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OVERSIGHT OF THE TRUMP ADMINISTRATION'S

RESPONSE TO THE COVID-19 PANDEMIC

TUESDAY, JUNE 23, 2020

House of Representatives

Committee on Energy and Commerce

Washington, D.C.

The committee met, pursuant to call, at 11:00 a.m., in Room 2123 Rayburn House Office Building, Hon. Frank Pallone [chairman of the committee] presiding.

Members present: Pallone, Rush, Eshoo, DeGette, Doyle, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, McNerney, Welch, Lujan, Tonko, Loebsack, Schrader, Kennedy, Cardenas, Ruiz, Peters, Dingell, Veasey, Kuster, Kelly, Barragan, Blunt Rochester, Soto, O'Halleran, Walden, Upton, Burgess, Latta,

Rodgers, Guthrie, Olson, McKinley, Kinzinger, Griffith, Bilirakis, Johnson, Long, Bucshon, Flores, Brooks, Hudson, Walberg, Carter, Duncan, and Gianforte.

Staff present: Joe Banez, Professional Staff Member; Kevin Barstow, Chief Oversight Counsel; Billy Benjamin, Systems Administrator; Jacquelyn Bolen, Counsel; Jesseca Boyer, Professional Staff Member; Jeff Carroll, Staff Director; Sharon Davis, Chief Clerk; Kimberlee Espinosa, Professional Staff; Austin Flack, Staff Assistant; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Stephen Holland, Health Counsel; Zach Kahan, Outreach and Member Service Coordinator; Saha Khaterzai, Professional Staff Member; Chris Knauer, Oversight Staff Director; Una Lee, Chief Health Counsel; Kevin McAloon, Professional Staff Member; Aisling McDonough, Policy Coordinator; Meghan Mullon, Staff Assistant; Joe Orlando, Staff Assistant; Kaitlyn Peel, Digital Director; Alivia Roberts, Press Assistant; Tim Robinson, Chief Counsel; Samantha Satchell, Professional Staff Member; Andrew Souvall, Director of Communications, Outreach and Member Services; Benjamin Tabor, Policy Analyst; Kimberlee Trzeciak, Chief Health Advisor; C.J. Young, Press Secretary; Nolan Ahern, Minority Professional Staff,

Health; Jennifer Barblan, Minority Chief Counsel, O&I; Mike Bloomquist, Minority Staff Director; S.K. Bowen, Minority Press Secretary; William Clutterbuck, Minority Staff Assistant; Diane Cutler, Minority Detailee, O&I; Molly Jenkins, Minority Press Secretary; Caleb Graff, Minority Professional Staff Member, Health; Tyler Greenberg, Minority Staff Assistant; Tiffany Haverly, Minority Communications Director; Brittany Havens, Minority Professional Staff, O&I; Peter Kielty, Minority General Counsel; Bijan Koohmaraie, Minority Counsel, CPAC; Ryan Long, Minority Deputy Staff Director; Mary Martin, Minority Chief Counsel, Energy & Environment & Climate Change; James Paluskiewicz, Minority Chief Counsel, Health; Brannon Rains, Minority Policy Analyst; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Alan Slobodin, Minority Chief Investigative Counsel, O&I; Natalie Sohn, Minority Counsel, O&I; and Everett Winnick, Minority Director of Information Technology.

The Chairman. [Presiding.] The Committee on Energy and Commerce will now come to order.

Today, the Committee is holding a hearing entitled, "Oversight of the Trump Administration's Response to the COVID-19 Pandemic". Due to the COVID-19 public health emergency, members can participate in today's hearing either in person or remotely via video conferencing.

As part of this hearing, the microphones of members participating remotely will be set on mute for the purpose of eliminating inadvertent background noise. Members participating remotely will need to unmute your microphone each time you wish to speak.

For members and witnesses participating in person, I encourage you to wear your mask whenever you are not speaking. Dr. Monahan stressed in the updated attending physician's COVID-19 guidelines that the use of face coverings is meant to protect other people in case the wearer is unknowingly infected, but does not have symptoms. By wearing our masks when we are not speaking, each of us is playing a vital role in protecting all members and staff who are in attendance, as well as the leaders of the administration's COVID-19 response who will be testifying before the committee today.

Due to the anticipated length of this hearing, the committee will take a 15-minute recess at 1:30 p.m. to provide witnesses a restroom break.

And finally, documents for the record can be sent to Benjamin Tabor at the email address we provided to staff. All documents will be entered into the record at the conclusion of the hearing.

And now, I recognize myself for 5 minutes for an opening statement.

Today, the Energy and Commerce Committee continues its important work overseeing the administration's response to the COVID-19 pandemic. It is difficult to overstate this disease's devastating impact. To date, more than 2.2 million Americans have contracted COVID-19 and, tragically, more than 120,000 have died. At the same time, more than 45 million Americans have filed for unemployment over the last three months. COVID-19 has wreaked havoc on this country's physical, mental, and economic well-being.

And the pandemic has been especially brutal to people of color and low-income communities. Thousands of families can tell stories of losing a relative without being allowed to visit them in their final days or the social isolation felt by seniors and others in long-term care facilities. Millions more could tell

us about losing their jobs or being forced to close a small business.

On top of the raw devastation of this disease, this committee must confront the fact that, had it not been for a sluggish initial response from the Trump administration, and a President in my opinion putting political considerations over public health, we could have done much more to mitigate the destructive impact of COVID-19. And we must learn from and correct the administration's mistakes, so that we are prepared to combat this disease as more outbreaks flare up this summer and the potential second wave comes in the fall.

Now testing has been a problem since the beginning, and while it has improved, we are still falling far short of the 900,000 daily tests public health experts believe we need. We are also hampered by the administration's refusal to develop and implement a national testing and contact tracing strategy. This cannot continue. I think we need federal public health experts to take more of a leadership role, and this administration is failing to allow that.

Public health must also be our first consideration as we accelerate research into a vaccine and treatments for COVID-19. We all want a vaccine to be developed as soon as possible. Before

any vaccine or treatment is distributed, our public health experts must ensure that it is safe, effective, and accessible.

And we must also take action to prepare our supply chain with sufficient quantities of vials, needles, syringes, and other products necessary to administer a vaccine. We also need to improve testing supply and our supply of personal protective equipment, or PPE, for our frontline workers and others throughout the economy. And while our supply of some PPE has improved, governors have told us that we are still far from where we need to be.

Fortunately, last month the House passed the Heroes Act, which provides our public health agencies with the mandate and the resources to ensure we are prepared going forward. The bill requires that HHS finally develop a national testing and contact tracing plan and provides $75 billion to carry it out. It also provides billions more to strengthen the Strategic National Stockpile and to increase research, development, and manufacturing of vaccines and treatments. And it ensures that all Americans will be able to receive free coverage of treatment, drugs, and an eventual vaccine with no cost-sharing. This legislation is needed today, but the Senate has failed to act and the Trump administration has threatened to veto it without

putting forward any policy vision of their own.

Now President Trump refuses to even acknowledge the challenge we face and the difficult work that must be done to prevent further destruction. Just this weekend, as outbreaks flared up and public health leaders continued to urge social distancing, the President put Americans at risk, in my opinion, by holding a political rally in Oklahoma. And at the rally, he suggested that his staff slow down testing to mask the true level of infection across the country. In fact, this morning the President said he wasn't kidding when he made those comments. And I think this was extremely reckless, and unfortunately, it continues the President's pattern of ignoring the advice of his own public health experts and it also sends a horrible message to some Americans that they, too, can ignore public health experts.

As this vicious disease continues to harm our country, it is extremely dangerous that the President, the Vice President, and others in this administration continue to downplay the risk we continue to face. All around the country, warning bells are going off, with hospitals struggling to keep up with the rate of hospitalizations and ICU beds filling up and emerging COVID hot spots. And the administration's unwillingness to face these

hard truths I think is going to lead more deaths and more needless suffering.

So, I am pleased that we have our nation's public health officials with us today. Thank you all for coming. I have admired your role and what you have done over the last few months. I think you can help us answer questions about what has gone wrong, what is improving, and how we can be prepared going forward. And I look forward to your testimony.

I now recognize our ranking member for 5 minutes for an opening statement.

Mr. Walden. Thank you, Mr. Chairman.

Before I begin, I have a parliamentary inquiry.

The Chairman. Yes.

Mr. Walden. Mr. Chairman, Committee Rule 9(b)(1) says that, "At full committee hearings, the chairman and ranking minority member shall be limited to 5 minutes each for an opening statement, and may designate other members to give an opening statement of not more than 5 minutes." And pursuant to this rule, I designated Dr. Burgess to give an opening statement. And I raise this because I know in the past at times only the chairman and ranking member have given opening statements. At other times, we have allowed the minority -- and you have I believe as well -- to

designate another member for 5 minutes.

Given the importance of this hearing, I would hope that we could work this out where the subcommittee chairmen and rankers could also comment. And I wonder if you would be willing to allow that.

The Chairman. Well, I appreciate your comments, Mr. Walden, but the answer is no. I mean, first, let me remind members that, pursuant to committee rules, all members' written opening statements will be made a part of the record. But, according to our rules, only the full committee chair and ranking member must be provided 5 minutes for an opening statement at a full committee hearing.

Now, you know, we don't have too many of these because, in the tradition of the Energy and Commerce Committee, we try to do all the hearings at the subcommittee level. But the problem with doing that today is that I thought this was important enough for a full committee hearing, but, plus, these witnesses are going to be testifying in areas that cross the boundaries of various subcommittees. And so, if we let the Health Subcommittee ranking members, we would have to let the ranking members of all the subcommittees, including O&I, and that is just going to drag things on too long. So, I decided that we would just have it

for the full committee members.

And I would point out -- I don't want to go into it -- I could give you all the record about how, when you were chair when we had full committee hearings, we just had it limited to the two full committee members. And I know you are not saying that we have to do it. You are just asking that we do it. But, given the fact that I would have to open it up to all the subcommittee chairs, and we would be here another hour, I think, I have decided to just proceed with the two of us.

Mr. Walden. Sure. Reclaiming my -- I guess I can reclaim the time on a parliamentary inquiry.

But I know in the past we would even be willing to divide that simple 5 minutes among both Mr. Guthrie and Dr. Burgess. I would suggest you could do the same on that side and limit it to 10 minutes.

The Chairman. Do you want to use your time for them?

Mr. Walden. No, I would yield it, as allowed for under our rules, the additional 5 minutes. Each side would have 10 minutes total.

The Chairman. No, because you see my point. My point is, if you just have the subcommittee chairs -- and nobody is prepared to do that at this point. So, let's just leave it the way it

is and you use your 5.

Mr. Griffith. Mr. Chairman, parliamentary inquiry.

The Chairman. Yes.

Mr. Griffith. What part of Rule 9(b) do you think does not give the ranking minority member the opportunity to delegate another member to give an opening statement of not more than 5 minutes? When I read this language, it is pretty clear, it is not a decision of the chair. It is, in fact, built into the rules that that is a decision of the ranking member, the ranking minority member, if he chooses to do so.

And as Jefferson's Manual opens up with very clearly -- and I didn't bring my copy down with me today -- but the rules are designed to protect the rights of the minority because the majority can do whatever it wants to whenever it wants to. And the rules that we adopted just at the beginning of this congressional session reiterated the fact that the minority ranking member not only gets his 5 minutes, or her 5 minutes, but that they may designate another member to give an opening statement of not more than 5 minutes.

So, while we have waived that in the past, I don't see anything in here that actually gives that decision to the chair. And while we are all friends -- and I know you do the best you

can, Mr. Chairman; I am not criticizing that personally -- I am just saying the rules are pretty clear that the ranking minority member gets to designate somebody, and it is not --

The Chairman. Well, that is not the way I read it. According to the rules, only the full committee chair and ranking member must be provided the 5 minutes for an opening statement at a full committee hearing. Anything else is discretionary with the chair and is "may".

Now, again, this interpretation is not unique to my term as chairman. At the first full committee hearing during the ranking member's term as chairman of the full committee, on October 25th, 2017, a hearing entitled, "Federal Efforts to Combat the Opioid Crisis," then-Chairman Walden announced, "At the conclusion of my opening statement, we now go to our witnesses." Full committee hearing, only the chairman and ranking member give opening statements just for our committee's benefit. So now, we go to our witnesses.

And then, in the 116th Congress, we continued the same practice of only providing the full committee chair and ranking member with 5 minutes each for opening statements at full committee hearings.

At both the May 22nd, 2019 full committee hearing entitled,

"Lift America: Modernizing our Infrastructure for the Future," and the July 25th, 2019 full committee hearing entitled, "Member Day," only the full committee chair and ranking member were provided time for an opening statement.

So, I am just continuing the same practice today that existed both under Mr. Walden's chairmanship and mine, and it is clearly discretionary. But the reason I am exercising discretion to not do it beyond the 5 minutes for each of the full committee chairs and rankers is because of the time limits. I mean, I guess now we are wasting time. But, I mean, look, I don't want to tell you what to do, but I am going to insist on that.

And I would rather proceed and hear from everybody.

All right, you are recognized, Mr. Walden, for 5 minutes.

Mr. Walden. Well, Mr. Chairman, I am frustrated by that. I know members on both sides, and in the past back to 2011 and 2013, chairs and rankers did work this out and did have others participate.

So, I will move on to my opening statement at this point.

I want to thank our distinguished panel of witnesses who are still working around the clock to understand this deadly virus and to develop public health standards to confront it, medicines to treat it, and a vaccine to end it.

COVID-19 laid bare how vulnerable we are and how much more we need to do as a government. I comment the work of my colleagues, Anna Eshoo and Susan Brooks, to modernize the Pandemic and All-Hazards Preparedness Act. And I acknowledge the incredible efforts of Fred Upton and Diana DeGette who wrote the 21st Century Cures legislation.

But, even with all of that work, COVID-19 hit the world like a tsunami, quick and deadly, leaving unprecedented destruction and disruption. Our distinguished speakers are like co-captains of America's rescue plane, a plane we are building while we fly. Congress has supported those efforts with historic levels of funding, resources, and flexibility.

Early on, President Trump stopped flights from China, and then, Europe. He tightened up our borders, established a presidential task force to coordinate efforts, and invoked executive authority seldom used except in times of emergency or war, including the Stafford Act and the Defense Production Act, and harnessed the power of American innovation through projects like Operation Warp Speed.

During this unprecedented response, the administration had to operate with very limited, often conflicting, data. Even with CDC guidance in hand, some governors chose to ignore that

guidance, and they actually forced sick nursing home patients back to the nursing homes, committing the deadliness mistake of the pandemic.

Meanwhile, backward-looking critics with unfair advantage of 20/20 hindsight attacked you and the men and women who worked alongside of each of you. I commend our witnesses today for keeping focused on the challenges at hand and for doing everything possible to beat this virus.

Six months ago, we had barely heard of this virus. During our briefings, most thought that, like SARS and MERS before it, we would get past this beast, which didn't even have a name back then. We quickly went from knowing little about this virus to creating a test for it and testing more than 25 million samples, with recent averages of more than 500,000 tests a day. But we all know there is more to be done.

Dr. Giroir is a distinguished admiral who became a self-proclaimed "swab guy," quote-unquote, because that is what America needed. We discovered there were only two nasal swab manufacturers in the world, one in Maine and one in Italy. And the President invoked the DPA ordering Puritan to make the swabs we needed, and then, provided funds made available through Congress to dramatically increase production in a new facility

in Maine.

Meanwhile, the President launched Project Airbridge to fly military planes to Italy to pick up swabs and to search the globe for other supplies that we found in complete limited supply here.

The State Department helped 101,386 Americans abroad get back home, often on government-chartered planes when commercial transportation was shut down.

With a potential increase of illnesses in the fall when coupled with the flu season, I asked my team to research every aspect of this health crisis and provide recommendations to improve our preparedness going forward. Mitigating a second wave of infections is critical, given the impact this virus has had not only on public health, but also on people's livelihoods and America's economy. We released the first recommendations on testing and surveillance three weeks ago and are preparing to release recommendations on therapeutics and vaccines very soon.

In less than six months, the United States has conducted millions of tests, manufactured medical equipment in car factories, used 3D printers to make personal protective equipment, developed multiple vaccine candidates, authorized use of more than 100 medical devices and drugs for emergency use, weighing the known and potential benefits and risks at the time

-- all at unprecedented speeds. These innovations have the ability to serve us well and far beyond this pandemic.

We have seen remarkable coordination, flexibility, and cooperation between the executive branch, private sector, faith groups, volunteers, and lawmakers. America is strongest when we work together to achieve common goals.

We are constantly learning how to improve our preparedness. We must adjust our response based off of facts at hand and focus on how to best move forward. We must unite in a common fight against this virus.

Just as America mobilized in World War II to do whatever it took, today our distinguished panelists have mobilized America's finest scientists, logisticians, and entrepreneurs to beat this deadly, microscopic enemy. Thank you for your leadership, for your years of public service, and for your dedication to this lifesaving mission.

Mr. Chairman, I yield back the balance of my time.

The Chairman. Thank you. I want to thank the ranking member.

And I would like to now introduce our witnesses for today's hearing. I keep calling it the White House Task Force on Coronavirus, but I don't actually know whether that is still in

existence or whether you are all members of it anymore.

So, first, we have Dr. Robert Redfield, the Director of the Centers for Disease Control and Prevention. We have Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health. We have Admiral Brett Giroir, Assistant Secretary for Health, U.S. Department of Health and Human Services, who is probably tired of hearing from me since I am call him all the time. And Dr. Stephen Hahn, who is the Commissioner of the U.S. Food and Drug Administration.

Thank you all for being here today, and I know it is going to be worthwhile.

At this time, the chair is going to recognize each witness for 5 minutes to provide their opening statement. Before we begin, I would like to explain the lighting system.

In front of you is a series of lights. The light will initially be green at the start of your opening statement. The light will turn yellow when you have 1 minute remaining. And, of course, you should try to wrap up your testimony at that point. And the light will turn red when your time expires. You probably know this already, but I will mention it again.

So, we are going to start with Dr. Redfield. You are

414 recognized for 5 minutes. Thank you.

STATEMENTS OF ROBERT R. REDFIELD, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION; ANTHONY S. FAUCI, DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH; ADMIRAL BRETT P. GIROIR, ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND STEPHEN M. HAHN, COMMISSIONER, U.S. FOOD AND DRUG ADMINISTRATION

STATEMENT OF ROBERT R. REDFIELD

Dr. Redfield. Good morning, Chairman Pallone, Ranking Member Walden, and distinguished members of the committee. Thank you for the opportunity to testify before you with my HHS colleagues.

Today, the COVID-19 pandemic continues in the United States and around the world. This pandemic is the greatest public health crisis our nation and our world have confronted in more than a century.

While overall case counts are going down, several communities are seeing increased cases driven by multiple factors, including increased testing, outbreaks, and evidence of community transmission.

Right now, the most powerful weapon against this disease are social distancing, face coverings, and hand hygiene. These

actions will help us contain transmission, along with readily available testing; comprehensive, timely contact tracing; timely isolation of known cases, and self-quarantine to break the chains of transmission.

Once again, I call on the American people to remain vigilant in our collective obligation to protect those who may be at risk for severe complications of COVID-19 due to age or underlying medical conditions. We must also lessen the burden of COVID-19 among racial and ethnic groups disproportionately impacted.

The CDC continues to improve its data collection of comprehensive data of each case, race, and ethnicity from our state, local, tribal, and territorial partners. Reporting from hospital surveillance sites, for example, has increased in completeness on race and ethnicity from 30 percent to now more than 80 percent. CDC is also receiving more complete data from our public health partners.

The recent CDC study examined more than 1.3 million COVID-19 cases and found that the most underlying health conditions were cardiovascular, diabetes, obesity, and chronic lung disease. Hospitalizations were six times higher for these individuals and death 12 times higher of those reporting these conditions compared to those without.

The CDC is working to ensure the equity and health outcomes and the social determinates are being addressed through the COVID-19 response. CDC continues to provide communities with technical expertise, tools, and information to confront the virus.

The CDC has created more than 1500 specialized resource and guidance documents that would have been consulted more than 1.5 billion times on the CDC website.

We have deployed over 5,000 personnel in the response. We have more than 40 rapid response teams on the ground now providing local health departments and health officials with expertise in epidemiology, surveillance, infection control, laboratory science, and community mitigation.

We are enormously grateful to the heroes of the response. That is the public health and health care professionals, the first responders, the critical infrastructure workers who have served and sacrificed too much.

CDC and our nation's public health partners are actively working on the front lines of this pandemic to remedy the shortcomings in a public health system that has been underresourced for decades. With your support, CDC has been able to award nearly $12 billion to states, territories, tribes, and

localities to enhance their response capabilities.

When confronted by any disease threats, CDC and public health departments must make real-time decisions based on real-time data. Data is the backbone of any disease threat response.

With the resources that Congress has provided, data modernization is underway. We also must ensure that our laboratories have resilience. Advanced technology, personnel, expertise, and supplies are being sourced.

Our public health workforce must grow exponentially to address COVID-19 and future public health threats. Thousands of contact tracers are onboard and being recruited by public health departments across our nation. The bottom line: sustained investment in the public health system is an investment in the health and prosperity of our nation.

Last, CDC has begun to prepare for the months ahead when the next season's influenza illness will occur simultaneously potentially with COVID-19, increasing the challenges on hospitals, health care professionals, and the public. This fall, before the seasonal circulation of influenza increases, I encourage the American people to be prepared and to embrace flu vaccination with confidence for yourself, your families, and the communities. This single act will save lives.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Redfield follows:]

**********INSERT 1**********

The Chairman. Thank you, Dr. Redfield.

Dr. Fauci?

STATEMENT OF ANTHONY S. FAUCI

Dr. Fauci. Thank you very much, Mr. Chairman, Ranking Member Walden. Thank you all for giving me the opportunity to discuss with you today the role of the National Institutes of Health in research addressing COVID-19.

The approach to the NIH is very similar to what we do with other emerging infections. It is a four-pronged approach. First, to study the fundamental knowledge of the virus itself, as well as the host response to the virus. The second is to help develop diagnostics and assays. The third is to characterize and test therapeutics, and the fourth is to develop safe and effective vaccines.

Speaking of the first, fundamental knowledge of the virus and what the virus is capable of doing, we have done a number of studies now that have informed how we are approaching therapeutics and vaccines. For example, the precise molecular structure of the spike protein, which is that part of the virus which actually gives it its name, coronavirus, because of these spikes that stick out from the virus, that is the way the virus binds to cells in the body. This has been precisely delineated by NIH scientists and those that we fund. Second, the

demonstration of the precise receptors where by the virus binds to cells in the body, allowing it to enter and cause disease. In addition, we develop animal models. We do natural history studies, such as understanding the virus in different demographic groups.

Second is the development diagnostics and assays. We need, and we will get within a reasonable period of time, based on a major investment in the RADx program, diagnostics that are point-of-care, simple, precise, sensitive, and specific. We hope by the end of the fall and into the early winter we will have these for wide distribution.

Third, the development and characterization of drugs. You have all heard of the first successful randomized, placebo-controlled trial of a drug called remdesivir, which was used in hospitalized patients with lung disease. It showed a statistically significant, but modest impact on decreasing the time to release from the hospital; namely, faster recovery. In addition, this drug is now being used in combination with another drug that blocks the inflammatory response, baricitinib. We are also looking at a variety of others: convalescent plasma, hyperimmune globulin, other drugs, monoclonal antibodies, as well as other immune-based therapies.

Fourth, the development of safe and effective vaccines, the hallmark of all really defining responses that we have to virus diseases. If you look at the history of viral diseases, it is generally vaccines that put the nail in the coffin of these types. We are now mounting a major effort in which we are collaborating with industry in public-private partnerships to get vaccine trials that are developed that harmonize with each other. In other words, they have multiple trials in which we have common questions that are being asked, common laboratories that are being looked at, common data and safety monitoring board, and common primary, secondary, and tertiary endpoints, so that the data can be compared from one to another.

You have probably heard that one of those vaccines -- and there are more than one; there are several that are moving along at various paces -- one of them will enter phase 3 study in July. This is one that has already shown in preliminary studies some very favorable response in the animal models that were developed. There will be others that will follow one month, two months, three months later.

Although you can never guarantee at all the safety and efficacy of a vaccine until you actually test it in the field, we feel cautiously optimistic, based on the concerted effort and

the fact that we are taking financial risks, not risks to safety, not risk to the integrity of the science, but financial risks to be able to be ahead of the game, so that when -- and I believe it will be when and not if -- we get favorable candidates with good results, we will be able to make them available to the American public, as I said to this committee months ago, within a year from when we started, which would put us at the end of this calendar year and the beginning of 2021.

I will stop there, Mr. Chairman, and be happy to answer questions later. Thank you.

[The prepared statement of Dr. Fauci follows:]

**********INSERT 2**********

588 The Chairman. Thank you, Dr. Fauci, and thanks for all your
589 contributions to fighting this pandemic. And I will say the same
590 about Admiral Giroir, who I bother the most.
591 You are recognized for 5 minutes, Admiral.

STATEMENT OF BRETT P. GIROIR

A Giroir. Thank you, Chairman Pallone, and I always enjoy our conversations. You call me anytime.

Ranking Member Walden, distinguished members of the committee, on March 12th, Secretary Azar requested that I lead the coordination of COVID-19 testing efforts within the Department of Health and Human Services. And I would like to be clear that, although I am no longer full time deployed to FEMA, I am maintaining my role of coordinating testing.

To date, the nation has performed over 27 million COVID-19 tests, now averaging about 500,000 tests per day. Even without any major technical advances, I estimate the nation will have the capacity to perform between 40 to 50 million tests per month by fall.

To address the public health challenges over the past months, we implemented a phased approach to meet the testing needs at each stage of the pandemic, especially now during reopening when the need for testing is the greatest. In early March, HHS and FEMA developed and implemented 41 community-based drive-through testing sites in locations prioritized by the CDC in collaboration with our state and local partners. These sites have tested nearly

300,000 high-risk individuals and served as prototypes that have been duplicated multifold.

Next, we leveraged trusted pharmacies to further implement community testing, especially for minorities and the underserved. This federal program is now providing testing at 611 locations in 47 states and the District, 70 percent of which are in communities with moderate to high social vulnerability. This program has tested over 688,000 individuals.

Federally Qualified Health Centers serve over 29 million people across the nation. They provide care to 1 in 5 of those uninsured, 1 in 5 rural Americans, 1 in 3 living in poverty, and 1.3 million homeless. Again, to assure we reach these most vulnerable among us, 93 percent of FQHCs offer COVID-19 testing.

To further expand access, we authorized all licensed pharmacists to order and administer COVID-19 testing under the Public Readiness and Emergency Preparedness, or PREP, Act. Over 90 percent of Americans live within 5 miles of a pharmacy, again assuring widespread availability.

On June 4th, using authorities provided to the Secretary under CARES, HHS released new mandatory laboratory reporting guidance, so that we can confirm that all groups are benefitting equitably from COVID-19 testing. Lab reports must include

demographic information like race, ethnicity, age, and gender.

And today, I am pleased to announce the selection of Morehouse School of Medicine as the awardee for a new $40 million initiative to fight COVID-19 among racial and ethnic minorities, as well as rural and other socially vulnerable communities. This cooperative agreement with the Office of the Assistant Secretary for Health's Office of Minority Health and Morehouse School of Medicine will develop and implement a strategic network of national, state, territorial, tribal, and local organizations to deliver COVID-19-related information to communities hardest hit by the pandemic. In the first year of this agreement, Morehouse School of Medicine will receive $15 million.

This massive expansion of testing resulted in unprecedented demand for supplies, reagents, and laboratory platforms. To meet this demand, we secured the global supply chain through a military airbridge. We worked directly with manufacturers to increase domestic production. We collaborated with external partners to validate new technologies. We secured and prioritized scarce point-of-care tests for state public health laboratories, the Indian Health Service, and other critical needs. Finally, we used Title III of the Defense Production Act to further invest in domestic manufacturing. These actions and others have enabled

our current efforts with states, territories, and tribes to implement evidence-based diagnostic and surveillance plans.

I would like to close by recognizing my fellow officers in the United States Public Health Service Commissioned Corps, the uniformed service that I lead. Four thousand four hundred and eighty-two officers have deployed to support the pandemic response, including to the Diamond Princess cruise ship in Japan, to our military bases repatriating Americans, to our community-based testing sites, to FEMA and task forces directly inside nursing homes, and to field hospitals across our nation, exemplifying the care and compassion that all of us feel for those who have suffered during this pandemic.

I thank each and every one of these officers and their families, and on their behalf, I would like to thank all of you in Congress for supporting our training needs and the establishment of a ready reserve corps to supplement our ranks during inevitable future national emergencies.

Thank you again for the opportunity to provide these remarks.

[The prepared statement of Admiral Giroir follows:]

**********INSERT 3**********

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684 The Chairman. Thank you, Admiral, and thank you for
685 mentioning the -- both military and civilians who are out front
686 and helping us during this crisis. We really appreciate all that
687 they do and we have to make sure that we help them as much as
688 possible.
689 So last, but certainly not least, because the FDA is just
690 as important, is Dr. Hahn, or Commissioner Hahn.

STATEMENT OF STEPHEN M. HAHN

Dr. Hahn. Chairman Pallone, Ranking Member Walden, and distinguished members of the committee, thank you for inviting me here today.

First, I would like to start by thanking all of you for your support of the agency and U.S. government with the laws that you've passed that become law of the land. It has helped a great deal in our response.

FDA has a critical role in the federal government's response to the COVID-19 pandemic. We remain focused on our mission of protecting and promoting the health and safety of Americans.

President Trump has requested and we have provided appropriate regulatory flexibilities to assure that the American public have access to critical medical products, safe foods, and the confidence that the government is taking measures to address important public health issues.

FDA has used our emergency authority since the beginning of this pandemic. We have issued more than a hundred emergency use authorizations for diagnostics, personal protective equipment, ventilators, and other devices, as well as for drug products.

Since the public health emergency was declared, we issued more than 50 guidance documents to help ensure the continuity of health care and safe food supply, and we put into place new initiatives to accelerate the development of needed products.

Additionally, we have kept the American public up to date on what they need to do to protect themselves and to contain the virus from spreading.

We are now preparing for the next phase of addressing this evolving crisis. It is mission critical that the agency continue to be diligent, assuring the safety of the products that we regulate, and that we also put in place processes needed to assure the protections that the public will need.

There are a number of experiences we have gained over the past few months that will inform our plans. We recognize that we must be bold in our decision-making and advance effective solutions to achieve challenging public health objectives.

Therefore, we have begun a comprehensive real-time review and assessment of our actions to date to address the COVID-19 pandemic.

The objective is to identify and address potential organizational and programmatic changes that should be implemented without delay to advance the ongoing response to

COVID-19.

We need to assure that we leverage what is working well while at the same time review our framework and policies to be positioned to effectively identify and respond to quickly evolving public health situations.

A major focus of this effort will be to identify what regulatory policies should be continued and accelerate it consistent with Executive Order 13294, signed by the president.

Durable policy, organizational and programmatic changes will be consistent with advancing the agency's public health mission and will inform our strategic priorities moving forward.

One of the challenges facing FDA during the COVID-19 pandemic is how to assure the timely review of medical product applications despite an incredible surge in volume and constraints on our ability to conduct onsite inspections.

I am pleased to announce today that FDA has maintained the same pace of meeting its goals on applications for medical products for the last six months it has maintained in recent years.

We are on target to meet our user fee goals for the drugs this year by reviewing and taking timely action on at least 90 percent of brand, generic, and biosimilar drug applications, even during the pandemic. Additionally, this work has continued at

a time when the number of applications received in some centers is substantially higher than the pre-COVID-19 times.

I want to thank the more than 17,000 employees of the FDA for their incredible efforts, one that reflects the remarkable dedication and commitment to the public health of all Americans.

Finally, I would like to discuss what is top of mind for all Americans, namely, the work that FDA is doing to facilitate the development of safe vaccines and therapeutics. FDA launched an emergency review and development program called the Coronavirus Treatment Accelerated Program, or CTAP, and we continue to work night and day to provide guidance and to review proposals from companies, scientists, and researchers who are developing therapies.

Let me be clear that data and science will dictate when we will have safe and effective treatments and vaccines for COVID-19, as Dr. Fauci just mentioned. Toward that end, FDA is using every available authority and applying every appropriate regulatory flexibility to facilitate the development and testing.

We have not lost sight of our solemn responsibility to the American people to ensure our decisions related to all medical products are based on science and data, and that is a commitment that the American public can have confidence in. And I assure

you that the FDA will provide leadership, expertise, guidance, information, and whatever else is needed as we continue to address this unprecedented challenge.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Hahn follows:]

**********INSERT 4**********

The Chairman. Thank you, Commissioner Hahn.

That concludes our openings from the witnesses, and so now we will move to member questions. Each member will have five minutes to ask questions of our witnesses and I will start by recognizing myself for five minutes.

Now, you know that I am very critical of the president for a lack of leadership from the start of this pandemic, which I think continues. And, of course, it is difficult because you work, in theory, for the president and I feel that many of you on many occasions actually wanted to take more leadership and be, as Dr. Hahn mentioned, or Commissioner Hahn, fully cognizant of the data and the science.

So it is difficult because I am going to ask you questions about the president's lack of leadership, and I know it is hard for you to answer those. So we will see.

But I do believe the president is encouraging behaviors that are not consistent with good public health such as encouraging thousands to attend a rally and not mandate the wearing of masks, and I can't imagine that NIH or CDC would suggest this as a best practice in the face of this pandemic.

So it is sort of like there is two versions of reality here. One is the president's and one is, hopefully, yours, based on

data and science. But I want to hear from the experts. So let me start with Dr. Fauci. You are a trusted voice and have always been candid with us and the American public.

Give us an unvarnished view of where we are at our fight against COVID-19, quickly if you can.

Dr. Fauci. Thank you very much for that question, Mr. Chairman.

It really is a mixed bag. We have a very large country, very heterogeneous, major differences, for example, between the New York metropolitan area and Casper, Wyoming.

If you look at how we have been hit, we have been hit badly. I mean, anybody who looks at the numbers we have had now over 120,000 deaths and we have had two and a half million infections. So it is a serious situation.

In some respects, we have done very well. Right now, for example, the New York metropolitan area, which has been hit extraordinarily hard, has done very well in bringing the cases down and using the guidelines that we have very carefully put together in a step wise fashion to try and carefully reopen their city and their state.

However, in other areas of the country, we are now seeing a disturbing surge of infections that looks like it is a

combination. But one of the things is an increase in community spread, and that is something that I am really quite concerned about that and you know that.

This has been something that has been in the press over the past couple of days. We were going down from 30,000 to 25,000 to 20,000, and now we sort of stayed about flat and now we are going up. A couple of days ago there were 30,000 new infections.

That is very troublesome to me. The way you address that, and I have said this over and over again, is you have to have the manpower, the system, the testing to identify, isolate, and contact trace in an effective way so that when you see those increases you can understand where they are coming from and you can do something about them.

Right now, the next couple of weeks are going to be critical in our ability to address those surgings that we are seeing in Florida, in Texas, in Arizona, and in other states. They are not the only ones that are having the difficulty.

Bottom line, Mr. Chairman, it is a mixed bag, some good and some now we have a problem with.

The Chairman. All right. Now, I am going to have to ask about the president because you talked about testing and how

important it is, and I -- you know, Admiral Giroir and I know how important it is.

At his rally over the weekend the president said, and I quote, "When you do testing to that extent you are going to find more people. You are going to find more cases. So I said to my people, 'Slow the testing down, please,' " unquote, and this morning he said he meant this.

So, Dr. Fauci, do you agree with that? Does it make sense that to safely open our economy we should be limiting the number of tests rather than ensuring that anyone who needs a test can get one? And you don't have to mention the president. I did. But tell us about the testing.

Dr. Fauci. I, as a member of the task force --

The Chairman. Your microphone is on?

Dr. Fauci. Sorry. I, as a member of the task force, and my colleagues on the task force, to my knowledge -- I know for sure that to my knowledge none of us have ever been told to slow down on testing. That just is a fact.

In fact, we will be doing more testing. As you have heard from Admiral Giroir, not only testing to specifically identify people in the identify, isolate, and contact trace, but also much more surveillance if you want to get your arms around and

understand exactly what is going on in community spread.

So it is the opposite. We are going to be doing more testing, not less.

The Chairman. And then let me just ask the same question of Dr. Redfield. Do you agree with the president on this? Do you think we should be testing more people? If you don't want to talk about the president, just tell us if you think we should be testing more people.

Dr. Redfield. As Dr. Fauci said, all of us have been and continue to be committed to increasing readily timely access to testing. We have made a marked improvement. We still have a ways to go.

One of the key things, as Tony mentioned, is surveillance, expanding surveillance because of the asymptomatic nature of this infection, and in doing so we are looking at ways that can really substantially enhance testing by potentially pooling samples.

So right now, as Giroir said, we are doing 500,000, 600,000 tests a day. If we can pool samples five to one, that would bring it to 3 million tests a day.

So we are continuing to try to enhance testing. It is a critical underpinning of our response.

The Chairman. Thank you, Dr. Redfield.

I recognize Mr. Walden now for five minutes.

Mr. Walden. Thank you, Mr. Chairman.

Let me -- let me go straight to the question that my colleague asked, and I will just ask each of you for a yes or no answer.

Has President Trump ever directed you to slow down testing for COVID-19 in the United States?

Dr. Redfield?

Dr. Redfield. No.

Admiral Giroir. No, sir.

Dr. Hahn. No, Congressman.

Mr. Walden. Thank you.

All right. Let us go to some other issues here.

Dr. Hahn, you created a website, I believe, on the FDA site dealing with convalescent plasma and antibody-rich investigational therapies that may help fight the virus.

What is the status of the research into the effectiveness of convalescent plasma in fighting COVID-19? What do we know right now?

Dr. Hahn. Thank you, Congressman Walden.

A really important question from a therapeutics point of view. As everyone here knows, convalescent plasma is where you take the natural immunity from a person who has recovered from

COVID-19 -- those antibodies -- and then administer to a person who is sick.

So we have partnered with BARDA and HHS as well as the Mayo Clinic to develop what is called an expanded access program. We have safety data from over 20,000 patients that shows this is a very safe therapy, and our preliminary assessment of the effectiveness of this plasma is quite encouraging.

We continue to look at the information. If those data hold, we will have potentially another weapon in the armamentarium against COVID-19, pending those final results. This will also allow us to have information that will feed the development of monoclonal antibodies and something else called a hyperimmune globulin, which we can pool that plasma and actually give it as an injection to people.

So I think it's a good news story right now. We have to wait for the final data to come in and we should know very shortly about that.

There are also several randomized trials looking at this as well that are ongoing across the country.

Mr. Walden. All right. Thank you very much.

Dr. Redfield, CDC has developed a new test to simultaneously detect two strains of influenza and the COVID-19 and is seeking

an emergency use authority.

How does the CDC envision its combined tests to be used?

Dr. Redfield. I think it is very important. As I mentioned, as we get to the fall, we are going to have influenza and COVID at the same time, and CDC is developing that test for the public health system. But in parallel, the private sector now has also got advanced development.

Maybe Dr. Hahn wants to comment on similar tests in the private sector. So to facilitate timely diagnosis of these two co-circulating pathogens.

Mr. Walden. Dr. Hahn, do you want to comment on that for 20 seconds?

Dr. Hahn. Yes, sir. In cooperation with Admiral Giroir, we have been working with companies to actually look at that. Admiral Giroir has been at the forefront of this. It has been a great relationship.

Mr. Walden. Admiral?

Admiral Giroir. I would just agree with my colleagues. We are all concerned about the possibly of co-circulation of influenza A and B as well as COVID-19 when it comes to flu season.

So we want to do everything we can to simplify the diagnosis,

and you can have a -- if you have a single test and we are working with multiple manufacturers. As is usual, the CDC is usually in the lead. But there are multiple manufacturers both at point of care and laboratory who will have this type of test available.

Mr. Walden. All right. Excellent.

You all have been subject to a lot of criticism, as has the president. Often that is leveled after we know facts we didn't know at the time when things started, and so it is really great if you have hindsight and 20/20 vision you can look back and say you should have done that then.

I want to look forward. What is it you need from Congress that you do not have now to have America ready for the fall? What should we be preparing for now for the fall?

I don't care who wants to start but I am down to a minute to answer. So Dr. Redfield?

Dr. Redfield. I think, first, I want to just express our appreciation to Congress for the supplemental funding. I think it is of note that CDC has been able already to disburse $12 billion to the states to help prepare their COVID responses and, really, that is an unprecedented amount of resources.

I would only ask that we look to how to make this a sustainable investment as opposed to a sporadic investment to this particular

challenge we have right now.

Mr. Walden. All right. Dr. Fauci, what do we need to worry about? What don't you have?

Dr. Fauci. Well, just to reiterate what Dr. Redfield said, we are extraordinarily grateful for the -- you know, the unprecedented amount of supplementary funded that the Congress gave to us, which really make it totally possible for us to do the kinds of things we need to do on an emergency basis.

But, again, to mention what Dr. Redfield said, we have to establish some corporate memory. I have said to this committee, literally, many times over the many years that we forget things when we get distant from them.

We are going through a terrible ordeal right now. We need to have in place the stable type of support for preparedness for outbreaks.

We will get through this. This will end, hopefully sooner rather than later. But we need to establish a system so that we are prepared for future outbreaks.

Mr. Walden. Thank you.

Mr. Chair, could the other two just answer that question quickly?

Admiral, what do you need you don't have? What should we

be worrying about?

Admiral Giroir. I want to express my thanks again --

Mr. Walden. Right.

Admiral Giroir. -- to the committee. But let me get to the point.

I think sustainability and commitment is very important. I was involved in Ebola in 2015 in Dallas trying to lead some of the policy options during that time, and you see over a five-year period we sort of forgot all the lessons that we were trying to get implemented, including PPE and other stockpiles.

I would say some of the biggest limitations, and I know everyone is working on this, is the national data infrastructure we need.

When we started out, I am calling up a hundred hospitals a day trying to understand who is on an ICU bed, who is not, who has a ventilator, how much you have left. And we got through this early not by systems but by people working 24/7.

The third thing is -- I am just going to pound it -- the vaccine infrastructure in this country, to promote vaccination, to promote vaccine confidence, to make sure that people have the right information about safety and efficacy, that we order enough flu vaccine, because we really need to get everybody vaccinated

this winter.

One thing that minimizes our problems is if we get everybody a flu vaccine. That is one less virus that could kill 20,000, 30,000, 50,000, 70,000 and, potentially, even be a co-infection with COVID.

Mr. Walden. Dr. Hahn?

Dr. Hahn. Thank you. Again, thank you for the support.

One big point I want to make here is that what we have learned during this epidemic is what Admiral Giroir said, is that we have an access to information issue.

We have learned that we need to collect real-world evidence in real time during an emergency, just like a doctor would do during an emergency, to inform decisions and how we could change them, moving forward.

So your support for real-world evidence generation would be incredibly helpful.

The Chairman. So now we are going to move to our members, based on seniority, and I think our next few are virtual. So I will just remind you to unmute. If you don't do so on your own I will just keep reminding you.

So next we have Mr. Rush from Illinois.

Mr. Rush. I want to thank you, Mr. Chairman, for holding

this important hearing.

Last week, the Health Subcommittee held an informative hearing on the racial and ethnic health disparities being highlighted by the coronavirus.

The distinction of all of these disparities are very troubling, even extremely outrageous. A Scientific American article published earlier this month found that if Black people were dying at the same rate as white Americans, at least 13,000 mothers, fathers, daughters, sons, and other loved ones would still be alive.

Even more shocking is that among those 35 to 44, Black men and women die from the coronavirus at least nine times the rate of white Americans.

Dr. Fauci, wouldn't it become apparent that institutional racism and structural discrimination are playing a part in why certain racial and ethnic communities are suffering more than white communities?

Dr. Fauci. I think I know what the -- I didn't hear it quite as clear as I want but I think I know what the congressman is referring to.

So when you are looking at the African American community and the minority community in general as a demographic group,

there are two elements that make it much more difficult for them and why they are suffering disproportionately.

One is the risk of infection. Because of economic and other considerations, the jobs that the majority of them would find themselves in does not allow them to protect themselves by looking into a computer and doing telework. Most of them are essential, on the outside, having to mingle in a society in which the virus is circulating.

So right at the get-go, they have a greater risk of getting infected. And then we know from a lot of experience now that the situation regarding whether or not you have serious consequences, hospitalizations, intubation, complications, and death relate very strongly to the prevalence and incidence of underlying comorbid conditions, which are, clearly, disproportionately more expressed in the African American population than in the rest of the population and that particularly includes hypertension, diabetes, obesity, chronic lung disease, and kidney disease.

So, unfortunately, we have a situation where it is sort of a double whammy of a negative capability of them to respond through no fault of their own because of underlying conditions and the conditions in which they find themselves with.

Mr. Rush. Dr. Fauci, would you consider racism itself as being one of the stresses that certainly impacts the African American community more in an extraordinary way that contributes to these comorbidities?

Dr. Fauci. I think the question was would I consider institutional racism as contributing. I don't think there is --

Mr. Rush. Yes.

Dr. Fauci. Yes. Thank you, Congressman.

Well, I mean, obviously, the African American community has suffered from racism for a very, very long period of time and I cannot imagine that that has not contributed to the conditions that they find themselves in economically and otherwise.

So the answer, Congressman, is yes.

Mr. Rush. Admiral Giroir, I applaud your announcement that provides for $100 million -- I mean, for $40 million to go into the Morehouse College of Medicine for contact tracing and testing.

I have introduced a bill, the TRACE Act, which calls for a $100 million for testing and contact tracing. Shouldn't we be seeing a larger amount, $100 million or more, for contact tracing and for testing?

Admiral Giroir. Thank you, Congressman.

For testing and contact tracing, we are going to need billions of dollars. I mean, that is the amounts of investment that we are doing partially through CDC.

This specific award is to have Morehouse lead a consortium of organizations like 100 Black Men, UnidosUS, the National Association of Community Health Workers, the National Council of Urban Indian Health, et cetera, et cetera, to really focus on the specific educational testing and linkage to care needs of underserved minorities and some of those also in the rural population.

My personal opinion is $40 million is a start. It is going to need to be a lot more than that in order to reach the people that we need to reach.

The Chairman. Thank you, Bobby. Thank you, Admiral.

Next is Mr. Upton from Michigan.

Mr. Upton. Thanks very much, Mr. Chairman, and I really appreciate the testimony that we have heard thus far and the interaction that we will have between all of our --

I guess the first question I have, Dr. Fauci -- good friend, thank you for your service for sure -- in recent weeks, of course, you made the statement [audio malfunction in hearing room] have as many as a 100 million doses of [audio malfunction in hearing

room] vaccine before the [audio malfunction in hearing room] year.

I have heard from a number of companies just in recent days AstraZeneca, Pfizer [audio malfunction in hearing room] hopes to have, perhaps, a billion doses before the end of next year, calendar year '21.

So as [audio malfunction in hearing room] move through the Phase II process [audio malfunction in hearing room] maybe even get into some production, a little bit later by somewhat early August. Not the approvals yet but [audio malfunction in hearing room] the promise of getting it to the marketplace and, really, saving the world. Let's face it.

What is your thought as to how early we may see an EUA, an emergency use authorization, approved for any of these vaccines, based on what you know today and under the scenarios that we may see something in the next number of months in terms of an approval? Lay out what you think is a real distinct possibility where we might end up being.

Dr. Fauci. Okay. Thank you for that. I didn't hear --

Mr. Upton. And Dr. Hahn as well.

Dr. Fauci. I didn't hear everything you said but I think I got enough of it to answer your question, at least the last part that I think is very important and I welcome the opportunity

to address this.

The idea about the doses that would be available, you know, a couple of hundred million doses in the beginning of the year, some companies saying that in a couple of years, a year or two, they will have as many as a billion doses, I think that is real.

Most people would raise their eyebrows and think that how is that going to happen, and it is because things are being done at risk. People -- companies are starting to plan to make doses even before you know the vaccine works.

So the risk of the speed is not risk to safety. It is not risk to scientific integrity. It is risk to money. So put that aside.

The point that Congressman Upton made I think is very important. We need to be careful that we don't jump because of our need to get vaccines for those who need it that we do not definitively prove safety and efficacy before we make decisions about distribution.

We have heard a lot about emergency use authorization. An emergency use authorization is important, but it has to be done in a situation where you fulfill the criteria for the emergency use authorization.

I would be very disappointed if we jumped to a conclusion before we knew that a vaccine was truly safe and truly effective because I wouldn't want the perpetual ambiguity of not knowing whether or not it is truly safe and truly effective.

That is the reason why we are doing several randomized placebo-controlled trials with power enough that could give us that answer.

I hope that answers your question, Fred.

Mr. Upton. Well, just one quick. What would be the earliest that you think, under the best scenario, that we might be able to see an EUA issued by [audio malfunction in hearing room] along with -- I guess it would actually be the FDA, right, that would actually issue that?

Dr. Fauci. Yes. The answer is yes.

Let me just quickly answer that and hand it over to Steve because he may want to answer that.

We are going into the first Phase I -- Phase III efficacy trial in July. It takes at least a month to get to the second dose because it is a prime boost.

It will take another couple of months to accrue or enroll enough people that if there is viral activity in the community, and we have our sites not only in the United States but all over

the world, in Brazil and in South Africa.

So if we get an efficacy signal, you are going to get an efficacy signal more quickly the more cases there are. Now, if it turns out that there are not a lot of cases, it may take longer and that is the reason why you can't give an accurate prediction of when you are going to get those data.

Steve, do you want to take it from here?

Dr. Hahn. Yes, thanks, Dr. Fauci.

So just a couple of issues to your point, Congressman Upton. One is we are -- we are working with the sponsors across the board -- private industry, Operation Warp Speed, et cetera -- those who are developing vaccines, and we are providing technical assistance regarding clinical trial design, the number of participants in the clinical trials, as well as the endpoints that we want to see to make an adjudication about safety and effectiveness.

And I want to emphasize what Dr. Fauci said and that is the acceleration is really around taking financial risk around the development process. The acceleration is not cutting corners with respect to the assessment of safety and effectiveness.

The American people can rely upon the fact that FDA has many experts in the vaccine area. We have been doing this for years,

and we will rely upon the science and data when it is available to us to make that adjudication and decision regarding an EUA. I cannot prejudge when that will happen.

The Chairman. Thank you. Thank you, Fred.

Next, we have the gentlewoman from California, Ms. Eshoo.

Ms. Eshoo. Thank you, Mr. Chairman. And morning, everyone. I would like to start with Dr. Redfield.

Doctor, we had a conversation over the weekend, and I expressed to you, really, my pain my disappointment about you as CDC director, the most prestigious institution in the world, infectious disease intervention.

The United States today is number one -- number one in the world in infections and in deaths. This is not anything that any of us can be proud of. The American people are in pain. They are grieving. There is a great deal of struggle in communities. There is confusion because for many reasons, and I urged you as head of CDC to speak directly to the American people.

I know the agencies are talking to each other. I consider that a whisper because the American people are not hearing you speak out. They deserve to hear the truth. We have heard Dr. Fauci time and time again putting out pertinent information to the American people. The American people are divided on this

issue of the virus. Imagine that. So I continue to urge you to speak out. You are a doctor. Put your white jacket on and speak weekly to the American people. They want to know what is coming, what is ahead. My constituents ask me on a consistent basis, what is next? What is our government doing? That is a haunting question. And so while we are doing the nice back and forth this morning, good questions on the part of members, I really remain dismayed and deeply disappointed.

We need leadership coming out of the CDC, real leadership. It was an outrage that there was a gathering in Tulsa. Six of the President's advanced people were infected and it is my understanding that two Secret Service agents were. How can the CDC allow this pandemic, this virus to be something political? You have to push back. You are a scientist. You are a doctor.

Now to Dr. Hahn, I am sure you have read the several articles regarding hydroxychloroquine. Every study states it doesn't work in any setting. In fact, it has known side effects, cardiac issues being one, so there is a danger in terms of the side effects. As Commissioner you see all the data. Are you going to inform the American people, doctors across the country, about these facts?

Dr. Hahn. Thank you, Congresswoman, for that question.

And indeed we are. I can refer the committee to several documents that we have put out over the last several weeks regarding hydroxychloroquine. With respect to the issues, we issued a safety alert particularly around the combination of hydroxychloroquine within other drugs that might affect the heart. And as you know we have taken recent action regarding --

Ms. Eshoo. Have you specifically spoken directly to the American people so isn't this notion about hydroxychloroquine?

Dr. Hahn. Yes, ma'am. There is an FDA Voices piece that is authored by me as well as a piece that is directly to the American people about the status of hydroxychloroquine.

Ms. Eshoo. This isn't paper. I want to know if you have spoken out verbally to the American people, to doctors across the country. People don't hear paper, with all due respect.

Dr. Hahn. Yes, ma'am, and I appreciate the question. But every opportunity I have had to be in the media I have been asked that question and I have communicated that same information about the current status --

Ms. Eshoo. You aren't answering the question, Dr. Hahn. There have been several disturbing articles expressing concerns related to political pressure being placed on the FDA by the

President. Can you state unequivocally that if any political pressure is applied to you and the FDA that you will immediately report that to this committee?

Dr. Hahn. I will certainly unequivocally state that if I receive political pressure I will report to this committee. I can tell you that I have not felt political pressure nor has the FDA to make any decision in any specific direction.

The Chairman. Thank you.

Ms. Eshoo. Well, it is not about decisions, it is about a direct political pressure. So thank you for your response and I yield back.

The Chairman. Thank you, Ms. Eshoo.

Next is Mr. Latta from Ohio.

Mr. Latta. Well, thank you, Mr. Chairman. And thanks to our witnesses and all the hard work that you have been doing over the last several months for not only the United States but for individuals from around the world. I really appreciate it.

Dr. Fauci, if I could start my questions with you. And I know that our leader, Mr. Walden, had brought some of this stuff. Would you further explain how an infected individual develops antibodies and how long those antibodies remain effective in fighting off the virus and are you seeing different levels of

antibodies in people who have been infected and what that means in terms of immunity?

Dr. Fauci. Thank you very much for that question, Congressman Latta. So we need to start off by saying that we want to assume that you are dealing with an antibody test that has been validated by the FDA or by the NIH. That is important because a lot of the confusion out there, there are tests that are not validated. But let's assume you have a good test.

Whenever the body gets confronted with a virus and recovers, even when they don't recover, the body is stimulated to make antibodies. In general, for viruses that we have a lot of experience with, those antibodies serve to protect you against exposure and infection after you are exposed to the same virus. So that is what we call immunological memory and these proteins block the virus.

The one thing we do not know yet with COVID-19 is the relationship between the type of antibody, because the best antibody is called neutralizing antibody, namely if this were the virus and this is where the virus binds to the cell, the neutralizing antibody blocks the virus from binding to the cell. There are antibodies against other parts of the virus that are called binding antibodies; they don't mean much. So you have

got to make sure you get the right antibody.

The second thing is, what we still don't know is what the relationship between the titer of the antibody is, namely the level of the antibody and the degree of protection. The third thing we don't know is how long or what the duration of that antibody is going to be. We are going to find these things out as we study these individuals over months and a year or more, but remember we are only a few months into this.

So, A, we know they make antibody; B, it is likely they are protected for some period of time, but we don't know how long that is going to be. So the question I always get asked, which is a subtext, does that mean if you are exposed and you have antibody that you are protected? Likely you are, but we don't know how long you are protected.

Mr. Latta. All right, thank you.

Dr. Redfield, when a vaccine or treatment is developed how will it be distributed to Americans?

Dr. Redfield. Thank you for the question. It is a critical issue that is currently under discussion within the team to look at what the appropriate prioritization for distribution is. I want to just comment that it may be very dependent on what the product is. Each of these vaccine products that are currently

being developed may in fact have differential utilization for different populations.

So there are serious considerations to try to develop those prioritizations and it is going to be important to develop them dependent upon the product that they are going to applied to.

Mr. Latta. Thank you.

Dr. Hahn, and thanks very much for all your work and thanks for taking my calls especially on Friday nights and on Saturdays. I appreciate it. The FDA provided an emergency use authorization for remdesivir. Do you expect or envision the FDA to issue anymore EUAs for potential treatments in the fall?

Dr. Hahn. Congressman, for potential therapies? Is that what you asked, sir?

Mr. Latta. Right.

Dr. Hahn. Yes. Yes, sir. So we are working very closely with sponsors regarding the development of therapeutics including with Operation Warp Speed. A hundred and thirty one clinical trials ongoing right now. I anticipate that we will receive data regarding several therapies in the future, plasma being one of them that we just discussed with Congressman Walden, and potentially also with some anti-inflammatory agents as well as for monoclonal antibodies. Those are being accelerated through

the pipeline and then on potential therapeutics as well as prophylaxis moving forward.

Again, can't prejudge the EUA process because we have to see the data. But I do anticipate that we will be receiving data.

Mr. Latta. Thank you very much.

Mr. Chairman, my time is expired and I yield back.

The Chairman. Thank you.

Next we have Ms. DeGette from Colorado.

Ms. DeGette. Thank you so much, Mr. Chairman.

I want to thank the panel and welcome all of you. Many of you have appeared in front of my subcommittee, the Oversight and Investigation Subcommittee, a number of times. And just to let you know, the O&I Subcommittee is going to be continuing its investigations both about how we responded to this and where we go in the future, so you can expect to hear from us.

I have some brief questions for each witness and I would like to start with you Admiral Giroir. The Chairman talked about comments last weekend saying that double testing because when you do testing, quote, you are going to find more people. And then again this morning, the President tweeted cases are going up U.S. as we are testing far more than any other country and ever-expanding. With smaller testing we show further cases.

This is what he says and he also said this morning that he doesn't talk about it. So I know the chairman asked Dr. Fauci and Dr. Redfield they have been expected to test less, I am going to ask you since you are now in charge of overseeing the tests, has the President asked you to do fewer tests?

Admiral Giroir. Thank you. And again I want to clarify that neither the --

Ms. DeGette. Yes or no will work. Yes or no will work, Admiral. Has the President asked you to do fewer tests?

Admiral Giroir. No, the President -- neither the President nor anyone in the administration has instructed that we should do less testing, have said that to me, and we are proceeding in just the opposite.

We want to do more testing --

Ms. DeGette. Okay.

Admiral Giroir. -- of higher quality.

Ms. DeGette. I want to ask -- so I want to ask you, Admiral, do you think that it is a good or a bad idea to do less testing so it will look like fewer cases?

Admiral Giroir. My purpose in leading is to increase the number of testing. The only way that we will be able to understand who has the disease, who is infected and can pass it, and to do

appropriate contact tracing is to test appropriately, smartly, and as many people as we can.

Ms. DeGette. Thank you so much.

Dr. Fauci, I wanted to ask you, I have seen some data the last few days that while cases are going up in this country, deaths are going down. And I have seen some reporting in the media that in part that is because younger people who tend to not to die from COVID are the ones being infected. Should we see this as a positive sign or should we still be worried?

Dr. Fauci. I think it is too early to make that kind of link, Congresswoman. Deaths always lag considerably behind cases. You might remember that at the time that New York was in their worst situation where the deaths were going up and yet the cases were starting to go down, the deaths only came down multiple weeks later.

So you are seeing more cases now while the deaths are going down. The concern is if those cases then infect people who wind up getting sick and go to the hospital, it is conceivable you may see the deaths going up. So I think it is too early to say because the deaths are going down.

Ms. DeGette. Thank you, Doctor. And I have another question, Dr. Fauci, for you. We have seen -- and I think you

and I have talked about this. Most vaccines take years, if not decades, to be approved and to be proved efficacious and sometimes we don't find a vaccine at all. I have two questions for you.

Number one, do you believe that we will find a vaccine for the coronavirus; and number two, do you still stand by the prediction you gave us some months ago that we could actually have a vaccine by early 2021?

Dr. Fauci. I feel cautiously optimistic, Congresswoman, that we will be successful in getting a vaccine. There is never a guarantee of that, but the early data that we are seeing regarding the immunogenicity and the induction of good responses makes me cautiously optimistic, always knowing that there is never a guarantee. You remember I told your committee a few months ago that a vaccine would be available from a year to 18 months. I said that in January of 2019 -- 2020. A year from January is December. I still think there is a reasonably good chance that by the very beginning of 2021 that if we are going to have a vaccine that we will have it by then.

Ms. DeGette. Thank you very much, Doctor.

Mr. Chairman, I will yield back.

The Chairman. I thank the gentlewoman.

Next we have Mrs. Rodgers from Washington State.

I hope.

Mrs. McMorris Rodgers. I am coming. Cathy McMorris-Rodgers is here. Am I here?

The Chairman. You are recognized for 5 minutes.

Mrs. McMorris Rodgers. Thank you, Mr. Chairman. I want to thank the chair and the ranking member for holding this hearing and appreciate our witnesses for testifying today.

COVID-19 is the challenge of the century as others have said. It is a health and economic crisis of our lifetime. We mourn the deaths of over a hundred thousand Americans and we must remember that we are not out of the woods yet. I want to especially express my heartfelt gratitude for the healthcare workers, the first responders, the emergency and essential workers who have been working around the clock to fight this virus, save lives, and keep our families safe. As our experts work tirelessly to develop a vaccine and treatment, I am confident that there is no country in the world who is better equipped to lead for a medical breakthrough than America. We can't trust China to lead.

And that is why the Trump administration has created programs like Operation Warp Speed for bringing together the very best in the public and private sector to develop countermeasures that

will fight the virus. We are leveraging the power of artificial intelligence, super-computing, and machine learning to speed up discoveries and enhance our knowledge base of the virus. In Washington State we have top researchers as well as biotech and pharmaceutical innovators who continue to be at the forefront of these breakthroughs. I look forward to learning more and appreciate all of you being here to help us understand what the administration is continuing to do to lead in the development of these tests and treatments that America needs so that we can usher in a new era of innovation and healthcare cures. To win the future, keep our families healthy and save lives, and to ensure our economy booms again, we must get this right.

Dr. Fauci, as you know, adjuvants maximize the effectiveness of vaccines. Would you just explain a little bit further what an adjuvant is and are there any novel synthetic adjuvants in the pipeline and, if so, how will they play a role in the administration's pursuit of a COVID-19 vaccine?

Dr. Fauci. Thank you very much for that question, Congresswoman. An adjuvant is a product distinct from the vaccine itself, but when given in conjunction with the vaccine it enhances the power of the immune response, so if you have a vaccine that gives a level of response that here when you get

an adjuvant together with it you often boost it to a much higher level.

We use adjuvants in several vaccines. The NIH has a major program in the pursuit and development of novel adjuvants of all different types. And, in fact, that is part of the program right now, to accelerate our vaccine development capability. So it is a good question but it is a very important part of what we do. Thank you.

Mrs. McMorris Rodgers. Thank you. Thank you for that.

Dr. Hahn, as you know, FDA's decentralization of diagnostic test oversight has been very helpful in expanding the availability of diagnostic tests for COVID-19 but it is temporary. Would you just speak to how this flexibility has benefited the general public and how you think it would be helpful in the future for outbreaks or novel viruses?

Dr. Hahn. Thank you very much, Congresswoman, appreciate the question. As you have pointed out, the flexibilities have allowed us to work with test developers. This has been throughout the COVID pandemic with all of our medical products a balance between the oversight so that we have tests that are valid, reproducible, accurate, but at the same time allow the developers the ability to have the freedom to develop those tests.

And we have developed this partnership that I think has been very fruitful moving forward. I particularly like it with respect to the flexibility given the states, your state in particular which has excellent public health laboratories, as well as the University of Washington, and New York State is another example of this.

Those are the sort of things that we are looking at now as we talk about how we want to move forward that we could potentially put in place on a permanent basis to facilitate test development. Hopefully, we will never be in a position again where we have to develop tests over such a short period of time like we have remarkably done during this time. But we really do need to talk about how these flexibilities could stimulate innovation and development of tests.

Mrs. McMorris Rodgers. Great. Well, thank you all. Thank you all for your leadership, your commitment during this time, the long hours, and I especially appreciate the way that we are looking forward to make sure that we are prepared in the future for whatever we may face. Thank you. Good to be with you.

The Chairman. Thank you.

Now we go to Mr. Doyle coming to us from Pittsburgh.

Mr. Doyle? Is Mr. Doyle --

Mr. Doyle. Sorry, Mr. Chairman. I forgot to unmute.

The Chairman. Thank you.

Mr. Doyle. Can you hear me now?

The Chairman. Yes. You are recognized for 5 minutes.

Mr. Doyle. Thank you, Mr. Chairman, for holding this hearing and to the ranking member also and to our witnesses for your service on behalf of the American people.

This committee has continued to conduct oversight of the Trump administration's shortcomings related to procuring and distributing personal protective equipment, or PPE. When states and hospitals were faced with critical shortages of PPE such as masks and gowns, President Trump passed the buck and said the federal government was, quote, not a shipping clerk. We saw the result of a failure of leadership. Without a national strategy, states have had to fend for themselves and even compete against each other for critical supplies. It has become so desperate out there that one former U.S. disaster official referred to this scramble as, quote, Lord of the Flies: PPE Edition. At a recent hearing before the Oversight and Investigation Subcommittee, Michigan Governor Gretchen Whitmer testified, quote, the lack of centralized coordination at the federal level created a counterproductive competition between

the states and federal government to secure limited supplies, driving up prices, and exacerbating the existing shortages.

Admiral Giroir, let me ask you. Do we have enough PPE for every front line worker who needs it whether they be healthcare workers, first responders, or thousands of others whose job puts them at risk? Are people still having to reuse N95 masks, for example, and if we don't have enough, why hasn't the administration invoked DPA to greatly expand the manufacturing of these supplies?

Admiral Giroir. Well, thank you for the question and I will do my best to answer that. Admiral Polowczyk is certainly running the supply chain with also Dr. Kadlec from ASPR. But being a member of the Unified Coordination Group at FEMA for the past 3 months, I am pretty familiar with this.

I think as Admiral Polowczyk testified before and I think we all know is that there was an absolute shortage of everything when this started. Everyone in the world was looking for the same supplies and we tried to manage that both from increasing the supplies and using the DPA multiple times. For example, there were three investments, DPA Title 1 for N95s -- 3M, Honeywell, and Owens & Minor -- to improve production.

We estimate that the country in the fall, if there were a

COVID outbreak to this degree would need about a 140 million N95s per month. We should have 180 million per month being produced domestically by that time. This was not available when we started in March. The industry was not here. This was all offshored.

And I will just say, cumulatively, between March 1st and June 19th, the government distributed or enabled the commercial distribution through the air bridge of 160 million N95 masks, 638 million surgical and procedural masks, 281 million gowns, and over 16 billion pairs of gloves. So this was really an enormous effort.

We need to better prepared. This all needs to be onshore. We are working with S&S 2.0 to have a 60- to 90-day supply. We talked to governors in every state. Many of the states are also doing their own supplies for 60 to 90 days. So I am confident moving from here on as we ramp domestic manufacturing that we are going to be in a much better position than we were 3 months ago.

Mr. Doyle. Thank you, Admiral.

Dr. Hahn, let me ask you. Since demand for PPE increased this spring, we have seen many actors with little previous experience in the supply field enter the market. Reports have indicated that some are selling counterfeit or low-quality

products that don't meet safety requirements or are unable to fill agreements. What steps is the FDA taking to ensure that companies are not circumventing federal oversight and injecting potentially substandard PPE into the United States market?

Dr. Hahn. Thank you, Congressman. This is a really important issue. During the height of this epidemic and the increased demand, we provided regulatory flexibility for companies but insisted that they provide certification, often foreign FDAs, if you will, certification that the PPE met the requirements that we have in place and that the foreign governments had in place.

But we did something else with respect to that and that is we also partnered with CDC and NIOSH, for example, with N95s to test, to verify that in fact that self-certification over the validity of the efficacy of the PPE was in place. And you have correctly identified that for a variety of reasons subsequent product that was shipped into the country did not meet those specifications.

We immediately took action to make sure that those were off of the market and continue to do that and monitor it very closely.

Mr. Doyle. Thank you, Mr. Chairman. I see my time has expired. I yield back.

The Chairman. Thank you, Mr. Doyle.

Next we have Mr. Guthrie coming to us from Kentucky.

Are you muted? Do you want to unmute?

Mr. Guthrie. I thought I did that. I apologize.

Hi. Brett Guthrie. I apologize.

I -- Dr. Hahn, I am interested in the COVID-19 counterfeit testing. And I have a bill that would bring -- it's called the Safeguarding Therapeutics Act that would ensure FDA has the authority to destroy the counterfeit testing devices. And I will follow up with a question with this.

What I am interested in, and what the people that I talk to every day are interested in, is what is going on in the future? How are we going to protect ourselves moving forward?

We need the lessons learned from the past. We need to look forward. And Dr. Hahn kind of answered on -- I mean, excuse me, Dr. -- Admiral Giroir answered on the PPE kind of moving forward. But if I can just go with Dr. Redfield, Dr. Fauci, and then Dr. Hahn, if you will talk about pool testing and how that might be effective.

What -- the people that I've talked to want to know what is it going to look like in March -- I mean, excuse me, what is it going to look like in August? Are kids going to be getting

back in school? Are our nursing homes going to be safe? That is what people are looking for.

So, Dr. Redfield, I know we are going to have flu, we are going to have COVID. What is the testing going to be like? Dr. Fauci, what do we need to be looking for? And Dr. Hahn, pool testing?

And I will just open it up for you three to talk about, what is it going to look like in August, and are our kids going to be able to go back to school.

Thank you. And I will start with Dr. Redfield.

Dr. Redfield. Thank you, Congressman. I think, first and foremost, it is really important that we continue to take this time to continue to accelerate our capacity to diagnose, obviously, readily available, timely test results. Build that capacity for isolation and contact tracing, and self-quarantine.

That is fundamental. We are working hard to do that. As I mentioned in January, we had about 6,000 contact tracers in this country. The beginning of June it was up to around 27, 28,000. It needs to continue to increase in my view towards 100,000, if we get that operationally functional. That is going to be critical for what we're doing.

Secondly, we do have to reinforce in the American public

the importance of the social distancing interventions that we have discussed, particularly face coverings, six feet distancing, and hand washing.

I anticipate that the states will begin to open up higher education and K through 12. It is going to be on a jurisdiction to jurisdiction decision. CDC will be issuing additional guidance on this topic in the days ahead as we continue to try to work and to give guidance on how to open up these, particularly the school systems, how to open them up safely.

I will end with nursing homes. I think we have made enormous progress in the long-term care facilities, enhancing infection control. Admiral Giroir may want to comment about the commitment that FEMA made to provide all nursing homes protective equipment for a period of time.

And we are continuing, I think, to have aggressive surveillance in the nursing homes across this country where we have recommended that all residents get tested so that we can start with a clean baseline of understanding where the epidemic is.

I will just end with the fact that although they only make up 0.6 percent of our population, nursing home residents have made up more than 35 percent of our mortality.

Dr. Fauci. Let me very briefly --

Mr. Guthrie. Thank you, Dr. Redfield.

Dr. Fauci.

Dr. Fauci. Yeah. Yeah, let me briefly address the question you asked about schools, because we get asked that all the time.

I think the important thing to point out is that, as you well know, we live in a very big country that is certainly not a unidimensional country. It is very, very different whether you are in a New York metropolitan area or Casper, Wyoming. So, when you are asking about schools you have to say where are you talking about, because we have different regions, different states, different cities, towns, and countries.

So, some counties may have such a low level of infection that schools can open in a way that is exactly like normal. Others may be in a situation where it isn't really bad where you want to close the school, but you might want to make some modifications, alterations of scheduling, things like morning/afternoon, one day or another day.

So, it is up to the local officials to evaluate where you are in the particular region, what the recommendations that we really very carefully put out about the guidance of opening schools.

So, you don't want to make one-size-fits-all for the United States. You want to tailor it to the degree of viral dynamics in the particular location that you are talking about.

Mr. Guthrie. So, looking forward, we are really only going to know when we get closer to that point so we can make those decisions. That is unfortunate, but obviously that is the reality.

I am about out of time, Dr. Hahn. I will submit a question for the record for pool -- for pool sampling.

Thank you very much. And I yield back.

The Chairman. Thank you, Mr. Guthrie. It sounded like there was a monster that was going to envelop you at some point there.

Next we have Ms. Schakowsky from Illinois.

Ms. Schakowsky. Thank you, Mr. Chairman. And I want to thank the witnesses.

I have to disagree with you, Dr. Redfield. I think nowhere has the Trump administration's lack of leadership been more apparent than in our nation's nursing homes and long-term care facilities where we have lost 50,000 residents and workers to COVID-19.

So, let's review some of the deadly failures.

1754 You delayed data collection on cases and deaths in nursing
1755 homes.
1756 You have not required -- required -- states to conduct
1757 testing.
1758 You are not giving workers adequate PPE -- and I agree with
1759 Congressman Doyle on that -- to protect themselves.
1760 You are allowing facilities to literally kick residents out
1761 of -- out onto the street if there is a more profitable COVID
1762 patient to take their place.
1763 And since CMS Administrator Verma who is responsible for
1764 the safety of our nursing home residents has declined Chairman
1765 Pallone's invitation to speak, let me refer then to Dr. Redfield.
1766 The CDC website explains that your mission is to save lives
1767 by providing health information that protects our nation. So,
1768 why didn't you require nursing homes to report any data on COVID-19
1769 cases and deaths until May, four months after -- you may remember,
1770 you told me about the first case in Illinois -- January 30th?
1771 And to report the case of human-to-human transfer.
1772 On July 4th -- on June 4th you testified before the House
1773 Appropriations Committee and apologized for CDC's inadequate --
1774 I quote -- response to COVID-19 race and ethnicity data. Yet,
1775 the same day CMS and CDC finally published COVID-19 data from

nursing homes, and failed to include race and ethnicity information.

So, when -- when my office asked CMS about the exclusion, we were told to ask the CDC.

So, will you promise to include race and ethnicity information moving forward so that we can identify the address -- and address the racial disparities in nursing home COVID-19 cases?

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

First, I want to stress that since the early beginning of the pandemic that we have initially encouraged all nursing homes to report the cases through their health departments and through our National Healthcare Safety Network as of May 8th.

Ms. Schakowsky. If I -- if I could -- if I could just briefly interrupt on the word encouraged. That, I think, is a problem, that there has been guidance, there has been encouragement, but what about mandating?

Dr. Redfield. As I said, that as of May 8th now it is a requirement that this be reported in through CDC, as CMS has made that required. And we are working to make sure this reporting is comprehensive to include ethnic and racial data.

As well as I would argue -- put forth that we have worked

hard to really accelerate training and retraining of infection control procedures in these nursing homes to, to try to mitigate the situation that, unfortunately, we did experience, as you pointed out, where the nursing home residents have taken a high burden of this initial outbreak.

We will continue to work to get this reporting. This reporting is going to be forward-facing. CDC will forward the data to CMS. CMS will forward face it so families can make decisions based on their understanding of how different nursing homes are performing.

We have recommended that the nursing homes, as you mentioned, that they screen all residents. And we have recommended that they screen all workers in nursing homes on a weekly basis because we do believe this is an important area that we have to do more as a nation to protect infections.

Ms. Schakowsky. Let me just say, this kind of suggesting and recommending has clearly not been enough, in my view. This is the view of many observers, families, workers, that there is a crisis in our nursing homes that persists, and that we insist that the government do more to help.

And I yield back.

The Chairman. Thank you, Ms. Schakowsky.

Mr. Olson of Texas.

Mr. Olson. Thank you, Chairman Pallone and lead Republican member Greg Walden for having this very important hearing. Welcome to our four expert witnesses. You all have been on the frontlines fighting the COVID-19 virus for about half a year now. We greatly appreciate all your efforts to make our country safer.

And a special howdy to a former Rice Owl like myself, Commissioner Hahn. Go Owls.

First of all, all of you know that Texas and Greater Houston have seen a spike in COVID-19 cases over the last week. Our state is at stage 3 of reopening and the trend is not good. To Dr. Tony Fauci of Houston, of Texas, Dr. Steve -- Peter Hotez put out a tweet, and I quote what he said, if this trajectory persists, Houston will be the worst affected city in the United States, maybe rival what we are seeing right now in Brazil, end quote. And that is damn scary.

The spike in the Greater Houston region is due to one country, Harris County, which is the county -- the third largest county in America in the county seat of Harris County -- I am sorry, Harris County and Houston, county seat of Houston, the fourth largest city.

Mr. Chairman, I would like to have a graph added for the

record about the spikes in Houston, in Harris County, and Fort Bend County.

The Chairman. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

Mr. Olson. Thank you.

There are many factors why we have this spike right now in Texas and in Houston. But what scares me the most is the increase in infectious cases in people aged 20 to 39, the so-called youngsters. In the last week they are one-third of the new cases in my hometown of Sugarland, in my own county of Fort Bend, in the Greater Houston region. This is because of their attitude.

To sum up their attitude my former boss Phil Graham said it best about these people, how they've -- how they view this crisis. Bending the COVID-19 curve and ending the pandemic is like going to heaven: everyone wants to go there but fewer and fewer want to do the hard work to make it happen. I call this the bad attitude curve.

And, Dr. Fauci, if you were king for a day, how could we change this bad attitude curve and make these people address this issue for the threat it truly is?

Dr. Fauci. Well, Congressman, you bring up a very good point. One of the very perplexing things about COVID-19 -- and I, as some of you know, have been dealing with viral outbreaks for the last 40 years -- I have never seen a single virus that is one pathogen have a range from 20 to 40 percent of the people have no symptoms, to some get mild symptoms, to some get symptoms

enough to put them at home for a few days, some are in bed for weeks and have symptoms even after they recover, others go to the hospital. Some require oxygen. Some require intensive care. Some get intubated, and some die.

So, you have a situation that is very confusing to people because some people think it is trivial, it doesn't bother me; who cares? And that is one of the reasons why what we do have is a lack of appreciation, that you have a dual responsibility. You have a responsibility to yourself, because I think thinking that young people have no deleterious consequences is not true. We're seeing more and more complications in young people.

But even though the majority -- the overwhelming majority of them do well, what you can't forget is that if you get infected and spread the infection, even though you do not get sick, you are part of the process of the dynamics of an outbreak. And what you might be propagating inadvertently, perhaps innocently, is infecting someone who then infects someone who then is someone who is vulnerable. That could be your grandmother, your grandfather, your sick uncle, or whom have you who ends up dying.

So, it is a very difficult messaging when people say, I am young, I am healthy; who cares? You should care, not only for yourself but for the impact that you might have on the dynamics

of the outbreak.

Mr. Olson. The bad attitude syndrome.

I am out of time. I have a question for the record for Dr. Redfield about hurricane evacuation of COVID-19 people from nursing homes.

I yield back. Thank you very much. The Chairman. Thank you, Mr. Olson.

Next we go to Mr. Butterfield from North Carolina.

You might have to unmute, G.K.

Mr. Butterfield. Thank you, Mr. Chairman. I made a note to do that and failed to do it, yes.

But thank you, Mr. Chairman, and thank you to all of our witnesses today.

Mr. Chairman, in response to COVID-19, Congress has appropriated significant funding through the CARES Act. And it looks like some of that money is finally getting into underserved communities. The Congressional Black Caucus Health Braintrust, led by Congresswoman Robin Kelly, has met with some or all of you. And we've written you to urge funding for minority institutions and communities to fight the pandemic.

Admiral, Mr. Secretary, you announced this morning that HHS has formed a partnership with the Morehouse School of Medicine.

That's good. A partnership to coordinate a strategic network of organizations to deliver COVID-19-related information to minority communities hardest hit by the pandemic.

Does the Morehouse funding give the medical school discretion to engage in aggressive contact tracing and other testing and education? We need more than information. What is their mandate?

Admiral Giroir. So, thank you for that question, sir.

The intent of this award is really not to empower Morehouse to physically do contact tracing themselves but to be a lead institution to build partnerships throughout the nation so that public health organizations, et cetera, can use the well over $11 billion that the CDC sent out.

So, we are not funding Morehouse to be the boots on the ground, we are funding them to be the brains behind the operation, to really extend our network throughout the minority and underserved --

Mr. Butterfield. Yes. Thank you for that. But how broad is their discretion, or are they restricted?

Admiral Giroir. They -- I would be happy to get into this, but they -- they assembled really a remarkable group of partners

using digital technologies, all types of network technologies. They have very broad discretion. This is out of my office --

Mr. Butterfield. That's what -- -that's what --

Admiral Giroir. And look, what I want to do -- I want to do is make sure that the underserved get the information, get testing, and get links to care.

Mr. Butterfield. Yes. You're saying broad discretion. Yes. That is what I wanted to hear, broad discretion.

Dr. Fauci, the Washington Post reported this morning that Arizona is seeing a troubling spike, the State of Arizona. And as we all know, President Trump is in Phoenix today for a campaign rally at Dream City Church. And I suspect he will not be wearing a mask. I know that will disappoint you. It will certainly disappoint me.

The Washington Post also reported that Arizona got its positive rate down to 7 percent, but now it is up to 20 percent after a 3-week rise.

In my state of North Carolina we had got it down to 7 percent. And now in North Carolina it is up to 10 percent.

So, 10 percent in North Carolina, up from 7; and 20 percent in Arizona. What is the Administration specifically doing to slow the spread in states like Arizona and North Carolina that

are seeing a rise? It can't -- it just can't be explained away by more testing.

Dr. Fauci. Well, Congressman, the percentages that you are speaking of are clearly indication that there are additional infections that are responsible for those increases. Because when you get an increase in the percentage of your tests that are positive, that is an indication that you do have additional infections.

So, one of the issues that we have spoken about that is very clear is that when you have those kinds of increases, you must implement on the ground as effectively as possible the manpower, the system, the tests to do identification, isolation, and contact tracing to try and blunt that surge of cases in the two states that you are speaking of. Hopefully, that will be successful in the blunting of those cases because, if not, then you have the danger of having a gradual insidious increase in community spread, which will be much more difficult to contain as the community spread amplifies itself.

Mr. Butterfield. Well, it just seems to me in closing, Dr. Fauci -- and you don't need to respond to this -- but it seems to me that the President seems to think that COVID is over and he can just push it all to the states.

The data that is coming out of the states shows the necessity, the absolute necessity for a national strategy. Because while the virus may seem contained in some areas, it is conceivable that we can see a resurgence everywhere. This frightens me and should frighten the American people.

Thank you, Mr. Chairman. I yield back.

The Chairman. Thank you, Mr. Butterfield.

So, now Dr. Burgess is here, and we will recognize him for five minutes.

Mr. Burgess. Thank you, Mr. Chairman. In fact, I was with you virtually earlier, so I heard all of the discussion back and forth. And I would ask unanimous consent that my opening statement be made part of the record.

[The opening statement of Mr. Burgess follows:]

********** COMMITTEE INSERT**********

Mr. Burgess. And I do want to thank our panelists for being here today. Outside of a tiny little bit that we tacked onto a budget hearing on February 27th, we really have not heard from this group enough in this committee, and certainly the Health Subcommittee. So, I want to thank you for your willingness to be here today and testify.

I would also observe that we are about the one-year anniversary of the passage and signing of the Pandemic and All-Hazards Preparedness Act. We had a wonderful opportunity in January, February, perhaps early March of this year to do some real-time introspection as to whether or not that bill had gotten things right. Did we do what we -- was it performing as intended? Was it going as expected? And for whatever reason, we chose to talk about flavored tobacco, horse racing, and ticket stubs instead.

So, we can be critical of the Administration, Mr. Chairman, but this committee -- this committee bears some of that responsibility as well.

Since we have been talking about community spread and increase in community spread, I also, Dr. Fauci, have been talking to some of my counterparts, physicians in the Lower Rio Grande Valley. And spread in that part near the border of Mexico --

community spread has been apparently significant over the last week to ten days.

I guess a question I would have for you and for Admiral Giroir is since we recognize community spread is increasing, and we recognize that there is still going to be the vulnerabilities of congregate living facilities, what are we doing to make certain that the appropriate amount of personal protective equipment is available to our congregate living facilities, extended care facilities, and nursing homes, not just in the Valley but any place where we see this community spread increasing?

Admiral Giroir. So, thank you, Dr. Burgess. Good to see you again.

Mr. Burgess. Good to see you.

Admiral Giroir. Again, I am familiar with the PPE situation from my work on the UCG at FEMA. And I think you -- I think you know that it was decided by the UCG very early that when we were able to secure the PPE, we would send directly to every -- and we are sending PPE directly to fifteen thousand -- I believe the number is four hundred -- nursing homes. And the numbers are really staggering. Millions of face shields, masks. Thirteen million pairs of gloves are already there.

So, that is being distributed right now. And there are going

to be multiple tranches of that.

Again, Admiral Polowczyk is running this through the Supply Chain Task Force. I've got all the swabs and all the tests. He runs the PPE, and we interact a lot. So that is going to be going all the way through August and September, through all 15,400 nursing homes, with multiple shipments of that.

Mr. Burgess. Do you agree that that is on the immediate horizon ahead, that is one of the big vulnerabilities, community spread is increasing in some places, but we also know we have got areas where there is congregate living people with multiple risk factors?

Admiral Giroir. So, I think as has maybe been said by the colleagues, we are clearly seeing community spread in a number of areas. If you look at counties, I think Dr. Birx detailed yesterday, there are about 110 counties of real concern throughout the country.

Mr. Burgess. Well, I guess, Admiral -- excuse me for interrupting, but my time is short. I guess what I am really asking is are we preparing and do our administrators and executives in nursing facilities -- nursing home facilities know how to access the vast amounts of personal protective equipment that is being made available through Airbridge and through the

work that you have done? Because if we don't get it to the end user, then it is a vulnerability and it will affect all of us.

Admiral Giroir. Very briefly because I know the time, I am going to say the answer is yes, because we decided to ship door to door because we couldn't necessarily rely on the state distribution systems, you know, because you just can't get that deep. So, the only way to do it is get the address and ship it.

And then, secondly, the testing regimens that are now mandated through CMS, recommended by CDC, are pretty excellent. Right? Every nursing home resident gets tested. Every worker gets tested every week. This is a very robust testing regimen --

Mr. Burgess. Sure.

Admiral Giroir. -- that we think is going to put high protection.

Mr. Burgess. Certainly has been in Texas.

Dr. Redfield, in just the very brief amount of time I have remaining, let me just ask you a question.

I heard some things, and of course people are concerned about -- about China, the impact that China has had on our ability to fight this virus. Are there people working in the CDC in Atlanta who are Chinese nationalists? Do you have such people on loan

from Chinese labs in the agency?

Dr. Redfield. Well, CDC does have an office -- CDC has an office in Beijing that is right next to the China CDC, and we work collaboratively on a series of things, particularly respiratory viruses and particularly influenza.

We haven't been brought in into the overall Chinese investigation of this current coronavirus epidemic. That's something I requested back on January 3rd and then formally on January 6th.

Mr. Burgess. I want to be helpful to you on that, so I will follow up with you. And I have some ideas of some other things that we might think about as well. But I think that is a critical part of our discussion going forward and being prepared into the future.

Thank you all. Thank you to the panelists.

The Chairman. Thank you, Dr. Burgess.

Next we go to Ms. Matsui from California. You may have to unmute.

Ms. Matsui. Thank you. I have unmuted. Thank you, Mr. Chairman. I want to also thank the witnesses for being here today. You have been on the clock 24/7, and we really appreciate it.

Now, while a lot of our questions today have focused on how we found ourselves in the midst of this pandemic, I would like to focus my questions on the future and how we are preparing for the coming weeks and months and the possibility for another dramatic surge in cases of a second wave this fall, particularly during flu season.

Dr. Fauci, it's nice to see you there. You have said that we are still in the first wave, and I understand that it's difficult to predict what a second wave would look like while we are still seeing high counts, high case counts and deaths currently. However, we must effectively prepare our communities, our healthcare workforce, and constituents for what could come as we make decisions about returning to work, going to school, and trying to readjust to what we consider somewhat normal life.

Dr. Fauci, I want you to put your kind of prognosticator cap on right now. What are the projected infection mortality rates for the second half of 2020 and for early 2021?

Dr. Fauci. Thank you for the question, Congresswoman. It is really impossible to give any projection about what the fatality rate or case rates are going to be. It's going to depend on so many factors. I think you alluded to that in the beginning

of your question.

When people talk about second waves -- and I have said multiple times publicly that we are still in the middle of the first wave. So, before you start talking about what a second wave is, what we'd like to do is to get this outbreak under control over the next couple of months, so that when we enter into the fall, early/late, and then early winter, that we have such a low baseline that when you do have the inevitable situation of cases appearing as you try to gradually reopen the country, which we are all trying to do to varying degrees, depending upon what state, city, town, or county you are in, that if you get a level that's very low, when you get new cases, you can contain.

And contain means identify, isolate, and contact trace, rather than have such a high level that when you get increases you have to mitigate right from the beginning. So that really, as you can imagine, complicates the situation and makes it impossible to predict what the case or fatality rate is going to be until you know where you are.

Do you get down to baseline? And, if so, can you keep it there as you enter into the complicating situation that will inevitably occur when we get into the winter and inevitably we will have a flu season? And that is the reason why we are saying,

all of us, why it is so important to really get as many people vaccinated with influenza as you possibly can, so that you can at least take off the table, for many people, one of the confounding issues that we are going to face this winter of two respiratory-borne infections simultaneously confounding each other.

Ms. Matsui. And what would you say, Dr. Fauci, understanding that we don't know yet, but we have a sense that we are going to have a second wave, what should the public know so they can be prepared for this? And what, as a country, can we all do to reduce the potential for this second wave and somehow or another manage it? Because I think that all of us believe something is going to be happening, and we need to know what we can do now.

Dr. Fauci. Thank you for that second part of the question. There are a lot of things that can be done. We know what the failings were early on: a lack of enough PPE, a lack of enough N95s, hospital bed issues, ventilator issues. All of that is right now being stored up in the Strategic National Stockpile in preparation for what we hope never occurs, but which very well might occur.

So, it's the preparation. Also, as Admiral Giroir had

mentioned, as we go into the fall, we likely will have the capability of doing 40 to 50 million tests per month, which means we can get a much better grasp of what the situation is of the dynamics of virus in the community. So, hopefully, we will be much better prepared if, in fact, we do get this second surge than we were months ago.

Ms. Matsui. Okay. Thank you very much, Dr. Fauci. And I yield back.

The Chairman. I thank the gentlewoman.

Next we move to Mr. McKinley.

Mr. McKinley. Thank you, Mr. Chairman. I'm going to direct my first question to Dr. Fauci. The New York Times, CNN, and The Washington Post have relentlessly criticized President Trump's response to COVID-19, calling it a failure. You heard today, a lack of leadership. But, wait. As you know, nearly 750,000 people have died in America from drug overdose, and we still don't have a solution. AIDS has killed over 700,000 people in America, and we don't have a cure for that either.

But, look, the first case of COVID was diagnosed in America just 155 days ago. And, according to testimony we had earlier this spring, the pharmaceutical experts say that we could have a treatment by fall and a vaccine by January, keeping in mind

it took almost 10 years to come up with a vaccine for the influenza and four years for mumps. Nevertheless, the media and the left simply can't help but criticize President Trump.

So my question to you is: do you think that President Trump is being judged fairly?

Dr. Fauci. Actually, that's an unfair question, because you are asking me to pass judgment on the press's treating of the President of the United States. That's --

Mr. McKinley. It may be unfair, but you've had -- numerous times you've commented and criticized -- or contradicted what the President said. So do you think he is being judged fairly?

Dr. Fauci. Well, it depends on what you mean. I mean, I work in the White House, and I believe that everyone there is doing everything they possibly can --

Mr. McKinley. Thank you.

Dr. Fauci. -- to do what they need to do.

Mr. McKinley. That's it. So, Dr. Fauci, you said as late -- and I've got a newspaper article here -- that as late as March 31st there was no consensus on wearing masks. And the President, as you know, relies on your expertise. Do you now regret not advising people more forcefully to wear masks earlier?

Dr. Fauci. Okay, we're going to play that game. Let me

explain to you what happened back then.

Mr. McKinley. It should be a yes or a no.

Dr. Fauci. No, there's more than a yes or no, by the tone of your question. I don't regret that, because let me explain to you what happened. At that time, there was a paucity of equipment that our healthcare providers needed, who put themselves daily in harm's way of taking care of people who are ill. We did not want to divert masks and PPE away from them to be used by the people.

Mr. McKinley. Okay. I have --

Dr. Fauci. Now that we have enough, we recommend --

Mr. McKinley. Reclaiming my time, I've got two more questions. So, thank you for that, Dr. Fauci.

So, Dr. Redfield, I am going to be directing this to you. Nursing homes, as we've talked about here earlier, make up nearly 40 percent of all of the COVID deaths. And the CDC issued guidance on proper protocol for these facilities, yet states like Michigan, New York, New Jersey, and California apparently -- apparently disregarded that guidance. So, Dr. Redfield, do you think the decisions of these governors led to unnecessary deaths in these nursing homes?

Dr. Redfield. Thank you for your question. I think the

critical issue here is -- two things. One, our guidance is just that: guidance. Two, areas that we could impact the nursing homes, particularly infection control, working together with CMS, very aggressively early on, after the Seattle outbreak was recognized in that nursing home, really rechanneled energy into looking at the effectiveness of infection control in those nursing homes, then restricted visitors to make sure --

Mr. McKinley. Do you think that the decisions led to unnecessary deaths by not -- by allowing infected residents to come back into the nursing home?

Dr. Redfield. I think, again, all of these decisions that have been made in the early days are subject to hindsight. We gave clear guidance on how people should be handled if they come into these nursing homes.

Mr. McKinley. Okay. Now, the third question -- back again to you, Dr. Redfield -- we know in the foreseeable future that we're not going to have a zero risk of transmission. We're not going to get to that. So if we want our economy to recover, we know our schools have to reopen. So, going back to the school question, in addition to tracing, distancing, wearing masks, what rate of infection is needed, in your mind-set, for children to

go back to school? What's the rate of infection? One percent?

Dr. Redfield. Yeah, I'm not prepared to give you that definitive answer. I am prepared to say that one of the most important things we need to look at is not the number of infections but the consequences of these infections. And there is two really big consequences. One is hospitalization and mortality, and the other is our economy, right?

And I think we are clearly seeing that, in many parts of our nation, that one can open our economy safely, but it is going to require more vigilance than some of us see right now with the social distancing. We're going to continue to try to emphasize the importance of social distancing, face masks, and hand-washing as we continue to do it.

It's my expectation that many jurisdictions will be opening schools. We're going to try to give the guidance to help them do it safely. I think you're right, as Dr. Fauci alluded to before, it is going to be influenced by the kinetics of the outbreak in the jurisdiction at the time. I'm not prepared to give you that number, but I think we're going to see progressive jurisdictions move to open schools in the fall.

Mr. McKinley. I yield back. My time's up.

The Chairman. We now go to Ms. Castor, the gentlewoman from

Florida. I'd ask everybody to unmute before they begin.

Ms. Castor. Great. Thank you so much. Thank you to our witnesses today.

When you compare the number of confirmed cases and the number of deaths in the United States with countries across the globe, it's really shocking. And it makes me angry and it makes me sad at the same time. We have 2.3 million confirmed cases. We have just over 120,000 Americans who have lost their lives just in a few months' time. And it appears that other countries have done a better job controlling the spread. They've done a better job on testing and tracing. Every advantage that the United States of America has with our scientists, our public health experts, something has gone wrong here, and I think it starts at the top. I think the President's behavior and comments have undermined our public health professionals every step of the way.

Dr. Redfield, I would like to know, how often do you interact with the President and talk to him about public health guidelines and bringing all of your expertise to bear? How often do you interact with the President?

Dr. Redfield. Well, I have regular interactions as part of the White House Task Force, as a member to it, and participate

in each and every one of the task force meetings. And as relates to my interactions directly with the President, I'm going to keep those between myself and the President.

Ms. Castor. Well, you know, every time the President contradicts scientists, every time he contradicts our public health experts, whether it's the wearing of masks or mass gatherings or drinking bleach or taking hydroxychloroquine, it costs lives. And I agree with my colleagues that we really expect you to be more outspoken when it comes to these public health advisories. It will cost lives, it has cost lives, and -- but I'll change direction now.

For Dr. Fauci, you know, Floridians are very concerned with the latest spike in cases. The Florida Department of Health announced, just a little while ago, we've got another 3,300 cases and 64 deaths just since what was announced yesterday. Twenty-five percent of the total cases in Florida have been confirmed in just the past 10 days, and we have a positivity rate of now up to 13 percent in the past week.

So, what message do you have for the State of Florida, and other hot spots across the country, as we have so many more young people who feel invincible that are testing positive and our economy is opened up? What is your advice to Floridians and

others in hot spots?

Dr. Fauci. You know, my advice to the Floridians is the advice I would give to anyone and everyone: to follow the guidelines that we have very carefully thought out and put out on how one can reopen or open America again. And that is to stay within the framework of the particular phase of reopening you are in and to not throw caution to the wind.

I think what happens, related to the comment I made a little while ago about the confusion there must be, particularly among young people who have a pent-up urge to go out, which is understandable, but what they need to appreciate is that they are part of a process of the dynamics of an outbreak. And although they themselves may perceive that they are at very low risk for something that would be deleterious to them, by propagating the process of the outbreak they may be indirectly hurting people by infecting someone, who then infects someone, who then infects someone who is vulnerable.

So they need to understand that. If we could get that message across, that it is not an all-or-none phenomenon; getting back to normality is going to be a gradual step-by-step process, and not throwing caution to the wind.

Ms. Castor. And what about masks for young people? There's

a lot of -- you know, they look at national leaders who are not modeling your advice and your behavior. What do you say? Because you're a trusted scientist and expert. What do you say directly about wearing masks and mass gathering?

Dr. Fauci. I will be very consistent, and I will say it yet again, that you should not congregate in crowds. You should keep distance. And even though many people, for a variety of reasons, do not listen to the -- not suggestion, but plea to not congregate in crowds, some people are going to do that anyway.

If you do, please wear a mask. And as you wear a mask, and you are in a situation where you are getting animated, in a demonstration or in a rally or wherever you are, avoid as best as possible the urge to pull your mask down and shout.

So, Plan A, don't go in a crowd. Plan B, if you do, make sure you wear a mask.

The Chairman. Thank you, Ms. Castor.

Ms. Castor. Thank you, Dr. Fauci. I yield back.

The Chairman. Next, we go to Mr. Kinzinger in Illinois. And unmute.

Mr. Kinzinger. Thank you, Mr. Chairman. I'm unmuted. Thank you, Mr. Chairman, and thank you to all of the guests for

being here. It's a weird time, and very important, so thank you.

I think, you know, one of the discussions is this communication's important. So, whether it's between Federal Government, state governments, local governments, nonprofits, businesses, but also international governments. And I think we need a lot more information, eventually, on what the Chinese Communist Party knew, what they withheld, and what real impact they had, and I look forward to that being more investigated.

We have all seen the stories about people who are testing positive for the virus and they show no symptoms at all. And, in some cases, it was able to spread through entire communities of people without ever knowing that they have been infected. So, Dr. Fauci, let me ask you, given the significant rate of these asymptomatic infections, how can antibody tests improve our understanding of the transmission of COVID-19 and to help identify populations at risk?

Dr. Fauci. Well, one of the things that we need to do, and I think that's very important, related to a previous question about getting the kinds of surveillance studies that allow you to get a much better handle on, A, the real percentage of asymptomatic carriers; B, the rate at which they infect others;

and a variety of other things, I mean, things that are really important questions.

We learned, interestingly -- actually, to my surprise, Congressman -- that when you look at asymptomatic individuals and people who are symptomatic, the level of virus in their nasopharynx is almost the same, which is almost counterintuitive, but it is a fact which tells you that the danger of transmissibility is such that it is very important to understand the penetrance of asymptomatic infected people.

And when you do get them, you need to identify them, isolate, and contact tracing. And questions that were asked, I don't know, an hour or so ago to the testing issue, we need to do much, much more surveillance testing. And so the 40 to 50 million tests per month that would be available as we get into the late summer and early fall are going to be able to ask some of the questions you're appropriately asking.

Mr. Kinzinger. Thank you. And --

Admiral Giroir. If I could just build on that for a second. The 40 to 50 million tests I said assumes no advances in technology, and that's not even including pooling. I do say pooling because the FDA just put up standards for validating pooling. So we would expect, based on preliminary data we have,

that on many tests we can at least pull 5 to 1, and maybe up to 10 to 1.

So when you do that math that I think will be validated very quickly by academic institutions and by large organizations, that number of 50 million is going to go up by five-fold, at least, per month.

Mr. Kinzinger. Great. Thank you. And that's what's amazing, frankly, is American ingenuity, when we put our minds to it and seeing the advances and hopefully when we get to a vaccine.

So, at the beginning of the pandemic, both my wife and I actually experienced what we thought were symptoms of COVID-19, and we recently decided that we would go in and get an antibody test. I had that done, and I found out that I was actually negative for the antibody.

So, Dr. Redfield, in your testimony you stated that, at this point, we don't know whether the presence of antibodies provides immunity to the virus. So, with this in mind, how does antibody testing help, if we don't know if it provides immunity to the virus? And what are the benefits of an antibody test from an individual patient perspective?

Dr. Redfield. Thank you very much for the question,

Congressman. I think right now, at this stage, I think important at the individual patient level, we don't know what it means, particularly, in terms of immunity, as Dr. Fauci said earlier. What it does mean -- again, assuming it is a reliable, approved-FDA test -- that you have been infected in the past. We don't know, though, what that means in terms of immunity.

Its value to us at CDC is its surveillance advantage. Right now, we continue to do surveillance throughout the United States through a variety of different systematic collections we are doing, and it allows us to see the full extent of the infection.

Right now, the data at a national level suggest that for every documented infection that we have as a case report there's actually about 10 other individuals that actually had been infected. That data will continue to be refined as we continue to expand our antibody testing, but I really think its major role right now is an important surveillance tool.

Mr. Kinzinger. Thank you. And I'll just add another question, I'll submit it for the record, about this virus lasting on surfaces.

But, with that, I will yield back. Thank you.

The Chairman. Thank you. And, thanks, I remind everyone that you can submit questions for the record, to the task force

and the witnesses, and that all opening statements will be entered into the record.

So, next we go to Mr. Sarbanes from Maryland.

Mr. Sarbanes. Thank you, Mr. Chairman. Can you hear me?

The Chairman. We can.

Mr. Sarbanes. Terrific. I want to thank the panel. Last month, the Trump Administration announced the launch of Operation Warp Speed to support rapid research and development of COVID-19 vaccines, therapeutics, diagnostics, and so forth. It's a project that is supposed to coordinate efforts across the Federal Government and engage the private sector, including at least five pharmaceutical companies that are developing vaccines.

So, I'm trying to understand a little bit better how that works. First off, there's been some concerns raised about the venture, including potential conflicts among its leadership, conflicts of interest.

Dr. Fauci, you have had decades of experience leading public-private partnerships with pharmaceutical companies to develop the vaccines. Transparency is important, is it not, in these collaborations?

Dr. Fauci. Thank you for the question. The Operation Warp Speed is an endeavor that is a Department of Defense/HHS, led

by Secretary Esper and Secretary Azar, to try and get diagnostics, therapeutics, and vaccines done in a way that is coordinated, with the maximum speed possible without sacrificing scientific integrity.

It is divided up into three groups. The leader of this is Moncef Slaoui, a person with great experience in industry; as well as General Perna, who is an Army General who is very well versed and very experienced in supply chain processes of getting vaccines, when we do get it, to be produced to the level that is needed, as well as to be distributed equitably throughout our society.

So it's a --

Mr. Sarbanes. Let me ask -- let me jump in, because I wanted to ask Dr. Hahn. I understand that a senior FDA official was initially tapped to lead the vaccine development under Operation Warp Speed, but then left the project out of concerns about political pressures to approve vaccines.

I assume you agree that the role FDA plays in this has to be one that's not impacted by political pressure, and that your agency is ready to adopt the highest standards in approving any vaccine that's developed under this initiative?

Dr. Hahn. Congressman, thank you for the question. Your

point is very well taken, and I can assure you that we will retain our regulatory independence. We will use the science and data that come to us, and we will use our high standards to assess the safety and efficacy of a vaccine. We have world-class experts who will continue to maintain that.

One point I do want to make clear, sir, is that we drew a very bright line between Operation Warp Speed and all of our sponsors. We do not engage in decision-making, neither I nor Dr. Marks nor Dr. Cavazzoni, with respect to those decisions. We provide technical assistance, as we do to all sponsors, but we've made it clear that we do not participate in those decisions because we absolutely must maintain regulatory independence and make the right decision for the American people based upon science and data.

Mr. Sarbanes. Thank you. And, again, I'm trying to understand sort of the boundaries or reach of the Operation Warp Speed effort. So, my initial sense is that it was focused on these five selected companies that are pursuing vaccine candidates. I'm not entirely clear -- and maybe that's not right -- but I'm not entirely clear on what this means for vaccine exploration/development beyond that.

For instance, I've been reading just over the last week or

10 days or so about this oral polio vaccine opportunity, maybe that it has promise, maybe it doesn't, but some inquiry there, I guess, may be warranted.

I'd like to get the panel's perspective on whether you consider those kinds of inquiries outside of Operation Warp Speed, or is Operation Warp Speed broad enough to accommodate those kinds of things in addition to whatever is happening with the five companies? And sort of from where your different agencies sit, what's your perspective and understanding of that?

So let me just, I guess, go down the line. Dr. Redfield, why don't we start with you, and then Dr. Fauci, and I guess Commissioner Hahn would be the other one.

The Chairman. Brief responses, gentlemen, because his time is up.

Dr. Redfield. Yeah, very quick. The only thing I would say is it's intriguing in terms of the potential, what we call viral interference with these live-virus vaccines, whether it's polio or measles, that they may impact another RNA virus from being able to establish infection. So, really, that's the hypothetical. I think it's intriguing, not for just this pathogen, but for other RNA viruses.

Dr. Fauci. Yeah. Very quickly, I think your question was,

is there room for other vaccines? The answer is yes, through multiple mechanisms. Anything is on the table. It could be through Operation Warp Speed. It could be through a number of mechanisms that we have in our research institution at NIH. So, I can understand your concern, but the doors are not closed to other candidates. You can be assured of that, sir.

Dr. Hahn. Congressman, from FDA's perspective, we absolutely -- the doors are open there as well. We are working with multiple different sponsors, pharmaceutical companies, as well as Operation Warp Speed. We will look at all data that comes across the door. We will provide technical assistance to all who want to develop a vaccine and therapeutics.

Mr. Sarbanes. Thank you.

The Chairman. Thank you. Mr. Griffith?

Mr. Griffith. Thank you very much, Mr. Chairman. I greatly appreciate it.

Dr. Fauci, and then Dr. Redfield, I'm going to put you all a little bit on the spot, because I want to talk about schools. And as you might imagine, a lot of constituents are very concerned about what's happening in the schools.

And, Dr. Fauci, you earlier made some statements which led me to believe that you believe that, not only nationally, but

even within a state the size of Virginia, we probably ought to be looking regionally, and maybe even locally, as to how we do it and how we go forward. Did I understand that correctly?

Dr. Fauci. You understood me correctly, Congressman. And that's the point I want to make, because it's really a source of confusion. It's not one-size-fits-all. I think you have to look at it at the local level, the county level, the regional level, the city level, the state level.

So, we often say, in America, should you or should you not be open? I mean, that is almost a non-question, because we're such a large country, and so heterogeneous, and such a range of involvement of this virus in different parts of the country.

Mr. Griffith. And, Dr. Redfield, I'll move to you because in the Commonwealth of Virginia they often are citing, and for various things related to schools and others, they cite the CDC. Do you agree with Dr. Fauci in his assessment?

Dr. Redfield. Yes. It needs to be a very targeted, jurisdictional decision.

Mr. Griffith. And I greatly appreciate that, because my district is four hours from D.C., even though people often think I am right next door. And then the district stretches from the very edge of it, which is four hours away, another

four-and-a-half hours, so that it ends up going further west than Detroit, Michigan. And the district, just my district, is larger than the State of New Jersey. So, even within the district, we may need to have some additional regional approaches. Would you all agree with that?

Dr. Redfield. Yes.

Mr. Griffith. And Dr. Fauci indicates that, as well.

All right. Commissioner Hahn, in a statement on March 30th, 2020, you recognized the importance of facilitating access to viral samples in order to speed up the development of tests. You noted that, in the future, making virus samples available earlier to commercial developers will be crucial to deploying tests quickly.

This certainly will not be the last time we face a rapidly spreading novel virus strain. How can the process for obtaining viral samples, especially inactivated viral samples, be improved in the future for quicker access?

Dr. Hahn. Congressman, thank you for that question. And I think that is one of the lessons learned from this situation with COVID-19, is that access to those samples is very important. We would work with NIH, with academics, with the CDC, to make sure that those are available.

And just to make a point, we, for serology tests, have made a reference panel now available to developers to actually facilitate that. That's an example of what U.S. government, FDA, NIH, and CDC could do.

Mr. Griffith. I thank you. And I apologize, Admiral Giroir? Did I say it close to correct?

Admiral Giroir. That's good enough.

Mr. Griffith. All right. Earlier this year you informed this committee that enough testing supplies would be distributed so that the states could test the recommended two percent of their populations per month. Yet, according to Johns Hopkins coronavirus testing trend tracking center data, only about 20 percent of the states are testing the recommended two percent of their population per month, while another 20 percent are testing less than one percent of their population per month.

Has the Administration been distributing supplies to states? And, if so, why do you believe some states that have testing supplies are not testing more of their population?

Admiral Giroir. So, thank you for that. Again, before the full state plans were just received -- and this was part of the PPP funding that we've reviewed, and we've reviewed them extensively with the CDC -- we set preliminary targets for every

state by phone calls with every single state, every single state health officer, epidemiologist.

Overall, in May, the target was about 12.9 million tests throughout the country and about 12 million were done. This is, really, very good considering many of the states try to do three or four times as many tests as they had done cumulatively during that time.

Mr. Griffith. So you think we are on track.

Admiral Giroir. I think we're really on track right now. It looks very good. Some states have underperformed, especially in May. Most of them have improved their performance in June. And our preliminary view of all of the state plans, the great majority of them, I mean, the overwhelming majority, were very good to excellent. So, everyone is getting the message, and I look forward to that.

Mr. Griffith. I thank you. And, Dr. Fauci, if I can come back to you. When we first started this, you know, we knew it was going to be tough, and that we were probably never going to get rid of this particular virus, but we talked about bending the curve and making sure our hospitals were ready. Based on your comments on PPE and face masks and so forth, I believe that you think that we're probably ready, maybe not perfect, but we're

ready. And have we not bent the curve?

I understand it's not over. It's not going to be over anytime soon. We've got to wear our masks and do what we're supposed to do, but don't you think we've bent the curve and that our hospitals are now ready? Is your mic on?

Dr. Fauci. Sorry, sir. Yes. We've been through a terrible ordeal. We've learned a lot. The preparedness now is clearly logarithmically different than it was in the beginning.

Mr. Griffith. And so we've bent the curve and our hospitals are ready.

Dr. Fauci. Right.

Mr. Griffith. I yield back.

The Chairman. Thank you. Next we go to Mr. McNerney, coming from California. Would you unmute?

Mr. McNerney. I thank the Chairman, and I thank the witnesses for your work and your expertise. Are you able to hear me there, Chairman?

Participant. We can hear you.

Mr. McNerney. Okay. Thank you. So, I am deeply concerned about President Trump's decision to terminate the United States' relationship with the World Health Organization. And I'm not alone in this concern. The head of the American Medical

Association has called the President's move a senseless action that will have significant harmful repercussions now and far beyond this perilous moment. It appears that the President is not acting on sound public guidance, but is instead scapegoating the WHO to deflect from his Administration's failure in responding to the COVID-19 pandemic.

According to a report in Vanity Fair, key U.S. agencies that work with the WHO on critical public health programs were not consulted or asked for an impact analysis before the President's decision to withdraw.

Dr. Fauci, were you consulted about the potential public health impact of the United States withdrawing from the WHO? And, if so, what were your recommendations?

The Chairman. Jerry, I apologize. We said we were going to take a break at 1:30 so everyone can go to the restroom or whatever for 15 minutes, and Dr. Fauci had to step out.

So I'm going to ask you to start over again. We will take a 15-minute break so everybody can use the restrooms, and then we'll start again with Jerry and you'll have to repeat your question.

This committee stands adjourned for 15 minutes.

[Recess.]

The Chairman. All right. The committee will reconvene. We will try to go as quickly as we can. And I appreciate everybody bearing with us. And if you have to step out, please come back.

And we left off with Congressman McNerney. Jerry, you are going to have to repeat your question, and unmute.

Mr. McNerney. Okay. Thank you, Mr. Chairman. I am assuming I am live now.

I want to remind the chairman that your video from the committee is coming in and out, so I am not sure if I am in sync or not.

But I am truly concerned by the President Trump's decision to terminate the United States' relationship with the World Health Organization. And I am not alone in that concern. The American Medical Association, for example, has called the President's move a senseless action that will have significant harmful repercussions now and far beyond this perilous moment.

It does appear that the President is not acting on sound public health guidance, but is instead scapegoating the WHO to deflect from his administration's failure in responding to the pandemic. Again, according to the Vanity Fair, key U.S. agencies that work with the WHO on critical public health programs were

not consulted or asked for impact analysis before the President's decision to withdraw.

Dr. Fauci, were you consulted about the potential public health impact of the United States withdrawing from the WHO? And, if so, what were your recommendations?

Dr. Fauci. Thank you, for the question, sir. I was not specifically consulted about the withdrawal or the attempt to withdraw.

The situation with many of us is that we have longstanding relationships with the WHO. The NIAID is a collaborating center. I have a memorandum of understanding with Dr. Tedros. Many of our bits of information that we get, Dr. Redfield and I are on a weekly call that is supervised by the WHO where we get the opportunity to speak to the medical leaders in the various countries.

So, with regard to what policy comes from the White House is not -- I have not been consulted on. And it hasn't really impacted the kind of interaction --

Mr. McNerney. I am going to interrupt you, Dr. Fauci. I can't -- it's like watching -- listening to a cell phone that is coming in and out. So I am going to go to my next question, which is really the same question for Dr. Redfield.

Were you consulted about the potential public impact of the U.S. withdrawing from the WHO? And if so, what were your recommendations?

Dr. Redfield. As with Dr. Fauci, no, not directly.

CDC has a long history with working with WHO. We continue that collaboration. We are working on both polio eradication, the Ebola outbreaks in the DRC, influenza surveillance across the world. So, we continue working at the technical scientist-to-scientist level. And so, we continue to do that.

Mr. McNerney. Again, I couldn't hear the response, and I hope the Committee improves the situation.

According to Dr. Ashish K. Jha, Faculty Director of the Harvard Global Health Institute, pulling this critical global health investment while the world is in the middle of battling a pandemic will have outsized consequences, and it will certainly make all of us less safe. And this will put more of lives at risk, not only globally but here in the United States.

Dr. Fauci, do you have concern with the President's decision to withdraw from the WHO?

Dr. Fauci. Yes, I do. And that is the reason why I am sorry that you did not hear my explanation.

What I was saying is that despite any policy issues that

come from higher up in the White House, we at the operational level continue to interact with the WHO in a very meaningful way, literally on a day-by-day basis.

Mr. McNerney. Thank you.

Dr. Redfield, if the United States formally withdraws from the WHO, how will that impact the CDC's ability to protect Americans?

Dr. Redfield. Yeah. We will -- as I said, we are continuing to work with WHO in our public health efforts in a number of different programs. And, again, the implication will become, you know, where there is colleagues and able to collaborate, clearly there can be limitations on our ability to provide direct funding to the WHO, but we have the ability to provide funding to the operations through different mechanisms, so we continue the public health work that we need to get done.

Mr. McNerney. Thank you, Dr. Redfield.

Well, as a member of Congress with a science background, I am concerned that science is being ignored for political purposes. We must be certain that consequential decision, like withdrawing from the WHO, are based on sound public health guidance and not on pursuit of a scapegoat. Science must have a voice at the table. Whether it is regarding treatments for

the current and future pandemics, climate change, or other issues of public concern, we must include science in decision making. Ignoring science is dangerous and a disservice to the American public.

Mr. Chairman, I yield back.

The Chairman. Thank you, Mr. McNerney.

Next, Mr. Bilirakis.

Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it. And I want to thank the presenters for their testimony today and all the work you do on behalf of our constituents.

Dr. Fauci and Dr. Hahn, in the scientific community's COVID-19 response we have seen unprecedented scientific collaborations and research information sharing at a pace unlike anything before in history. Clinical trials are approved in record time, while laser focus remains intent on patient safety.

Regulators and drug manufacturers are learning from each other from joining together in the critical fight against COVID-19.

In line with that innovation, is the COVID-19 Evidence Accelerator, which is a public/private partnership initiative launched by the Reagan-Udall Foundation for the FDA, in collaboration with Friends of Cancer Research, to advance

understanding of COVID-19 through focus on analysis of real world diagnostic and clinical data.

Question: do you believe these scientific collaborations will lead to lasting changes in how we innovate for drugs and vaccines -- for drugs and vaccines? How will the innovation changes affect research into diseases like ALS and Alzheimer's disease?

Dr. Fauci, if you -- okay. All right, Commissioner Hahn.

Dr. Hahn. Congressman, thank you for highlighting this really important endeavor and partnership with the Reagan-Udall Foundation and the Friends of Cancer Research. This effort is an attempt to really accelerate, as the name implies, the use of real world evidence in our decision making from a development and a research point of view.

A couple of points I would like to make, sir. And I do thank you. One is, we have to be really careful that we do this in a robust and careful way because the gold standard remains clinical trials, randomized clinical trials. That is important that we understand that level of evidence.

However, in a rapidly moving situation like we have now with COVID-19, where we make decisions based on the data that is available to us at the time, having additional data afterwards,

as those decisions play out, as we gather evidence how tests work in the real world, about how treatments are administered, very pragmatic data that allow us to then go back and revisit the decision, to me there is nothing wrong with that, that is actually a really good thing. As the doctors in the room know, when you are taking care of a patient and you get more data, you bring that back to the table. In fact, you must incorporate that in your decision making.

Mr. Bilirakis. Absolutely.

Dr. Hahn. So, I think this is a great opportunity. I would love to see us do more. But as I mentioned earlier when asked that question, I would love to continue the conversation with Congress.

Mr. Bilirakis. Very good.

Dr. Fauci, would you like to respond?

Dr. Fauci. Yeah. I totally agree. I think that what Dr. Hahn has mentioned is something that spills over into what we do at NIH and NIAID, is the clinical trial process, which is really the gold standard of those types of decisions.

Mr. Bilirakis. Very good. Thank you.

The next question is for Dr. Redfield. Has CDC coordinated with agencies, such as the Administration on Community Living,

to improve efforts to protect the elderly?

What steps has CDC taken to foster increased collaboration between the public health sector, and aging services sector, to meet the needs of older adults during this pandemic?

Dr. Redfield. Thank you, Congressman.

Mr. Bilirakis. Thank you.

Dr. Redfield. CDC has a long, established relationship with the ACL to continue to work on health and well-being, particularly the elderly, but also people with disabilities. We work together in trying to cross-clear information from other agencies, and their materials.

Also, CDC has reached out to, obviously, AARP to help to provide tools for older adults that we can get out and take advantage of their distribution. And we will continue to do that.

Obviously it is a critical group. It was highlighted in terms of the morbidity and mortality in this particular pandemic, as you know. So, again, I think we will continue to cross-collaborate with the ACL and try to help facilitate their mission.

Mr. Bilirakis. Excellent.

Next question, again Dr. Redfield. Given the fact that we continue to learn about the virus in real time, how often is CDC

updating its testing guidelines?

Dr. Redfield. Well, it is intermittent. We recently posted our updated testing guidelines last Friday. And I know, as we've gotten some feedback from the states, there's an interim week posting that is going to come to clarify a few issues this week probably.

And then, on top of that basic guideline, we are posting specific guidelines for specific situations. So, we did infrastructure, critical infrastructure, we did nursing homes, we did medical. This week I suspect we are going to do K through 12 and higher universities. And then I suspect shortly thereafter we are going to do non-critical infrastructure, businesses.

So, we are trying to add specific testing guidelines to specific situations. And, obviously, when there is new science and new situations we update them in that setting. But I think you will see there is going to be a series of targeted testing guidelines for unique situations that will be posted over the next several weeks.

Mr. Bilirakis. Very good. I appreciate that.

I yield back, Mr. Chairman. Thank you.

The Chairman. Thank you.

Next member is the gentleman from Vermont, Mr. Welch.

Unmute, please.

Mr. Welch. Thank you very much. Thank you very much, Mr. Chairman and our Ranking Member Walden. Thank you for your patience and for your extraordinarily good work.

I think it is fair to say that not a single member of this committee, Republican or Democrat, as of December of last year, or even January or February, had any notions that there was this emerging threat from the coronavirus. But, on the other hand, my understanding is that public health officials always anticipate, and there are two things that are essential to be ready. One is preparation, and two is communication.

I want to ask a few questions about preparation. My understanding is that the National Security Council had a playbook for early response to high-consequence emerging infectious diseases. And that indicated that we should, in preparation, move swiftly to fully detect outbreaks, procure PPE, secure supplemental funding, use the Defense Production Act.

Are any of the witnesses aware of that report having been followed in 2019 or January or February of 2020? Just a yes or no.

It sounds like the answer is no.

Dr. Fauci. No, I am not exactly sure what you are referring to. I think you are referring to a document that was put out prior to the outbreak about what the response should be.

Mr. Welch. Right.

Dr. Fauci. Yes. You know, if you look substantively, much of what is put -- that was in that document, actually was implemented with the exception, as I think you are alluding to, is that the amount of stockpiled PPE and other items that were needed were not at the level that we were able to respond in as efficient way as possible.

Mr. Welch. Right.

Dr. Fauci. Right.

Mr. Welch. And there was a real delay in the use of the Defense Production Act.

Also, there had been a White House Global Pandemic Response Team that was eliminated in May of 2018. Anyone think that that was a good decision, to eliminate that?

I am not there to see your responses. I take it the answer is no.

In the travel ban that the President did implement January 31, as I understand it, that only applied to foreign nationals coming from Wuhan, but it did not include permanent residents

or family members or nationalized American citizens. Did that significantly limit the benefit of that travel ban?

Dr. Redfield. Thank you for the question, Mr. Congressman. This is Redfield, CDC.

Mr. Welch. Yes. Very briefly, if you would, because I don't have more time.

Dr. Redfield. Yeah, those individuals, those individuals as American citizens were qualified to come into America when allowed. They went into 14-day quarantine.

Mr. Welch. But the quarantine wasn't enforced, is my understanding.

Let me ask a few other questions about communication. I am sure that every one of you, who is very careful about your communications, knows how important that is. When the President said on February 23, 2020, that the stock market is starting to look very good, and the coronavirus looks very much under control, if any one of you agrees with that, can you raise your hand?

And on February 27th --

ADM Giroir. I am sorry, we didn't, none of us heard that question. Could you just repeat that?

The Chairman. Peter, could you repeat the question again?

Mr. Welch. What I said is that communication is extremely

2964 important. And we have before us extremely good and careful
2965 communicators, for which I thank them.
2966 On February 23, 2020, President Trump indicated that the
2967 stock market is, quote, starting to look very good, and the
2968 coronavirus is, quote, very much under control.
2969 Does anyone at the table agree with that statement? If so,
2970 raise your hand.
2971 And another statement was that --
2972 The Chairman. Peter. Peter, listen to me.
2973 Mr. Welch. Yeah.
2974 The Chairman. You have got to give them a chance to respond,
2975 because you are not here.
2976 Did you hear his question? If you don't want to respond,
2977 that is fine. But I just --
2978 Dr. Redfield. He asked us to raise our hands.
2979 The Chairman. Oh, I see.
2980 Dr. Fauci. Nobody raised their hand.
2981 The Chairman. Okay. So nobody raised their hands. Okay.
2982 Next.
2983 Mr. Welch. All right. On February 27th President Trump
2984 said that COVID-19 will disappear like a miracle. Do any of you
2985 -- did any of you agree with that statement by President Trump

at that time? If so, raise your hand.

The Chairman. Okay. No hands were raised, Peter.

Next.

Mr. Welch. And, finally, President Trump indicated on March 9 that COVID was comparable to the common flu. I heard your testimony, Dr. Fauci, and you are fearful about the flu making the situation worse. But do you agree that there is any comparison between COVID and the common flu? That is for Dr. Fauci.

The Chairman. You have to put your mike on, Dr. Fauci.

Dr. Fauci. Sorry.

It is not the common flu.

Mr. Welch. Okay, thank you. I see my time is up. I yield back.

The Chairman. All right, thanks a lot.

Mr. Johnson of Ohio is recognized for five minutes.

Mr. Johnson. Well, thank you, Mr. Chairman and Ranking Member Walden, and to our witnesses. Especially our witnesses, for taking your critical time. The work that you are doing is so very important. Obviously we are not out of the woods with this virus yet, so you are still on the front lines of it.

You know, I want to shift gears a little bit and talk about

something I don't think I have heard anybody else talk about. You know, during this COVID-19 pandemic and the associated lockdowns and distancing orders, many vulnerable Americans, for the first time, became isolated and, in many cases, too fearful or unable to get essential health care.

In eastern and southeastern Ohio where I live, and across rural America, unfortunately this can be the reality even in normal times. A specialist could be a three-hour-plus drive away, or a symptom could go unchecked for days because an elderly person might not have a loved one close by to drive them to their doctor.

Increased use of telehealth could help alleviate this problem. Telehealth has been a priority of mine for a long time, and it has taken on a new sense of urgency with so many elderly and medically-compromised people finding it potentially hazardous to leave their homes due to COVID-19.

I am really pleased that President Trump and his administration used the emergency authority that Congress gave them to remove the regulations and red tape that had previously hindered robust deployment of telehealth. And as a result, countless vulnerable Americans now have access to their doctors from the safety of their home, ensuring continuity for essential

medical care.

I have heard patient after patient, and provider after provider, who have taken advantage of these safe, new services. They love the convenience of it and the immediate access to care. They tell me they don't want to go back to the way that it was before.

It is time for Congress to make robust access to telehealth permanent for all Americans, especially the most vulnerable among us.

So, Dr. Fauci, I would like to start with you.

Do you believe that telehealth practices, virtual doctors visits, could be an effective tool in helping to promote -- or, protect vulnerable individuals in the event of a second wave of COVID-19, or even in a future infectious disease pandemic?

Dr. Fauci. Yes, I do, sir. I believe that telemedicine is a very important component. It should have been even more implemented. But as we look forward in the future, I think you are going to see a lot more of that, not only for the reasons that you bring out, given the specific situation we are in now, but for a variety of other situations.

And I think Admiral Giroir has a very keen interest in this.

ADM Giroir. Thank you. I would just like to emphasize

that, as well, is that I think we have learned tremendous lessons about the utility of telemedicine, lessons that most of us thought that would be there.

But for example, just to understand the uptake, the week of January 15th there were only 500 telehealth visits by Medicare. The week of April 15th there was 150,000 of them. We have seen telehealth visits be instrumental in combating our burgeoning SUD issues, particularly with opioid use disorder, teleprescribing, increasing access to buprenorphine.

So, I think all of us with M.D.s behind our name understand that the whole key is getting health care to people where they are, and not making them come to a major tertiary or quaternary center, unless they really need to be there. So, we are all very anxious to increase the use of telemedicine going forward.

Mr. Johnson. Okay. Well, Dr. Redfield, you know, during the last several months we have seen situations where at risk, elderly, and isolated individuals have missed regular doctor appointments and preventative health screenings. As one of America's leading public health experts, can you speak briefly to the dangers to public health if patients looking to continue mental health treatment, to check in with their specialists, or even to consult with their doctor, are not able to do so over

an extended period of time?

Dr. Redfield. Thank you very much, Congressman.

I think it is important to emphasize that, you know, as we did limit health care, largely the purpose was to keep certain jurisdictions from overwhelming their health systems when we were working towards the peak.

Unfortunately, with health care being broadly limited across the nation, as you point out, there were real health consequences. Clearly, an individual's mental health services, individual's substance abuse services, but also, you know, individuals, we have a marked decline in childhood immunization. Many people missed their preventative medicine visits for mammograms or pap smears or colonoscopies.

So, it is really important that we get the health system back and operational. And I do think the introduction of telemedicine is a critical component and something that needs to stay as part of the innovation, as we work more and more to move from a disease-based system to a health system. So, I think it is critical.

We have seen an increase in suicides. We have seen an increase, obviously, in drug use disorder. It is important to get these health services back and operational in a manner which

the American public can access.

Mr. Johnson. Well, thank you very much.

And my time has expired. So, Mr. Chairman, I yield back.

The Chairman. Thank you, sir.

Next is the gentleman from New Mexico, Mr. Lujan.

Unmute your connection, there.

Mr. Lujan. Thank you, Mr. Chairman.

Dr. Redfield, under federal statute the CDC is required to treat tribal epidemiology centers as public health authorities, and share all data and data sets. Dr. Redfield, last week your staff indicated in writing that the data sharing issue -- what is that, Mr. Chairman?

The Chairman. Commenting on your artwork. I apologize.

Mr. Lujan. Oh.

Dr. Redfield, last week your staff indicated in writing that the data sharing issues reported in Politico were merely a miscommunication with a single tribal epidemiology center. But that isn't true.

My office has confirmed that this problem goes beyond a single center and the center's report that they have encountered problems obtaining other data sets from CDC, beyond COVID-19.

Dr. Redfield, do I have your commitment to work with each

of the 12 tribal epidemiology centers to sure they get access to all the data they are entitled to under law?

Dr. Redfield. Yes. The initial episode that you brought up was obviously a significant miscommunication. But you are right, that there is still issues to be worked out. Our team is currently working with the tribal epidemiology center, and we are committed to correcting that for all tribes.

Mr. Lujan. So, Dr. Redfield, you could direct your staff right here and now to release that data. Is that something you are prepared to do?

Dr. Redfield. I didn't hear. I'm sorry, I didn't hear the question.

Mr. Lujan. Dr. Redfield, you could direct your staff right here and now to release that data to the tribal epidemiology centers. Is that something you are prepared to do?

Dr. Redfield. We are working with them as we speak. One of the keys, Congressman, is to make sure that we have secure data systems to transport the data. And that is in fact what our teams are working to -- to finalize that. And as soon as that is finalized, to maintain the security of the data, it will be transferred.

I have been told that that is going to be completed,

hopefully, this week or within the next one to two weeks for all 12 tech directors.

Mr. Lujan. Thank you, Dr. Redfield. And please report to the Committee when that is done. Thank you.

The Trump administration failed to bring COVID-19 testing to scale in the early months of the pandemic. Even now, five months later, testing capacity is nowhere near where America needs it to be.

On January 31st Secretary Azar declared COVID-19 a public health emergency. Five weeks later, on March 6th, President Trump infamously declared that, quote, anybody that needs a test can have a test. They are all set. They have them out there, close quote. Yet, on the same date, fewer than 3,300 tests were completed in the United States.

On April 28th President Trump said testing in the United States would surpass five million per day.

Admiral Giroir, yes or no, are we currently in the United States conducting five million tests per day?

ADM Giroir. No, we are not. We are doing about 500,000 single tests per day.

Mr. Lujan. That's my understand, about half a million tests.

Now, nearly every leading public health expert agrees that the centerpiece of reopening the country is robust testing, tracing, and isolation strategy. One public health expert has said, quote, the lack of testing has been not only a public health catastrophe in the U.S., but is also a direct cause of our economic suffering, close quote.

Admiral Giroir, we have been hearing both proclamations and promises on increased testing for months now, and every time they come up short. What is going to be different moving forward? And how does the United States get to the 50 million tests promised, particularly in light of the President's evident lack of concern over the need for testing?

ADM Giroir. Thank you, Congressman, but I disagree with your question. I don't believe we have come up short every time we have said something. Since March 12th I have been very forthright about what we are going to provide, what the imitations are, what some of the constraints are, and that we are doing everything possible to increase that.

Right now we are doing about 15 million tests per month. Although we have need for more testing, our national positivity rate is about 6.5 percent, so we are certainly getting in the range. Right now six or seven states are above 10 percent. We

have to really surge into those areas.

When I tell you 40 to 50 million tests that is because I know every single lab producer, what they are doing, when they are providing it, how they are going to distribute it, and how many swabs are going to be there. So, the capacity will be there for 40 to 50 million tests, at least, in the fall. And I have that provider by provider, material by material.

And, hopefully, it will be much greater than that when we have pooling, and hopefully some of the new technologies from the NIH, from BARDA, that we can move into that realm.

Mr. Lujan. Thank you, Admiral Giroir. And I appreciate your leadership and respect you very much.

The one area where I disagree though, is that President Trump promised 5 million tests per day very soon, on April 28th, and we are still at only half a million tests each day. That appears that we have fallen short. So, I continue to look forward to working with you.

And with that, I yield back, Mr. Chairman.

The Chairman. Thank you, Mr. Lujan.

Next we have Mr. Long, from Missouri.

Mr. Long. Thank you, Mr. Chairman.

And, Dr. Hahn, there are a number of initiatives between

the federal agencies and private industry to accelerate the entire process for the development, manufacture, and distribution of COVID-19 therapeutics. The administration recently established Operation Warp Speed, and FDA has set up a Coronavirus Treatment Acceleration Program, or CTAP, as they call it.

Could you talk about the FDA's role in the development of therapeutics under Operation Warp Speed? And how does the FDA integrate its work and its own initiatives, like CTAP, with Warp Speed?

Dr. Hahn. Thank you, Congressman, for the question.

Approximately 10 weeks ago, FDA stood up what we call CTAP, Coronavirus Treatment Acceleration Program, as you mentioned, and that was for a variety of reasons. One is we indeed wanted to accelerate the development of therapeutics on behalf of the American people but do it in a very robust way that looked at the science and data.

We also, because we had gotten a significant number of applications and at this point our best estimate is double the normal of applications that we have during a regular time pre-COVID, because of that we had to prioritize applications based upon science and the highest priorities of science. So across the spectrum of our medical products CTAP allowed us to prioritize

the science and then address those applications, because what we wanted to do is make sure that we in real time with those applications address any questions that developers had.

I think the other important point here is that we had people come to the FDA who had never before applied to the FDA for an application of any sort, whether it be an emergency use authorization or an IND, and so we really had to hold hands with industry, with sponsors, with academia, to try to help get through the process.

I think a great example of what can be done is the work we did within IND to get the remdesivir protocol up and running and the speed with which I think it was completed that ultimately led to a EUA. We are working with all sponsors, sir, not just Operation Warp Speed, but we are providing all sponsors, but and including Operation Warp Speed technical assistance.

What are the trials that we think need to be done, what are the end points that need to be looked at, how can we accelerate those clinical trials and the design, and we will continue to do that as we continue to go through this pandemic.

Mr. Long. Okay, thank you.

And Dr. Fauci, could you speak to the HHS's role as part of the Warp Speed and its efforts to accelerating manufacturing

capacity and ensuring the manufacturers can invest early and aggressively in vaccine and therapeutic development?

Dr. Fauci. Thank you very much for that question, a very important question. Congressman, and that was one of the things I refer to earlier on in the discussion. That as part of the process of developing the vaccines in Operation Warp Speed that there is employment of contracting organizations to already start scaling up development of vaccines, particularly the first one that I mentioned that will go into a Phase 3 trial in July has already had contracted through HHS and BARDA, for the production by a contracting organization of hundreds of millions doses, ultimately, the first group of which would be delivered at the end of the year and the rest in the first quarter of 2021.

Mr. Long. Okay, yes. Thank you. I was a little confused in your opening remarks. Of course, we have been here a long time today and I can't remember exactly everything that I have heard, but I was wondering about that so thank you for clarifying.

And, Dr. Hahn, I will go back to you. Looking long term, what do you think the FDA and Congress could do to promote domestic manufacturing of drug therapy?

Dr. Hahn. Congressman, this is a very important issue and I appreciate you bringing it up. We have seen across the medical

products that we regulate issues related to redundancy in manufacturing and our dependence particularly in the foreign sphere where during a public health emergency we might have a lot of difficulty given the increased demand of having access to those supplies, both precursor products such as pharmaceutical precursors as well as final finished form of the drugs and PPE.

So very much we have been working on our technical assistance because manufacturers depend upon our technical assistance to help them develop the manufacturing procedures that lead to a quality product. We very much are leaning in on this. It is one of our major initiatives for advanced manufacturing but also domestic manufacturing. It would be very good to work with Congress further on this.

I think this is a particularly important lesson learned and the more we can bring manufacturing home and provide that redundancy to the supply chain, I think the better off we will be in the future. Thank you.

Mr. Long. Okay. I am getting the red light so I do yield back. Thank you all.

The Chairman. Thank you, Billy.

Mr. Tonko of New York. Unmute.

Mr. Tonko, are you muted?

Mr. Tonko. Can you hear me?

The Chairman. Yes. Now we can.

Mr. Tonko. Okay. Hey, thank you, Mr. Chairman, and thank you to our panelists for all the information exchange.

Last week, while participating in a telephone town hall with my constituents, I got a simple question from Ruby in Schenectady for which I had no good answer. She asked me straightforwardly, if the government is telling everyone to wear a mask in public, why does President Trump refuse to wear one?

So, Dr. Fauci, please help us set the record straight. What does the evidence tell us about the benefits of face masks or face coverings when it comes to transmitting or contracting COVID-19?

Dr. Fauci. Thank you for the question, Congressman. So although we don't know the exact percentage, we can say very clearly that wearing a mask is definitely helpful in preventing acquisition as well as transmission. The data for your wearing a mask and if you are inadvertently not knowing you are infected, protecting you from infecting someone else, is stronger data than the data that says that you will be protected.

However, everyone agrees in the public health sector that wearing of masks is beneficial. It may not be perfect, as we

3316 often say wear it and don't let the perfect be the enemy of the
3317 good, it is always better to have a mask on than to not have a
3318 mask on both for acquisition and for transmission.
3319 Mr. Tonko. Thank you. And I listened earlier in the
3320 hearing to my friends and colleagues talk about this spike in
3321 numbers in Texas, and I couldn't help but think that precautionary
3322 efforts come to prime importance. They can be defined and written
3323 or they can be shared by example. And so I, unfortunately,
3324 witness as the President seems to believe he is above this
3325 evidence-based recommendation you just described and has
3326 rejected, or injected, rather, politics into public health. Not
3327 only as he refused to be seen on camera wearing a face mask, but
3328 last week he claimed that some Americans are wearing masks as
3329 a way to signal disapproval of him.
3330 Now I think that, you know, leadership as a form of
3331 precautionary instruction is required of the President and any
3332 of us in elected office. We should be setting the right example.
3333 Does the President's refusal, Dr. Fauci, to wear a face covering
3334 and his efforts to politicize the wearing of face masks send the
3335 wrong message about the advice coming from public health experts
3336 like yourself and others who are at that expert table?
3337 Dr. Fauci. No, I don't think I can comment on what the

President's, the multiple factors that go into the President not wearing a mask. Certainly, I wear a mask in public all the time not only because I want to protect others and to protect myself, but also to set an example. So I guess that answers your question.

Mr. Tonko. Yes. And have you had any time to advise the President to wear a mask in public? If so, what was the response that you received?

Dr. Fauci. I have not directly recommended to the President to wear a mask, but I think it is very clear to anybody in the country, because I talk about it so often, of the importance of having physical distance with a mask and if you are going to be either beyond your control or by your own choice in a crowd that it is imperative to wear a mask at all times.

Mr. Tonko. Thank you.

And, Dr. Redfield, let me turn to you. On April 3rd, I believe, CDC released guidance recommending the use of face masks or face coverings in public settings such as grocery stores, and more recently CDC issued recommendations suggesting that employees that were [audio malfunction in hearing room] face covering as well as promoting their use when someone is likely to raise his or her voice such as at a protest for racial justice or at a political rally.

So what prompted the need for these recommendations and what does the American public need to know about the use of face masks and whether and when they should wear them?

Dr. Redfield. Thank you very much for the question, Congressman. I want to echo the comments Dr. Fauci made. You know, our recommendations are clear. One of the most powerful weapons we have against this virus remains as it was before and that is social distancing, face coverings, and our ability to practice rigorous hand hygiene.

Clearly, when we recognize that asymptomatic transmission or pre-symptomatic transmission was significant, that is when it was clear that we wanted to recommend that all individuals wear a face covering in order to, you know, protect other individuals in case they were asymptomatically infected. We continue to recommend that. Our recent guidance on mass gatherings, we again tried to illustrate the importance of trying to maintain social distancing and to wear face coverings.

And as Dr. Fauci said, in the event that you are not going to maintain that distance, it is critical that you wear a face covering.

Mr. Tonko. Well, I think it is unfortunate that like so much of the administration's response, the message coming from

the White House undermines the message coming from public health experts [audio malfunction in hearing room] support the health of the American people.

With that I yield back, Mr. Chair, the balance of my time.

The Chairman. Thank you, Mr. Tonko.

Next is Mr. Flores from Texas.

Mr. Flores. Thank you, Mr. Chairman. I want to thank each of our witnesses for appearing today. My internet access is a little bit spotty today, so hopefully you will be able to hear me.

I want to brag on the Trump administration and the team witnesses that are here today for the response to the SARS-CoV-2 spread. First of all, we have several new therapeutics underway. We have several vaccines under development. We have had a huge expansion in the supply of testing materials, PPE, ventilators. The regulatory response to deal with clearing out the roadblocks that would typically impede the development of these items has been impressive. The great example is the huge expansion in telemedicine which has happened just in the last few weeks despite some of us trying to promote that for years. Dr. Fauci made a pretty pointed statement earlier in this hearing talking about the reason that things are different region by region, and I would

like to talk a little bit about the responses that were done region by region, so here are some state level statistics on COVID-19 as of yesterday.

New York State has six percent of the population, but it has twenty-two percent of the total U.S. deaths. Michigan has three percent of the U.S. population but it has about five percent of the total U.S. deaths. If you look at my home state of Texas, we have nine percent of the population but only two percent of the deaths.

Now, again, these are all spot values as of yesterday. Of the top seven states that represent sixty percent of the deaths, all of those are led by Democratic governors. When you look at the cases' number of deaths, New York State's fatality rate is six percent and Michigan's is nine percent, whereas Texas is three percent.

So what concerns me are the stark differences in fatality rates and some states' percentage of deaths compared to their percent of the population. It is obvious that some governors made big mistakes, but we are not hearing much about that today in addressing the spread of SARS-CoV-2. It is interesting that while those governors were complaining about President Trump, they were ignoring their own populations.

So, specifically, I think we ought to talk about our elderly at-risk population who contracted COVID-19 and let's start with these stats. In Michigan, 1,947 patients in long-term care facilities died from COVID-19. In New York that number was 6,200. In Florida that number is only 1,637 and this is despite the fact that Florida has a long-term care population that is far higher than both Michigan's and New York's.

In Michigan, state officials declined a proposal to use new, vacant, unlicensed facilities to house patients who tested positive for COVID-19. Instead, Michigan put those patients in nursing homes with other uninfected patients. And as we have heard previously in this hearing, in New York the health department ordered nursing homes and rehab centers to accept COVID-19 patients who were discharged from hospitals. This led to more than 4,500 patients who tested positive for COVID-19 being put back into long-term care facilities.

Now compare these policies to Florida where state officials set up isolation centers that focused on treating patients with COVID-19.

So my questions for Dr. Fauci and Dr. Redfield are as follows: As I noted, there have been fewer deaths reported in Florida's long-term care facilities compared to either Michigan's or New

York's despite the long-term care population of Florida being significantly higher. So can you talk specifically about these approaches to elderly care and whether putting COVID-19-positive patients in nursing homes with non-infected patients was good policy and were the decisions in the best interest of our seniors?

So, Dr. Fauci?

Dr. Fauci. Well, obviously, if you put someone who is a potentially infected patient into a nursing home there is a risk of their being spread. I think you gave a lot of data and a lot of situations in which there really was a moving target and whether or not there really was a facility to put individuals in, so I really feel uncomfortable in commenting about that because I was having trouble following each and every one of the data points that you were giving.

But, Bob, do you have any further insight into that one?

Dr. Redfield. Thank you very much, Congressman. Two points. First, and we are working to try to understand the multivariance, as you have pointed out, that at least on the cases there has been differential mortality both in different jurisdictions as well as within the long-term care facilities in different jurisdictions and really looking at the multifactors to see that if they are controlled for whether there is any

difference and that we really don't know at this point, but we are looking at it.

Mr. Flores. I want to ask you and Dr. Fauci a simple question. Which state had a better approach to dealing with elderly patients, Florida or New York?

Dr. Fauci?

Dr. Redfield. He wants to know which state had the --

Dr. Fauci. I don't think I am in a position to evaluate that. That is not in my purview of anything that I am responsible for.

Mr. Flores. Dr. Redfield?

Dr. Redfield. I would just say that, clearly, Congressman, if you look at, as I have said before, consequences and impact, for me, consequences and impact is obviously morbidity and mortality. And as you pointed out that the mortality rates in nursing homes were clearly better in Florida than opposed to New York, but the causation is what I am not willing to speculate on, and without doing controlling for the different variables that we have individuals with the same extent of comorbidities in those two nursing home settings.

So I think that investigation will be complete and we will get an understanding of why there is differential mortality in

nursing homes as well as why there is differential mortality in different jurisdictions as you pointed out.

The Chairman. Thank you, Mr. Flores. Thank you.

Mr. Flores. I ask you to provide that information subsequently. Thank you. I yield back.

The Chairman. Now we go to Iowa, Mr. Loebsack. Unmute.

Mr. Loebsack. All right, thank you. I should be unmuted. Am I unmuted?

The Chairman. Yes. You are good.

Mr. Loebsack. Okay, thank you. Thank you, Chairman Pallone and Ranking Member Walden, for this important hearing today and I want to thank all these witnesses for their expert testimony. I know it has been a tough several months here for you folks trying to lead the way through this.

I had hoped also that Administrator Verma would be here today willing to join the panels. I believe that Congress needs a fuller understanding of how the administration is meeting the resource needs of hospitals and nursing homes, but since she is not here, I do have a few questions for Admiral Giroir as the Assistant Secretary for Health.

I think that Dr. Fauci kind of answered this question already, very briefly, but Admiral Giroir, do you believe that

our healthcare providers that are serving on the front line within our hospitals have the personal protective equipment, the supplies, the resources that they need today at this particular moment?

Admiral Giroir. Today at this particular moment, I do believe they have the supplies that they need. And let me tell you, when we get a report of a nursing home or another facility that says they don't have the supplies, literally, we call those places individually to understand what their needs are. So at this point in time, I think we are meeting those needs.

Again, the challenge is if the first wave gets worse or we have a second wave, are we going to be able to meet those challenges and that is what the S&S 2.0 is, to make sure we have at least 90 days. Yes, sir.

Mr. Loebsack. No, that is -- no. Thanks, I appreciate that.

I want to move on to the future, if you will, but before I do that I do want to ask every one of the panelists whether he agrees that it is likely that we will, in fact, see a second wave. I know there is a lot of controversy, right, as to whether we are still in the first wave, if you will, and it is sort of disproportionately -- the different regions are kind of dealing

with it in just in different ways and are feeling different effects as well. But if I could just go down the panel beginning with Dr. Redfield and truly a simple yes or no answer, do you believe that it is likely that we will see a second wave in the fall or the winter?

Dr. Redfield, you first.

Dr. Redfield. Yes, it is simple. I am not sure I would call it a wave, but I want to make it clear we are going to experience significant coronavirus infection in the fall and winter of 2020 and 2021.

Mr. Loebsack. Okay. Thank you.

Dr. Fauci?

Dr. Fauci. Yes, certainly there will be coronavirus infections in the fall and winter because the virus is not going to disappear. It is too --

Mr. Loebsack. Okay, thank you. I appreciate that.

Dr. Hahn?

Dr. Hahn. Congressman, I agree with Drs. Fauci and Redfield.

Mr. Loebsack. Thank you.

And I left you to last, Dr. Giroir. I am a little bit out of place there, I apologize, because I do want to ask you about

going forward and in particular what steps is the Department taking to help hospitals and healthcare providers prepare for a potential or perhaps likely, if you will, second wave of surging cases in the coming months?

Dr. Giroir?

Admiral Giroir. Okay, thank you. I don't want to take up all your time because it is really everything from understanding what the needs are to understanding the supply chains down to the individual hospital levels. Because, like I said, when we started out it was impossible to know what supplies were being used objectively, what ventilators were being used objectively.

We have gone through that -- all the way to the therapeutics that Dr. Fauci has talked about and Dr. Hahn, of course -- remdesivir, steroids, hopefully plasma -- all these things and everything in between. It is really all hands on deck and all our task forces are still operational including the Hospital Resilience Task Force that is not only dealing with COVID, but if this happens again we don't want our immunization rates to plummet. We don't want our mammograms to plummet. We don't want our colon cancer screenings to plummet.

All of these things were really victims of the COVID response just like COVID patients were, so we need to fix all of that.

Mr. Loebsack. All right.

Okay, one last question, Dr. Giroir. As you know, hospitals have struggled dramatically, financially, through all this, especially when they could no longer perform elective surgeries because they had to be ready for the COVID patients. And we did pass legislation here in Congress, obviously, to provide $175 million in direct funding to providers for expenses and lost revenue.

What is the status, Dr. Giroir, of the next allocations of the remaining funding that is yet to be distributed from the provider fund?

Admiral Giroir. Yes. I am sorry. I am going to have to take that one for the record because the Secretary and the people on that side are really controlling that but we will be happy to supply that answer to you from --

Mr. Loebsack. I look forward to that. My time is expired, anyway, but thank you all. Thank you, Dr. Giroir, and thank you, Chairman Pallone, and I yield back.

Mr. Walden. Mr. Chairman, before you proceed --

The Chairman. Yes.

Mr. Walden. -- there is quite an uproar on social media about the fact Dr. Fauci has changed face masks and the

implications thereof. Do you have any comment?

Dr. Fauci. I am an avid Washington National fan, so I thought I would break up this a little bit by putting on my Washington National face mask.

The Chairman. Okay. Thank you.

Next we have Mrs. Brooks.

Mrs. Brooks. Thank you, Mr. Chairman, and thank you all so very much. We got going thinking about the Nats a little bit. We miss all of them playing baseball.

I would like to talk a little bit about what you all suggested with respect to sustainability of funding. Dr. Redfield, I think for decades we have underinvested in our nation's public health infrastructure. Can you tell us what is it we need to do? You all mentioned sustainability, but if you could, you know, talk with us about what steps would be necessary. Not just federal government, state and local, what do we need to do to really think about our public health infrastructure in this country?

Dr. Redfield. Thank you very much, Congresswoman. It is so important and I have said this that this now is the time, because for decades we have underinvested in what I call the core capabilities of public health, day-to-day analytics that have predicted data analysis, laboratory resilience, public health

workforce, emergency response form, and then our global health security around the world.

Mrs. Brooks. And those are all the different things that you think everyone -- state, local, and federal -- ought to be investing in at higher levels.

Dr. Redfield. And we need to do it. And when you look at it, if you didn't quite palpate it before we are going to probably spend close to seven trillion dollars, all right, because of one little virus that came which we recognized very early. We used the capacity that we have and, you know, I said, you know, the critics will be there, but we will do the postmortem when we are done.

We have all done the best that we can do to tackle this virus and the reality is it brought this nation to its knees. And I would say now is the time. It requires a sustained investment in terms of the core capability. Many of you may not know the nuances of, say, funding for the agency I run, CDC, but there is no core funding. It is all through different PPAs that are provided by Congress.

We need core public health funding and many people don't know that CDC provides up to 70 percent of the public health funding for every state, local, territory, and tribal health

department in this nation. So we have got to invest in that in a sustainable way with a purpose that that is core-based funding.

Mrs. Brooks. And might the states also invest at higher levels and local governments as well.

Dr. Redfield. I think you said it right there. This needs to be a partnership.

Mrs. Brooks. Right.

Dr. Redfield. It is not all the burden of the federal government to invest in public health at the local level. And the reality, if the public, if your funding of CDC was to go away tomorrow public health infrastructure across this nation would just crash. We are right now the backbone of it and it should be a partnership.

Mrs. Brooks. Thank you.

I want to talk, Dr. Hahn, a little bit about Operation Warp Speed. It really sounds like an exciting effort. It is a great project. We are, the United States is the global leader in vaccine development. But I have to tell you, because we are working at warp speed and your companies that you are working with and all of the government agencies and everyone is working at warp speed, there are many who have concerns about vaccine safety and efficacy.

And when we get to that point which hopefully is at the end of this year or early next year where one of these products breaks through and gets there, what do you want to tell the American people and the world in many ways about the safety and the efficacy and the steps that we are taking to make sure that when that vaccine does break through that it, you know, it will be safe for everyone to use?

Dr. Hahn. Thank you, Congresswoman Brooks. I really appreciate the question. And Dr. Fauci, certainly, as a world's expert can speak to vaccine development, I can tell you from the regulatory perspective of FDA we have world-leading experts in the assessment of vaccine safety and efficacy. The world looks to FDA. The world looks to the U.S. to actually make those assessments. What I can promise the American people, we will work with companies. We will work with Operation Warp Speed to provide the assistance so the right studies are done with the right information.

But we will independently look at those data and we will make a decision in the best interest of the American people with respect to safety and efficacy. We will use science and data to do that.

Mrs. Brooks. So, Dr. Fauci, maybe I should have started

with you before going to the regulatory side. So what would you like to say to the American people?

Dr. Fauci. Yes. I think that Dr. Hahn said it very well. But I just want to emphasize, you know, I think there were some good intentions about using the word "Warp Speed," but I, myself, flinched a little because I know that people might think it is reckless because it is warp speed. It isn't. There are risks, but the risks are all financial risks and that is what people need to understand.

They are not compromising the safety at all nor is there compromise of scientific integrity. When you do a vaccine under non-emergent conditions there are various steps. And because companies make investments in this, what they do is they don't make an investment in this step until they are pretty sure this step works, and then they go to the next step. And one of the most important steps is when you start, you know, gearing up to make many, many doses. You are not going to make an investment of a half a billion or more dollars to produce doses unless you know it works.

So what this particular program says, we are going to assume it is going to work so we are going to put investment in preparing the sites for Phase 3 even before we knew that the Phase 1 was

successful. We are going to be making doses even before we know it is effective. So what you are doing is you are cutting down on time but you are not cutting down on the process of safety and science, so if you lose, the only thing you lose is a lot of money.

Now nobody likes to lose a lot of money, but we feel we would rather lose a lot of money and gain 4, 5, 6, 7 months than have a result and have to wait 4, 5, 6, 7 months to get the vaccine.

Mrs. Brooks. Thank you. Thank you. I yield back.

The Chairman. Thank you, Mrs. Brooks.

And now we go to Mr. Schrader from Oregon.

Mr. Schrader. Thank you, Mr. Chairman.

I want to thank everybody here for all the hard work you are doing.

But I am concerned, very concerned, that the American people are laboring under some gross misapprehensions as a result of some of the information that is out there.

Dr. Fauci, what is the average time to develop a vaccine?

Dr. Fauci. It depends on the vaccine and the situation in which you are doing it. If you are developing a vaccine in the middle of an outbreak --

Mr. Schrader. I am just asking, what is the average?

Dr. Fauci. About seven years.

Mr. Schrader. All right. And what was the fastest we have ever done? What is the quickest a vaccine has been developed to date?

Dr. Fauci. Well, it is probably, I think, the Zika vaccine, which we developed, was about a year and a half, but it was never brought to full fruition because Zika kind of disappeared.

Mr. Schrader. And say there is a vaccine. What is the probability that a vaccine comes to market actually?

Dr. Fauci. Oh, if it is successful, it is a high probability.

Mr. Schrader. Well, I am just saying, all these vaccines we have got out there being developed, what is the probability they are going to make market entry?

Dr. Fauci. There are more failures than there are successes.

Mr. Schrader. It is about 6 percent.

Dr. Fauci. Right.

Mr. Schrader. What is the chance that, even with a vaccine, this virus will be eradicated? And I would look to flu for a little bit of an example, influenza. How effective is that vaccine?

Dr. Fauci. The influenza vaccine is variable because the virus changes rapidly.

Mr. Schrader. Much like this virus?

Dr. Fauci. We don't know that yet.

Mr. Schrader. Well, we already know it has mutated, right?

Dr. Fauci. Yes. That doesn't make any difference. All RNA viruses mutate. That doesn't mean they change.

Mr. Schrader. If I was a mother, or a hard-working American citizen, and I am trying to bank on my family's future, how long do I wait? I am very worried that many, many Americans are waiting until there is a vaccine, maybe a year and a half at best, out there, and that is going to be the panacea, and they are all going to be okay. I think that is a terrible miscalculation. I am not blaming anybody here, but it is a terrible miscalculation on the part of many Americans. So, I am going to stay home, not go to work, not send my kid to school, and I am going to hunker down and I am going to be okay. I will just wait for that vaccine. I think we have to start talking in terms of vaccine as one of many tools in the toolbox, so we don't end up in particular problems. Dr. Redfield --

Dr. Fauci. I agree with you completely.

Mr. Schrader. Well, that needs to get out there a little

bit more.

Dr. Redfield, to that end, I am very concerned with the school year coming up. The CDC never recommended closing schools this spring. And yet, many, many, many school districts across the country closed. Right now, the CDC guidance talks about different considerations. How likely is it that a second-grader or, frankly, even a teenager, is going to maintain social distancing of 6 feet all the time?

Dr. Redfield. I think you know the answer to that, Congressman.

Mr. Schrader. All right. Thank you. That is a rhetorical question. I appreciate that.

How about a school bus where you are supposed to have one child per row? School districts maybe in some states are much more flush with money than mine. We can barely afford the school buses we have now. What is the chance of having 3 foot or less --

Dr. Redfield. Yes, I mean, I think you raise the reality. As we look at --

Mr. Schrader. I am just concerned -- I am sorry to interrupt; I have limited time. And some of these are rhetorical. But I am just worried that we are making all these pie-in-the-sky

public health perfection recommendations that have no chance in hell of actually happening at the local level. They don't have the money. They are dealing with human nature, especially children. Look, adults aren't much better, from what we can see around the country. But for children, we have to have recommendations, I think, that are realistic.

What is the incidence rate of this disease in children?

Dr. Redfield. We still don't know the infection rate in children, but we do know, when you say "disease" --

Mr. Schrader. Well, we do know internationally it is less than 2 percent.

Dr. Redfield. When you say "disease" --

Mr. Schrader. And Dr. Fauci makes a correct comment that, oh, but they can infect others.

It would seem to me a smart use of our precious dollars -- I mean, you talk $7 trillion. We don't have $7 trillion, Doctor. We spent over $3 trillion, which is twice what we spend in a year, and we did that in one bloody month, for good reason. And you guys are showing us good results, and I appreciate that.

But we need to make sure that citizens out there aren't withholding Johnny and Suzie from going to school because they think this is all going to be over in a month and a half or two

months. That is what the President tells -- that is what we are telling them, or they are getting that impression. That is wrong. And if we have kids not going to school, we run the huge risk of the wealthy kids get a great education online with their nice moms and dads; the lower-income kids get no education.

Dr. Redfield. The comment I would like to make is that -- it is so important -- the inference of what you are saying is, we need to use the knowledge that we have now, which we didn't have then. As you know, CDC did not recommend closing schools. Okay?

Mr. Schrader. Yes, sir. Thank you for that.

Dr. Redfield. And we didn't recommend it because we didn't think it was a one-size-fits-all. We close schools jurisdiction by jurisdiction when we see issues in the schools.

So, I do think we have to focus, as we move forward in the fall. And now -- what I said before, on the consequences of this virus, and those consequences are mortality and hospitalization and the economy. Right? And I think when you see that, you will see that different recommendations for the jurisdictions will come to rise. And as you said, I am pretty confident we are going to be opening our schools. And your comments are true; we need to open our schools with the reality of how we expect those schools

to act, based on the consequences of what we think this virus is going to pay for those individuals in school. That doesn't mean we don't have to be vigilant about protecting the vulnerable. We need to work on that in those families, but no longer does that mean we have to shut down schools, shut down the economy. It means we have to focus on how to prevent the consequences of this virus.

Mr. Schrader. Thank you very much. I am sorry for the line of my questioning.

The Chairman. Thank you.

Mr. Schrader. I yield back.

The Chairman. All right. Now we go to North Carolina, Mr. Hudson.

Mr. Hudson. Thank you, Mr. Chairman. Thank you for holding this hearing today and for convening such an esteemed witness panel.

Admiral Giroir, it is a pleasure to see you. I appreciate all the work we have done together, particularly on the opioid epidemic. I want to thank you and all of the distinguished witnesses for taking time out of your very busy schedules to be with us here today.

I, first, want to give a lot of credit on our coronavirus

response to President Donald Trump and to the individuals on this panel who worked tirelessly to get us to where we are. The Trump administration has taken decisive action early and often to combat this virus and keep us safe. Eleven days after the first confirmed case in the United States, President Trump declared a health emergency and restricted travel from China and any foreign national who posed a risk of infection. And a little less than two months after the first confirmed case, President Trump declared a national emergency.

The same goes for our testing capacity. The Trump administration has gone from a few thousand tests a day in March to close to half a million tests a day in June, and anticipates being able to perform 40 to 50 million tests a month by September. That is a staggering improvement for a virus we knew nothing about last year. This is not to mention the Herculean efforts made on PPE with Project Airbridge and ventilators with all the public-private partnerships to grow our capacity.

As we all have grappled with the coronavirus outbreak, we have all had to acknowledge how little was known about it. Even months after its arrival, we are still grappling with questions such as how and if it will mutate, if our immune system can develop appropriate antibodies, and what, if anything, our genetic makeup

says about our vulnerability to the virus.

What has become clear, though, through all this uncertainty, is our need for data. Getting the full picture from the data is important to my district because of racial disparities. If you look at cases reported by race in Cumberland County in my district, there were 71 white individuals, 202 African American individuals, but, then, 638 unknown. I noted in our health hearing last week the disparity in COVID-19 cases in my district. Fifty-seven percent of the COVID-19 cases at Cape Fear Valley Hospital in Fayetteville are in African Americans, despite being just 34.9 percent of the county population. It is paramount that we have as much data as possible, so that we can address this issue.

Congress recently required new reporting requirements under the Paycheck Protection Program and Healthcare Enhancement Act. Labs are required to submit data to the CDC on a number of factors to help us understand how and where the virus is spreading, such as race, ethnicity, age, sex, geographic region, and other relevant factors. It is important to note, though, that in most cases lab employees are not actually interacting with the patient. This makes it important to ensure that all providers are fully engaged on collecting this data to obtain the most complete

demographic information.

Admiral Giroir, what actions can we take so that all providers, including those in physician offices and hospitals, know to collect all of this demographic data?

Admiral Giroir. Yes, we feel very comfortable, but we are going to continue our efforts to make sure that everyone does know this. It was guidance that was put out. And again, as you said, it is essential.

One thing -- although the PPP did authorize the Secretary to make this, there were no enforcement mechanisms in PPP. So we are enforcing this through emergency use authorization enforcements of the laboratory tests. So, I just want to put that just for your information.

But, yes, I am absolutely committed to aggressively getting this information. It is not only African Americans. African Americans have suffered horribly with this disease. Latino Americans are also at very high risk, and the highest risk are Native Americans and Alaska Natives who suffer even higher rates. So all these are critically important to us.

Mr. Hudson. Yes, sir. Thank you.

As I noted earlier, the Trump administration has greatly increased our testing capacity. One area that has had

uncertainty, though, is the serology testing, something that could help us tremendously as we reopen the economy and people move back to work.

Commissioner Hahn, in recent months, we have seen a large number of serology tests enter the market, some decisively not as accurate as others. The FDA has since taken action to remove several of these. How is the FDA ensuring that only high-performance serology tests are available in the U.S. market?

Dr. Hahn. Congressman, thank you for the question. As I think you know, when we issued our original regulatory flexibility around serology testing, it was not known completely how these tests would be used and what the operating characteristics of them were. Our guidance allowed these to be used in a real-world setting. At that time, we required the manufacturers to certify that the tests had been validated. We found that in some cases that certification was not correct. And so we developed a partnership with the National Institutes of Health, NCI, to actually do a U.S. Government independent validation. And as you probably know, sir, over 20 of those tests have been taken off the market. We have subsequently required that all manufacturers provide us with that manufacturing data, and if they don't, they have to be removed from the market. We continue

to look into that, and we will continue to follow that policy, sir.

Mr. Hudson. Thank you.

Mr. Chairman, I see my time has expired. So, I will yield back.

The Chairman. Thank you.

Next, we go to Mr. Kennedy in Massachusetts. Joe, are you there? Did you unmute? Joe, you have to unmute. I think he is there, but you are still muted, Joe. Mr. Kennedy, you are speaking, but we can't hear you. Are you there?

All right. We are going to go on. We will come back to Mr. Kennedy.

Next is Mr. Cardenas. Mr. Cardenas, unmute. Maybe there is a technical problem; I don't know.

Mr. Cardenas. Can you hear me now?

The Chairman. Yes. You are recognized for 5 minutes.

Mr. Cardenas. Okay. Thank you so much. Thank you, Chairman Pallone and Ranking Member Walden, for holding this important hearing.

And thank you to the expert witnesses that we have before us, and we all appreciate all the work that you are able to do when you are allowed to do it.

This February, there has been a steady flow of reports of the Centers for Disease Control and Prevention, otherwise known as the CDC, being sidelined. Its experts have been overruled. And in the midst of a pandemic, this is unacceptable.

Dr. Redfield, earlier this month you expressed concern that the CDC's public health messages on COVID-19 weren't resonating with the public. Dr. Redfield, why hasn't the CDC held regular media briefings during the pandemic, as the CDC has done during past public crises, where it can provide clear evidence-based information directly to the public and where the media can ask questions? Is it possible the lack of regular and direct communication from CDC has been contributing to the public's confusion about how to best protect themselves in this health pandemic crisis?

Dr. Redfield. Thank you very much, Mr. Congressman.

The CDC has communicated in different ways. Clearly, first and foremost, we have put out over 1500 guidances or --

Mr. Cardenas. Excuse me, Doctor. Dr. Redfield, the President has proven very, very clearly that when you get in front of a podium and you actually have a press conference, you have a higher likelihood that you are going to reach more people.

My specific question is, why aren't you having more of those

press conferences like the CDC has done previously?

Dr. Redfield. And I was trying to add that, through our things, we have had about or we have reached 1.5 billion people so far. We have regular conferences with the local, state, territorial, tribal health departments every week almost, and every day we have special conferences reaching out to special interest groups, whether it is business, faith communities, et cetera. We have also had conferences, as you know, and we have re-instituted our now biweekly press conference with the open press. And so, I do think that CDC does continue to communicate, but more at the local level than, let's say, at the national level.

Mr. Cardenas. Thank you, Dr. Redfield. You actually answered my question, and I appreciate all the local work you have been doing. But in the past, the CDC has been more of a national presence and a voice in previous issues where we have had health crises. And I hope that you are able to change that and continue doing your local, but actually be more present on the national, as the biggest voice on the national stage has been President Trump. And there is no question that he has misled the public, certainly with his actions and his words, by not wearing masks and refusing to do so, and actually telling the public that he is not going to do that.

In February, Dr. Messonnier with the CDC warned us that the virus could possibly cause severe disruption to our everyday life. She was right. Yet, she was contradicted by both the President and Secretary Azar. And in April, Dr. Redfield, you confirmed that a second wave of the virus in the fall could be difficult, and President Trump immediately contradicted you in real time. And I will quote him. The President said, "You may not even have corona coming back." End quote.

Dr. Redfield, do you believe the public would have been better prepared, and state and local public health officials better supported to face this pandemic, had CDC and other public health experts not been ignored or contradicted at the national level, like the President contradicted you in real time?

Dr. Redfield. Well, I think, Congressman, obviously, we continue to try to get our message out. And I thought Dr. Messonnier obviously did a service in sharing her perspectives at that time, in letting people understand what could be on the horizon, which obviously eventually was on the horizon. I have tried to do the same in making the American public prepared that this fall and winter is going to be difficult and we need to be prepared for it.

Mr. Cardenas. Thank you, Dr. Redfield, and thank you for

complimenting Dr. Messonnier for her bravery and her willingness to speak up at the moments as necessary.

I am concerned, gentlemen, that we have a problem right now, that over 120,000 lives have been lost in the United States due to COVID-19. And yet, the public is still not on the same page as they should be when it comes to how to protect themselves, and they are getting mixed messages at the national level from our leaders. So what I hope and pray is that the CDC make its presence more aware and more clear with evidence-based advice to the American people.

And then, also, I have got to hope and pray that -- and I am going to ask some questions to be forwarded back to the committee as to the misleading statements such as touting the fact that PPEs have been provided to the American people to the tune of a few million here and there, when, in fact, some of you have actually reported that, ideally, we should be in the billions of PPEs. And I am going to ask those specific questions, so that the full public can hear the answers and we can have it on the record of this committee.

My time has expired. I yield back. Thank you.

The Chairman. Thank you.

Next, we go to Mr. Walberg from Michigan.

Mr. Walberg. Thank you, Mr. Chairman.

And thanks to the panel for sticking with us for this lengthy period of time. And thank you for your work. Whether we agree or disagree, we are kind of learning this all together, aren't we, and building it on the fly to some degree.

As we have discussed already, and as you know, there were a handful, five states to be exact, including my State of Michigan, where my governor ordered, required through an executive order, nursing homes to admit COVID-19-positive patients back into their facilities. This proved to be a terrible policy, as we found out, with the consequences for our seniors, with almost 2,000 nursing home residents in Michigan having died. That is accounting for one-third of our State's COVID-19 deaths.

Dr. Redfield, some officials in the five states that issued these executive orders have indicated they were following guidance from the administration. What guidance? And you used that term expressly earlier on, and I appreciate that, because I do think that is what we do give at the federal level when we talk to the states. But what guidance did HHS and CDC release as it relates to admitting COVID patients in the nursing homes? And secondly, what obligations are states under to follow that guidance?

Dr. Redfield. Thank you very much, Congressman, for the question, an important question.

CDC did, in fact -- and does, in fact -- have guidance for nursing homes. The guidance that you are referring to was guidance that was grounded in the fact that there were some situations where the nursing homes were refusing to take any COVID patients at the time. So, CDC did issue a series of important prerequisites that the nursing home had to have in place in order to accept these patients that they had admitted to the hospital back, when they came back.

Fundamental to that was that they had the appropriate facilities to isolate that individual; they had the appropriate infection control capacity to maintain that. So, it really was not saying you have to take somebody back. It is that you have to be open to taking care of COVID patients, provided that you have the capacity to do it correctly.

Mr. Walberg. And correctly is the key thing?

Dr. Redfield. And correctly -- and so that that patient doesn't spread the infection to other individuals. And I think some of the speeches that we have heard in the press fail to understand that it is to do it correctly. As you know, over half of the nursing homes in this nation right now, over 7,000 nursing

homes in this nation, have a COVID patient in them. The question is how to do it correctly and safely.

Mr. Walberg. And save the lives, yes.

Dr. Redfield. And save the lives.

Mr. Walberg. Well, it gets down to data as well. So, let me ask you, what are the obstacles to collecting and reporting the data that you are now requiring -- and my governor has finally started to put out -- what are the obstacles to collecting and reporting this data, particularly among seniors living in nursing homes? And what steps has CDC already taken to improve data collection from the states?

Dr. Redfield. CMS says now required. As you know, the nursing homes are reporting their data, and they report it to CDC, and then, CDC reports it on to CMS. And CMS has it as actionable.

Right as we sit here today, a majority, over 90 percent of nursing homes -- I think it is north of 80; I think we are between 80 and 90 percent -- are actively reporting through our system already since that request was required a couple of weeks ago. And we are working to get all 100 percent of the nursing homes to be reporting, as required by CMS.

And that data also is complemented -- I mentioned earlier

about the ethnic groups and data. That data actually comes in originally with now all testing. You all have helped us in that. Now any test that is done for COVID has to come and has a series of key data points, to include ethnicity and race, so that we can maintain that for all cases across the country, independent of if they are a nursing home or not.

Mr. Walberg. Thank you. We hope it helps.

Dr. Fauci, three questions that I have for you relative to yesterday -- the University of Michigan announced its plans for the fall semester, to consist of a mixture of in-person and remote classes. As schools prepare for the fall semester, what factors should they be considering? And I am thinking of higher education here. What do we know about the transmission of COVID in young adults that would help inform the decision to reopen colleges and universities? And thirdly, should reopening look different for a school like the University of Michigan versus a school like Hillsdale College in my district with 1500 students in a rural community?

Dr. Fauci. Yes, all good points. Again, one answer could probably spill over into each of the questions. You really have to consider what the state of the epidemic is in the particular place that you are at. Now, if you have very, very few cases,

like in a small college in a county, I think you can be really very liberal in the opening.

What schools are doing -- and they are doing it in a very creative way -- is to try to make sure that there is separation enough that you have situations, where, first of all, masks should be done at all times without exception. You have got to protect the vulnerables. You have got to allow both faculty as well as students who are in that category of underlying conditions to be able to have the capability of either teaching or learning online. You have to have the capability of, when you get an infected student, which you invariably will, no doubt, to be able to remove that student to a safe, comfortable place for the period of time until they can go back. If you leave them in the community, you are going to wind up having a situation that could make the whole thing fall apart. That is just a few of the things we need to do. But, importantly, you have got to look at what the status is in your particular situation.

The other thing is, people who work with the students -- namely, people who feed them, people who clean -- they need to be also paid attention to, because often, be it in a cruise ship or be it in a nursing home, it is the staff who might bring in an infection, and then infect the individuals who are in a much

larger group.

Mr. Walberg. Thank you. I yield back.

The Chairman. Thank you.

We are going to go back now to Mr. Kennedy.

Mr. Kennedy. Hopefully this time it works. There you go.

The Chairman. We can hear you.

Mr. Kennedy. All set, Frank? Beautiful.

Mr. Chairman, thank you. Apologies for the interruption beforehand.

I want to thank our witnesses for being here. And Chairman, thank you for calling this hearing. And to the witnesses, thank you for your service and your willingness to stay so long into the afternoon.

I want to start -- this is now about a month ago. I had been in Chelsea, Massachusetts, a community just outside of Boston that has a rate of infection roughly six times higher than the State average. And I was delivering meals at a nonprofit, local nonprofit there, with food lines longer than I have ever seen anywhere in the world.

On my way out of the community, I called one of the heads of the local community health center and I asked what else they needed for help. The individual I spoke with said that they had

recently received some mapping software and they were looking for cool spots in the community. I asked him, why cool spots? Aren't you looking for the hot spots? And he said, no, we know that everybody is being exposed. What those cool spots will tell us is where we haven't been testing. You know what the biggest cold spot was? The public housing facility where, in a population of 900 people, four had been tested -- four.

This administration has failed so completely to prepare our nation for this pandemic that working communities largely made up of people that our government and our society have deemed to be essential, that we require to be essential, they were left in their wake with no help and nobody.

Just days ago, President Trump stood up before the American public and told us that he asked his administration to slow the tests down because what they were viewing was that tests were accelerating and it was instrumental to his political survival. And I know that we received testimony today that his statements here were not true, although the President has also contradicted that again, saying he does not joke.

But to my people in Massachusetts and our people in Chelsea -- maybe they are predominantly Black and brown, men, women, and children -- this administration's failure to test was no joke.

It has been deadly.

We have nearly 120,000 people that have died, over 2 million that are sick, and 45 million Americans that are out of work. We are four months into this crisis, and the administration's best plan to confront the racial inequities that we are talking about is collecting long-overdue demographic data. Yes, we need that data.

We know that Black and brown people across this country are more than twice as likely to die as those who are white from this virus, and more than six times as likely if you are Black and in Washington, D.C. In Massachusetts, the positive rate among Black and brown residents is three times higher than for white residents.

So, yes, we need more data, but only because the administration spent months ignoring what advocates had tried to warn us about in those first months. So, let's talk about the actions that this administration is taking to confront these inequities.

Dr. Redfield, I will start with you. The CDC finally released guidance requiring demographic data from commercial testing companies earlier this month, but it does not take full effect until August 1st. Do you believe that that lag time is

acceptable, as thousands are diagnosed still every day?

Dr. Redfield. Thank you very much, Congressman, for your question.

I can say that we are committed to making sure that we get comprehensive data, particularly on race and ethnicity, as well as data on these underlying comorbidities, so we can better understand --

Mr. Kennedy. I appreciate that. Doctor, we are talking about collecting it on August 1st for a virus that arrived on our shores in January and February. I have limited time, but that wait seems to be quite substantial.

I want to move on because there is news that I think broke today that indicates that the federal government is going to stop supporting testing sites in Texas and other states. We see skyrocketing numbers of cases. Actually just stopping this federal support for those testing sites, is that going to be effective at helping to mitigate the spread of the virus?

Admiral Giroir. So, I will take that question. Thank you very much.

So, the first set of testing sites were 41 sites that were completely federally run under federal contracts. The retail sites have now been over 600, and then, the retail sites on their

own are over 1400. There are tens of thousands of testing sites. The only sites that we sunsetted, with the full agreement of the governors because I spoke to all of them, were 13 remaining sites, seven that were in Texas that were the 1.0 variety that were ready to go, because there were so many other sites around them. We matched each site to FQHCs surrounding them, to retail sites. So we are not withdrawing the support for well over 2,000 sites. We are just transitioning those 13.

Mr. Kennedy. And very quickly, briefly, because I don't have much time here, but we have seen 45 million Americans lose their jobs. Yet, we have an administration that continues to push the need for work requirements for individuals on Medicaid.

Yes or no? I will go down the list, starting with Dr. Fauci. Do you believe that implementing work requirements is going to be an effective measure to stop the spread of coronavirus?

The Chairman. We are going to have to just limit you to the response, Dr. Fauci.

Dr. Fauci. I didn't get the question. I am sorry.

The Chairman. He asked about work requirements.

Mr. Kennedy. Now that 45 million Americans have lost their jobs, is implementing work requirements an effective way to stop the spread of coronavirus?

Dr. Fauci. I am not sure I am qualified to answer that question. I really have not been involved in that.

Mr. Kennedy. I believe you are very qualified to answer that question, Doctor, respectfully.

Dr. Fauci. I didn't even hear -- sir, I am sorry, but I really didn't even hear the question or understand it. So I am not trying to evade.

Mr. Kennedy. No, no, no, no. Okay. Let me clarify, if the Chairman would give me one minute.

Given that 45 million people have lost their jobs, and the administration still continues to move forward in trying to implement work requirements, will the implementation of work requirements be helpful at stopping the spread of coronavirus?

Dr. Fauci. Right, yes, I think that would be a problem. I agree with you.

The Chairman. All right. Your microphone wasn't on, but you said it would be a problem.

Mr. Kennedy. Thank you. Thank you, Doctor.

The Chairman. All right. We are going to go now from Massachusetts to Savannah. Mr. Carter?

Mr. Carter. Thank you, Mr. Chairman. And thank all of you for being here. I appreciate it.

The administration has done an exceptional job, in my opinion, of increasing testing capacity over the past several months. And I know that it is our desire and our goal to get testing to 40 to 50 million tests per month by September. And in order to do that, we greatly need to expand testing.

I have said that, in order to roll out our economy, we need two things. First of all, we need robust testing. Secondly, we need personal responsibility. That is, following the advice of members of the Coronavirus Task Force in making sure we are washing our hands, wearing masks, et cetera, et cetera.

Admiral Giroir, earlier you said that 90 percent of Americans live within 5 miles of a pharmacy or a pharmacist. And I don't mean to correct you, but it is actually 95 percent of Americans live within 5 miles of a pharmacist, making them the most accessible health care professionals out there.

I wanted to ask you -- and, Admiral Giroir, you and I have talked about this many times before -- do you think the administration should utilize the pharmacy personnel and the profession for expanded testing, especially community pharmacists who can help rural and medically underserved communities? I know that we have made it to where pharmacists can provide these tests, but not all pharmacists. And what I

am getting at is if we could get to where in the rural and the medically underserved communities, the pharmacists there would be able to do it as well.

Admiral Giroir. So, thank you, Congressman.

Mr. Carter. Admiral, can you respond?

Admiral Giroir. Yes. Thank you, Congressman.

And you know how I feel about this. I think pharmacists are one of the most underutilized professions in the country, for their training and their expertise, and also their trust from the population. And I would just like to put an exclamation point behind everything you have said.

In order to work with the independent pharmacist even more than the retail pharmacist -- and I am sorry, I know this is your world -- but there is an organization that is sort of an intermediary between that, that we are working with to make sure that we could bring more and more of the independent pharmacists under contract through our community-based testing program.

But I am all onboard. Whether it is telehealth, pharmacists, community health workers, we need to get health into the community, and pharmacists are a great way to do that.

Mr. Carter. Thank you, Admiral.

And I actually have submitted bill text that would do just

this, that all the pharmacists are onboard with. And it is over at HHS right now. And I would just like to ask all of the members here of the task force, if you could help me to get that review completed, so we can move forward, I would appreciate it.

Also, I wanted to talk -- you know, I have been sitting here listening to colleagues on the other side of the aisle who have been saying that the administration and this task force has not done enough to save lives. And as you know, we have talked about the fact that 42 percent of the COVID have been from .6 percent of the population, and that has been nursing home residents.

Now I do not in any way consider myself to have more expertise on communicable diseases than any of the four of you who are sitting here today. However, I will tell you that, in my professional career as a pharmacist, I was a consultant pharmacist and I worked in nursing homes. I spent almost 30 years in nursing homes. So I do know nursing homes, and I know that is the last place that you want a positive patient to be at.

And I just want to point out, in fact, I can remember servicing a 100-bed facility years ago that, for whatever reason, did not get the flu vaccine, and we lost almost 20 percent of our population in that nursing home as a result of the flu outbreak, because we didn't get the flu vaccine that year. So,

I have seen this firsthand and I have experienced it.

And that is what upsets me so much about the decision of some of these governors to put these patients in the nursing home, which would have been the worst place they could have put them in. Now I say all of that to say that, you know, I still believe in humanity, and I don't think any of those governors who made that decision did it intentionally. And I don't think they would have done it if they had known what it would have resulted in.

And I say that to point out to all of us on this committee and to everyone in Congress that I think the administration has done an outstanding job, and I think they have saved us. Well, have they done everything right? No. No, they haven't. And would they do things differently if they could? Yes. And I believe that these governors would have done things differently if they could. But to point fingers and say that no one cared about saving lives, I think that is despicable, and I don't think that is fair whatsoever.

Dr. Redfield, I know that you seem to have had a bullseye on your chest today, for whatever reason. But I know that the CDC has done some great things and made some great, positive comments. Can you just tell us some of the useful materials that you have released from the CDC?

Dr. Redfield. Well, we have put out the guidances really in a variety of different areas, as you know, and obviously, focusing on nursing homes; focusing on obviously individual mitigation steps to limit the spread; focusing on first responders, health care settings.

I will say something about the nursing homes that I really hope we consider. As we are looking to the fall, I think there needs to be more serious consideration in jurisdictions that have multiple nursing homes to look at whether certain nursing homes are prioritized for COVID patients, just because of the situation we went through before.

But we continue to put guidance out on them, but going back to school, going to camp, daycare centers, K through 12 -- wherever the American public seems to have a need for guidance, we either put out a guidance document or we put out what we call a consideration document, which gives people some better understanding of the impact of COVID and how they can protect themselves safely in those particular environments.

The Chairman. Thank you. Thank you, everybody.

Mr. Carter. Thank you, and thank all of you.

And I yield back, Mr. Chairman.

The Chairman. And I just want you to know we have got 10

left. So hopefully, if you have to take a restroom break or something just go out and come back.

Are you going to be able to stay with us for these 10? We will try to make it brief.

All right. Mr. Peters of California is next.

You want to unmute, Scott?

Mr. Peters. Yes. I was just getting it.

Thank you, Mr. Chairman. I appreciate the witnesses coming today. You know, the monumental challenge that our country is facing has come in large part due to the failure to develop and deploy sufficient diagnostic testing in time to monitor and control the spread of the virus.

In February, on the 29th after it became clear that CDC's tests would not be able to perform, FDA began authorizing the emergency use of molecular diagnostic tests, and since then FDA has authorized more than 110 emergency use authorizations -- has issued more than 110 authorizations for diagnostic tests, and that has done a lot to increase our overall testing capacity.

Unfortunately, we still don't know much about the accuracy of these tests, and while we might typically expect the tests to undergo large patient studies to determine the level of accuracy, the emergency use authorizations require a much lower

standard, so only a small number of validation steps.

While most screening tests will never be 100 percent accurate, false negatives can lead to devastating consequences. For example, there have been reports that the White House tests that they use to screen individuals before they visit the Oval Office may produce false negatives 20 percent of the time.

So, Dr. Hahn, FDA has said that it has asked test manufacturers to conduct follow-up accuracy studies on tests that have received emergency use authorization.

Can you tell us how many of these tests -- how many of these tests have you requested follow-up accuracy testing on and of that number how many have been shown to be accurate?

Dr. Hahn. Thank you, Congressman, for that question, and I just want to emphasize the point that you made, which is that in an emergency situation our EUA authorities allow us to look at the risk benefit, and early on in a pandemic with limited numbers of supplies on our -- or not supplies, but reagents to test the actual diagnostic accuracy, we rely upon a certain set of data to make that decision initially.

We have actually required in the post-marketing setting the collection of data for a number of companies and they have come back to us with those data, and we have made adjustments to the

EUAs for those tests.

But even in those situations where we haven't required a formal post-marketing assessment of the tests, we have collected on our own and with the companies and with academics real-world data.

We incorporate all those data into our assessment of the tests. And I will just take, sir, for a moment, serology tests where we have taken over 20 off the market based upon our own independent evaluation in U.S. government.

We will continue to make those efforts and we will continue to look at those data and adjust our recommendations and tell end users, be very transparent about the operating characteristics of the tests so that they can use them in the best way possible.

Mr. Peters. About how many adverse events reports have you received on diagnostic tests so far?

Dr. Hahn. Sir, I will have to get back to you with the exact number. We have received a number, and I mean double-digit numbers, of reports about all of these tests. But I would be glad to get those data for you, sir.

Mr. Peters. Okay. And just to confirm, if a follow-up accuracy study comes back and it is shown to be inaccurate, you

have moved and you will continue to move to take those tests off the market?

Dr. Hahn. Absolutely, sir, and we promise to be transparent and post that on our website.

Mr. Peters. Thank you very much.

I want to ask Dr. Redfield a question about digital contact tracing. Do you agree that digital contact tracing tools can enhance our traditional contact tracing efforts, particularly proximity tracking tools that use Bluetooth technology to identify people at risk of COVID-19 infection?

Dr. Redfield. Thank you very much for the question.

Clearly, these new digital technologies that are -- have been developed for contact tracing are important to be evaluated and to see how they will contribute.

I want to emphasize, though, that first and foremost, the most important component we believe of contact tracing is the human capacity to do that, and this is why we are working to aggressively increase the number of contact tracers.

But we currently are in the process of evaluating it to see if it is value added.

Mr. Peters. Dr. Redfield, let me just -- let me just point out, because I only have 45 seconds.

Dr. Redfield, let me just point out, I would really think it would be a shame if we took the technology from the 1980s and didn't employ the technology that we have today.

Bluetooth technology can tell you who you have been around within a certain proximity with great accuracy and with great speed. It can be anonymized so that no one knows who the particular person is.

But if you have your Bluetooth on, you don't have to know who you were standing next to at the protest or in the restaurant or in the bar. If the person's test is positive, it can go into a system. And Google and Apple, MIT, UCSD are working on these things.

So, in fact, you could be automatically almost in real time warned that you have been in proximity to someone who has tested positive, and can behave accordingly.

For speed and for accuracy, I hope you will give a good look to Bluetooth technology because it could be private and it is certainly more accurate and certainly faster than the technologies we used back in the 1980s.

We can do better, and I yield back.

Dr. Redfield. Yes. I just want to just emphasize, Congressman, that we are aggressively evaluating that technology

with Google, Facebook, to actually see how it impacts it.

So I agree with you, it is really important. We have programs evaluating each of it in partnership with Google and Facebook right now, and we will continue.

The question is just to see exactly the best way for this technology to be used. It is not a question of not seeing it as something that potentially could be very important.

Mr. Peters. Thank you.

The Chairman. Thank you.

We are going to go to Montana now, Mr. Gianforte.

Unmute, please.

Mr. Gianforte. Thank you, Mr. Chairman. I appreciate the recognition.

I want to thank all the witnesses for their time today. The people of Montana appreciate you and all the health professionals who are working so hard to keep us safe and deal with this virus.

As we mourn the lives of those lost to COVID-19, we must also think about how to continue to safely reopen our nation. Testing is critically important to both help limit the spread and restore confidence to the public.

Montana has seen an uptick in positive test results but not

a large uptick in hospitalizations. This could be seen as indicating that increased testing is finding more mild and asymptomatic cases.

I have heard from hospitals and private labs across Montana that they would like to provide their own testing services to help their communities and provide certainty to large employers as well as rapid response capability for tourists that are coming to see our national parks and great public lands in Montana.

Admiral Giroir, there has been an enormous increase in availability of diagnostic testing since the early stages of the pandemic. Test manufacturers rapidly scaled up their production capacity to meet the unprecedented need for testing.

Could you describe for us the administration's collaboration with the private industry in establishing this massive diagnostic and serological testing infrastructure and the availability of supplies for state health agencies as well as the commercial supply chains?

Adm. Giroir. So thank you, and I will try to be brief because I know your time is limited.

It has really spanned -- as you said, it is a public-private partnership and we have been working very tightly with FDA as well because innovation has been key to that.

Just to give you an example, when we opened our first 41 testing sites using nasopharyngeal swabs, which would require a full PPE and full PPE changes, if we ran those 41 sites full-blown we would have exhausted 80 percent of the stockpile for PPE within the first week.

So it was really vital that the FDA was able to work with sponsors to validate other types of equipment to span our -- to expand our supplies.

Let me just say that the public-private partnership, whether it is working with the ACLA labs -- that is the Quest, LabCorp, Mayo, BioReference -- they have done over half the tests in the country to date. It has been absolutely critical.

Every laboratory manufacturer that supplies test kits for these laboratories are working with us. We have a relationship manager with every one so we know what their limitations are, can we get around it with the DPA, can we help them with their supplies, what can we do to maximize the number of tests, moving forward.

And, again, I will just say with Montana it has been a real special case because although we have lots and millions and millions and millions of tests, there are only a few that are really geared to rural areas and they are in very short supply.

So we have been working very closely to get, for example, the Sofia test and the point of care to Montana, because you are not in the middle of New York City where you have the umpteen million-dollar machines. You are really in a rural area like in Alaska.

So it's not just the numbers. It's the type and it is mixed with innovation.

Mr. Gianforte. Great. Thank you, sir. And it sounds like the public-private partnerships have really been central to your strategy to scale up testing capacity.

What efforts are ongoing in that area to further develop public-private partnerships?

Adm. Giroir. They really have been critical because the public health laboratories are an essential first line of defense. But as of now, they have only done about 7.5 percent of the overall testing. So the majority -- you know, overall, it is the hospitals and academic institutions and about half with the commercial sector.

The swabs -- you've jested about swabs -- when I dropped into this on March 12th I thought we had 10 manufacturers, 12 manufacturers.

There was one in Italy and one in Maine, and everybody

repackaged the same product and it, you know, was the most -- is the hardest to make, most difficult to get was the only one that was authorized.

I never thought I would send a C-17 over to Italy, to pack a C-17 full of swabs. But that is what we needed to do. So the public-private partnerships, whether it is the manufacturers, the retailers, and the pharmacists, have been absolutely essential.

It is really the only way to scale what we needed. If you have a small outbreak you could do it within the traditional infrastructure. But like in World War II, you know --

Mr. Gianforte. Thank you, sir.

Adm. Giroir. -- everybody has to participate.

Mr. Gianforte. Yes. Thank you, sir.

Commissioner Hahn, in the limited time I have here, a health professional in Montana wanted me to ask if you have confidence in the accuracy of the antibody test currently available, and what steps are being taken to ensure we avoid a supply crunch for those tests as well?

Dr. Hahn. Thank you, Congressman.

We have authorized over 20 serology tests. My recommendation to users across the country in, particularly,

public health, is to use those tests that are authorized under the EUA process with the FDA.

We are undergoing an independent validation of data that manufacturers have sent to us to ensure that we can actually corroborate what the manufacturers have sent.

If we are not able to do that, we are asking those and taking those off the market. We are being very transparent on our website, and I am very happy to have a conversation with the health professionals in your state, sir.

Mr. Gianforte. Thank you.

The Chairman. Thank you.

Mr. Gianforte. Mr. Chairman, I yield back.

The Chairman. Thank you.

We are going to go now to Michigan, Mrs. Dingell. We are coming to you from the Dingell Room there.

Mrs. Dingell. Thank you. Thank you, Mr. Chairman, and I want to thank all of our witnesses for being here today and your patience in dealing with all of us.

Believe it or not, there is widespread agreement on something, which is that we are not going to be able to safely return to anything resembling what we once knew as normal until we have a safe and effective vaccine.

In Congress we have moved quickly to facilitate development of such a vaccine, investing billions of dollars of funding in BARDA and NIH.

Public and private researchers have taken those resources and run with them, speeding through the Phase I and Phase II trials, clinical trials, with multiple companies now announcing that they are about to begin Phase III trials as soon as next month or soon after.

This speed is unprecedented, and I want to be very clear as I ask these questions I am not an anti-vaxxer. Vaccines have eliminated disease and expanded life spans -- extended life spans.

But as members of this committee have been told many times, Phase III trials are where the rubber meets the road in developing a new drug.

It is where you test a new drug in human patients on a wide scale, evaluating constantly for side effects and, ultimately, determining the effectiveness of a vaccine.

One of the vaccine candidates which is working with NIH has announced that their Phase III clinical trial will enroll 30,000 patients and another Operation Warp Speed candidate company has said it will enroll 8,000 patients.

These are much lower than historical vaccine trials, which

have enrolled 60,000 to 70,000 patients in the past. And I know that there can be consequences.

I was one of those unlucky people that got Guillain-Barre after the swine flu shot decades ago. But to this day, I know the benefits of the swine flu shot far outweighed the risks and that we must develop this vaccine.

But we have got to talk about important issues so people believe in this vaccine.

Dr. Fauci, will you explain the importance of testing larger populations in Phase III clinical trials?

Dr. Fauci. Yes. Thank you very much for that very important question.

The size of the trial is calculated, really, on a statistical basis of the number of infections that you might need to get a certain percentage of efficacy.

So you figure out do you need this level of efficacy or this level, and how many hits or how many events do you need in the trial, and it was based on that that the statisticians came up with a 30,000-person.

I want to point out something that I think you were hinting at, and I agree with you completely. You want to make sure, particularly when you have a new vaccine for a brand new disease,

that not only can you get a signal of efficacy but you really feel good about safety.

And the more people you get in the trial before you release that vaccine to the public, the more confident you are in the safety. We are going to have a different kind of an approach, Congresswoman Dingell, to the Phase III trial.

We are going to have subsets of that that will be looked at much more carefully for safety, particularly for the concept and the phenomenon of enhancement, because that is one of the things we are concerned about that, paradoxically, if you get a suboptimal response to the vaccine and you do get infected you could actually have an enhancement.

So I hear you very, very loud and clear. Safety is a very important issue and we are going to be paying very close attention.

You may not have heard, or not, my comment earlier on in the hearing when I said I wanted to make sure that before we let a vaccine out to the general public we are as confident as to the efficacy as we are of the safety. And I promise you that I will be an advocate for that very, very strongly.

Mrs. Dingell. I did hear you, and I do trust you. But I still had to ask the question.

I want to ask Dr. Hahn a question, very quickly. A number of observers have said that we won't know the vaccine's long-term safety and effectiveness if we move forward with these too quickly.

I hear what Dr. Fauci is saying and I know the importance, but what steps will FDA take to ensure effectiveness in evaluating data from the clinical trial and will you commit to receiving that full effectiveness data from Phase III before we authorize or approve the vaccine?

Dr. Hahn. Congresswoman, thank you very much for the question, and I just want to reiterate one thing I said earlier and that is that the science and the data will guide our decisions.

We have world-class experts at the FDA. We are working on right now guidance for sponsors and developers of vaccines to exactly address the question that you are asking.

We will be transparent about that guidance and forward leaning, and we will work with the sponsors to ensure that the data we need to make those decisions are available.

And I promise you, ma'am, that we will wait for the data that we need to make that adjudication around safety and efficacy.

The Chairman. Thank you, Mrs. Dingell.

Mrs. Dingell. Thank you both.

The Chairman. Okay. Now we are going to move to Mr. Veasey of Texas. Unmute, please.

Marc, are you there?

Mr. Veasey. Can you hear me?

The Chairman. Yes. You are recognized for five minutes.

Mr. Veasey. Okay. Mr. Chair, thank you very much.

I wanted to ask a question about something disturbing that I saw in Politico this morning, and it is concerning the data collections that are underway at CDC.

It was implied in the article that there were attempts to downplay true statistics, and I was wondering how is CDC determining the death count that is updated daily?

If you could touch on that, Dr. Redfield, that would be -- I would sure appreciate it.

Dr. Redfield. Thank you very much, Congressman.

There was a report. There was -- cases are reported to CDC from state and territorial local health departments either as confirmed cases or probable cases.

They come in through different data streams and then they are verified to get the final numbers. There was a coding glitch on June 19th from the State of New York where there was

approximately 5,000 cases that were probable cases that the coding glitch assumed that they were counted in the confirmed case list.

So that one day there was a 5,000 confirmed case undercounting, which was -- it occurred on the 19th of June. It was identified on the 19th of June and it was corrected. And there were no coding glitches that affected deaths.

Mr. Veasey. So let me ask you, so if a patient that -- if a patient has COVID and they die of sepsis, is that still a COVID-related death? Are you still going to count that as a COVID-related death?

Dr. Redfield. It depends on how it is coded by the state health department or the city health department or the county health department, whoever has jurisdiction for that, because it is coded at the local level.

Mr. Veasey. So then -- so the death count could be a lot higher than what we are seeing right now on the news?

Dr. Redfield. Yeah, I think each coder -- each physician tries to understand on the death certificate what the primary cause of death was.

Was it COVID that then caused complications that leads to sepsis, or is it somebody who had an asymptomatic COVID infection

who got hospitalized for, say, a contaminated infection in their arm and led to sepsis.

So these are individual clinical decisions that are made on the death certificate.

Mr. Veasey. So based on that, what do you think the actual COVID death rate is? Would you have the -- would you have --

Dr. Redfield. I would continue -- yeah, I would continue to rely on the data that we have that is basically reported through the current reporting system where it is then based on the death certificate -- the actual death certificate that is defined by the clinician responsible for making that determination, and that is the numbers that we use.

Mr. Veasey. Okay. Thank you very much.

And I wanted to ask Dr. Fauci a quick question with my remaining time.

Dr. Fauci, there was a grant that was -- it was a coronavirus-related grant that was not renewed and I wanted to talk with you to make sure that we just get the facts straight about this because I was really concerned about this.

Does the -- do you know why this grant was canceled or if anyone at the White House or HHS pressured your colleagues to do so and, specifically, I wanted to talk with you about the

National Institutes of Health.

There was a decision made by the Trump administration to cancel research on a grant that was specifically focused on coronavirus emergence while we are in the midst of this coronavirus pandemic, and it just didn't make any sense to me why this grant would be canceled.

Dr. Fauci. Is the question you are asking, why was it cancelled?

Mr. Veasey. Yes. Why was this -- why was this grant cancelled when we are in the middle of this pandemic? It seems like it would have been very helpful for us to have this research, considering we know very little about COVID-19.

Dr. Fauci. Right. Okay. It was canceled because the NIH was told to cancel it.

Mr. Veasey. And why were they told to cancel it?

Dr. Fauci. I don't know the reason. But we were told to cancel it.

Mr. Veasey. Okay. Thank you very much, Mr. Chairman. I have no further questions.

The Chairman. Thank you.

We are going to now go to New Hampshire.

Ms. Kuster, unmute please.

Ann, you got to unmute. Ann, are you there?

Ms. Kuster. I am, and I did unmute, Frank. Can you hear me?

The Chairman. Yes, we can. You are recognized for five minutes.

Ms. Kuster. It is so embarrassing. I am sorry. I had already unmuted and started.

So thank you, Chairman Pallone, for holding this hearing, and to all our witnesses for your patience today.

In addition to efforts related to the research, development, and manufacturing of a COVID-19 vaccine, there will also be work needed to ensure that the vaccine is widely adopted and equitably distributed, specifically, decisions about the allocation of the vaccine, efforts to support provider training, public education, and coverage considerations to ensure that the vaccine is not only available but available to everyone in every community, including communities of color, among immigrants and refugees, those living in rural areas, and of course, our elders.

In the absence of a vaccine plan from the administration, I am concerned that attention to this necessary work is being overlooked and we will repeat the errors and mistakes that were made earlier in the pandemic.

Admiral Giroir, the framework and documents HHS has released do not address these details and other factors that will be critical to reaching COVID vaccination rate goals.

Could you comment on that and the bipartisan letter that this committee called on the administration to create a national COVID-19 vaccine plan?

Adm. Giroir. Thank you, ma'am. A very important question.

I am not on that work group. That is Dr. Redfield and, I believe, Dr. Fauci, and they can answer that question for you.

Ms. Kuster. Great. Thank you. I would appreciate it.

Dr. Redfield. Thank you very much, Congresswoman.

This is a critical area. Just as Dr. Fauci has commented how important it is that we have begun to take the financial risk to have these companies be able to start manufacturing --

Ms. Kuster. And I am sorry to interrupt. Our time is short and the day is long.

Admiral Giroir, what I am asking about is not the creation of the vaccine. It is a national vaccine plan to equitably distribute the vaccine.

Dr. Redfield. Right. I was --

Ms. Kuster. I have legislation to require the

administration to create a plan on the equitable distribution. That is the focus of my question.

Dr. Redfield. Yes. The quick answer is that is part of the overall working plan and it is in development.

Ms. Kuster. It is not available at this time? When can we expect it will be available?

Dr. Redfield. I will have to defer that to the Secretary of Health and the Secretary of Defense that are in charge.

But I can tell you that is an essential part of the current plan to develop the distribution strategy that will also address the equitability issue.

Ms. Kuster. My understanding from when Dr. Eric Wright came before our committee is that it could take up to a couple of years to manufacture the materials to administer the vaccine and that those plans had not developed. Do you know about the manufacturing of the supplies to deliver the vaccine?

Dr. Fauci. That is currently a plan that is under the purview of a combination of General Gustave Perna, who is one of the co-leaders of the Operation Warp Speed.

He has been specifically brought in by the Secretary of Defense to work with the Department of Health and Human Services to make sure that not only the vaccine itself is equitably

distributed but also that all of the material that is needed for the proper distribution.

So this falls under his purview and he was specifically brought in by the Department of Defense to address that issue.

Ms. Kuster. And do you know if there is a plan to promote public health messaging --

Dr. Fauci. Yes.

Ms. Kuster. -- and materials to counter vaccine hesitations in the country?

Dr. Fauci. Yes. That is a very good question. I am glad you asked it and I have the opportunity to answer it.

What we are doing is a combination of a couple of things. We are employing our community activist groups that we had originally put together during the days when we had the HIV group and they are now an important part of all of our clinical trials networks.

So we are going to employ the community outreach mechanisms that we already have. But also the CDC traditionally over the years has been very heavily involved in making the prioritization which usually is the most vulnerable people first.

But I will let Bob talk about that since --

Dr. Redfield. I will just say, very quickly, that we are

very involved in the critical area you brought up in developing the communication strategy.

It is going to be fundamentally critical, as well as I mentioned already we are working on developing the distribution strategy for -- but the communication strategy is very important and it needs to -- it will be beginning to be operationalized soon, just like we are getting ahead on the manufacturing.

The Chairman. Thank you, Ann.

Ms. Kuster. Thank you. My time is up and I yield back.

Thank you, Mr. Chair.

The Chairman. Thank you.

Now we go to Illinois, Ms. Kelly -- Robin Kelly. Please unmute.

Ms. Kelly. Thank you. Yes, I am. Thank you, Mr. Chair, and thank you to the witnesses for all their patience.

I also wanted to thank Dr. Redfield and Dr. Fauci for the extra meetings with the CBC and the Tribal Caucus.

As we have heard data has revealed across the country, including in my district and in the city of Chicago, minority communities shoulder a disproportionate burden of COVID-19 cases and fatalities.

The virus has exposed centuries of health inequities

stemming from historically racist policies affecting the social determinants of health.

As chair of the Congressional Black Caucus Health Brain Trust, I am concerned by this tragic reality. The most recent CDC data showed that American Indians and Alaska Natives have a hospitalization rate approximately five times that of whites.

Black people are hospitalized at four and a half times the rate of whites, and those who are Hispanic or Latino are admitted to the hospital approximately four times more often than white people.

Despite these disparities, CDC's racial and ethnic demographic data is still extremely lacking. It is my understanding that 52 percent of reported coronavirus cases in the U.S. are still missing information on race or ethnicity.

That is why we included a number of requirements in the HEROES Act that the House passed in May that would require the federal government to better track and publicly report COVID-19 racial, ethnic, age, sex, and gender data as well as require the various federal agencies to modernize their data collection methods to account for inequities.

Dr. Redfield, you have admitted publicly that the

administration's four-page COVID-19 demographic report was inadequate, and while you announced that CDC will require all lab tests to include information about a patient's race, ethnicity, age, and zip code, the most recent report from CDC shows that more than half of the data you have is missing racial and ethnic information.

Consequently, I worry that this is a little too late, and this new rule lacks a clear enforcement mechanism. What further actions is CDC taking to address these data gaps? How is the CDC working with state, local, territorial, and tribal public health departments and labs to support their efforts to collect this information across the country?

Dr. Redfield. Yes. Thank you very much, Congresswoman. As we discussed I think last week, we are continuing to make progressive progress and to ensure that the requirement to include the race and ethnicity issue on all tests submitted for COVID is completed.

There is a progressive improvement, as you -- I think you have noticed. The same with the hospitalizations. I think we are up to 80 percent now. That is still not where we need to be. We are working to get to 100 percent, and we are going to just continue to work with our state, local, territorial, tribal

leaders to get that accomplished, as well as the laboratories and the hospitals and the long-term care facilities, because it is critical that we do have that information, as you point out.

Ms. Kelly. Thank you.

And, Admiral Giroir, what steps is the Administration taking to gather missing data, including data for minority neighborhoods and congregate facilities like nursing homes, jails, and prisons?

Admiral Giroir. I think I caught about half of that, ma'am. But let me just say that I am sorry. It is the internet connection.

The Chairman. Robin, repeat it.

Ms. Kelly. What steps is the Administration taking to gather missing data, including data for minority neighborhoods and congregate facilities like nursing homes, jails, and prisons?

Admiral Giroir. So all kind of different very, very important subgroups that we are working with. I don't think it is possible on the testing data to reconstruct what the racial and ethnic makeup is of the tests that were done in March and April and May. I don't think that is a possibility. Looking forward, we are absolutely going to mandate that.

On the enforcement mechanisms that you talked about, we might want some help with that because the authorization did not have

an enforcement mechanism. So we looked very deeply to do that. We were not able to do criminal/civil monetary penalties, et cetera, but we are working through the EUA mechanism.

And I don't want to put too fine a point on it, but I would like to turn the switch and have this tomorrow. I would have liked to have had it two months ago, because it really is critically necessary. We are targeting our resources to those areas, but not getting all of the feedback of the numbers that we need.

But one thing, for example, the major reference laboratories, just to give you an idea of the complexity, they have done over half the tests. They don't collect any of those tests. That comes from tens of thousands of individual physicians, pharmacists, others. So we are working with this very complex system to make sure each of those tens or hundreds of thousands of people provide that data, so we can get it.

But you have my personal commitment, as a person whose job -- my day job is working on health disparities to make sure we get this as quickly and as accurately as possible.

Ms. Kelly. Thank you. And my office will be in touch, so we can work together and we can give you the help that you need. Thank you so much.

And I yield back.

The Chairman. Thank you.

Ms. Barragan is here. You are recognized for 5 minutes.

Ms. Barragan. Thank you. Thank you, Mr. Chairman, for having this hearing.

This pandemic is still raging. Over 119,000 Americans have died, and cases are still rising in 29 states, with over 20,000 new infections per day. In fact, 12 states set records for the most daily cases in the past week, and we know that Black, Latinx, and Native Americans are bearing a disproportionate burden of the Administration's failures to address this pandemic.

Meanwhile, the Trump Administration seems to have moved on. The last time the White House task force held a full press briefing was April 27, and the task force is now winding down. Admiral Giroir is stepping down as the Administration's testing czar, despite the fact that we still need to greatly expand testing.

We still don't have enough tests. We still don't have enough PPE. We don't have a vaccine, and this fall we could see another wave of infections, yet President Trump last month declared, and I quote, "We have met the moment, and we have prevailed."

Dr. Fauci, do you believe we have prevailed? Has the fight

against COVID-19 been won?

Dr. Fauci. I wouldn't use the word "prevail." I would say that we are still in the middle of a serious outbreak. There is no doubt about that.

Ms. Barragan. Instead of devoting his time and effort to taking this pandemic seriously, President Trump is hosting campaign rallies, packing thousands of people tightly together without masks, in direct opposition to the guidance of all public health experts, just so that he can hear the crowds chant his name.

Clearly, this President has decided the best strategy to deal with the greatest threat against this country during his presidency is to bury his head in the sand and wish it went away.

Dr. Redfield, as the director of the CDC, your advice to the President is important now more than ever. Dr. Redfield, when was the last time you spoke to the President about the country's response to this pandemic?

Dr. Redfield. Thank you, Congresswoman. As I mentioned before, the interactions and discussions I had with the President I will keep to myself. But I do meet with the task force every --

Ms. Barragan. Dr. Redfield, I am not asking for the content

of your conversation. I am asking when you talked to him last. Has it been a week? A day? A month?

Dr. Redfield. Again, I am going to stay with my same answer, that I continue to talk with the task force whenever the task force meets. And I think --

Ms. Barragan. Thank you, Dr. Redfield. I think the fact that you won't tell this committee when the last time you spoke to him, whether it was days or months ago, is a real concern.

Dr. Fauci, when is the last time you spoke to the President?

Dr. Fauci. About two and a half weeks ago.

Ms. Barragan. Thank you, Dr. Fauci.

Admiral Giroir, when is the last time you spoke to the President?

Admiral Giroir. It was about two and a half weeks ago as well, maybe three weeks ago. If you don't mind just me clarifying, because I do think it is really important. I am remaining the testing lead. A lot got misconstrued because I said I was not going to be 100 percent of the time at FEMA, because my current position also works on ending HIV, substance use.

So I am still going to maintain the testing lead, but I am also integrating back into some of my other office functions.

Ms. Barragan. Thank you for clarifying that.

Honorable Hahn, when is the last time you spoke to the President about the pandemic and the response?

Dr. Hahn. It has been some time since I spoke about the pandemic response. I did have a conversation in the last couple of weeks.

Ms. Barragan. Would you say that it had been more than a month ago?

Dr. Hahn. No, ma'am.

Ms. Barragan. Okay. Dr. Fauci, you have been candid in the past about the shortcomings of the Federal Government's response and what more is needed. Dr. Fauci, as painful as these spring shutdowns have been, if we don't put in the effort now -- expand testing, prepare for a second wave, develop national strategies for contact tracing and vaccinations -- could we see our progress reverse? And could we be forced to shut down again if cases again get out of control?

Dr. Fauci. In describing what is going on, it is a very complicated situation and a mixed bag. There are certain parts of the country, certain areas, cities, states, that have actually done very well and are following the guidelines that we put together -- the gateway, phase 1, phase 2, phase 3. New York

City is one of them. Actually, Washington, D.C., is another.

There are other areas, other states, other cities, that have not done so well. I have a considerable concern about those because I want to make sure that we get everything under control. It is not there yet. I hope as the weeks and months go by we will be able to do what you are referring to and mobilize the identification, isolation, and contact tracing in those states, the ones that have recently been in the news -- Florida, Arizona, Texas -- and those states that are now having a serious problem.

So it really is a mixed bag. We have some doing really well and some really in trouble.

Ms. Barragan. Right. But, Dr. Fauci, just to clarify, in the areas where it may get out of control -- and we certainly know there are states that are doing that now -- would you say that we might have to go backwards and some of the progress may be taken away and we may have to shut down?

Dr. Fauci. Yeah. I wouldn't necessarily -- first of all, I agree with what you are saying. I wouldn't necessarily say an absolute shutdown/lockdown.

Ms. Barragan. Right.

Dr. Fauci. But if someone is going from gateway to phase

1 to phase 2, and they get into trouble in phase 2, they may need to go back to phase 1. I don't think they necessarily need to go back to lockdown.

Ms. Barragan. Thank you. Thank you all.

With that, I yield back.

The Chairman. Thank you.

Now we go to Delaware, Ms. Blunt Rochester. Please unmute.

Ms. Blunt Rochester. Thank you, Mr. Chairman. And thank you so much to the panel. We know that under normal circumstances uninsurance, health insurance, the lack of that, as well as the underinsurance of individuals, is a big problem for our country. But right now with the current pandemic and the high unemployment rate, it is an absolute crisis.

I don't want to turn this into a debate about the Affordable Care Act or Medicaid expansion or any other policy disputes that we may have. The fact remains that millions of people in our country are either without health insurance or they can't afford to use it. And they are especially vulnerable right now.

There are close to 30 million people without health insurance in this country. And for those people, it will undoubtedly be harder to receive testing and treatment. And when a vaccine is developed, they will likely struggle to access that vaccine.

Dr. Fauci, as a matter of public health, would you agree that during a pandemic such as COVID-19 it is in everyone's interest for people to be quickly tested, treated, and ultimately vaccinated?

Dr. Fauci. I agree.

Ms. Blunt Rochester. And, Dr. Fauci, if approximately 30 million people in this country can't easily access treatment and vaccines because they lack health coverage, doesn't that present a public health risk?

Dr. Fauci. I feel as a physician, a scientist, and a public health official that everyone should have access to the kinds of things that we are talking about -- testing, as well as accessibility to a vaccine and health care.

Ms. Blunt Rochester. Admiral Giroir, the Administration has suggested that money from the Provider Relief Fund, which is supposed to help struggling providers, is how it will pay for care for the uninsured. When can we expect a comprehensive plan from this Administration for how it plans to provide treatment and vaccines to people regardless of insurance status?

Admiral Giroir. The vaccine plan I think is currently underway, as you heard Dr. Redfield do that. There are -- I work very closely with HRSA on making sure that everyone can get free

testing. That program is underway, and the claims reimbursement for treatment is up to about $186 million now. So I know that is ongoing and would be glad to have HRSA or anyone else answer any specific more questions that you would have.

But I do agree with the premise again that it is absolutely critical, not only in a pandemic but under any other times, that people who need testing get the testing, that they get the health care that they need, and most importantly there are no impediments whatsoever to getting vaccinated.

Ms. Blunt Rochester. I don't know if anyone on the panel could answer this question, but were there conversations about expanding Medicaid or opening up enrollment for the ACA to actually mitigate the risks?

Admiral Giroir. So I am just going to say that I am not a member of the task force but am at most of the meetings as an invited guest for obvious reasons. And I think there were discussions across the board about all options. All options were looked at and discussed in order to make -- it was clear that the objective needed to be that no one should be waiting at home in need of care because of a lack of coverage.

And I would say that every option was really looked at, and the leadership of the Administration at the White House decided

on this way to move forward.

Ms. Blunt Rochester. I will reserve my comment to just say that I think those options would have been no-brainers.

I championed legislation included in the Heroes Act that would require insurers to cover COVID-19 treatment with no cost sharing, and the Heroes Act also included a provision that would provide coverage of COVID-19 treatment and vaccines through Medicaid for everyone who is uninsured.

I sincerely hope our colleagues in the Senate will take up the Heroes Act, so that we can make sure that everyone in this country can access the treatment and vaccines they need.

I yield back the balance of my time.

The Chairman. Thank you.

Next is Mr. Soto of Florida. Please unmute.

Mr. Soto. Thank you, Chairman. I want to go through a little bit of a timeline. On January 23 through 28, President Trump received two intelligence briefings on the coronavirus according to White House officials. From early January well into mid-March, President Trump deliberately misled the American people into believing the coronavirus was, quote, "well under control." He declared on several occasions, quote, "It will disappear." And as late as March 12 he stated, quote, "It is

going to go away."

The very next day, on March 13, he finally declares the national emergency. Approximately 50 days passed from the time President Trump received his first coronavirus intelligence briefings until he finally declared the national emergency.

Add in 6 weeks we lost in ramping up testing at the CDC due to contamination and the results of President Trump's disastrous response have been deadly, the United States has more COVID-19 deaths and more cases than any country in the world. Over 120,000 Americans are dead, 2.4 million Americans contracted the virus, and the economic fallout has left 43 million Americans out of work.

To argue that President Trump's response has somehow been a success is really quite astounding. It is our job to conduct oversight and hold the Administration accountable, regardless of the American -- regardless of your party.

So moving forward, Dr. Fauci, the House has already passed the Heroes Act, which includes $75 billion in additional coronavirus testing, contact tracing, and isolation measures. How important is this funding to our continued efforts to combat COVID-19 in the United States?

Dr. Fauci. Thank you for that question, Congressman. As

we have said throughout this hearing, clearly testing, even more widespread testing on a surveillance basis, is absolutely essential for us to really get a full understanding of the penetrance of this, particularly among individuals who are asymptomatic.

So the short answer to your question: it is very important.

Mr. Soto. Thank you. And, Dr. Fauci, how important is this additional funding to stop recent increases in COVID-19 cases as seen in my home State of Florida?

Dr. Fauci. Again, in attune with what I just mentioned, the more that you understand the dynamics of the infection, the more that you understand the distribution, the more chance you have of better control for identifying, isolating, contact tracing, and concentrating the resources in those areas where you have the most problem. You won't know that unless you know exactly what the penetrance is in your community.

Mr. Soto. Thank you.

Commissioner Hahn, there is a shortage of remdesivir in Central Florida in and around my district. Will the FDA be able to assist us with this shortage? And have we seen other shortages of remdesivir across the country?

Dr. Hahn. Congressman, really appreciate the question.

We are working closely with HHS, as well as the White House Coronavirus Task Force, who are responsible for the distribution of the remdesivir. We do know that we have a supply in this country, and I am very happy to work with you and with others.

So I would be glad to have our folks get in touch with yours to make sure that there is adequate supply for Central Florida.

Mr. Soto. Thank you, Commissioner Hahn.

Dr. Redfield, we saw after the [audio malfunction in hearing room] we lost [audio malfunction in hearing room] in ramping up testing. And now do you think that the United States' relationship with the World Health Organization is important to the future of combating the coronavirus, both in the United States and worldwide?

Dr. Redfield. Thank you very much, Congressman. We continue to have an important public health relationship with the WHO. We have had a long history of partnership with them. We are currently involved in a number of very important public health efforts -- the eradication of polio, responding to the Ebola outbreak in the DRC, developing our influenza surveillance system across the Nation, so we continue that partnership at the scientific and public health level.

Mr. Soto. Thank you, Dr. Redfield. And so it is going to

be very important not to defund the World Health Organization, since it so important to our national interest.

And with that, I yield back.

The Chairman. Thank you.

And last but certainly not least is Mr. O'Halleran.

Mr. O'Halleran. That always bring a smile to everybody's face, Mr. Chairman.

Members of the panel, thank you for being here today.

I am going to start out with the forest fire. I have been at three of them the last week, because my district has eight going on right now. And when I get to an incident control meeting, the commander of that incident control team is there, and then the division managers for that fire are all there, too, or on the phone and being able to address the issue, as are all of the community organizations -- police, fire, emergency response groups.

They are all on those meetings, and there is multiple meetings during the course of the week with the citizens of those communities at risk. And now I am in a process where I am trying to figure out how this whole process is working from the standpoint of we are here now. What has happened happened; we can't change that. But going forward, how are we going to address that we

have enough of the testing equipment and training -- not training -- equipment, the tracing equipment, in order to address the issues potentially in October, November, and into the winter?

How are we going to, or will we have, a command and control system that doesn't include 50 people doing whatever they want to do, and not any ability to react to hot spots as they occur as quickly as they should maybe? And are we going to be ready?

Hot spots -- Navajo is my district. I have White Mountain Apache in my district. White Mountain Apache, over 1,500 have gotten the virus. That is out of 12,000 people. Navajo -- the whole Nation knows what happened on Navajo. It took us weeks to get enough help up there to be able to address that problem, and White Mountain Apache are still calling me all the time saying, "Where is this? And where is that?"

So it is obvious that we have a shortage right now. How can we be guaranteed that we are going to have the necessary equipment and materials to be able to address it coming up during a flu season and the pandemic at the same time?

And then transparency and accountability. I don't know how right now you trace transparency and accountability in the system because it is almost impossible, because nobody takes -- nobody

says, "That was my fault."

So, and I think every one of your groups has done an outstanding job. I just can't find out what you are doing on a regular basis. I hear something on the news, but that doesn't mean that I really end up knowing what it is.

And so, Dr. Fauci, could you explain to me where we are at now and how are we going to attack these hot spots and address all of the issues I just talked about by the fall? And will we be prepared?

And I guess most of all, is the entire process of -- how do we educate the public that has different ideas and concepts right now to be able to understand the complicated nature that all of you have addressed here today and the overwhelming need to cooperate with one another as America always has?

Dr. Fauci?

Dr. Fauci. You asked a lot there. I will try to be succinct in my answer. So where we are now, as I mentioned a little bit ago, that it really is a mixed bag. It is a big country, it is very heterogeneous, and you can't have essentially a unidimensional approach to the difference between Arizona and the things you are responsible for and New York City metropolitan area.

Some areas have done very well, are well controlled; they are going through the guidelines to open America. Others that we have discussed in detail today are doing poorly, and we are very concerned about them. So you are talking about what about as we get into the fall, into winter?

The first thing that we would need to do is to try as best as possible to get the complete outbreak under control, so that everything is at such a low level that when there are cases that come up, you can contain them as opposed to mitigating, where you are essentially chasing after a forest fire that you just mentioned. Hopefully, we will get that under control soon.

The other thing we need to do is to get the material, which we are doing -- and Admiral Giroir, I am sure, will comment on that because he has done a phenomenal job of doing that -- getting the PPE, getting the ventilators, getting the equipment that we need, and have them in store, so that if -- and I hope it is if and not when -- but if we ever need them, we will have them and not be in the situation that we were in in February and March.

Mr. O'Halleran. Will we have them by October and November?

Dr. Fauci. I believe we will. We certainly will have the testing that we did not have early on. We will have it by October.

With regard to the other things, the PPEs and the others,

perhaps Admiral Giroir can help you with that.

Mr. O'Halleran. Thank you.

Admiral Giroir. Thank you. And, again, this is what we spend all of our time working on under the cooperation with Department of Defense, FEMA, HHS. We have already talked about testing. And if you want a person with accountability, it is me. If we don't have it, you look at me, it is my problem.

But the whole testing infrastructure is really working together. The laboratory supplies, the laboratory testing, the NIH program, the BARDA program is all working in synergy, and I am coordinating all of that to make sure it happens.

In terms of PPE, we have a long -- we had a long way to go because almost nothing was made in the United States. I mean, literally, almost nothing was made in the United States. I mentioned earlier that a good example would be the N95 masks, and Admiral Polowczyk tells me as a result of everything we are going to have about 180 million per month made in the United States by the fall. That is ramping up very quickly, so we feel pretty good about that.

And ventilators were just a good success story. I worked a lot on the ventilator problem early on. I am an intensive care physician. That is probably the only thing I do best is work

with children on ventilators. But we were very concerned about that, and by July we will have about 50,000 in the stockpile. We only had 19,000 to begin with, but we will have 50,000. So we think -- we know we are going to be in good shape for that.

And I am going to use a word of Dr. Fauci. I am cautiously optimistic, but I am very cautious, and I still don't sleep well at night because we have a long way to go.

And I just want to make the point that everyone has made. It is not like this is all going to happen to us. The American people have a lot to say about this, and we want to emphasize following the guidelines, following the phases, avoiding mass gatherings, wearing these things, using hand hygiene.

We have a lot to say about where this is going to go, but we all need to continue to work together to make that happen.

Mr. O'Halleran. Thank you, Admiral.

And I yield.

The Chairman. Thank you. Let me thank all of you for bearing with us for 6 hours I guess, and a really thorough analysis of what is going on. So I want to emphasize again, we really appreciate your being here and your thoughtful responses to everything. Thank you so much.

And I am going to let you go because I have a long list here

of documents to read for the record, so you don't have to stay for that, but thank you again.

I want to remind members that, pursuant to committee rules, they have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared. And I ask each witness to respond promptly to any such questions that you may receive.

And we would like to insert in the record by unanimous consent the following documents: a letter from the American Society of Microbiology to the committee dated June 23, 2020; a letter from the Alzheimer's Association to the committee dated June 23, 2020; a letter from AFSME to the chairman dated June 23, 2020; a letter from the American Society of Hematology dated June 23, 2020; graph from Representative Olson on COVID-19 cases in the Houston area; a statement from Representative Burgess dated June 23, 2020; and a letter from Ranking Member Walden on Committee Rule 9(b)(1) dated June 23, 2020.

[The information follows:]

**********COMMITTEE INSERT**********

The Chairman. And I will repeat again that any member that wishes to submit an opening statement for the record is certainly encouraged to do so.

And with that, at this time, the committee is adjourned. Thank you to everyone.

[Whereupon, at 4:47 p.m., the committee was adjourned.]