The Path Forward on COVID-19 Immunizations

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

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ADVISORY
FROM THE COMMITTEE ON WAYS AND MEANS

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February 19, 2021
No. HL-1

CONTACT: (202) 225-3625

Chairman Doggett Announces Health Subcommittee Hearing on The Path Forward on COVID-19 Immunizations

House Ways and Means Health Subcommittee Chairman Lloyd Doggett announced today that the Subcommittee will hold a hearing on "The Path Forward on COVID-19 Immunizations" on Friday, February 26, 2021 at 2:00 p.m.

This hearing will take place remotely via Cisco WebEx video conferencing. Members of the public may view the hearing via live webcast available at www.waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMdem.submission@mail.house.gov.

Please ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, by the close of business on Friday, March 12, 2021.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its events accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories are available [here].

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WITNESSES

Ashish Jha, M.D., M.P.H.
Dean of Brown University School of Public Health
Witness Statement

Georges Benjamin, M.D.
Executive Director of American Public Health Association
Witness Statement

Kimberly Avila Edwards, M.D.
Director of Advocacy and External Affairs at Ascension Seton
Witness Statement

Ann Lewandowski
Executive Director of Wisconsin Immunization Neighborhood
Witness Statement

Reshma Ramachandran, M.D., M.P.P.
National Clinicians Scholar at Yale School of Medicine
Witness Statement

Clay Marsh, M.D.
West Virginia COVID-19 czar and Vice President and Executive Dean for Health Sciences at West Virginia University
Witness Statement

THE PATH FORWARD ON COVID-19 IMMUNIZATIONS

Friday, February 26, 2021

House of Representatives,

Subcommittee on Health,

Committee on Ways and Means,

Washington, D.C.

The subcommittee met, pursuant to call, at 2:16 p.m., via Webex, Hon. Lloyd Doggett [chairman of the subcommittee] presiding.

Chairman Doggett. Good afternoon. The committee will come to order.

And I want to welcome everyone. I think we have got a great turnout, some excellent witnesses this afternoon and exploring an important subject.

While many of us are here in Washington today for transactions, many of our colleagues are scattered across the country for this virtual hearing, and even those of us here in Washington are not gathered in the committee room. So, in compliance with the regulations for remote committee proceedings pursuant to House Resolution 8, we will follow those. And the authority has allowed us to continue to do this work while we are spread across the country.

Before we turn to today's important topic, just a few ground rules as we navigate the hearing. First, consistent with H.R. 8, the committee will keep microphones muted to limit background noise. Members are responsible for unmuting when they seek recognition or being recognized for their questioning.

Second, members and witnesses must have their cameras on while present in the hearing. If you need to step away, please turn off your camera and audio and then log out.

Finally, I believe that we are in good shape as far as the voting schedule this afternoon. We should be able to complete our work before votes reoccur. It is my intention to continue proceedings throughout this period.

If I have any technical difficulties, as I did for a moment signing in this afternoon, I will ask Mr. Thompson from California to act as chair while I get rejoined.

I thank all of you for your patience as we navigate this technology and continue serving our country.

I will now proceed to an opening statement and then call on Mr. Nunes for his opening statement.

Though we have great scientific achievements that we are all very happy about, this week we have mourned the loss, the tragic toll of half a million Americans lost to COVID-19. And the numbers don't tell it all, because it is a friend, a neighbor, a family member that has been lost. And we know that more deaths and infections are on the way until we get most Americans immunized and until we are sure that we have protection from the various variants that are popping up now.

Turning vaccines into vaccinations has been incredibly chaotic. So much of the spread of infection and the rising death toll could have been prevented by effective Federal leadership relying on good science. It is truly incredible to me that our country, advanced as it is, could have the highest percentage of deaths of any place in the entire world.

After extraordinary overpromising and underdelivering last year, President Trump, you will remember, promised 100 million doses would be out before New Year's Eve, then lowered it to 20 million, and still was not, by New Year's Eve, to even forward that many doses out, much less get them into people's arms.

To date, our healthcare workers and long-term care residents who are in Group 1A have not all been vaccinated, and those who await in 1B face great uncertainty. President Biden was left without an immunization plan, sufficient vaccine, and with what can only be described, I think, as a colossal mess.

Today's hearing is focused on the path forward, as we have safe and effective vaccines and a humane administration that wants to offer leadership and partnership.

In little more than a month, President Biden has begun stabilizing vaccine production and distribution, increasing supply. We have these new Federal initiatives, including the FEMA mass vaccination hubs across the country, a direct to pharmacy dose, direct partnership of community health centers. And yet we do still face a number of problems.

For each of us as members of this committee, regardless of party, I think our concern

about vaccine access begins at our home area. In my part of Texas, we are still not where we need to be. Too many vaccine providers remain unsure when and how many doses they will receive. The State may be getting notice from the Biden administration of 3 weeks or now months, but that notice is not getting on to the actual healthcare providers.

Seniors wait anxiously, calling, unable to get into one central registry in most places, often trying to get on the list of every provider anywhere in the area, and then finding themselves at these mass vaccination sites in long lines. For many, appointments are only available online. If they lack the skills to use broadband or they don't have broadband, they don't get considered.

Vaccination sites also remain concentrated in wealthier White areas, making it difficult for those who have borne the greatest infection burden to access shots.

In some areas, the State has been a problem. That has been true of an important site at the Alamodome in San Antonio, where we have been unable to get from the Governor a certainty of the supply that will be available.

As President Biden recognized in his COVID-19 Health Equity Task Force, the burden, of course, has not been shared equally. Nationally, Latinos are more than 3 times more likely to be hospitalized and 2.3 times more likely to die from the virus as compared to Anglos. African Americans, Asian Americans have also suffered. Yet nationally, only 3 percent of Latinos have been vaccinated, and that is true in my home State also.

While wonderful to have the safe and effective vaccines as a strong defense against the virus, taxpayers have an interest in knowing the terms of the agreements made to obtain defense and what we paid for them and what it will cost in the future. The Trump administration hid all that it could about these secret agreements with vaccine makers, and what we do know is that this Congress has appropriated billions and billions for vaccines with essentially no limitations on how the money is expended.

Today, in response to that, in a bipartisan, bicameral initiative, I filed the TRACK Act -- that is Taxpayer Research and Coronavirus Knowledge Act -- to secure that information. We will explore accountability, how we get reasonable pricing and sufficient and expedient supply of vaccines, which rightfully the taxpayers have funded, largely as angel investors in this enterprise. That becomes particularly important as we recognize that we may well need these vaccines, much like a flu shot or with boosters in the future long after an emergency has been ended.

While too many still wait for the vaccine, there are other people who wait in fear, who are hesitant to be vaccinated. Some worry because of problems in the past with medical racism in our country, but for many, that hesitancy is tied directly to the false notion and conspiracy theories of anti-vaxxers.

Failure to seek immunization, just like failure to wear a mask or socially distance, will result in even more infection and death. I think we have to directly rebut the anti-vaxxer, anti-science message.

At the same time, there are some people who are vaccinated, a very, very small portion, perhaps about 1 out of a million, that actually do suffer some injury. Most of these are not related to the vaccine but the way the vaccine is administered. There is a longstanding Vaccine Injury Compensation Program, but it has not been updated for many years. And I think it will be important to do that as I propose, in new legislation, a vaccine compensation modernization act.

There are many other challenges that we will explore today. After watching the production of Hamilton, I think the American Medical Association leadership chose as their campaign slogan "This is Our Shot." Well, our goal today is to ensure that we make the most of our shot for our country to defeat this virus.

I want to thank our panel for joining us, our colleagues for being here for such a good

turnout, because it reflects -- while we may have differing insights, it reflects a common concern and desire to address this challenging problem.

And, with that, I will call on my colleague and our ranking member, Mr. Nunes, for his opening comments.

[The statement of Chairman Doggett follows:]

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

Mr. Nunes. Well, thank you very much, Chairman Doggett, for calling this hearing. And I want to thank all six of our witnesses for being here today. We are happy to have your expertise.

Before we start, a point of process. Mr. Chairman, over the past two subcommittee hearings you have presided over, you provided 11 witnesses to our 2. Especially on bipartisan issues like this one, I would hope that going forward you would allow a more proportional ratio of witnesses and witness invitations for the minority.

It is truly remarkable that less than a year after President Trump declared a national emergency over COVID-19 outbreak, we are here to discuss COVID-19 vaccines that are already being distributed and administered to the American public. We would not be in this position without the incredible efforts of Operation Warp Speed, a Trump administration-led initiative to accelerate and facilitate the aggressive development and manufacturing of COVID-19 vaccines.

Through the program's tremendous work, the FDA has approved two double-dose vaccines from Pfizer and Moderna. Additionally, a single-dose vaccine from Johnson & Johnson could be issued an emergency use authorization as soon as today. I believe it did receive that, if the news reports are correct. Vaccines from other companies such as AstraZeneca and Novavax are in late phase clinical trials.

It is plausible that we could achieve herd immunity by the end of this summer and achieve our goal of crushing the COVID-19 virus and getting American lives back to prepandemic normalcy. To reach the finish line, Congress should focus on four key priorities.

First, we must take the lessons learned from States whose vaccination campaigns have been the most successful and apply them to other States and localities to get as many

Americans vaccinated as fast as possible.

In my home State of California, vaccine distribution has been slow, confusing, and a frustrating process. Governor Newsom's vaccine rollout has been plagued by technical glitches and distribution problems, and California continues to lag behind many other States in overall vaccinations. Overburdened areas like the area I come from, the Central Valley, as well as Los Angeles, are dealing with dwindling supplies and have struggled to meet overwhelming demand for the vaccine.

By contrast, States like West Virginia are successfully vaccinating their elderly and high-risk populations. Today, we will hear testimony from Dr. Clay Marsh, West Virginia's coronavirus czar, on the techniques they used to achieve this success, such as using COVID-19 vaccine hotline, implementing a decentralized hub-and-spoke model for local pharmacies to participate in vaccinations, and crafting clear priority schemes to guide who gets vaccinated and when.

While each State must tailor its vaccine distribution process to meet the needs of its unique population, our Governors and local health officials should take note of what practices work best so we can vaccinate Americans as quickly as possible.

Second issue, given the threat of COVID-19 virus mutations, we must improve domestic manufacturing and enhance supply chain logistics. While our current available vaccines show effectiveness against strains, manufacturers are gathering more data and preparing more booster shots to bolster vaccine effectiveness.

Last October, Ways and Means Republicans introduced the Commitment to American GROWTH Act, to incentivize American medical independence and boost our business investments and manufacturing innovation. With these measures, we can reduce our dependence on China and other countries, encourage small biotech companies to boost American manufacturing, and ultimately improve public health.

Third issue, as we ramp up our vaccine production and inoculate more Americans with COVID-19 vaccines, President Biden needs to start following the recommendations of CDC and begin supporting the safe reopening of in-person schooling.

In a February White House press briefing, CDC Director Walensky noted there is increasing data to suggest schools can safely reopen, regardless of whether teachers are vaccinated. Additional data has shown that at least 75 percent of communities in the U.S. can reopen schools without generating new COVID-19 outbreaks.

By adhering to CDC protocols of mask wearing, social distancing, and improved ventilation, we can combine these efforts with wide-scale vaccinations to create a safe environment for teachers and students to swiftly return to their classroom.

And finally, we must address concerns over the vaccine and emphasize that receiving the COVID-19 vaccine is safe, effective, and will bring us closer to our goal of herd immunity and a return to normal. Data shows that as of January 21, 31 percent of Americans still want to wait to see how a vaccine is working before taking it, while 13 percent of Americans say they definitely do not want to take the vaccine.

In light of concerns over the novelty of the vaccine, potential side effects, and the government approval process, we just need to amplify the science that demonstrates that receiving the COVID-19 vaccine is not only safe and effective, but will reduce the threat of serious complications and illness from COVID-19 and improve our overall health.

I want to thank you, Mr. Chairman, and yield back. I look forward to listening to our witnesses.

[The statement of Mr. Nunes follows:]

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

Chairman Doggett. Thank you very much, Mr. Nunes.

And, without objection, all members have an opportunity to submit an opening statement for inclusion in our record.

I will now welcome our panel of distinguished witnesses, and we are fortunate to have such a strong panel today.

First, Dr. Ashish Jha, dean of Brown University School of Public Health, and a frequent commentator on the issues we are discussing today.

Dr. Georges Benjamin will be testifying next. He is the executive director of the American Public Health Association, to which we all look for sound advice about public health matters.

A special welcome from Austin to Dr. Kimberly Avila Edwards. She is at the Dell Children's Hospital as a practicing pediatrician, and she is the director of advocacy and external affairs there.

And I would like to call Mr. Kind, who provided some good advice about a witness, to tell us more about challenges in rural areas.

Ron.

Mr. Kind. Mr. Chairman, thank you for having this very important and timely hearing [inaudible] the essence of what we can do, get shots in the arm.

But it is my honor to introduce to the committee today [inaudible] from Wisconsin, Ms. Lewandowski, the executive director of the Wisconsin Immunization Neighborhood, WIN for short, where she builds successful community partnerships to address vaccine hesitancy and also access to vaccines, especially in our rural area.

She is an immunization leader in Wisconsin and has worked to place equitable distribution to rural communities at the forefront of our State's agenda. She is also the Rural

Wisconsin Health Cooperative liaison to the Wisconsin Immunization Network and co-chaired the State's advisory committee on vaccine distribution.

And the ranking member, Devin, may be interested, in addition to her work in Wisconsin, she has been recognized for extraordinary service in California for her contributions to the 2009 H1N1 influenza response.

So, Ann, we are very happy to have you here today. We look forward to your testimony and your answers.

Thank you, Mr. Chairman.

Chairman Doggett. Thank you, Mr. Kind. And we look forward to your testimony.

After we hear from her, we will hear from Dr. Reshma Ramachandran. I want to say it correctly. And she is a health services researcher, family physician, and National Clinical Scholars Program fellow at Yale. And I look forward to her insights.

And now I want to call on our colleague Mrs. Miller, whose State has been doing rather well in getting shots into arms, for the purpose of introducing an expert to tell us how it is done.

Mrs. Miller.

Mrs. Miller. Thank you, Chairman Doggett and Ranking Member Nunes, for this opportunity to introduce my friend and fellow West Virginian, Dr. Clay Marsh.

Dr. Marsh, we are so glad to have you here today.

West Virginia has been leading the Nation in vaccinating our citizens against COVID-19. We are often near and sometimes even over 100 percent of total doses that have been administered. This has been no easy feat and has been a success, thanks to Governor Justice and Dr. Marsh.

Dr. Marsh is West Virginia's COVID-19 czar, as well as the vice president and executive dean for health sciences at West Virginia University. As a nationwide leader in

the field of medicine, he has published over 140 academic papers and holds more than 20 patents or patent disclosures.

Along with those achievements, he has seen our State through the pandemic and led us with a steady hand in ensuring West Virginia can recover and reopen safely.

Thank you, Dr. Marsh.

Chairman Doggett. And we will now begin hearing from our witnesses. I would ask you to summarize your testimony in 5 minutes or less. We have your written testimony. Given the remote nature of this both for you and for our colleagues later, as the 5-minute mark approaches, I will do a gentle tap that I hope you can hear from afar so that we keep our hearing proceeding along.

So, Dr. Jha, would you lead off, please?

Let's see. I believe you still need to unmute.

Dr. Jha. Yeah. Thank you.

Chairman Doggett. There we go. Great. I can hear you.

STATEMENT OF DR. ASHISH JHA, DEAN OF BROWN UNIVERSITY SCHOOL OF PUBLIC HEALTH

Dr. Jha. Perfect.

Chairman Doggett, Ranking Member Nunes, thank you so much. It is such an honor to speak in front of your committee today.

You know, it has been a year since the virus that causes COVID-19 was first detected on our shores, and in that year, more than 28 million Americans have known to become infected and more than half a million of our fellow Americans have perished as a result of this infection.

This is such an immense degree of suffering that we as a Nation have gone through, largely due to missed opportunities, missed opportunities to set up a testing infrastructure that could stop the spread of the disease, our failure to protect healthcare workers, these incredibly courageous men and women, with adequate PPE, and more recently, our inability to vaccinate Americans as soon as vaccines became available.

But things are getting better. We have two highly effective vaccines authorized, and I am very hopeful that today or tomorrow the FDA will likely authorize a third highly effective vaccine. Vaccinations are getting into arms, and the numbers are rising. We are seeing drops in infections and hospitalizations and deaths. But we are not out of the woods quite yet, but we are making progress.

So today, I want to focus, as this committee is focused, on vaccines and vaccinations. In the time since Pfizer and Moderna vaccines were authorized, the rollout has been disappointingly slow and uneven. If we are to continue to make progress, we should understand what went wrong and what went right. And because vaccinations are driven by States, we need to understand the role of the Federal Government in this effort.

The Trump administration invested billions of dollars into vaccine development and manufacturing. Those investments were very, very good things, but the Trump administration failed to pay adequate attention to what happens after vaccines are produced and delivered to States.

Vaccines didn't end up in people's -- don't end up in people's arms by themselves. The States were largely unprepared, short on staff, with an exhausted public health workforce, and no concrete plans for implementation. And, unfortunately, the Trump administration did too little to help them.

The messy rollout of vaccines only began to improve when, through congressional action, money started to flow to States. And over the past month, with congressional support

and under the Biden administration, vaccine administration has started to improve.

As of last night, roughly 91 million doses have been delivered and 67 million doses administered. About 22 million Americans, about 7 percent of all Americans, have received both doses, far short of the Operation Warp Speed often repeated goal of 50 million Americans fully vaccinated by the end of January.

With States left on their own, vaccine distribution has varied widely. States like Connecticut and West Virginia have fully vaccinated about 1 in 10 people. States like Iowa and Utah, about half that.

Not surprisingly, some States are using up nearly all their vaccine supplies and other States are keeping more than a third of their doses on the shelf. And even within States, the distribution has hardly been even.

The communities hit hardest by the pandemic, Black and Latino communities, are the communities least likely to have been vaccinated, at least that is what we know from the data we have. But, unfortunately, we don't have very good data on this. About half the States are not fully reporting their data on who is getting vaccinated and who is not.

Why have we done so poorly on equity? It isn't for a lack of good intentions. Beyond not having adequate data, we have created systems that are far too complex. Online portals to schedule vaccinations are difficult to access and navigate. They make it nearly impossible for someone without great digital skills to get an appointment. And when appointments do become available, they are often at times that essential workers can't make.

We must do better. So how do we do better? First, we have to strengthen the State-Federal partnership in public health. You know, the history of public health in America is that States lead and the Federal Government provides support. We must recommit to that partnership.

Equity must be the reality and not just the aspiration. That means focusing on Black

and Latino communities through pop-up and mobile clinics, engaging community leaders, and, yes, collecting and publicizing data based on race and ethnicity so we know what is working and what is not.

And I do believe -- and I am so thrilled about this hearing today -- that we have to learn from successful States, such as West Virginia and Connecticut and New Mexico. We will hear more from them, but as I understand it, having spoken to State leaders across the country, keeping things simple, accessible, easy to use is fundamental to that.

You know, we are very close to the finish line with this pandemic. We have the evidence-based tools to get us there: wearing masks, avoiding crowds, testing, and, of course, getting Americans vaccinated. And as cases fall, we will be able to scale back these restrictions and bring this pandemic to an end and get our lives back. We have more than enough capacity to do it. The question is how quickly, and that is ultimately up to us.

Thank you so much.

[The statement of Dr. Jha follows:]

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

Chairman Doggett. Thank you very much, Doctor.

Dr. Benjamin?

STATEMENT OF DR. GEORGES BENJAMIN, EXECUTIVE DIRECTOR OF AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. Benjamin. Hi. Good afternoon, everyone. Chairman Doggett, Ranking Member Nunes, and members of the subcommittee, let me just thank you for the opportunity to address you here today. And I know that many of my members have been directly engaged in the national effort to end this pandemic.

Mr. Chairman, let me first, you know, send my support and concerns to the people of Texas and the other States in the region that are still challenged from the severe weather you recently had.

As you may know, many of my members were also impacted from the storm and are actively working to help your residents and people in the other affected States recover. So I just wanted you to know that our thoughts and prayers are with you.

You, of course, have my written testimony, so let me focus a little bit on this issue of getting shots in the arms equitably. Now, we know that wearing a mask, washing your hands, social distancing, and avoiding large crowds, as well as getting vaccinated, is the secret for changing the trajectory of this pandemic.

We also know that getting this life-saving vaccine studied and improved expediently through the Federal system with really full scientific transparency and rigor was absolutely a remarkable success. And as Ashish pointed out, we also know that having a safe and effective vaccine and getting those vaccines into the arms of the susceptible population are

two entirely different things.

So as of this morning, you know, we have administered over 68 million doses to people, with 46 million having received one dose and about 21 million having received the full two doses. But, of course, despite this encouraging progress, we are still seeing troubling trends and disparities when it comes to who is being vaccinated, particularly in communities of color.

One of the big issues about data by race and ethnicity remains an issue, and our Nation just absolutely has to do a better job there. This is something that has really plagued the whole response from the beginning. But having a full and accurate record of the demographics of this vaccine effort is essential to ensure we focus more effectively on the populations who are most at risk.

Now, the Kaiser Family Foundation has been tracking vaccine administration and has found and documented these significant disparities in vaccination in both African Americans, Hispanics, Native Americans, and Asian Americans compared to non-Hispanic Whites. These disparities represent the impact of both vaccine hesitancy as well as vaccine access barriers.

Now, in the area of hesitancy, we know that about 40 to 50 percent of the population have stated that they are not sure they will get vaccinated. As you know, these numbers have moved all over the place. And most of these folks are actually curious about the vaccine but not anti-vaccine. They just don't know enough about it to get vaccinated.

In our studies about communicating health information to these individuals, what we have understood is that messenger matters and the message matters. There are certain words and approaches that we think if one uses, they will increase vaccine adaptation.

So telling your message to the audience, because perceptions about vaccine differ by race, age, political party, and geography. Discuss the benefits of the vaccine as well as the

consequences of not taking it. Find out and address what their specific concerns are and avoid judgmental language. Describing the vaccine development process, telling folks what it does, what it doesn't do, what safety and side effects actually mean, and the ongoing safety precautions that are in place to track potential complications. Doing so, we think we can increase people's acceptance of the vaccine. We obviously have to deal with a range of disinformation and misinformation that is out in the community.

You have already heard some of the issue about some of the structural barriers. You know, not having a computer. Access to WiFi or broadband is a big issue, not only for people getting appointments, but for our kids who had to stay home from school.

Lack of a single point of entry remains a big problem. Even though the CDC has the website VaccineFinder, it also, of course, you know, it takes you to your individual States, and that often remains confusing for many people.

We just don't have enough telephone-based appointment systems. And language barriers remain a big problem. Limited number of available appointments, primarily due to the vaccine shortage issue, but also, we need to make sure these appointments are available over extended hours and weekends. So, you know, if all the vaccine appointments are gone during the day, if you are a bus driver or even if you are a doctor or nurse and you work shifts, you are not going to be able to get an appointment.

We got a whole range of logistical issues about where these vaccine sites are placed. So if you don't have a car, if it is not close to public transportation, or if there is not a health infrastructure -- and that is particularly an issue in our rural communities -- then there are challenges to getting vaccinated.

You know, the equitable vaccine distribution within States continues to be a problem, in particular when you look at some of the vaccine redlining. Now, that is a term that some people have thrown around, because we are seeing vaccine preferentially going into

communities of affluence over underserved communities of high COVID impact.

Vaccine tourism. That is where people jump the line by going to different States or different communities to get vaccinated ahead of the resident population.

Now, in some places where we have regional issues, like here in the Washington, D.C. area, it seems to be a relative tradeoff of the folks going to Maryland and then the folks coming from D.C. into Maryland are pretty much equal, but that is not always the case in all of our communities. The problem is when a group jumps ahead of the line and takes vaccine from one of the designated populations and, in effect, crowds them out from getting their shot.

We also know that putting local pharmacies in communities is a good thing, except that many of them that are actually giving the vaccinations aren't in the inner cities and communities where they are most needed. But some of the pharmacies are doing a range of innovative things to reach into those communities, and so we should applaud those efforts, but we should encourage all those pharmacies to do that. West Virginia, as you know, did that very, very successfully by looking at local pharmacies, and I understand we are going to hear from them today. Federally Qualified Health Centers that are also in the community have the community trust.

And finally, I just want to advocate for us rebuilding our public health system, because we need a strong public health system if we are going to do this in the future.

And I thank you for the opportunity for testifying with you today.

[The statement of Dr. Benjamin follows:]

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

Chairman Doggett. Thank you, Doctor.

Dr. Avila Edwards?

STATEMENT OF DR. KIMBERLY AVILA EDWARDS, DIRECTOR OF ADVOCACY AND EXTERNAL AFFAIRS AT ASCENSION SETON

Dr. Avila Edwards. Chairman Doggett, Ranking Member Nunes, Chairman Neal, Ranking Member Brady, and members of the subcommittee, thank you for the opportunity to testify today. My name is Dr. Kimberly Avila Edwards, and I am a pediatrician by training, with almost 20 years of experience in multiple roles, including serving the underserved in central Texas.

Ascension Texas is a ministry of Ascension, one of the Nation's leading nonprofit and Catholic health systems, with a focus on delivering compassionate, personalized care to all, with special attention to persons experiencing poverty and those most vulnerable. On behalf of Ascension, thank you for holding this important hearing.

Our path forward on COVID-19 vaccinations has to focus on the most vulnerable and hesitant populations. We all know that there are many out there who will have to overcome significant challenges to get their vaccine, and some will have to be convinced to get vaccinated. These are the people we need to reach.

They include the mother of one of my patients in clinic. I practice on a mobile clinic that serves uninsured children. Among our patients' families, one mother stands out. She is a hardworking cafeteria staff member in a local elementary school. She brings her daughter for every well check and every appointment for her daughter's asthma. Their family has limited transportation options but were able to bring her and her daughter to and from clinic

using ride-share companies.

Mom is very attentive to her daughter's healthcare needs, but does not have access to consistent healthcare to help and monitor her own diabetes. It is of the utmost urgency that she and many more like her receive a COVID-19 vaccine as soon as possible.

Over the past year, COVID-19 has touched every one of our lives, though some have certainly been impacted far more severely than others. We have seen a disproportionate impact of COVID-19 on Black and Hispanic individuals, families, and children. The Hispanic community has consistently accounted for more of our COVID-19 deaths than their share of the Texas population. Of Dell Children's Medical Center's pediatric intensive care unit admissions for COVID-19, 87.5 were Hispanic.

There are many underlying causes for such disparate rates of infection and severe illness, and our data show that Hispanics admitted with COVID-19 experience significant challenges to health and well-being because of social impediments to health.

For far too long, social determinants of health, such as income levels, geography, housing infrastructure, access to transportation, language barriers and other drivers have been known to have a greater impact on a person's health and quality of life than even the clinical care they receive. But the pandemic has shone a spotlight on just how much these factors impact access to medical care and health outcomes.

At Ascension, we are working hard to get everyone vaccinated, especially those who are the hardest to reach and most vulnerable. We have been developing partnerships with community-based organizations and bipartisan leaders who share our mission, piloting models for drive-through clinics, holding focus groups on hesitancy to learn what works, and working on other strategies to do our part.

To address challenges in reaching vulnerable populations and reducing hesitancy, we are also partnering with trusted community voices, including physicians, healthcare workers,

faith and business leaders, and public servants. These trusted voices can amplify accurate, authentic, culturally sensitive and linguistically appropriate messages addressing hesitant population.

Now what we need is a predictable supply of vaccines. There is much more to do, and Ascension and Ascension Texas have the capability, community relationships, patient trust and commitment to get the job done.

We ask that you consider the following recommendations: One, work with the administration to establish a national blueprint for States and health departments that outlines a set of consistent pathways through which healthcare systems can continue to partner and contribute to vaccination efforts, especially for those hard to reach; two, continue the important work to improve the vaccine supply; allow qualifying health systems to receive vaccine supplies directly from manufacturers; establish uniform vaccine reporting standards; five, ensure COVID vaccine trials include a diverse set of children of all ages.

And finally, on behalf of our organization, I want to personally ask that each of you not lose sight of how deeply the pandemic has impacted children. It will remain critical for policymakers and healthcare providers to focus efforts on addressing mental and behavioral health challenges that have been exacerbated by the pandemic.

Thank you again for the opportunity to testify today. Ascension appreciates your focus on ensuring the continued nationwide vaccine rollout is equitable, accessible, and successful for all Americans. We remain eager to continue working with you and with our State, local, and community partners to live out our mission.

I look forward to answering any questions you have and want to thank Dr. Benjamin for his thoughts for my fellow Texans.

[The statement of Dr. Avila Edwards follows:]

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Chairman Doggett. Thank you, Doctor, very much.

Ms. Lewandowski, you may proceed.

STATEMENT OF ANN LEWANDOWSKI, EXECUTIVE DIRECTOR OF WISCONSIN IMMUNIZATION NEIGHBORHOOD

Ms. Lewandowski. Good afternoon, Mr. Chairman, Mr. Ranking Member, and members of the House Ways and Means Subcommittee on Health. May name is Ann Lewandowski, and I am the Rural Wisconsin Health Cooperative liaison and executive director of the Wisconsin Immunization Neighborhood. I would like to thank Representative Kind and Chairman Doggett for the opportunity to be here today.

The issues I am highlighting impact Americans, regardless of their geographic locality, even while I address them from a rural lens.

I am proud to represent a network of over 190 immunization coalitions that have worked to keep their communities free from infectious diseases for many years. No doubt, many of us will continue to address vaccine access and hesitancy long after the much-desired day that COVID-19 is no longer a national topic of discussion.

The message I want to share with you today is simple and has been repeated by my esteemed colleague. We must ensure the choice to be vaccinated is easy for all Americans. We must support this choice with funding for vaccine infrastructure and community relationships.

The biggest challenge today is limited vaccine supply. The Wisconsin Department of Health Services reports that providers requested over 400,000 first doses for vaccines this week. The Federal allocation that Wisconsin received was 120,000 first doses.

The message that vaccine remains scarce gets lost as Federal policymakers discuss millions of vaccine doses over many months. Please allocate funds to create a Federal communications task force to help the public understand continued vaccine scarcity. This task force should help Federal spokespeople create consistent messaging that reduces confusion with the public. Finally, it can ensure that changing science is communicated effectively for the vast majority of the public who are nonscientists.

Like many States, Wisconsin is rapidly approaching expanded eligibility for some essential workers. The most effective way to reach these workers is to bring vaccine to work sites, leaving primary care to continue to vaccinate those above 65.

We must make sure these clinics are held on nights and weekends to accommodate nontraditional work schedules as needed. Community-based clinics should be easy to access. We can leverage data to determine the best location to place vaccine clinics.

The data is expensive to purchase locally, but economies of scale make it relatively inexpensive to purchase at the Federal level. For example, Community Data Platforms estimates they can cover the entire United States for roughly $5 million.

We can help all willing Americans get vaccinated by funding partnerships with faith groups, clarifying rules for mobile vaccinators, and using civic groups, such as Rotary International, Lions International, and the National Council of Negro Women. These trusted messengers will help us begin to address vaccine hesitancy.

Vaccine hesitancy comes down to two key emotions: fear and distrust. These emotions leave communities vulnerable to misinformation that spreads much like a virus, according to data from the World Health Organization. These emotions do not listen to data or numbers. Facts don't matter when you are worried about your livelihood.

If you distrust big government, you likely won't trust a vaccine developed with government support. If you mistrust the government, you also likely won't trust it when

government officials say you need to be vaccinated. It is really that simple.

We overcome distrust by diving deep into communities. You have heard the impact of the message and the messenger. We need to find the community -- we need to find the person that families call when they are in crisis. This is the best person to become a COVID-19 vaccine champion. They may be hesitant themselves, but the time we spend helping them understand the COVID-19 vaccine will pay dividends in the long run when it comes to vaccine uptake in our community. If we can coach them to understand vaccine hesitancy, they become the most cost-effective investment in vaccine infrastructure.

The Ad Council has done extensive research on messages that motivate people. It comes down to our relationships with others. We know that caring for the neighbor who has heart disease, the woman battling breast cancer at church, and the diabetic one are the people and relationships that matter and will motivate people to get vaccinated if they are hesitant.

We do not need to add more statistics that use large numbers. People don't understand them and, frankly, they don't really care. We need the stories of hope. We need the stories of the woman who is asthmatic who is worried about the vaccine but says she will be vaccinated for her community. We need to talk about the things that bind us together -- community relationships -- and coming back together in person.

Thank you for this opportunity to speak with you today, and I look forward to your questions.

[The statement of Ms. Lewandowski follows:]

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Chairman Doggett. Thank you for your helpful comments.

Dr. Marsh.

STATEMENT OF DR. CLAY MARSH, THE WEST VIRGINIA COVID-19 CZAR AND VICE PRESIDENT AND EXECUTIVE DEAN FOR HEALTH SCIENCES AT WEST VIRGINIA UNIVERSITY

Dr. Marsh. Well, thank you, Chairman Doggett, Ranking Member Nunes, and certainly Congresswoman Miller, for your leadership and support and friendship for West Virginia. It is really a distinct honor to be here with you. And I want to thank also and congratulate the other witnesses who are testifying today for their good work.

So I want to briefly overview our story in West Virginia and just to remind this esteemed group that West Virginia, going into the COVID-19 pandemic, was rated by Kaiser Family Foundation as the most vulnerable State in the country. We had many, many health problems to overcome at baseline.

And as we look at our response to COVID, I think this is really a story, as Ms. Lewandowski said, of culture and coming together and caring about your neighbors and caring about your families. This is not about being number one, two, three on the list.

In West Virginia, we sought to do what Albert Einstein said is to make complex simple. And we decided, with the leadership of our Governor, that our target would be to save lives, to protect health, and to maintain the capacity of our hospital healthcare systems and their function as well as community function.

And as we looked at our own epidemiology data, we recognized that the average age of a West Virginian dying of COVID-19 is 77 years old. 77.5 percent of West Virginians

dying were over 70 years old, 92 percent over 60 years old, and 97 percent over 50 years old. As we looked further, we found that half of our deaths came from our nursing home population.

So as we sought to understand how we could most quickly put shots in the arms of our most vulnerable people in West Virginia, we created a team of teams type approach that we call the Joint Interagency Task Force. This is a task force that is run by our best logistics experts and crisis management experts in our National Guard. We have 15 sectors represented around the table, and these sectors include healthcare, primary care, pharmacy, boards of medicine, FEMA, Federally Qualified Health Centers.

And we tasked our leaders of our long-term care area with our pharmacy group to understand how we could best most quickly gets shots in the arms of our nursing home residents which, again, accounted for half of our deaths. And they looked and said that the Federal Pharmacy Program wouldn't work because of the rural nature of West Virginia. We had over 200 pharmacies, of which half were locally privately owned.

So we decided to go a different way and start a network of local pharmacies. Went to Operation Warp Speed; they agreed. And by doing that, we were able to immunize 85 percent of our nursing home residents, first shots by the end of December 2020, second shots by the end of January 2020. And we also then looked at our critical workforce and focused on those over 50, because of the epidemiology data we saw, and quickly then pivoted to our aged population over 65.

To date, we have been able to immunize first doses of 160,000 of our 350,000 over-65-year-old West Virginians and second doses of 80,000. And as a result of this, in 2021, over the first 7 weeks, we have seen an 85 percent reduction week to week in mortality, a 73 percent reduction in hospitalizations. We have seen fewer ICU patients and ventilated patients than we have seen since November.

And we look at this event as a black swan event. So we know that we can't predict the future, so we have set up a rapid learning cycle. We have commander's intent. We know what we want to see done. And we do control vaccines very carefully and expect the vaccines to be used completely at the end of each week. But we give everybody in the State the ability to be creative and figure out how they can work in their communities to immunize their friends and families. And we know that we all shine brightest in the service to others.

And we appreciate the opportunity to share our story here briefly, but, more importantly, we are very proud to be part of this United States of America, and we hope to learn from everyone we can, and we are happy to share any lessons learned to help any other State care for their citizens the way that we want to care for ours.

So thank you.

[The statement of Dr. Marsh follows:]

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Chairman Doggett. And thank you very much, and congratulations on the success that you have had.

We are now going to move to the questioning period. Before doing that, I want to circulate and place in the record two documents that have either been sent to you or will be circulated to you.

One is from AARP, just a letter that offers their views about the chaos in trying to get an appointment and their concern about healthcare disparities. And the second is the CRT Latinx COVID-19 research project, which was prepared by Ruben Cantu and the Community Resilience Trust, in partnership with the Austin Latino Coalition, led by Paul Saldana.

These focus on some of the issues that our witnesses have referred to about the disproportionate impact on the Latinx community and the disparities in services between I-35 West and East, the highway that divides our community, and offers some comments about how to get more equity.

I also realize that I have -- well, first, let me just say, without objection, those two documents will be included in our record and circulated. And if any other members have documents they wish to circulate, we will certainly want to add them in the record.

[The information follows:]

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Chairman Doggett. But before we begin questioning, someone I have been eager to hear but slow to recognize, Dr. Ramachandran. Doctor, please proceed.

STATEMENT OF DR. RESHMA RAMACHANDRAN, NATIONAL CLINICIANS SCHOLAR AT YALE SCHOOL OF MEDICINE

Dr. Ramachandran. Thank you, Congressman.

Chairman Doggett, Ranking Member Nunes, and distinguished members of the subcommittee, thank you for the invitation to testify today. My name is Reshma Ramachandran. I am a researcher and a fellow in the National Clinicians Scholars Program at Yale School of Medicine. I also serve our Nation's veterans as a physician at West Haven Veterans Affairs Medical Center. I am honored to testify before you today. My remarks reflect my own views and not that of my employers nor the organizations I work with.

There is no doubt that the record-breaking availability of multiple safe and effective vaccines is an incredible scientific achievement. This would have not been possible without financial support from taxpayers, whose dollars fueled government agency research and Federal programs such as Operation Warp Speed.

The Moderna vaccine, which is one of two currently available in the United States, benefited fully from this public support for its development and manufacturing.

For several vaccine candidates, the American public has taken on the risk of creating these vaccines by not only paying up front for their development and production, but also, again, for their purchase.

Despite this, both manufacturers and the U.S. Government have left the American people in the dark on how their taxpayer dollars are being spent and whether access to these

vaccines will be guaranteed. As a first step, Congress must make transparent exactly how much the public is investing in the development, manufacturing, and purchasing of COVID-19 vaccines, as well as the agreements that clarify the spending terms.

Over the past year, Operation Warp Speed has repeatedly announced the allocation of billions of taxpayer dollars to individual vaccine manufacturers. Other government agencies, including the NIH, have also been granting funds and resources to these companies.

These are worthwhile and necessary investments, but no comprehensive database exists of these expenditures. Moreover, access to these spending agreements has been incredibly difficult, with only heavily redacted versions being available after several requests and lawsuits.

As a result, it is unclear who owns this publicly funded technology and whether the American people have any recourse should the companies face production delays, as you have seen repeatedly over the past months, or if they set excessive prices. Additionally, modified versions of these vaccines are now being developed to prevent against rapidly emerging highly transmissible variants, built on this publicly funded research.

Clarifying who owns a vaccine technology and data through transparency of these agreements would inform whether the U.S. Government is able to help boost supply of the future adapted vaccines.

One solution to ensure full transparency of both taxpayer spending and the conditions for the financing has been outlined by Congressman Doggett in the Taxpayer Research and Coronavirus Knowledge, or TRACK, Act. This bill would create a user-friendly public database of any agreements as well as all Federal funding across agencies for biomedical R&D related to COVID-19.

In addition to transparency of taxpayer funds and terms, Congress should require all agreements with companies to include protections for patients to ensure adequate supply and

access. These should apply not only to current vaccine candidates, but also to modified versions meant to address variants built on taxpayer-funded technology.

All licenses awarded by the U.S. Government for publicly funded COVID-19 technology must be made open and nonexclusive. In doing so, the U.S. Government would be able to license vital data and technology, especially during a pandemic, to multiple manufacturers to meet demand. Moreover, Congress and the administration could require companies to share their vaccine technology and data, to further boost supply and ensure access.

One comprehensive approach would be to couple section 1498 in full use of the Defense Production Act, as has been outlined by Senator Elizabeth Warren and Representative Katie Porter in their letter last month to the Biden administration. Finally, as has been narrowly included in a few contracts, Congress could also require reasonable pricing in exchange for procurement of doses.

Manufacturers have repeatedly stated that they have set a lower pandemic price for these vaccines. Still, they are anticipating significant profit margins this year and have confirmed that prices will be higher in the future. While the Federal Government has been able to secure modest discounts, future pricing of COVID-19 vaccines will likely be problematic for patients, as annual doses will be needed and pandemic pricing will no longer be available.

Lest we not learn from other vaccine markets, my research found that both public and private sector prices for the influenza vaccine rose over the past two decades, despite larger volumes distributed, multiple manufacturers, and several similar products being available. Such a pattern for COVID-19 vaccines of increasing prices would have significant implications on health spending, public health program budgets, and insurance premiums for those with private plans.

My patients often ask me when they might receive the vaccine, as our leaders have had to make tough decisions we have heard about to prioritize populations for the vaccine rollout due to limited supply. By safeguarding transparency and access, Congress would be ensuring a future our patients have already paid for, one of hope and being able to receive and afford this vaccine and no longer having to wait and be burdened by this devastating disease.

Thank you for your time, and I look forward to your questions.

[The statement of Dr. Ramachandran follows:]

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Chairman Doggett. And thank you.

And we will move on to questions, and let me begin with you. And I mentioned the TRACK Act, and pleased to have Senator Braun and bipartisan support for this measure. But what is it going forward, if the price of vaccines continue to go up, based on the flu experience, why is it important for the public to have information about the investment it has made and the agreements that have been reached?

Dr. Ramachandran. Thank you, Congressman, for your question, and it is a very critical question for us to answer now. The importance of us looking at the experience of the influenza vaccine and what has happened in terms of price increases has significant implications on the public health program budgets. As I mentioned, every dollar that we are spending on vaccines today and in the next few years in purchasing them are dollars that we won't be able to spend on other critical public health programs as well as the recovery from this pandemic.

In addition to that, the agreements actually outline whether or not the U.S. Government can lay claim rightfully to this publicly funded technology. And this has important implications now, as we are seeing scarcity as being a hindrance for a number of populations from being able to receive the vaccine, and also in the future when we need access to future adapted vaccines meant to address variants.

So I would hope that, you know, Congress would be able to step in and act on the behalf of the American people to claim ownership of this technology that we ultimately funded and derisked completely for companies.

If this pattern continues as we have seen with flu, likely what we will see is that patients, even through their insurance premiums, will see this cost being reflected, and government plans will also have to take on the burden of paying more and more for this

vaccine.

Some companies have even said they would charge $150 or $175 per dose this past week in the next few years, which is exorbitantly expensive and would be billions of dollars for the government, but also for patients to be shouldering ultimately.

Chairman Doggett. Of course, we don't have any information about how the prices were set, either by the Trump administration or the Biden administration. If there is some limitation on price, isn't that likely to reduce the possibility that we will have the vaccine that we so desperately need?

Dr. Ramachandran. That is a great question as well. We actually have seen in a couple of agreements that the government was successfully able to include reasonable pricing provisions. This was after a number of requests, FOIA requests, Freedom of Information Act requests, and lawsuits. And so that shows us that it is possible for companies to work with the U.S. Government around things like reasonable pricing.

The other part of this too is, you know, we need to have also reasonable pricing in place, given that the public has already subsidized, not just development but also production, building these manufacturing facilities and also advanced purchasing of these vaccines even before authorization.

So we really derisked the process from bench to bedside, and it is critically important for the government to act on the behalf of the American people to lay claim and make sure that the prices are reasonable.

Chairman Doggett. Thank you.

Dr. Avila Edwards, we know -- let me see if I -- yeah, okay, I think it is unmuted now. We know that some vaccines are now either approved or about to be approved that do not have the efficacy above 90 percent that we saw in the first two.

How do we overcome the perception, particularly in communities that have been

overlooked at getting access, especially the Latinx, African-American communities, that they are going to only get kind of the second rate of vaccine, that they are being discriminated against in the type of vaccine that they get? What is the best way to deal with that?

Dr. Avila Edwards. Thank you for that question. I think it is very important, very timely. What I like to focus on as a physician is that they are all effective. They are all keeping individuals out of the hospital and not having severe disease.

So I am encouraged, personally, by all of the approved vaccines that we have, because which vaccine is right is so individualized and there are so many multifactorial factors that go into determining whether one dose is better than two doses if you cannot schedule that second dose or you have transportation issues. So, again, the fact that they are all effective is what the message needs to be.

Chairman Doggett. Thank you very much.

And, Dr. Jha, you discussed the issue that I raised with the Vaccine Injury Compensation Modernization Act that I will be introducing in your written comments. Could you just comment briefly on the importance of having an effective and just vaccine injury program as a tool to address hesitancy?

Dr. Jha. Yes. Congressman, thank you for that question. And absolutely. You know, one of the successes of the vaccine programs that we have had over the last decade has been this vaccine injury program, which has compensated in a no-fault mechanism to people who have suffered injuries. It has been open, it has been transparent, but it needs to be modernized. It needs to be brought up to 2021 standards.

Currently, the COVID vaccines are actually covered through a different mechanism, which raises the bar and makes it more difficult for people to get compensation.

I really believe that, first of all, the COVID vaccines should be covered through the VICP, the Vaccine Injury Compensation Program, not the CICP, the Countermeasures Injury

Compensation Program.

But the legislation you have introduced, which would expand the number of masters who make the determination, make the program more accessible, easier, I think would go a long way to both compensating people who are injured, because even though these vaccines are extraordinarily safe, they are not 100 percent, because nothing in life is 100 percent. And the truth is that there will be people who will have some reactions or even injuries from these vaccines and they should be compensated.

But as you suggested in your question, that will also build confidence in the process and allow, I think, more people to feel confident about getting the vaccine. So I think those are very important steps forward.

RPTR ZAMORA

EDTR HUMKE

[3:18 p.m.]

Chairman Doggett. Thank you so much.

Mr. Nunes.

Mr. Nunes. There we go. Sorry about that.

Chairman Doggett. I wanted to be sure you were there.

Mr. Nunes. Yeah. Thank you, Mr. Chair.

My question is for Dr. Marsh. As I discussed in my opening statement, California is having a rough time of its initial vaccine distribution rollout. According to the CDC, California has used only about 60 percent of its allotted vaccine doses ranking in the bottom third of all 50 States.

While some areas in my State, such as San Francisco and Long Beach, have been able to vaccinate eligible residents Governor Newsom's distribution plan has left behind areas such as my district in the San Joaquin Valley. For a State that is home to Silicon Valley, it is depressing to see California leave behind citizens who are struggling to access and navigate the signup process.

Last week, several of my colleagues from California Republican delegation sent a letter to Governor Newsom demanding answers on how they are determining vaccine allocations to counties, healthcare providers, and pharmacies, as well as asking how many doses are awaiting distribution in the State of California.

Dr. Marsh, given the success of West Virginia's vaccine distribution process, what advice do you have for California to reverse this flawed vaccine rollout and get more Californians inoculated?

Dr. Marsh. Well, thank you, Congressman. You know, I would be hesitant to render any opinions about any State, and certainly California is a very complex State relative to West Virginia. But I do think that simplicity of intent is very important, so once you understand what the goal is, it is easier to achieve it.

I think that having a top-down versus meets bottoms-up approach to vaccine distribution is very important. We have been very intentional about controlling the flow of vaccine into the State. We have five hubs that bisects the State so that we can receive vaccine in a close distance to any site in the State that we decide to vaccinate.

We allocate just in time amounts of vaccine. We are very disciplined about the target group, the priority groups that we will allow people to vaccinate. But then we are very much in favor of every one of our locations, which are located in all 55 counties at federally qualified health centers, at hospital-based clinics, and at some pharmacies to be creative in the way that they deliver vaccines.

And we have had stories of people that drive to, you know, to a person's house who is not able to get out to vaccinate them, and these are really West Virginians taking care of each other. So I do think simplicity of purpose, management of vaccine, constant watching of making sure that no vaccine goes to waste and no vaccines are left on the shelf, I think those have been important parameters for us.

Mr. Nunes. Thank you. Dr. Marsh, and what is the -- where do you stand now with your vaccination goals? Are you where you expected to be? When do you expect to kind of meet your threshold?

Dr. Marsh. Well, thank you, Congressman Nunes. We very much want to finish our over 65-year-old population, and we believe with the additional vaccine doses that we are starting to receive that we can accomplish that in the next month. We then will pivot to our medically complex patients, and we will also start to look at some of our over 16-year-old

population who have particular problems like Down syndrome, who had solid organ transplantation, who have acquired or who have congenital problems or require caregivers, and we have other categories as well that we hope to rollout soon.

But our focus will continue to be to save lives, and we believe the faster that we can put at least one shot in the arm of our most vulnerable population the better we will do and the more that we will keep the viral variants from becoming a big issue in West Virginia.

Mr. Nunes. And the new Johnson & Johnson one-shot, if that does indeed get approved here, when do you think that that one will be on the market from what you are hearing?

Dr. Marsh. We hope that if this gets FDA approved and if the advisory committee for immunization practices gives their perspective then we should see vaccine next week, we believe. And if we get that vaccine, our hope is that we will use that on our same vulnerable population. As was mentioned, we believe that the protection against severe side effects, death, hospitalization is really the critical determinant of the allocation.

Mr. Nunes. That is great. Well, Dr. Marsh, thank you for coming in. I want to thank all the witnesses today.

And, Mr. Chairman, I will yield back.

Chairman Doggett. Thank you, Mr. Nunes.

Mr. Thompson.

Mr. Thompson. Thank you, Mr. Chairman, and thank you to our excellent panel of witnesses for being here today.

It sounds like we all agree that getting shots in arms is our number-one priority right now, and getting businesses back open and kids back in school and ending this unprecedented isolation, getting people vaccinated is the irreplaceable first step towards whatever normalcy is going to look like.

And so I would like to start my questions there. And I have a question for Dr. Jha. You raised a number of points I would like to ask you about, but I will start with the big-picture question. Right now you mentioned that roughly 19 million Americans are fully vaccinated. Do we have any sense or is there any consensus on how many Americans need to get fully vaccinated in order for us to start returning to pre-pandemic life? Is there a critical mass we need to reach, 300 hundred million people, 320 million? What should we know?

Dr. Jha. So, Congressman, fabulous and probably one of the hardest questions in the pandemic right now.

Mr. Thompson. You can do it.

Dr. Jha. So there is, what is the herd immunity threshold and there is some disagreement among scientists, but we think it is probably in the 75 to 85 percent range, which gets us into the 250 million-plus Americans. But we don't need to get to herd immunity just through vaccinations.

There are two things to remember: One is, probably about 85 million Americans have been infected with the disease. We only identify 28 million, probably another other 50, 55 million Americans have been infected and are not aware of it. So we already have quite a bit of population immunity.

The bottom line is, once we get above 50, 55 percent of Americans having population immunity, infection numbers will come way down, many things will start becoming quite safe to do, even if it is not fully back to herd immunity and life, kind of, a new normal.

So I see this as a glide path towards a new normal, and I really expect that by the time we get into the summer a lot of things that we value, a lot of gatherings will start becoming quite possible and safe, certainly among people who are vaccinated. There is a bit of a cyclical nature to this virus, so we are going to have to deal with the next fall and winter.

One of the reasons I think a lot of us worry about making sure that people have confidence in the vaccines is if we end up with only 60 or 70 percent of people vaccinated, we are going to have a really tough next winter, because the virus will come back. There is a seasonal component to it. And so one of the things that we have to focus on is also that long term. But I think you should see the economy really starting to do much, much better as early as this summer.

Mr. Thompson. Thank you. And then another question for you, Dr. Jha. I want to ask about a growing concern in California related to new strains of COVID that has emerged over the last couple of months. And by the end of this month or by the end of next month, experts predict that this strain will account for over 90 percent of the new cases in our State, and the initial signs are very troubling. It is more transmittable, more harmful to the body, and significantly less responsive to existing vaccines. Can you just let us know anything about the risk posed by these new strains and what we should be looking out for and what we should be worrying about?

Dr. Jha. Yes, absolutely, Congressman.

Mr. Thompson. Do we need to do something different because of these?

Dr. Jha. Well, so it is, first of all, worth understanding that new strains and new variants come about when you see large outbreaks. Large outbreaks basically give the virus a chance to have more mutations, and so basically we are pushing our luck every time we have large outbreaks because more variants will come up. And one of the reasons why many of us have been calling for trying to keep the virus levels as low as possible is that it gives the virus fewer opportunities to mutate.

Now, to your specific question around the California variant, we are learning still about it. There is new data about a potential new variant in New York. We are going to see things like this. So far, we have not seen any data that I am aware of that any of these

home-grown variants or even any of the international variants make our vaccines totally ineffective. They may make it a little bit less effective, but these vaccines are just really impressive and still going to hold up, I believe.

And the single biggest thing we can do to deal with these variants is suppress the virus and get lots and lots of people vaccinated quickly so that we stop giving the virus more and more chances to mutate. It mutates every time it infects new people. It has the opportunity to. And our best strategy here is vaccinate quickly, suppress the virus, and we get our lives back.

Mr. Thompson. Thank you very much. I yield back.

Chairman Doggett. Thank you.

Mr. Buchanan.

Mr. Buchanan. Thank you, Mr. Chairman.

I want to thank all of our witnesses today. Obviously, Sarasota, Florida, my region, we have 225,000 people 65 and older, so it is very critical we get the shots in the arms sooner than later.

I did want to mention one thing before I get into questioning. I toured one of our facilities, the public health facilities that they have used. They are administering 2,000 shots a day, very impressive because one thing I didn't realize, half of the workers or more were volunteers. So it is nice to see the community come together and I am sure a lot of other communities, everybody understands the significance of this.

Dr. Marsh, I wanted to ask you, you have had quite a bit of success. I know West Virginia is a smaller State compared to some of the other States. But one of the things I found in business over the years, and we had offices, 15 regional offices originally out of Michigan and California and everywhere, and I found that true in most of my business career.

I am a big, big believer in decentralization. We look at the Federal Government, and

there is certain things they can do, but it seems at the end of the day the success you have or other States have is going to be a lot in terms of the governor and the local leadership and people working together.

Not to say the Federal Government doesn't provide resources, the CDC, and other things, but I wanted to get your thought on that, because they can also give us best practices. Trying to manage 350 million people compared to individual States, to me, it is a big deal, and I think -- I applaud West Virginia for what you have done. What is your thoughts on it?

Dr. Marsh. Well, thank you, Congressman. You know, certainly, as I mentioned, our approach is a bit of a top-down meets bottoms-up, but I think a key success factor for us has been that we are very disciplined with the allocation of the vaccines to our hub sites and to those spoke sites that then focus on the targeted populations that we are committed in our priority scheme to approach.

But we absolutely want the sites that are administering the vaccinations to have that flexibility so that they can work within the scope of their own community, their own population so that they have lots of freedom and flexibility to be able to be creative.

And, in fact, what is really fun about that is we have gotten a lot of feedback, and we have continued to iterate our approaches at different hub-and-spoke sites based on the feedback that we are getting from some of those that then share with others.

Mr. Buchanan. Let me ask you, because at schools across the country is a big issue. You seem like -- pretty much at every level kids are back in school, minimal risk, I am sure there is some, but minimal risk in terms of in-person learning. I assume they are back in school 5 days a week from K to 12 and universities. Is that what is happening in West Virginia?

Dr. Marsh. Well, thank you, Congressman. So what we have done is looking at our own epidemiology data and working with Dr. Emily Oster from Brown University, we have

determined with our governor that pre-K through 8th grade will be in session for 5 days a week, and we are appropriately focused on the mitigation measures to protect people in the classroom.

But because of the difference in the national data around the spread in classrooms that pre-K through 8 has a substantially lesser transmission rate in class and classrooms than it does then in the communities, but high school has the same rates in the classrooms as the communities. We are then tethering the high school in-person attendance to the community rates, and we have seen those dramatically go down in West Virginia as well. And we do have higher education classes in all of our colleges going on, and, of course, we are tracking those carefully.

Mr. Buchanan. And one last question. How would you, in terms of additional funding that we are going to provide here probably shortly in the near future, how much of an impact will that have for you to get that additional funding to be able to get where you need to be and where you want to get quicker?

Dr. Marsh. I appreciate that, Congressman. I mean, certainly, you know, we have many people in our State that are suffering and additional funding will help them. But related to the pandemic response, you know, the further an accelerated production of vaccines are critical for us and then having the ability to continue to grow the infrastructure so that those vaccines come to bear, we will be able to quickly turn those into vaccinations, so thank you.

Chairman Doggett. Thank you very much.

Mr. Kind.

Mr. Kind. Well, thank you very much, Mr. Chairman.

And, listen, I want to thank our panelists for their excellent testimony here today.

But, Ms. Lewandowski, let me start with you and thank you again for your testimony

and your availability. But I noticed you didn't toot your own horn in your opening statement, but after the initial stumble out of the block in Wisconsin, I think we now rank in the top five of States when it comes to getting doses in arms once we receive those doses. So I just want to thank you and the Wisconsin immunization network for all the hard work you have done to turn that around and the success rate that we have seen.

But let me ask you, given your work in the vaccine residency area, that while the numbers are going in the right direction, meaning down, we still -- Mr. Chairman, I don't think someone is muted. Can we unmute?

Mr. Kildee. I think it is the chairman.

Mr. Kind. Mr. Chairman? Thank you.

Chairman Doggett. Thank you very much. Let's see, Mr. Adrian Smith.

Mr. Kind. Mr. Chairman, you are not muted.

Chairman Doggett. Okay. Thank you.

Mr. Kind. Okay. Thank you. Ann, back to you [inaudible] of the residency. While the numbers nationally seem to be getting better, we still have a challenge in rural America. Why is that, and do you have a one or two top recommendations of what we can do to have that trust and confidence in rural America too?

Ms. Lewandowski. Yes. So as I mentioned in my testimony, these are complex issues. Rural America is diversifying. There are Hispanic populations that we need to be able to reach with accurate and culturally sensitive messaging, but we also need to understand that many of our rural communities have felt left behind. And this COVID-19 has been yet another opportunity for us to leave them and sort of ignore their needs.

And so we need to make sure that they know that we see them, we hear them, we invest in them. If we are demanding that rural communities need to go online to receive a vaccine appointment that they have access to the broadband. As my esteemed colleagues

mentioned, there is not health infrastructure in the rural communities, so we need to be bringing vaccines to them.

In our experience in the data that we see in rural Wisconsin, the farther you are from a vaccine access point the less likely you are to be vaccinated. And so if we can start to bridge that gap with mobile vaccine clinics hosted with community -- a trusted community messengers who are able to go in and say, this is something I am doing, I have done it, it is okay, these are strategies that we can use to make sure that even our rural communities have confidence in this vaccine.

Mr. Kind. Yeah. And with that, Mr. Chairman, Dr. Wenstrup and I had just sent a letter to the administration's COVID task force telling them that if they are going to be stepping up this Federal information campaign, let's not forget about the rural areas, let's make sure we are investing that information in rural media markets, trying to get local rural validators involved too where there is greater trust.

So I would ask unanimous consent to have that letter inserted in the record at this time, Mr. Chairman.

And, Ms. Lewandowski --

Chairman Doggett. So ordered.

[The information follows:]

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

Mr. Kind. -- I feel as if, maybe I might be wrong, but we are underutilizing primary care physicians as far as patients going to them for information, for signing up for vaccination, knowing where to go, and then getting that information included in the electronic medical records, which I think is another glaring gap that is developing here. Are we using primary care physicians enough given that roughly 75 percent of the population has a primary care assigned to them right now?

Ms. Lewandowski. So I think that is a very complex question. I think it is an excellent one. I would point out that in Wisconsin we have a very wonderful Wisconsin immunization registry, and so this registry is required to be used by any immunizer, and so as they immunize that will go into the registry. Occasionally there are challenges with interoperability with medical records, but all providers who are providing vaccine should have access to that registry.

And I think right now the issue is vaccine supply, and so primary care models are not receiving as much supply as they could, and so we are underutilizing all of our providers. As I mentioned, we had a request for over 400,000 vaccines this week, and we only have 120,000 coming in our Federal allocation.

Mr. Kind. Great. Well, thank you.

Mr. Chairman, I yield back. Thank you.

Chairman Doggett. Thank you, Mr. Kind.

Mr. Adrian Smith.

Mr. Smith of Nebraska. Thank you, Mr. Chairman. Thank you to all of our witnesses here today. Your perspectives and expertise I certainly appreciate, and obviously this is a very timely discussion.

It is hard to imagine how far we actually have come, and I think it is just amazing that

after only 1 year not only are we on the cusp of three vaccines having been approved to fight the pandemic but we have already administered over 66 million doses and counting, obviously.

I appreciate what the previous administration, the Trump administration did, and even so incredibly amazed at the private sector and the incredible talent and innovation of the vaccine -- American vaccine manufacturers that, you know, here we are with an opportunity to start thinking post pandemic. I don't want to rush out there too far, but I am glad that we are making progress.

So as vaccines are being rolled out across the country to ensure that those on the front lines are protected and certainly those with the highest risk of COVID complications, that they are also protected. So I am glad, again, that we are making progress.

One of the most impactful, I think, measures for our economic recovery, and more than just economics too, but the recovery for our country is the reopening of schools for traditional in-person learning. I am glad to say that the schools of my own congressional district in Nebraska have been excellent examples here. Many of them are already operating fully in person, and I have to say that that is done for the great benefit of the students themselves.

So we have known for months now that depriving students of in-person instruction actually puts them at a very serious disadvantage for both learning and I think what many will consider necessary socialization.

A recent assessment of online versus in-person learning by middle and high school students at a large school district in Nebraska found that the percentage of online-only students are failing two or more classes to be over three times higher than those physically in the classroom.

The CDC has made it very clear that in-person learning can be undertaken with

risking increases in COVID transmission -- without risking increases in transmission so long as certain basic precautions are taken.

I think it is important to note that there is even $64 billion in unspent, already appropriated funding for K-12 schools, which is currently waiting to be used in safely reopening schools. And actually that $64 billion does not even include the efforts currently underway, as I speak, to add to the spending. Yet, many school districts, especially in very urban areas, are still absolutely opposed to bringing their students back into the classroom.

Now, Dr. Marsh, like Nebraska, West Virginia has seen a significant number of schools returning to either hybrid or fully traditional in-person instruction. Do you think it is possible to safely reopen schools before widespread vaccination has actually been completed?

Dr. Marsh. Well, thank you, Congressman. Certainly, looking at our own epidemiology data, we saw very little spread in classrooms. Where we saw spread was people coming from the community. We did see some spread on sports teams. The only spread between students and adults were in special-education classes where students weren't wearing masks or in music classes where people were singing or playing a wood or a brass instrument.

So we believe that the schools are safe. Again, we are working with Dr. Emily Oster, looking at the North Carolina data showing really no spread between students and teachers during the last school year in 2020. So we have offered our teachers over 50 years old and school personnel service workers vaccination as an extra precaution, because, again, our epidemiology data suggested that 97 percent of our deaths in West Virginia are in people over 50 years old. But we did not think vaccination was required to bring the students back to class.

Mr. Smith of Nebraska. Would you have any advice that you would offer schools, maybe two or three top priorities, that you might recommend given your perspective?

Dr. Marsh. Well, certainly, you know, in looking at the epidemiology data in the schools, make sure the schools are undergoing good mitigation practices as outlined by CDC and others. And then I think that, you know, working and making sure that you are tracking the schools very closely to make sure if there are any outbreaks that you are immediately investigating them so the people do feel safe there.

But otherwise, we know the benefit for the students is significant. And we know, from a long-term perspective, if you have students that don't finish college, particularly in rural States like West Virginia, they have a susceptibility to lower life expectancies and earlier deaths and much more problems with addiction-related problems.

Mr. Smith of Nebraska. All right. Well, thank you very much. I do appreciate your expertise and insight.

And I yield back the balance of my time.

Chairman Doggett. Thank you.

Mr. Blumenauer.

Mr. Blumenauer. Thank you, Mr. Chairman. And I appreciate you assembling for the committee the range of expertise here to help us do a deeper dive on the aspects of vaccination, the various approaches that have been taken. It is informative and it is something that I think we all want to do our best to understand how to take advantage of the opportunity in the vaccine development.

I must say, I have been no fan of the previous administration and being asleep at the switch and losing .5 million people, wildly disproportionate to any other country in the world, especially one that is as rich and powerful as the United States. But we have had remarkable success, I think, with the development of the vaccines, and I give them credit for that. I am sorry there is no good coordinated plan in terms of how we get them into the arms, but you are all working to be able to fill that gap.

Mr. Chairman, I guess the one question that I would pose to our panelists deals with the success of these, now it looks like, three vaccinations going forward and the difference that we face. With the Johnson & Johnson it is a different -- it has different characteristics, different timeframe.

And I am wondering if we have any suggestions from you about, if we are going to have three vaccines available with these different characteristics, how do we communicate to the general public so that it doesn't raise more questions? We have already seen some examples of really weird behavior of people trying to intervene and stop vaccinations. Some people are a little leery. I am hearing this at home from people that I don't think should be quite this apprehensive.

And now with three choices and the different characteristics, I would really value your advice and counsel about how you would suggest we approach communicating this with the general public.

And I would ask any of the panelists to talk brief responses. I would like to hear from several of you, if time permits.

Somebody jump in.

Dr. Benjamin. Hi, Congressman. Thank you. This is Dr. Benjamin. You know, for many people, assuming the J&J product gets approved, as we believe it will, you know, taking one shot is quite convenient. And I think we have got three products. They have different attributes, but people make decisions about multiple products all the time.

And I just think we have to tell people that, first of all, take what is available to you because getting vaccinated now is more important than waiting to what might be available in the future. And, again, for many people, particularly people in inner cities and communities where, you know, taking off work is a challenge, getting that one shot with an effective vaccine that is going to certainly protect them from getting very sick or dying should be a

high priority, and I think we can share that with them. And the fact that now the Pfizer product has been approved for an easier storage in refrigerators I think will make that product even more available to communities.

Mr. Blumenauer. Great. Thank you.

Other thoughts about how we communicate this, Dr. Jha?

Dr. Jha. Yes. So let me just very quickly say, to me they really are three superb vaccines. And I personally -- and I have been communicating this to the public, I have been very clear that I would take any three of them. I have already gotten mine so I am not going to get another one, but certainly with my family I have been very clear that people should get whichever is available.

And people like to focus on that headline number of lower efficacy maybe for the J&J, and I remind them that the J&J vaccine was tested in a different population. It was tested in South Africa and Brazil; Moderna and Pfizer vaccines were not. And they were tested with the new variants and did superbly well, and there were no people who got hospitalized or died from the variants with the J&J vaccine.

So, boy, I would be hard pressed to know which one I would pick if I had a choice de novo, and what I tell people is, if you can get a vaccine that is authorized by the FDA, get it.

Mr. Blumenauer. Ms. Lewandowski, do you have any thoughts on this?

Ms. Lewandowski. I would simply echo my colleagues that one vaccine is fantastic. It is easier to get. Highlighting that it was tried against the variants, something that the other vaccines were not, so we actually know those numbers, and particularly the numbers that no one was severely ill or died are critical pieces of information. But I think the top-line message needs to be, get whatever vaccine is available to you in your community that it fits your life, fits your schedule. Some people can't come back.

Mr. Blumenauer. Great. Good advice. Thank you very much.

Chairman Doggett. Thank you very much.

Mr. Chairman, thank you.

Chairman Doggett. Mr. Reed?

All right. How about Mr. Kelly?

Okay. Then I believe Jason Smith.

Mr. Smith of Missouri. Thank you, Mr. Chairman.

Chairman Doggett. Thank you. Please proceed.

Mr. Smith of Missouri. Thank you.

It has been a long and difficult year for many Americans, but the worst is behind us. Because of President Trump and the brilliance of Operation Warp Speed, we are on a path towards herd immunity less than 1 year after the beginning of a once-in-a generation pandemic. 13.9 percent of Americans have already received their first dose of the vaccine. Over 64 million doses have been administered thus far. It is a truly remarkable achievement.

The Biden administration inherited a robust vaccine program from President Trump and what we see happening today would not be possible without the contracts he negotiated.

Dr. Jha, I found your testimony that President Trump failed to make adequate investment and distribution infrastructure or to support States' efforts to do so in June once we saw promising data on the Pfizer and Moderna vaccine to be disingenuous.

I am sure you are aware that this vaccine was developed in record time and the average vaccine takes 5 to 10 years to develop. I am sure you are also aware that President Biden was expressing concern with any promising vaccine under development as recently as September, significantly undermining public trust. I hope this helps you to understand the irony of your criticism.

In terms of opening the economy, I am extremely frustrated by the current administration's pessimistic and often contradictory approach. Dr. Fauci's messaging

especially has been downright damaging. He has said continued public health measures for vaccinated individuals would only be necessary if the vaccine was on the low end of effectiveness.

The vaccines currently available are over 90 percent effective. More importantly, they are nearly 100 percent effective at preventing hospitalizations and death. Yet, Dr. Fauci still discourages those who are vaccinated from visiting restaurants or seeing family.

For comparison, the swine flu vaccine developed under the Obama administration was estimated to just over 50 percent effective. The effectiveness of the COVID vaccine combined with data from Israel showing that if you are vaccinated you are not spreading the virus raises the question, why does the Biden administration continue to tell us we will not return to any semblance of normalcy until 2022?

The answer is clear. This is all political. The public health emergency provides Democrats with an excuse to push a serious and progressive wish list on the American people.

The administration knows it is safe to reopen the schools, yet they are beholden to the teachers' unions. They know that it is safe for a vaccinated individual to eat at an indoor restaurant or visit family, yet this undermines their narrative of their control.

A lot of the folks I represent back home in Missouri are already hesitant to get the vaccine, and if we continue to tell them it is not the key to return to normalcy, what incentive do they have? Thirty-one percent of Americans are waiting to see if the vaccine is working before taking it. Another 13 percent have definitely said they will not get it. Without public trust or the desire to get vaccinated, we will never reach herd immunity. It is essential that fear mongering and pessimistic messaging ends.

The United Kingdom has announced all coronavirus restrictions will be lifted by June of this year. A study by Columbia University found that we could reach herd immunity by

May of this year. In my opinion, the current timeline to reopen the economy that this administration is operating under is not ambitious enough.

Dr. Marsh, can you please comment on the data coming out of Israel showing the vaccine is, in fact, preventing virus spread?

Dr. Marsh. Thank you, Congressman. Yes, there is, I think, evolving data to suggest that people that do get vaccinated with the -- mostly with the Pfizer vaccine in Israel but that the fully vaccinated folks have very little problem with persistent infection or infectivity.

I do understand that, you know, this is an evolving set of issues, and as I said before, you know, that we are constantly learning, and -- but I think that the data does support what you are saying about that there is less concern today from the data that at least I am aware of that people might be able to express virus after full vaccination.

Chairman Doggett. Thank you. Your time is expired.

Ms. Sewell. And, Ms. Sewell, if your time permits, perhaps you can permit Dr. Jha an opportunity to respond.

Ms. Sewell. Thank you, Mr. Chairman.

I want to start by thanking you and the Health Subcommittee staff for putting together today's event. This has been really, really informative, and I want to thank the witnesses for being here as well.

I can think of no bigger challenge for us as a Health Subcommittee than to help to figure out a way that we can make policies to reverse the trends that have made communities like I represent the most at-risk for chronic illness as well as COVID morbidity to make sure that they are addressed and we beat this pandemic, crush this virus, and get the economy back to what we -- to normal as well as to make sure that our kids can go back to school and that we can all be productive.

I couldn't -- you know, when I thought about COVID-19 pandemic and the vaccination challenges that we are facing right now, I think often of one particular constituent of mine, Pamela Rush, who died of COVID-19 last year. She suffered from diabetes and heart disease along with a myriad of other chronic conditions. She lived in a county with no hospital, a rural county in my district, and she only had -- that county only had one primary care physician.

Nearly every single indicator of poverty in America found its home in Pamela Rush. What keeps me up at night is the knowledge that for nearly every one of her issues, political will has stood in the way for us to find solutions, bipartisan solutions that could have saved her life. Both being Black and being in a rural area are more likely than White and urban counterparts to die from COVID-19.

Since the start of COVID-19, as of yesterday, in my home State of Alabama, 9,831 Alabamians have died. And according to the recent data, approximately 50 percent of the cases account for 14 -- for the 14 counties that I represent. That means that we have a lot of challenges, sir.

And, Mr. Chairman, I would ask unanimous consent to enter into the record this Bloomberg article from February 25 entitled, "A Black Neighborhood in Alabama Has Yet to Get a Single Vaccine Dose."

Chairman Doggett. Thank you. Without objection, it is so ordered.

[The information follows:]

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Ms. Sewell. Alabama ranks second to last in the percentage of people receiving at least one COVID vaccine. We can and we must do better. This includes focusing our attention on the systemic inequities in our healthcare system that have only been made worse by the COVID-19 pandemic.

As our Nation continues efforts to combat COVID-19, it is imperative that we focus on ways to bolster the effective and equitable distribution of the rollout. It was really very important for us to have this hearing today to hear from our experts.

I would like to ask a question to Dr. Benjamin, the executive director of the American Public Health Association. Dr. Benjamin, we know that the hardest hit populations remain -- are in underserved and unaccounted for areas that are mostly communities of color.

According to the Alabama Public Health Department, as released in their weekly report, Black people in my State account for 17 percent of the received vaccinations even though we make up 27 percent of the State population, while White counterparts in our State, 80 percent of them receive vaccinations and they make up 68 percent of the population.

So, Dr. Benjamin, your organization has identified the critical role communication plays in urging vaccination adoption across different population groups. Can you talk to me about how technology can be used and trusted community leaders can be used in order to spread the word and to get legitimate concerns about vaccination hesitation in communities of color. Alabama, given the Tuskegee experiment, there is a large fear of that in my particular State and in my particular district.

But how can we use technology solutions like survey platforms and text-based post surveys and other things to help us with this challenge, acknowledging that we also have a challenge in most of these areas infrastructure wise with broadband? I do want to understand how we can get not only the use of technology but the use of more broadband as a solution to

part of the problem.

Dr. Benjamin. Well, let me just say that it is very important for Congress to support our Nation dealing with these broadband deserts. That is an absolute clue that we have to do and not just for health but for education.

As you know, the Ad Council just rolled out just the other day a new ad campaign, called "It Is Up to You." We have been a part of that campaign, and at least the first initiative part is focused on communities of color. And we went out and we talked to people in communities of color and we are using people who are culturally competent.

We have ads, we have social media text, we are using really both an air game and a ground game to reach those communities.

I think the most important part of that campaign is using people that people trust. Now, nobody knows me, but if I can influence people that are in the community, leaders of faith -- so we have got several leaders of faith in those communities that we are trying to give the information to so that they can, you know, basically preach from the pulpit.

And, of course, many of them are doing it just as we are doing now on Zoom, through remote education. And so getting our leaders of faith to do that is going to be very important, getting sports figures, et cetera.

Ms. Sewell. Absolutely. I know that my time is cut short, Mr. Chairman.

I just want to say for the record that I think that it is critically important that a lot of the strategies that we are talking about today get implemented across the Nation. I think a national strategy on dealing with inequities with the vaccination is something that is critically important not only for communities of color but for rural communities as well.

Access is a problem, Mr. Chairman, and we have to do better in making sure that we provide funding for mobile units, that we provide funding for broadband, that we actually encourage these mass testing sites and the use of Federal efforts like in other States -- in some

States with using National Guardsmen to help to roll this out. We can't do enough to make sure that we have an equitable distribution of this vaccine in order to curb and crush this virus.

Thank you, all.

Chairman Doggett. That is certainly right.

Mr. Schweikert.

Mr. Schweikert. Thank you, Mr. Chairman. And, actually, in an odd way, some of my questions are actually going to dovetail to Ms. Sewell.

First off, one of the little side math projects we were trying to do in our office is understand the populations that we are being told are under receiving the vaccination at the same time looking for some data on populations that are vaccine skeptical. If I was to turn to the panel and say where can we go to find quality, not a document talking about who we want to communicate to or are culturally credible communicators, but first some data facts?

The reality of it is, Arizona may be the most urbanized State in the country. My congressional district is urban/suburban, so I don't particularly know the facts of dealing with States that have lots of rural communities. But I am looking at our numbers, and our numbers look substantially different than other States. Is that because we are in an urban/suburban environment?

So first question to the panel, if I came to you right now and said, I just need the best factual data on populations that are first vaccine skeptical, where would I go? Anyone want to step up and take a shot at that?

Ms. Lewandowski. Sure. Representative, I would recommend that you visit the Kaiser Family Foundation. They have been extremely good at --

Mr. Schweikert. And can I interrupt you, I am going to ask you to speak up as loudly as you can.

Ms. Lewandowski. I am so sorry. Congressman, I would recommend that you visit the Kaiser Family Foundation. They have been instrumental in providing very good --

Mr. Schweikert. Yeah, believe it or not, that binder is sitting right here on the side of me.

Ms. Lewandowski. Yes, so I would use them. They present it very wonderfully. It has tables and as much data as you would like to find.

Mr. Schweikert. And my reason for a little bit of focus on this, Mr. Chairman, is in one hand we will take a shot at a State, Texas, Arizona, wherever it is, and say, well, not enough of my Hispanic population is receiving the vaccine, but then you need to look here how much of that same population I have -- may have a cultural barrier or a skepticism barrier that also is an additional barrier to getting that person into getting that stick in their arm and understanding that some of these numbers have other levels of complication that we need to deal with.

Also, Mr. Chairman, with your permission, I would like to actually submit a couple of articles to the record.

Chairman Doggett. Thank you. Yes.

Mr. Schweikert. An article from Florida in regards to the distribution model, reaching out and working with ride sharing to get those that have some transportation issues as a community good.

In Arizona, we are actually using a -- privately funded with the Salvation Army acting as the coordinators with Uber using their Social Good Fund to actually get those who have some transportation issues to actually some of the massive vaccination sites. And my understanding is the same project is being done with Lyft in Florida.

But I want us to sort of think a little bit more broadly than our typical sometimes partisan talking points, that there are some of these creative ideas out there on, how do you

reach out to the population? Do you immediately say this has something to do with them being discriminated against? Are we dealing with more cultural sensitivity issues of comfort, and can we do a better job in understanding that? And is it -- Ann, help me pronounce your last name.

Ms. Lewandowski. Lewandowski --

Mr. Schweikert. But you spoke to it on how we must communicate to diverse populations and when we are getting there, and then can we use technology, as Ms. Sewell and some of the others spoke about, community ride sharing, some of the other ways you get populations that may not as mobile?

So I will get those articles submitted to the record, and with that, I yield back, Mr. Chairman.

Chairman Doggett. Thank you for your articles. That will be included in our record.

[The information follows:]

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Chairman Doggett. And, let's see, Mr. Evans.

Can you unmute there? There you go.

Mr. Evans. Can you hear me?

Chairman Doggett. Yes, sir. Go ahead.

Mr. Evans. Mr. Chairman, thank you.

Mr. Chairman, I would like to ask the question to the Dr. Benjamin. Dr. Benjamin, as many as 20 million people lack access to the internet. And in my home city of Philadelphia, only 71 percent of residents had internet access in 2017.

An article in the March issue of American General Public Health, which your organization published, points to the need for bidirectional communications in which government health providers and others use feedback from communications to better target their communication.

Clearly, different populations need different communication channels to be reached, different messengers and different messengers whom they trust to understand and care about that. What technology solutions have you found most useful in the effort to address equity challenges?

Dr. Benjamin. Well, you know, there are several solutions. There is a thing called Text for Baby that was used to try to get mothers to get good, early prenatal care. That was a system that was used many years ago. It has also been used to try to help people to get access to foods.

But at the end of the day, you are going to have to communicate with them and then you are going to actually have to take the vaccines into the communities to get people vaccinated, and also using community health workers that are actually going in door to door banging on doors to talk to communities.

Because, as you know, even though people may know those communities are underserved, unless you actually go in the community with people that know the community and can reach those folks, you are not going to get them to come out and vaccinate.

Mr. Evans. Do you have any examples throughout the Nation you can point to specifically related to communities of color?

Dr. Benjamin. There is a program that is being done out of the Tulane University by the dean of the school of public health at Tulane University that is working with barbers and beauticians and actually have people going into the community banging on doors, talking to people, that is one program.

The second one is the Cure Violence Program in Los Angeles, which is a program that does violence interruption, but they have pivoted to getting their folks in the community actually going and talking with people door to door to engage them.

Some of them are using text-based solutions as well as part of their interventions, but most of them quite frankly are doing one-on-one interventions and talking to communities and getting in those communities just because not having access to technology is a really big problem.

Mr. Evans. You know, I don't know if you are familiar with in Philadelphia we have the Black Doctors Consortium, a group of doctors have gotten together and given the vaccines. As a matter of fact, they did one day --

Dr. Benjamin. Yes.

Mr. Evans. -- around the block and were extremely successful. Their numbers were greater than the city's numbers.

Dr. Benjamin. Four thousand.

Mr. Evans. Yes, exactly. You are familiar. Yes, they did that. So, I mean, if you have got that kind of milage, I mean, obviously that is something we should use every and

anywhere, you know. It works. I thank you for your comment.

I thank you, Mr. Chairman. I yield back.

Chairman Doggett. Thank you very much.

Ms. Chu.

Ms. Chu. Oh, okay.

Chairman Doggett. Sorry to skip over to you.

Ms. Chu. Yeah, thank you.

Well, Dr. Jha, I have heard from the Pasadena Public Health Department in my California district, which is very eager to administer the vaccine, they indicate that they are able to administer at least four times the amount of vaccines per week than the supply they are allocated, and even more if there were vaccines that were provided to local providers and employers and additional pharmacies.

I have heard similar stories from cities large and small in my district who are clamoring for more vaccine. But one issue that came up over and over again was a lack of reliable data, especially during the initial vaccination rollout.

The Pasadena Health Department has to track who is getting vaccinated and the progress being made in the community, but individual providers did not report data to them accurately or completely leaving out information on when the vaccine was administered and the race and the address of the vaccine recipient.

Providers were also inconsistent in reporting their inventory on hand, and many did not provide a uniform system to individuals that were seeking the vaccine. And that wasn't -- this kind of problem wasn't specific to individual providers as contractor corporations like CVS and Walgreens also did not perform well either with communication or data tracking.

So, Dr. Jha, can you discuss the data challenges we have seen in this vaccine rollout

and how Congress and Federal partners can help improve on this data collection, and would the continued lack of reliable or incomplete data hamper our vaccination effort?

Dr. Jha. Yes. So, Congresswoman, thank you for that question, and it really gets to the heart of this whole pandemic response. I will come to vaccines in a second. But this is not a vaccine-only problem.

The lack of reliable public health data has been a major reason why we have been consistently slow to respond to changes in the pandemic, why it took us months to figure out that it was disproportionately impacting communities of color. We have really had a hard time tracking infections and hospitalizations, and a lot of that has come about because private sources have come in and pulled together data.

So we have a much broader problem in our country in the way that we have invested in public health data infrastructure. You know, the High Tech Act from about a decade ago did quite a good job of getting money out to doctors and hospitals, but we have not put in similar kinds of resources into public health agencies, and we are unfortunately bearing the cost of that. And so that is the bottom -- that is sort of the big-picture overview.

Now, when you come to your question around vaccines, this shows up pretty consistently day-to-day. Providers who are providing the vaccine don't always report that data as reliably as they are supposed to. The key pieces of information like which vaccine was it, when was the person supposed to come back, that information isn't always conveyed.

So, you know, we have obviously got to find our way through it with this vaccination campaign, because it is critically important that we get those things right. But as we emerge from this pandemic, we absolutely have to go back and say, can we bring our data systems up to the 21st century.

Because we just -- this is no way to fight a pandemic where you are consistently blind, lacking information about almost every part of this pandemic. So this is a longstanding

problem that we are unfortunately bearing the fruits of.

RPTR BRYANT

EDTR ZAMORA

[4:16 p.m.]

Ms. Chu. Dr. Benjamin, recently we had a meeting with the city managers of my district, and they said that while they are all very supportive of the massive vaccination sites that are being supported by the State and Federal Government, such as Dodger Stadium and Cal State University, Los Angeles, there are significant concerns with how to vaccinate the population of nonmobile seniors.

In Los Angeles, if you don't have a car, public transit isn't always a realistic option. And many of these seniors are in assisted living facilities or other congregate care settings where they can't leave the facility once, let alone twice, to get the vaccine.

So my cities said that they do have the ability to set up community-based vaccination sites that would help reach this population if the vaccine supply increased sufficiently to make such a thing possible.

So, Dr. Benjamin, can you discuss the benefits of incorporating community-based vaccination centers, such as community health centers, local governments, corporate partners like CVS, in reaching these vulnerable populations, and what are the most effective ones?

Dr. Benjamin. Thank you very much, Congresswoman. You know, so they are absolutely effective. One of the things I know CVS is doing, because I talked to them just the other day about this, is that, first of all, they are reaching out to their established customers and contacting them. And as vaccine becomes available, they are going to reach out and get those folks in to get vaccinated.

Second thing is they are doing pop-up clinics in inner cities, because, as you know, many of these sites are not necessarily in the -- that actually have the vaccine may not be

close to those communities, even though there is a pharmacy in those communities.

Just this past Sunday, I had a chance to volunteer with my health department, and we went into the east side of the county, Montgomery County, Maryland, outside Washington, D.C., and I got a chance to vaccinate people in a community which is about 80 percent African American and has the fourth largest prevalence of folks of color. And we were vaccinating people 75 years of age and older. In fact, I got to vaccinate a gentleman who was 100 years old.

So I think by moving into that community, we were trying to demonstrate that you have got to take the shot to the people versus bringing the people to the shot. Obviously, if you are in a congregate setting where you can't go out, you need to take it into that center, just like we did long-term care facilities.

Chairman Doggett. Thank you very much.

Dr. Wenstrup?

Mr. Wenstrup. Well, thank you, Mr. Chairman. Thank you all for being with us today, I appreciate it.

You know, as one of the physicians in Congress, we were pretty well kept up to speed with what was going on with Operation Warp Speed and really having a chance to have oversight to make sure that it was being done correctly.

I always want to take a moment to thank all those Americans that got into these trials for this vaccine, because they are really the heroes for us, because somebody had to trust that this was something that they should do. And I think we fail to mention that a lot of times. And this was quite a tremendous American project that really came to fruition when you think that our previous fastest vaccine took 4 years.

And one thing I want to recognize, we talk about it, look, the logistics of this thing is tremendous. And I think it was wise to bring in the Department of Defense, who is very

good at logistics and getting things anywhere in the world in some of the best ways that we can.

But I think what was also unique about this, that when a drug got to Phase III, we were producing 100 million doses. That has never happened before, that I am aware of. And so we are sitting here and we are complaining about supply chain. And we do want more vaccines out there, and I also appreciate what is being said about they are all effective. I think that is an important point to be making to the American people.

But we are really so far ahead of the game than what has ever been done before. And take a moment to celebrate that, even though we have troubles. And, you know, rolling something like this out is very challenging. Just look at the rollout of the Affordable Care Act, which had 2 years to prepare.

So there are many challenges. And what I like is that we are talking about solutions to those challenges that we maybe didn't anticipate, or just think of the size of this country and how difficult it is.

And so I don't really want to spend time like some have, you know, being critical. A lot of people made mistakes along the way. That is not surprising. Even the scientists said, well, we think it will go away this summer, like other viruses do. But it didn't, okay?

So let's try to get away from the things that are bringing out fear and let's deal with what is real. And that goes whether it is the schools reopening or as we are rolling this out.

In my district, I did have the opportunity to visit a new manufacturing plant that are making the coolers. Now, this looks just like a cooler you would take to the beach, but it can go to minus 100 degrees Celsius. That is unbelievable and a very amazing thing, but this is all part of the supply chain problem. And so the point is to, you know, get these out, get it out as best we can, as fast as we can and do it right. But I know it is frustrating, but let's keep working on it.

We have heard a lot of solutions. We have heard from West Virginia, where things work. You know, I still serve in the Army Reserve, but I went out with our National Guard to do drive-up testing, and I am going to go out with the National Guard to do drive-up vaccinations as well.

And in one of my rural counties, they used their fairgrounds and volunteers. Nurses, doctors from that community are out there putting shots in arms, driving through the barn at the fairgrounds. It is working, and it is the community that is doing it.

And so it seems pretty clear that we have a problem with supply, because what I have seen is, as soon as they get it, they are getting it out. And I appreciate some of the challenges that Dr. Benjamin talked about and Mr. Evans talked about, you know, getting into the communities. I will be glad when we have this very much great supply at our Federally Qualified Health Centers. I think that is going to be important.

But one of the things that was supposed to happen is, going back to November 1, States were supposed to have a plan for distribution and personnel in place as best they could, and obviously, that didn't happen the way it should. And that was before the vaccine came out. So the best intentions were there.

But I want to ask Dr. Marsh, since they did so well in West Virginia, would you say on November 1, was West Virginia ready to go or did you develop these best practices as you went?

Dr. Marsh. Well, thank you, Dr. Wenstrup. I really resonate with your comments. This is the most complex operation we have ever done in our country, in my opinion, and so we are all learning as we go.

Certainly, I think that your comments are absolutely right on. The fact we have really effective vaccines is fantastic and really unprecedented. But I do think that as we go forward, the one opportunity that we have is to share more with each other.

I do think that we have not shared enough between States, and even though we are all different, there are similarities. I think that expertise in logistics and supply chain become really critical for our future.

Mr. Wenstrup. Thank you.

Chairman Doggett. Thank you very much.

Mr. Schneider.

Mr. Schneider. Thank you, Mr. Chairman. I want to thank you for holding this critically important meeting today. And I want to thank our witnesses for sharing your perspective with us, your insights, in what I know has been a long meeting.

Every one of us, every member on this committee has received just an incredible deluge of outreach from our constituents. Everyone asks, when and where can we get our vaccine? Their messages are often a mixture of hope, fear, and anger over the current state of the vaccine rollout in our country.

Now, it is true the previous administration prioritized vaccine development, but I also think it is fair to say that they completely failed to put into place sufficient planning to ensure those shots got into people's arms efficiently and equitably. As was just noted, this is an incredibly complex operation, in part because of its scale -- the entire country -- and in part because of the timing. It has to be done as quickly as possible. But a vaccine is only as good as its supply and the distribution chains allow it to be.

The Biden administration has worked diligently to rectify what was left behind by the previous administration, including increasing supply by 70 percent, deploying thousands of vaccinators and support staff across the country, including today announcing that we will have a mass vaccination site in Chicago and other places, and dramatically increasing the number of vaccination sites across the country. However, too many Americans are still facing hurdles in getting their needed vaccines.

Now, I have come to think about this problem concisely in what I call the four Ps:

Product, making sure we have enough vaccine to vaccinate the entire country. With the addition of the Johnson & Johnson, we are making good progress towards that.

Prioritization, making sure we are getting it to the people who need it the most urgently and getting to everyone as quickly as possible.

Place, and as someone else said earlier, the closer people are to where they can get vaccinated, the more likely they are to be vaccinated. We have got to get it to more places.

And finally, process, the ability to get an appointment, to know where to go, when to be there, and know you are going to get your shot and, if necessary, a second shot.

We are struggling with all of these issues, but I think more than anything else, we are struggling with that process issue. People are really frustrated in their inability to know where to be, when to be there.

So if I can, Ms. Lewandowski, you mentioned some of this in your testimony, but I was hoping you could elaborate on the steps you think we need to take at the Federal level to improve that process, that scheduling capacity. What should we be doing as Members of Congress to try to help facilitate that? And then if there is time left, I would like to give that to Dr. Jha to respond further to the question.

Ms. Lewandowski. Thank you. So, as Dr. Jha said and as I mentioned in my written testimony, we do have a map called VaccineFinder. It was turned on yesterday, but it has very limited data for many States. This could help. I have noticed that my own State, Wisconsin, has just overlaid another location finder.

One of the things that you can do as elected Representatives is help the CDC collect these individual locations, because if you are in a family like mine, I have parents in California, Colorado, and even in Florida. And so if I were to need to help them, I would need a national location that I could go to to say, where is the closest place for them to be

vaccinated?

Then we need to fund additional registration systems. My own State in Wisconsin has a public health registration system that is rolling out, but it is only limited to a few public vaccinator locations. State registries should be available to every provider, and it should interface with their electronic medical record and current scheduling capacity.

And so, finally, I would also add that adding capability for hotlines, phone hotlines, very robust ones, must be added. You know, with the two-in-one system, that could help people find -- look on VaccineFinder and help people know.

So there are so many steps, and I have outlined many of them in my written testimony, so I hope that you read it.

And I will yield the rest of my time.

Mr. Schneider. Thank you, and I appreciate that. People are so frustrated about getting the appointment. Anything we do will help that.

And, with that, if Dr. Jha would like to respond, I am happy to yield my time to him.

Dr. Jha. Yes. So, Congressman, let me just add a couple of things. We are missing a really big opportunity right now, because here is what is going on. Right now, we are in a situation where we have much more demand than supply.

I promise you that in 2 months, we are going to have a lot more supply than demand, and we are going to wonder what happened to all those people who were knocking on the door who have not gotten vaccinated. And we are not doing anything to keep track of that.

What we want is a simple system. Everyone should be able to sign up. Based on whatever priority your State has created, you get vaccinated. And we want to take all the people who are lower priority, let's say a younger healthy person who we want vaccinated in May when there are plenty of vaccines around. And we keep them engaged. We don't say, come back in May. Right now, if you try to go get vaccinated in Massachusetts or Rhode

Island or pretty much any State, if you are not eligible based on current things, it says, come back in 2 months. This is not how we should be doing this.

So we have got to push our States to have simple systems that draw people in. Look, send people an update by an SMS text message every week, saying, you are 3 weeks away or you are a month away. Keep people engaged. We are going to need them vaccinated in a month and a half.

I feel like we are just missing this massive opportunity. It breaks my heart to see how we are handling this.

Mr. Schneider. Thank you. My time is expired. I yield back.

Chairman Doggett. Thank you very much.

Mr. Estes?

Mr. Estes. Thank you, Mr. Chairman. Thank you for allowing me to join this committee for the very important hearing. And I want to thank our witnesses today as well.

You know, vaccines are a key part of reopening the economy and returning to our normal American lives. Thanks to the Trump administration's Operation Warp Speed, we are able to help bring about successful and effective vaccines to fight COVID-19. It is an incredible achievement for the United States. You know, without Operation Warp Speed, we still would not have vaccine for several years to come.

With vaccines and a better understanding of how the virus operates, it is now necessary we start to work on how do we return to normal. That means getting back to school and getting back to work. And to do this, we have to make sure we get shots to whoever wants them as efficiently as possible.

In December, the Trump administration began this process ensuring that States receive doses of the Moderna and Pfizer vaccines, allowing them to tailor distribution to the needs of their communities. While some Governors leveraged existing State distribution

channels and funding from the CARES Act, others hampered health officials with unnecessary red tape and political gimmicks.

I am disappointed that my State of Kansas has been slow to distribute vaccines to high-risk Kansans in rural areas. Kansas has been last in the country in getting people vaccinated for several weeks that the vaccine has been available. And further complicating these efforts has been Kansas leadership has struggled to report accurate information to the CDC.

Yesterday, the CDC reported that nearly 755,000 doses have been given to the State, with nearly 531,000 doses administered, while the Kansas Department of Health and Environment is reporting that nearly 695,000 doses have been distributed to the State, with only 506,400 doses administered. These numbers are off by tens of thousands, unfortunately.

It is clear that many States have to work to improve the distribution process immediately. That starts with better collaboration between the agencies involved. I want to urge State, local, and Federal officials to work together with others to find solutions and get the job done. Now is not the time to duck that responsibility.

Millions of Americans are counting on the transparent and efficient vaccine distribution to see loved ones again or to worship again in person. I know Americans are ready to get back to work and get back to their lives. It is time that we focus on helping make that happen.

I look forward to working with my colleagues to further protect Americans from the virus and ensure that our Nation is prepared to handle future threats to our public health.

Dr. Marsh, in the State of Kansas, we have had a great deal of struggle working with the rural counties. And similar to West Virginia, we have a mixture of urban areas as well as rural areas. So the leadership in Kansas has been struggling with balancing the vaccine

distribution across all of those counties and keeping updated reporting to the CDC.

What suggestions do you have from one State to another to get more shots in people's arms and ensure that we are meeting all reporting requirements?

Dr. Marsh. Thank you, Congressman. I think that that is a challenge for many States. For us in West Virginia, as I said, we have established now a vaccine place in each one of our 55 counties. We have allocated the vaccines based on the percent of that population per county that has our prioritized population, either essential workers over 50 or citizens over 65, and we work to make sure that each dose, each allocation of vaccine is utilized completely by the end of the week so that we zero out every week.

And because we have pharmacists that manage the vaccines, that we are consistently getting six doses of the Pfizer vaccine out and we are oftentimes getting an extra dose of Moderna as well, which gives us a rate of vaccination over 100 percent of what we are given, allocated, although now that that is changing the way that things are being counted.

So I think that having the rigorous and disciplined supply chain, so that you track your vaccines so you are not giving excess amounts of vaccines, that you are giving vaccines to places where you know they can be delivered.

But the most important thing -- and this has been mentioned before -- is this is not about, you know, coming up with some number or ranking or some responsibility that is a burden. This is about taking care of your community. This is about saving people's lives. This is about taking care of your neighbors, your family.

It is very, very personal in West Virginia, and I think that that is the spirit that is helping West Virginia do well, because people are doing this out of love for each other as opposed to out of a sense of burden or some rank.

Mr. Estes. Great. Thank you, Dr. Marsh. It is important that we get the vaccines distributed, we don't lose any to waste, and make sure that it gets out and distributed across to

all the population.

With that, I yield back, Mr. Chairman.

Chairman Doggett. Thank you.

Mr. Gomez.

Mr. Gomez. Thank you, Mr. Chairman. I appreciate it. I enjoy listening to people's presentations.

The issue of the distribution of the vaccine and the equitable distribution was always a top concern of mine, even in the early days of seeing who was getting tested for the COVID vaccine. And it was COVID for who had COVID.

It was completely foreseeable. All this was completely foreseeable. It was just -- which really makes me angry. It makes me so livid sometimes I would want to bang on this table, even though I know that there is no one here to feel it, right? But it makes me extremely upset.

I represent the east side of Los Angeles, a very immigrant Latino neighborhood. And there are a lot of challenges. I also have the largest Korean population in the country. I have a Chinese population, a Filipino population. So it is really complex.

But I always knew, and maybe some folks, I know some people on here were on Oversight with me, same thing with the Census. The places that were going to do the worst were the ones that didn't have access to broadband, didn't have access to internet. They were too much reliant.

So all of you, you all know that, and it just really makes me upset to an extent that we are still -- we are doing better, but it has to be quicker, right? It has to be quicker.

And I would say that we are going to be not judged if we got out of the pandemic, but if our communities that are the lowest income and people of color died at disproportionately high rates for their population size and their percentage. That is what we are going to be

judged by. Just like in a famine or a dry spell, who is getting impacted? And it always tends to be the poor people. It always tends to be the immigrants.

I have a few questions. One, there are some instances where there are vaccine jumpers, right? The people that are not in the tier trying to get in, right? And some of them -- and there have been stories in the L.A. Times that that has happened. What are some steps that are being taken in the other States?

I know, Dr. Marsh, I am going to -- usually I don't call on the Republican witnesses, but you said something that piqued my interest. You said, we are really strict on the categories. Can you kind of get into that a little bit? And then I will ask Ms. Lewandowski from Wisconsin.

Dr. Marsh. Thank you, Congressman. You know, we believe very deeply that a vaccine in an arm of our prioritized population will save lives. And that becomes a really sacred duty. And so part of what we do is we work with all of our vaccine centers.

And we are not inflexible. Of course, if somebody comes in and they are with their spouse and their spouse is 64 years old and they are 66 years old, we will, of course, administer vaccines. But we make sure people have valid, you know, identification with residence in West Virginia.

But also, we have really tried to articulate, communicate well to our citizenry, not only the people that are eligible in our priority schemes to get the vaccine, but to ask our population to defer that sort of gratification so that you are really caring for somebody else. We are calling on better angels of people.

And one of the things about West Virginia, although in many ways West Virginia may have been felt to be left behind in some ways, the spirit of community and family and service is something that really resonates.

And ultimately, our citizens have been so good about saying, we will wait our turn.

We will wait our turn so other people can go first. And as I said in my earlier statement -- and I will be short -- we have seen an 85 percent reduction over the first 7 weeks in the deaths in West Virginia, which is unbelievable and really a testament to our citizens' ability to defer for our really highly prioritized population.

Mr. Gomez. And, Ms. Lewandowski?

Ms. Lewandowski. Thank you. So what I believe, what I have seen in the data that has been replicated in Milwaukee and other areas, is these communities need to be served. They need to be served by the doctors who know them and so they know that they are a part of the community.

As somebody who did prioritization in Wisconsin, I am horrified when I see a 33-year-old healthy person receiving a wasted dose when that could have gone into the arm of a 65-year-old. But really, that is when you need to talk with your providers, help them understand, help the public understand, as Dr. Marsh said, why we are prioritizing people, so that there is less anxiety and so that people know, are willing to come in.

And we know that Black and Brown communities are eager to be vaccinated, but also make sure that that public health infrastructure comes to them so that it is delivering to them where they are, rather than dragging them into other locations that may be challenging, through partnerships with Lyft and others that are very successful.

Mr. Gomez. Thank you. And I am out of time, but I wish we didn't have these 5-minute limits right now, because there are things that we can all learn from each others' States, right? It doesn't matter if you are a red State or a blue State; it is about who is doing the job well.

So I just want to commend all the States that are doing the job well. That is the only way we are going to make people feel that we are all in this together. So thank you.

With that, Mr. Doggett, I yield back.

Chairman Doggett. Thank you. And that is very true.

Mr. Horsford.

Mr. Horsford. Thank you, Chairman Doggett, for leading this important hearing. And thank you to our witnesses for your incredible insight.

I want to start by saying thank you. Thank you to all of the individuals who are helping on the front lines of this pandemic to crush this virus. I want to say thank you to the National Guard, to the first responders, to the healthcare workers, to the health agencies, and all of the other local officials who are doing all that they can to defeat COVID-19. We are going to crush this virus, and we are going to do it together.

I had an opportunity a few weeks ago to visit a couple of vaccine distribution sites in my district to listen and to learn directly from these individuals what I needed to be doing as their Representative to better help my constituents get access to the vaccine. And that is why I am voting, in fact, today to pass the American Rescue Plan, so that I can give the support that is desperately needed for us to win this war against COVID-19.

In Nevada, cases have declined 55 percent in the past 2 weeks, and we continue to see a downward trajectory in hospitalizations. And our State has the ninth highest COVID-19 vaccine utilization rate, using 91 percent of our allotted vaccines while the national average is 85 percent.

Well, recently I conducted a telephone townhall. I spoke to Gwen, a constituent from Las Vegas, who is a primary caregiver for her 85-year-old mother. She asked that as the caregiver of her mother, would she be able to get the vaccine at the same time. Gwen is 60 years old and, according to our priority guidelines, she is not, unfortunately, in a priority group to get vaccinated yet.

This is a missed opportunity, because according to The Washington Post article, Black, Latinx and Native American communities are twice as likely to die of COVID-19 and

are dying at rates significantly higher than their White counterparts. That is a racial health equity issue that we must address now and another reason why we must pass the American Rescue Plan.

Dr. Edwards, if Black Americans have shorter life expectancies, and other people of color, and a higher incidence of chronic health conditions, shouldn't policies consider these disparities in prioritizing groups for vaccinations? And what are some approaches that we should be taking to vaccinate people at younger age cohorts to avoid this issue?

Dr. Avila Edwards. Thank you so much for that question. Absolutely, partnerships are important. Your story resonated so much with me. Here in Texas, I am very proud of the partnerships that we have been able to create to have drive-through vaccines and that tomorrow we will be having a mass vaccination effort to vaccinate 3,000 in our community at a local racetrack.

And so those partnerships, whether it is with county, our bipartisan county judges, our FQHCs, our public health department, our hospital systems -- it just resonated so much with me to hear what your constituent said, because I vaccinated a 103-year-old woman whose daughter also brought her and asked me the exact same question. But with these partnerships, we have opportunities to keep in contact with these individuals.

So that when we bring the 103-year-old former teacher who now serves as such an example to her former students, who are in their 70s -- and she was so proud to tell us that -- when we bring her back, I know her daughter is going to be there. And if we have that communication opportunity through these partnerships, then when we do get the vaccines like Johnson & Johnson, we will be able to have her aware, regardless of prioritization.

As we get more vaccine, we will be able to vaccinate more people. And it is through the partnerships that we have seen so successfully here at Ascension Texas and Ascension nationally that will get us to where we need to go, so we can be in contact with our families,

with our patients, with the individuals that we know at least within our system are those that are highest risk because of race, ethnicity, social determinants of health.

Mr. Horsford. Thank you.

Dr. Lewandowski, just quickly around the community healthcare workers and their effectiveness in being able to reach those who are the most vulnerable and most in need of the vaccine. What barriers exist due to the lack of consistent mandatory funding for health departments could we be addressing to improve that issue?

Ms. Lewandowski. So we know a messenger who looks like us, who feels like us is going to be effective. And I know in Wisconsin, most of our health departments do not have the ability to hire community health workers. So what we have been trying to do is partner with community programs like the National Council of Negro Women. These are very involved women. They are out there. They know their community.

And so letting them know, hey, there is a vaccine clinic, get this out to your network. And helping them become de facto health workers is the model that we have to do, because we have not had the funding to hire these women and train them as community health workers, even though they are performing that role.

Mr. Horsford. Thank you, Mr. Chairman. I yield back.

Chairman Doggett. Thank you.

Mr. Rice.

Mr. Rice. Thank you, Mr. Chairman, for the experts on this panel.

This bill contains $100 million, I think, to build a subway in California. Do you think this coronavirus rescue bill building a subway in California is going to reduce the incidence of coronavirus? Just anybody.

Yeah, I didn't think so.

It has also got close to a billion dollars for a bridge in New York. I am wondering if

you experts believe that that is going to reduce the incidence of coronavirus.

Yeah, I didn't think so.

It has also got $65 billion to bail out union pension plans that have been chronically underfunded. Any reduction in coronavirus?

I didn't think so.

Moving on to more substantive things. Dr. Jha or Jha -- I am not sure how to say your name, sir -- you really said some things that were interesting. You said that once we got to 50 percent with immunity, there would be a big drop-off in infection. And you said you thought, by your estimates, 85 million people had already been infected. I have heard even higher than that. In fact, I am sure you know there was a physician at Johns Hopkins last week who said that he thought coronavirus would be in steep decline in the next month.

So you think 85 million infected. That is 26 percent of the population. According to CDC, 14 percent of the population has been inoculated. So that is 40 percent right now today. And we are doing, according to the Biden administration, a million and a half vaccines per day. So every 2 days, that is 3 million people or 1 percent of the population for one dose, 4 days for two doses.

So every 4 days, we add a percent. So in 40 days, we will be at your 50 percent, if my numbers are right. And not only that, that doesn't factor in the 80,000 people a day that are currently getting infected. So over 40 days, that would be another 1 percent.

So we would be at 51 percent in 40 days at current levels of vaccination. Do you agree with that, sir?

Dr. Jha. So, Congressman, just one small disagreement on the math, which is, remember, we are vaccinating some people who have been previously infected. So you can't just --

Mr. Rice. Right, yeah.

Dr. Jha. -- add those two groups together. But that said -- I don't think we are at 40 percent right now. But, to your point, the bigger picture point you are making, sir, I do agree with. And I don't think a million and a half doses a day is where we are going to be. I think in much of the month of March, we are going to be at 2 million does a day and maybe even closer to 2.5 million doses a day.

Mr. Rice. Okay. I want to go to Mrs. Lewandowski.

I am sorry, sir. I want to give you more time --

Dr. Jha. That is fine.

Mr. Rice. Mrs. Lewandowski, you said that you are requesting 400,000 doses, but you are only getting 120,000 doses. Well, I mean, I understand why you are not getting 400,000, because Wisconsin makes up about 1.75 percent of the whole population of the country. So to get you 400,000 doses, we would have to be making 3.5 million a day, and nobody thinks that that is in the immediate future, right? So you are not going to get your 400,000. A week, excuse me.

You are allocated 120. Now, didn't you say 120 is what you are allocated, 120,000?

Ms. Lewandowski. Beginning this week, it is 120-. We were at 71,000.

Mr. Rice. Right. So here is what worries me, here is what worries me, because I want the public to have the truth, I mean, whatever the truth is.

And a month ago, we were inoculating 800,000 a day, and then 2 weeks ago we were at a million a day, and now we are saying it is a million and a half.

But if you only get 120 and you do the math on that, Wisconsin is a portion of the population, that would mean we are only doing a million a day. Has that hundred and -- excuse me, a million -- yes, that is right, a million a day nationwide. Has that number varied by week?

Ms. Lewandowski. Yes, it has varied by week. But also, it is important to

remember that I was very specific that this was first doses that were requested.

Mr. Rice. Okay. So you are getting more doses than that.

Ms. Lewandowski. Yes. We get second doses automatically shipped.

Mr. Rice. So how many doses are you getting per week now, then?

Ms. Lewandowski. So the number of second doses is not highlighted and publicized as well as we would like. So transparency around that would be very good.

Mr. Rice. Okay. That makes me feel better about those numbers.

And, Dr. Marsh, I wanted to speak to you and just amplify what Mr. Horsford said and others. I have eight counties, some more urban than others. South Carolina publishes a dashboard of how the county inoculations are going. And, you know, at first, every State with this massive rollout is going to have wrinkles.

And we weren't getting vaccines in arms, and our Governor, to his credit, lit a fire under the hospitals. He actually said, if you don't put your vaccines in arms, we are going to end elective surgery in South Carolina. We will do an executive order to end it. And guess what, they got vaccines in arms.

But the problem is, in their haste, they are doing it in urban areas, right, because they want to get the vaccines in arms, and it is the easiest place to do it. So, for example, Charleston County has 126,000 vaccines in arms. Marion County, which admittedly is 10 percent of the population of Charleston County, and these poor folks who heard me talk about Marion County. So it is the poorest county in South Carolina, 57 percent African American. Do you know how many vaccines they have had? Charleston County has had 126,000. They have had 365,365.

So, you know, there is a problem with facilities in delivering that. There is a problem with people being mobile. Just your number one specific suggestion on how we take care of those folks.

Chairman Doggett. Very briefly, if you would, because he is way over his time.

Dr. Marsh. Absolutely. I think it is that same sort of commitment to each citizen as part of our larger community and that we feel like that this is our duty.

Mr. Rice. Thank you.

I yield back. Thank you, Mr. Chairman.

Chairman Doggett. Mr. Kildee.

Mr. Kildee. Thank you, Mr. Chairman.

And to all the witnesses, thank you. This has been a very helpful, informative hearing.

I would like to focus just for a moment on -- and I know we talked a little bit about this, I think Mr. Blumenauer raised it -- around the Johnson & Johnson vaccine. We have heard from their executives that emergency use authorization would allow them to have -- and correct me if I'm wrong, maybe Dr. Jha, start with you -- something in the neighborhood of 20 million single-dose vaccines available to ship by the end of March.

So I guess maybe comment on that, in terms of what you think the scale is. But my question, and I would ask Dr. Jha to comment, but maybe if other panelists want to comment. My question is, some of what I am hearing from folks and that is they are just trying to figure out, you know, how to game this out.

If Johnson & Johnson becomes available, I am hearing from some, well, I don't know, maybe I will wait and see if Pfizer or Moderna is going to be available. I would hate to, you know, get one and then a few weeks later have another available for me. I think you kind of get where I am going with this.

Could you help us understand, any of you, how you think we should address this question, knowing that the efficacy of each is unique and different but all very high.

And then one other question that came up when I was in a meeting with the Michigan

State Medical Society, and that is a concern to somehow engage physicians' offices in the relationship physicians have, you know, with their own patients regarding distribution.

Start with Dr. Jha, but then I would ask any other panelist to join in.

Dr. Jha. So absolutely, Congressman. A couple of great questions. Twenty million doses in the month of March is huge. It is going to be a single dose, so it is the equivalent of 40 million doses of a Moderna or Pfizer, except you don't have to come back 3 to 4 weeks later.

I think one of the reasons I am so optimistic that we are going to get to very high levels of vaccination as we get into May and June is because Johnson & Johnson is going to be on board. We are going to have plenty of Moderna and Pfizer vaccines. And the hope from Johnson & Johnson is that we are going to get to 100 million doses by July of just that. You know, that would be amazing.

So certainly by midsummer, everybody in America -- and probably earlier than that -- everybody in America who wants a vaccine will be able to get one.

You know, in terms of the communication, it is really a challenge. And so much of this is about how these vaccines get reported and the trials of the way they design them. And, again, these are incredible trials. I am not beating up on anybody. But the headline number they report is not actually the number anybody really cares about, and it is very hard to capture in a one-line headline in a newspaper or in a 30-second blurb on CNN.

And, again, those guys are doing the best they can. But that is just the reality of this, which gets to your broader point, which is this probably would be ideal if people could sit down with their physicians and have this conversation, because, as I have said previously, I would be delighted to take the Johnson & Johnson vaccine. If I had a J&J vaccine available today and a Moderna vaccine available tomorrow, I would be happy to take a J&J today. I don't feel like I would need to wait.

They are all terrific vaccines for the things that we care about. And, fortunately, if we could find ways for patients to engage with their physicians, it would make an enormous difference, because then physicians and nurses can help patients understand these issues. They are complicated and they just don't fit on a headline.

Mr. Kildee. Thank you.

Other panelists?

Dr. Ramachandran. Yes, Representative Kildee, thanks for this question. I am a primary care physician. I get this question pretty frequently from our Nation's veterans, but other folks I also see in the community.

You know, I echo a lot of things that Dr. Jha would say. But one of the concerns I do have is that Johnson & Johnson also had delays, like the other manufacturers, in terms of promising supply. And so, because we have kind of relied on these companies on being open about their supply and their supply chain, we kind of are left knowing kind of a little bit too late sometimes about how much supply there is.

And so I would tell my patients that because of this, because of unexpected delays that are occurring, despite the public having funded the technology and also production, that they should take any vaccine that is going to be made available to them.

And, you know, if the U.S. Government did step in to help ramp up supply, this would mitigate a lot of the questions that are coming up during this panel about prioritization and those tough decisions, if the government did step in to lay claim on this publicly funded technology in the first place.

Mr. Kildee. I wonder, Ms. Lewandowski, if you could comment both on this question, but particularly as it relates to the Johnson & Johnson vaccine, your thinking about the impact that this might have on rural populations.

It would seem to me that the storage, flexibility that comes with it, the fact that it is a

single shot, may make it -- and I don't know that we game out, you know, particular vaccines for particular populations, but I wonder if you could just comment on the efficacy of, from an operational standpoint, targeting the use -- perhaps Dr. Marsh will have a thought on this -- the use of that particular vaccine in rural communities where the storage issues and the transportation issues might argue for that.

Ms. Lewandowski. Thank you for that question. So what we have always --

Mr. Kildee. I am sorry, I can't really hear you. I think you are --

Ms. Lewandowski. I am sorry. The position that we have always taken for rural communities is the minimum order is more important than storage, and the number of doses in a vial is critical for that flexibility.

I believe that you are absolutely correct, that providers and doctors who know their communities should have the flexibility to order that vaccine. That should not be something that is driven by politics or any sort of policy.

But I do believe that people who are serving vulnerable populations, whether they are rural, whether they are urban, will know if it is feasible to come back, to have the same group of people show up a month later and all of that.

I know even there are some acceptability positives with the Johnson & Johnson vaccine. The Moderna and Pfizer vaccines were subjects of misinformation campaigns for months before they were released. And the mRNA technology is not well-understood.

And we are lucky that the Johnson & Johnson has not had that same campaign, which means that some people who are distrustful of the Moderna and Pfizer platforms may be more willing to accept the Johnson & Johnson, even if it seems like there is a lower efficacy with that headline number.

But, again, I would reinforce and say that these are different trials, they have different variants, and it is still a great vaccine.

Chairman Doggett. Thank you very much.

Let's see, Mrs. Miller.

Mr. Kildee. Thank you.

Mrs. Miller. Thank you, Chairman Doggett and Ranking Member Nunes. And I want to specifically thank you for allowing me to take part in this today, because it is so very important.

And to every one of you witnesses, thank you so much. This is such an example of how important it is that we talk to each other and we listen to each other. It makes an incredible difference how we move forward.

And I also want to make a comment about Dr. Wenstrup and how, with him being a Congressman as well as a physician, I think he really has a perspective that is very fair and something that we should listen to, because, you know, that has been his life, and he can share things with us in a very bipartisan manner.

West Virginia has been leading the Nation in distributing vaccines. On Wednesday, our Governor, Jim Justice, announced that if West Virginia were its own country, it would rank seventh in the world for its rate of vaccination. Given how rural our State is, this has been a mammoth undertaking from Federal, State, to local communities and stakeholders. West Virginia has come together to ensure that we can efficiently and effectively get the vaccines to those who need it the most.

No two States are the same, and that is why we cannot mandate a one-size-fits-all approach to vaccine distribution. However, we have seen many States tie their own hands, and they have gotten into political correctness of who should be vaccinated and when, when we must keep our eyes on the ultimate goal, which is vaccinating as many Americans as possible as quickly as possible, so that we can reopen our economy, reopen our places of work, and get our kids back into school.

Dr. Marsh, thank you for your testimony. You illuminated the great efforts West Virginia has undertaken to save lives. Will you elaborate on the success of Operation Save Our Wisdom, and tell us why this was such a critical first step for the State to take?

Dr. Marsh. Thank you, Congresswoman. And thank you for your service to our State, and for each person here. This is absolutely a bipartisan issue that we are dealing with.

You know, one of the things that is really striking, so Governor Justice really focused our vaccination priority on our older part of our population. But for those of you who don't know this data, it is something that I find incredibly powerful. This is CDC data.

So if you compare 18- to 29-year-olds who are infected with COVID-19 and you look at hospitalization risk and death risk, then 50- to 65-year-olds versus 18- to 29-year-olds have a 30 times risk of death and a 4 times risk of hospitalization; 65- to 75-year-olds have a 90, 9-0, times risk of death and a 5 times risk of hospitalization; 75- to 85-year-old Americans have a 220 times risk of death and an 8 times risk of hospitalization; and Americans over 85 have a 630 times risk of death and a 13 times risk of hospitalization.

So as we target and focus on saving lives and reducing the burden on our hospitals, then it becomes very obvious that we want to vaccinate our elders. And as I mentioned, our nursing home population was half of our mortality rate, as it has been in many other States and countries. And today, in many of our nursing homes, we have no outbreaks. We have single numbers of death across whole nursing home segments. So this approach is highly effective.

And I would say -- and I have heard Dr. Jha talk on TV before and other people -- that I think a single dose of these vaccines is very, very effective. And I am not saying we shouldn't vaccinate with two doses, as the FDA has said, but it is really, I think, incumbent upon us, particularly with the viral variants that are starting to come forward, for us to get as

many first shots in the arms of as many of our citizens as possible. And if you target our older population, then you have a fighting chance at really not only helping reduce the replication errors, the variants, but also of saving a whole bunch of lives.

And in West Virginia, as I say, over the first 7 weeks of 2021, we have seen an 85 percent reduction week to week in deaths in West Virginia.

Thank you.

Mrs. Miller. West Virginia also has had a unique utilization of local pharmacies in distributing vaccines to our rural communities among the hills and hollers. Can you describe how West Virginia has tackled the challenges of rolling out the vaccine?

Chairman Doggett. If you can briefly. Thank you very much. And thank you, Mrs. Miller.

Dr. Marsh. I will be very short.

Well, thank you, Congresswoman. I think this is really, really critical, because this is where the personal relationships come in. And, for instance, in our nursing home population, I think the national average is 71 percent of the residents and 30-some percent of the staff. Because of our preexisting relationships, we had 85 percent of the residents and over 65 percent of the staff agree initially to be vaccinated.

So this is really about us caring about each other and giving these personal relationships an opportunity to really make an impact.

Mrs. Miller. Thank you so much. I yield back.

Chairman Doggett. Thank you so much.

Mr. Beyer, can you wrap this up?

Mr. Beyer. I will.

Chairman Doggett, thank you for doing this. I would really like to thank all of our experts for hanging in over 3 hours to talk to us.

I read something that Congresswoman Miller just talked about, the local pharmacies. And, Dr. Jha, I will give you sort of a different twist on it, because I think, you know, the Biden administration has done a wonderful job ramping up the vaccines, but the Federal Retail Pharmacy Partnership Program is causing a lot of confusion in Virginia. We have got a very good State system, good local systems that are preregistering folks. And instead, in D.C. this morning we saw this panic lottery.

This preregistration system allows local health departments to work together with the State to proactively address inequities, get the vaccines to the right people, but the Federal Retail Partnership Program is completely disconnected from the State and local health departments. And if there was tons of vaccine, that might be okay, but there isn't.

Can you speak to the inequity problems that the Federal Retail Pharmacy Program is creating, the multiple websites, the need for computer access, well-resourced folks getting vaccines outside their health district, even crossing State lines?

It actually reminded me this morning, when I was a teenager, of calling the radio station to try to get concert tickets, when you had to call every couple of minutes. And it wasn't necessarily to the most needy, it was to the most manipulative.

Dr. Jha. Yeah. So, Congressman, a couple of thoughts. And thank you for that question, and it has been a real problem.

So on the long-term care facility side of this Federal partnership, West Virginia went a different direction. Obviously, Dr. Marsh has laid that out and it is well-known. What is interesting is I look across the country and I see three States that have done a superb job. There are many, actually, and I don't want to just -- but I am just going to single out three. West Virginia is certainly one of them, Connecticut is another one, and New Mexico is another one. So three States, very different approaches.

Connecticut stuck with the Federal pharmacy program for long-term care facilities,

but they were very, very aggressive about making sure that all of the hang-ups and all of the problems that many States were facing, they solved them. They really, really kind of were proactive and aggressive. It is just my way of saying, with the right focus, you can get these things -- you can get these things solved.

You know, on the issue of inequity, there are two quick points on this. One is just to address something Dr. Marsh said. One of the problems of the first dose and then followed up with everybody needs a second dose right away is in the first pass of the first dose, almost everybody who got these vaccines were White. Let's just be very explicit. There were very few Latinos, very few African Americans. Now, we are spending the next month giving all those folks second doses. We are giving out more second doses than we are first doses right now.

So if we want to expand to the issues of equity and try to get more vaccines happening among African Americans and Latinos, it is going to be very, very difficult, because we are right now spending, you know, a large chunk of our time giving out second doses. So something to think about in terms of the issue of delaying that first dose and letting other people, vulnerable people get their first dose.

You know, on the Federal partnership on pharmacies, I agree with you that it has certainly opened up a lot of opportunities for gaming. I think my general strategy has been you got to get -- you got to get vaccines to the communities that you want to target and you have got to work with community-based organizations. Chicago, Oak Street project I think it is called, has been one of the kind of highlights of this.

So there are ways of doing this. But the issues you raise really are things that we are going to need to address going forward.

Mr. Beyer. Thank you very much.

I want to jump on one neglected group of essential workers, and that is Federal

Government employees. We have so many Social Security workers and IRS workers and others who are essential to keeping this economy going who can't work from home, and yet they have necessarily been put behind people that have preexisting conditions or are older, as Dr. Marsh talked about, people my age that are a lot more likely to die.

So we have come together asking CDC -- maybe, Ms. Lewandowski, you might have a perspective on this -- Federal employees are scattered all across, all through my congressional district -- is trying to ask the Federal Government to help get them to this group of essential workers.

Ms. Lewandowski. So I am delighted that you asked that question, because it has been a question that has been plaguing me in my role as co-chair of the State Disaster Medical Advisory Subcommittee on Vaccine Distribution in Wisconsin.

So when we were making our priority groups, we were told that at least U.S. Postal workers who are Federal employees -- and this was in January, and I mean no criticism -- but we were told that U.S. Postal workers and other Federal employees would be covered by vaccine supply, similar to those working at the VA. Now, my understanding, due to the suspension of the SDMAC, is that that has not yet happened.

And so I think that that is a question to be posed to the administration, to CDC, where do these people fit in. They should absolutely not fall through the cracks. They should be addressed through some system, whether it is Federal, whether it is State. But, yes, I agree these people need to be served.

Mr. Beyer. Thank you.

I think I have a very generous clock, but one quick, last thought for you, Dr. Jha, and I ask this as the parent of two Brunonians. One of my Republican pals earlier today said, why not just herd immunity? You know, what if we had not done mass social distancing, shut down our businesses? Instead of the 500,000 dead that we have, where would we have

been?

Dr. Jha. Yeah. You know, we don't do herd immunity for any deadly infectious disease for a reason. It kills a lot of people, and it often doesn't work because, over time, immunity can wane. You have new people being born into our society, children, and then you have to have a strategy where you are constantly getting kids infected. It is not what we do when we have alternatives. We would have had many, many more thousands, hundreds of thousands people die if we had really taken that strategy.

And the other thing, of course, something I brought up, variants and mutants arise when you give the virus lots of chances to infect people. All of these variants have arisen in the context of large outbreaks. If we had let these outbreaks just run, I can promise you we would have many more variants to deal with, many more potentially deadly ones.

So it is not a good strategy. It is not a serious strategy. And I think, you know, the strategy that you have got to do is you have got to get as few people infected as possible, build good treatments, good diagnostics and vaccines. We have done well in some of those areas, less well in other areas.

I do think that we are going to be able to get through this now with the vaccines, three vaccines that we have. We will have probably one or two more. And then we have to make sure we do better next time.

Mr. Beyer. Thank you very much. Thank all of you for staying to the very end.

Mr. Chairman, I yield back.

Chairman Doggett. Dr. Jha and Mr. Beyer, thank you. This is a very good point for us to conclude our hearing on. We have gone a full 3 hours. And I think each of our witnesses has made a real contribution to our understanding of the complexities and the challenges that we face.

Our members do have a couple weeks in which they can submit written questions and

those questions and answers are made part of the formal hearing record.

I do appreciate all of our colleagues, both those who are on our subcommittee and several who joined us from the full Ways and Means Committee, for your participation. It has been very helpful. I hope we can continue working together to address this vital health issue.

Thank you, and that officially concludes our hearing.

[Whereupon, at 5:15 p.m., the subcommittee was adjourned.]

Submissions for the Record follow:

Center for Fiscal Equity

National Association of Chain Drug Stores

Premier Inc.

The Children's Partnership

Zebra Technologies