn't get in misinterpreted, have therapy that we could use. But that needs to be proven first.

So, in summary, the work that is being done at the NIH is involved both in the development of a vaccine in the long term and in the development, hopefully, of therapies in the shorter term. I will be happy to answer questions after all the presentations. Thank you.

Chairwoman MALONEY. Dr. Redfield, you are now recognized for your testimony.

STATEMENT OF DR. ROBERT REDFIELD, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. REDFIELD. Thank you very much. Good morning, Chairwoman Maloney, and Ranking Member Jordan, and members of the Committee. Thank you for the opportunity to share CDC's role in the U.S. response to this novel Coronavirus. CDC is a science-based, data-driven organization. Science and data drives our decisionmaking and will continue to do so as we form changing guidelines and recommendations. This is a new virus and many uncertainties remain. Our public health response must be flexible.

From the outset, CDC and the U.S. Government partners implemented an aggressive multi-layer strategy to slow the introduction of this virus to the United States to buy time for our scientists to learn how this virus behaves, to prepare our Nation's public health infrastructure and healthcare system for the possibility of a global pandemic that would impact your communities, and to educate Americans on how best to prepare for eventual disruptions to their daily life and the potential risk to their families.

The Administration's interagency containment strategy relied on evidence-based public health interventions. Initially, early case recognition, isolation, and contact tracing, travel advisories, and targeted travel restrictions, the use of quarantine for individuals returning from transmission hot zones such as China, Japan, and now the Grand Princess. Absence of immunity and treatment, our Nation's public health response has relied on traditional public health activities.

As I said, early diagnosis, case isolation, contact tracing, and targeted mitigation to slow the emergence of this virus in the United States. On February 25, this global outbreak reached an inflection point. This was the first day we saw more cases outside of China than inside of China. We observed rapid wide spread person-to-person transmission in South Korea, Iran, and Italy, and long before the first case of communities spread in California.

Science and data collected from here in the United States and abroad are revealing certain characteristics about this virus. At first, the Chinese scientists reported fewer than 30 cases of pneumonia combined to one province, the Hubei province. Today, there is more than 110,000 confirmed cases worldwide, and yesterday 99 percent of the new cases that occurred in the world were outside of China. This virus spreads through respiratory droplets, sneezing, coughing, and hand contamination.

Asymptomatic transmission is possible. Reports out of China looked at more than 70,0000 individuals with this infection and found that 85 or 80 percent of the patients actually developed mild illness and recovered, while 10 to 20 percent developed serious illness. Children and young people seem not to get sick. This disease disproportionately affects older adults and particularly those with serious underlying health conditions.

Two months ago, Chinese scientists shared the genome sequence of the virus to the world, and within a week, CDC scientists developed a diagnostic test that is now being used in more than 75 U.S. public health labs across 50 states with the capacity in the public health system to test up to 75,000 people. As of today, CDC has received confirmation of more than 990 cases of COVID–19 in 38 states plus the District of Columbus. It is with great sadness that I report now 31 deaths in the United States.

As we experience the growing community spread in the United States, the burden of confronting this outbreak is shifting to states and local health professionals on the front lines. We appreciate your support to increase the public health capacity of your communities and our Nation. This difficult, critical decisions are being made by state and local leaders to mitigate the spread and CDC continues to provide guidance and support as requested.

There is not a one-size-fits-all approach to the mitigation decisions that need to be made. They need to be made based on the local situation by local health authorities and civic leaders. CDC has put more than 630 staffers in the field to support the state and local Health Departments in the repatriation efforts.

Finally, CDC is committed to this mission. We will continue to work 24/7 to protect the American people from this significant global health threat. Thank you, and I look forward to your questions.

Chairwoman MALONEY. Thank you. Dr. Kadlec, you are now recognized for your testimony.

STATEMENT OF DR. ROBERT KADLEC, ASSISTANT SECRETARY, PREPAREDNESS AND RESPONSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. KADLEC. Thank you, Chairman Maloney, Ranking Member Jordan, and the distinguished members of the Committee. My remarks will be very brief because I think in some ways we want to retain all the time for your questions, but I do want to acknowledge the vital role Congress has played in this outbreak that began in 2002 with the passage of the Bioterrorism Act that created critical programs like the Public Health Emergency Preparedness Program at CDC, the Hospital Preparedness Program that I manage, and as well as a number of other critical pieces of legislation such as Project Bioshield, the Pandemic All Hazards Preparedness Act, and its reauthorization most recently as the Pandemic All Hazards Preparedness and Advancing Innovation Act, and finally the Public Readiness and Emergency Preparedness Act.

All these tools that you have given us have been vital in confronting this virus in this current outbreak. I also want to acknowledge the role that additional moneys that you provided in supplementals over the years for the H1N1 pandemic in 2009, for the Ebola outbreak in 2014 that helped us create a national Ebola

treatment network that has been vital to manage and care for patients who have been afflicted with this disease.

As far as my role in this activity at this point, I have four principal functions. My first and foremost responsibility as we transition from containment of this disease to a hybrid approach and strategy of containment and mitigation is to be the incident management for the Secretary of Health and Human Services to ensure that we have a unified, coordinated, and synchronized effort across HHS and across the U.S. Government, consistent with the national response framework and emergency support function number eight for medical and public health preparedness and response. I also basically support the healthcare system through the Hospital Preparedness Program and our regional disaster response network that we have created with your support.

Then third, it is basically work with NIH, with FDA, with our DOD colleagues to rapidly develop, accelerate the development of therapeutics, diagnostics, and vaccines that could be used in this outbreak.

And finally, providing direct support to state and local entities. During this most recent event with the Grand Princess that is now docked in Oakland, we are working directly with the state of California, the city of Oakland, and with our interagency partners to safely disembark all those passengers, American and non-American, and manage the crew to ensure that they are safe and return to their homes, but more importantly protecting the communities that will be receiving these individuals.

So, with that, I will yield the remaining of my time back to you, Madam Chairman, and thank you.

Chairwoman MALONEY. Thank you very much. Dr. Rauch, you are now recognized for your testimony.

STATEMENT OF DR. TERRY M. RAUCH, ACTING DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH READINESS POLICY AND OVERSIGHT, DEPARTMENT OF DEFENSE

Dr. RAUCH. Chairman Maloney, Ranking Member Jordan, and members of the Committee, thank you for this opportunity. The Department's top priority is the health and safety of our personnel around the world. To address the COVID–19 outbreak, we immediately disseminate for self-protection guidance beginning early in the outbreak and continue to issue a series of guidance as the situation evolves.

The Department remains aligned with guidance from the CDC, while allowing limited location and command flexibility as required by mission or local circumstances. In the area of for self-protection, the Department issued an initial guidance on January 30, 2020 that addressed the current situation at the time, the risk to DOD personnel, individual prevention and protection measures, healthcare information, patient screening and isolation information, and information on diagnosis, treatment, and reportable medical events.

The guidance also listed the CDC travel advisory level for China and referred to the CDC criteria for identifying a person at risk or under investigation. The guidance also directed personnel on ac-

tions to take if they suspect they have had an increased risk of exposure due to travel or close contacts.

Following the initial for self-protection guidance, on February 7, 2020 we issued guidance for monitoring personnel returning from China. This guidance remained in step with the CDC and provided further measures to prevent the spread of the disease. Furthermore, the guidance directed the identification of service members and a 14-day restriction of movement and monitoring of service members returning from mainland China after February 7, 2020. It has specified actions by the service member during their restriction of movement to reduce the potential spread of disease.

The guidance is recommended to DOD civilian employees, and contractor personnel, and family members returning from China follow existing CDC guidance. On February 25, 2020, the Department issued additional guidance providing a risk-based framework to guide commanders in implementing health protection measures based on local circumstances and their command mission.

The entire series of for self-protection guidance may be found on our defense.gov website. As the Department assesses and manages risk to personnel and mission, the capability to diagnose COVID–19 to better inform treatment decisions and help track disease spread is vital, and one important factor is diagnostic testing capabilities. Currently the Department has 13 labs approved to perform COVID diagnostic testing.

The Department is also working quickly to develop expeditionary lab kits which can be used in the field, military environment to mitigate risk to the Force and mission.

Finally, as we know there is no vaccine to protect the Force. There is no antiviral to treat the Force. Therefore, the Department is working on several vaccine initiatives and an antiviral treatment to protect and treat the Force. This is in collaboration with the interagency efforts.

I am grateful for the opportunity to provide further detail on our efforts to contain and mitigate this outbreak. Thank you to the members of this Committee for your commitment to the men and women of our Armed Forces and the families who support them.

Chairwoman MALONEY. Thank you. Mr. Currie, you are now recognized for your testimony.

STATEMENT OF CHRIS CURRIE, DIRECTOR, EMERGENCY MANAGEMENT AND NATIONAL PREPAREDNESS, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. CURRIE. Thank you, Madam Chairwoman, Mr. Ranking Member, other members of the Committee. As you know, GAO's role is to provide oversight of other Federal agencies. So, what I want to do today is I am talking about two things. First is a report we issued just two weeks ago on the national biodefense strategy for the Federal Government, and second is to offer some observations based on decades of work we have done, looking at past pandemics and outbreaks and public health preparedness.

For decades, we have been concerned about the U.S. preparedness for these types of events. Unlike cyber events or natural disasters, they are rare, which makes it incredibly difficult to maintain focus on these types of things and avoid complacency setting in

once an outbreak is contained. Also biodefense is extremely fragmented across the Federal Government.

There is over two dozen Presidential appointed officials and agencies that have some sort of roles or responsibilities in biodefense, and so coordination just at the Federal level is extremely difficult, let alone state, local, and private level as well. The good news is the strategy that was issued in 2018, according to our assessment, is the most comprehensive to date that we have seen. It does a good job of defining roles and responsibilities, and steps agencies need to take to better coordinate.

We did identify some challenges that we were concerned about. One of those is we still don't see a good mechanism across agencies to coordinate budgets. DHS, CDC, HHS, USDA, they all have separate budgets. They can't tell each other what to do or how to spend their money, and so some sort of centralized oversight mechanism across that is still critical and we recommended that they take steps to address that.

I would like to pivot and talk a little bit about the current outbreak and make it clear that we don't have enough information to conduct a full out assessment of the response right in the middle of the response. That is very difficult. But some of the challenges we are seeing in the public are highlighted by decades of work we have done over the years and past outbreaks and frankly things that we have been concerned about if we had a large domestic outbreak here in the U.S. The first is roles and responsibilities across the Government.

While I think it is pretty clear upfront that the public health emergency HHS is the lead, many questions are still being raised about the roles of other Departments, particularly as this becomes a bigger domestic issue.

For example, the Department of Homeland Security, questions have been raised about whether a Stafford Act Declaration should be brought into play like a natural disaster to bring in additional funding and authorities that provides who communicates with the public at the Federal, state, and local level has been a challenge. This is something we have pointed out before.

On the issue of testing, you know, we have pointed out that HHS has provided over $20 billion since 9/11 in preparedness funding to states and locals. That number has decreased over the years. I think that, you know, this is a direct correlation to the investments we make in preparedness.

Again, it is very, very difficult to sustain these given other priorities when we don't have outbreaks all the time. The last thing I would just mention really quick is moving forward as we conduct after action reviews and exercises.

So, there have been after action reviews done after prior outbreaks. What we see in the emergency management field is that often the after action reviews are conducted really well and then once the outbreak is stopped or the disaster is over, there is no followup on the gaps that are identified in the years to come.

So, this completes my prepared remarks. I look forward to your questions.

Chairwoman MALONEY. Thank you all for your testimony. I now recognize myself for questions. I want to ask about testing. I am

being asked over and over again why the United States is so far behind other countries and why the American people cannot get tested.

Our first case of Coronavirus was on January 21 and the U.S. has tested approximately 4,900 people so far. In contrast, South Korea has already tested almost 200,000 people. They can test 15,000 people a day. South Korea can test more people in one day than we tested over the past two months. So, Dr. Fauci, why are we so far behind Korea in testing and reporting this crisis?

Dr. FAUCI. Thank you very much, Chairwoman Maloney. I would—I don't like to pass the buck, but Dr. Redfield has the numbers and a little map that he might want to show you about that because I don't have that in front of me.

Chairwoman MALONEY. OK. Is the worst yet to come, Dr. Fauci?

Dr. FAUCI. Yes, it is.

Chairwoman MALONEY. Can you elaborate?

Dr. FAUCI. Well, whenever you have an outbreak that you can start seeing community spread, which means by definition that you don't know what the index case is and the way you can approach is by contact tracing, when you have enough of that, then it becomes a situation where you are not going to be able to effectively and efficiently contain it. Whenever you look at the history of outbreaks, what you see now in an un-contained way—and although we are containing it in some respects, we keep getting people coming in from the country that are travel-related.

We have seen that in many of the states that are now involved. Then when you get community spread, it makes the challenge much greater. So, I can say we will see more cases and things will get worse than they are right now.

How much worse it will get will depend on our ability to do two things, to contain the influx in people who are infected coming from the outside and the ability to contain and mitigate within our own country. Bottom line, it is going to get worse.

Chairwoman MALONEY. Well bottom line, Mr. Fauci, if we don't test people, then we don't know how many people are infected. Is that correct?

Dr. FAUCI. That is correct. And as I am sure that Dr. Redfield will tell you, looking forward right now, as commercial entities get involved in making a large amount of test getting variable—when you do two aspects of testing, one a person comes in to a physician and asks for a test because they have symptoms or a circumstance which suggests they may be infected.

The other way to do testing is to do surveillance where you go out into the community and not wait for someone to come in and ask for a task, but you proactively get a test. We are pushing for that and as Dr. Redfield will tell you that the CDC has already started that in six sentinel cities and will expand that in many more cities.

But you are absolutely correct. We need to know how many people, to the best of my ability, are infected, as we say, under the radar screen.

Chairwoman MALONEY. Now, I really want to get to South Korea and their 50 mobile testing sites that they have set up where people can just drive up, get a quick swab, get a test and results in

two days. And this is a question to Dr. Fauci and to Dr. Redfield. These are centers that minimize the interaction between patients. It helps mitigate the risk. And why haven't we set up these mobile labs? Are we planning to set them up? Dr. Fauci and Dr. Redfield?

Dr. FAUCI. Well again, I will start by telling you, the NIH would in no way be responsible for setting that up. So, I can't tell you what I can do.

Chairwoman MALONEY. Dr. Redfield?

Dr. REDFIELD. Just to say very quickly, CDC's role in this was—we very rapidly, within almost 7 to 10 days developed a test from an unknown pathogen once we had the sequence. We did that because we wanted to get eyes on it, CDC, so that the Health Departments across this Nation can send samples to us and we would test them.

Second, we rapidly tried to expand that and scale it up with contractors so each public health lab in this country would have that test. During that process of quality control, we found out one of the reagents wasn't working appropriately and we had to modify that with the FDA that took several weeks to get that completed.

But the test was always available in Atlanta, if you sent the sample to us, and there never was a time when the Health Department could not get a test. They had to send it to Atlanta. Now our Health Departments have 75,000 test. Most Health Departments now, over 75 Health Departments, have the test.

Chairwoman MALONEY. How many tests are we planning to produce in the United States?

Dr. REDFIELD. Well from a public health point of view, we put out 75,000. The other side as Dr. Fauci said, which is really not what CDC does traditionally, is to get the medical private sector to have testing for patients. And when the Vice President brought all the testing companies to the White House last week, we got enormous cooperation from them all to work together.

As we sit here today, Quest and LabCorp are now offering this test in their doctor's offices throughout this country. But it is not for an individual just to take a test, they need to go see a healthcare professional, have an assessment to determine whether a test is indicated, and then get that test.

In New York, just so you know, on February 29, Harold Zucker, your Health Commissioner, asked if he could use our EUA to begin to get Wadsworth approved, and the FDA worked with him within one day and got their test up and running in the state of New York at the Wadsworth lab.

So, we are working hard to get testing available. My role is to get it available for the public health system, and is Dr. Fauci said, start these large surveillance programs, but on the other side there is a private sector to get it to clinical medicine. And I think you will see that with LabCorp and Quest out, those tests are rolling out.

Finally——

Chairwoman MALONEY. Will these that private labs be reporting and are they reporting into CDC their results?

Dr. REDFIELD. We have set up now a surveillance system.

Chairwoman MALONEY. Are they reporting now?

Dr. REDFIELD. It is being worked as we speak today. The LabCorp and Quest will—they dump into our national reporting base.

Chairwoman MALONEY. My time has expired and I recognize the distinguished member—oh, she left. OK. I recognize the gentleman from the great state of Tennessee, Mr. Green is recognized.

Mr. GREEN. Thank you, Madam Chair, and thank the witnesses for being here. I am incredibly disappointed in the politicization of this COVID–19 response. The 24/7 criticism the President is undergoing is unwarranted at a minimum and absolutely maligns the hard work done over years of our Nation's doctors and scientists at places like the CDC, the NIH, the FDA, the HHS, DHS, FEMA, and DOD have prepared for just such an eventuality.

Make no mistake about it, this virus is a serious problem, but that concern was immediately shown by our President as evidenced by his historic response and I would like to take a second to correct the record. On December 31, Wuhan officials posted the first notice saying they were investigating a pneumonia outbreak.

On January 7, the CDC established an incident management system, just seven days later. On January 17, CDC sent 100 plus staffers to specific airports in the United States to screen all people coming from Wuhan. On January 21, just three weeks after the announcement, the CDC activated its Emergency Operations Center.

On January the 29, the President established the Presidential Task Force. On January 30, still less than a month from the initial announcement, the State Department issued a do not travel warning to China. January 30, the World Health Organization announced that the Coronavirus is a public health emergency of international concern, meaning before the World Health Organization even announced a global concern, the Administration was working on its response for almost a month and had already established a Presidential Task Force.

On January 31, to the cries of racism, President Trump proactively suspended entry of foreign nationals who had been to China in the last 14 days. On the 31st, the President issued quarantines, and through Secretary Azar, a public health emergency for the entire Nation. On February 11, the World Health Organization named the virus COVID–19. Let that sink in, the Administration's first response a week after the Wuhan announcement.

The virus hadn't even been named by the World Health Organization yet. It isn't named until day 42. Meanwhile the CDC, the NIH, and all the agencies of our scientific community with acronyms that boggle the mind, have been working feverishly to sequence the RNA of the virus, to get its proteins, messenger RNA sequence and get a vaccine going. On February 24, the President unveiled the initial plan.

Yet according to the leadership of the other party, our President has failed us months of response, and yet they are accusing our President of failing us. On February 26, the President appointed the Vice President head of the whole of Government response. That appointment is in keeping with the 2015 Obama era Blue Ribbon Panel on Biodefense.

On February 29, 60 days after the Chinese announcement, sadly America lost its first victim to COVID–19. So, 53 days before Amer-

ican lost a single life to COVID–19, the Administration was already working diligently to prepare our country. You have heard the witnesses describe the Herculean efforts their various departments are taking to protect the lives and health of Americans.

I want to thank the dedicated men and women of CDC, NIH, FDA, HHS, DHS, FEMA, and DOD for the years of work that has gone into preparing for this type of effort, and their tireless 24/7 response since the announcement just 71 days ago.

America will lose lives to this virus, but as was noted by Obama appointee and former Director of the CDC, Tom Frieden, had the President not responded so quickly, we would not have been prepared as we are and more lives would have been lost. Madam Chairman, I yield.

Chairwoman MALONEY. Thank you. I now recognize the gentleman from Massachusetts, Congressman Lynch. He is recognized for five minutes and I want to thank him for his help in preparing this hearing. Thank you.

Mr. LYNCH. Thank you, Madam Chair, and thank to the witnesses. I want to echo the call for unity that was expressed by the ranking member early in this hearing. I am proud to say that every single member of this Committee, Democrat and Republican, voted for $8.3 billion to deal with the Coronavirus.

We all did so, I think, consistent with your request from our public health officials. I think America is best when we have a unity of purpose, a singularity of mission, and we are all on board. But that much being said, I have to say that the President's statements from the beginning of this has been contrary to the direction that you have given us.

The President on March 6 told the people in my district publicly that the tests were ready. "Anybody who wants a test can go be tested. They are beautiful tests, beautiful tests." That is not a medical term. So, my constituents went to their local health centers, went to their hospitals, there were no tests, zero, zero. I know they are rolling out now, but this was back on the 6th. That is not a good situation.

He said this in front of some of you at a public hearing at a press conference and I saw no one step up and say, no, the President wasn't correct. The tests are not there. They are not ready. They are not beautiful. They are not available. So, we need a unity of purpose but we are not going to get that when the President is telling people that the cases of Coronavirus are going down not up. They doubled yesterday in my district, doubled.

I represent part of Boston. Myself and Ms. Presley share that city. It is not a backwater medically or technically. It is very advanced. The President has made some bizarre statements here. And look, I want to be together with my Republican colleagues but when the President said he has an uncle who went to MIT in the 1930's and that he has a natural affinity and ability for this, it has got to raise some red flags.

We need you to step up. We need—and Dr. Fauci, you have been great on some of the stuff and pushing back. When the President said, we are going to get a vaccine fairly quickly, a matter of months, you know, you were good to step up and say no, it is going to be a year and a half. But you know, we really need honesty here.

And when the President is making statements like this, we need pushback from the public health officials. You know, standing behind him and nodding silently or an eye-roll once in a while is not going to get it. We really need—you know, when I say things that are immediately considered political because I am a Democrat and I am elected, but you know, you have a certain level of credibility and honesty that I think that should be persuasive to the American people.

So, I just ask you to be more forthright when the President makes statements like this. We need leadership but we need people to be very much aware of the dangers that are out there. You know, the cases are not going down. The American people should be aware of that. You should be forthright in explaining that.

When the Secretary of the—when the President's economic director says we got this contained, not quite air tight but almost there, we need you, we need you our public health officials to step up and say that is not true. That is hurting us. That is making the spread of this virus, you know, more extended, more prolific, and more possible.

The American people really have to step up here and make sure that, you know, they are aware of the dangers.

Dr. Fauci?

Dr. FAUCI. I appreciate your comments, but I can tell you absolutely that I tell the President, the Vice President, and everyone on the task force exactly what the scientific data is and what the evidence is. I have never, ever held back telling exactly what is going on from a public health standpoint. Thank you.

Mr. LYNCH. Thank you.

Chairwoman MALONEY. The gentleman's time has expired. The gentlelady from North Carolina, Ms. Foxx, is recognized for five minutes.

Ms. FOXX. Thank you, Madam Chairman, and since our current ranking member did not use all of his time, I may steal some of that in mine and since you went over a little also. Thank you. I want to thank our witnesses for being here and I think the very fact that we are having these hearings they are being held all over the Congress and the fact that there are the press conferences every day disputes what some of our colleagues are saying that the facts are not getting out there.

I want to thank all of you all for being here and for telling the facts to the American people because I do think that is important. And I also want to thank my colleague from Tennessee for outlining what has been done because we tend to forget the good actions that have been taken because of the direct criticism of the President, which I think is totally unwarranted.

I do think it is helpful that we explain the facts but also not scare everybody about this problem, but ask them to be sensible about what they are doing. Dr. Kadlec, I understand that BARDA amended its contracting process to place all proposals not related to Coronavirus in a queue until the threat of this virus subsides.

Nobody has mentioned that but it is really all hands on deck and a focus totally on Coronavirus. Is that correct?

Dr. KADLEC. Yes, ma'am. We are accepting additional proposals on other things related to non-corona activities, but right we are focusing on the immediate concern.

Ms. FOXX. I know that BARDA is a fairly small entity and not a lot of attention has been paid to it, but we need our Nation to remain prepared for all threats including biological, nuclear, and influenza, and that is part of what BARDA does. So, would you mention what additional personnel authority BARDA needs to ensure that its response to COVID–19 and its normal work for biological and nuclear countermeasures is performed as well as possible?

Dr. KADLEC. Yes, ma'am. Some of those authorities I think were given during the supplemental direct hiring authority. There is a proposal that was considered or a consequence of the 21st Century Cures Act, which was creating an innovation platform and we probably need some relief in terms of Federal campaign cap waivers there.

But I think quite frankly, what BARDA has been extraordinary in, in its very short history, is to basically get 50 approvals for a variety of countermeasures and devices that are vaccines, therapeutics, diagnostics in its very short history. It is the little engine that can.

And I think it is one thing that working with NIH, and working with DOD, has been very successful to advance: things like, during the Ebola crisis, diagnostics; as well as what turned out to be the first FDA-approved licensed vaccine for Ebola.

So, I think with resourcing, BARDA can and is a great part of the asper team that really, I think, does provide a significant capability in concert with NIH and with our DOD colleagues.

Ms. FOXX. What you indicate is that there is a lot going on that people aren't aware of, groups of people working within the Government to try to anticipate the kinds of things that happen with the Coronavirus.

We will never be able to stop all kinds of problems like this, but at least we have people working very, very effectively in these areas.

Dr. Redfield, I think Dr. Fauci tossed over to you a few minutes ago the opportunity to speak about some of the issues and the concerns about getting the necessary medical supplies out to people. Would you like to expand on what you weren't able to talk about earlier?

Dr. REDFIELD. I would just like to again try to emphasize the development that we did for the diagnostic test. And again, I do think we developed that very rapidly so that the public health community could have eyes on. That test was at CDC. We rapidly tried to get it to the Health Departments.

During our quality control, we basically found one of the reagents wasn't working. But as I said today, we got the public health labs now throughout this country have adequate testing to do, their public health message and mission. The other side of the mission is the clinical mission and I think that is the concern of most American citizens. How do I get evaluated?

And again, that really has to work through the private sector. It wasn't really the public health lead for CDC to get the laboratory

tests, but I will say that the test we did develop, we published and let everybody use it. They could redevelop it.

There was regulatory relief so any CLIA certified lab, according to the FDA, was given relief. They could develop the test just like we did and they could use it, and some universities have done that. We also were—there was relief to IDT, the manufacturer that made our test for public health purposes. They were given the regulatory relief to actually make that test and sell it to hospitals.

That is the 1 million, 3 million tests that people refer to that are rolling out for that side. But most importantly, and we really need to give credit to the diagnostic companies of this Nation. When they met with the Vice President, they didn't come one company at a time.

They had already agreed as a group they were going to figure out how to get this diagnostic test as rapidly as possible for the American public that needed it. And as I said today, yesterday they began that at both LabCorp and Quest. So, there should be, again, increase in availability across this Nation through the private sector.

Ms. FOXX. I worry about what we heard when we discussed HR3, that were HR3 to become law, that we would lose much of that ability through the private sector to come up with the cures that we need to come up with. So, I am very pleased to see this cooperation with the public-private partnership. And thank you very much Madam Chairwoman, for your indulgence.

Chairwoman MALONEY. Thank you. The gentleman from Tennessee, Mr. Cooper, is recognized for five minutes.

Mr. COOPER. Thank you, Madam Chair. I am delighted to hear the bipartisan praise of our public health workers, our professionals, and I hope that colleagues on both sides of the aisle will heed your good advice. First question, can U.S. doctors or patients order some of these tests from South Korea?

Dr. REDFIELD. Important question when was asked by the chairwoman about the difference. The difference between the South Korean test and our test is they would have to go through our regulatory process in the FDA to get approval to use——

Mr. COOPER. So, the answer is no.

Dr. REDFIELD. Currently no under the regulatory issue.

Mr. COOPER. OK. What are the names of these South Korean companies or enterprises that offer these tests?

Dr. REDFIELD. The basic difference, Congressman, is when we CDC developed our test, if you give me a second, we developed to make sure it could work on the platforms that we would put in all the public health labs. Those platforms were based on our flu surveillance.

So, we used a technique called thermal cycling, which is not a high-throughput. What the Koreans have done is they have used a high throughput platform, which is now being done in New York at the Wadsworth lab and now is being worked on by LabCorp and Quest to bring it in.

So, it is a different platform. Roche is really the company, I think, I am not sure but I can get back to you, which was the platform that they used. It is a high throughput that allows many, many tests to be done a single time.

Mr. COOPER. So, the South Koreans used a Swiss company, or wherever Roche is headquartered, to supply the need?

Dr. REDFIELD. I will get back to you on the specific, sir. Make sure I don't misinform you.

Mr. COOPER. So, American doctors or patients will have to Google this to try to find out because we are not eliciting this information today.

Dr. REDFIELD. We will get back to you. But I will tell you LabCorp and Quest are up aboard and most American doctors either use one of those two lab services for their clinical practice.

Mr. COOPER. Well, LabCorp and Quest are wonderful companies, but still, we are behind South Korea in terms of making testing available. So, how do we solve this gap?

Dr. REDFIELD. What is going on right now, rather than the public health platform that we used—if we had developed a test on the Korean platform, none of our public health labs could have done it because they don't have the instrumentation.

So, right now the private sector and certain labs have begun to transfer that to what we call the high throughput. And so you are going to see those high throughput, the same technology, is going to be approved in the United States and used by different private sector groups.

Mr. COOPER. So, now finally we are turning toward what you call high throughput. And that maybe from Roche or may be from somewhere else or maybe at the Wadsworth lab now in New York, but finally one day we will have it.

Dr. REDFIELD. I would try not to use the word finally. I guess I am not making myself clear. In my role to get it in the public health labs, we build it on a platform that they had the instrumentation.

Mr. COOPER. What is the name of the company that supplied the faulty reagent?

Dr. REDFIELD. Well, it was—we should be careful. The third control did not perform the way we wanted it to perform. There is two possibilities. One that that reagent at that time, there was a contamination, but the other possibility is biologic, that prime repairs folded on themselves and it didn't perform. It has been corrected and the new——

Mr. COPPER. Substandard, faulty, whatever name you want to use, what is the name of that company?

Dr. REDFIELD. Well it was produced by IDT, you know, initially, and we have worked with them to correct that and CDC together.

Mr. COOPER. Are there any plans to have drive-thru testing in America so that we do not panic emergency rooms when people come in and cough?

Dr. REDFIELD. Not at this time. I think we are trying to maintain the relationship between individuals and their health care providers.

Mr. COOPER. That is very interesting as a response. So, the professional monetary relationship comes before public health?

Dr. REDFIELD. No, that was not my point. And maybe Dr. Fauci wants to comment. My point was, in order to assess risk and the appropriateness that these individuals get the proper care, we believe that this is something that still has value to be dealt with

within the setting of clinical medicine. But I will ask Tony to comment.

Dr. FAUCI. It is exactly what you said. It is trying to preserve—not anything about monetary, that is really not a consideration at all. It is the trying to get people to at least on a telephone call basis to be able to phone their physicians ahead of time and say, I believe I have a situation.

The physician would probably say, stay at home and give them the instructions of how to get a test. It is the relationship between the patient and the physician. I have no indication at all of the financial on that.

Mr. COOPER. Well, most Americans don't really have a doctor. They rely on the ER to help and people are panicking ERs apparently. I see that my time has expired. I wish I had more time. Thank you, Madam Chair.

Chairwoman MALONEY. Thank you. The gentleman from Georgia, Mr. Hice, is recognized for five minutes.

Mr. HICE. Thank you, Madam Chair. Thank each of you for being here. Dr. Fauci, you said earlier in answer to a question that you believe the worst is yet to come. I think everyone up here on both sides, we have been in briefings on this.

Many of us on multiple briefings, and I think everyone up here would agree with you from the information we are hearing. I am curious though with the steps that were taken early on from declaring a public health emergency, restricting travel, giving each of your organizations freedom to move forward to try to combat this, and a host of other things, how important was were those decisions? Would we be in a worse situation, for example, had there not been some travel restrictions?

Dr. FAUCI. I believe we would be in a worse position, sir. But if I might, with respect, look ahead now, we need to do a lot more.

Mr. HICE. Oh, there is no question.

Dr. FAUCI. And I would like to maybe use just a few seconds to make a point——

Mr. HICE. Make it quick because I want concise answers because I want to yield.

Dr. FAUCI. I yield back to you.

Mr. HICE. OK. Alright. Thank you. One of the issues, and I do appreciate the cooperating spirit here today. I know Schneider and I, we worked together to put together a bill, he led the way, on trying to make sure medical devices are here if there is a shortage and I think in that kind of spirit of cooperation, we all need to address this issue that is critical to our country. And I am curious specifically on the medical supplies and medical devices. Are we going to be facing a shortage?

Dr. FAUCI. Yes. I believe that if we have a major outbreak, we are definitely vulnerable to shortages, but Dr. Kadlec knows more about that than I do.

Dr. KADLEC. Sir, I would just characterize it at this point, and again, the FDA has a responsibility to look at the entire supply chain of pharmaceuticals and drugs in the country. So, they have had that responsibly.

I am looking at particularly the things that we need for this outbreak right now, and I just want to highlight the issues around some protective equipment, much of it is sourced from overseas.

Some of it is domestically manufactured. And yes, we could have spot shortages. We are working with different companies and different sectors to enhance both their increased capacity here domestically, as well as obtaining supplies from overseas on affected areas to meet the demand.

The most important to man is with health care workers, ensuring they have the respiratory protection and barrier protection so they can see and treat patients without the risk of getting infected and being lost to the cause.

Mr. HICE. OK, thank you. Dr. Redfield, real quickly if you would, is there any way that the regulations, rules that are standing in the way of the FDA from getting tests here, being purchased, is there any way those regs can be waived in a National Emergency?

Dr. REDFIELD. Initially, the regulations were in fact there and that is why we had to go through and get approval. The Commissioner actually gave regulatory relief so that any individual now can go back and——

Mr. HICE. But you just answered a moment ago that we cannot purchase those tests from South Korea and you said because of regulatory interference. My question is, can those regulatory requirements be waived in a National Emergency?

Dr. REDFIELD. I would have to refer that to the Commissioner of the FDA.

Mr. HICE. OK, and last question real quickly and I want to yield to the gentleman from Tennessee. Dr. Redfield, are our tests better than their tests, more accurate?

Dr. REDFIELD. I would say our tests are accurate. I am not going to compare it to theirs.

Mr. HICE. OK. I just want to know if we are talking apples to apples or something else. So, far as you know, South Korean tests are accurate as well?

Dr. REDFIELD. I would assume. I can only comment that our tests are accurate.

Mr. HICE. Alright. With that, I want to yield to the gentleman from Tennessee.

Mr. GREEN. Mr. Hice, thank you. Dr. Redfield, I was on the phone yesterday with the CDC and the NIH and they suggested that the South Korean test used only a single IG and not IGG and IGM. Would you explain to my colleagues here why that single immunoglobulin test versus ours, which is a two immunoglobulin test, why our test is so much better?

Dr. REDFIELD. Congressman, you are referring to the test. Actually the tests that we are currently using and they are using to detect acute infection is to measure the antigen that is in the oral, nasal or pharyngeal space and they are actually using a molecular test for that. What you are referring to is the test that we are trying to develop to understand the full extent of this outbreak.

And that is a serological test. Or they can measure it in oral and nasal secretions and measure certain like an IGG. CDC has developed two serological tests that we are evaluating right now so we can get an idea through surveillance, what is the extent of this out-

break? How many people really are infected? And that is being moved out now to do these extensive surveillance programs.

Mr. GREEN. Madam Chairman, can I get one more question on that same line. Or do you—I can wait for someone else to yield. Thank you.

Chairwoman MALONEY. Let's wait for someone else. I want to try to keep to the five minutes because many members are here and they all have important questions on both sides of the aisle. I now recognize the gentleman from Virginia, Mr. Connolly. He is recognized for five minutes and I appreciate his help on this hearing.

Mr. CONNOLLY. I thank the Chair. Some of my friends on the other side of the aisle, including the ranking member, began sanctimoniously to say we don't want to politicize this issue. It is too important. Well, we didn't politicize the fact that the global health and security biodefense desk at the National Security Council was dismantled by this Administration two years ago.

We didn't politicize the funding of public health in the United States at the budget that in fact made critical cuts, which we restored. We aren't the ones that call the alarm being raised about this pandemic. That is fake news. That came out of the President of the United States mouth and no gas lighting is going to hide that.

And politicization, when the President of the United States finally did go down the CDC with you, Dr. Redfield, we appeared wearing this hat. A campaign hat in the middle of a crisis. We will not be lectured about politicization and all of your words and sanctimony will not cover up the fact that this Administration was not prepared for this crisis and it put lives at risk, American lives at risk.

We didn't have the test we needed. We didn't have a diagnostics we needed. The President made patently false assertions, which Dr. Fauci corrected, about the development of the virus. In fact, he was more concerned about what was happening on the stock market than he seemed to be concerned about American public health. That is shameful and you can't cover that up.

We will not be silent nor will we be intimidated by charges of politicization in pointing it out because lives are at stake. Dr. Redfield, you indicated one size does not fit all and I think that is true. But there is a concern that we don't have any kind of uniform protocols and guidance for localities and states.

So, for example, Mr. Cooper's state has decided not to identify a specific County where a Coronavirus victim may be present, just a region of the state, whereas in my state we are being quite precise about where our victim may be identified.

They corrected that today. But again, there is confusion. Do we close things? Is there a certain number that we are worried about? When do people get tested? How do they get tested? What is the guidance about going to an ER as opposed to seeing your physician? What if you don't have a physician? There is real concern here about the need for more uniformed guidance. Granted one size does not fit all, but that doesn't mean there is no guidance at all and no protocols that states and localities could refer to. Would you comment?

Dr. REDFIELD. Thank you. A very important question. First, we do have very specific guidance for a variety of things that the CDC has published, really targeting more the business community, hospitals, long-term care facilities. But the point you raised, I think, is the most important: what guidance are we giving public health officials to figure out their mitigation strategy based on their circumstance?

And I will so say, yesterday we did post for everyone an algorithm for how they can go through jurisdiction by jurisdiction for what to do for individuals and families at home, what to do for schools and childcare, what to do for assisted living and long-term care facilities, what to do for the workplace, what to do for community and faith organizations, what to do for the healthcare setting because I couldn't agree with you more that we want to give guidance.

We put that out. We are, as we speak today, working with four jurisdictions to get very specific on exactly what CDC is recommending in those four situations so that the rest of the Nation can see how to begin to operationalize it.

Mr. CONNOLLY. And if I could just quickly ask Dr. Fauci, was it a mistake, Dr. Fauci do you believe, to dismantle the office in within the National Security Council charged with global health and security?

Dr. FAUCI. I wouldn't necessarily characterize it as a mistake. I would say we worked very well with that office. It would be nice if the office was still there.

Mr. CONNOLLY. We have a bill to solve that, a bipartisan bill. I thank you and I thank the Chair.

Chairwoman MALONEY. Thank you. The gentleman from Wisconsin, Mr. Grothman, is recognized for five minutes.

Mr. GROTHMAN. Thank you. I would like to—I appreciate you all being here. I bet I have had a chance to talk to you in maybe five or six different panels since this crisis broke and I am glad you are all so ready to come to Washington. I am going to talk a little bit about, I am not sure yet the public overall is in line with the things you are telling us.

I think in part that is because in the past we have had crisis around SARS comes to mind in which we expected all sorts of horrible things to happen. And because maybe all these horrible things didn't happen, the public, or many members of the public, are not that alarmed yet. I want to talk a little bit about the numbers in China and what we expect the numbers to be the United States.

The things I have here show that right now in China there been about 3,000 deaths. Do you guys agree that probably the worst is over in China or do you think that number is going to continue to escalate or slowly drop?

Dr. REDFIELD. I think China is a great sign of encouragement. They had—in the last couple days, they have really gone down to under 50 cases per day. So, they really have now got control of the outbreak.

Mr. GROTHMAN. OK. So, in the United States, when you look at the trajectory of what happened in China and what happened in the United States based upon what over three weeks a month, or how far are we into this situation in the United States?

Dr. REDFIELD. I think that is the critical question, that for a period of time this outbreak seems to go in a very arithmetic way and then it goes logarithmic. So, for example, you can just go back three weeks ago and Italy had hardly any infections. They had almost 1,800 infections confirmed just last night. So, we are fighting hard now between our containment strategy and as Dr. Fauci will say, the expanded mitigation.

Mr. GROTHMAN. Let's compare to something the average American understands and that is the common flu. Can you tell us every year kind of where we start and how much it grows, and how many new people get the flu every day?

Dr. FAUCI. Yes. I can't give you a precise number sir, but one of the things we are trying to emphasize that the American people——

Mr. GROTHMAN. Well, I only met five minutes. Can you tell us about how many people, say, get the flu every year and how many new people are diagnosed with the flu? I didn't hear you.

Dr. FAUCI. Yes, I am sorry. You know, we about five percent or so to 10 percent of the population, we have about 30,000 deaths. It ranges from 15,000 to about 69,000 to 79,000 per year.

Mr. GROTHMAN. OK. Based upon the current trajectory, how many people do you think will get this new virus and how many people do you think will die?

Dr. FAUCI. We cannot predict.

Mr. GROTHMAN. I know you can't predict but there must be, you know, you have a graph, we have the beginning of a graph. We know this is going to go up. We have the experience of China. We have the experience of Italy. Can you can you give us some projections?

Dr. FAUCI. It is going to be totally dependent upon how we respond to it. So, I can't give you a number. If we now sit back complacently——

Mr. GROTHMAN. I am not asking to be complacent. I am asking for a realistic and that is what the public is looking for——

Dr. FAUCI. I can't give you a realistic number until we put into the factor of how we respond. If we are complacent and don't do really aggressive containment and mitigation, the number could go way up and involve many, many millions. If we start the contain, we could flatten it. So, there is no number answer to your question until we act upon it.

Mr. GROTHMAN. I will give you a question. Now you mentioned earlier today that I think one of the basketball tournaments, I think for the Ivy League, they have cutoff their tournament all together on the other. Nobody talks about—every night they play a like, I don't know, 8 to 10 NBA games and nobody talks about shutting them down. Is the NBA under-reacting or is the Ivy League overreacting?

Dr. FAUCI. We would recommend that there not be large crowds. If that means not having any people in the audience on the NBA plays, so be it, but as a public health official, anything that has large crowds is something that would give a risk to spread.

Mr. GROTHMAN. OK, I will just emphasize again. You said about 30,000 people die every year from the regular flu. Do we know the ages of the people so far who are dying of the of the new flu?

Dr. REDFIELD. Yes, so for me for the Coronavirus right now, for example, in Italy the average age of death is over the age of 80. Most of the deaths that we have seen are over the age of 70.

Mr. GROTHMAN. OK, I will yield. Maybe give Dr. Greene another chance to ask a question.

Mr. GREEN. Thank you. Very quickly, Dr. Fauci, you took the Hippocratic Oath right?

Dr. FAUCI. Excuse me?

Mr. GREEN. You took the Hippocratic Oath?

Dr. FAUCI. I did.

Mr. GREEN. OK. Are you offended by someone suggesting that you might intentionally not speak out when you are confronted with something that could harm your patience and violate your Hippocratic Oath?

Dr. FAUCI. Yes, I just made that point a few moments ago. As I have said, I have always, not only with this Administration and Madam Chairperson, you said I served four Presidents, with all due respect to Reagan and George H.W. Bush, I have served six Presidents and I have never done anything other than tell the exact scientific evidence and made policy recommendations based on the science and the evidence.

Chairwoman MALONEY. OK. The gentleman from Illinois, Mr. Krishnamoorthi, is recognized for five minutes.

Mr. KRISHNAMOORTHI. Thank you, Chairwoman. Good morning and thank you for coming in today. Yesterday, the Governor of Illinois said I am very frustrated with the Federal Government. We have not received enough test. I want to understand why. Director Redfield—Director Redfield over here.

The first Coronavirus case in the U.S. was confirmed on January 21. At that point CDC began developing a test kit to diagnose Coronavirus cases. The FDA gave CDC emergency authorization to manufacture and issue this test kit around February 4, isn't that right? Unfortunately, however, testing did not get underway because of the problems with the test kits.

Specifically CDC's Atlanta manufacturing facility had quality control problems. On February 24, one month after Coronavirus was found in America, officials discovered that CDC's Atlanta facility was contaminated.

Whether it was because of the contamination or biologic problems, which you had alluded to, test kits coming from that facility were flawed and had to be replaced, dramatically slowing down our response.

Dr. Redfield, I know you are investigating the cause of the contamination in the Atlanta facility. Is the person who oversaw the Atlanta facility at the time of the contamination still in charge of the current manufacturing process?

Dr. REDFIELD. This is currently under investigation at this point. And I think I am going to leave it there, sir.

Mr. KRISHNAMOORTHI. So, you can't give us assurance that the person who bungled the production process hasn't been removed. Recovering from that misstep cost us precious weeks and now month, sir. Meanwhile the virus spread and people died.

I respectfully disagree with your earlier characterization that we had an aggressive response and we had an early diagnosis when

one month after the first Coronavirus case was detected, we still have not shipped manufacturing and we still not shipped test kits to public labs.

Now, let's currently discuss testing efforts underway in the U.S. and other countries. You have a copy of this chart before you. We talked about South Korea and the U.S. Let me just drill down for a second because this is very instructive.

The U.S. and South Korea both experienced their first confirmed Coronavirus cases roughly within a day of each other. The U.S. on January 21 and South Korea on January 20. Interestingly, both countries developed a test to diagnose Coronavirus roughly around the same time. The U.S. on February 4 and South Korea on February 7, just three days later, but then our testing at that point, the activities diverge dramatically.

Here we have a chart that shows the testing activities of four countries, the U.S., South Korea, Italy, and the UK on three separate dates and three paths in the past three weeks. You see, from 0 till March 10, South Korea tested 4,000 people for every million persons in its population. Italy in the blue bar tested 1,000 people for every million people in the population. UK 400 for every million. Now where is the red bar representing the United States, Dr. Redfield?

Dr. REDFIELD. I don't see it on that graph.

Mr. KRISHNAMOORTHI. I don't see it either but I can assure you that the data is there, it just doesn't show up. It doesn't show up. It turns out that Korea had tested 4,000 people for every million of its citizenry and we are at 15 people for every million people in this country. That is a response.

A testing response is almost three hundred times more aggressive than what is here in this country. And the problem, Dr. Redfield, is that when we don't test as rapidly as we should, the virus spreads and people die. Now let's talk about the situation going forward. Vice President Mike Pence said on Monday, "before the end of this week, another 4 million tests will be distributed."

But the real question I submit is not when the test will be distributed, it is when the tests will be performed on people so that they can know whether they have contracted Coronavirus.

Now South Korea currently tests 15,000 people per day, whether it is through high throughput, low throughput, medium throughput, it doesn't matter. They test 15,000 people per day. Dr. Redfield, when are we going to be reaching 15,000 people per day tested in this country?

Dr. REDFIELD. Well first I would say, Mr. Congressman, it really does depend on the clinical indication. I think one thing I would like to point out again. The CDC developed this test for the United states public health system. We did not develop this test for all of clinical medicine. The test for clinical medicine, we count on the private sector to work together with the FDA to bring those tests to bear. And I said——

Mr. KRISHNAMOORTHI. So, you are blaming the private sector?

Dr. REDFIELD. I am not blaming.

Mr. KRISHNAMOORTHI. You are passing the buck to a private sector. Sir, because of this the virus is spreading, people are getting sick, people are dying. Thank you.

Chairwoman MALONEY. The gentleman yields back. The gentleman from Kentucky, Mr. Comer, is recognized for five minutes.

Mr. COMER. Thank you, Madam Chairman, and I cannot think of a more important Committee hearing that would take place in Congress this week than the one we are having now. And I was very glad to see Congress come together last week in a bipartisan way after we have spent many months in the very partisan environment here with respect to the impeachment hearing.

But Congress came together to pass a very important Corona supplemental that I think everyone would agree is making a huge difference in America's defense against the Coronavirus outbreak. But I have been very disappointed to hear some of the comments by my colleagues on the other side of the aisle. Chairwoman Maloney mentioned the political spin. Mr. Connolly mentioned the politicization and fake news.

I just wanted to mention a couple of things that have been written and said by the press and Democrat leadership. The New York Times a little over two weeks ago had a headline, "Let's call it Trump virus. If you are feeling awful, you know who to blame" and then House Majority Whip Jim Clyburn said when asked if he had confidence in the Administration's response, he said, "absolutely not. They are just fooling around.

It just reminds me so much of Katrina." I take a bit of issue with the politicization of something that should be focused on bipartisanship and working together to save lives because we have a crisis. Americans are truly and rightfully concerned and I think that that Congress needs to work hand-in-hand with the Administration.

I don't believe the Administration has gotten the credit it deserves, especially with respect to the President's decision to cutoff the border, which has undoubtedly given the CDC and health officials time to prepare for this outbreak. I am not confident the last Administration would have made that decision for fear of political incorrectness or whatever.

So, I think the President should get a lot of credit for making that decision. But I want to focus on some things that are important to people in Kentucky because there is a lot of concern, there is a lot of misinformation. So, my simple question would be to anyone on the panel, which are the best website for concerned Americans to get onto that have factual information and important tips on how average everyday Americans can prepare for this?

Dr. FAUCI. So, there are two. One is, the core one is cdc.gov. And within that is Coronavirus.gov. But cdc.gov will ultimately get you very quickly to anywhere you want to go.

Mr. COMER. So, my next question to anyone on the paddle, in the era of fake news and social media, how can Americans ensure that the information that they are sharing on the social media is accurate information? Is there—do you have any advice on that?

Dr. FAUCI. Yes, I think for the most part, at least from my experience, social media can often be as detrimental as it is helpful. That's the reason why, sir, I think the first question that you asked would be, one to go to the source of that data CDC—and I am not CDC, but I am saying CDC is a data-driven organization. And if you really want the facts and the data, I would just go to *cdc.gov*.

Mr. COMER. We will make sure. Our office, I am sure. Just about every office here will start sharing that information. I want to switch gears in my last minute.

Represent, along with Congressman Green, Fort Campbell Military Base, Fort Campbell, Kentucky. Kentucky, Tennessee, but can you tell us what is being done to ensure that there is not an outbreak, first of all, on our Military bases to protect our troops? Second, what our Military is doing to be able to be in a position to help fight this if this is a mass outbreak?

Dr. RAUCH. I will I can take that one. Thank you for the question. So, we have put out a series of for self-protection guidance that is aligned to the CDC recommendations and we have tailored those, that guidance for self-protection for Military Commanders, and particularly for Installation Commanders.

Installation Commanders and Military Commanders have a lot of latitude between right and left limits within our guidance that they can command and protect their Military population. Now, what we are also doing is working with the interagency efforts to develop vaccines and also to develop antiviral treatments.

And we are working with the interagency to develop what we call expeditionary field diagnostic kits because we want kits that we can push far forward. We have missions all over the world. We need to get our medical capability distributed.

Mr. COMER. Well, thank you and hopefully Congress can work with you all in a bipartisan way, we can together and help do everything we can to protect American lives. With that, Madam Chair, I yield back.

Chairwoman MALONEY. The gentleman from Maryland, Mr. Raskin, is recognized for five minutes.

Mr. RASKIN. Thank you. Dr. Fauci, we have got two enemies in this crisis, one is the virus and one is he misinformation about the virus. And I want to quickly clear up a few things that have been said over the course of this process. One was by the President in early February when he said it looks like by April, you know, in theory when it gets a little warmer, it miraculously goes away. Is there any scientific reason to believe that?

Dr. FAUCI. The basis for any surmising that that might happen is based on what we see every year with influenza, which actually as you get to March and April and May, it actually goes way down, and other non-Novel Coronavirus, but common cold Coronaviruses often do that.

So, for someone to at least consider that that might happen is reasonable, but underline but, we do not know what this virus is going to do. We would hope that as we get to warmer weather it would go down, but we can't proceed under that assumption. We have got to assume that it is going to get worse and worse and worse.

Mr. RASKIN. OK, the President predicted that there could be a vaccine in a few months. I think you contradicted that today and I think you contradicted that at that time. I just want you to be very clear. Is there any chance we will have a vaccine in a few months?

Dr. FAUCI. No, I made myself clear in my statement.

Mr. RASKIN. OK. Dr. Redfield, the first case of community spread of Coronavirus took place on February 26. That is infection of someone who did not have a clear travel history to China or direct contact with someone who did. Why wasn't the decision made on February 26 to expand your testing criteria for anyone displaying Corona-like symptoms at that point instead of waiting until March 4 to broaden the criteria?

Dr. REDFIELD. Well, that is a good question, Congressman. I mean we always left the discretion to do testing to the local public health groups. If you look, we always had that discretion. We never refused testing from anybody but we did give guidance, as you point out, originally to do testing for individuals that presented with certain clinical scenarios secondary to travel to China.

Those two cases in California and several others obviously led us to reconsider those and make it very clear that we wanted upfront to tell clinicians if they suspect it and if the Health Department suspected, they should send that sample to the Health Department or us at CDC.

Mr. RASKIN. OK, we have been hearing stories about people who have had very compelling reasons to get tested but were not able to. I will give you one example. A nurse in California was quarantined after treating a patient who had Coronavirus and then showed symptoms of the disease herself.

On March 5, the day after you brought in the testing criteria, she put out a statement about her situation, and she said, "the public County Officer called me and verified my symptoms and agreed with testing but the national CDC would not initiate testing.

They said they would not test me because if I were wearing the recommended protective equipment, then I wouldn't have had the Coronavirus. Are you familiar with this case?

Dr. REDFIELD. No, and I would think that this is a misunderstanding if it did occur.

Mr. RASKIN. OK. So, what is the standing criteria, the existing criteria for testing now so we have no confusion about it?

Dr. REDFIELD. Again, it is the—if a clinical physician, a physician, a nurse practitioner, a healthcare provider feels a test is indicated then we——

Mr. RASKIN. Based on what?

Dr. REDFIELD. Based on their clinical assessment.

Mr. RASKIN. And that is based on the—does it require that the person have to have had contact with someone who had been on a cruise or had been to China?

Dr. REDFIELD. No. This is their clinical assessment. We are not going to judge the clinical assessment. We also say, if it is the clinical assessment of the—if it is the assessment of the public Health Department, those individuals. And again, these are decisions.

What happens is in the time when testing was limited to Health Departments, the local Health Department makes that decision and then they—but they have followed CDC guidance. Now if we made it very clear, it is up to the individual healthcare provider and the individual public health to make that decision.

Mr. RASKIN. OK. Could you make a public service announcement right now for people who are asking the question of whether or not they should be tested? I hear from constituents who are having flu-

like symptoms. They want to know what should they do? What should they do?

Dr. REDFIELD. Well, as Dr. Fauci said, the first thing I would do is to tell them to contact their healthcare provider or their emergency room and tell them they are concerned they may have Coronavirus infection and then follow their instructions to where to get the test. Alright, and then proceed with getting the appropriate clinical evaluation.

Mr. RASKIN. OK, so they should call someone before they go in?

Dr. REDFIELD. Well, we would like to do that because if you really think you are infected, we are trying to avoid someone to walk into a 200-person, 100-person emergency room. First, just a call in advance and then they will arrange exactly how they are going to get to test, how they are going to see the patient. They are going to be prepared when that patient comes to the emergency room. They are going to be able to isolate them, get them tested, get them properly evaluated.

Mr. RASKIN. OK. Thank you for your work on behalf of the American people. I yield back, Madam Chair.

Chairwoman MALONEY. Thank you. The gentleman from Texas, Mr. Cloud, is recognized for five minutes.

Mr. CLOUD. Thank you, Chairwoman. Thank you all for being here today. Appreciate your work on this. Dr. Redfield, I appreciated you talking about the ever changing dynamics of the situation, especially in the sense that scientists even every day are learning more and more on how to deal with this and how to address it.

It has been difficult, of course, to get information out to the public, especially in a hyper politicized environment. I like to spend some time trying to clear the record on that as we try to find the proper balance between creating a proactive, positive response to real threats as opposed to instigating overreaction in the public and finding a healthy balance.

Dr. Fauci, can you, by way of comparison, briefly explain how does COVID–19 compare to other previous health situations, SARS, H1N1, things like that.

Dr. FAUCI. Sure, sir. Thank you for the question. Well SARS was also a Coronavirus in 2002. It infected 8,000 people and it killed about 775. It had a mortality of about 9 to 10 percent. So, that is only 8,000 people in about a year. In the two-and-a-half months that we have had this Coronavirus, as you know, we now have multiple multiples of that.

So, it clearly is not as lethal, and I will get to the lethality in a moment, but it certainly spreads better. Probably for the practical understanding of the American people, the seasonal flu that we deal with every year has a mortality of 0.1 percent. The stated mortality over all of this when you look at all the data including China is about three percent. It first started off as two and now three.

I think if you count all the cases of minimally symptomatic or asymptomatic infection, that probably brings the mortality rate down to somewhere around one percent, which means it is 10 times more lethal than the seasonal flu. I think that is something that people can get their arms around and understand.

Mr. CLOUD. But less lethal than H1NI or SARS?

Dr. FAUCI. Absolutely not. H1N1 is even—the 2009 pandemic of H1N1 was even less lethal than the regular seasonal flu. It was a pandemic——

Mr. CLOUD. I am trying to help the American people know where to appropriately set their gauge.

Dr. FAUCI. I think the gauge is that this is a really serious problem that we have to take seriously. I mean people always say, well the flu, you know, the flu does this, the does that. The flu has immortality of 0.1 percent. This has mortality of ten times that, and that is the reason why I want to emphasize, we have to stay ahead of the game in preventing this.

Mr. CLOUD. OK. Could we speak to the supply chain for a second, Dr. Kadlec. We are telling people to wash their hands, sanitation, all that kind of stuff. A lot of this stuff comes from China. They are going to the stores seeing these dry up. What are we doing from the, I guess, FDA standpoint to ensure supply chains, that we have all these—everything we need.

Dr. KADLEC. Sir, you know, I know there has been a run on Purell but I think water works just as well just in terms of that case, but it does require people to frequently wash their hands and maintain good hygiene, cover the cough, covers sneeze, don't touch your face, and again, ensure that you continue to wash your hands.

Mr. CLOUD. In my understanding in the legislation we just passed last week too, you know, face mask for health professionals. Of course, not for every citizen walking around but for health professionals. Then we have U.S. supplier that could provide them but we, House leadership didn't put the legal framework in it necessarily. Is there anything the FDA is doing to allow U.S. based companies to participate better?

Dr. KADLEC. So, I think one thing the FDA issued was emergency use authorization about expanding the use of particular masks, N95 respirators that could be used. There are two types, one used by industry, one used by the healthcare industry, and basically making that available for increased so the numbers will be increased.

There is a high demand for masks, particularly in the healthcare setting. Depending on what model you use, you may need up to $3.5 billion. That is a high number. That is a model. All models are wrong but some are useful, and that number could be as low as $600 million. And so what we are doing now is we are trying to increase the amount of masks that are available both N95 respirators and surgical masks which could be used in low-risk settings by healthcare workers.

And in that way, we have issued a request for proposal for 500 million masks.

Mr. CLOUD. OK, I have time for one more question so——

Dr. KADLEC. Yes, sir, sorry.

Mr. CLOUD. Regarding testing Dr. Fauci, we have had people calling 911 showing no symptoms, asking for an ambulance to take them to a hospital to be tested. So, who should be tested? At what point should they be tested? At what point are the test actually helpful? What about false negatives, those kind of questions. Who should we really be concerned about?

Dr. FAUCI. OK, so very briefly as Dr. Redfield has responded multiple times on this, there are really two buckets, if you want to call it. If you have someone who has a reason to believe that they are infected, either that they have symptoms or they have come into contact with someone who is either travel-related or who is in fact documented to have been infected, are exposed.

That is something that if you go to a physician, you get a test, and you find that that individual is infected. The other that was discussed a fair amount over the last several minutes is this surveillance type where you are not looking to see if anybody has been exposed, but you want to find what the penetrance of this particular infection is.

That is a different thing than the physician-patient relationship. That is trying to get a feel for what is out there and that is what the CDC is doing now in six sentinel cities.

They will expand that throughout the country so that we will be able to, hopefully very soon, to get an idea, forgetting the people think they might be infected, who actually is infected.

Chairwoman MALONEY. The time has expired. The gentleman from California is recognized for five minutes.

Mr. ROUDA. Thank you, Madam Chair. Like all of the members up here, we are getting constant communication from our constituents wanting more information and I applaud all of you for being forthright with the American public. That is exactly what we need. In times like this, communication is so important.

And if you are going to err on one side or the other, over-communication is clearly more important than under-communication. Dr. Kadlec, I had the fortunate opportunity to be with you earlier this week and see firsthand the work that you are doing to help address this issue as well as your peers.

I want to talk about one of the slides you shared with me and it was a bell curve that showed what would happen across United States as far as the spread of this disease if mitigation efforts were not taken by the American public and your agencies versus mitigation efforts to basically flatten that bell curve.

And I think the primary purpose of that is so that our healthcare facilities and physicians, as well as the supplies, are not for lack of a better term overrun by a steep bell curve. Am I correct in making that statement?

Dr. KADLEC. Yes, sir.

Mr. ROUDA. And I think another way to say it too is not a question of if, it is a question of when the virus continues to spread across the United States, but we want to pace it out as long as possible. Is that a correct statement as well?

Dr. KADLEC. Yes, sir.

Mr. ROUDA. Thank you. One of the issues in helping to address this is the fact that we do not have enough test kits. We know that many individuals, as my fellow member to the right of me, Mr. Raskin, pointed out, there are individuals who have requested test kits and have not been able to access.

My understanding is as late as last Saturday, ground zero in King County, Washington, the healthcare professionals from that facility still did not have access to test kits. Mr. Redfield, do you know if that is true or not?

Dr. REDFIELD. We have provided test kits to the Health Department. The University of Washington has developed their own tests——

Mr. ROUDA. Were those test kits available last Friday?

Dr. REDFIELD. Yes, sir.

Mr. ROUDA. Thank you. And without test kits, is it possible that those who have been susceptible to influenza might have been miscategorized as to what they actually had, that it is quite possible that they actually had COVID–19?

Dr. REDFIELD. The standard practice is the first thing you do is test for influenza. So, if they had influenza, they would be positive for——

Mr. ROUDA. But only if they were tested. But if they weren't tested, we don't know what they have?

Dr. REDFIELD. Correct.

Mr. ROUDA. OK. And if somebody dies from influenza, are we doing post-mortem testing to see whether it was influenza or whether it was COVID–19?

Dr. REDFIELD. There is a surveillance system of death from pneumonia that the CDC has. It is now in every city, every state, every hospital.

Mr. ROUDA. So, we could have people in the United States dying for what appears to be influenza when in fact it could be the Coronavirus or COVID–19?

Dr. REDFIELD. Some cases have been actually diagnosed that way in the United States today.

Mr. ROUDA. Thank you. I want to turn a little bit to the to the CDC website because I really appreciate the information that you are putting out and it is so important to the American public, but I also want to make sure that they fully understand it. On the CDC website, there is a published a guide called, "Framework for mitigation actions for protect communities from COVID–19."

In that graph, it provides three levels of transmission. None, in other words you are in a community where there is no reports of any cases whatsoever. The second area is minimal to moderate. And the third is substantial. Dr. Redfield, how many cases of Coronavirus are considered to be, "minimal to moderate"?

Dr. REDFIELD. Right now when we see basically transmission cases, particularly if they are not linked, we are looking at cases in the 25 to 50 range to see that groups begin to move into the moderate range, sir.

Mr. ROUDA. OK. Thank you. That is helpful. I would suggest that the CDC put that on their website so that the average American can read it and understand exactly the precautions they should take. So, then substantial, I would assume, is when you have 50 cases or more in your community, you can consider it substantial?

Dr. REDFIELD. Yes, sir.

Mr. ROUDA. OK. Thank you. And I would go back to Dr. Fauci, you talked about this is serious. We are seeing activities across the Nation, school closing, sporting events being discussed about having them held in other places, major events being canceled or rescheduled.

This would suggest this is a really serious issue and I share the thoughts of the member from Wisconsin that I think we are con-

cerned that we are not getting the full understanding or modeling that has taken place that would suggest the true impact of this virus across the United States as well as potential models for deaths.

Can you elaborate a little bit—and I get that there is no perfect model, but can you be helpful in helping us understand what we are really looking at here?

Dr. FAUCI. Yes, if you look at the curves of outbreaks, historically, that is similar to this, the curve looks like this and then it goes up exponentially, and that is the reason why it depends on how you respond now. So, if we wait till we have many, many more cases, we will be multiple weeks behind.

You know, I use the analogy at the press conference yesterday and I will use it today. It is the old metaphor, the Wayne Gretzky approach. You know, you skate not to where the puck is but to where the puck is going to be. If we don't do very serious mitigation now then what is going to happen is that we are going to be weeks behind and the horse is going to be out of the barn.

And that is the reason why we have been saying, even in areas of the country where there are no or few cases, we have got to change our behavior. We have to essentially assume that we are going to get hit. And that is why we talk about making mitigation and containment in a much more vigorous way. People ask, why would you want to make any mitigation, we don't have any cases. That is when you do it because we want this curve to be this, and it is not going to do that unless we act now.

Mr. ROUDA. Thank you, doctor. Madam Chair, I yield back.

Chairwoman MALONEY. Thank you. Thank you so much. The gentleman from Ohio, Mr. Gibbs, is recognized for five minutes.

Mr. GIBBS. Thank you, Madam Chair, and thank you all for the work you are doing. The huge challenge and I know the stress you must be under and could never thank you enough because I think CDC and all our agencies are doing the best they can in this unprecedented circumstance. I also was glad to see Governor Newsom, California come out and say some good things the Administration is doing and the help, and I think the Government in Washington should do the same.

You know, just talking about politicization which shouldn't happen. We should be together on this. But one thing that really astounded me was all the talking heads and some Members of Congress criticizing Vice President Mike Pence take the lead on this, head this up because he is not a medical professional.

I would think when I look at this that a person at that that office, that level, that office that helps bring the agencies together, whether maybe help clean out some of the red tape and bureaucracy, would you concur that that has been helpful to have that level—our top level our Government involved at that level for your working relationship when you are especially working between agencies?

Dr. FAUCI. Yes, sir.

Dr. REDFIELD. Absolutely.

Mr. GIBBS. I just make that point because I hear that criticism and I think that they are either being political or they don't know what the heck they are talking about. Probably a little of both. I

also think it is amazing, and I want to praise the CDC has done to develop a test in one week. Is that unprecedented to develop a test——

Dr. REDFIELD. I am going to have my friend, Dr. Fauci, answer.

Dr. FAUCI. I mean, obviously the technologies of today, being able to develop a test as quickly as that, the same way as we were able to use the sequence to get a vaccine started at least in the trial——

Mr. GIBBS. And I fully understand the vaccine because you have got all the testing of a good safety, efficacy, and all that, but we are relatively close to an anti-viral——

Dr. FAUCI. You know, you say relatively close but we don't know if it works so I don't want to promise anything. We are testing them. If they are effective, they will be distributed but you don't want to do that unless you know they are effective.

Mr. GIBBS. I do want to talk a little bit about the timeline. You know, it broke in China and then South Korea, Japan, Italy, and the United States, and you know elsewhere.

As you say, it has really mushroomed. Seems to me when the next four weeks for us are really critical because it is—can we kind of maybe think we are getting information on China. I know sometimes it is not reliable. But also, we are seeing it happen in South Korea and Japan. And maybe they peaked a little bit? Maybe they are on the better side that curved now?

Dr. REDFIELD. I think, you know, I think you are right Congressman. Clearly China has got controlled of the outbreak. They had 20 cases in the last 24 hours. Where our real threat right now is Europe. That is where the cases are coming in for. So, in a way if you want to just be blunt, Europe is the new China.

Mr. GIBBS. OK. I praise you, Dr. Fauci, talking about doing as much mitigation as we can. It is critical but would you concur that my assessment, the next the rest of this month and next four weeks, is the really critical time for us?

Dr. FAUCI. It is critical, yes. And it is critical because we must be much more serious as a country about what we might expect. We cannot look at and say, well, they are only a couple of cases here, that is good, because a couple of cases today are going to be many, many cases tomorrow.

Dr. REDFIELD. We would like all Americans to take a good look at that mitigation strategy, as Tony said. We have zero, but they need to be fully engaged in that mitigation strategy as well as those with moderate and more severe. This is a time for everyone to get engaged. This is not just a response for the Government and the public health system, it is a response for all of Americans.

Mr. GIBBS. I understand that. Another thing that is not really being reported because it doesn't—it is not as you know, raises the ratings, everybody is talking about it, the number of cases and the number fatalities, but also I have seen the reports worldwide. We have better than 50 percent recovery rates, is that right?

Dr. REDFIELD. Right now we would say it's probably about 85 percent, sir.

Mr. GIBBS. No, 85 percent of people affected are——

Dr. REDFIELD. Are recovering. 80 to 85—about 15 to 20 percent——

Mr. GIBBS. OK. I was just looking at the John Hopkins real time chart and there are like 120,000 confirmed cases and about 60,000 or something like that——

Dr. FAUCI. Any times when you look at the chart it is about half. But at the end of the day, if you look at historically, for example the experience we have had with China, about 80 percent of them have the disease that makes people sick but they ultimately recover without substantial medical intervention. It is 15 to 20 percent that have the serious disease and high mortality.

Mr. GIBBS. And the bulk of them have been people with underlying health conditions and over 70, right?

Dr. FAUCI. The elderly as well as people with underlying conditions like heart disease, lung disease.

Mr. GIBBS. I am out of time. I just want to say I think we need to do what we need to do, be vigilant, but we also need to be responsible and not lose our heads on this because I think we are going to get over this with time, with the great work you are doing. Thank you. I yield back.

Chairwoman MALONEY. Thank you. The gentleman from California, Mr. Khanna, is recognized for five minutes.

Mr. KHANNA. Thank you, Madam Chair. First, let me thank you, Dr. Fauci. I have known you, worked with you, and I have complete confidence in your leadership and appreciate your service.

And Dr. Redfield, I think it is important to realize that you have served our country in the Army, you serve this Nation—we need to be focused not on personalizing this but figuring out what we can do to solve the issue. Now, one of the things that I think they should teach us as a country with all the anti-Government rhetoric, why do we need Government, Government is the problem.

How about we consider how inadequately we have been funding Government and public health. The CDC budget is $11 billion, 1.5 percent of our defense budget, $738 billion. Dr. Redfield, do you think our country would have been safer if let's say we had twice the CDC budget, if we had put that three percent of our national defense budget in our capacity?

Dr. REDFIELD. Thank you, Congressman. I think it is important to realize that for, you know, decades we have underinvested in the public health infrastructure of this Nation. As many of you know, CDC's funding that we get from Congress, about 70 percent of it goes out to local and state, territorial and tribal Health Departments. They are the backbone of our health system.

And if anything, I think you can look, I would rather see during my legacy to help over prepare our Nation's public health system with what I call the core capabilities of data modernization and predictive analysis, laboratory capacity at the local, public health labs, making sure we have the human personnel and the public health communities, the rapid response fund that we are very appreciative that Congress gave us, and build a global health security platform for the 2030, 2050——

Mr. KHANNA. And Dr. Redfield, while you have the country's attention, how much would that cost? Because right now we are spending—I think most people realize this is a national security issue and we are putting 1.5 percent into the CDC of the defense budget.

The NIH budget is $41 billion which is less than five percent of National Security. I mean, why isn't there bipartisan call to double these budgets, triple these budgets. I mean, what would you ask the American people and Congress to prepare?

Dr. REDFIELD. I appreciate the opportunity Congressman and I would have to get the back to you with an exact estimate of all that.

Mr. KHANNA. Dr. Fauci, do you have a view——

Dr. FAUCI. Yes, I mean we have been well funded at the NIH but I think that we need to continue to have a consistent well funding. What happens is that there is inconsistency at times but luckily over the last four or five years the Congress has been quite generous with us.

Mr. KHANNA. One question I do have is the WHO had tests and some of the other countries use these tests. Why shouldn't we be using these tests?

Dr. REDFIELD. I think it is important to understand about the key for proving test in this country from other countries. They can go ahead and apply through the FDA and get registration and be dispersed.

Obviously, one of the reasons we developed the test that we developed was to try to make it as available as rapidly to the American public health. So, I would defer that question to the Commissioner at what the exact hoops are for the foreign companies to get their test approved.

Mr. KHANNA. Do you think we need to look at streamlining these types of crisis approval for things like WHO testing, which 60 other countries are using or there are stories in the New York Times about how leading scientists have come up with tests in Seattle that weren't approved. I mean is there has got to be a better way of getting these tests out there.

Dr. REDFIELD. I will say that when this was recognized when I was practicing in the Army, I could develop a test and then use it in clinical medicine. Somehow between then and now there was not regulatory discretion for us to do laboratory developed tests. The Commissioner did though, I think it was on February 29, issue regulatory discretion. So, the University of Washington or say Columbia could actually develop their own tests and actually use it, rather than have to file what we call an emergency use authorization. They could start using their test and file that 15 days later.

Mr. KHANNA. Let me ask one final question. I genuinely believe that we have the most brilliant scientists and entrepreneurs in the world in the United States, and the question is if we want to come up with an antiviral treatment, vaccine treatment, what it is—and I want both Dr. Fauci and Dr. Redfield to answer. What is it more that you need from Congress? Because no one cares about us lecturing people. No one cares about what we have to do. What are the resources that you need so the scientists and the technology and the entrepreneurs can solve this?

Dr. FAUCI. From the NIH standpoint, it is the consistency of funding which thankfully you have been able to do. You go back to 1998 to 2003, you doubled the NIH budget. Then we went through a very, very flat long period of time which actually was very difficult because it discouraged young investigators from get-

ting involved. For the last few years, we have had a good consistent increase. What you can do is to continue to give the kind of investment in medical research that is consistent and predictable.

Dr. REDFIELD. I would say first and foremost, the most important thing that you already have done is the establishment of the rapid response fund. You know, prior to that, we would have to go to our foundation, and ask them to raise money for us to respond to an emergency. The more flexibility you can do, enabling CDC to have a rapid infectious disease response fund, I think is really one of the most important tools we have right now. And you all have started to do that already and we are very thankful.

Chairwoman MALONEY. So, thank you for that important point. The gentleman's time has expired, and let me intervene here. I have been told that our witnesses need to leave now. I don't know what is going on at the White House. The White House is telling reporters that this meeting is not an emergency. They are saying it was scheduled yesterday. However, that is not what your staff has told us.

Your staff said the White House did not tell them about this sudden meeting until this morning, right before our hearing. There seems to be a great deal of confusion and a lack of coordination at the White House. I hope this does not reflect on the broader response to this crisis. We have asked your staff if you can come back and resume this hearing at 2 p.m. after your meeting at the White House. They have not responded to our request.

And I am not going to adjourn this hearing. I am going to recess it. We haven't even gotten through half of our members, either side—excuse me. I will finish in a second. You haven't even gotten through half of our members. We will continue to work with your staff to have you back to finish the hearing and answer the rest of the questions from our members.

Finally, let me close with this, this Committee sent you a request for information a week ago. We asked for basic information about the crisis and your plans for the response, but you have not provided us with anything. We understand that you are incredibly busy but a lot of this information should be at your fingertips.

We need this information because we keep getting sometimes misinformation from the White House and we have an independent obligation to the American people. So, I have one last question, will you commit to producing the information we requested at least regarding testing, Dr. Fauci?

Dr. FAUCI. Madam Chairperson, I am not sure what information referring to that we did not provide. Are you talking about the National Institute of Allergy and Infectious Diseases?

Chairwoman MALONEY. We sent a letter with all the Subcommittee chairs and myself requesting information to every Department, yours, the CDC, FDA.

Dr. FAUCI. I will check this immediately after to find out what the issue is.

Chairwoman MALONEY. Thank you. Thank you very much.

Mr. ROY. Madam Chairman, may I interject you for one second. I have got timely issue. I know you all need to go down to the White House——

Ms. SCHULTZ. Madam Chair, I do as well. I have a very specific District related question. There are people in danger——

Mr. ROY. Madam Chair, I just—I have got the floor here——

Chairwoman MALONEY. Please, please, we will yield to the ranking member and then to the gentlelady from Florida for the last question—regular order. We are going to go to a recess after I recognize the ranking member for his closing statement.

Mr. ROY. Well, I appreciate the Chairwoman. We all recognize the importance of what is going on here. And I think it is important to have level heads about what is happening and that we want to make sure that you guys can go do your work but it is important that you come back. It is extremely important that you come back. We do have urgent questions.

I believe that the gentlelady from Florida has extreme concerns of urgency to the people that she represents. I can tell you that I do representing San Antonio. I sent a letter, Dr. Rauch, to the Department of Defense two and a half weeks ago and I have not received a response because I am troubled about the lack of response from the Department of Defense in helping us deal with the fact that we have people who have tested positive who are being held at an Air Force base in San Antonio and we don't have a plan on what to do with them.

I want answers to these questions and I want to be able to have you all respond to those questions when we come back. And I hope that will be this afternoon regardless of whatever is needs to be discussed at the other end of Pennsylvania Avenue.

I think there are very serious concerns that some of us want to have addressed and I think that right now we have got 380 evacuees heading to a base in San Antonio yet I have got an email right here from city council mayor and leadership in San Antonio saying they don't have adequate plans on what to do with those who have tested positive.

So, I expect you all to come back down here today in accordance with what the Chair is asking so that we can have those questions answered. Thank you.

Chairwoman MALONEY. Well, responding to the ranking member, will you all be back at 2 p.m. today?

Dr. FAUCI. We are going to have to see—the reason I am saying that, Madame Chairperson, is that we have a Task Force meeting at—what time is it? We have a task force meeting at 3:30 p.m. in the White House. I will get myself down here at 2 p.m. if you would like me down here, but I would have to be at the Task Force meeting at 3:30 p.m. in the White House. I don't know how we are going to work that.

Chairwoman MALONEY. We will continue discussion. We will stand at recess so that you can get to this meeting. We are in recess. Thank you.

[Recess.]

Chairwoman MALONEY. The Committee will come to order. I want to thank some of our witnesses, Dr. Kadlec, Dr. Rauch, and Mr. Currie for coming back. We are deeply appreciative for your time and your service. I have an update on our scheduling.

Before I do that, I want to point out two critical developments just since we recessed this morning. First, the World Health Orga-

nization has now officially declared the Coronavirus outbreak to be a pandemic.

Second, the number of confirmed cases has skyrocketed to 938. Just four days ago, it was 164. That is more than fivefold increase just this week. In terms of resuming our hearing today, we have been informed that Dr. Fauci and Dr. Redfield have been unavoidably detained at the White House. We don't know what is going on, but they cannot come back.

As a result, we will resume this hearing tomorrow, Thursday, at 11 a.m. We have been informed by the agencies they will all be here and we hope to have enough time to finish all of our members' questioning. Therefore, the Committee will stand in recess until 11 a.m. tomorrow.

[Whereupon, at 2:43 p.m., the committee recessed, to reconvene at 11 a.m., Thursday, March 12, 2020.]

CORONAVIRUS PREPAREDNESS AND RESPONSE (Day 2)

Thursday, March 12, 2020

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM
Washington, DC.

The committee met, pursuant to notice, at 11:05 a.m., in room 2154, Rayburn House Office Building, Hon. Carolyn B. Maloney [chairwoman of the committee] presiding.

Present: Representatives Maloney, Norton, Clay, Wasserman Schultz, Sarbanes, Welch, Kelly, Plaskett, Pressley, Gomez, Tlaib, Porter, Haaland, Jordan, Higgins, Norman, Roy, Green, and Keller.

Chairwoman MALONEY. The committee will come to order. I thank all of our witnesses for returning this morning. We appreciate the recognition of our interest and our oversight responsibilities.

This is a crisis that is evolving quickly. Since our hearing yesterday, the World Health Organization declared the coronavirus outbreak a global pandemic.

CDC has now reported that we have almost 1,000 confirmed cases. That is up from 100 reported cases a week ago, a 900 percent increase.

Americans are worried. They are scared. It is essential that we are able to hear directly from the health officials leading this effort with just the facts.

I am going to go to the Republican side first, which is where we left off. Before I do that, without objection, the following three letters we sent on March 3 to HHS and CDC requesting basic information including about testing are entered into the record.

Chairwoman MALONEY. We have not gotten any response to those letters and, with that, I recognize Mr. Higgins.

Mr. HIGGINS. Thank you, Madam Chair.

Dr. Fauci, gentlemen, thank you for returning today and let me ask Dr. Fauci, do you lead the Executives Task Force regarding our Nation's response to coronavirus?

Dr. FAUCI. No, I don't, sir.

Mr. HIGGINS. Your status is what on the task force?

Dr. FAUCI. No, I don't—I don't lead the task force. The task force is led by the vice president of the United States——

Mr. HIGGINS. Yes. Understood. But you are the lead scientist is my question.

Dr. FAUCI. We have several scientists. We have myself. Dr. Redfield. We have Dr. Burkes. We have Dr. Kadlec. We have several scientists.

Mr. HIGGINS. Right. The scientists I have spoken with in committee see you as the lead man and I believe most of America does, and we greatly respect you and these gentlemen being here today.

However, let me clarify for America watching that according to the rules of this committee, members have the opportunity to submit our questions in writing, and given the nature of this challenge and the president's announcements of last night, with all due respect, Madam Chair, I believe that this hearing should have been canceled or postponed and these gentlemen should be able to go and do their work. There is a time—there is a time in battle when you need your front-line men on the front line, not in the rear with the gear.

And these gentlemen showed us great respect to be here today, and the oversight role is incredibly important. But you gentleman have work to do. I will be submitting my questions in writing and my office will publish those questions and your answers in a press release at a later date.

Madam Chair, I urge you to consider adjourning this hearing and I yield the balance of my time to the ranking member.

Mr. JORDAN. I thank the gentleman for yielding.

I would now yield to the—if it is appropriate the chair would yield to the gentleman from Tennessee, Mr. Green.

Mr. GREEN. Thank you, Mr. Ranking Member and Mr. Higgins.

My first question is for Mr. Kadlec. I want to talk a little bit about PPE, if I could, and a concern about liability and the liability protections that might be very important for, you know, the fact that this is such a catastrophic event and we are—we are pushing to the extreme our stocks on PPE.

If you could comment about that and, specifically, the liability issues.

Dr. KADLEC. Yes, sir. You are correct that there is a great demand for personal protective equipment, particularly respirators—N95 respirators. There—we have a limited supply in our Strategic National Stockpile.

Annually, about 350 million respirators are used. Only a small percentage of that is used by the health care industry, about 35 million, and we believe that the demand for that could be several hundred million to up to a billion in a six-month period. So, it is a very high demand item.

There has been a strategy to basically, and CDC had provided guidance on reuse—how can we use them longer. We have gone to the manufacturers in how they can surge more and many of them are doing that, and domestically, even though some of their sources for product—finished product—is from overseas like China.

And then the third thing is is what can we do to basically use masks that haven't been used for the medical area. Nonmedical N95s could be used in that fashion, and FDA is basically certified through an emergency use authorization. The N95 respirators used in manufacturing and in mining and in construction could be used in health care settings.

They are very similar but not the same, but could be used that way. And the only thing that is keeping a lot of manufacturers from selling those masks to the broader health care population is because of liability provisions or lack of liability protections.

There is the Public Readiness Emergency Preparedness Act that was passed in 2005 that basically indemnifies manufacturers, distributors, and users of these masks or, pardon me, of users of products that are defined as a device or as a covered countermeasure.

When we—so I happened to be on the staff that did that legislation in 2005. We did not consider a situation like this today. We thought about vaccines. We thought about therapeutics.

We never thought about respirators of being our first and only line of defense for health care workers. So, we think that is a very important capacity and capability is to include language or modify the PREP Act to include language to include respiratory protective devices for that purpose and that is a significant critical pass now item.

Mr. GREEN. Thank you very much for that—for that answer.

Dr. Redfield, I had a bunch of constituents ask me after yesterday's hearing what is the difference between a public health lab and a commercial health lab?

Now, everybody in this room kind of understands that. But what you, for the record, and for the folks that are watching on TV make the clarification between those in the few seconds I have left?

Dr. REDFIELD. Thank you very much. We have a series of public health labs throughout this country whose primary purpose is to do surveillance to kind of get eyes on what is going on in the community, and CDC has worked cooperatively with them.

As you know, about 70 percent of our funding that we get from you all is then distributed to the state and local, territory, and tribal health departments, including their public health labs.

There is also clinical medicine—the practice of clinical medicine, the private sector, that actually tries to provide diagnostics so we can diagnose diabetes or anemia, lots of different diseases and it is really the engagement of the private sector to get these tests into clinical medicine, which is—it is a partnership between the private sector. CDC usually develops the test first, gets it out into the health departments to do surveillance, and then the private sector comes in to provide the clinical tools we need to basically diagnose patients, not the surveillance of a community.

Mr. GREEN. OK.

Chairwoman MALONEY. OK. Thank you.

The gentlelady from Florida, Ms. Wasserman Schultz, is recognized for five minutes.

Ms. WASSERMAN SCHULTZ. Thank you, Madam Chair.

Dr. Redfield, yesterday my colleague, Mr. Raskin, asked you about a nurse in California who was quarantined after treating a patient with coronavirus and showing symptoms of the disease herself. She couldn't get tested, if you recall, even though her local public health department recommended one.

She said this, and I quote, "The public county officer called me and verified my symptoms and agreed with testing. But the national CDC would not initiate testing. They said they would not

test me because if I were wearing the recommended protective equipment then I wouldn't have the coronavirus."

Dr. Redfield, when you were asked about this yesterday you said this, and I quote, "This is a misunderstanding, if it did occur."

You testified that, quote, "The test was always available in Atlanta, where CDC is located. If you sent the sample to us and there was never a time when a health department could not get a test, they had to send it to Atlanta."

You claimed that CDC's testing criteria never placed restrictions on who got tested. Rather, that that was only guidance and, quote, "We always left the discretion to do testing to the local public health group."

So, the committee staff reached out to National Nurses United, the union representing this nurse who was not able to receive a test and they sent us the following statement last night, and Madame Chair, I ask unanimous consent that this Statement be entered into the record.

Chairwoman MALONEY. So, granted.

Ms. WASSERMAN SCHULTZ. According to National Nurses United, "In recent weeks our union has been made aware of multiple circumstances"—and the statement is up on the screen—"multiple circumstances in which health care workers have been exposed to a 0919 infection and have not received COVID–19 tests, despite requests for testing."

They continue, "There have been too many cases where exposed health care workers have been refused testing for this to be considered a misunderstanding.

Further, members of our union across the country have reported countless cases in which testing has been refused to patients when clinicians have recommended it."

Dr. Redfield, the national union that represents nurses across this country just issued a statement publicly contradicting your testimony yesterday before this committee.

So, I ask this question, will you admit that there is a serious problem in this country with individuals, even health care workers, obtaining access to testing for coronavirus?

You have to turn your mic on.

Dr. REDFIELD. Thank you for your question, Congresswoman.

Ms. WASSERMAN SCHULTZ. You are welcome.

Dr. REDFIELD. I am going to be looking into this in depth, as I said yesterday. Clearly, we need to protect the health care workers on the front lines. In general, these are local decisions on which health care workers need to be tested and exposed by the——

Ms. WASSERMAN SCHULTZ. OK. But these are workers that—these are people who contacted CDC and it is CDC that they say turned them down and said that they couldn't be tested.

Dr. REDFIELD. And I will look into that in detail and get back to your office in—as soon as I can.

Ms. WASSERMAN SCHULTZ. Well, as soon as you can, hopefully, will be today. There are countless more examples of problems with people getting access to tests all across the country including in my home state of Florida.

We need to have someone in charge of making sure that as many people as possible across this country have access to getting tested as soon as possible.

Who is that person? Is it you? Is it the vice president? Can you give us the name of who can guarantee that anyone but especially health care workers who need to be tested can be?

Dr. REDFIELD. As I tried to explain to Congressman Green, from the CDC perspective——

Ms. WASSERMAN SCHULTZ. OK. I am asking for a name. Who is in charge of making sure that people who need to get tested, who are indicated to be tested, can get a test? Who?

Dr. REDFIELD. Yes, I was trying to say that the responsibility that I have at CDC is to make sure all the public health labs have it and they can make the judgment on how they want to use it.

Ms. WASSERMAN SCHULTZ. But they are referencing people who have been advised to be tested to you and they have been turned down. So, is it you?

Dr. REDFIELD. As I said, I am going to look into the specifics there for——

Ms. WASSERMAN SCHULTZ. I know that. So, basically, you are saying—reclaiming my time. Basically, you seem to be saying, because you can't name anyone specifically, that there is no one specifically in charge that we can count on to make sure that people who need to be tested, health care workers or anyone else. There is not one person that can ensure that these tests can be administered. Yes or no?

Dr. FAUCI. My colleague is looking at me to answer that. Here we go.

Ms. WASSERMAN SCHULTZ. OK.

Dr. FAUCI. All right. So——

Ms. WASSERMAN SCHULTZ. And I do have another question so if we can kind of get to hear the question.

Dr. FAUCI. So, very quickly, the system—the system does not—is not really geared to what we need right now, what you are asking for. That is a failing.

Ms. WASSERMAN SCHULTZ. And—a failing, yes.

Dr. FAUCI. It is a failing. Let us admit it. The fact is the way the system was set up is that the public health component that Dr.—that Dr. Redfield was talking about was a system where you put it out there in the public and a physician asks for it and you get it.

Ms. WASSERMAN SCHULTZ. OK.

Dr. FAUCI. The idea of anybody getting it easily the way people in other country are doing it we are not set up for that. Do I think we should be? Yes. But we are not.

Ms. WASSERMAN SCHULTZ. OK. That is really disturbing, and I appreciate the information.

Madam Chair, if I can just, quickly, as my other question, which is the question I wanted to ask yesterday.

We have four—in my home county we have four positive Port Everglades workers who were tested positive for coronavirus.

These employees, according to our State Department of Health, likely contracted the virus with interactions with infected passengers on ships that they were working at the time during their

shift, ships that held—six to eight ships that likely held upwards of 50,000 passengers.

The people on these ships who were potentially exposed should have been notified so they could have taken swift steps to protect themselves and others. They deserve to know that they had been exposed to someone with the virus.

Yet, when I asked our Department of Health what steps were being taken to determine who came in contact with these employees—when I asked the port, the cruise lines yesterday, the State Department of Health, the department was not forthcoming, didn't direct the cruise lines to notify the passengers.

Instead of being forthcoming with me, the public and those passengers, I couldn't get a straight answer from the Department of Health and they said that they were going by CDC guidelines.

So, Mr. Redfield, what—Dr. Redfield, what are the CDC guidelines for notifying people who have potentially been exposed to a confirmed coronavirus case and shouldn't passengers on the relevant ships worked by the Port Everglades employees who have coronavirus been notified in a timely manner so they can take precautionary measures? They still haven't been notified.

Dr. REDFIELD. Thank you very much, again, for both your concern and your question. I know you got a chance to speak to Admiral Rendon I think yesterday about that.

Ms. WASSERMAN SCHULTZ. Yes.

Dr. REDFIELD. And CDC last night spoke with the Princess Cruise staff about this situation. They agreed to send a notice to all passengers on the ship where the greeters have worked. We are, obviously, in contact today with the Florida Health Department.

We would concur that individuals that have been exposed, particularly in a cruise setting, should be notified. I think the controversy here, Congressman, is its—I think the state actually thinks they may have gotten infected in the community. But I think we should err on the side of concern and get these passengers notified.

Ms. WASSERMAN SCHULTZ. The state—respectfully, the State Department of Health specifically said in the epidemiological study that they did they had not—these employees had not traveled internationally, and they had not had contact in the community with anyone with coronavirus.

So, now days and days have gone by. Thousands of passengers floated around the ocean with people who had coronavirus likely on the ship they were on and days and days have gone by with no notification, no precautions that those—that those passengers should have taken and they could be out there spreading coronavirus right now.

And today, to this day, the cruise lines still have not been notified and urged by any public health entity to notify their passengers to make sure that they can figure out whether they have been exposed.

Dr. REDFIELD. My only comment was after you brought this to Admiral Rendon's attention we did have that conversation and the Princess Cruise ships——

Ms. WASSERMAN SCHULTZ. It is not just Princess. This is the—this is the——

Chairwoman MALONEY. The member's time has expired but the witness may answer the question.

Ms. WASSERMAN SCHULTZ. Thank you. Thank you.

Dr. REDFIELD. I just said that based on that the company with the cruise ship staff agreed to send a notice to all passengers that were on a ship in which any of these greeters worked.

Ms. WASSERMAN SCHULTZ. Madam Chair, I just want to point out it was not just Princess Cruise Lines. This is the second largest cruise port in the world and there is more than just Princess Cruise Lines that these—that these employees worked.

Dr. REDFIELD. We will followup to see what the state—that any ship that had passengers that these individuals could have exposed will be notified.

Ms. WASSERMAN SCHULTZ. Thank you, and I deeply appreciate the members' indulgence.

Chairwoman MALONEY. OK. The gentleman from South Carolina, Mr. Norman, is recognized for the equivalent time.

Mr. NORMAN. A point of order. Do I get seven minutes?

Chairwoman MALONEY. Yes, you do.

Mr. NORMAN. Thank you so much.

I just want to thank each and every one of you for coming here. I agree with my—Congressman Higgins that, you know, you all need to be on the front lines. I admire you for coming in here.

There is nobody watching across this country that has listened over the last few days that doesn't recognize you are doing all you can do. There are certain people, certain groups, that want to find every fault.

We are in uncharted waters here. You all are drinking not from a fire hydrant but from a tidal wave. I respect and admire what you are doing.

So, please know the majority of the country understands why we weren't aware of—I mean, we didn't—we didn't anticipate this. You all are handling it and we do appreciate it.

First question, what—I just met with a company, a Fortune 500 company who is looking at testing their employees as they come in the door and, yet, their concern was, one, frivolous lawsuits, class action suits by trial lawyers, HIPAA violations, health—you know, you just can't take temperatures of people without all type—getting into all type of issues.

What would—for any of you, what would you say for them to do?

Dr. REDFIELD. CDC has published our guidance for businesses. I encourage them—I heard the first day it got over 500,000 downloads. I would like people to really look at that guidance carefully.

Second, there are complexities, as we already spoke, about testing—probably most importantly, the number of people who could actually have this virus and actually have no symptoms.

The other reality is when the test turns positive after you actually are infected is still a scientific question. I can defer to Dr. Fauci.

So, at this stage, we really would like to see the tests provided to those individuals that feel they were exposed in the clinical setting as we—as we continue to try to expand that, those individuals

that, obviously, are presented with flu-like symptoms in the hospitals.

Obviously, we want to see the tests used for broader public health surveillance. I think that is the stage we are in. But I would like to see if Tony wants to add something.

Dr. FAUCI. No, it is. There are two types of situations. Dr. Redfield described one, which was the classic tried and true CDC-based situation where it is based on the doctor-patient interaction where a doctor has a patient who wants to get tested for cause.

They are sick. They have been exposed or what have you. That works well. The system right now as it exists of doing a much broader capability of determining what the penetrance is in society right now is not operational at all for us. And what the CDC is doing now is that they are taking various cities—they started with six and then they are going to expand it—where they are not going to wait for somebody to ask to get tested.

They are going to get people who walk into an emergency room or a clinic with an influenza-like illness and test them for coronavirus. If you do that on a broader scale throughout the country, you will start to get a feel for what the penetrance is and that is a different process.

Unfortunately, our system from the beginning was not set up to do that and that is the reason why we are not able to answer the broader questions of how many people in the country are infected right now. We hope to get there reasonably soon, but we are not there now.

Mr. NORMAN. What is your opinion on the question I was asked by this employer, do I give—do I take the risk of when you walk in that door with no symptoms, you just see what—whether it is the temperature or whether it is asking questions, they are petrified of the—of the outcome if they do that.

They are also petrified of somebody having the virus when they walk in the door and then being held liable if they infect. And this company has 500 employees. They do shifts, working three shifts. What would you—what is your advice?

Dr. REDFIELD. You know, at this point, our strongest advice is that people that are sick need to stay home. Those companies that are in areas where we are having significant cases, if they can, you know, telework we are recommending that.

Those companies that are aware with cases we are asking for social distancing. We are not asking for everybody to come at the lunch time and sit at the same table. We put out a series of guidelines.

But what we are not advocating, you know, and, obviously, individuals that just returned from Italy or France or Germany we would like them to stay home for 14 days.

But we are not advocating the use of these tests in a broad way in the absence of a relationship with a physician or public health official to make that determination.

Mr. NORMAN. Second question. We have got probably 80 people in this room. The questions that I am getting asked, what are the—in this room today, what are the likelihood—I don't know what who—I don't know who has got what in this room.

Walk me through the likelihood of any one of us in this room getting the virus, assuming somebody here has the symptoms.

Dr. REDFIELD. Again, still the real risk in general right now—and this is why the president took the action he did last night—within the world now over 70 percent of the new cases are linked to Europe and in the United States I think it was now 30 states in our country—30 of our—30 states or more were linked actually to cases of Europe.

Europe is the new China and that is why the president made those statements. Clearly, we can only continue to emphasize the basics that we have all said about washing your hands, obviously, staying away from people who are sick, learning how to cough correctly, don't touch your face, although we all know it is very complicated, you know, to try to not touch your face during the day.

But I think it is really important that we also are moving quickly with broader mitigation strategies based on the virus, and Tony may want to add to this.

So, some of that is really encouraging social distancing in the workplace, really encouraging social distancing in restaurants, really encouraging social distancing at sporting events.

So, Tony, you want to add?

Dr. FAUCI. Yes. So, sir, it is a great question because you are right, everybody is asking it and the issue is in the spirit of staying ahead of the game right now we should be doing things that separate us as best as possible from people who might be infected and there are ways to do that. You know, we use the word social distancing, but most people don't know what that means.

For example, crowds. We just heard that they are going to limit access to the Capitol. That is a really, really good idea to do. I know you like to meet and press the flesh with your constituencies. I think——

Mr. NORMAN. Not now.

Dr. FAUCI. I think you need—I think you need to really cool it for a while because we should—we should be practicing mitigation even in areas that don't have a dramatic increase.

I mean, everyone looks to Washington State. They look to California. They are having an obvious serious problem. But their problem now may be our problem tomorrow.

So, we have got to act like there is going to be a problem and that means doing everything you possibly can to do the guidelines that the CDC puts up which sound very simplistic but they are really important.

Mr. NORMAN. Common sense.

Dr. FAUCI. Common sense. Yes.

Mr. NORMAN. Finally, I know when this first became public, we—I think this country had test kits out in an effort to find a vaccine to those willing, I guess, to be tested. Where are we on that?

Dr. REDFIELD. I want to just sort of stress the complexity of getting tests, as we have heard from a number of your colleagues, is not just about having the reagents that CDC originally made for a test.

You, obviously, need that test kit and we have put out in the public health system over 75,000. So, the public health labs have that.

But the public health labs actually have to have the people to do the test and what is their capacity to do the test. They have to have the equipment to do the test and what is the capacity of the equipment they have.

They have to have some of the early reagents that they need. Not to get too technical, but you got to extract nucleic acid in order for the test to go into our kit.

So, there is a whole system that we can see that there is different, you know, limitations as we expand, expand, expand.

CDC—I tried to explain why we used the system we did, which is, you know, a thermocycler system, which is not a system that you can do, you know, tens of thousands of tests very easy. You are really limited at some labs between, say, 20, 50. CDC can do between 300 and 350 a day. OK.

There is other systems that can do, really, thousands, OK, and those systems are what are coming online with LabCorp and Quest, and actually New York State, really, recently got approved to put their system online.

So, I want people to sort of understand that, you know, that whole—that whole scenario in terms of actually—and then, you know, one of the great things about LabCorp and Quest coming in is they already have the distribution system, the collection system.

So, the more they get into the clinical marketplace the faster the American public are going to get access to this.

Mr. NORMAN. Well, I just want to thank you.

And, Madam Chairman, I appreciate you letting me have eight minutes. Thank you so much. Thank each one of you.

Chairwoman MALONEY. I hear—getting some good questions and good answers.

The gentleman from Vermont, Mr. Welch, is recognized for five minutes.

Mr. WELCH. Thank you very much.

You know, the question for us now is what can we do and how best do we do it, and if I understand—and this is directed to Dr. Fauci and Dr. Redfield—is that the two essential things are testing and the social distancing or quarantine or separation, keeping us apart from one another, is that more or less correct?

Dr. FAUCI. Yes. I would put the social distancing and other issues of preventing infection ahead of the testing. But the testing is very important. Don't get me——

Mr. WELCH. All right. And let me go on the testing, because I heard two different emphasis from each of you.

Dr. Redfield, you were, as I understood it, focusing on the doctor-patient relationship and the doctor triggering the test in response to a request from a patient.

Dr. Fauci, what I understood you to be saying is that surveillance testing is very useful, and we are seeing that with drive-through testing. Am I correct in describing a difference?

Dr. FAUCI. Yes, there is a difference, but we should be doing both.

Mr. WELCH. Well, that is what I am saying then.

Dr. FAUCI. Yes. Right.

Mr. WELCH. Do you agree with that, Dr. Redfield?

Dr. REDFIELD. Yes. The CDC is—you know, we have multiple surveillance systems for respiratory disease and flu. I think we have, you know, multiple different systems we use——

Mr. WELCH. We don't want to hear about that. We got to——

Dr. REDFIELD. No, but we are——

Mr. WELCH. This is right now with this virus. What——

Dr. REDFIELD. We are moving——

Mr. WELCH. Should we be having our states like Vermont be doing surveillance testing and figure out how to do that in the next question?

Dr. REDFIELD. What I was trying to say is we are now moving our—the COVID–19 into that system. We started with the six. We are going to expand jurisdictions. We put——

Mr. WELCH. All right. So, yes or no, should we——

Dr. REDFIELD. Yes.

Mr. WELCH [continuing]. In addition to be doing——

Dr. REDFIELD. Yes.

Mr. WELCH [continuing]. The individual testing the surveillance testing?

Dr. REDFIELD. We should be doing—we should be doing both. I agree with Dr. Fauci.

Mr. WELCH. OK. So, information, data, is power, correct?

Dr. FAUCI. It is critical and that is what I have said, I think, at the last part of the hearing and now.

Mr. WELCH. You did.

Dr. FAUCI. The system was geared for the individual doctor-patient.

Mr. WELCH. Right.

Dr. FAUCI. What we are going through now transcends that. We need to do more than that.

Mr. WELCH. Right. There is a public health issue. So, a person who presents has got a problem but it is a problem that, unfortunately, that individual is going to share with a lot of other folks indirect.

Dr. REDFIELD. Yes, and when that individual is confirmed it triggers the public health response around that individual.

Mr. WELCH. Let me keep going. Because one of the things we have to get here all of us represent folks who are going to be getting sick.

So, this is a—not a red state blue state type of deal. We are all in this together and, in fact, if we are not in it together, we will all get sick together.

So, on this question of travel, which is one of the big issues, you know, the president is banning travel from a number of European countries. Does it make sense to exclude a single country, Great Britain?

Dr. Redfield, is there a medical reason to do that?

Dr. REDFIELD. We were looking at the extent of new cases in different areas and the reason that Schengen area, because there is no borders——

Mr. WELCH. I don't have that much time.

Dr. REDFIELD. OK.

Mr. WELCH. I will tell you, I am mystified. If you have a number of European countries where there is a travel ban I can accept that if that is a medical recommendation about how to combat this.

But then you have one country that is singled out for exemption, even though the cases in that country are higher than a number of others. How does that medically make sense? I will ask you, Dr. Fauci.

Dr. FAUCI. Well, I will do it quickly, hopefully. So, when we were looking at the pure public health aspect of it we found that 70 percent of the new infections were coming from—of the new infections in the world were coming from Europe, that cluster of countries, and of the 35 states 30 out of 35 of them who were more recently getting infections were getting them from them. That was predominantly from Italy and from France and from Germany.

Mr. WELCH. OK. Thank you.

Dr. FAUCI. So, when did this—no, there is an answer to your question.

Mr. WELCH. Go ahead. OK.

Dr. FAUCI. So, when the discussion was why don't we just start off and say banned from Italy, we were told by the State Department and others that in fact you really can't do that because it is sort of like one country, the whole European thing. And the reason I believe that the U.K. was left out was because there is a difference between——

Mr. WELCH. All right.

Dr. FAUCI [continuing]. The ease of transportation between the European countries and the U.K.

Mr. WELCH. Well, that is Brexit. Thank you. But let me go on to my last question.

My understanding is that the best preparation is advanced preparation. I mean, it turns out we don't have the tests that we need. There is a lot of confusion about it.

If before this virus hit us, we had those tests in place, we had systems and backup plans in place, that is where you get the head start to keep that curve lower.

I am going to ask you, Mr. Currie, as the head of the GAO, was it helpful in our advanced preparation to have disbanded the National Security Team Global Health Security and Biodefense Directorate?

Mr. CURRIE. No, sir. I don't think it was. I mean, we and others have recommended for years that there has to be some sort of central coordinator above the departments and agencies because the departments and agencies can't tell each other what to do.

Mr. WELCH. All right. I am going to finish.

That is one thing that is on the administration. I don't—Mr. Roy, I agree with you, but I say we ought to put that back in place. We got to be prepared in advance and I hope we could work together to do that.

I yield back.

Chairwoman MALONEY. Gentleman's time has expired.

And the gentleman from Texas, Mr. Roy is recognized.

Mr. ROY. I thank the gentlelady.

If I might reserve my time for a minute. I do want to make one observation, that—first of all I want to thank the chair. I think it

is important that the witnesses come back today, and I would respectfully disagree with my colleague from Louisiana.

I think it is important that we hear this because you have got 435 Members of Congress who, importantly, have to go home and explain to our constituents what is going on.

So, I think this is very important that we have this hearing and continue to have it and thank the gentlemen for being here to do that.

And second, I would observe that when we have these six-and seven-minute intervals, the gentlelady from Florida was able to explore the questions long enough to get responses and to have a back and forth and I think these—that is important.

I think we ought to have that kind of a dialog instead of we get these short increments and we are firing away in order to get our camera time and ask our questions.

So, I appreciate having that flexibility. I think that is a good thing is all I am saying to the chair and I appreciate it.

Chairwoman MALONEY. OK. Thank you.

Mr. ROY. Back to—so on my time I would say, first of all, thank you to Dr. Kadlec, Dr. Rauch. Thank you for your time yesterday. You addressed the issue that we were dealing with in San Antonio. I think that is a good example of how the administration can respond and deal with these kinds of issues and I appreciate you doing that. We resolved that. Thank you. Or at least I think we have.

Second, our job as leaders is to present, in my view, calm, resolve, focus on the facts, and to go through this so that—so that the American people know that we are on top of this. And I believe that we are on top of this, but we are trying to move forward positively.

I think we need to—we know now we need to minimize social engagement while, importantly, maintaining commercial activity. Our lives depend on vibrant commercial activity. So, we have a responsibility to talk about this in a rational and sane way so that we maintain commerce, the very commerce that will save lives, the very commerce that will allow us to be able to produce wealth and opportunity and create jobs and be able to pay for things while having the kind of social distancing that the gentlemen are referring to. We have got to come up with ways to do that.

Last night, I spoke on the phone with Dr. Shuren at the FDA and got some updates on some of the testing information because I wanted to talk to somebody at the FDA, and my understanding in response from them—and he is not here to testify, so I want to validate this—was that he talked about upwards of 2 million tests—those aren't individual test kits but the ability to test 2 million times were coming to availability this week, 3 million more in the next week and that we have got a rather large and robust testing ability coming to market shortly, that we have got private enterprises producing these tests.

We have got universities, state public officials that have the ability to test and that we are now getting to the place of scalability to ramp up and have a fairly sizable large amount of testing ability in our robust Federal system.

Would you agree, Dr. Redfield, that that is the trajectory of where we are headed?

Dr. REDFIELD. Since March 2, there has been, I have been told, over 4 million tests now to have entered the market. But what I want to say the test isn't the whole answer.

Mr. ROY. Right.

Dr. REDFIELD. You need people to do the tests, laboratory equipment to do the test. You need some of the reagents that actually now are in short supply to prepare the test. You need the swabs to take the test.

So, we are working very hard with the FDA to make sure all these different pieces—you know, right now the actual test to do this coronavirus test I think we have the test in the marketplace.

The question is how do you—how to actually operationalize them and I think that is what Tony and I are saying is the big challenge right now.

Mr. ROY. Well, and I appreciate that because that goes to the heart of—there is a lot of rhetoric flying around both sides of the aisle, all over the place, about tests, test kits, testing, and what we can do.

We have a significant amount of scalability in this country that we have got to leverage for our benefit but also recognize we have 330 million people. That is compared to 50 million in South Korea.

We have different—we have a Federal system. We have states. We have to navigate through that, and we need to make sure that we have the right tests and the tests are effective.

There are some questions, as I talked last night, about whether the Korean test was as effective as we might prefer. There is some debate about that.

So, is that a fair statement about making sure that we are working through to make sure we have got the right tests while we are working to make sure we have got all the materials, by the way, remembering that we have got supply chain issues we have got to deal with, given the worldwide connection and the supply chain.

Dr. REDFIELD. Yes. A critical regulatory role that the FDA really holds, which is important that we have tests that actually work, and we actually can be assured of that.

I can tell you that the tests that are currently being put out both by—to the public health labs and by LabCorp and the private labs they actually work.

The challenge is really, and this is what I want to really emphasize, we focus so much on the actual kit of the test.

Mr. ROY. Right.

Dr. REDFIELD. We have to focus now on the whole—the whole system to get that testing really rolled out both for surveillance, which is CDC's main job, and to clinical medicine.

Mr. ROY. That assertion was made a little bit earlier or a question was raised about who is in charge, right. One of the difficulties of a Federal republic like ours, right, is that there isn't one person in charge of making all of this happen, right.

But isn't that also—you know, some people might say that is a bug versus a feature. Some might argue that it is a feature with 50 laboratories of democracy, with 50 states and universities and labs being able to produce different ways of coming up with testing

and navigating this and our markets being able to scale up and produce that that is something, again, keeping in mind that the American people are listening and that we are trying to explain how this system works, that there isn't a singular top-down approach in our country to doing this.

But that is the same America that has, you know, stomped out Nazism, that has put a man on the Moon, that has cured polio, that has gone through and done the things that were reacted in 9/11, built and rebuilt southern Manhattan, that this is the America that rises up to deal with these kind of solutions and I think it is important that we talk about that in its complexity and its wholeness.

Dr. REDFIELD. I would like to make one comment because Bob Kadlec is here, and he is in charge of our overall what we call incidence management structure. Maybe he would like to comment.

Mr. ROY. I would appreciate that, Dr. Kadlec.

Dr. KADLEC. Well, thank you, sir, and thank you, Dr. Redfield.

Very simply, given the nature of our system and particularly the Federal Government where there are health components across the domain, Department of Defense, VA, Department of Homeland Security, the responsibilities fall to my position to basically manage and integrate and synchronize those efforts so we can kind of come with a unified response most importantly to support state and local authorities in disasters.

Mr. ROY. Right. Thank you, Dr. Kadlec.

Madam Chair, I appreciate it.

Chairwoman MALONEY. Thank you. Thank you.

The gentlewoman from Illinois, Ms. Kelly, is recognized.

Ms. KELLY. Thank you, Madam Chair, and thank all of you for being here. I know you have been working very hard, and I have seen you multiple times myself.

I am the chair of the congressional Black Caucus Health Braintrust and also my district is urban, suburban, and rural. When I hear you talk about there is 30 states that have been affected so far but within those states do you see it more urban or is it a mixture?

And I know—and I am talking about the people that have it by no obvious means, not the people that were in Italy and where they go back to live, but just the people that are getting it by not an obvious means.

Dr. REDFIELD. Yes. Just for clarification, when Tony and I were mentioning the 30 out of 35, it was really at a time for the analysis that comes from Europe. As of this morning now we have 44 states and the District of Columbia that have reported at least one case.

And I will say that I am not going to comment in the distribution. I can get that exact information for you. But it is—you know, we are seeing more and more jurisdictions report their initial case across the country now.

I think this is one of the big reasons why the president made the decision. We need to use our efforts right now to really continue to try to contain this outbreak with the cases we have and let the public health system focus on that around those clusters, do aggressive mitigation.

But if we continue to have individuals coming in that seed new communities all through the country, it will be very hard for us to get control of this and that is why this is sort of an integrated multi-layered public health approach right now.

But don't underestimate the importance of our local public health system to do their public health job. It still is something we shouldn't give up on.

Ms. KELLY. Yes. Well, I won't, but my concern also is in underserved communities. They have a lack of access to, you know, some of the public health or health care.

Dr. REDFIELD. I will say it is our concern, too. I mean, we are trying to look at strategies now for homeless populations. We really are concerned for really all of America.

Ms. KELLY. Mm-hmm. The other thing is, a doctor I know told me that she received a fax and the fax said that she could—I am trying to think for her exact words—work around or go around the CDC and get tests herself and swab the nose like you talked about, and then Quest Lab would pick up the test.

Is that correct? She is in New Jersey.

Dr. REDFIELD. Yes, that is correct. Getting the—again, the spirit of America. When the vice president met with all of the major diagnostic companies they didn't come there as individual companies.

They said, we are in this together. How can we step up. And they are all moving up, Quest and LabCorp being the biggest. They are all—they are activated their entire system and they are beginning to phase those tests in.

The real kick will come when they are able to transfer the platform from the platform that we developed to what we call this high through-put platform which I am told should happen soon.

They are working hard to validate that with the FDA so they can go to the high through-put platform, like New York State was validated yesterday, Chairwoman. So, they are up and running with the high through-put platform now.

Ms. KELLY. And then also quarantine is for those exposed but not yet sick. But if someone in quarantine gets sick do you switch them to isolation onsite or move them to a private hospital? What happens?

Dr. REDFIELD. Yes. If they do get sick and then we—of course, someone's in self-isolation or self-quarantine at home, they are being monitored for symptoms, if they—if they do become symptomatic they get a comprehensive medical evaluation and then, obviously, either return to home isolation if that is the medical appropriate decision for them—that it is just a sore throat—or if they look like they need medical attention they are going to get hospitalized and managed in isolation.

Ms. KELLY. And then how are those costs covered for a private hospital? Does CDC cover their out-of-pocket cost or how does that work?

Dr. REDFIELD. Well, the department has the authority to reimburse those, OK. CDC has the authority. The department has authority. The department—we are working now to determine the best way to accomplish that.

Ms. KELLY. And have you—maybe someone asked you this—looked over the legislation that we will be considering today? Have you?

Dr. REDFIELD. I haven't seen the legislation.

Ms. KELLY. OK. Thank you. I yield back.

Chairwoman MALONEY. Thank you.

The gentleman from Pennsylvania, Mr. Keller, is recognized for five minutes.

Mr. KELLER. Thank you, Madam Chair, and thank you to the panel for being here again today.

I know there has been a lot of things that have happened and we have actually been trying to—I know we did the supplemental appropriation and made the funds available, also communicating with many Federal and state agencies to make sure we get information out to our constituents.

So, that is a lot of what we have done. Even this morning had a couple briefing, a bipartisan briefing in the Capitol Visitors Center, also on the phone with the White House and some other—some other people.

In addition to that, in Pennsylvania our secretary general—physician general, excuse me—Physician General of the Commonwealth, Dr. Rachel Levine, actually had a call with all members of our delegation and members of the Pennsylvania General Assembly to go over what the Wolf administration is doing.

So, there has been a lot of activity as far as what I have seen trying to make sure people are informed. I know we talk about social distancing. So, maybe I can just cover that because I know one of my colleagues had a question about that, too.

You mentioned social distancing. But what does that mean for—I know we talked about a lot of sporting events and schools, but are there any other private events where people might want to think about social distancing and what might those places be?

Dr. REDFIELD. I will have Tony add. But we are giving out guidance in terms of the size of events that should happen, you know, and really discouraging people from having large events.

Now, it is different in different communities by the kinetics of the outbreak right now. I mean, we are looking at each community to develop it. That is why we put our matrix out there. Social distancing is we want people to stay six feet away or more.

Mr. KELLER. OK.

Dr. REDFIELD. So, if you—if you can have an event and keep people outside and they can stand 10 feet away from each other, you know, that is how we refer to social distancing.

But you see—we really are, you know, in a mode that this is time for big events like March Madness, big events like these big sports arena things to take a pause for the next four to six to eight weeks while we see what happens with this outbreak in this Nation.

Mr. KELLER. OK. Thank you.

And, again, I am going to reference back what the physician general had said so far because I know there has been a lot of questions about testing and Dr. Levine said so far in Pennsylvania in every case where a doctor deemed a COVID–19 test to be medically necessary that test was performed.

So, that is according to Dr. Rachel Levine. She later went on to say that the state has the capacity to do the number of tests per day that they need to or that they can do their capacity and mentioned actually LabCorp and Quest Diagnostics are now able to provide the tests in Pennsylvania.

These companies will report any positive results to the state and they will be made public. So, it appears like Pennsylvania—you know, the fifth largest state by population in the Nation and the world's eighteenth largest economy—has sort of figured this out because she goes on to say, we will meet the—we will meet the demand for testing and we are following the guidelines to do that.

So, Pennsylvania is able to do that. What things might have happened in Pennsylvania that we could put in place in other parts of the country if they are having trouble with testing?

Dr. REDFIELD. Thank you, Congressman.

I think the big issue is just effective communication because, you know, Quest and LabCorp is really in all of the states in the country.

Moving forward, we have gotten—all the public health labs have gotten the resources from CDC. I was told by the head of the American Public Health Labs in the last 24 hours that he has gone through all the public health labs and not a single lab lacks the kit, the reagents, the capacity to do testing right now.

So, I do think a lot of it is just effective communication.

Mr. KELLER. Well, it seems—it seems like Dr. Levine and the people of the Pennsylvania Department of Health seem to be headed in the right path. So, I am glad for that and I am just—I am just hopeful that we can replicate that.

Dr. REDFIELD. I would just like to add my congratulations to them. I mean, I know Rachel well. They are a very serious health department and they have stepped up.

Mr. KELLER. Thank you.

Dr. Fauci, what can we do as Congress to continue to work with the Trump administration and state health agencies to ensure that the public health experts and private sector health care providers have what they need to continue to respond to COVID–19?

Dr. FAUCI. I believe you have already done that in—to a big extent by the supplement that you have done, the $8.3 billion supplement, which really allowed us to do the kinds of things. Each of us are responsible for different aspects of the response.

I know, speaking for myself and my agency, the NIH, the amount that we got from that supplement—that we will get from that supplement—will allow us to really accelerate what we have done in the arena of therapy as well as the development and acceleration of vaccines.

So, I want to thank you for that. That is probably the most important thing.

The other thing I think is important is what you are doing right now to have the opportunity to come before you within reasonable—now, I don't want to come every day but to come enough to be able to really get the American public to really hear from us because this is an evolving situation. It is not static. It is not one off and you are done. It is going to just evolve over the next several weeks.

Dr. REDFIELD. I just want to add one point. It has been so important. CDC just announced that we are going to award over $560 million to the front lines of this response. That is the local, state, and territory health departments.

Mr. KELLER. Thank you.

Chairwoman MALONEY. Does the gentleman yield back?

Mr. KELLER. I yield back.

Chairwoman MALONEY. Thank you.

The gentlelady from the Virgin Islands, Ms. Plaskett, is recognized for five minutes for her—such time as you may consume.

Ms. PLASKETT. Thank you. Well, let us not do that. I could talk for a long time.

But thank you very much, Madam Chair, and I want to thank you gentlemen. I was there at the briefing that you had this morning. I know that you went over to the Senate. You were here yesterday, and you have come back. And so your openness is really appreciated and the information that you are sharing with us that we will get out to the American people to try and make sure that the right information is there.

One of the things that I just want to mention that I am concerned about is as we are doing this containment and we close schools, there is a digital divide in this country where young people will have issues with keeping up with work.

In some of the areas, the urban areas that my colleague, Ms. Kelly, was talking about, in the Virgin Islands we have the highest broadband capacity in the United States outside of New York City but the lowest rate of connectivity to homes. And so these are the things that I think we also need to be concerned about.

We are looking at supporting economies but just our children alone as well as the issues of health and nutrition that I think many kids will face if they are restricted from going to school when so many of them rely on school lunches and breakfasts for their nutrition.

But I wanted to ask you about isolated areas like the Virgin Islands. We are concerned right now. We have an individual of interest that has been isolated. But, like ourselves and Puerto Rico—like Puerto Rico is like us—we have not fully recovered from the hurricanes of 2017.

We have seven hospital beds available between the two hospitals for a population of over 100,000. That is very troublesome as to what is going to happen to us. So, I am glad that you said, Dr. Redfield, that you have the funds, you believe, in place now to do a response.

Can you tell me, one, in terms of personnel what—Dr. Kadlec, I think you would be the appropriate person. How do we get these out? How do you get your personnel out? Because along with the shortage of beds we also have a shortage of personnel.

Dr. KADLEC. Thank you, ma'am, for the questions. I mean, there are two elements to our ability to response to these kinds of scenarios and one is through our National Disaster Medical—Disaster Medical Assistant Teams, or DMATs, and those are intermittent Federal employees who work across the Nation at some of the premier hospitals and medical institutions around the country—Mass General, Stanford, the like.

And so, obviously, in a scenario when there is a potential event of this nature where it can happen anywhere and everywhere in the country, we have to be very selective in how we do that and we have been deploying those assets to respond to events.

So, that is one part of it. The other part of it is with the Public Health Commission Corps, who are a vital member of our, if you will, team. They belong to the assistant secretary for health. There are several thousand of them.

I think the intent of Admiral Giroir, though he is not here today, is to expand their expeditionary role to serve in these kinds of capacities.

Today as we speak in Seattle in the nursing home that is being afflicted by the COVID virus, there are almost two dozen Public Health Commission Corps officers that are working to assist health care workers there.

Ms. PLASKETT. So, now, are you able to bring people to locations that are in need and how do you prioritize what those locations are?

Dr. KADLEC. Well, obviously, it is going to be based on the need and based on what the capabilities are domestically or in that area.

So, based on our conversation before this hearing, I have already contacted my principal deputy about your situation and our intent to find ways that we can augment or support what is needed for your constituents.

Ms. PLASKETT. Great.

Mr. CURRIE. Ms. Plaskett, can I mention something really quick?

Ms. PLASKETT. Yes, please. Mr. Currie?

Mr. CURRIE. Sorry, I can't help myself because I do work on disaster recovery for FEMA and I have been to the Virgin Islands after Hurricane Irma. And I would suggest that you talk to FEMA as well because, you know, they do have an open—still an open disaster declaration on the island. You know, I have been to the hospital in St. Croix. I know it is destroyed. I know they have a temporary hospital. So——

Ms. PLASKETT. Well, we don't have a temporary hospital. It has been approved.

Mr. CURRIE. Not yet. Right.

Ms. PLASKETT. Two years later.

Mr. CURRIE. So, I suggest you contact FEMA because they have a lot of people on the ground there and in Puerto Rico——

Ms. PLASKETT. Sure.

Mr. CURRIE [continuing]. And check with them on what they can do under the—under the umbrella of the current recovery.

Ms. PLASKETT. Sure. I mean, I have found that FEMA has been great in disaster initial recovery, but the aftermath and rebuilding is a little slower. The fact that we still two years later do not have our mobile unit for a hospital shows that there are gaps in FEMA as well.

So, I do understand. You know, there is a question of should all of these kinds of things—is this a disaster and should this be all within one umbrella so that we are not talking to disparate agencies at the same time. But I agree with you and I believe our Governor is having that discussion.

The other thing I wanted to bring up very quickly is cruise ships, and you talk about containment. We know that individuals coming off of a cruise ship cannot be tested immediately.

So, when you have individuals who—places like the Virgin Islands which rely heavily on tourist populations, what is your advice to us in terms of ensuring that we contain ourselves so that we do not have a spread of this?

Dr. KADLEC. Well, ma'am, one thing that is ongoing is that the cruise industry is trying to advance what would be healthy kind of practices for their own—for their own cruise ships so they can monitor people.

Naturally, they have submitted a proposal to the U.S. Government kind of outlining what their approach is. I think one of the things they include there is actually monitoring, doing surveillance of their passengers, being able to do testing of their passengers on the boat, having medical referral capacity to medivac them if they have to and even having quarantine capabilities.

So, that is an ongoing dialog between the cruise industry and the U.S. Government. So, I think it is—they see it as an important responsibility to their customers and to their passengers and we agree as well.

Ms. PLASKETT. Mr.—Dr. Redfield, did you want to add something?

Dr. REDFIELD. Well, we have definitely put out our guidance that we are strongly advising individuals with serious medical conditions, especially the elderly, that they should reconsider all cruise travel at this point.

Ms. PLASKETT. Now, that supports the passengers that are there from being infected by others. But what about those who are passengers infecting individuals when they come off of the cruise ship?

Dr. REDFIELD. So, again, this is why it is so important—the surveillance. As we know, there is, I think, 12 cruise ships across the world right now that have been looked at for potential COVID–19.

As Dr. Kadlec said, there is very active discussions right now going on to what decisions should be made about the cruise industry at this time.

Tony, I don't know if you want to add anything.

Dr. FAUCI. There was a meeting with the cruise ship executives, the CEOs, to tell them they really got to come forth with a plan to tighten up the protection of people who go on as well as what happens when they go off.

So, that is—that is—they have been given the mandate to fix it and if they don't fix it then they are going to maybe get some regulations that they don't like.

Ms. PLASKETT. Thank you. Thank you very much.

I yield back.

Chairwoman MALONEY. The gentlewoman from Massachusetts, Ms. Pressley, is recognized.

Ms. PRESSLEY. Thank you—thank you, Madam Chair, and thank you to our esteemed witnesses for returning to day.

You know, since the beginning of the COVID–19 outbreak we have seen not only the spreading of the virus but also a rapid spreading of racism and xenophobia. We have witnessed at the highest levels, in fact, of the Republican Party fanning irrespon-

sibly these flames. One colleague tweeted that "Everything you need to know about the Chinese coronavirus," unquote.

My district is home to nearly 32 percent foreign-born residents with more than a quarter immigrating from Asia. This painful rhetoric has consequences. Restaurants across Boston's Chinatown have seen up to an 80 percent drop in business and I believe this has everything to do with the rapid spread of misinformation and paranoia.

It is critical that we stand against these inciteful messages and assuage fear in our communities, and we do that by dispelling untruths and misinformation. We can only do that by sharing the facts and that is why I am grateful to have you here today so that we can get to the truth about this virus.

Thirty thousand residents across my district are uninsured and lack access to health insurance coverage. Many of these people are low wage hourly workers, food service staff, nursing aides, hotel workers. A day off from work due to illness could mean losing a month's worth of groceries.

The CDC's website advises people experiencing symptoms related to coronavirus to stay home and seek out medical care. But it doesn't really address the realities of living uninsured.

Dr. Redfield, if I am a symptomatic hotel worker who is pre-diabetic, uninsured, and lacks the savings to cover the cost of testing and treatment, what specific guidance do you have for me?

Dr. REDFIELD. A very important question. Obviously, we want you to be able to stay at home and this, I think—I don't know exactly where it is, Tony, but I think there is, clearly, a great recognition of this issue by the White House Task Force and I don't know where it is in the—as far as it is, you know, in getting its way to you. But I can tell you, we have addressed this as a critical public health component.

We need these individuals to be able to do their 14 days at home and not have to sneak out for an hourly job because they have to pay for their cost of living. So, I can tell you that the White House task force is addressing this.

Tony, do you want to add any——

Ms. PRESSLEY. Well, Dr. Redfield, if I might. Will the cost of testing be covered?

Dr. REDFIELD. Cost of testing will be covered.

Ms. PRESSLEY. And what about treatment?

Dr. REDFIELD. Cost of treatment will be covered.

Ms. PRESSLEY. OK. And so—and I appreciate that these conversations are happening. In terms of information that is public facing and accessible to the general public, as of this hearing neither the CDC's portal for coronavirus or its FAQ—frequently asked questions—page has information about what the tests cost, who will cover it, and whether uninsured people can be tested.

And so this has contributed to the confusion and the panic. So, can you please make a commitment today to add this information to the website?

Dr. REDFIELD. We will—we will do our best to clarify. Related to costs, particularly for LabCorp and Quest, they haven't really defined it. But they have shown their leadership in rolling it out independent of that.

But I will get as much information as I can on that website and keep it updated.

Ms. PRESSLEY. OK. So, I can take that as an affirmative, a yes. OK.

Dr. Fauci, I am uniquely concerned about people with autoimmune disorders and those dealing with underlying health conditions like HIV or lupus.

Briefly, is there any specific guidance for how these vulnerable groups can protect themselves?

Dr. FAUCI. They fall into the—that is a great question, Ms. Pressley. Thank you for asking it.

They fall into the category of those that I have been saying multiple times at this hearing and other places—are in that category that if they get infected likely many of these people are on immunosuppressant drugs, particularly people with autoimmune disease, that they need to take extra special precaution.

In other words, they are vulnerable and they need to help protect themselves and society needs to help to protect them. In other words, keep people who are sick away from them.

Keep them even more stringently apart from crowds. Don't travel unless it is necessary on long trips and, above all, stay away from cruise ships.

Ms. PRESSLEY. OK. All right.

So, I want to turn to another issue. One group we haven't heard much about are the 2.3 million people who are in prison or jail.

Mr. Redfield, about 10 percent of federally incarcerated people are over the age of 60. Many of these people have underlying health conditions and, based on your own criteria, are most at risk for severe complications due to infection from the coronavirus. These individuals often lack access to alcohol-based sanitizer, hand soap, warm water, and regular showers.

Dr. Redfield, yes or no, has the CDC offered guidance to the Federal Bureau of Prisons about the coronavirus?

Dr. REDFIELD. Let me get back to you with the specifics of what we have done. I know we have guidance to the correctional system in general. But rather than answer or give you a half answer, let me get back to you and I will do that today.

Ms. PRESSLEY. OK. So, not a yes or a no, unsure——

Dr. REDFIELD. I just want to be accurate. OK.

Ms. PRESSLEY. OK. All right. So, you know, certainly, prisons can be incubators for infectious disease and that puts those in prison at risk as well as those who are employed there.

What recommendations and protocols has the CDC provided to Federal, state, and local corrections systems about preventing or responding to an outbreak?

Dr. REDFIELD. And, again, Congresswoman, I want to—I will get back to you today. I want to be accurate with my response.

Ms. PRESSLEY. OK. So, you will get back later today?

Dr. REDFIELD. I will.

Ms. PRESSLEY. All right. Thank you, Doctor.

And just because the administration has touted and expressed commitment to criminal justice reform as a priority, you know, this president has granted less commutations than the prior administration.

However, with overcrowding the Federal corrections system is a breeding ground for deadly outbreak.

Dr. Fauci, has the president or any member of the task force raised clemency power as a method of preventing a potentially devastating outbreak?

Dr. FAUCI. To my knowledge, no. But I—you know, they may have done it not in my presence but to my knowledge they have not.

Ms. PRESSLEY. OK. All right. thank you, and I yield.

Chairwoman MALONEY. The gentlelady yields back.

The gentleman from Ohio, Ranking Member Jordan, is recognized for five minutes.

Mr. JORDAN. Thank you, Madam——

Chairwoman MALONEY.—for as much time as he may consume.

Mr. JORDAN. Thank you, Madam Chair. I appreciate our witnesses being here today. I am going to yield again to Dr. Green and let him ask some followup.

Mr. GREEN. Thank you, Mr. Jordan.

I want to make a couple points and then ask some questions. The first point I wanted to make is on the 2015 Biodefense Study that was done under the Obama Administration.

The Trump administration has followed that. That recommended that the vice president be the person in charge of the task force and President Trump's administration has followed the recommendations of the Obama Administration on that and I just want to be clear about that because there has been some criticism.

On the South Korean tests, we have had a lot of comparisons of how they have done testing much faster than us. I have a letter from the FDA that says the South Korean tests—I want to make sure this is on the record—the South Korean test is not adequate.

A vendor wanted to purchase it and sell it and use it in the United States and the FDA said, I am sorry, we will not even do an emergency use authorization for that test. So, I have that letter if anybody wants to see it.

Dr. Rauch, I would like to ask you a question about the DOD and their—as I understand it, they have assessed field hospital resources. They have their ICU beds and ventilators. You have got the count. Can you tell us a little bit about what the DOD is prepared for or has looked into should we exceed private hospital bed capacity?

Dr. RAUCH. Yes, thank you for that—for that question. We have done a current assessment of our military treatment facilities. We know the number of beds. We know the amount of staff per bed.

We know the amount of occupied beds. We know the ICU capability and we know our alternatives for increasing the number of beds and increasing the staff for those—for those beds. We also know the inventory of our personal protective equipment for the medical force. So, that is for the—that is for the MTFs.

We also have done an assessment and we know the current capability—the current status of our military operational deployable medical assets. So, we have that for ready to respond—we stand ready, you know, to respond to the commander in chief's needs.

Mr. GREEN. As the Nation needs. Thank you.

I want to ask, and I think the question might be best for Dr. Fauci. You know, we—most of the people on this panel we are not scientists.

I consider myself to have the equivalent of an orange belt in this, you know. I know just enough to get myself in trouble. But, you know, the rapidity, the speed with which you guys have gotten this vaccine up and, you know, ready to go into stage one is unprecedented.

It is breaking records and I want you to just brag a little bit on yourselves. Tell us how hard that is and why we should all be very grateful for the folks that have put that together.

Dr. FAUCI. Well, why don't I just describe what it is instead of self-congratulating?

[Laughter.]

Mr. GREEN. OK. That is fine. That is fair.

Dr. FAUCI. All right. So, it really is the culmination of a lot of basic research over the years and we thank the committee, as always, for the—you know, the kind of support that Congress has given the NIH, which not only does research ourselves but funds investigators throughout the country and the world.

The platform that we use, and we are not—this isn't the only one. There are more than a handful of vaccines going. But the ability to use technologies that we never had before to take the sequence—so the Chinese didn't have to send us the virus.

They just published the sequence on a public data base. We knew the gene that would code for the protein that we wanted to make our vaccine. So, all we did was pull the information right out of the data base.

We made it—synthesized it very easily overnight, stuck it into our platform and started making it, and we said at that point that it would take, I would say, two to three months to have it in the first human.

I think we are going to do better than that and I would hope within, you know, a few weeks we may be able to make an announcement to you all that we have given the first shot to the first person.

Having said that——

Mr. GREEN. Wow.

Dr. FAUCI [continuing]. I want to make sure people understand, and I say that over and over and over again, that doesn't mean we have a vaccine that we could use.

Mr. GREEN. Right.

Dr. FAUCI. We mean it is record time to get it tested. It is going to take a year to a year and a half to really know if it works.

Mr. GREEN. Right. I really did want to be clear on that, too, and thank you.

If I could ask or make one other quick statement, Madam Chairman, and I will be very fast.

Chairwoman MALONEY. You have got to be fast because we are being told that they have been—this is their third meeting of the day and we have to go back to a strict five minutes because they have to leave soon.

Mr. GREEN. Real—I will be real quick.

Chairwoman MALONEY. OK.

Mr. GREEN. Over the weekend, the cruise ship—I had a constituent call. There were meds that she had run out of because the ship was still at sea. I called HHS.

They found somebody at Coast Guard. They flew that woman's medications out to the ship. You guys are doing great work. Thank you very much.

Chairwoman MALONEY. Thank you very much. The gentleman yields back.

And the gentlelady from Michigan, Ms. Tlaib, is recognized for five minutes.

Ms. TLAIB. Thank you. I am sorry that I am all the way in the corner here. But I really think this is an important conversation about the extent and making sure we have access to information for our residents at home.

You know, earlier this week, Congress's attending physician told the Senate that he expects between 70 to 150 million people to eventually contract the coronavirus in the United States.

Dr. Fauci, is he wrong?

Dr. FAUCI. Who was it that said? We have to be——

Ms. TLAIB. It is Congress's attending physician.

Dr. FAUCI. Yes. I think we really need to be careful with those kinds of——

Ms. TLAIB. Sure.

Dr. FAUCI [continuing]. Predictions because that is based on a model. So, what the model is—all models are as good as the assumptions that you put into the model. So, if you say that this is going to be the likely percent of individuals——

Ms. TLAIB. So, what can we do to define it? Is it testing?

Dr. FAUCI. No. No. It is unpredictable. So, testing now is not going to tell you how many cases you are going to have.

Ms. TLAIB. Mm-hmm.

Dr. FAUCI. What will tell you what you are going to have will be how you respond to it with containment and mitigation. So, I just want make a point that I hope the public gets.

When people do models, they say this is the lower level, this is the higher level, and what the press picks up is the higher level and they will say you could have as many as. Remember, the model during the Ebola outbreak said you could have as many as a million. We didn't have a million. OK.

Ms. TLAIB. Oh, that is great. OK. So, I spoke to federally accredited clinics in my district and one of the things that they are noticing is capacity regarding their front line kind of health care workers and various hospitals that rely on about—one hospital in my district relies on a thousand Canadian nurses from Canada that come across.

I think the total for the whole state of Michigan is 3,000. So, they are very worried about borders being closed and not getting access to those really front line communities that need help.

I do want to air it for folks, and this could be a question to Dr. Kadlec. I am really concerned about this because one of the federally accredited clinics said, you know, that is her biggest worry is that folks are not going to be able to come back to work and what are we doing to prepare those individuals.

In the meantime, while you do this, I do want to just submit for the record congressional doctor predicts 70 to 150 million U.S.

Ms. TLAIB. So, and this is important because I think we need to continue with the sense of urgency and not try—because the more we do that I think the more important it is that my colleagues understand the supplemental bill that now is being told to be hold up for two weeks for help to communities like ours around the country, is now being held up and politicized when this is really—there is no R or D next to this coronavirus.

It needs to be able to move forward so we can—but, Mr. Kadlec, can you answer the question? Because this is exactly what I heard from the hospital, two of the hospitals and two of my federally accredited——

Dr. KADLEC. Well, ma'am, two parts, to deconstruct your question. One is about the question about whether or not border crossings would be inhibited, and I would have to refer to the Department of Homeland Security.

But the other one, there are some work practices that have to be evaluated. There have been others who have questioned about whether or not the issues of furloughs are necessary for people who have been exposed or potentially at risk for coronavirus and how that works.

I mean, in the state of Washington, for example, there are health care workers who are actually working. They are coronavirus positive but asymptomatic and they are continuing to work on coronavirus patients so that they don't pose a hazard to someone who is not ill with coronavirus.

So, there are some issues that have to be sorted out there. But I will have to go back and—for your question about the border control issue. I would have to make that reference to DHS.

Ms. TLAIB. Yes, and I will followup as well. I mean, my last thing is, Dr. Redfield, you know, I think it is really important for this body and I think both of my colleagues on both sides of the aisle would want you to commit to providing the committee the current plan of how many tests that you can produce right now, what the plan is, whether they are expected to be ready and how many people they will cover.

And I don't know if you can do that, and make sure you work with our chairwoman in getting that information to us by the end of this week.

Dr. REDFIELD. I can tell you that we are trying to stand up a national reporting mechanism that is going to put not just the CDC's test, not just the public health lab tests, but the LabCorp tests, the Quest tests, and the individual hospital labs so that we can have a single site where people can say how many tests have been done, how many tests are positive, and behind that we are trying to look at least in the public health system where, you know, what is our current inventory in the public health system.

And I can, obviously, relate that to my colleagues to see if there is a way for us to do that in the clinical system.

Ms. TLAIB. Yes. Yes.

Dr. REDFIELD. But we will have—we will—we have it now, but it is incomplete because if the states truthfully lag in their reporting because they are actually trying to do——

Ms. TLAIB. Yes. I don't know if that is a yes or no. But get us the plan. That would be great. I think one of the things, too, is, you know, I caution us because we are all so worried about the commercialized economy stopping.

But we shouldn't be risking our lives for corporate greed. We should really be taking care of our families. And when we don't pass a supplemental that has been worked on hard from front line people of various departments of making sure we have, you know, people that have to not go to work.

I mean, I am telling you one of my state agencies right now where you go get your IDs closed down because people didn't show up to work because they want to make sure they are getting protection, that they are being able to get access to testing and all those things, and I think it is really critically important that we understand that urgency because on the ground offices are being closed, businesses are being closed right now, not just large events.

Chairwoman MALONEY. OK. OK. Thank you.

The gentlelady from California, Ms. Porter, is recognized for five minutes.

Ms. PORTER. Dr. Kadlec, for someone without insurance, do you know the out-of-pocket costs of a complete blood count test?

Dr. KADLEC. No, ma'am. Not immediately.

Ms. PORTER. Do you have a ballpark?

Dr. KADLEC. Out of—with a co-pay, ma'am?

Ms. PORTER. No, the out-of-pocket. Just the typical cost.

Dr. KADLEC. I do not, ma'am.

Ms. PORTER. OK. The CB—a CBC typically costs about $36. What about the out-of-pocket costs for a complete metabolic panel?

Dr. KADLEC. Ma'am, I would have to pass on that as well.

Ms. PORTER. Do you have any idea? Do you want to take a ballpark?

Dr. KADLEC. I would say $75.

Ms. PORTER. OK, $58.

Dr. KADLEC. Getting closer.

Ms. PORTER. How about Flu A? The Flu A test?

Dr. KADLEC. Ma'am, again, I would take a guess at about maybe $50.

Ms. PORTER. $43. Flu—this is like "The Price is Right." Flu B?

Dr. KADLEC. Too high again. I would—I would probably say $44.

Ms. PORTER. That is good. How about the cost of an ER visit for someone identified as high severity and threat?

Dr. KADLEC. I am sorry, ma'am. What was the question again?

Ms. PORTER. How about the cost of an ER visit for somebody identified as having high severity or high threat?

Dr. KADLEC. High severity—ma'am, that is probably about $3,000 to $5,000.

Ms. PORTER. OK. That is $1,151.

Dr. KADLEC. Too high again.

Ms. PORTER. This all totals up to $1,331. That is assuming they aren't kept in isolation. Isolation can add up for one family already $4,000, and fear of these costs are going to keep people from being tested, from getting the care they need, and from keeping their community safe.

We live in a world where 40 percent of Americans cannot even afford a $400 unexpected expense. We live in a world where 33 percent of Americans put off medical treatment last year, and we have a $1,331 expense, conservatively, just for testing for the coronavirus.

Dr. Redfield, do you want to know who has the coronavirus and who doesn't?

Dr. REDFIELD. Yes.

Ms. PORTER. Not just rich people but everybody who might have the virus?

Dr. REDFIELD. All of America.

Ms. PORTER. Dr. Redfield, are you familiar with 42 CFR 71.31—30, excuse me? 42 CFR 71.30. The Code of Federal Regulations that applies to the CDC. 42 CFR 71.30.

Dr. REDFIELD. I think if you could frame the—what it talks about that would help me. I don't——

Ms. PORTER. OK. Dr. Redfield, I am pretty well known as a questioner on the health and—for not—not tipping my hand. I literally communicated to your office last night and received confirmation that I was going to be asking you about 42.7—42 CFR 71.30.

This provides the director may authorize payment for the care and treatment of individuals subject to medical exam, quarantine, isolation, and conditional release.

Dr. REDFIELD. That I know about and——

[Audio malfunction in hearing room.]

Ms. PORTER [continuing]. Commit to the CDC right now using that existing authority to pay for diagnostic testing free to every American regardless of insurance?

Dr. REDFIELD. Well, I can say that we are going to do everything to make sure everybody can get the care they need.

Ms. PORTER. No. Not good enough. Reclaiming my time.

Dr. Redfield, you have the existing authority. Will you commit right now to using the authority that you have vested in you under law that provides in a public health emergency for testing, treatment, exam, isolation without cost? Yes or no.

Dr. REDFIELD. What I am going to say is I am going to review it in detail with CDC and the department——

Ms. PORTER. No. I am reclaiming my time.

Dr. Redfield, respectfully, I wrote you this letter, along with my colleagues Rosa DeLauro and Lauren Underwood—Congresswoman Underwood and Congresswoman DeLauro. We wrote you this letter one week ago.

We quoted that existing authority to you and we laid out this problem. We asked for a response yesterday. The deadline and the time for delay has passed.

Will you commit to invoking your existing authority under 42 CFR 71.30 to provide for coronavirus testing for every American regardless of insurance coverage?

Dr. REDFIELD. What I was trying to say is that CDC is working with HHS now to see how we operationalize that.

Ms. PORTER. Dr. Redfield, I hope that that answer weighs heavily on you because it is going to weigh very heavily on me and on every American family.

Dr. REDFIELD. Our intent is to make sure every American gets the care and treatment they need at this time of this major epidemic and I am currently working with HHS to see how to best operationalize it.

Ms. PORTER. Dr. Redfield, you don't need to do any work to operationalize. You need to make a commitment to the American people so they come in to get tested. You can operationalize the payment structure tomorrow.

Dr. REDFIELD. I think—I think you are an excellent questioner, so my answer is yes.

Ms. PORTER. Excellent. Everybody in America hear that. You are eligible to go get tested for coronavirus and have that covered regardless of insurance.

Please, if you believe you have the illness follow precautions. Call first. Do everything the CDC and Dr. Fauci, God bless you, for guiding Americans in this time.

But do not let a lack of insurance worsen this crisis.

Dr. REDFIELD. And I would just like to echo what you said. It is a public health—a very important public health that those are—those individuals that are in the shadows can get the health care that they need during this—the time of us responding to this outbreak.

Chairwoman MALONEY. Well, thank you. And the Gentlelady from New Mexico, Ms. Haaland, is recognized for five minutes.

[Audio malfunction in hearing room.]

Ms. HAALAND. Thank you, Madam Chair, and thank you, gentlemen for being here today. We really appreciate you answering our questions. Dr. Redfield, I want to start with you first. The first four cases of Coronavirus have been found in New Mexico, my state. We had a conference call with Governor Lujan-Grisham yesterday. She mentioned one of two of the cases is a couple that lives in in Segura, New Mexico. Small town of, you know, seventy-thousand people perhaps. And they were on a cruise ship themselves. They came back to New Mexico. Nobody notified the state or the health department about them being on a cruise ship where coronavirus was found. So, they were in New Mexico just doing their normal, everyday life for ten entire days before the governor or the state was alerted to have them tested and it turned out they were positive. So, I am, you know, we're of course worried in a small town like that the virus could spread pretty rapidly. And so I want to, a lot of attention has been paid to testing. Will we have adequate testing? And I, I'd like to know, this adequate testing, I have to believe it will reveal an exponential number of cases throughout the country. How, what is the responsibility to just, make sure that we're getting this information out to people. People on a cruise ship where coronavirus was known to be found shouldn't be walking around for ten whole days before we're alerted to that fact.

Dr. REDFIELD Thank you very much Congresswoman.

Obviously, the complexity of tracking down people, whether it is ships or planes, is a complicated issue. First, you have to have accurate contact information and I can tell you one of the things with the interim Federal rule we recently did for airlines, in the past maybe 20 to 30 percent of the information we would get would be actually actionable.

I am happy to say now we are probably over 90 percent. We are getting the manifests from cruise ships and working with local health departments to try to track down these individuals when we do have a confirmed case.

And this is why Dr. Fauci and all of us have now really weighed heavily this is not the time to be cruising. We really do realize that these are environments that can really amplify transmission.

Ms. HAALAND. Thank you. Thank you, Dr. Redfield. Thank you.

I want to turn our attention—I think you have mentioned—you know, all of you have mentioned several times today that big crowds need to be avoided. Is that correct?

And I want—first of all, I want to just talk about our president for a moment. On March 8, he tweeted that fake news media is doing everything possible to make us look bad. On February 28, he called the coronavirus a Democratic hoax in the—in front of a huge rally, which was on national TV.

A Brazilian official who was—who met with President Trump at Mar-a-Lago has just tested positive for the virus, and he has just boasted recently about his March 25 rally in Florida that it is all sold out and he has yet to cancel it.

And this behavior—this is the behavior that our country has to contend with. He is our president. He is the leader of our country.

You have been sitting here for hours and yesterday telling us that we need to avoid big crowds. And I am going to tell you that I have Republicans in my district who I care deeply about. I don't want them getting infected.

Every single one of us here have constituents all over our districts who we don't care who they support for president—we don't want them getting sick.

And I applaud my Governor, Michelle Lujan Grisham, who just canceled all mass gatherings in our state, and I almost feel like saying the president can do whatever he wants. He is an adult.

He can be careless with his own health if he wants to. That is his choice. But the millions of Americans who would go to a rally because he has told them that it is a hoax, they don't know the truth, apparently, and it is up to all of us to make sure that they do know the truth.

And I understand the position you are in. If you can't tell the president to his face stop all your rallies, cancel every single rally that you have planned because American lives are at stake, then I implore you to give that message to every Governor of every state in this country.

We have to—we have to stop this where it is, and I appreciate you being here.

And thank you, Madam Chair. I yield.

Mr. CLAY.

[Presiding.] The member's time has expired.

The gentleman from Maryland, Mr. Sarbanes, is recognized for five minutes.

Mr. SARBANES. Thank you, Mr. Chairman. Thanks to the panel.

Dr. Fauci, I have been trying to sort of distill the testing issue against the backdrop of moving from containment to mitigation in my mind and I would like you to maybe just comment on it very briefly.

Our failure to get the testing done early in effect means we missed the containment window and now have to move rapidly to the mitigation stage of this thing.

In other words, you have kind of been intimating don't wait for the surveillance testing. Don't wait for the person to person testing to make a judgment about what we have to do. We are past containment, well past it.

There might have been a moment when we could have had an effective strategy around there if the testing had been deployed better. But we now got to go straight to mitigation in anticipation of the fact that whatever testing will now happen will show us that the community spread has been happening for weeks and so forth.

Is that a fair characterization?

Dr. FAUCI. With all due respect, sir, it is not totally fair and let me, very briefly, try and integrate what you said, part of which was true but part of which I think is maybe a little misleading.

First of all, clearly, we have said many times and I have said publicly we had a problem with the testing and if we needed the kind of surveillance we are not there yet.

I don't think you can draw a direct line to that lack of having it in the beginning to the fact that we are now doing mitigation.

No. 2——

Mr. SARBANES. Fair enough. Fair enough.

Dr. FAUCI [continuing]. We don't—you don't necessarily give up containment when you go to mitigation. You can do some containment at the same time you are doing mitigation.

But I would emphasize, and I am glad you are giving me the opportunity to state it yet again because you can never state it too much, is that right now all of us, regardless of what testing is going on, need to be doing the kind of distancing, avoiding crowds, teleworking where possible.

I said it many times and I will say it again, this is not business as usual. If you live in a state or a region where there are just a few or no cases, it doesn't matter. You really need to do the——

Mr. SARBANES. Let me ask you—thank you. That is a very good clarification.

Let me ask you a science question——

Dr. FAUCI. Sure.

Mr. SARBANES [continuing]. Just so I understand. If somebody got the virus three, four weeks ago, just thought they had the flu or a bad cold or something, recovered from it, they are now essentially immune from getting the virus again. Is that correct?

Dr. FAUCI. We haven't formally proved it. But it is strongly likely that that is the case.

Mr. SARBANES. OK.

Dr. FAUCI. Because if this acts like any other virus, once you recover you won't get reinfected.

Mr. SARBANES. And if they then came down with another cold not related to coronavirus—thought maybe it was coronavirus, got tested—would that test show that they had gotten the coronavirus or not?

[Audio malfunction in hearing room.]

Dr. FAUCI. If you do an antibody test, if you wait weeks and months after you have recovered, the antibody test will tell you whether that person was formally infected with coronavirus.

Mr. SARBANES. OK. Following up on that, if somebody has the immunity and in that sense is not a carrier, they could still transmit, right, if they were in a space where they got the virus somehow on their skin or something else so they could still put someone else at risk even though in their mind they are thinking, I am now immune and therefore I am safe to move around, in a sense. Is that true? No?

Dr. FAUCI. Absolutely not.

Mr. SARBANES. OK.

Dr. FAUCI. Thank you for asking the question.

So, let us say I get infected and whether I get sick or not I clear the infection from my body. I do two tests 24 hours apart, which is the standard to say I am no longer infected.

A month and a half from now you do an antibody test and that test is positive, I am not transmitting to anybody because my body has already cleared the virus.

So, even though my antibody test says you were infected a month or two ago, right now, if there is no virus in me, I am not going to be able to transmit it to anyone.

Mr. SARBANES. Asking a slightly different question, I am going to run out of time so I will come down maybe or I will ask you offline so I understand that better.

I did, in the last 25 seconds here, though, just want to say that I would like to followup Dr. Kadlec, I believe, in terms of the Federal Government's plans around telework because, obviously that is going to be critical in terms of continuity of operations.

A lot of folks are already doing that on a discretionary basis. But I am going to be interested in what the agency wide response is there.

I do—I do have something I would like to enter into the record, Madam Chair, which is a—is testimony from AFTE in part relating to the importance of telework and what they would like to see in that space, and I would ask unanimous consent to submit that for the record.

Thank you.

Mr. CLAY. The gentleman from California is recognized for five minutes.

Mr. GOMEZ. Thank you, Madam Chair.

Thank you all for being here. Last night, President Trump announced that starting on Friday at midnight he is suspending all travel from and to Europe to the United States for the next 30 days. Only the United Kingdom and appropriately screened Americans are exempted from this ban.

The CDC previously recommended that all Americans avoid travel to China, Iran, South Korea, and Italy. It has recommended that older adults or those with chronic medical conditions propose postpone travel to Japan.

Dr. Fauci, will a travel ban like this have significant impact on reducing the community spread of the coronavirus—that is, cases that are already in the United States?

Dr. FAUCI. Yes, that is the—the answer is a firm yes and that was the reason, the rationale—the public health rationale why that recommendation was made.

Because if you look at the numbers it is very clear that 70 percent of the new infections in the world are coming from that region, from Europe, seeding other countries. Firs thing.

Second thing, of the 35 or more states that have infections, 30 of them now or most recently have gotten them from a travel-related case from that region. So, it was pretty compelling that we needed to turn off the source from that region.

Mr. GOMEZ. Can I—let me—so I have been in a lot of the briefings. I have been listening to you very carefully. What changed between, you know, when you were here to last night when it—to all of a sudden impose this ban, this travel ban?

Dr. FAUCI. Yes. Well, we, as you probably know, as I mentioned, we meet physically once a day every day, conference calls and telephone calls during the day between briefings, and what happens is that things evolve as you see the cases and when you look at the data all of a sudden we had China being the seed, and we did that with China.

And then as the days and weeks get by it became clear it wasn't China anymore. It was another region.

Mr. GOMEZ. So, something changed, right? So, this was always an option that was always on the table.

Dr. FAUCI. Yes. But the dynamics of the outbreak changed. It shifted from a China to the rest of the world to Europe to the rest of the world.

Mr. GOMEZ. And you yesterday quoted Gretzky. You want to be where the puck is.

Dr. FAUCI. Right.

Mr. GOMEZ. Not where it is at. Where the puck is going to be.

Dr. FAUCI. Yes.

Mr. GOMEZ. Do you expect that the administration will issue additional travel restrictions in the future?

Dr. FAUCI. I think if, in fact, the dynamics of the outbreak mandates that, they would seriously consider that. I can't say yes or no. But I can tell you it would be seriously considered.

Mr. GOMEZ. OK.

Dr. Redfield, what other countries is the CDC watching for similar recommendations?

Dr. REDFIELD. Well, as Dr. Fauci said, you know, clearly, it was Korea and Italy and Iran that really became our next epicenters. Unfortunately, because Italy spread to the region, now we really have a major regional outbreak now in Europe.

We are continuing to really watch the whole world. At this point in time, it really is Iran, Korea, and the mainland Europe that are the epicenters right now and with Europe driving the global outbreak for sure for the last couple of days.

Mr. GOMEZ. OK. One of the things that has been expressed is that the president also warned older Americans to avoid nonessential travel to crowded places. CDC has recommended that vulnerable individuals avoid travel to—such as long plane rides and, in particular, avoid cruises.

I know that this means older adults with chronic health conditions. What are older adults? How do you define that?

I mean, that is not a loaded question. I am just——

Dr. FAUCI. The reason I laugh, my standard answer is anybody older than me.

[Laughter.]

Dr. FAUCI. But that is not a good answer. You know, generally, it is 60, 65 years old.

Mr. GOMEZ. In here in Congress—young and I am 45. So, what does that tell you?

Dr. FAUCI. That is the general. But I think——

Mr. GOMEZ. What is the age?

Dr. FAUCI. Generally, people refer to it as 60, 65 years old as elderly. However, the thing we need to point out that is important is that there is numerical age and there is physiological age.

There is a great deal of variability in the vulnerability of a person based purely on their age. You could have a 75-year-old person who is vigorous and has a really robust immune system.

You can have somebody that is 60, 65 not nearly good. It isn't linear based on just your age.

Mr. GOMEZ. The reason why is—the reason why we are asking these questions is that the constituents really want specifics, right. Like, if I am above 60 and I am a marathon—you know, I am 60 and I am out of shape then maybe I shouldn't be traveling. Now, if I am 70 or older and I am a marathoner and I do X, Y, and Z and, like, everything looks great, then it might not be as severe, correct?

Dr. REDFIELD. Yes, I was just going to say this is driven by the mortality of this infection. Clearly, individuals that are under 30, under 40, under 50, we have seen these individuals may get a really severe cold and they recover or they may be asymptomatic.

When you look at the mortality in Italy, the average age of death was somewhere between 82 and 84. When you look at the overall mortality that we are seeing across China and everything, it is really in the 70's.

So, we are really trying to get the most vulnerable out of an environment where they may catch this virus.

Chairwoman MALONEY.

[Presiding.] The member's time has expired.

Mr. GOMEZ. Thank you.

Chairwoman MALONEY. The gentlelady from the District of Columbia, Ms. Eleanor Holmes Norton, is recognized for five minutes.

Ms. NORTON. Thank you, Madam Chair.

Gentlemen, we are here in the Nation's capital where a state of emergency has been declared by the mayor of the District of Columbia.

This is a tourist Mecca. Millions come from all over the world and all over the country. I am concerned about our health care providers and our first responders.

Social distancing is not really an option for them. They are, in a real sense, the last line of defense. For example, in New York we heard of doctors and nurses who have reportedly been exposed to the virus.

Let me ask you, Dr. Redfield, can any medical provider who wants to be tested today be tested?

Dr. REDFIELD. Again, I think that would be a decision that the hospital would make and the individual's physician. But your point, the importance of protecting our providers with the proper infection control procedures is critical. We put out guidance and we need to continue to do that.

Ms. NORTON. So, there needs to be some prioritization of who—obviously, people who have been exposed. But if we get beyond that, people who expose themselves, it seems to me, ought to be given first priority.

Mr. Kadlec, let me ask what HHS is providing—is advising providers to do to ensure that there is not a shortage of medical staff.

Dr. KADLEC. Yes, ma'am. And I think that is a critical issue here in terms of evaluating not only the personal protective posture of physicians who are managing patients with this particular virus but also those that are working in emergency rooms and in other areas where there is a risk they could be exposed in that setting.

A couple areas that are being considered are what are the particular work-related rules as would require people to be furloughed from work if they were exposed. There was a question earlier about someone being in an appropriate protective posture, exposed, and then there was a question whether they would even be furloughed.

And, again, it gets back to your possible question of testing. If that is an appropriate intermediate means to keep a health care worker on the job in lieu of that kind of absence or excuse from work.

Ms. NORTON. We awoke this morning to find that the World Health Organization had officially declared this to be a pandemic. I am worried about personal protective equipment. I guess I should ask you, Mr.—Dr. Kadlec.

Will shortages of personal protective equipment like face masks and gloves, et cetera, hamper public health response? What priority is given to who gets these—this vital equipment?

Dr. KADLEC. Well, ma'am, that is a great question because, quite frankly, there is a potential risk. Much of what we get is sourced from overseas.

We are working actively with manufacturers and distributors to make sure two things happen. One is that supply chains are uninterrupted. The second thing is that allocations go preferentially to health care workers over others.

Ms. NORTON. Is the—is the Health and Human Services Department taking any steps here in the United States to boost production of these supplies——

Dr. KADLEC. Yes, ma'am, they are.

Ms. NORTON [continuing]. Of these supplies so that people are—I mean——

Dr. KADLEC. Yes, ma'am. Yes, ma'am.

Ms. NORTON [continuing]. Who is manufacturing these supplies? Is that continuing?

Dr. KADLEC. Yes, we are and, basically, we are—we have released a request for proposals for a half a billion N95 masks. To boost production, we are working with manufacturers to make sure

that they have the raw materials which are sources to the United States so they can surge and many of them——

Ms. NORTON. So, all the people who make——

Dr. KADLEC. Yes, ma'am.

Ms. NORTON. All these supplies, the gloves and—they are all boosting?

Dr. KADLEC. Yes, ma'am. They are—they are boosting them and looking to source it from the—one thing that I mentioned earlier was, again, the importance for liability protection for some of these manufacturers, particularly around N95 masks.

Ms. NORTON. Then that should be in our bill then that we are working on that?

Dr. KADLEC. Yes, ma'am. That is a must pass bill because that is critical to enable more——

Ms. NORTON. Well, we will be sure that—because we are working on a bill as I speak, trying to make it a bipartisan bill.

Finally, let me ask you, with—about Italy, because Italy is the worst case scenario that can educate us about what is—what could happen to us, and I understand that doctors anticipate hospitals running out of beds within a week in Italy if the spread continues.

If the rates continue here—or let me ask you, are we doing anything to keep the United States from running out of beds, for example, in Washington State?

Dr. KADLEC. Yes, ma'am. In fact, we are doing a couple things there and the state is working with HHS and doing things on their own.

But they are using alternate care facilities to offload some of the—some of the people who were moderately ill and putting them in settings that segregate them from regular hospitals, so it won't——

Ms. NORTON. And what kind of facilities?

Dr. KADLEC. Motels, for example. And the same thing is happening in the state of California. HHS is working with the state there to basically identify alternate care facilities for low acuity patients.

The one thing that is a concern is whether or not high acuity beds, intensive care beds, could be at risk and we are monitoring that very carefully.

And, again, looking for alternative solutions that we could use to make sure that we can take care of anyone who has this virus but, more importantly, take care of people who don't have the virus but who have other medical needs.

Chairwoman MALONEY. Gentlelady's time has expired.

And the gentleman from Missouri, Mr. Clay, is our last member to question today.

Mr. CLAY. Thank you, Madam Chair, for this hearing. And yes, I am batting cleanup. So, I would like to ask about a story that broke yesterday.

According to Reuters, since mid-January the NSC has ordered HHS to classify top-level discussions related to the coronavirus. The topics of these discussions have reportedly included, and I quote, "the scope of infections, quarantines, and travel restrictions."

Dr. Kadlec, is it true that HHS has been holding classified coronavirus hearings?

Dr. KADLEC. So, we are holding them in a classified room. But the nature and the content of those conversations are not classified.

So, we have been doing secure video conferencing across the interagency and that requires going into a classified space. I could see how it would be misinterpreted as such. But the nature of the conversations are unclassified.

Mr. CLAY. And so how many meetings since mid-January have been held in those——

Dr. KADLEC. Too numerous to count, honestly.

Mr. CLAY. Too numerous——

Dr. KADLEC. The—we are meeting several times a day if not more at different levels of the organization to basically address critical questions as it relates to the safety and health of Americans, the adequacy of supplies, the adequacy of our health care system.

Mr. CLAY. Yes, but it is my understanding that some officials are left out because they don't have the correct level of security clearance.

Dr. KADLEC. Sir, that is an administrative challenge sometimes because these secure places are administered by classification rules that have nothing to do with the content of the conversation but just the physical access to the place.

Mr. CLAY. Really?

Dr. KADLEC. So, these individuals have to be escorted in and, again, the nature of the conversations have to remain unclassified in those settings and they are unclassified by the virtue of the content.

Mr. CLAY. Does that inhibit our ability in any way to get the expertise we need into the room?

Dr. KADLEC. No, sir. I think in the case of the White House situation room, which is the highest level of classification you can have, we have all the appropriate people in the room to make those decisions, including individuals who have no clearance—security clearance at all.

Mr. CLAY. According to one official, because these meetings have been held in SCIF, critical government experts have been then excluded in these discussions and this practice, quote, "seemed to be a tool for the White House, for the NSC to keep participation in these meetings low."

Are you familiar with 28 CFR Section 17.22?

Dr. KADLEC. Well, sir, I would have to—sir, if you would hum a few bars I could probably guess it. But I worked on the Senate Intelligence Committee and I have to admit I believe it is related to the security practices in these——

Mr. CLAY. Here is what the section describes. The information shall not be classified in order to conceal an efficiency violations of law or administrative error to prevent embarrassment to a person, organization, or agency, to restrain competition or to prevent or delay release of information that does not require protection in the interests of national security.

Information that has been declassified and released to the public under proper authority may not be reclassified.

Do you know that we have discussed at length today the need for our government agencies to be transparent with the American

people and they deserve answers to be able to protect themselves and their families from this pandemic?

Is the information being discussed in these meetings all actually classified under the definition of classified security information?

Dr. KADLEC. They are totally unclassified and I think it has been the intent of Secretary Azar and our department to be radically transparent, to make sure that anything that we can share and I will allude to my colleagues on the right of me, Dr. Fauci and Dr. Redfield, who have been participants, to offer their observations as well.

Mr. CLAY. Go ahead, Doctor.

Dr. FAUCI. Totally—I totally agree with Dr. Kadlec. There really is no function or classification. It is merely an access thing, and there are people that we need are in there and there is nothing that we say in there that we are not—that we are afraid to say to you right here.

Mr. CLAY. OK. And so you would be willing to share that information with us that——

Dr. FAUCI. We have been. In fact, all the questions we have asked are reflective of what has gone on in that room.

Mr. CLAY. Well, and I appreciate that. Appreciate your openness and transparency, and I look forward to working together to resolve the issues that we face as a Nation.

And with that, I yield back, Madam Chair.

Chairwoman MALONEY. The gentleman yields back. And I just want to thank all of you for testifying.

Would you like to make a statement, Mr. Redfield?

Dr. REDFIELD. Chairwoman, I——

Chairwoman MALONEY. Doctor—Dr. Redfield.

Dr. REDFIELD. That is all right. I would like to just make two clarifications, one of which I did yesterday and one of which I did today, if I could have a second to——

Chairwoman MALONEY. Absolutely.

Dr. REDFIELD. So, yesterday, I want to clarify that when I was asked about manufacturing of the tests, the original tests, I just want to clarify that CDC did manufacture the original CDC test that we used at CDC and we also manufactured the initial test we sent out to states, and IDT manufactured the kits after that. So, I just want to get that on the record.

Second, in my comments today I wanted just to clarify that we are currently examining all avenues to try to ensure that the uninsured have access to testing and treatment, and we are encouraging the use of the federally qualified health centers that can do this at reduced or free, and we will continue to update both the Congress and the public on all available resources for this population.

Chairwoman MALONEY. Thank you for clarifying that.

Yes, uh-huh?

Dr. KADLEC. Madam Chairman, I do have one errata from yesterday. I misspoke. When talking about BARDA I mentioned they had 53 FDA approvals I was incorrect. It is actually 54.

Chairwoman MALONEY. That is very accurate. Would anyone else like to make a statement?

Well, I want to thank all of your for testifying today. We realize that this is the third testimony, third meeting that you have taken today. We appreciate it. We appreciate you coming back. Thank you for your public service, your hard work, your dedication.

And particularly, I want to thank Dr. Fauci for serving six presidents. Six presidents. And speaking so truthfully and honestly to the public as all of you have. I can't tell you how many people have contacted me that they now understand more about it.

They feel better about it. You have truly performed an incredibly important public service by speaking really to the American people, as you are today, on this panel.

We thank you so, so very much. And I do want to say a very special thank you to Mr. Jordan. This is his last day as ranking member of this committee.

We all thank him for his service. He will be moving to ranking member on the Judiciary Committee but not leaving the committee. So, we can continue working together.

And I understand that you will be taking your staff with you. So, I want to thank them for their excellent hard work and also my own staff that has really worked on this hearing and on all of the matters before it.

I just also understand that you will be going next door, as I understand it. So, I am wondering if you would—I yield to you. I am very sorry you are leaving, quite frankly, and I have enjoyed working with you.

Mr. JORDAN. Same here, Madam Chair. That was very nice and I appreciate those kind words. I am not going far. I will be sitting right here, so I would just be one seat further. But thank you for your—for your work and it has been a pleasure to work with you.

Thank you to our witnesses again and for the work you are doing for the American people.

Chairwoman MALONEY. The American people are very grateful.

Without objection, all members will have five legislative days within which to submit additional written questions for the witnesses to the chair, which will be forwarded to the witnesses for their response.

I ask our witnesses to please respond as promptly as you are able. This hearing is adjourned.

[Whereupon, at 12:56 p.m., the committee was adjourned.]

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