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SELECT SUBCOMMITTEE
on the
CORONAVIRUS CRISIS

PREPARING FOR AND PREVENTING THE NEXT PUBLIC HEALTH EMERGENCY:

Lessons Learned from the Coronavirus Crisis

FINAL REPORT
DECEMBER 2022

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EXECUTIVE SUMMARY

Since it was established on April 23, 2020, the Select Subcommittee on the Coronavirus Crisis has been investigating the effectiveness, efficiency, and equity of the nation's response to the coronavirus pandemic. The Select Subcommittee's work has produced an extensive investigative record. The committee has released 37 investigative reports and other disclosures examining topics that range from how financial technology companies facilitated fraud in pandemic relief programs to how meatpacking companies prioritized profits over the health of their workers. The Select Subcommittee has held 42 hearings and Member briefings, exploring a similarly broad range of issues to understand the many challenges presented by the coronavirus crisis and how best to address them.

This report reflects the culmination of the Select Subcommittee's work, as authorized and directed in the 117th Congress by House Resolution 935.[1] The Select Subcommittee's findings—based on firsthand accounts, contemporaneous records, expert testimony and other evidence—identify pre-existing vulnerabilities, failures in leadership and program implementation, and predatory actions by private actors that contributed to extraordinary loss of life, economic suffering, and waste, fraud, and abuse during the crisis. The findings also detail elements of the federal government's response that succeeded in ameliorating the crisis. All of these lessons should inform preparations for and responses to future public health and economic emergencies.

The United States was underprepared for a major public health crisis for years before the coronavirus pandemic. Chronic underfunding and longstanding health disparities put many Americans at heightened risk of becoming infected and developing severe illness as a result of the coronavirus. The United States had long failed to invest in measures necessary to prepare for a global pandemic, including failing to maintain the Strategic National Stockpile (SNS) and to adapt to indications that federal agencies were likely to be stymied by a lack of cooperation and communication failures in the event of a major public health calamity. These factors were exacerbated by the Trump Administration's disastrous initial response in 2020. The Trump Administration failed to recognize the looming threat as reports of a novel pathogen emerged in early January and failed to take sufficient measures to prepare the country by developing adequate testing or acquiring sufficient personal protective equipment (PPE) and other critical supplies.

Once the coronavirus outbreak erupted into a full-blown crisis, the Trump Administration engaged in an unprecedented campaign to control and even manipulate the work of scientists leading the public health response. The Trump White House blocked the Centers for Disease Control and Prevention (CDC) from conveying accurate information to the public, installed political operatives who sought to downplay the pandemic, and even attempted to alter and manipulate CDC guidance, scientific studies, and public health orders to serve political goals. The Trump White House also sought to interfere in the Food and Drug Administration's (FDA) authorization of coronavirus treatments and vaccines, pressuring FDA officials to reauthorize hydroxychloroquine as a coronavirus treatment after it was shown to be ineffective and potentially dangerous, rushing FDA to accelerate the authorization of convalescent plasma, and even blocking the release of coronavirus vaccine guidance out of fear that recommended safety protocols would delay the authorization of a vaccine until after the 2020 presidential election. On top of all of this,

the Trump Administration embraced a dangerous and discredited herd immunity via mass infection strategy many months before vaccines were available.

The Trump Administration's reckless pandemic response resulted in devastating and lasting harm. The toll of the coronavirus fell hardest on those who were already most vulnerable. Communities of color suffered disproportionally high rates of coronavirus infection, hospitalization, and death. Nursing home residents suffered high levels of infections and deaths, exacerbated by understaffing and meager wages and benefits for their workers.

Upon taking office, the Biden Administration led a historic vaccination campaign, administering 200 million coronavirus vaccine doses within 100 days. Yet corporate entities that failed to live up to their obligations to address the public health crisis threatened to undermine this effort, as did predatory actors who promoted misinformation, fueled by right-wing extremists and others seeking to profit by selling discredited and dangerous treatments. The rampant spread of misinformation has led to damaging distrust in public health expertise. It has also contributed to harassment, threats, and attacks on public health officials working on the coronavirus response and convinced far too many Americans to decline lifesaving coronavirus vaccines—resulting in hundreds of thousands of preventable deaths.

* * *

The economic toll of the coronavirus crisis also brought devastation to American families, inflicting particular harm on those who were already struggling. The pandemic-induced economic crisis led to 20 million Americans losing their jobs in April 2020 alone, pushing the unemployment rate from 2.5% to 14.7% in just two months. This devastation fell hardest on low-income workers and their families, who were disproportionately women and people of color and were more likely to work in hard hit sectors that experienced closures and disruptions. These workers were also more likely to lack the financial protection needed to cope with sudden losses of income and critical workplace benefits like paid leave needed to withstand a health crisis.

Congress acted swiftly to address the sudden economic devastation, enacting the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Families First Coronavirus Response Act (FFCRA), and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) in March 2020. Yet the Trump Administration's implementation undermined the effectiveness of many relief programs and kept badly needed aid out of the hands of struggling Americans while lining the pockets of wealthy corporations and those seeking to profit off of the economic crisis.

Early in the crisis, the Trump Administration failed to get Economic Impact Payments (EIPs) enacted by the CARES Act into the hands of approximately nine million Americans who were entitled to them. It failed to ensure that payroll support programs that went to businesses were equitably distributed and could save the jobs of the workers who they were intended for. The Trump Administration also failed to ensure that large-scale financial relief programs served citizens and mid-sized businesses, rather than just large corporations. It similarly failed to take effective action to prevent vulnerable Americans from losing their homes.

The Trump Administration's poor implementation of economic programs also failed to safeguard taxpayer funds and protect them from fraud. Substantial fraud was committed against pandemic relief programs, possibly well into the tens of billions of dollars. Programs operated by the Small Business Administration (SBA) were particularly vulnerable to fraud. Approximately $86 billion in potential fraud has been identified as having been committed against the Economic Injury Disaster Loan (EIDL) program. The Trump Administration failed to implement basic safeguards against fraud during the early operation of that program, likely contributing to this high level of potential fraud. The Paycheck Protection Program (PPP) was similarly vulnerable to fraud because of poor oversight and heavy delegation of applicant screening to unqualified and unscrupulous financial technology (fintech) companies.

In addition to exposing relief programs to high risks of fraud, the Trump Administration gave generous benefits to large companies, while other greedy actors simply sought to benefit from the crisis. In one case, senior Trump Administration officials overrode career officials to give a $700 million CARES Act national security loan to a company that the Department of Defense (DOD) had determined not to be critical to national security. The Trump Administration also awarded contracts worth tens of millions of dollars to inexperienced companies to administer the Farmers to Families Food Box Program (Food Box Program), leading to waste and abuse of taxpayer dollars in a program designed to feed hungry Americans. In similar acts of greed, corporate landlords acted aggressively to evict tenants, notwithstanding eviction moratoriums and federal programs available to disburse aid to tenants in need.

After assuming office, the Biden Administration worked with Democrats in Congress to swiftly enact the American Rescue Plan (ARP), which immediately decreased hunger and other hardships for struggling Americans. The new administration also worked to improve the implementation of pandemic relief programs, thus making the distribution of relief more equitable and reducing exposure to fraud. The Biden Administration's vaccine rollout aided a historic economic recovery in which all of the jobs that had been lost at the onset of the pandemic were rapidly regained. The United States added more than 10 million jobs between January 2021 and November 2022, surpassing the pre-pandemic total and bringing the unemployment rate down to 3.7%.

* * *

Informed by the Select Subcommittee's oversight work and extensive investigative record, today's report also provides recommendations to strengthen the nation's ability to prevent and respond to public health and economic emergencies. These 30 recommendations focus on mitigating ongoing risks still posed by the coronavirus, making critical investments in the nation's public health and economic relief infrastructures, decreasing vulnerabilities to future crises, and guarding the integrity of relief programs. They include the following:

- Increase bivalent booster uptake through a targeted booster campaign in order to prevent thousands of deaths and hospitalizations and save billions in direct medical costs.

- Accelerate the development of pan-coronavirus vaccines and nasal vaccines to address the ongoing evolution of coronavirus variants.

- Accelerate the development of new anti-viral treatments to create a robust pipeline of effective options for vulnerable Americans.

- Maintain testing capacity to ensure convenient and efficient at-home testing options, while developing better tests to detect a range of common respiratory viruses.

- Promote ventilation and filtration systems to mitigate the spread of respiratory viruses.

- Continue to evaluate the role, responsibilities, staffing and contents of the SNS, particularly with respect to emerging and infectious disease outbreaks.

- Ensure that sufficient funds are allocated to adequately stock the SNS, to maintain and replenish supplies for medical countermeasures, and to allow for shifting investments and resources as appropriate.

- Review and close gaps in federal agency diligence processes for awarding procurement contracts to reduce the risk of waste, fraud, and abuse.

- Increase funding for federal, state, local, tribal, and territorial public health agencies, ensuring that annual funding is predictable and sufficient to build long-term capabilities.

- Invest in modernizing public health data systems at the federal, state, and local level to make them more flexible, dynamic, and interoperable.

- Make sustained investments to grow and retain a culturally competent public health workforce trained in surveillance and detection, risk communications, laboratory science, data systems, and disease containment.

- Develop procedures and training to protect scientific decision-making at federal agencies from political interference.

- Modernize public health communications to ensure critical, accurate information reaches all Americans, including underserved populations.

- Examine opportunities to protect the public health workforce, including by establishing a national reporting system for incidents of violence against public health officials and providing legal protections for workers facing harassment and threats.

- Explore opportunities to limit the spread of harmful misinformation.

- Pass legislation to ensure that individuals with Long COVID can access the critical services that they need.

- Expedite and fund clinical treatment trials and educate health care providers and the public on Long COVID.

- Increase the federal government's collaboration with international partners to strengthen its ability to protect people from future threats and mount a coordinated, effective, and equitable response to major global health crises when they do occur.

- Pass legislation to ensure government institutions and public health agencies are fully equipped to prevent and respond to future challenges.

- In advance of future emergencies, assess and improve the federal government's ability to distribute emergency federal relief equitably, particularly to the lowest-income Americans who are extraordinarily vulnerable to disasters.

- Tailor any relief programs that are implemented by private-sector institutions more effectively to prioritize businesses or workers who lack other means of accessing credit.

- Support the permanent maintenance of new state and local government infrastructure for distributing emergency rental assistance, in order to deliver future emergency aid in a timely manner and to provide a consistent, effective lifeline to prevent evictions and homelessness.

- Invest in housing affordability for lower-income American families, including by ensuring that they must pay no more than 30% of their income on housing, to reduce Americans' vulnerabilities to losing their homes in a crisis.

- Require or encourage states to modernize and reform their unemployment systems to reduce Americans' vulnerability in future crises.

- Provide SBA with resources to expand its capacity to address surges in applications for Economic Injury Disaster Loans during catastrophes or national crises.

- Enact a program of universal paid sick, medical, and family leave to advance economic recovery, equity, and public health preparedness.

- Make permanent investments in the child care sector to improve affordability for families, increase wages for caregivers and early educators, and expand the sector's capacity so child care challenges do not remain a barrier for parents' participation in the labor market.

- Expand and improve federal agencies' economic data collection tools and methods, building on advances made during the coronavirus crisis in highlighting economic vulnerabilities and inequities.

- Ensure the Internal Revenue Service (IRS) continues to have resources to surge the processing of partial tax transcripts to prevent fraud and ensure integrity in SBA's EIDL program.

- Include proactive fraud controls in future relief programs, including but not limited to rigorous vetting and oversight of all private-sector entities with delegated responsibilities for administering the programs and safeguarding taxpayer dollars.

INTRODUCTION

On December 30, 2019, an alert appeared in ProMED—a crowdsourced disease alert website and newsletter—describing an outbreak of an unexplained respiratory disease in Hubei Province, China.[2] This alert turned out to be one of the earliest reports outside of China of a pathogen that would be identified by January 10, 2020, as a novel coronavirus, spreading to multiple continents within weeks, killing over 100,000 Americans within six months and over a million in two-and-a-half years.[3]

ProMED's alert caught the immediate attention of top scientists at CDC. Dr. Nancy Messonnier, Director of CDC's National Center for Immunization and Respiratory Disease at the time, told the Select Subcommittee during a transcribed interview that she convened a virtual team and directed others to go out and collect more information. CDC employees in China who were 12 hours ahead of Atlanta-based staff had seen the alert and "were already working on trying to gather additional information."[4] Dr. Anne Schuchat—then Principal Deputy Director of CDC—told the Select Subcommittee during a transcribed interview that, upon seeing the report of "five or seven cases," she "sent an email to a number of staff who scientifically or organizationally might have known more about this situation and asked did they know anything and could they let me know."[5] A few hours later, she discovered that there were "something like 27 cases … more than was in the [ProMED] report."[6]

Dr. Messonnier called then-CDC Director Robert Redfield shortly thereafter. He told the Select Subcommittee that he heard the news while gathered with his family on New Year's Eve:

> I received a phone call from CDC, and I think it also involved CDC China … And the gist of that call … was that there were 27 cases of an undefined respiratory illness or what they called non-specified respiratory illness which were linked to a wet market in Wuhan. And it was not flu, and they didn't have all the other data at the time.[7]

CDC employees learned that the Chinese Center for Disease Control and Prevention "was sending a group of their own, mostly influenza staff, to evaluate the epidemiology, to understand who was getting sick, where they were getting sick" and "to collect new specimens and also verify that the full breadth of testing of various pathogens was underway."[8] Dr. Daniel Jernigan, CDC's Deputy Director for Public Health Science and Surveillance and Incident Manager for CDC's coronavirus response from January to March 2020, told the Select Subcommittee during a transcribed interview that by December 31:

> [T]he staff had received information from colleagues that were at the Wuhan consulate regarding concerns about a seafood market and potential for respiratory disease transmission in that setting. That information got from the embassy's consulate there to others at the embassy, and then to our own staff which were embedded at the embassy.[9]

Dr. Jernigan recalled, "within a day or so we understood that the usual pathogens that might be a cause, influenza, RSV, parainfluenza et cetera," had been ruled out and that the outbreak was in "a category of unrecognized or unexplained."[10]

Dr. Redfield spoke with Dr. George Gao, Director of the Chinese Center for Disease Control and Prevention, on January 3, 2020. Dr. Redfield told the Select Subcommittee that he had a "good relationship" with Dr. Gao from their previous work as virologists.[11] During their initial call, Dr. Gao said that China had detected 27 cases of a non-specified respiratory illness. According to Dr. Redfield, Dr. Gao said "that he didn't feel there was evidence of human-to-human transmission, and that all of the cases came from a wet market and that was it. We didn't get into any more detail."[12]

A few days later, Dr. Gao provided Dr. Redfield with more information on the 27 known cases. Dr. Redfield told the Select Subcommittee that he "noticed that three of them were in what we call clusters. So like a husband and a child, or brother and sister." He recalled:

> And I said, George, the clusters bother me, because you really think they all walked by the same animal and all got infected, or do you think it's possible one of them got infected, and then they transmitted to others in the cluster?[13]

Dr. Redfield spoke with Dr. Gao again several days later. Dr. Gao reported that he had looked outside of the wet market and found "hundreds of cases and they had nothing to do with the wet market." Dr. Redfield recalled that Dr. Gao "was distraught when he went out and followed up on my request to look at people with non-specified pneumonia that had nothing to do with the wet market. He told me, Bob, we have hundreds of cases, it's already out of control."[14]

Dr. Redfield told the Select Subcommittee that he pledged the "full support of CDC," telling Dr. Gao he "would be ready to send the CDC team to augment his ability if he would invite us, which he said he wanted." In what Dr. Redfield described as an "unusual" request, Dr. Gao asked for a formal offer to the Chinese government:

> [N]ormally he would just invite us and we would go. In this circumstance, he told me I had to write a formal letter because he had to get approval up his chain of command, which I did as an email I think on the 3rd or 4th of January. When I returned to the office on Monday, I think it was January 6th, I wrote a formal letter on CDC stationery offering to provide support.[15]

Dr. Redfield told the Select Subcommittee that he attempted to follow up with Dr. Gao "a number of times," but received no response. He said, "I still assumed that they were going to be inviting us in during that period of time, and I kept – I kept asking George when our invitation was coming."[16]

Within the first two weeks after reports of the coronavirus emerged, Dr. Redfield asked Department of Health and Human Services (HHS) Secretary Alex Azar to call his own Chinese counterpart to request that CDC be granted access to China to obtain information on the unknown pathogen and lend assistance. Dr. Redfield said that Secretary Azar made that call, and that he

also "asked Secretary Azar and eventually directly asked President Trump to reach out the President of China to request it."[17] When asked whether he received reports back on either of the phone calls, Dr. Redfield, responded, "No."[18] Dr. Redfield told the Select Subcommittee that he was uncertain as to whether CDC's requests to access China were denied or simply ignored. He said:

> I think Secretary Azar, and I don't remember the specifics, … I know I felt that there wasn't a response. And I know President Trump made the call, I wasn't on it, but there was no invitation.[19]

Dr. Redfield said that, apart from his calls to Dr. Gao and outreach to the World Health Organization (WHO), he did not make further attempts to obtain access to China.[20]

Although an incident management structure was formed on January 7, 2020 to execute CDC's preparedness plan, little information about the outbreak came from elsewhere in the federal government.[21] Dr. Redfield told the Select Subcommittee that he struggled to obtain updates on the developing crisis: "I didn't get any information coming to me from the intelligence community. If anything, we may have given what information we had to the intelligence community."[22] Then-Assistant Secretary for Preparedness and Response (ASPR) Dr. Robert Kadlec similarly recalled during his transcribed interview:

> My information from our intelligence sources in HHS were, quite frankly, lousy. … I was making requests, saying, 'What does the IC [Intelligence Community] know, tell me what can we glean on this.' And in frank honesty, even if we were in a SCIF, top secret thing, I wouldn't tell you more than what was known by CDC at that time.[23]

Media reports indicate that, within the Trump White House, a National Security Council (NSC) staff member began collecting information—largely from informal personal channels—and convened an interagency meeting to assess the situation.[24] But the Trump Administration, including the President himself, failed to follow up on Dr. Redfield's requests or otherwise seek critical information about the emerging pathogen. Instead, the President met with Xi Jinping on January 15, 2020, to sign a $200 billion trade deal, easing a months-long trade war that had followed the United States' imposition of tariffs on Chinese goods.[25] On January 24, after the second coronavirus case was confirmed in the United States, President Trump tweeted:

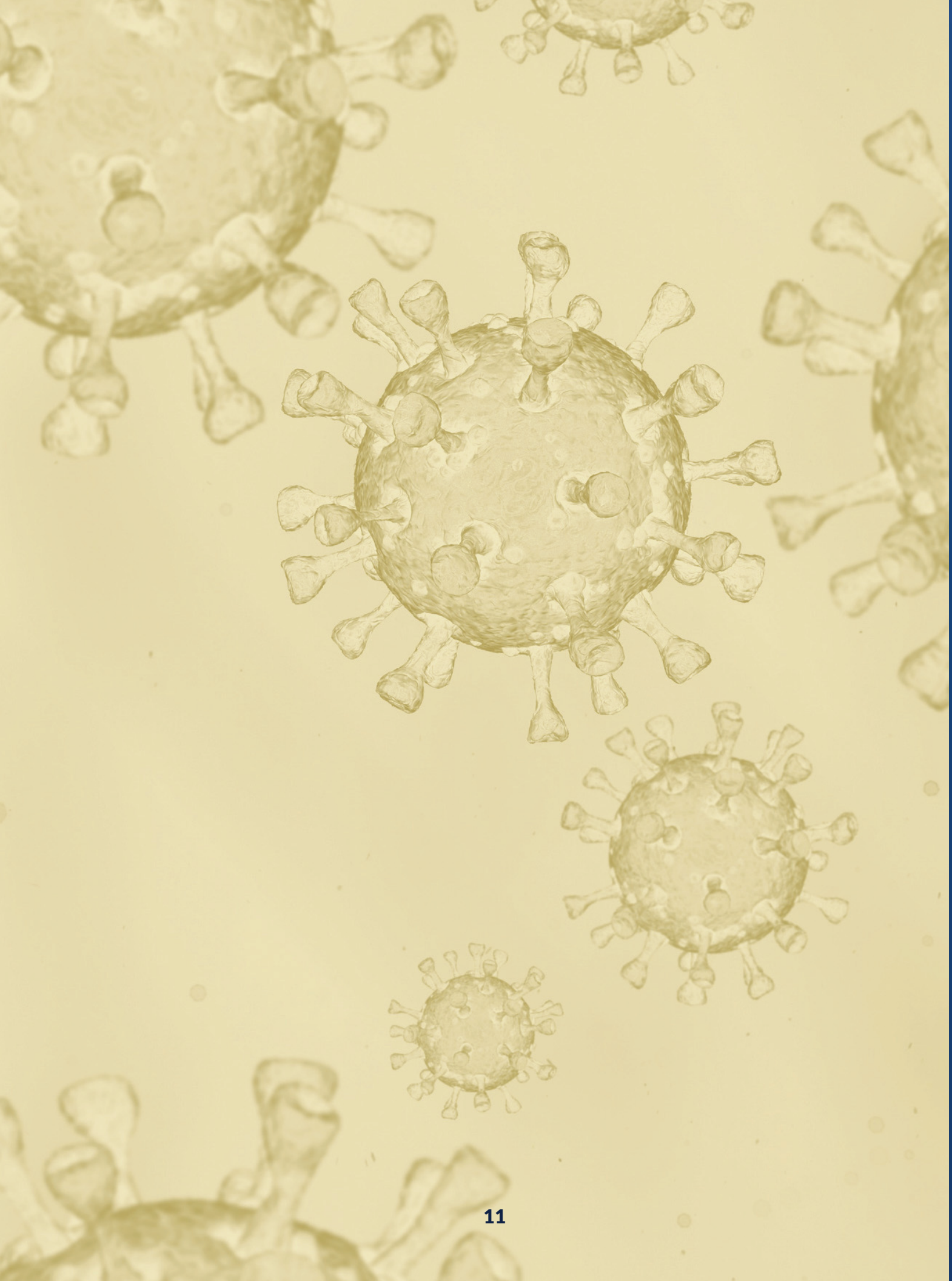
> China has been working very hard to contain the Coronavirus. The United States greatly appreciates their efforts and transparency. It will all work out well. In particular, on behalf of the American People, I want to thank President Xi![26]

CDC officials told the Select Subcommittee that the lack of critical information and failure to quickly mount a coordinated effort hampered the country's ability to respond. Dr. Messonnier described having "incomplete information about transmission patterns in China" in January 2020, saying that she felt "frustrated that we didn't understand everything that we wanted to understand about the virus."[27] According to public reporting in early 2020, CDC advisors said that a lack of information about the coronavirus was curtailing efforts to quell the outbreak.[28]

On top of its failures to obtain critical information, the Trump Administration delayed action. Despite reports of a state of emergency in Wuhan that drove Chinese officials to construct new hospitals in a matter of days,[29] confirmed coronavirus cases outside of China on January 13 and 15, and the first confirmed case in the United States on January 20,[30] the Trump White House did not establish its own Coronavirus Task Force until January 29.[31] Even with that structure in place, Dr. Schuchat told the Select Subcommittee that early task force meetings remained "tactical about the small issues rather than the big … tsunami that was coming." She said:

> [D]uring this relatively chaotic period there wasn't strategic level guidance. . . . I don't think we had a strategic convening happening that allowed the highest priority issues to get settled. I think there was pretty much—that was a problem, not just in those first couple months, but probably in the first—maybe the first year.[32]

This "chaotic period" manifested itself in a multitude of failures, including a failure to strategically deploy resources, to obtain critical supplies, to develop necessary and functional testing, to identify the fact that the virus was replicating itself through asymptomatic spread, and to recognize the way in which the country's largest global health crisis in a century would upend American lives.



I. Heightened Susceptibility to Public Health Threats and the Trump Administration's Mismanagement of the Crisis Resulted in the United States Having a Higher Coronavirus Mortality Rate Than the Majority of Its Peer Countries

At least 1,077,000 Americans have died of the coronavirus—more than any other country in the world.[33] The United States has a mortality rate of 328 deaths for every 100,000 residents,[34] greater than all but five other members of the Organization for Economic Co-operation and Development, and all but 15 other countries worldwide.[35] By comparison, Germany has lost 191 of every 100,000 residents to the coronavirus, Australia has lost 64 residents out of every 100,000, and Japan just 40. [36]

These comparatively poor outcomes were in no small part attributable to the Trump Administration's mishandling of the crisis response in 2020, including its failure to recognize and respond to the threat posed by the virus in early weeks, its political interference in the public health response, and its pursuit of herd immunity via mass infection strategy that sought to amplify the spread of the virus in the months before vaccines became available. The Trump Administration's rejection of proven public health measures enabled predatory actors who spread misinformation and who continue to impede the nation's response by sowing distrust in proven public health tools, especially vaccines. However, the United States was ill-prepared for the pandemic even before the virus was identified. Decades of health disparities—particularly in rural communities and communities of color—underinvestment in public health, and barriers to access to health care—on top of the Trump Administration's failures—contributed to the tragic toll, which fell disproportionately on vulnerable groups.

A. Long-term Underinvestment in Public Health Infrastructure and Longstanding Health Disparities Put the Nation at Increased Risk from the Coronavirus.

Fawn Sharp, President of the National Congress of American Indians, told Select Subcommittee Members during a June 4, 2020, briefing:

> Long before the pandemic hit this country, we were already in a crisis. [W]hat we've found is that not only do we have an inability to protect ourselves during this pandemic, but … every sector of the funding that we receive from the federal government is chronically underfunded, whether that's law enforcement, health care, education. Every part of our public life is deeply impacted.[37]

The United States entered the coronavirus crisis with an underfunded public health infrastructure, impeding federal, state, and local governments' ability to rapidly respond to the virus.[38] Chronic underfunding of the country's public health system jeopardized the country's ability to mount an effective response to infectious disease threats, combat chronic illnesses, and promote overall good health.[39] Public health agencies were forced to use data systems that were "antiquated and in dire need of security upgrades," and were "blamed [by governors and other elected officials] for unreliable data."[40] As Dr. Redfield said in April 2020,"our nation failed over decades to effectively invest in public health."[41]

The nation also faced a shortage of health care workers. A 2016 study anticipated that, by 2020, the country would face a shortage of 150,000 registered nurses.[42] As the population ages, so does the demand for nurses; however, not enough individuals are becoming nurses, while many are leaving the profession. Over half of registered nurses are over 50, and 19% are over the age of 65. As these nurses retire, they are not being replaced in sufficient capacity to meet demand because of lack of space in nursing programs and faculty shortages. In 2019, nursing programs rejected over 80,000 qualified applicants due to lack of capacity or resources.[43]

Similarly, the country faced a pre-pandemic shortage of physicians that continues to worsen. A 2021 survey found that 20% of physicians plan to leave their jobs within two years. Another one-third plan to reduce their work hours within one year.[44] These physicians are not being replaced, and the country is falling further behind in keeping up with demand from an aging population.[45] As of May 2022, 37 states are predicted to have physician shortages as soon as 2025, with rural areas having less availability of care than urban and suburban locations.[46]

The coronavirus crisis exacerbated this problem: many health care facilities became short staffed when health care workers became infected with the coronavirus themselves.[47] While hospitals struggled to find capacity for patients in need, health care staff experienced "burnout, exhaustion, and trauma."[48] As Dr. Joseph Kanter, State Health Officer and Medical Director at the Louisiana Department of Health testified during a September 2021 Select Subcommittee hearing, "state and local health departments need help shoring up their workforces before they buckle under the weight of a … long pandemic."[49]

This underinvestment and lack of capacity has been particularly dangerous for communities of color, which have experienced systemic health care disparities that had long gone unaddressed.[50] People in some racial and ethnic minority groups experience higher rates of poor health and disease for a range of health conditions, including diabetes, hypertension, obesity, asthma, heart disease, cancer, and preterm birth, when compared to their white counterparts.[51] The pre-pandemic life expectancy of American Indians and Alaskan Natives was 5.5 years less than for Americans overall.[52] People of color are more likely to have higher rates of underlying medical conditions, have less access to healthy food and clean water, and more exposure to environmental pollutants.[53] They may also delay seeking care due to health care discrimination and cost of care, and when they do seek care, they have less access to quality clinics and hospitals. These systemic health care and socioeconomic disparities leave communities of color vulnerable in normal times and at heightened risk in any public health emergency.[54]

B. Before the Coronavirus Crisis, the United States Had Not Sufficiently Invested in Pandemic Preparedness, Despite Well-Known Risks.

1. The Strategic National Stockpile was drastically undersupplied and inadequately equipped to respond to the coronavirus crisis.

Well before the onset of the coronavirus pandemic, government officials had contemplated a public health emergency requiring readiness and response on a national scale. Following the first Severe Acute Respiratory Syndrome (SARS) crisis in 2003, the H1N1 flu pandemic in 2009, and the Ebola crisis of 2013, American public health leaders launched readiness programs and

issued blunt warnings about the need to prepare for the next inevitable public health emergency.[55] Nevertheless, lapses in pandemic planning across numerous prior administrations left the country's strategic reserves of medical equipment undersupplied and public health officials underprepared for the coronavirus outbreak.

Beginning in 1999, the federal government established a stockpile of medical and protective supplies at a network of sites across the country now known as the SNS. The SNS was established to provide for the health security of the United States in the event of a bioterrorist attack or other public health emergency.[56] It was designed to assemble large quantities of essential medical supplies that could be deployed to states and communities during an emergency within hours of a decision to do so. Since its inception, the SNS has responded to multiple large-scale emergencies including floods, hurricanes, and influenza pandemics.[57] But in 2020, the stockpile proved to be inadequate to supply the PPE and medical equipment needed to respond to the early months of the coronavirus crisis.[58]

The state of the SNS in 2020 can be attributed, in part, to a failure to replenish the stockpile following past public health crises. By the late 2000s, the federal government had deployed substantial supplies of protective and medical equipment to assist with numerous emergencies but failed over time to replenish the SNS inventory. For instance, by 2009, the federal government had distributed more than 85 million N95 respirators—nearly 80% of the stockpile's supply at the time—without continuously resupplying the SNS with those products. That trend continued under the Trump Administration and, by 2020, the majority of the SNS's N95 stockpile was depleted and many of the remaining respirators had expired. The heavily depleted N95 respirator supply proved inadequate for the demands of the coronavirus pandemic, remaining in short supply for months and forcing health care practitioners to use expired products and reuse single-use equipment multiple times.[59]

The SNS was also not equipped with diagnostic equipment necessary to respond to the novel coronavirus. Several senior officials from HHS explained to the Select Subcommittee that both before and after the H1N1 influenza pandemic, federal pandemic planning was narrowly focused on an outbreak of symptomatic influenza, in which tests and testing equipment would not be necessary to evaluate whether individuals were infected with the disease. As a result, testing supplies and equipment in the SNS—which became vital to controlling the spread of the coronavirus due to the asymptomatic nature of its spread—were severely lacking at the time of the coronavirus outbreak.

Dr. Kadlec, the ASPR at the onset of the coronavirus crisis, explained during a transcribed interview with the Select Subcommittee that the federal government's pandemic preparedness efforts were "focused on pandemic influenza preparedness" and that those efforts were "devoted to creating a strategy and implementation plan that were very detailed on the nature of the response to influenza pandemic" and which did not require diagnostic testing. Dr. Kadlec described that approach as, "a significant hallmark and a flaw, if you will, of the planning assumptions of our historic influenza planning pandemic plan."[60] Admiral Brett Giroir—who served as HHS Assistant Secretary for Health at the onset of the coronavirus pandemic and was named the Trump Administration's "Testing Czar"—said that a longstanding focus on symptom-based pandemic influenza was "the underlying issue." He said: "[W]e planned for pandemic influenza, and testing

just wasn't that important for flu. . . . So testing had not been a major focus of any pandemic plan, and that is the ultimate root." He emphasized that this problem had been building for many years, noting that if there had been "15 or 20 years of diagnostics preparation, there probably wouldn't have been a need for a 'testing czar,' but there wasn't, and so we need[ed] to do it in real time."[61]

In 2018, HHS shifted control of the SNS from CDC to ASPR, which coincided with a shift in prioritization of SNS spending away from medical countermeasures designed to respond to infectious disease outbreaks and toward biological and chemical weapons defense.[62] According to a recent analysis by the Government Accountability Office (GAO), in the years immediately preceding the coronavirus pandemic, HHS expended the majority of its SNS budget—approximately 75%, or $3.5 billion—on the purchase of medical countermeasures related to anthrax and smallpox. During that period, HHS obligated only $33 million for ventilators and made no obligations over $1 million for PPE, further exacerbating the shortages of supplies integral to controlling the spread of the coronavirus.[63]

These failures to replenish the SNS over time, plan for infectious disease outbreaks beyond pandemic influenza, and inventory supplies to respond to a broad array of possible public health emergencies left the SNS drastically undersupplied at the inception of the coronavirus outbreak. In December 2019, the SNS contained only 16.9 million gloves, 12.6 million N95 respirators, 4.8 million gowns, 19,000 ventilators, and no nasal swabs, transport media, or pipette tips used for diagnostic testing.[64] The lack of national inventory of PPE and medical supplies in the early months of 2020 contributed to widespread and prolonged shortages of equipment needed to protect health care workers and first responders from infection.

2. A 2019 pandemic simulation alerted Trump Administration officials to preparedness challenges, yet these challenges remained unremedied at the onset of the coronavirus crisis.

In 2019, HHS ran a series of interagency exercises involving officials from 12 states and at least a dozen federal agencies dubbed Crimson Contagion with the goal of evaluating the federal government's readiness for a global influenza-like pandemic. According to Dr. Kadlec, who led the exercise with the Federal Emergency Management Agency (FEMA), the simulation identified numerous deficiencies in the federal government's plans to respond to a real-life pandemic scenario. Despite the government's notice of these pandemic readiness deficiencies, many of the warnings that came out of this simulation proved to be challenges that impeded the nation's response to the coronavirus crisis.[65]

Dr. Kadlec told the Select Subcommittee during his transcribed interview that Crimson Contagion identified "a lot of problems" including "lack of integration" across federal agencies in charge of emergency preparedness and response.[66] According to public reporting, friction emerged, for instance, between agencies within HHS, like ASPR and FEMA, which is traditionally in charge of disaster response. The exercise also identified a lack of coordination between federal agencies and state and local public health officials.[67]

The simulation further identified shortages of medications, PPE, and ventilators, as well as weaknesses in the United States' capability to quickly manufacture essential medical equipment,

supplies, and medicines. In December 2019, Dr. Kadlec briefed Congress on some of these findings, including that the "U.S. lacks sufficient domestic manufacturing capacity and/or raw materials for almost all pandemic influenza medical countermeasures, including vaccines and therapeutics, the needles and syringes needed to administer them, and personal protective equipment, including masks, needles, and syringes." He continued, stating that "in a pandemic, global manufacturing capacity will likely not be sufficient to meet demand, resulting in an inability to import adequate quantities of medical countermeasures."[68]

During his transcribed interview, Dr. Kadlec elaborated on the point that Crimson Contagion revealed that "everything that we probably would need in a pandemic, PPE—all PPE, and other things, critical health care stuff, were sourced from China. And whether it emanated from China or somewhere else, the likelihood would be the supply chains would be disrupted and we just have just-in-time supplies." He further highlighted that:

> [W]hat we found is that the distributors didn't have visibility into the hospitals. The distributors had marginal visibility upstream to the manufacturers. If they didn't have—some like [C]ardinal [Health] has its own manufacturers, its own stuff, but not everybody does. And nobody had really [sic] visibility into the raw materials and precursors that would be needed from this, which we source largely from India and China.[69]

Notwithstanding the supply chain and manufacturing problems modeled by the Crimson Contagion exercise, the national coronavirus response was plagued throughout 2020 by a lack of domestic manufacturing capabilities and persistent shortages of PPE and medical supplies.[70]

C. The Trump Administration's Failed Stewardship Over the Pandemic Response and Persistent Pattern of Political Interference Undermined the Nation's Ability to Respond to the Pandemic.

1. Trump Administration officials failed to adapt the government's pandemic response as public health experts' understanding of the virus evolved.

Government scientists' and public health experts' understanding of the coronavirus evolved rapidly in late January and February 2020. While scientists and experts obtained emerging information about the virus through deployments on the ground, clinical observations, and peer-reviewed publications, the nation's public health agencies were slow to tailor coronavirus response strategies to reflect experts' prevailing understanding of the virus.

a. <u>The focus on symptomatic transmission of the coronavirus hampered the country's ability to control and mitigate its spread.</u>

On January 17, 2020, CDC and Customs and Border Protection instituted an enhanced entry risk assessment and management program to screen air passengers arriving in the country with the goal of reducing the importation and spread of the coronavirus. The process began at

three airports in Los Angeles, San Francisco, and New York City, targeting passengers arriving from Wuhan, China presenting with symptoms so that they could be separated and tested for the coronavirus.[71] One CDC quarantine medical officer who served at one of those airports starting in mid-January spoke with Select Subcommittee staff on the condition of anonymity. The officer said that frontline CDC officials who were assigned to screen travelers as they deplaned were instructed not to wear PPE, including masks, gloves, and face shields, so as not to alarm arriving passengers.[72] At the same time, CDC personnel conducting tertiary screenings—evaluating passengers in secondary areas who had been flagged by frontline workers as a potential risk—were allowed, and even required, to use protective equipment.[73] According to the officer, on February 2, CDC updated its policies and required frontline workers conducting the initial screenings to wear surgical face masks but not face respirators.[74] The officer told Select Subcommittee staff that CDC officials were concerned that if the public observed health officials using full protective equipment it "might cause fear" and that they were "concerned how this might appear politically."[75] While the airport screening policy expanded over the next two months to incorporate more airports and travelers arriving from additional countries, government efforts to contain and mitigate the spread of the coronavirus failed to evolve in response to the growing understanding that the virus could spread—and was spreading—asymptomatically.[76]

As early as January 2020, public health experts reported that the coronavirus could spread through contact with asymptomatic or pre-symptomatic carriers. On January 24, a study appeared in the *Lancet* discussing a familial cluster of cases in China associated with the coronavirus, noting that it is "crucial to isolate patients and trace and quarantine contacts as early as possible because asymptomatic infection appears possible."[77] During a press conference held by HHS on January 28, Dr. Redfield acknowledged that "[t]he Chinese have reported transmission in the asymptomatic phase" but said "CDC has not been given the opportunity to review that data." He said: "We're going to present the data that we have and we're not necessarily going to reaffirm someone else's conclusion."[78] During his transcribed interview, Dr. Redfield told the Select Subcommittee that, at the time of that press conference, he believed that asymptomatic spread "was not the major way" that the virus was spreading and, as a result, health officials "were still operating under the SARS-MERS model" which projected spread based on symptomatic transmission.[79] On January 30, scientists published a study in the *New England Journal of Medicine* (NEJM) examining asymptomatic transmission of the coronavirus to a German businessman and his coworkers. The authors explained the implications of their findings, writing: "The fact that asymptomatic persons are potential sources of 2019-nCoV infection may warrant a reassessment of transmission dynamics of the current outbreak."[80]

In February 2020, additional studies showed that focusing on asymptomatic and pre-symptomatic spread would be a critical factor in mitigating the impact of the pandemic. Authors of a February 18, 2020, correspondence in NEJM wrote about asymptomatic infections in travelers returning from Wuhan, stating:

> In this effort to evacuate 126 people from Wuhan to Frankfurt, a symptom-based screening process was ineffective in detecting SARS-CoV-2 infection in 2 persons who later were found to have evidence of SARS-CoV-2 in a throat swab. We discovered that shedding of potentially infectious virus may occur in persons who have no fever and no signs or only minor signs of infection.[81]

A February 19 correspondence in NEJM that measured the viral load of SARS-CoV-2 in upper respiratory specimens stated that: "The viral load that was detected in the asymptomatic patient was similar to that in the symptomatic patients, which suggests the transmission potential of asymptomatic or minimally symptomatic patients."[82]

As research was beginning to show that asymptomatic spread was occurring, it was becoming apparent that symptom-based airport screening was insufficient to slow the spread of the coronavirus. A study published on February 6, 2020, in a European infectious disease journal found thermal screening of travelers at airports infected with the coronavirus to be an ineffective means of detection, finding that an estimated 46% of infected travelers may not be detected by screening at airport entry or exit.[83]

As early as February 2020, CDC career scientists advised government officials that asymptomatic and pre-symptomatic transmission was a driving factor of coronavirus spread, warning that government policy to contain the virus based solely on symptomatic transmission was insufficient. Dr. Daniel Wozniczka, a veteran of the Commissioned Corps of the U.S. Public Health Service and Epidemic Intelligence Service (EIS) submitted a whistleblower complaint to the Select Subcommittee about his experience working on CDC's pandemic response, including his role working on tertiary screening at Honolulu International Airport. Dr. Wozniczka said that, in late February, he "began to raise concerns that CDC policy was only accounting for symptomatic spread of the virus," telling his EIS supervisors in Hawaii that "this was not an appropriate or rational response in light of the scientific research available at the time."[84] According to Dr. Wozniczka, throughout late February and March, many of his EIS colleagues raised similar concerns during their deployments at other airport screening stations throughout the country, warning: "In order to slow the spread of the virus, the CDC needed to lead public policy to address the more important concern of asymptomatic/presymptomatic spread."[85]

On February 29, 2020, an EIS response team was deployed to Seattle, Washington to respond to coronavirus outbreaks at various health care facilities. Dr. Wozniczka recounted that within a week of the deployment, his EIS colleagues in Seattle reported internally that "the data was clear: Many of the cases fueling the Seattle outbreak were the result of asymptomatic/presymptomatic spread."[86] Despite these warnings, CDC continued to expand symptomatic airport screening procedures. Effective March 14, as Europe became a new epicenter of coronavirus outbreaks, travelers from 26 countries in the European Schengen Area, the United Kingdom, and Ireland were added to airport screening procedures, and the number of airports conducting screenings expanded to 13.[87]

According to Dr. Wozniczka, his EIS supervisor received the concerns expressed by Dr. Wozniczka and his colleagues and did not express any contradictory beliefs regarding the prevailing science. In fact, CDC updated its own internal guidance to reflect the new understanding of asymptomatic spread. Dr. Wozniczka explained:

> To protect its own staff, CDC was using the correct, science-based guidance before they made it public. On March 9, 2020, the CDC issued internal guidance that staff

> returning from COVID deployments must quarantine for 14 days before returning to the office, regardless of if they were presenting symptoms.[88]

Nevertheless, CDC's external facing policies remained unchanged. Dr. Wozniczka said he "felt trapped" because "[t]he data was telling them what it would take to slow the virus and protect the public, but their agency—the global leader in health science—was not acting accordingly."[89]

On March 27, 2020, the Seattle EIS deployment team published a Morbidity and Mortality Weekly Report (MMWR) detailing asymptomatic spread in Washington State—the first time CDC independently demonstrated asymptomatic spread, approximately two months after the first *Lancet* and NEJM publications and a month after Dr. Wozniczka and his colleagues first raised the alarm about recognizing asymptomatic transmission.[90] In a call with Select Subcommittee staff, Dr. Wozniczka said that CDC's failure to recognize the prevailing science and acknowledge asymptomatic spread earlier was "not only scientifically incorrect but cost billions of dollars and tens of thousands of American lives."[91] Ultimately, the resource-intensive screening program yielded just nine positive test results, representing 0.001% of all travelers screened, or one case per 85,000 travelers.[92]

Other officials within CDC and at the White House shared the belief that syndromic border screenings were misguided and contributed to community spread. Dr. Deborah Birx told the Select Subcommittee during a transcribed interview that, when she began her position as White House Coronavirus Response Coordinator on March 2, 2020, she was "concerned very much about asymptomatic spread and the depth and breadth of asymptomatic spread" including concerns that airport screening "was symptom-based and that people were relying on fever and symptoms both for screening and for reporting later." She believed that, as a result of symptomatic airport screening, "50% or more of the cases were being missed that were responsible for community transmission."[93]

Dr. Martin Cetron, Director of CDC's Division of Global Management and Quarantine, told the Select Subcommittee during a transcribed interview that he was frustrated by CDC's focus on symptomatic evaluation rather than mitigation strategies. According to Dr. Cetron, public health officials' reliance on airport screening came "at the expense of thinking about the level of domestic mitigation that was going to be necessary" which "[w]as becoming very, very clear by February." Dr. Cetron told the Select Subcommittee that "[t]hings weren't being taken seriously enough" and "weren't moving quickly enough," and that he "just didn't feel like there was enough listening going on." Dr. Cetron explained that the nation's "overreliance on border measures alone" detracted from ramping up other necessary preparedness measures like "testing, isolation, quarantine, cohorting, mask use, all of that other stuff" which "could mitigate the impact," "alleviate the strain on health care systems," and "save lives." He concluded that expanding containment and mitigation efforts in February "would have helped significantly alleviate a lot of—a lot more suffering and death."[94]

b. Trump Administration officials' prioritization of repatriation detracted from efforts to implement mitigation measures.

In the initial months of 2020, multiple agencies across the federal government, including CDC and the Department of State, led efforts to repatriate Americans who were working and traveling abroad. Beginning in January, the United States chartered flights to evacuate American diplomats, consulate staffers, and private citizens from the coronavirus epicenter in Wuhan, China, implementing health screening and quarantine measures for those passengers.[95] In February and March, repatriation efforts expanded to include Americans traveling on cruise ships around the world—efforts that required coordination and cooperation from numerous senior officials and federal agencies.[96]

One of those efforts included repatriation of Americans traveling on the Diamond Princess cruise ship which had docked outside of Japan in mid-February due to a coronavirus outbreak onboard the vessel. As was widely reported at the time, the decision regarding the proper method of transporting Americans home, and how to best maintain infection control, was fraught due to numerous positive test results obtained prior to the departure of the return flight.[97] Repatriation efforts consumed the time of numerous senior officials from multiple agencies, including the White House Coronavirus Task Force itself.[98]

Dr. Schuchat told the Select Subcommittee during a transcribed interview that, while important, the focus of public health leaders on repatriation in late February—when the coronavirus was beginning to spread widely around the United States—instead of on initiating mitigation measures detracted from the "bigger priority" of ensuring that the nation was adequately prepared for the eventual spread of the virus. Dr. Schuchat said:

> I don't think I can convey how much technical, policy, and human resources were focused on repatriation in February. As you can imagine, every location, cruise ship, had a jurisdictional issue with multiple departments and state as well as federal level authorities, and a good number of ASPR, CDC, and the leadership, HHS or other departments, were focused on repatriation at a time when the virus was spreading, and the issue of initiating mitigation and other measures in affected communities in the U.S. I believe was a higher priority.[99]

As a result of the government's narrow focus on repatriation, Dr. Schuchat explained that "there were key areas, like scaling up PPE and getting our arms around the supply chain and protecting the health care system and so forth," that "didn't get sufficient attention because of the leadership and policy time that was going into the repatriation mission." She said, the "whole of government . . . should have been focused on those bigger picture items":

> [W]e were trying to queue up the planning for community mitigation for—you know, in our efforts to delay the spread, we were trying to queue up the health care preparedness in terms of PPE and reusables, and what was the strategy to get enough where we knew we didn't have enough supply. That couldn't get onto the agenda because most of the conversations were, how are we going to deal with this batch of cruise ship people.[100]

Dr. Schuchat expressed that officials' disproportionate focus on repatriation was "another sign of how underprepared we were, you know, frontline public health organizations and on certainly the policy level." As a result of "the focus on the repatriation challenges and the cruise ship issues," "we didn't have the right policy governance to get the key issues escalated and decisions made."[101]

2. A lack of coordination between public health agencies contributed to the nation's impaired coronavirus response efforts.

a. CDC failed to develop and deploy an accurate test for the coronavirus in the earliest weeks of the pandemic.

As reported cases of the coronavirus began to grow throughout January 2020, the need for countries to develop an accurate test for the virus became increasingly apparent.[102] On January 11, the genetic sequence of the coronavirus was posted online by Chinese researchers and shared directly with WHO.[103] Two days later, the WHO publicly released a protocol for designing a test for the coronavirus.[104] The United States elected to forgo using that protocol and instead developed its own test at CDC. However, initial tests experienced well-documented validation issues that hampered the country's early testing capabilities and materially impaired the federal government's ability to track and mitigate the spread of the virus in the earliest weeks of the pandemic.[105]

The Select Subcommittee obtained an October 2020 Root-Cause Analysis (RCA) conducted by CDC's Office of Laboratory Science and Safety, which examined the factors contributing to CDC's failure to detect the performance problems with the initial tests. This document confirms earlier reporting detailing the findings of the analysis and that CDC formally requested an emergency use authorization (EUA) for its test from FDA on February 3, 2020.[106] FDA granted the EUA the following day, clearing its use in any CDC-qualified public health lab in the country.[107] On February 6, as public health labs began receiving the test kits, CDC's Respiratory Viruses Branch made two important discoveries: First, the quality control testing previously performed on the kits did not follow the EUA procedure. Second, after the correct quality control procedure was performed on three kits, one of the kit's controls, called the "No Template Control," was positive with the "N3 molecular target," which should have been negative—indicating that there could be a 33% kit failure rate.[108] In a transcribed interview with the Select Subcommittee, Rear Admiral Michael Iademarco, Director of CDC's Center for Surveillance, Epidemiology, and Laboratory Services, said that a 33% kit failure rate constituted a "significant" performance issue.[109]

Despite these discoveries, CDC did not halt delivery of its test kits or issue a performance alert to public health labs that received its kits.[110] On February 8, 2020, labs began reporting test kit verification failures.[111] Over the next several days, more labs reported problems with the N3 component of the test, causing many to forgo coronavirus testing until CDC remediated the issue.[112] In a newly released February 15 email, Jeff Shuren, Director of FDA's Center for Devices and Radiological Health, told FDA Commissioner Dr. Stephen Hahn and other FDA leadership that approximately 26 public health labs had reported false positive results and informed them that there were "two new issues regarding the CDC's test." Dr. Shuren explained that some labs were

now reporting potential false positives with the N1 component of the test, indicating that there were possible design issues beyond the N3 component. He also told FDA leadership that it was "particularly concerning" to learn that the test CDC validated for purposes of the EUA "used a different lot of components than the test that was manufactured for public health labs, i.e., they were made by two different entities (and they clearly perform differently)"—a finding that is consistent with one of the RCA's conclusions. According to Dr. Shuren, CDC "shouldn't have done that" and, after they did so, "should have told us [FDA] at the outset."[113]

Ten days later, Dr. Shuren informed FDA Chief of Staff Keagan Lenihan that "CDC hasn't settled on what they want to do with their test (e.g., use test using N1 and N2 or also use N3)." Dr. Shuren said that his team "can't get a straight answer" from CDC on how to proceed.[114] During his transcribed interview with the Select Subcommittee, Dr. Hahn acknowledged that FDA was frustrated with CDC at this time over CDC's approach for remediating the issues with the test kits.[115] With progress on testing stalled for weeks, FDA advised that public health labs could use CDC's test kit without the problematic N3 component. On February 28, 2020, Dr. Messonnier announced that labs "can start testing" using "revised instructions" from CDC that excluded reliance on the N3 component.[116] By the end of February, the United States had conducted fewer than 500 tests. By comparison, South Korea—which made significant investments in commercial development of diagnostic tests following lessons learned from the Middle East Respiratory Syndrome (MERS) outbreak in 2015—had tested at least 65,000 people.[117]

CDC's internal RCA ultimately identified "process failures, a lack of appropriate recognized laboratory quality standards, and organizational problems related to the support and management of a laboratory supporting an outbreak response" as root causes of the test kit failure.[118] It concluded that "CDC's failure to detect the EUA Test Kit verification problem prior to distribution is a quality process failure of incalculable cost."[119] A CDC analysis published on December 15, 2021, determined that the test kits were impacted by both a design flaw and contamination issues.[120] In his transcribed interview with the Select Subcommittee, Dr. Redfield acknowledged the early challenges with the test kits and disclaimed responsibility for the design flaw, stating: "had I been involved in those decisions at the time, I would have recommended a contract manufacturing company manufacture those" primer components instead of having CDC produce the components in house.[121]

Multiple experts have cited the extended delay between the release of the genetic sequence of the coronavirus on January 11, 2020, and the deployment of a reliable test in the United States as a critical factor that allowed the virus to spread throughout the country largely unchecked in the earliest weeks of the pandemic. It has also been recognized as a misstep that contributed to public distrust in CDC.[122] Dr. Redfield told the Select Subcommittee that it was "a personal disappointment to me that CDC wasn't patted on the back for developing a test rapidly and deploying it."[123]

b. The federal government did not promptly engage diagnostic test manufacturers or adequately incentivize test development early in the pandemic.

Multiple senior officials told the Select Subcommittee that the early response effort was impaired by the federal government's failure to fully engage diagnostic test manufacturing companies or incentivize the rapid development of tests at the outset of the coronavirus outbreak. According to Dr. Hahn, FDA wanted to conduct formal outreach to diagnostic manufacturing companies to encourage them to develop and seek authorization of coronavirus tests as early as late January 2020 but was advised "that HHS was not in favor of it" at that time, citing potential ethical and legal concerns. Instead, FDA eventually began proactively communicating with industry regarding test development around mid-to-late February 2020, after Secretary Azar told Dr. Hahn in a meeting that FDA was allowed to "go ahead" with such outreach.[124]

Echoing Dr. Hahn's statements, Dr. Redfield told the Select Subcommittee that the first time that he was part of "a serious discussion" about the federal government working with commercial diagnostic companies to scale up testing was after the Vice President took over the White House Coronavirus Task Force in late February 2020. According to Dr. Redfield, this conversation occurred during a meeting at the White House where large diagnostic companies were finally urged by the Administration "to get engaged in this."[125] Dr. Birx likewise confirmed that no one in the federal government had contacted some of the largest diagnostic companies operating in the United States to coordinate on testing until after she arrived at the White House on March 2, 2020.[126]

Reflecting on this timeline, Dr. Redfield told the Select Subcommittee that he believes "there was a missed opportunity" in January 2020 for the federal government to "stimulate" private sector development of coronavirus tests by incentivizing production with funding from the Biomedical Advanced Research and Development Agency (BARDA) and working in partnership with FDA "to accelerate tests for commercial use."[127] Dr. Redfield explained that he believed industry was initially reluctant to invest in the development of coronavirus tests after their experience with outbreaks of MERS and SARS, "where they converted all this money and developed these tests and there was no market for them." As a result, Dr. Redfield said the private sector initially operated under the assumption that the coronavirus "was going to be another SARS and MERS" and "was not going to go anywhere." He acknowledged that this thinking contributed to "a severe shortage" of tests during the early months of the pandemic.[128] Additionally, according to Dr. Hahn, as CDC was struggling to develop a reliable coronavirus test, there was a misconception among some public health laboratories that FDA had "chose to work solely with CDC" on developing a coronavirus test and had advised outside labs to stop developing other tests. Dr. Hahn told the Select Subcommittee that these perceptions were not true and reflected "a fundamental misunderstanding of what the agency does," while contributing to delays in scaling up production of diagnostic tests in the United States.[129]

c. HHS revoked FDA's authority to conduct premarket reviews of lab-developed tests.

Amid CDC's stalled efforts to develop and distribute a reliable coronavirus test during the earliest weeks of the pandemic, some clinical laboratories expressed frustration about what they perceived as the lack of speed in FDA's authorization of lab-developed tests (LDTs) for the coronavirus.[130] Historically, FDA often waived premarket requirements for LDTs via agency enforcement discretion, allowing most of these tests to be used without premarket review or other formal agency clearance.[131] During the coronavirus public health emergency, however, FDA required diagnostic test developers to seek premarket review of their coronavirus tests, so the agency could validate the accuracy and reliability of the tests before they were put to use.[132] According to Dr. Hahn, FDA's goal for these requirements was to ensure potentially inaccurate coronavirus tests would not reach the market and drive incorrect public health decisions.[133] Dr. Redfield told the Select Subcommittee that he "had a number of calls" with Dr. Hahn around this time in which he argued that FDA "needs to grant regulatory discretion" so that LDTs could be deployed for the coronavirus prior to FDA completing its premarket review.[134]

FDA ultimately issued an enforcement policy on February 29, 2020, under which certain labs were permitted to market coronavirus LDTs prior to receiving FDA authorization once the developer validated the test and notified FDA of its intention to start testing patient samples. As part of this policy, FDA said that it expected labs to submit an EUA request within 15 business days from the date they began using the test.[135] According to an FDA document obtained by the Select Subcommittee summarizing the agency's role in early diagnostic test development, this policy "put these labs on the honor system, and prioritized early access."[136] Dr. Hahn told the Select Subcommittee that, in hindsight, "it would have been ideal" had FDA made this policy change sooner because potentially "really good tests would have been put on the market" earlier, which "would have expedited testing."[137]

In the spring of 2020, HHS undertook a legal review of FDA's authority to regulate LDTs. This review culminated in a June 22 memorandum from HHS's General Counsel concluding that the legal authority relied on by FDA to regulate LDTs had "several weaknesses" that made its policy vulnerable to a legal challenge. The memorandum also noted that "some stakeholders, including many state university laboratories, have complained that this policy hindered their ability to develop and use LDTs to detect the virus that causes COVID-19."[138]

Dr. Hahn told the Select Subcommittee that HHS officials raised the prospect of revoking FDA's premarket review authority over LDTs in early July 2020.[139] Specifically, Dr. Hahn said that HHS Chief of Staff Brian Harrison expressed concerns that FDA "was stifling innovation and making it more difficult for LDTs to be commercially available."[140] Dr. Hahn said that he disagreed with these concerns, and that HHS and FDA initially brokered a compromise in which FDA would continue regulating LDTs during the coronavirus public health emergency, but would support revisiting the broader issue of FDA's legal authority over LDTs at a legislative and policy level once the emergency ended.[141] Consistent with these statements, in a newly released August 21, 2020, email to Dr. Hahn under the subject "LDT Next Steps," Stacy Amin, FDA's Chief Counsel, recounted that she sent a "draft compromise" to HHS's General Counsel on July 6 and spoke with him that same day, after which he told Ms. Amin that "[h]e agreed with the compromise and asked me to brief it to WHCO [White House Counsel's Office]."[142] However, according to

Dr. Hahn, HHS subsequently "went back to the original proposal" and drafted a statement for FDA stating that FDA "would no longer require mandatory reviews of LDTs" and that FDA "had determined that they were illegal."[143]

Dr. Hahn told the Select Subcommittee that he and Secretary Azar had a "tense" telephone conversation regarding these issues on August 6, 2020.[144] According to Dr. Hahn, Secretary Azar wanted FDA to publicly announce that it no longer had jurisdiction over the premarket review of LDTs. Dr. Hahn said that he refused, citing FDA's longstanding position that the agency had the requisite legal authority to regulate LDTs and concerns with allowing unvalidated coronavirus tests onto the market.[145] Dr. Hahn said that Secretary Azar "raised his voice" and was "very vocal and demonstrative" during the call."[146]

On August 19, 2020, HHS unilaterally issued a one-paragraph announcement stating that FDA may not require premarket review of any LDTs—including coronavirus LDTs—absent a notice-and-comment rulemaking process.[147] The announcement was posted on HHS's website, not FDA's, and indicated that it was created by HHS's Office of the Assistant Secretary for Public Affairs, led at the time by Michael Caputo—a close political ally of President Trump who, as previously reported, bullied and threatened career CDC officials who contradicted Trump Administration messaging on the coronavirus.[148] According to a newly released email from Ms. Amin, HHS also instructed FDA's Chief Counsel not to be involved in the matter moving forward, after Ms. Amin "voic[ed] disagreement over the web statement."[149] Dr. Hahn said he raised objections to HHS's unilateral action with White House Domestic Policy Council Director Joe Grogan and Dr. Birx, but to no avail.[150] According to press reports, Secretary Azar decided to revoke FDA's premarket review authority over LDTs—despite strong objections from FDA leadership—as part of an effort to deflect responsibility for the federal government's inability to scale up testing capacity more rapidly during the earliest months of the pandemic.[151]

On November 15, 2021, HHS Secretary Xavier Becerra announced that HHS was withdrawing the Trump Administration's policy limiting FDA's ability to require premarket review for LDTs, explaining that in doing so, "HHS is helping to ensure that COVID-19 tests work as intended."[152]

3. The Trump Administration failed to implement a successful strategy to manage the supply chain and acquire sufficient PPE in the critical early months of the coronavirus crisis.

a. <u>The Trump Administration ignored early calls to mobilize supply chains and domestic manufacturing.</u>

Documents and information obtained by the Select Subcommittee demonstrate that numerous individuals, including those appointed by President Trump, were aware of the need to shore up the manufacturing and procurement of PPE and other medical supplies in the early months of the coronavirus crisis. As early as January 2020, there were multiple warnings about the potential impact of the coronavirus and the need to implement a national strategy to alleviate shortages of critical supplies. Despite these warnings, the Trump Administration was slow to mobilize the supply chain and scale up testing capabilities, putting the nation at a severe disadvantage in its ability to control the spread of the coronavirus.

By January 30, 2020, reports publicly warned that the United States would quickly run out of protective equipment like masks in the event of a full-blown pandemic—which it also lacked the capacity to produce at scale.[153] On February 7, WHO warned of a potential "chronic shortage of personal protective equipment."[154] Reports throughout February continued to warn about the need to increase domestic production of medical supplies.[155]

A memorandum released by the Committee on Oversight and Reform in July 2020 detailed how industry leaders reached out to Trump Administration officials in early 2020 regarding the need to ramp up manufacturing of critical medical supplies in response to the coronavirus. Representatives from the Health Industry Distributors Association (HIDA), an industry group representing medical distribution companies that acted as a conduit between members of the health care distribution industry and the Trump Administration, told Oversight Committee staff that the organization facilitated calls with federal agencies as early as January 30, 2020. During those calls, HIDA member companies raised concerns about supply chain issues resulting from the coronavirus. For example, one company—Owens & Minor—stated that as early as February 2020, its internal projections showed that the demand for PPE would outpace available supply sources, even assuming PPE usage at the relatively conservative rate associated with the seasonal flu. Calls coordinated by HIDA continued throughout February and March and included representatives from ASPR, CDC, HHS, FEMA, NSC, and the SNS. HIDA representatives stated that, although "folks in the industry saw that things were getting worse, and their requests for guidance w[ere] increasing week by week," "guidance wasn't coming" from the Trump Administration regarding how to project or prepare for the increasing demands for PPE and medical supplies.[156]

Even officials within the White House warned about the potentially devasting impacts of the coronavirus and the need to increase supplies of PPE and other medical equipment vital to protecting American lives. In both January and February 2020, internal White House memoranda warned about the possible harms of coronavirus spread, including that infection could put millions of Americans at risk of illness or death and described expected needs for PPE over the next four-to-six month period.[157] Documents and information previously released by the Select Subcommittee in March 2021 revealed that at least one senior White House advisor, Director of the White House Office of Manufacturing and Trade Policy, Peter Navarro, warned of the expected need for PPE and advised the Trump Administration to strengthen domestic supply chains in early 2020.[158]

Although the Trump Administration was advised by numerous parties and stakeholders early in 2020 of the significant risk posed by the coronavirus, it failed to heed advice about how to adequately prepare for the imminent emergency. Instead, President Trump downplayed the seriousness of the looming crisis, and his Administration failed to develop and execute an effective strategy to combat the pandemic.[159] This led to competing and chaotic efforts to acquire supplies—both inside and outside the Trump White House—with inadequate results.

b. President Trump delegated management of the supply chain to senior White House Advisor Jared Kushner, who relied on a team of inexperienced volunteers and consultants.

On March 29, 2020, President Trump announced the creation of a White House supply-chain task force that would be led by White House Senior Advisor Jared Kushner with the goal of augmenting the domestic supply and availability of PPE and medical supplies.[160] Instead of using experienced federal procurement officials, the task force was staffed, in part, by a team of young volunteers overwhelmingly drawn from venture capital and private equity firms, who sourced and followed incoming leads for PPE.[161] One volunteer, Max Kennedy, who served on the task force and provided information about that experience to the Select Subcommittee, explained: "None of the volunteers working on the sourcing team had any significant experience in procurement or distribution. Every volunteer on the sourcing team came from a finance background and was under 28."[162] Jessica Stone, a partner at Boston Consulting Group (BCG) who worked on efforts related to the supply chain task force, affirmed the presence of these volunteers, saying during a transcribed interview that "they came from like private equity or places in New York, companies in New York" and they "were vetting leads on PPE."[163]

In addition to these volunteers, the task force was comprised of contractors from management consulting firms, including BCG and McKinsey & Company (McKinsey) which worked on the task force in a consulting capacity. During a transcribed interview, Daniel Moskovic, a partner in McKinsey's health care practice, explained that his "main role [was] to advise the government in analyzing data and providing information and recommendations to inform the government's decision-making" and conduct "research on best practices that health systems were using to preserve PPE." When asked about his prior experience before joining the task force, Mr. Moskovic said that he "didn't know anything about government contracting when [he] started." Mr. Moskovic characterized his work for the task force as being "quite unusual," saying "this type of work is atypical—or was atypical for me" because he had not previously performed any consulting work for a government entity.[164] Sonya Hoo, a partner at BCG, told the Select Subcommittee that BCG's work involved "getting a sense of where PPE was manufactured and where it was likely to be coming from into the U.S., and sort of how, you know, the physical goods would be distributed within the U.S."[165] Prior to their work for the task force, neither Ms. Hoo nor Ms. Stone had experience in federal procurement or distribution.[166] Nevertheless, Ms. Hoo, Ms. Stone, and Mr. Moskovic all told the Select Subcommittee that no training was provided to them by FEMA or the federal government prior to or during their work.[167]

According to Mr. Kennedy, the task force struggled to keep up with the voluminous number of incoming leads regarding possible PPE suppliers. Mr. Kennedy explained: "Our team was relatively small compared to the number of leads. There were hundreds if not thousands of leads, and only about 10 volunteers. This overloading made it more difficult to be responsive to every lead, slowing down response times and causing confusion."[168] Furthermore, volunteers were told to prioritize tips from "VIPs" including political allies, associates of President Trump, and Republican Members of Congress. At the same time, other leads provided by medical professionals with longtime manufacturing contacts, but no political connections, were passed over or ignored. For instance, Mr. Kennedy described how he was told to prioritize leads from Avi Berkowitz, Mr. Kushner's Chief of Staff, Charlie Kirk, Jeanine Pirro, a Fox News Channel host,

Tana Goertz, creator of the "Women for Trump" coalition, and Albert Hazzouri, a friend of President Trump.[169] Mr. Kennedy said the work of the task force was further impeded as volunteers were instructed to use personal email accounts when sourcing leads, causing confusion among distributors and manufacturers.[170]

Ultimately, the task force's efforts do not appear to have resulted in a meaningful increase in procurement of PPE or medical supplies. According to public reporting, federal officials with years of experience devising emergency plans said that it was difficult to identify specific contracts that the task force had successfully sourced. Multiple FEMA officials familiar with these efforts said they were largely ineffective in securing life-saving equipment for the government and led to missed opportunities to procure PPE from legitimate sources.[171] Mr. Kennedy similarly said:

> I was not aware of FEMA directly procuring any PPE while I was there. I know the government did procure some PPE for the national stockpile, but most of it was due in late 2020 or 2021. Numerous leads were sent to procurement, but they did not move forward as far as I know.[172]

The McKinsey and BCG contractors who spoke with the Select Subcommittee did not contradict this account, saying they had no visibility into the amount of PPE ultimately sourced by the task force. When asked what the results were of his efforts on the task force, Mr. Moskovic said, "I don't know, and I didn't have visibility into anything—into anything going on outside of the purview of folks who [we] were interacting with and topics we were directly engaging with." Despite his work with the task force, Mr. Moskovic did not have a sense of the amount of PPE, if any, that was procured, saying, "I couldn't tell you if it was zero to any, I have no idea."[173] Ms. Stone confirmed that, while she understood the purpose of the task force was "to bring in as much PPE as possible," she "can't speak to the overall success or not" of the task force.[174]

Mr. Kennedy attributed FEMA's failure to procure PPE to the fact that "[n]o one on the sourcing team had any procurement experience, which likely slowed down the process." Mr. Kennedy called the task force's procurement efforts a "hugely inefficient operation," saying the process was "highly iterative and confusing, with many missteps and frequently duplicated work."[175] Mr. Moskovic echoed that sentiment, saying that the efforts "lacked some organization" as there were "competing efforts that ran parallel to one another." Mr. Moskovic expressed: "I think there was inefficiencies, absolutely." He elaborated, saying:

> There was a lot of effort focused on purchasing. And to the discussion we had earlier, that was—that was time that was spent trying to take whatever supply was in the system and corral it. When, as we discussed, the real fundamental solutions were supply expansion, either by making more stuff or reusing stuff and demand mitigation. So, you know, if you asked me my opinion on it … I don't know if those efforts saw success.[176]

c. Project Airbridge wasted taxpayer money and had a negligible impact on supplies distributed in the early months of the pandemic.

At the end of March 2020, rather than procuring PPE directly, the Trump Administration established "Project Airbridge," which allocated taxpayer funds to provide free transportation for PPE procured by private sector companies.[177]

The short-lived program was unfocused and shrouded in secrecy.[178] The Trump Administration declined to make any substantive decisions about which recipients would receive the PPE brought in by Project Airbridge or the amounts they could be charged—for upwards of 50% of the PPE imported at taxpayer expense, private companies had full discretion regarding where to sell it, to whom, and at what price. The only guidance for pricing was that PPE should be sold "at a reasonable price (i.e., the price that a prudent and competent buyer would be willing to pay given available data on market conditions)."[179] Mr. Kennedy confirmed that "[f]or goods that were shipped by the air bridge, 50% of the materials had to be distributed to hot spots" but he "was not aware of any pricing controls."[180] Where the supplies that were ultimately delivered by Project Airbridge were distributed remains largely unknown.[181]

Notwithstanding the Administration's ambitious claims about the success of Project Airbridge, it had a negligible effect on the nation's capacity to respond to the pandemic.[182] While the Trump Administration widely touted the project's role in distribution efforts, the project imported a relatively small number of supplies that were ultimately distributed around the country. On June 16, 2020, Vice President Pence stated: "Our administration launched a partnership with private industry that, as of June 12, had delivered more than 143 million N95 masks, 598 million surgical and procedural masks, 20 million eye and face shields, 265 million gowns and coveralls, and 14 billion gloves." In reality, only about 7% of that PPE came through Project Airbridge.[183] When asked about his thoughts regarding the success of the project, Dr. Kadlec expressed that Project Airbridge would have been more effective "if we could have gotten more product. The problem was not flying it over. We had the means between the military and FedEx and UPS to do that."[184]

d. Former White House Director of Trade and Manufacturing Policy Peter Navarro circumvented proper procurement channels and sought contracts without adequate diligence or competition.

Former White House Director of Trade and Manufacturing Policy Peter Navarro led his own secretive supply acquisition efforts, without clear results. Rather than relying on experienced federal procurement officials and public health experts, Mr. Navarro utilized unaccountable outside advisors to negotiate multi-million-dollar contracts without adequate competition or due diligence. In 2021, the Select Subcommittee released evidence showing how Mr. Navarro pressured agency officials to award lucrative contracts to companies he preferred, instead of pursuing traditional routes through experienced government contract officials, leading to two contracts of questionable utility and a failed loan agreement.[185]

i. *Contract with Phlow Corporation*

In one case, Mr. Navarro pushed BARDA to award a multi-million-dollar no-bid contract to manufacture pharmaceutical ingredients to Phlow Corporation—a first-time government contractor that had been incorporated just months earlier, in January 2020.[186] The Select Subcommittee obtained emails showing that on March 20, 2020, Mr. Navarro wrote to BARDA Director Rick Bright and Dr. Kadlec, saying:

> My head is going to explode if this contract does not get immediately approved. This is a travesty. I need PHLOW noticed by Monday morning. This is being screwed up. Let's move this now. We need to flip the switch and they can't move until you do. FULL funding as we discussed.[187]

A week later, on March 26, Mr. Navarro sent an email to Phlow's CEO and officials at FEMA and HHS, writing: "Phlow needs to be greenlit as soon as humanly possible. … Please move this puppy in Trump time."[188] Following Mr. Navarro's efforts, BARDA awarded a four-year, $354 million contract to Phlow on May 18, 2020, to manufacture active pharmaceutical ingredients (API) and generic drugs. The contract included options worth an additional $458 million, for a total value of up to $812 million over 10 years—the largest contract ever awarded by BARDA at the time.[189]

ii. *Contract with Airboss Defense Group*

The Select Subcommittee also uncovered evidence that Mr. Navarro pushed a separate, $96 million sole-source contract for powered respirators and filters from AirBoss Defense Group (ADG), without any apparent due diligence or competition. On March 22, 2020, retired General John "Jack" Keane—a paid consultant to ADG whom President Trump had recently awarded the Presidential Medal of Freedom—sent an email to Mr. Navarro stating, "sent you a catalog of items that ADG can provide, all needed for fight vs CV19. They can surge." Mr. Navarro replied, "On it."[190] The next day, ADG submitted a $96 million proposal to the White House to supply powered respirators.[191] Mr. Navarro responded that the company should "consider it done" and instructed ADG to begin delivery, even though no contract had been executed.[192] An ADG executive later sent an email describing a March 25 call, saying:

> I received a call from Mr. Navarro and Dr. Hatfield [sic] telling me that 'your government appreciates what you can do, and now we need you to trust your government and begin to execute.' 'We will get you on contract as quick as we can. Everything you have requested is ok.'[193]

On March 31, FEMA executed the final contract as a sole-source award—even though multiple manufacturers made those same products—agreeing to pay the full $96.4 million requested by ADG.[194] This award contributed to a 327% increase in ADG's net sales between April and June 2020 over the previous year and to a more than $12 million increase in gross profit for ADG's parent company for the same period.[195]

iii. *Proposed Loan to Eastman Kodak Company*

On August 4, 2020, the Select Subcommittee launched a joint investigation with the Committee on Financial Services and the Committee on Oversight and Reform regarding a letter of intent signed on July 28 between the Eastman Kodak Company (Kodak) and the U.S. International Development Finance Corporation (DFC) for a $765 million loan to manufacture pharmaceutical ingredients.[196] The amount of the loan raised immediate questions due to the fact that Kodak had no prior experience manufacturing pharmaceutical ingredients.[197] Further questions were raised after it was reported that Kodak's CEO had purchased Kodak shares and been awarded 1.75 million stock options by the company's board in the weeks before the loan was announced.[198] Two days after the Select Subcommittee launched its joint investigation, the Trump Administration placed the deal on hold, conceding that "allegations of wrongdoing raise serious concerns."[199]

The Select Subcommittee investigated the circumstances that led to Kodak's receipt of the letter of intent from DFC, and identified evidence that Trump White House officials, led by Mr. Navarro, had pushed Kodak to significantly increase the scope of the loan it sought to domestically manufacture APIs. The Select Subcommittee found that, on March 20, 2020, Kodak wrote to the White House to offer assistance with manufacturing hydroxychloroquine—a drug that had received an EUA from FDA one day prior after President Trump touted it as a powerful coronavirus treatment.[200] Kodak estimated that it would need $15.3 million to produce a chemical used in hydroxychloroquine and sought a loan from the federal government to do so. Kodak acknowledged in emails to HHS and FDA that it lacked the capacity to meet FDA's requirements for current good manufacturing practices (cGMP) and would "need a waiver from the FDA's cGMP requirements" to manufacture hydroxychloroquine.[201] Despite the company's own admission that it had no experience in pharmaceutical manufacturing, Mr. Navarro's staff entered into active discussions with Kodak executives about increasing the size of Kodak's loan request. A report by a Special Committee of Kodak's Board of Directors indicates that Mr. Navarro's office encouraged Kodak to "think bigger" in seeking a loan substantial enough to develop capacity to produce pharmaceutical ingredients.[202] Mr. Navarro's office then introduced Kodak executives to officials at DFC, who would ultimately be responsible for the proposed loan.[203] Mr. Navarro praised the announcement of the loan on July 28, saying it posed "minimal risk to the taxpayer" and had been executed with "the greatest of due diligence."[204] The loan was put on hold less than two weeks later and ultimately never issued.

e. The Trump Administration's inability to alleviate supply chain shortages created a heightened risk of waste, fraud, and abuse of taxpayer resources as federal agencies rushed to award contracts to unvetted suppliers like Federal Government Experts.

Skyrocketing demand for PPE and other critical medical equipment caused global supply shortages after the onset of the coronavirus crisis in early 2020. These shortages jeopardized the health of frontline workers, patients, their families and caregivers, and the public.[205] Federal agencies, states, and private parties were left to fend for themselves during the early months of the pandemic.[206] This led to fierce competition on the open market for limited supplies—resulting in

increased prices and a rush to award contracts to unvetted suppliers as quickly as possible. These conditions created a heightened risk of waste, fraud, and abuse of taxpayer resources.[207]

The Select Subcommittee released a report in June 2021 detailing its investigation into federal contracts awarded to Federal Government Experts, LLC (FGE) by FEMA and the Department of Veterans Affairs (VA) for N95 masks in the early months of the coronavirus crisis.[208] This investigation found that FGE's Chief Executive Officer and owner, Robert Stewart, Jr., fraudulently acquired $38.7 million in federal contracts by lying to FEMA and VA officials, claiming that he was in possession of large quantities of N95 masks when, in reality, he had none and no realistic plan to obtain any. Evidence obtained by the Select Subcommittee also revealed that federal procurement officials failed to perform adequate due diligence prior to awarding these contracts, despite clear red flags.[209]

As detailed in the Select Subcommittee's report, VA awarded FGE a $35.4 million contract for six million N95 masks on April 10, 2020. Mr. Stewart was able to drive up the price VA would pay per mask—a price that was more than three times the manufacturer's price—by claiming FEMA officials intended to purchase millions of masks.[210] After FGE failed to deliver the promised masks, VA's Office of Inspector General (OIG) opened a criminal investigation into Mr. Stewart with the Federal Bureau of Investigation (FBI), the U.S. Attorney's Office for the Eastern District of Virginia, and DHS OIG. VA and FEMA ultimately terminated their contracts with FGE on April 29, 2020, and May 26, 2020, respectively.[211]

Additional evidence obtained by the Select Subcommittee reveals that a VA official involved in the agency's contract negotiations with Mr. Stewart forwarded several internal emails to VA OIG prior to the award of the contract, saying that they were "[s]truggling with potential price gouging." On April 4, 2020, the official told the OIG:

> We've had multiple fraudulent vendors I've caught and have disappeared as we continue perform [sic] due diligence on these people. My concern is people at individual VAMCs [VA Medical Centers] who are let careful [sic] are going to get had. More and more people are asking for money up front as the market tightens. I[']d love to have a conversation. We got some solicitations that even appear to have fraudulent masks.[212]

VA OIG replied, stating: "This sounds like some of the exact type of cases our Investigative Development Division is interested in." Despite this apparent concern, VA awarded FGE a multimillion-dollar contract. Soon after, VA officials "became less and less confident" in Mr. Stewart and found "working with FGE post-award was very hard."[213]

Additional evidence shows that these officials warned a supply chain officer in VA's Rocky Mountain Network not to place an order with FGE on April 16, 2020, stating "there is about a 0% probability that VA will receive any of the 6 million N95 masks" from the first contract.[214] *ProPublica* published findings from an investigation into Mr. Stewart's inability to procure N95 masks on May 1, 2020, which reported that VA had canceled its contract with Mr. Stewart due to his failure to perform.[215] Despite this, Mr. Stewart continued to seek federal contracts and sent another email on May 3, 2020, offering to provide N95 masks. In an internal email, VA officials remarked: "Didn't we just terminate an order with them?"[216]

The Select Subcommittee revealed in 2021 that the Carl Vinson VA Medical Center in Dublin, Georgia awarded Mr. Stewart a second contract on May 15, 2020, under which Mr. Stewart promised to deliver 85,000 masks for $249,900.[217] Newly released evidence shows that Mr. Stewart secured this second VA contract using the same fraudulent scheme he used to obtain the FEMA contract and first VA contract—specifically, by falsely representing that he had millions of N95 masks and was already supplying them to other federal agencies.

For example, on April 30, 2020, a VA procurement official at the Carl Vinson VA Medical Center contacted FGE, stated: "I am in need of a bulk order of N95 Mask…please let me know immediately if you can provide these items."[218] Mr. Stewart quickly confirmed "we have 1860s available" and that FGE could fulfill an order of 80,000 N95 masks for a total of $239,200 or $2.99 per mask.[219] Mr. Stewart's quote mirrored the false information he provided to VA in April 2020 in order to secure the first contract, including that FGE could provide "pre-covid19 pricing" through a "production line contract with 3M, Inc" and that "[t]ypically, these orders are delivered with[in] 12-17 business days after award of contract."[220] Internal emails released in 2021 show that VA headquarters officials contacted 3M on April 29, 2020, confirming that FGE "was NOT an authorized reseller of 3M products." Agency officials acknowledged to each other privately: "One lie after another with this company."[221]

Newly released documents show that Mr. Stewart also lied to VA officials by claiming that FGE could provide disposable disinfectant wipes used in health care settings. Internal emails show that Mr. Stewart told VA they were "on back order until mid month" but that he would have "up to 800 tubs when they come in and there are 50 or so in each tub."[222] As detailed in the Select Subcommittee's June 2021 report, Mr. Stewart never possessed any PPE and had no realistic plan to obtain any.[223]

On May 5, 2020, Mr. Stewart told VA that "the min order we can support is 100,000 units," offering to "combine this order with a larger order" in an attempt to entice the procurement official into awarding the contract.[224] After failing to receive a response, Mr. Stewart followed up with VA the next day:

> Good Afternoon – I wanted to follow up on our last email exchange as I am placing an order for GSA currently and wanted to see if you had determined if you still needed N95 mask(s). As stated we place orders on production run basis – if Im [sic] able to combine you order [sic] with the current GSA one I am placing I'll be able to expedite the shipping to you.[225]

When asked by VA whether Mr. Stewart had "the capabilities to supply large quantities of the 1860s face masks," Mr. Stewart doubled down on his lies by claiming: "Yes we currently are supplying masks to several hospitals at 500k a week to three different locations. As well as Fema for 1m every 15 days."[226] Email communications show that Mr. Stewart then spoke with a procurement official on the phone, who followed up via email stating: "Thanks again for speaking with me a moment ago and confirming that you do have capabilities to provide the N95 1860s facial mask."[227]

A *ProPublica* reporter reached out to VA's Press Secretary on May 12, 2020, inquiring about "contractors the VA has hired to procure PPE who had no previous government contracts," specifically mentioning the cancellation of FGE's first $34.5 million contract on April 29.[228] Deborah Kramer, the Acting Assistant Under Secretary for Health for Support, asked her procurement and logistics staff at VA headquarters to pull the information needed to respond to the reporter's questions. Separately, the Carl Vinson VA Medical Center in Georgia awarded Mr. Stewart the $249,900 contract on May 15, 2020.[229]

After the contract was awarded, Mr. Stewart provided false and misleading updates to officials—just as he did with his first VA contract and the FEMA contract. For example, on May 27, 2020, Mr. Stewart emailed officials at the Carl Vinson VA Medical Center stating:

> Good morning – I wanted to let you know I should have shipping information on this order within the next few days. After the president invoked the Defense Production Act (DPA Title III) 3M has requested that all companies have a DPAS number in order to verify they are registered in SAM and with the Department of Commerce to receive these goods and deliver them to federal agencies. This is a new requirement and I am unsure the time frame on it however, our 3M distributor advised it is required due to the fraud surrounding PPE. … I will advise once I hear back from Department of Commerce – we may need a letter or a call from you verifying this is for the VA – I sent them the letter but It [sic] may need further information.[230]

The Select Subcommittee's investigation previously found that DHS OIG interviewed 3M officials five days prior, and that those officials confirmed that FGE was not an "authorized channel [partner] of 3M in the United States" and would not have "access to any respirator products directly from 3M." Mr. Stewart had tried to contact 3M earlier in the month by reaching out to the company's Chief Executive Officer via email and LinkedIn.[231]

Mr. Stewart continued to make false statements to VA officials to cover up his inability to deliver PPE, including on June 1, 2020, when he wrote to a contracting officer: "In the event we are not able to secure the DPAS number this week—we will have to terminate the PO as we wont [sic] be able to make the delivery time."[232] One procurement official seemed concerned about this response, asking for a recommendation based on Mr. Stewart's email. The next day, another contract officer seemingly dismissed the concern, stating:

> There's a problem with these Masks worldwide, most all the vendors are having Problem [sic] getting these mask [sic] at a certain time frame do [sic] to 3M. 3M no [sic] that there is a lot of vendors getting these mask [sic] and increasing the prices, These Masks if the [sic] were bought from 3M is probably 10.45 a box.[233]

On June 4, 2020, Mr. Stewart blamed his delay on FEMA and the Department of Commerce for not approving his DPAS application. In response, VA officials discussed terminating FGE's contract, stating:

> We can cancel this order, which we will not be able to get the N95 masks, because this is problem [sic] globally, GSA doesn't have them. …To put it, [sic] there's no N95 Mask, even if these vendors say they have them…it's probably not true.[234]

On June 5, the VA procurement official who initially reached out to FGE on April 30 sent an internal email with a subject line of "Heads Up!," stating: "Please do not certify the invoice for a bulk order for N95 masks unless the masks are delivered."[235]

VA officials found themselves in a desperate situation as they tried to find alternatives to FGE. On June 9, 2020, an official from the Carl Vinson VA Medical Center stated they were "in a crunch" for N95 masks. Another official responded:

> I hate to say this but everyone is in a crunch for these particular Mask's [sic]. I spoke to some of my Contracting Counterparts across the Nation [sic] Most are ordering the KN95 Masks. As you can see from the vendor you forward [sic] me yesterday. They are selling these 3M N95 Masks at a higher rate. …are we willing to Pay $8.50 dollars for one Mask, if these were in Stock at GSA, these mask's [sic] sell for 0.89 cent each. This is a call that you will have to address with your leadership, what are they willing to pay and what are they willing to accept?[236]

On June 15, 2020, after many follow-up communications regarding delivery time, Mr. Stewart told VA that FGE had not received any updates from FEMA or the Department of Commerce and was therefore unable "to fulfil [sic] the order as 3M will not release product to us to fulfil the order." VA terminated the contract for convenience the following day.[237]

Mr. Stewart pleaded guilty to making false statements to VA and FEMA, and to wire fraud and theft of government funds, on February 3, 2021, and was sentenced to 21 months in prison and three years of supervised release by the U.S. District Court for the Eastern District of Virginia on June 16, 2021.[238] He was released on July 22, 2022.

Although no taxpayer dollars were ultimately paid to Mr. Stewart under these contracts, officials admitted that working with Mr. Stewart was "a waste of time for the government" and cost the agency labor hours. The risk of waste could have been reduced or prevented through adequate preparation and planning. Instead, however, the Trump Administration refused to implement a coordinated national strategy to alleviate PPE shortages during the pandemic and left federal agencies and states unprepared and unable to protect vulnerable populations from the risk of the virus. As a result, federal agencies had to pay "a premium for the supply" and rush to award multimillion-dollar contracts "as quickly as possible," including to an unvetted supplier that they had concerns about.[239]

As VA OIG has recognized, "the need for expedited contracts for medical supplies and other life-saving resources"—coupled with "the challenges of monitoring billions of dollars in pandemic-related emergency spending" and "the ingenuity and speed exhibited by bad actors"—created "a trifecta of high-risk conditions" that increased the risk of waste, fraud, and abuse during the pandemic.[240] Like Mr. Stewart, many bad actors tried to take advantage of the pandemic by seeking large supply contracts that they knowingly could not fulfill.[241] One high-level VA

contracting officer who approved the termination of Mr. Stewart's first contract told the FBI in June 2020 that he was personally involved in "about 15 investigations" related to potentially fraudulent contracts awarded during the pandemic, noting: "The level of foolishness during COVID-19 had become pure ridiculousness."[242]

4. Trump Administration officials waged an unprecedented campaign to control CDC and politicize public health during the coronavirus crisis.

The Select Subcommittee's investigations found that the Trump Administration compromised CDC's scientific integrity during the coronavirus crisis in an attempt to serve the former President's political goals. The Select Subcommittee detailed in an October 2022 staff report how Trump Administration officials usurped control of CDC communications and blocked public health officials from providing accurate information about the coronavirus to the American people; installed political operatives who sought to downplay the seriousness of the pandemic and retaliated against career officials who contradicted Trump Administration talking points; overruled scientists to weaken multiple CDC guidance documents and to exploit and counteract CDC's public health authorities to achieve political goals; and attempted to manipulate the content and block the publication of CDC's scientific reports and destroy evidence of that interference.[243]

a. <u>The Trump White House blocked CDC from conveying accurate information to the public and installed political operatives who sought to downplay the pandemic and attack CDC scientists who told the truth about the coronavirus.</u>

After a February 25, 2020, CDC telebriefing "angered" President Trump, the White House wrested control of coronavirus communications away from CDC and ordered that all media requests related to the pandemic be approved by the Office of the Vice President prior to release. Thereafter, Trump Administration officials blocked CDC from conducting telebriefings on critical, emerging public health issues for three months and restricted scientists from participating in interviews—at a time that coincided with a rapid explosion in coronavirus cases. Then-CDC Director Dr. Robert Redfield told the Select Subcommittee that "for a while, none of our briefings were approved" and that he believed the American people "should have heard from the public health leaders" during this time. Then-CDC Principal Deputy Director Dr. Schuchat similarly said that "there was a point where they [CDC staff] stopped asking because they [Trump Administration officials] kept saying no" to public appearances. According to Kate Galatas, a senior communications official at CDC, the requirement that CDC obtain clearance for its public messaging "created big confusion" at CDC and caused "delays in being able to share information."[244]

In April 2020, as the number of coronavirus cases grew exponentially and hospitals in many cities became overwhelmed, President Trump installed Michael Caputo—his close political ally—as Assistant Secretary for Public Affairs at HHS, allowing him to take over approval of coronavirus communications. According to Ms. Galatas, Mr. Caputo used "bully-ish behavior" designed to make CDC personnel "feel threatened" in order to control CDC messaging. In one incident, Mr. Caputo expressed that he was "very displeased" with statements made by CDC's

Deputy Director of Infectious Diseases Dr. Jay Butler during a June 12, 2020, telebriefing that he felt were "too alarming." Dr. Butler told the Select Subcommittee that he "was not really asked back to do telebriefings" after the incident. In another incident, Dr. Paul Alexander—a Senior Advisor to Mr. Caputo—attacked a forthcoming CDC report as "garbage" and designed "to hurt the public and the administration." He advocated for CDC officials to be fired, saying "he [Dr. Redfield] gots [sic] to start firing people in large numbers there! This agency is working against the President daily!" Trump Administration officials also repeatedly sought to alter CDC and HHS press materials to promote misleadingly positive news, downplay coronavirus risks, and attempt to redirect blame away from the Trump Administration for its poor handling of the pandemic. For instance, on May 8, 2020, Dr. Alexander sought to edit talking points about a CDC report, telling Mr. Caputo in an email: "this is how I am supporting the messaging . . . . Any way to help you and showcase your work for this great President."[245]

b. Trump Administration officials "compromised" public health guidance and brazenly interfered with CDC's public health authorities to achieve political goals.

Trump Administration officials repeatedly interfered in the process for drafting and issuing CDC coronavirus guidance—overruling CDC scientists to weaken public health recommendations in an apparent effort to benefit President Trump's perceived political interests. The Select Subcommittee's investigations found that Trump Administration political appointees altered or otherwise interfered in a series of coronavirus guidance documents, including CDC's guidance for faith communities, a meatpacking plant, polling locations and voters, restaurants and bars, and testing. Dr. Redfield acknowledged in a transcribed interview that Trump Administration officials "compromised" CDC's coronavirus guidance documents on multiple occasions. He said that the process for developing coronavirus guidance "got complicated" during the pandemic and that it gave him "PTSD." Dr. Redfield also noted that White House officials in the Office of Management and Budget (OMB) effectively wielded veto power over CDC's coronavirus guidance, explaining: "we didn't get the approval usually to issue the guidance until OMB gave it a thumb's up."[246]

In addition to compromising public health guidance, Trump Administration officials also interfered with CDC's public health authorities. The Select Subcommittee found that Trump Administration officials exploited CDC's Title 42 authority to effectively close the southern border—a decision with an attenuated public health rationale that advanced the Trump Administration's longstanding anti-immigration and anti-asylum agenda. Dr. Cetron told the Select Subcommittee that the Title 42 order issued on March 20, 2020, "was not drafted by me or my team," but was instead "handed to us"—and that he recalled participating on calls about the order during which White House Senior Advisor Stephen Miller "was speaking." Dr. Cetron said that he "excused" himself from working on the Title 42 order, which was ultimately signed by Dr. Redfield, due to his concerns with the lack of a public health justification for the order.[247] Trump Administration officials also blocked CDC from deploying a mask requirement on mass transit ahead of the fall and winter 2020 surge, despite clear evidence justifying the requirement and the private sector pressing for "the federal government being more clear or strong about" using masks in these settings, according to Dr. Schuchat. The Select Subcommittee further found that Trump Administration officials rejected CDC's plan to extend its No Sail Order through the winter of 2020-2021, following lobbying from the cruise line industry and their allies. CDC instead issued

a Conditional Sail Order, which Dr. Redfield said made "a lot of people" "angry," including "your Florida Governor," who questioned why any CDC regulation was needed. Dr. Redfield recounted that he "felt very strongly" about standing firm against calls to let the No Sail Order expire without any replacement, stating: "if signing the Conditional Sail Order meant that I was resigning or being fired as CDC Director, that was going to happen."[248]

c. Trump Administration officials sought to manipulate the substance and block the dissemination of CDC scientific reports.

Trump Administration appointees sought to influence the process, manipulate the content, or block the dissemination of at least 19 different CDC scientific reports that they deemed to be politically harmful to President Trump. Trump HHS political appointees ultimately succeeded in altering or delaying the release of at least five scientific reports, as well as pressuring CDC to change the editorial process for MMWR series—the agency's primary vehicle for scientific publication of timely, reliable, authoritative, accurate, objective, and useful public health information and recommendations. The Select Subcommittee revealed that HHS Secretary Alex Azar directed CDC to change the MMWR editorial process in May 2020, following a conference call where Secretary Azar and other Trump Administration officials made it clear they were "not happy" that one of these reports did not draw a politically advantageous conclusion they desired, according to Dr. Redfield. CDC Chief of Staff Kyle McGowan and Deputy Chief of Staff Amanda Campbell informed the Select Subcommittee that Secretary Azar warned that "if the CDC would not get in line, then HHS would take control of approving the publication of the MMWRs." CDC ultimately acceded to Secretary Azar's directive.[249]

CDC employees also told the Select Subcommittee that they were ordered to destroy evidence of a Trump Administration appointee's political interference. During a transcribed interview, Dr. Christine Casey, Editor of the MMWR, stated that Dr. Michael Iademarco—who oversaw the MMWR—directed her to delete an email from Dr. Alexander threatening to put a stop to the MMWR publication, and that she understood the instruction came from Dr. Redfield. Dr. Casey's statements confirmed a prior account from MMWR Editor-in-Chief Dr. Charlotte Kent. Dr. Redfield and Dr. Iademarco subsequently denied giving this direction.[250]

d. The Trump Administration's assault on the nation's public health institutions resulted in lasting harm.

The Trump Administration's politicization of CDC took a significant toll on the career scientists working tirelessly to protect the nation during a once-in-a-century pandemic. In his transcribed interview, Dr. Butler described how Trump Administration officials' "intentional discrediting" of CDC's integrity adversely impacted agency morale: "when people have committed to public service, it's really demoralizing to be characterized as a villain in the public health response, or even in the future of our country." The degree of control and hostility that the Trump Administration exerted on CDC fundamentally undermined Americans' trust in public health. Dr. Cetron explained that this "erosion of credibility and trust really harms the ability to persuade people to take sometimes difficult steps that's in our joint collective interest."[251]

When asked if she believed that allowing CDC to convey accurate scientific advice to the public would have resulted in fewer Americans dying during the early months of the pandemic, Dr. Schuchat told the Select Subcommittee: "Yes, I do." Echoing Dr. Schuchat, Dr. Cetron said that "there are people, you know, who are no longer with us that would have benefited from that kind of very clear messaging."[252]

5. The Trump White House relentlessly attacked FDA's coronavirus response.

The Select Subcommittee's investigations documented multiple instances where Trump White House officials executed coordinated pressure campaigns that sought to bend FDA's coronavirus decision making to the White House's political will. Evidence uncovered by the Select Subcommittee and detailed in an August 2022 staff report revealed that the Trump White House exerted extreme and inappropriate pressure on FDA to reauthorize hydroxychloroquine after it was shown to be ineffective and potentially dangerous; strongarmed FDA to deliver misleadingly positive news about convalescent plasma as a coronavirus treatment on the eve of the 2020 Republican National Convention; and blocked FDA from issuing guidance on coronavirus vaccine authorizations for weeks in an attempt to ensure that the first vaccine could be authorized before the 2020 presidential election.[253]

a. Trump White House Officials pressured FDA to reauthorize hydroxychloroquine as a coronavirus treatment after it was shown to be ineffective and potentially dangerous.

Dr. Hahn told the Select Subcommittee that Mr. Navarro exerted inappropriate pressure on him to reissue an EUA for hydroxychloroquine after FDA revoked its EUA for the drug on June 15, 2020, due to its inefficacy as a coronavirus treatment and potential safety issues. The Select Subcommittee's investigation revealed that Mr. Navarro and Dr. Steven Hatfill—then-an adjunct assistant professor at George Washington University whom Mr. Navarro brought into the White House in January 2020 to work as a full-time volunteer on the coronavirus response—engaged in what Dr. Hatfill called a "knife fight" with Dr. Hahn and other federal officials over hydroxychloroquine.[254]

Mr. Navarro and Dr. Hatfill coordinated with representatives at the Henry Ford Health System (HFHS) in an effort to reauthorize hydroxychloroquine while obscuring the White House's involvement. The Select Subcommittee found that Dr. Hatfill drafted "a new EUA request" at Mr. Navarro's direction, "selected" HFHS to be the submitting institution, and then "transferred the EUA reinstatement letter over to … the Ford System," which allowed the renewed EUA request to be submitted by HFHS instead of someone affiliated with the White House. HFHS submitted the renewed EUA petition to FDA on July 6, 2020, but FDA denied the petition the following month. Meanwhile, Dr. Hatfill courted researchers to pursue a study to show the purported benefits of hydroxychloroquine by dangling millions of taxpayer dollars in promised funding.[255]

Working from inside the White House, Mr. Navarro and Dr. Hatfill sought to generate outside support for hydroxychloroquine by engaging known extremists and prolific conspiracists like former White House Chief Strategist Steve Bannon, Dr. Jerome Corsi, and the Association of

American Physicians and Surgeons (AAPS), which, among other radical conspiracies, propagated the theory that President Barack Obama used a covert form of hypnosis to win the 2008 presidential election. Under Mr. Navarro's supervision, Dr. Hatfill coordinated with AAPS Executive Director Dr. Jane Orient and Mr. Bannon to gather support for a petition he drafted to "keep pressure on the FDA and the new EUA request" that he was spearheading with HFHS. Dr. Hatfill also engaged Senator Ron Johnson to push the White House to pressure FDA into renewing the hydroxychloroquine EUA. Senator Johnson met personally with White House Chief of Staff Mark Meadows in late August 2020 to advocate for the reauthorization. He reported back to Mr. Navarro and Dr. Hatfill that "Meadows said he would ask Sec Azar to issue whatever approval HHS can issue." Outside the United States, Dr. Hatfill and Mr. Navarro coordinated on hydroxychloroquine with Dr. Paolo Zanotto, a virologist who the Brazilian Senate has since recommended be charged criminally for promoting false coronavirus cures.[256]

As their efforts stalled, Mr. Navarro and Dr. Hatfill escalated their pressure campaign by attacking federal officials who they believed stood in the way of their attempts to reauthorize hydroxychloroquine—including publicly discrediting these officials, pushing for federal investigations into their actions, and advocating for their termination. For example, after an August 5, 2020, meeting of the National Institutes of Health (NIH) COVID-19 Treatment Guidelines Panel—where Mr. Navarro was scheduled to present "Perspectives on Hydroxychloroquine," despite lacking any relevant scientific expertise—Dr. Hatfill outlined a plan to have the Department of Justice (DOJ) "start an investigation of the Fauci Panel." Dr. Hatfill described this plot as designed to "shut them up for a bit," after which White House officials would "pull Hahn in and ask him to re-establish the EUA," contending Dr. Hahn was "weak and will fold when he sees what is going on." Dr. Hatfill expressly tied the timing of these actions to when voting in the November presidential election would begin, assuring Mr. Navarro: "Within 10-14 days of the start of HCQ outpatient treatment—figures should start to decrease," concluding: "Is that not about the same time that some sort of voting goes on ??"[257]

Throughout their coordinated pressure campaigns, Mr. Navarro and Dr. Hatfill took steps to conceal the White House's involvement, including by using private email accounts, including encrypted ProtonMail accounts, to conduct official government business, apparently without properly preserving these records in accordance with the Presidential Records Act.[258]

b. President Trump expressed "dismay" about perceived delays in an EUA for convalescent plasma, while the White House hastily convened a press conference that grossly misstated the data.

During his transcribed interview with the Select Subcommittee, Dr. Hahn recounted that NIH Director Dr. Francis Collins told him during a White House meeting in the weeks before the Republican National Convention that President Trump had "express[ed] dismay over NIH potentially putting up roadblocks" to the timeline for FDA's authorization of convalescent plasma as a coronavirus treatment, after NIH officials raised concerns about insufficient efficacy data to support an EUA. After President Trump accused FDA of being part of the "deep state" and deliberately stalling progress on therapeutics like convalescent plasma, Dr. Hahn said he called the

president on August 22, 2020, and told him that "we either were nearing a decision or had made a decision" on an EUA. FDA issued an EUA for convalescent plasma the next day.[259]

On August 23, 2020—the day before the start of the Republican National Convention—the White House hastily convened a press conference to tout the convalescent plasma EUA. Ahead of the press conference, FDA Associate Commissioner for Media Affairs Emily Miller sent an email to Dr. Hahn advising on his talking points for the press conference, telling him to "[m]essage positive always" and to "phrase it in real language." Dr. Hahn proceeded to grossly misstate the implications of the efficacy data on plasma during the press conference, after which he issued a public apology. Dr. Hahn told the Select Subcommittee that he did not seek to clear his apology through the "normal channels" in the Trump Administration.[260]

c. Trump Administration political appointees blocked FDA coronavirus vaccine guidance due to "objections" over how it would impact the authorization timeline ahead of the presidential election.

By September 2020, FDA had drafted guidance advising coronavirus vaccine manufacturers that they should submit phase three trial data in their EUA applications that included a median follow-up duration of at least two months (60 days) after the completion of the primary vaccination series. According to Dr. Hahn, officials in Secretary Azar's office expressed concerns about whether it was "appropriate" for FDA's proposed guidance to advise manufacturers to submit 60 days of surveillance data. Beginning around mid-September, Dr. Hahn said FDA had multiple meetings and calls with Secretary Azar, HHS Chief of Staff Brian Harrison, and HHS Deputy Chief of Staff for Policy Paul Mango—none of whom are doctors or otherwise specialized in immunology or vaccinology—regarding the "timeline" and the "scientific and clinical rationale for the guidance." By that time, it was clear that the guidance would likely result in FDA not authorizing a vaccine until after the presidential election.[261]

After FDA's guidance was sent to the White House for review, Dr. Hahn said "[t]here were objections about it" from Mr. Meadows and other White House officials, including "pushback about the issue of the 60 days" of surveillance data. Dr. Hahn said he "objected" to attempts to change the guidance because "any changes would be obviously reported and would further reduce vaccine confidence." During a September 23, 2020, press conference, President Trump decried the guidance as "a political move" that "has to be approved by the White House," which "may or may not approve it." With its formal vaccine EUA guidance stalled for weeks by the White House, FDA unilaterally released an informal set of briefing materials on October 6, which included an appendix that summarized advice that FDA had provided to industry regarding vaccine EUA applications. The advice listed in this appendix publicly revealed that FDA sought two months of surveillance data in an EUA application, despite the ongoing "objections" from the White House.[262]

Dr. Hahn told the Select Subcommittee that FDA did not seek approval from HHS or the White House before releasing the informal guidance but noted that he "proactively reached out to the White House to let them know that this was going." Later that day, Dr. Hahn said he was called by Mr. Meadows and told that FDA's formal vaccine EUA guidance was now approved.[263]

d. The Trump Administration's crusade against FDA resulted in damaging consequences for the coronavirus response.

As a result of the Trump Administration's nearly year-long crusade against FDA, morale inside the agency cratered, and public confidence in FDA's scientific integrity was shaken in the midst of a once-in-a-century pandemic. In his transcribed interview with the Select Subcommittee, Dr. Hahn elaborated on the concerns he held regarding the public's waning confidence in FDA's work during the pandemic:

> I was concerned about the entire environment: A presidential election, bitter divisions in the country and in Congress. And, to me, it was a pretty significant combination of factors that led to a decrease in science and confidence in science and medicine, et cetera.[264]

Reflecting on President Trump disparaging FDA scientists as being part of the "deep state"—when they were working to ensure that safe and effective coronavirus vaccines, treatments, and diagnostics would be made available to the American people as quickly as the science allowed—Dr. Hahn explained the toll these relentless attacks had taken on the civil servants inside his agency:

> [T]hey had been working really hard, our workload had doubled, and they also were worried about the potential impact that it would have on the public perception of the agency. There's a lot of pride at the agency and what they do.[265]

6. Trump Administration political appointees intervened at the behest of meatpacking companies to limit coronavirus protections in an industry where workers faced high risks of infection, death, and community spread.

The Select Subcommittee's investigations found that Trump Administration political appointees acted at the behest of corporate actors to limit worker protections in a major industry with high coronavirus risk. Public reports indicated that workers in the meatpacking industry faced particularly high risks from the coronavirus early in the pandemic. The Select Subcommittee conducted an investigation of the largest companies in the industry—JBS USA Food Company (JBS), Tyson Foods, Inc. (Tyson), Smithfield Foods (Smithfield), Cargill Meat Solutions Corporation (Cargill), and National Beef Packing Company, LLC (National Beef)—and the Trump Administration's response to the risks faced by these companies' workers.[266]

The Select Subcommittee found that the toll of the coronavirus on meatpacking workers was even greater than previously known, with more than 59,000 workers at the five companies contracting the virus in the pandemic's first year, and at least 269 dying as a result.[267] These large meatpacking companies prevented additional protections from being put in place to protect workers in part by engaging in a concerted effort with Trump Administration political officials to insulate themselves from oversight, to force workers to remain in dangerous conditions, and to shield themselves from liability for any resulting worker illness or death.

a. Meatpacking companies successfully enlisted Trump political appointees to advocate against health protections for workers.

As tens of thousands of meatpacking workers fell ill and hundreds died in the early months of the coronavirus crisis, Trump Administration political appointees advocated for the interests of meatpacking companies—not their workers or the public. As described in a report by Select Subcommittee staff released on May 12, 2022, senior Trump Administration officials prioritized the concerns of meatpacking executives in implementing coronavirus policies that affected meatpacking workers' safety, and even intervened to prevent state and local governments from guarding workers against coronavirus risks.[268]

The Select Subcommittee obtained emails showing that the meatpacking industry had a close relationship with a key Trump Administration appointee with influence over coronavirus policy and used that influence to halt policies that would have provided greater protection for meatpacking workers. In mid-March 2020, a meatpacking industry representative spoke with Department of Agriculture (USDA) Under Secretary for Food Safety Mindy Brashears about the White House Coronavirus Task Force, saying that the industry "would certainly like" for Ms. Brashears "to be involved in any discussion regarding meat."[269] By the following day, USDA was reportedly "in the leadership role" on the Task Force, which "delighted" the representative.[270] A few weeks later, industry representatives discussed how they were "fortunate" to have USDA as their "primary regulator" because it was "representing [the] industry's interests in every important interagency conversation."[271]

In March 2020, a Tyson executive emailed the head of the North American Meat Institute about requests from state and local health authorities to improve coronavirus safety measures at Tyson plants: "So far, we've been able to handle these situations, but at some point we may need to get Mindy involved if we are forced to shut down a plant."[272] A few months later, a meatpacking lobbyist told a Foster Farms executive that Ms. Brashears "hasn't lost a battle for us" in connection with efforts to block a local health department order to implement coronavirus measures in a Foster Farms facility.[273] Career USDA officials told the Select Subcommittee that Ms. Brashears' and her subordinates' pattern of interference with state and local health departments in issues of plant safety was "exclusively handled at the political level," with career staff being "walled off," and leaving "no paper trail" of such meetings.[274] Internal meatpacking industry emails similarly show Ms. Brashears personally calling and texting with industry representatives, giving them her personal cell phone number, and using her personal email account to communicate with them.[275]

Trump Administration officials also did the industry's bidding by weakening federal guidance and directives intended to keep workers safe. As meatpacking workers realized that working conditions were unsafe, meatpacking companies enlisted Trump Administration officials to prevent workers from staying home out of fear of coronavirus infection. In April 2020, the CEOs of JBS USA, Smithfield, Tyson, and other meatpacking companies had a call with Secretary of Agriculture Sonny Perdue, during which they asked him to "elevate the need for messaging about the importance of our workforce staying at work to the POTUS or VP level" and separately stressed the need to make clear that "being afraid of COVID-19 is not a reason to quit your job

and you are not eligible for unemployment compensation if you do."[276] These efforts led to Vice President Pence issuing a direct message to meatpacking workers in a press conference that "we need you to continue . . . to show up and do your job," admonishing recent "incidents of worker absenteeism."[277]

Also in April 2020, Trump Administration officials weakened CDC guidance on coronavirus protections for meatpacking workers at the behest of industry executives. Smithfield CEO Ken Sullivan obtained early draft CDC guidance on safety precautions for meatpacking workers.[278] Sullivan marked up the draft by hand with comments criticizing recommendations to "physically separate employees" and to have flexible attendance policies.[279] Sullivan emailed complaints about worker protections in CDC's guidance to USDA Under Secretary for Marketing and Regulatory Programs Greg Ibach, a Trump political appointee, who quickly responded: "We are on it."[280] Within a few hours of sending these revisions to USDA officials, a Smithfield executive was told by his colleague to "Expect a call" from "one of Perdue's deputies, important guy" and "an ally."[281] Dr. Redfield did ultimately weaken the guidance for meatpacking worker safety after USDA Secretary Perdue relayed Smithfield's critiques. One CDC scientist told the Select Subcommittee that Dr. Redfield "water[ed] down" this guidance by adding qualifiers like "if feasible" in front of safety measures.[282]

b. Meatpacking companies successfully lobbied the Trump USDA and White House to issue an order purporting to insulate them from state and local regulations and liability for worker infections and deaths.

When Trump appointees were unable to stop local health departments from intervening to protect meatpacking workers, the industry convinced the Trump White House to issue an executive order that purported to absolve the industry from responsibility for workers' safety related to the coronavirus. By mid-April 2020, meatpacking companies expressed anxiety that their allies at USDA and the White House were unable to block a handful of state and local public health measures. For example, an industry representative lamented that:

> Plants are being closed. Health depts. are making decisions (Greeley [Colorado]), governors are making surprise decisions (Sioux Falls [South Dakota]), health departments are showing up unannounced at plants (Waterloo IA), and the media reporting is going to create more attention from health departments and governors in other communities IMO. It seems to be cascading and our friends at USDA and the VP's office are not able to stop it.[283]

To combat local health department efforts, Smithfield and Tyson proposed that the Trump Administration issue an executive order signed by the President that would insulate meatpacking companies from oversight by state and local health departments and provide protection against lawsuits for worker illnesses and deaths. Tyson's legal department drafted the proposed order and the companies, through their industry representative, shared it with allied USDA political appointees who had previously helped them lobby or interfere with decision-making by other arms of federal and state government.[284] Meatpacking industry representatives and companies—Smithfield and Tyson in particular—then engaged in regular communications with political appointees at the White House and USDA in the days leading up to President Trump's issuance of

Executive Order 13917.[285] This contact between the industry and high-level Trump Administration officials included calls between Smithfield CEO Ken Sullivan and White House Chief of Staff Mark Meadows; a joint call with Mr. Sullivan, Mr. Meadows, and Tyson CEO Noel White; a call between White and Vice President Pence's Chief of Staff Marc Short; and a call from Mr. Meadows to Mr. White asking if White would be willing to meet with President Trump.[286] President Trump's ultimate order adopted the themes and statutory directive laid out in Tyson's proposed draft, invoking the Defense Production Act (DPA) to ensure meatpacking plants "continue operations."[287]

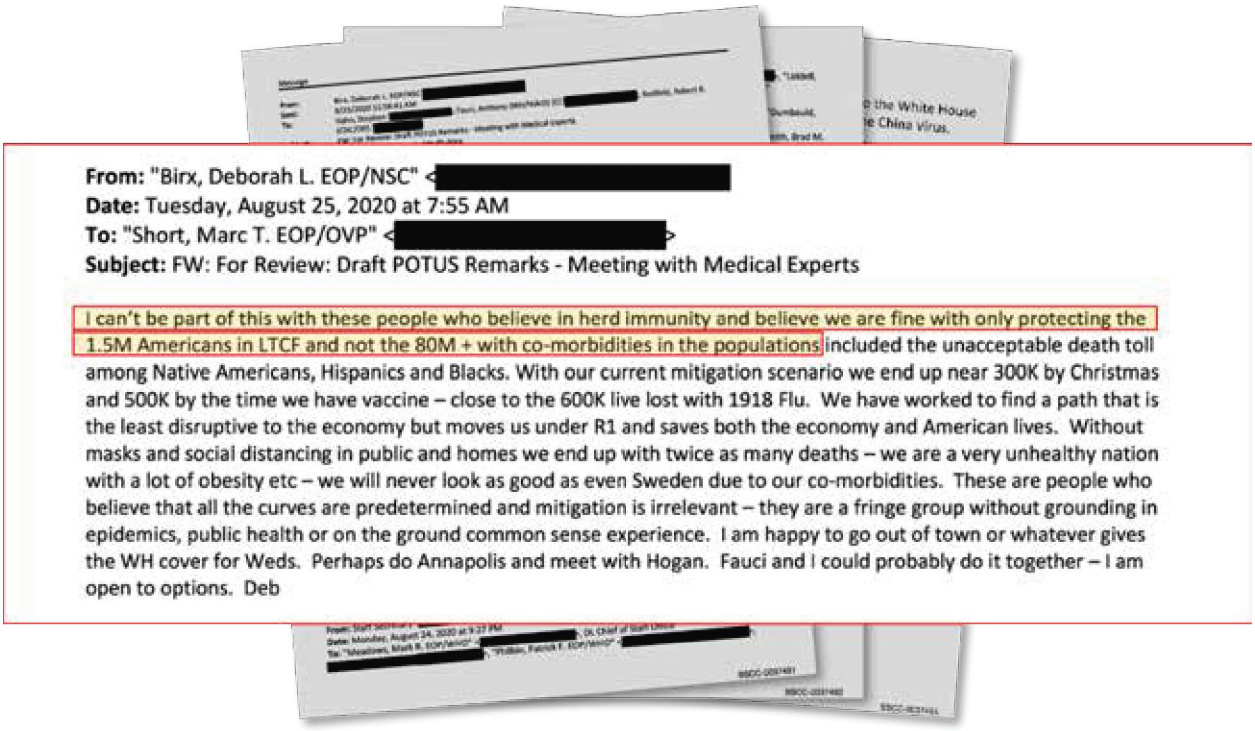
7. The Trump Administration embraced a dangerous and discredited herd immunity via mass infection strategy.

In a June 2022 staff report, the Select Subcommittee revealed extensive evidence that senior Trump Administration officials embraced a dangerous and discredited herd immunity via mass infection strategy as they failed to curb the spread of the coronavirus. This strategy enabled Trump Administration officials to convince themselves that they were right to do nothing to limit the spread of the virus in the second half of 2020 and likely resulted in many deaths that could have been prevented by an effective national mitigation strategy.[288]

a. <u>The Trump White House secretly hired a herd immunity proponent and gave him sweeping access to top officials.</u>

In July 2020, then-White House Senior Adviser Jared Kushner furtively hired Dr. Scott Atlas—a radiologist and Senior Fellow at the conservative think tank the Hoover Institution who had no background in infectious diseases—to "help advise the president" on pandemic policy. The Select Subcommittee found that Mr. Kushner initially took steps to conceal Dr. Atlas's hiring for several weeks. After his role as a Special Advisor to the President was publicly announced, Dr. Atlas received extensive access to the highest levels of government and "had the ear" of the president on pandemic policy, according to Dr. Redfield. Mr. Kushner included Dr. Atlas in a series of high-level meetings referred to as "China Virus Huddles," which were used to hone the White House's coronavirus messaging and address key "operational aspects" of the response outside of the White House Coronavirus Task Force structure. Dr. Birx told the Select Subcommittee that she had reason to believe that President Trump received "parallel data streams" from Dr. Atlas that differed from the coronavirus data provided by the White House Coronavirus Task Force, and that this information influenced President Trump to downplay the severity of the virus and reject many mainstream mitigation measures.[289]

The Select Subcommittee uncovered internal memoranda used by Dr. Atlas to push the Trump Administration to jettison mitigation measures and deliberately reduce coronavirus testing—months before the first coronavirus vaccines were available to the public. Dr. Atlas used his White House position to recruit herd immunity proponents to come to Washington, D.C., to meet with multiple senior Trump Administration officials and, according to Dr. Redfield, "convince people that herd immunity was going to save us, and this thing was going to go bye-bye." In August 2020, Dr. Atlas successfully arranged for three herd immunity proponents to meet with President Trump and Vice President Mike Pence to discuss their views on the pandemic response. Dr. Birx refused to attend these meetings, telling Mr. Short:



From: "Birx, Deborah L. EOP/NSC" <[redacted]>
Date: Tuesday, August 25, 2020 at 7:55 AM
To: "Short, Marc T. EOP/OVP" <[redacted]>
Subject: FW: For Review: Draft POTUS Remarks - Meeting with Medical Experts

I can't be part of this with these people who believe in herd immunity and believe we are fine with only protecting the 1.5M Americans in LTCF and not the 80M + with co-morbidities in the populations included the unacceptable death toll among Native Americans, Hispanics and Blacks. With our current mitigation scenario we end up near 300K by Christmas and 500K by the time we have vaccine – close to the 600K live lost with 1918 Flu. We have worked to find a path that is the least disruptive to the economy but moves us under R1 and saves both the economy and American lives. Without masks and social distancing in public and homes we end up with twice as many deaths – we are a very unhealthy nation with a lot of obesity etc – we will never look as good as even Sweden due to our co-morbidities. These are people who believe that all the curves are predetermined and mitigation is irrelevant – they are a fringe group without grounding in epidemics, public health or on the ground common sense experience. I am happy to go out of town or whatever gives the WH cover for Weds. Perhaps do Annapolis and meet with Hogan. Fauci and I could probably do it together – I am open to options. Deb

Dr. Birx wrote that the group of doctors Dr. Atlas invited to the White House were part of "a fringe group without grounding in epidemics, public health or on the ground common sense experience." In October 2020, Dr. Atlas also coordinated a meeting between Secretary Azar and the authors of the discredited "Great Barrington Declaration," which advocated for the herd immunity strategy that Dr. Atlas was actively promoting. Secretary Azar issued a tweet after the meeting recognizing that the approach articulated by the Great Barrington Declaration authors was a "strong reinforcement" of the Trump Administration's ongoing response strategy.[290]

b. Dr. Scott Atlas successfully pressed the Trump Administration to weaken CDC's testing guidance and reduce coronavirus testing, without any countervailing mitigation measures, well before vaccines were available.

Dr. Atlas set in motion significant changes to CDC's testing guidance within days of arriving in the White House that would upend CDC's public health recommendations by minimizing the need for widespread testing and undercutting policies that could mitigate the spread of the coronavirus. On August 3, 2020, Dr. Atlas prepared a memorandum which argued that testing was playing an outsized role in the response, contending: "people have been convinced that 'testing, testing, testing' is urgent for everyone—that is false." He claimed that it was "harmful to do massive testing, especially since actions on many positive tests are not always necessary."[291]

Dr. Redfield revealed to the Select Subcommittee that "significant people" inside the Trump Administration made clear shortly after Dr. Atlas arrived that "there needed to be some curtailment of the amount of testing that was done as relating to evaluating people that were exposed." Dr. Redfield and other former Trump Administration officials told the Select

Subcommittee that Dr. Atlas spearheaded changes to CDC's testing guidance to stop recommending that all close contacts of individuals with coronavirus get tested. Admiral Brett Giroir, the Trump Administration's "Testing Czar," told the Select Subcommittee that the White House Coronavirus Task Force approved a draft version of this weakened testing guidance that included a recommendation that all close contacts isolate for 14 days. The weakened testing guidance was published on August 24, 2020—without any isolation recommendation. Weeks later, after an intense backlash by public health experts, CDC restored its original recommendation that all close contacts be tested and added a 14-day isolation recommendation—prompting Dr. Atlas to become enraged and to speak "aggressively" at Dr. Redfield for overseeing these changes. Admiral Giroir told the Select Subcommittee that he recognized the potential that "somebody wanted to fire me" for his involvement in restoring the original testing recommendation.[292]

Dr. Birx told the Select Subcommittee that the August 24, 2020, testing guidance ultimately resulted in a "dramatic decline of the number of tests performed during the end of August and the beginning of September." In a September 16, 2020, email obtained by the Select Subcommittee, Dr. Atlas acknowledged to other senior White House officials that testing had decreased but argued that "the 'alarm' of fewer tests makes no sense" and that "pushing more testing is destructive to opening:"[293]

Atlas, Scott W. EOP/WHO

From: Atlas, Scott W. EOP/WHO
Sent: Wednesday, September 16, 2020 8:35 AM
To: Short, Marc T. EOP/OVP; Kushner, Jared C. EOP/WHO; Lyons, Derek S. EOP/WHO
Cc: Rader, John N. EOP/WHO; 'Boehler, Adam'; Atlas, Scott W. EOP/WHO
Subject: please read: 16SwptData and daily report
Attachments: 16September2020Data.pptx; WH_Daily_Report_20200916.pdf

The interpretation of the information is seriously incorrect and leads to wrong, harmful policy decisions.
1) The rise in "hospitalizations per case" or "deaths per case" – this is a very misleading indicator and incorrect to base policy on. If testing goes down, which it has, the denominator of hosp/case (and deaths/case) becomes smaller and the fraction is higher.
2) We have a continually decreasing number of pts in the hospital, with no increase in "confirmed (proven) Covid hospitalizations" per week in any age group, on Dr B's WH Daily in this very email
3) nationally, the number of hospitalized patients is at its lowest now; deaths are decreasing, too
3) the "alarm" of fewer tests makes no sense - we are not testing simply to drive a fraction downward.
4) the appropriate stat to monitor disease is if people are getting sick - without errors due to variability in testing is "Covid-like illness to ED" https://covid.cdc.gov/covid-data-tracker/#ed-visits
- USA continues to decrease, now only 1.5% (smallest in months and steadily declining)
- the so-called red states (ID, SC, UT, VA) for CLI to ED:
ID: 2%, decreasing from 5% in mid-July
SC: 3%, decreasing form 8% in mid-July
UT: 2%, steadily decreasing from 5% from mid-July
VA: 2%, steadily decreasing from 3% from mid-July
5) calling a state "red" based on test positivity is a bad decision – it is completely arbitrary, and again based on a fraction that is grossly misleading, because it changes with who and how many get tested.
5) pushing more testing is destructive to opening – a) the overwhelming majority of PCR tests are misleadingly positives, now widely known, even reported in the NYT, because positive test does not mean contagious.; b) we are quarantining people due to a positive PCR test for non-contagious virus. Locking down businesses and schools and society is harmful and contrary to our policy. (ACTION needed – guideline to change PCR testing to less than 32 cycles)

****
Scott W. Atlas, MD
Special Advisor to the President
EEOB [redacted]
mobile [redacted]

c. Top Trump Administration officials embraced Dr. Atlas's herd immunity strategy, resulting in preventable illness and death.

Dr. Atlas told the Select Subcommittee that Mr. Meadows, Mr. Short, Assistant to the President Hope Hicks, and Mr. Mango, among others, came to support at least some of the pandemic policy views he was urging the Administration to adopt. He also said that he inferred that President Trump "was in agreement" with his views on the pandemic, given President Trump's "own words." Dr. Redfield acknowledged that Dr. Atlas "successfully got a lot of people within the Task Force and the White House to believe that all we had to do was get to herd immunity" in order to contain the virus. Doctors on the White House Coronavirus Task Force took their concerns about Dr. Atlas and his views to Mr. Kushner and Mr. Short, but no action was taken. Dr. Birx told the Select Subcommittee that Vice President Pence was "well aware" of her concerns regarding Dr. Atlas's impact on the coronavirus response.[294]

With Dr. Atlas's influence entrenched, the Trump White House did little to attempt to curb the spread of the coronavirus in the fall and winter of 2020 and early 2021—even as outbreaks surged across the country. Using Dr. Atlas to provide a veneer of scientific backing for inaction, the Trump Administration instead focused on downplaying the threat of the virus leading up to the November presidential election—while also allowing the pandemic response to take a "back-seat" as senior officials focused their efforts on campaigning and promoting former President Trump's false claim that the election results were fraudulent. In late October 2020, White House aide Dr. Hatfill acknowledged in an email that, "with the election so close, COVID is taking a back-seat" despite the fact that "the disease is rearing it [sic] ugly head again."[295] Dr. Birx informed the Select Subcommittee that Trump White House officials "were actively campaigning" for the presidential election in the fall of 2020, and that this narrow focus on campaigning "took people's time away from and distracted them away from the pandemic."[296]

As the outbreak continued to worsen nationwide in November and December 2020, Dr. Hatfill noted that his focus "shifted over to the election fraud investigation in November"—chasing baseless conspiracy theories about voter fraud instead of taking steps to ensure the nation was responding effectively to the pandemic. When asked by a university colleague on January 5, 2021, why he was not "fixing the virus," Dr. Hatfill admitted: "Because the election thing got out of control. I go where my team goes."[297]

Dr. Birx informed the Select Subcommittee that more than 130,000 American lives could have been saved after the first wave of the pandemic if President Trump and his Administration had implemented "optimal mitigation across this country." More Americans died from the coronavirus from November 2020 through February 2021 than during any other four-month period throughout the entirety of the pandemic to date.[298]

D. The Toll of the Coronavirus Fell Disproportionately on the Most Vulnerable.

1. The coronavirus had a devastating effect in already overburdened nursing homes.

In June 2020, the Select Subcommittee initiated an investigation into the impact of the coronavirus crisis on nursing home residents and staff at five for-profit nursing home chains in the United States: Consulate Health Care (Consulate), Ensign Group (Ensign), Genesis Healthcare, Inc. (Genesis), Life Care Centers of America (Life Care), and SavaSeniorCare (Sava).[299] These five companies were the largest for-profit nursing home chains in the country at the onset of the coronavirus pandemic. They collectively operated over 850 skilled nursing facilities around the country and were charged with caring for 80,000 residents as of June 2020.[300]

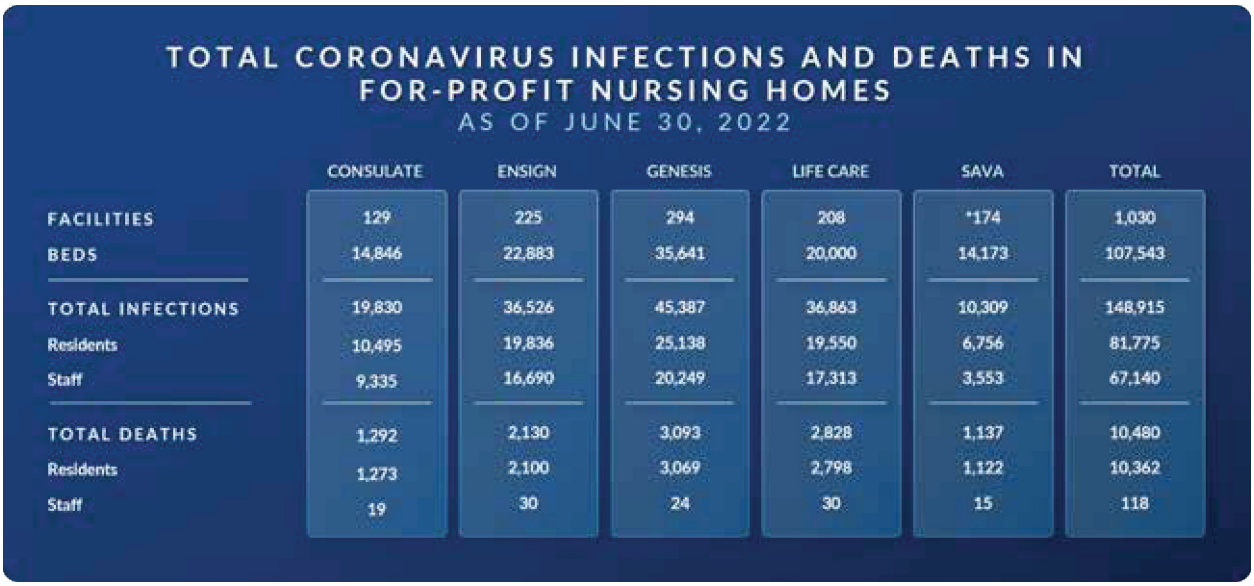
Reports had shown that nursing homes had experienced severe coronavirus outbreaks in the early months of the pandemic, resulting in the deaths of thousands of residents, as well as research showing that for-profit companies tend to receive lower ratings, provide lower quality of care, and experience more safety deficiencies than non-profit facilities.[301] As of 2016, approximately 70% of nursing homes in the United States were for profit, and more than half of all nursing homes were chain-affiliated.[302]

The Select Subcommittee collected data on total infections and deaths across the five companies and documented a total of 81,775 coronavirus infections and 10,362 deaths among residents, and 67,140 infections and 118 deaths among staff.

The Select Subcommittee also sought to understand how staffing practices, wages and benefits, and administration of vaccinations and boosters have impacted nursing home residents and staff throughout the pandemic. Due to the large number of facilities operated by each company, the Select Subcommittee collected data for each of these categories for a sample of 15 facilities per company. Where possible, these facilities were selected to ensure diversity in size, geography, and historical ratings.[303] The Select Subcommittee's analysis of data from these facilities found that the five companies investigated have each had significant staffing deficiencies throughout the course of the pandemic, have often provided low wages and poor benefits to their front-line workers, and have continued to lag in coronavirus booster vaccination rates, despite having initially robust primary series vaccination rates. The Select Subcommittee's findings are based on documents obtained from the five companies, staff briefings provided by the Centers for Medicare & Medicaid Services (CMS), discussions with dozens of public health experts and nursing home advocates, and sworn testimony obtained at a public hearing.

a. Nursing homes operated by the for-profit chains investigated faced severe outbreaks during the coronavirus crisis.

From its onset, the coronavirus pandemic wreaked havoc in nursing homes across the country, with devastating effects for residents and staff in many facilities.[304] Internal company records of Consulate, Ensign, Genesis, Life Care, and Sava obtained by the Select Subcommittee reveal that facilities owned and/or operated by these companies experienced at least 148,915 total coronavirus cases and 10,480 deaths among residents and staff from the onset of the pandemic through June 2022.



	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	TOTAL
FACILITIES	129	225	294	208	*174	1,030
BEDS	14,846	22,883	35,641	20,000	14,173	107,543
TOTAL INFECTIONS	19,830	36,526	45,387	36,863	10,309	148,915
Residents	10,495	19,836	25,138	19,550	6,756	81,775
Staff	9,335	16,690	20,249	17,313	3,553	67,140
TOTAL DEATHS	1,292	2,130	3,093	2,828	1,137	10,480
Residents	1,273	2,100	3,069	2,798	1,122	10,362
Staff	19	30	24	30	15	118

Total confirmed infections and deaths from the coronavirus at five investigated companies between February 2020 and June 2022.[305] **Sava has divested the majority of the 174 long-term care facilities that it owned in June 2020. As of June 2022, Sava owned a total of 18 facilities. This number was reduced to 12 as of November 2022.*[306] *Consulate has also been restructured since 2020.*[307]

Formal counts of coronavirus infections and deaths across these companies have not previously been made public at the corporate owner level. While weekly counts of coronavirus infections and deaths at for-profit long-term care facilities are reported to CMS, this data is only provided at the facility level—often under names and corporate structures that can obscure common ownership—thus making it difficult for the public to understand how many residents and staff under the care of a common corporate manager have fallen ill or died.[308] The table above presents, for the first time, a clear picture of coronavirus infections and deaths at facilities owned and/or operated by the five for-profit nursing home chains under investigation.

b. Nursing home facilities have been understaffed throughout the pandemic.

Adequate staffing—both in terms of the total number of staff and their level of training and specialization—is crucial to ensuring nursing homes are able to provide quality care for residents.[309] Federal law requires that each nursing home has "sufficient nursing staff" to "assure resident safety" and the "highest practicable physical, mental, and psychosocial well-being" of residents.[310] Federal law requires all nursing homes to maintain 24 hours of licensed nursing coverage per day, including a registered nurse (RN) on-site for eight hours, but does not otherwise specify staffing requirements. Under current regulations, larger facilities are not required to have more nursing staff on-site than smaller facilities.[311] A 2001 CMS study recommended that RNs dedicate at least 0.75 working hours, or 45 minutes, to each resident each day, and that Certified Nursing Assistants (CNAs) dedicate at least 2.8 hours, or two hours and 48 minutes, to each resident each day.[312] This means that a 100-person facility where staff work in eight-hour shifts should have more than nine RNs and at least 35 CNAs every day to provide the recommended

level of care for its residents. As these guidelines are recommendations rather than requirements, many states have imposed their own rules to ensure residents receive adequate care.[313]

Insufficient staffing in the nursing home industry is a longstanding problem that has continued throughout the coronavirus pandemic.[314] In the second quarter of 2021, according to staffing data collected by CMS, average staff hours for all nursing homes nationwide failed to meet the 0.75-hour recommendation for RNs at 0.66 hours per resident per day, and failed to meet the 2.8-hour recommendation for CNAs at 2.04 hours per resident.[315] When nursing staff dedicate less time per resident, they typically care for a greater number of residents, thus coming into contact with more residents and increasing the risk that infections will spread. Additionally, when nursing homes are understaffed, facilities tend to rely more heavily on workers with lower levels of training. When a facility has insufficient RNs on staff, a greater volume of resident care may be left to less trained professionals such as Licensed Practical Nurses or CNAs, who may not be qualified to perform certain functions that RNs are trained and licensed to do.

As a result of these factors, there is a demonstrated association between inadequate nursing home staffing and lower quality of care.[316] A CMS study has found that inadequate staffing was a likely root cause for a "range of serious problems including malnutrition, dehydration, pressure sores, abuse and neglect."[317] By contrast, higher staffing levels for CNAs have been associated with fewer deficiencies during nursing home inspections, while higher staffing levels for RNs have been associated with lower rates of emergency department use, hospitalization, and rehospitalization.[318] The impact of insufficient staffing was magnified by the coronavirus crisis. Multiple studies have found that higher staffing ratios mitigated the effect of coronavirus outbreaks and resulted in fewer nursing home deaths—yet such circumstances were far too rare.[319]

For many years, nursing homes advocates have accused nursing home operators of maintaining fewer direct care staff on weekends than on weekdays.[320] CMS recently required nursing homes to submit staffing data for weekends, which confirmed this disparity.[321] Weekend shifts are often less popular with nursing home staff.[322] In the words of one health policy expert, "It's not like the day-to-day life of nursing home residents and their needs vary substantially on a weekend and a weekday. They need to get dressed, to bathe and to eat every single day."[323] While some residents may receive more visitors on weekends, and some of those visitors may be able to help care for loved ones in the absence of sufficient staff, untrained visitors are far less capable of providing care, particularly to residents who need assistance with basic daily tasks, and may only be on-site for relatively brief periods of time. During the coronavirus crisis, visitors were prohibited for months, eliminating even this inadequate stopgap and leaving residents even more vulnerable on weekends.

The Select Subcommittee obtained data on staffing ratios showing the average time RNs and CNAs dedicated to direct resident care at 15 facilities belonging to each company for the January 2020 through June 2022 period. [324] Staffing ratios for all five companies were separated by weekdays and weekends. This data underscored the staffing deficiencies that have plagued the nursing home industry and jeopardized the health and safety of nursing home residents.

The average of all 30 months' weekday RN staffing ratios for all 15 facilities operated by the four companies for which data was available (60 facilities total) was 0.66, falling short of the

recommended minimum of 45 minutes (or .75 of an hour) by approximately five minutes per resident, per day.[325] At 42 of these 60 facilities, the average of all 30 months' weekday RN staffing ratios was below the 45-minute minimum recommendation. There was significant variation between individual facilities and during different months. For example, one Sava facility had one month in which the RN staffing ratio was 0.13 on weekdays—meaning that an RN was on-site for about eight minutes per resident over the course of the entire day on a given weekday—and a total of nine different months in which the weekday RN ratio was 0.15 or less.[326] The average of the 30 months' weekday RN staffing ratios at three other Sava facilities, on the other hand, exceeded the recommendation.[327] Similarly, the average of all 30 months' weekday RN staffing ratios at one Consulate facility was 0.22, and this metric fell below 0.30 at four other Consulate facilities, while at two others this average exceeded the recommended ratio at 0.86 and 1.0, respectively.[328]

Weekend RN shortages were even more severe. The average of all 30 months' weekend staffing ratios across four companies with data was at 0.34—a shortage of nearly 25 minutes per day. The average of the 30 months' weekend staffing ratios fell below the standard at 56 of the 60 facilities reviewed, and each company's 30-month average weekend staffing ratios across its 15 surveyed facilities failed to meet the standard. This figure was the lowest for Consulate, at only 0.12, and highest for Genesis and Life Care, at 0.45. Shortages were even more severe at certain facilities in certain months, again revealing tremendous variation in levels of care, even within the same company. One Sava facility in Texas had eight months in which the weekend RN staffing ratio was zero. [329] A different Sava facility in Connecticut exceeded the recommended standard on weekends in every month, with an average of the 30 months' ratios of 1.04. Such facilities that exceeded the recommended average were rare, however. One Life Care facility had an RN weekend staffing ratio of 0.02 in both May and October 2020, while another Life Care facility had the same ratio on weekends in November 2021.[330] A Consulate facility in Virginia had weekend RN staffing ratios of 0.03 or lower during 16 of the 30 months for which data were provided—meaning that on weekends for more than half of the review period, an RN was on-site for at most one minute and 48 seconds per resident, per day.[331] For one of these months, the ratio was zero.

STAFFING RATIOS FOR REGISTERED NURSES, BY COMPANY
JANUARY 2020 - JUNE 2022

WEEKDAY

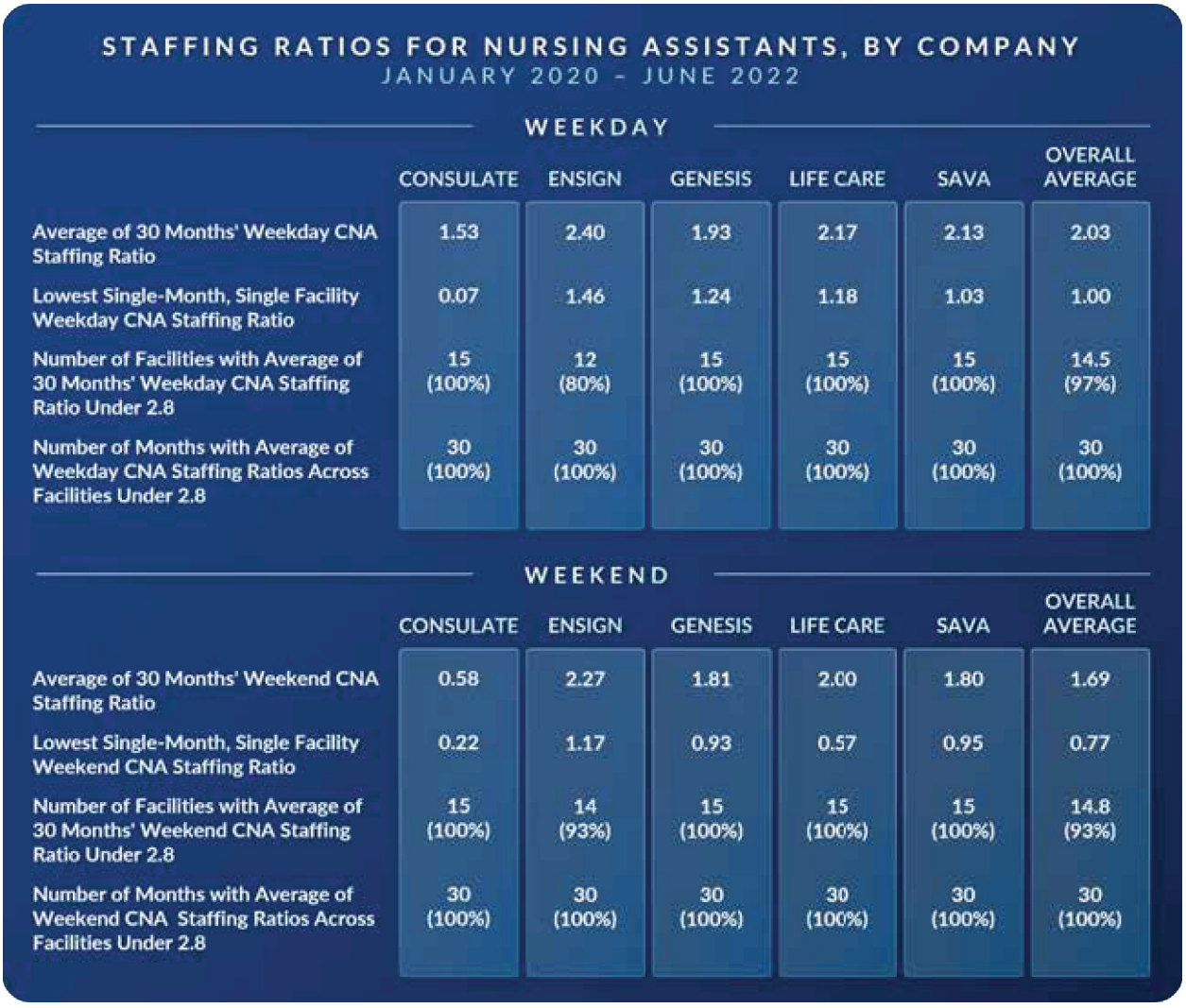
	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 30 Months' Weekday RN Staffing Ratio	0.53	N/A	0.70	0.79	0.60	0.66
Lowest Single-Month, Single Facility Weekday RN Staffing Ratio	0.11	N/A	0.15	0.18	0.12	0.14
Number of Facilities with Average of 30 Months' Weekday RN Staffing Ratio Under 0.75	11 (73%)	N/A	10 (67%)	9 (60%)	12 (80%)	10.5 (70%)
Number of Months with Average of Weekday RN Staffing Ratios Across Facilities Under 0.75	28 (93%)	N/A	26 (87%)	9 (30%)	30 (100%)	23.25 (77.5%)

WEEKEND

	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 30 Months' Weekend RN Staffing Ratio	0.12	N/A	0.45	0.45	0.35	0.34
Lowest Single-Month, Single Facility Weekend RN Staffing Ratio	0.02	N/A	0.09	0.02	0.00	0.03
Number of Facilities with Average of 30 Months' Weekend RN Staffing Ratio Under 0.75	15 (100%)	N/A	14 (93%)	13 (87%)	14 (93%)	14 (93%)
Number of Months with Average of Weekend RN Staffing Ratios Across Facilities Under 0.75	30 (100%)	N/A	30 (100%)	30 (100%)	30 (100%)	30 (100%)

Staffing ratios for registered nurses at 15 facilities of Consulate, Genesis, Life Care, and Sava between January 2020 and July 2022. Averages were calculated by totaling monthly ratios at each facility and dividing by number of months reviewed.[332] *Ensign combined staffing ratios for RNs with ratios for licensed practical nurses (LPNs) and was therefore excluded from average calculations.*[333]

The average of the 30 months' weekday CNA staffing ratios across all companies was 2.03 hours per resident per day, translating to about two hours and two minutes in which a CNA could be attending to residents, falling below the recommendation by 46 minutes per day. This shortage was more drastic on weekends, where the overall average of all months' ratios fell to 1.69, or about one hour and 41 minutes in which a CNA was attending to residents each weekend day. None of the five companies had any month during which the average of the CNA weekday or weekend staffing ratios across the sampled facilities met the recommended minimum. The average of the 30 months' weekday CNA staffing ratios at just three facilities met the recommended minimum, all of which were Ensign facilities. For weekends, this benchmark was met in just a single facility—one of the same Ensign facilities that had also exceeded an average of 2.8 on weekdays.



Staffing ratios for nursing assistants at 15 facilities of each investigated company between January 2020 and July 2022. Averages were calculated by totaling monthly ratios at each facility and dividing by number of months reviewed.[334]

The Biden Administration is taking action to address chronic staffing issues at nursing homes. In February 2022, CMS launched a public input process and research study on nursing home staffing, with the goal of developing a federal rule concerning minimum staffing standards.[335] The proposed rule is on track to be released by spring 2023.[336] This rule is an important step to ensure nursing home residents are given sufficient time and attention for direct care, which may ultimately curb resident neglect and its attendant health harms, and provide better quality working conditions to nursing home staff.

c. Many nursing home direct care staff have been paid low wages.

Low pay and lack of employee benefits, such as paid sick leave, are pervasive problems in the nursing home industry that predate the coronavirus pandemic.[337] Many workers in the nursing home industry earn lower wages than they could working in warehouses or in other sectors that do

not require specialized training.[338] Chris Brown—a CNA who worked at a nursing home in Chicago, Illinois—told Select Subcommittee Members during a June 11, 2020, public briefing that he made $13.90 per hour prior to the pandemic until he received a small increase in hazard pay. Mr. Brown said:

> We're expecting people to come to work and put themselves at risk for a pay that's not worth it. … People go to school and they have to take a state board for this. They need to raise up the pay that these CNAs are getting. I can go to McDonalds and flip a burger, and I can make more than I'm making … doing the back-breaking work of taking care of someone's family member.[339]

CNAs—most of whom are women (91%) and people of color (58%)—experience high rates of poverty, with 12% living below the federal poverty line and 34% relying upon some form of public assistance.[340]

The failure of nursing homes to provide adequate pay and benefits to staff may have exacerbated the impact of the coronavirus crisis. Due to low pay, some nursing home staff work in multiple facilities to make ends meet, which increases their risk of contracting infectious diseases like the coronavirus and spreading them between facilities to nursing home residents and other workers.[341] The failure of many nursing homes to offer paid sick leave similarly increases the risk of outbreaks because it puts staff in the difficult position of having to choose whether to show up to work sick (or after a possible exposure) and get paid or stay home and go unpaid.[342] More than 400,000 workers have left the nursing home industry since January 2020, citing poor pay and benefits, stress and exhaustion, dangerous working conditions, and limited advancement opportunities—contributing to worker shortages that have impacted resident care.[343]

The Select Subcommittee obtained wage data for various job categories on a monthly basis for the 15 sampled facilities at each company from January 2020 through June 2022.[344] These data show the often very low hourly pay these essential workers have received over the course of the pandemic.

All of the companies paid CNAs—who are on the front lines of resident care, often serving as the backbone of many nursing home facilities—less than $20 an hour, on average, with the exception of Genesis during the first six months of 2022. At many facilities, these critical workers were paid near poverty-level wages. All companies had certain facilities that paid CNAs less than $13.00 per hour in 2020—the year in which the coronavirus ravaged nursing homes across the country, and nursing staff were asked to put themselves on the front lines of this life-threatening crisis nearly every day.[345] CNAs at one Sava facility were paid average hourly rates as low as $9.25 in both October and November 2020, $9.33 in January 2021, and $9.85 in January 2022—far less than at retailers like Target and Amazon, which paid more than $15 an hour as of 2021.[346]

PAY DATA FOR NURSING ASSISTANTS

		CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
AVERAGE HOURLY PAY	2020	$15.31	$17.67	$17.73	$15.20	$12.99	$15.78
	2021	$16.62	$17.88	$19.30	$17.25	$13.50	$16.91
	2022	$19.78	$19.53	$22.91	$19.46	$13.98	$19.13
LOWEST AVERAGE HOURLY PAY FOR ANY FACILITY, ANY MONTH	2020	$8.47	$12.68	$11.93	$9.81	$9.25	$10.43
	2021	$10.31	$12.33	$13.21	$13.43	$9.33	$11.72
	2022	$12.16	$15.04	$15.63	$16.07	$9.85	$13.75
HIGHEST AVERAGE HOURLY PAY FOR ANY FACILITY, ANY MONTH	2020	$30.00	$25.16	$35.28	$24.65	$23.17	$27.65
	2021	$24.73	$28.28	$27.86	$22.03	$18.95	$24.37
	2022	$34.43	$27.90	$34.82	$22.90	$18.64	$27.74

Average hourly wages for nursing assistants at 15 facilities of Consulate, Ensign, and Sava from January 2020 through June 2022, and for 15 Genesis facilities from June 2020 through June 2022. Wage data for Life Care consists of all facilities in 2020, and a sample of 15 facilities from January 2021 through June 2022. Companies produced average hourly wages for nursing assistants at each of a sample of 15 facilities for each month during the review period. Overall averages were calculated by totaling month-by-month data and dividing by number of months reviewed to determine the average.[347]

PAY DATA FOR REGISTERED NURSES

		CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
AVERAGE HOURLY PAY	2020	$32.41	$42.03	$38.63	$31.99	$32.27	$35.47
	2021	$36.95	$42.75	$41.76	$36.43	$33.36	$38.25
	2022	$44.48	$45.33	$47.96	$37.78	$33.95	$41.90
LOWEST AVERAGE HOURLY PAY FOR ANY FACILITY, ANY MONTH	2020	$19.44	$29.44	$30.01	$17.42	$26.69	$24.60
	2021	$28.35	$29.64	$30.49	$26.00	$35.07	$29.91
	2022	$30.49	$33.77	$37.77	$28.98	$24.00	$31.00
HIGHEST AVERAGE HOURLY PAY FOR ANY FACILITY, ANY MONTH	2020	$70.05	$63.41	$54.60	$75.05	$43.98	$61.42
	2021	$75.58	$57.38	$71.70	$43.27	$40.63	$57.71
	2022	$71.23	$61.96	$64.77	$47.80	$40.76	$57.30

Average hourly wages for RNs at 15 facilities of Consulate, Ensign, and Sava from January 2020 through June 2022, and for Genesis from June 2020 through June 2022. Wage data for Life Care consists of all facilities in 2020, and a sample of 15 facilities from January 2021 through June 2022. Companies produced average hourly wages for RNs at each of a sample of 15 facilities for each month during the review period. Overall averages were calculated by totaling month-by-month data and dividing by number of months reviewed to determine the average.[348]

Wage data shows that the average of all 30 months' hourly pay for RNs across the 75 sample facilities was more than $30 per hour. Some RNs received much more—with certain companies paying RNs an average of as much as $75.05 (Life Care), $71.70 per hour (Genesis), or $63.41 per hour (Ensign) at certain facilities in certain years. The companies varied substantially in terms of average wages paid to RNs, although average RN wages tended to increase each year.

Additionally, paid leave policies at the investigated nursing home companies may have left out many workers. Before the pandemic, Sava and Consulate only provided paid sick leave to full-time employees.[349] From April 2020 to October 2020, Sava authorized 112 hours of coronavirus-specific sick leave for full-time employees and 56 hours for part-time employees. After that period, Sava granted sick leave based on "individual center needs."[350] Consulate's policy also changed during the pandemic to allow paid time off for on-the-job coronavirus exposures.[351] Genesis and Ensign provide paid sick leave to full-time employees, but not to other staff unless required by state or local law, and have not changed these practices during the pandemic.[352] Life Care does not have a consistent sick leave policy across facilities; some part-time employees receive paid sick while others do not, a practice that existed before the pandemic and remains in place. [353]

d. Initial vaccination rates at nursing homes investigated were high, but booster rates have lagged.

Given the significant role nursing home operators play as caretakers, health care providers, and employers, vaccinating their residents and staff has largely depended on them. To understand whether vaccinations have been effectively administered among the nursing homes investigated, the Select Subcommittee obtained data concerning the percentage of residents and staff who received coronavirus vaccines and boosters, separated by facility and by primary vaccination series versus booster doses.[354] The Select Subcommittee found that while rates for primary series vaccinations were generally high among both residents and staff across all companies, booster rates were significantly lower.

i. *Nursing home residents*

Each of the companies investigated had average primary series vaccination rates among residents between 77% and 84% across the sample of facilities reviewed by the Select Subcommittee. These rates spanned a wide range. On the high end, the primary series vaccination rate was 99% among residents at a Sava facility in Connecticut, 97% for residents at a Consulate facility in Florida, and 95% for residents at a Genesis facility in Kentucky. An Ensign facility in California also had 99% of residents receive a primary vaccination series, while a Life Care facility in Massachusetts had a rate of 100%. On the low end, one Consulate facility in Florida had a vaccination rate of 42%, while a second Genesis facility in Kentucky had only 57% of residents vaccinated.

VACCINATION AND BOOSTER RATES AMONG RESIDENTS AT 15 SAMPLE FACILITIES

VACCINATION RATE

	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 15 Facilities' Primary Series Vaccination Rate	77%	84%	83%	84%	84%	82%
Primary Series Vaccination Rate at Facility with Lowest Rate	42%	58%	57%	63%	66%	57%
Primary Series Vaccination Rate at Facility with Highest Rate	97%	99%	95%	100%	99%	98%
Number of Vacilities with 80% or Higher Primary Series Vaccination Rate	6	9	11	10	9	9

BOOSTER RATE

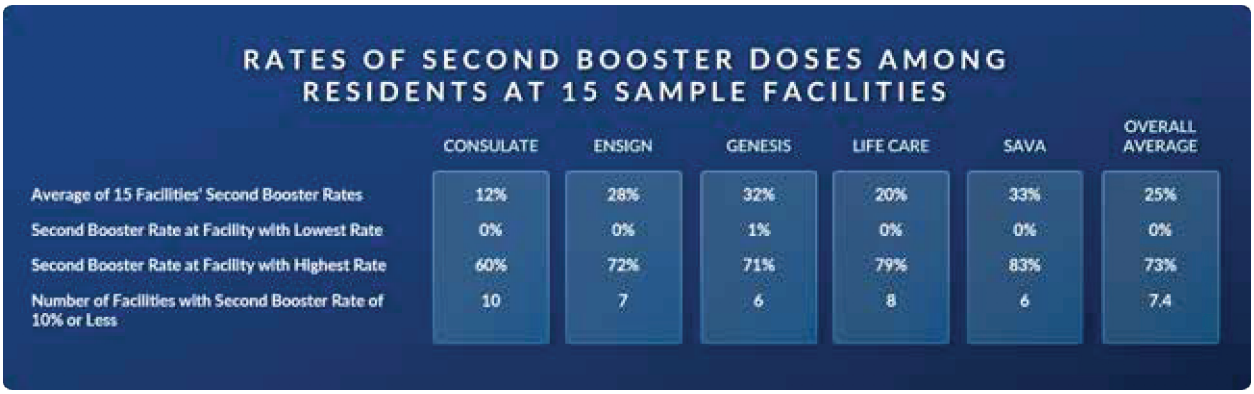
	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 15 Facilities' Booster Rates	43%	64%	71%	65%	74%	63%
Booster Rate at Facility with Lowest Rate	8%	0%	41%	27%	40%	23%
Booster Rate at Facility with Highest Rate	85%	96%	91%	95%	98%	93%
Number of Facilities with 50% or Higher Booster Rate	5	12	13	12	14	11.2

Average primary series and booster rate for residents of 15 facilities of each investigated company as of July 2022. Booster rates consist of the percentage of residents who have received any vaccine after a completed primary series.[355]

The average booster rate of all facilities across all companies was 63%—a concerningly low rate given that booster doses have been available for high-risk individuals since September 2021, have been demonstrated to protect against severe illness, hospitalization, and death, and are particularly important for high-risk individuals such as those residing in nursing homes.[356] Rates across and within companies were not uniform. Eleven of 15 Genesis facilities reviewed and nine of 15 Ensign facilities had at least a 70% rate among residents. Seven facilities belonging to both Life Care and Sava—just under half of sampled facilities for each—had more than 70% of residents receive boosters during the period reviewed, while only four facilities belonging to Consulate reached this rate.

On March 29, 2022, FDA authorized second booster doses for patients 50 years of age and older and certain immunocompromised patients over age 12—populations that are likely to encompass a large percentage of nursing home residents.[357] Yet data showing resident uptake of second booster doses reflect an average rate of only 25% across the five companies, with many facilities having rates as low as 0%. Nearly half of all reviewed facilities had rates lower than 10%. Studies show that immunity derived from primary vaccination series and the initial booster

eventually wanes, making it essential that nursing home facilities ensure residents are up to date on coronavirus boosters, which now include the bivalent booster authorized in October.[358]



RATES OF SECOND BOOSTER DOSES AMONG RESIDENTS AT 15 SAMPLE FACILITIES

	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 15 Facilities' Second Booster Rates	12%	28%	32%	20%	33%	25%
Second Booster Rate at Facility with Lowest Rate	0%	0%	1%	0%	0%	0%
Second Booster Rate at Facility with Highest Rate	60%	72%	71%	79%	83%	73%
Number of Facilities with Second Booster Rate of 10% or Less	10	7	6	8	6	7.4

Average second booster rate for residents of 15 facilities of each investigated company as of July 2022. Second booster rates consist of the percentage of residents who have received at least one dose after completion of both a primary series and one additional dose.[359] *Booster rates do not include bivalent boosters.*

ii. *Nursing Home Staff*

Primary series vaccination rates among nursing home staff were even higher than those of residents at the facilities reviewed but dropped off even more significantly when it came to boosters. The average primary series vaccination rate for staff was 89% across the five companies. Seven facilities across these four companies had 100% primary series staff vaccination rates: three Sava facilities, two Genesis facilities, one Life Care facility, and one Ensign facility.

VACCINATION AND BOOSTER RATES AMONG STAFF AT 15 SAMPLE FACILITIES

VACCINATION RATE

	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 15 Facilities' Primary Series Vaccination Rate	83.6%	87%	92%	87%	94%	89%
Primary Series Vaccination Rate at Facility with Lowest Rate	61.9%	66%	71%	73%	81%	71%
Primary Series Vaccination Rate at Facility with Highest Rate	95.9%	100%	100%	100%	100%	99%
Number of Vacilities with 80% or Higher Primary Series Vaccination Rate	9	11	13	12	15	12

BOOSTER RATE

	CONSULATE	ENSIGN	GENESIS	LIFE CARE	SAVA	OVERALL AVERAGE
Average of 15 Facilities' Booster Rates	33%	42%	54%	44%	58%	46%
Booster Rate at Facility with Lowest Rate	16%	0%	14%	14%	13%	11%
Booster Rate at Facility with Highest Rate	69%	100%	98%	98%	97%	92%
Number of Facilities with 50% or Higher Booster Rate	3	5	7	5	9	5.8

Average primary series and booster rate for staff at 15 facilities of each investigated company as of July 2022. Booster rates consist of the percentage of staff who have received any vaccine after a completed primary series.[360]

Booster rates, however, saw a substantial drop-off among staff at facilities reviewed. The average of the facilities' booster rates across all five companies was 46%. At two Ensign facilities, booster rates among staff were 0%, while each of the other four companies had facilities with booster rates as low as 13% to 16%. For four of the five companies—Consulate, Ensign, Genesis, and Life Care—a majority of facilities reviewed had staff booster rates lower than 50%. Given the low percentages of staff at these establishments who have received any additional vaccine dose since their primary series—which could have occurred nearly two years ago—and the eventual waning of vaccine-induced immunity, it is essential that nursing homes ensure more of their staff receive coronavirus booster installments.[361]

The vaccination and booster trends among the five companies investigated by the Select Subcommittee are largely consistent with industry-wide vaccination data. According to CMS data, as of November 2022, approximately 87% of residents and 87% of staff in long-term care facilities had received full primary series of the coronavirus vaccine, while approximately 41% of residents and 25% of staff were reported as being up to date on coronavirus boosters.[362]

2. The pandemic's toll has fallen most heavily on minority communities.

Chairman Clyburn observed that racial inequity has been "laid bare by the coronavirus pandemic."[363] In the first half of 2020, African Americans and Latinos had death rates from coronavirus that far outweighed those of whites.[364] While 62% of the population age 45-54 in 2020 was white, this population accounted for only 22% of coronavirus deaths in that age range. In fact, researchers observed in June 2020 that, "in every age category, Black people are dying from COVID at roughly the same rate as white people more than a decade older."[365] Disparities were even more pronounced in some states such as Louisiana, where in April 2020, African Americans represented 70% of coronavirus deaths despite being only one third of the state's population.[366] The rates of death between minorities and non-minorities narrowed through 2021 and 2022 due to a higher opposition to the coronavirus vaccine in white communities.[367] However, cumulative data shows that minority communities have experienced overall higher rates of infection, hospitalization, and death from the virus.[368]

The racial disparities discussed above with respect to higher rates of underlying medical conditions, less access to healthy food and clean water, and more exposure to environmental pollutants all contributed to these higher rates of negative outcomes.[369] A Washington University St. Louis study identified two factors that had an "overwhelming" impact on how rapidly coronavirus infections spread throughout a community—population density and long term exposure to air pollution—factors which disproportionately affect communities of color.[370] Another study from Harvard Medical School "found evidence of a synergistic association of poor diet and increased socioeconomic deprivation with COVID-19 risk that was higher than the sum of the risk associated with each factor alone."[371]

Black and Hispanic workers also comprise a higher percentage of frontline workers who were required to interact with the public during the coronavirus crisis, such as public transit operators and food-service workers, as compared to their overall representation in the workforce.[372] This put Black and Hispanic workers—and their families—at greater risk of exposure to the coronavirus. Black and Hispanic Americans are also more likely to live in inter-generational households, thus putting whole families at risk when one member contracted the virus.[373]

E. Life-Saving Vaccinations and the Biden Administration's Stewardship Helped the Nation Emerge from the Coronavirus Crisis, Yet Decisions Made by the Trump Administration, Actions Taken by Private Companies, and Predatory Actors Spreading Misinformation Have Undermined These Efforts.

Upon assuming office, President Biden took immediate action to overcome early mismanagement of the coronavirus crisis, administering 200 million vaccine doses within its first 100 days—double the Administration's initial goal of 100 million vaccinations.[374] The Biden Administration's robust efforts to increase supply and equitable access to life-saving coronavirus vaccines resulted in over 228 million Americans having completed a primary vaccination series today.[375] This historic vaccination campaign profoundly altered the trajectory of the pandemic, preventing over two million deaths and 17 million hospitalizations through the end of March 2022.

Researchers at The Commonwealth Fund estimated there would have been an additional 66 million infections and nearly $900 billion in associated health care costs in the absence of vaccination.[376]

Shortly after taking office, President Biden also committed to restoring trust in the federal government by using a science-driven approach to lead the nation's pandemic response—a sharp contrast to the Trump Administration's pattern of allowing political considerations to overrule and obstruct the work of career scientists.[377] The Biden Administration took a number of steps that allowed the country to overcome the crisis phase of the pandemic, including putting forth a comprehensive national plan to mitigate its spread and working with Democrats in Congress to pass the American Rescue Plan to ensure that federal, state, local, and tribal governments had the necessary resources to do so. The American Rescue Plan made significant investments in state and local public health departments and provided critical funding to support the safe reopening of 99% of schools in America.[378] The Biden Administration also used American Rescue Plan funding to make historic investments in coronavirus testing capacity, advance equitable access to coronavirus treatments, and make hundreds of millions of high-quality masks available to Americans for free.[379]

Unfortunately, contracts awarded by the Trump Administration, actions taken by private companies, and the spread of misinformation by predatory actors have undermined these efforts.

1. Emergent BioSolutions, which received a vaccine manufacturing contract from the Trump Administration despite red flags, wasted hundreds of millions of taxpayer dollars manufacturing defective vaccines.

The Select Subcommittee's joint investigation with the Committee on Oversight and Reform uncovered extensive failures by Emergent BioSolutions, Inc. (Emergent), which resulted in the destruction of 525.2 million doses of taxpayer-funded coronavirus vaccines manufactured between July 2020 and February 2022.[380] Despite clear red flags, the Trump Administration awarded Emergent a $628 million contract in May 2020 to support the manufacturing of Johnson & Johnson and AstraZeneca coronavirus vaccines. Emergent's failures wasted hundreds of millions of taxpayer dollars and hindered the federal government's ability to meet the urgent, global need for coronavirus vaccines.[381]

The Committees' investigation revealed that the Trump Administration was aware, prior to awarding the contract, of serious problems and deficient controls at Emergent's Bayview facility in Baltimore, Maryland that could impact vaccine manufacturing. The Committees released documents reflecting two inspections conducted by BARDA and FDA in April 2020, which warned of "substantial evidence" of noncompliance with quality standards, including "inadequate quality unit oversight," "failure of quality systems," persistent problems with mold, poor disinfection of plant equipment, and inadequate training of employees. Disregarding these findings, the Trump Administration recommended that Johnson & Johnson and AstraZeneca partner with Emergent to manufacture coronavirus vaccines.[382]

Over the course of the investigation, the Committees exposed how Emergent executives privately expressed serious concerns about the company's manufacturing shortcomings at the same

time they promoted the capabilities of the Bayview facility and solicited and negotiated multimillion-dollar contracts with Johnson & Johnson and AstraZeneca. Emergent's then-Executive Vice President of Manufacturing and Technical Operations privately acknowledged that he had warned Emergent senior executives "for a few years" about the company's deficient quality systems, including that "room to improve is a huge understatement."[383] Internal communications obtained by the Committees showed that this executive confided to Emergent's President and Chief Executive Officer (CEO) in June 2020 that the overall state of quality systems at the facility "keeps me up at night," yet assured an AstraZeneca senior vice president that Emergent was "confident Bayview has the appropriate fundamental quality systems and the capable workforce to successfully execute this acceleration." This took place after AstraZeneca expressed concerns in July 2020 that FDA had determined "Emergent isn't prepared for commercial manufacturing."[384]

Additional inspections and audits conducted in June, July, and September 2020 by Operation Warp Speed, BARDA, FDA, Johnson & Johnson, and AstraZeneca identified numerous, critical deficiencies that Emergent failed to remediate before it began manufacturing vaccines.[385] In a transcribed interview with the Select Subcommittee, Dr. Kadlec said he was unaware of these findings, despite his role overseeing BARDA as Assistant Secretary for Preparedness and Response and involvement with Operation Warp Speed during the Trump Administration. Dr. Kadlec acknowledged that these findings were "kind of a big deal" and that "it seems like a drum beat of issues that were being raised."[386] The Trump Administration added $30 million to Emergent's contract in late July 2020 to reserve additional manufacturing capabilities at Bayview.[387]

The Committees' investigation revealed that Emergent executives continued to internally acknowledge compliance shortcomings and the lack of commercial manufacturing experience at the Bayview facility after the company began manufacturing coronavirus vaccines. Internal communications obtained by the Committees show that Bayview's Senior Director of Quality emailed Emergent's Executive Vice President of Business Operations in advance of an FDA site visit in September 2020 stating, "Our risk is high!" and, "we lack commercial GMP [good manufacturing practices] compliance maturity" and "we are not in full compliance yet-BUT-we are making batches NOW." Emergent also admitted to HHS in July and August 2020 that its staff were mostly "temporary employees [with] little or no pharmaceutical experience." Johnson & Johnson, AstraZeneca, and FDA repeatedly warned Emergent between September and December 2020 that it was not meeting quality standards and not ready for commercial manufacturing. An outside consultant to Emergent provided a stark warning about Emergent's manufacturing in November 2020: "I am stating very loudly that this work is NON-CGMP compliant. And a direct regulatory risk."[388]

Emergent failed to remedy these issues, subsequently producing millions of doses of contaminated vaccines while receiving millions of dollars from Johnson & Johnson, AstraZeneca, and the federal government. In his transcribed interview, Dr. Kadlec said he was unaware that roughly 61.2 million Johnson & Johnson and AstraZeneca coronavirus vaccine doses were rejected or aborted due to microbial contamination and equipment failure during his tenure as ASPR in the Trump Administration, although he was generally aware that concerns about Emergent's manufacturing had developed during that time.[389] The Committees' investigation found that

inexperienced staff and high employee turnover at the Bayview facility impaired Emergent's quality systems and contributed to the vaccine contamination. In a briefing to the Committees, FDA acknowledged, "Clearly, in retrospect, they hired a lot of individuals not as familiar with vaccine manufacturing, that did not have adequate training to do so."[390]

Evidence obtained by the Committees also revealed that Emergent took repeated steps to hide evidence of its failures from the federal government. Immediately before an FDA site visit in February 2021, Emergent employees removed quality-assurance "hold tags" from Johnson & Johnson vaccine batches—which indicated that the containers had a potential quality issue. The containers were re-tagged after the inspection and "before the end of the evening." In an email obtained by the Committees, an outside consultant stated that the tags were removed "to avoid drawing attention to the two subject containers during the tour by the FDA inspectors." Multiple senior leaders at Emergent were aware of the removal of the tags, including the Vice President of Manufacturing Operations, the Quality Assurance Manager, the Senior Manager in Quality Systems, and the Senior Director of Quality.[391] Two days before this incident, Emergent awarded millions in raises and bonuses to its senior executives, praising them for their "exceptional leadership" and "exemplary" performance in 2020—as vaccines were being destroyed, as revealed by the Committees. Emergent even rewarded the executive who had previously admitted that Bayview's quality systems "keeps me up at night" with a "special bonus" of $100,000—on top of a regular bonus of $320,000—in recognition of his "exceptional performance" in 2020 "related to COVID19."[392]

After Emergent notified HHS in March 2021 that it had cross-contaminated millions of Johnson & Johnson and AstraZeneca coronavirus vaccines, internal communications show that Emergent personnel expressed concern that HHS was "getting too involved." Company executives strategized on how to evade questions from HHS.[393] The Biden Administration permanently halted production of AstraZeneca's vaccine and paused manufacturing of Johnson & Johnson's vaccine in April 2021.[394] At a Select Subcommittee hearing on May 19, 2021, Emergent's Chairman and CEO apologized and acknowledged some of the company's failures but continued to minimize the seriousness of vaccine contamination at the Bayview facility.[395]

Emergent claimed to have addressed quality concerns and deficiencies subsequently identified by FDA during inspections in June and July 2021 and resumed manufacturing for Johnson & Johnson in August 2021. However, the Biden Administration canceled its partnership with Emergent and terminated the company's multimillion-dollar contract on November 1, 2021, because the company had failed to follow federal manufacturing standards as required by its contract.[396] Johnson & Johnson representatives later confirmed to the Committees that "there continued to be issues" with manufacturing at the Bayview facility during the winter of 2021, up until Emergent stopped manufacturing in early February 2022. The Committees investigation revealed that foreign regulatory authorities from the European Union, Canada, and South Africa conducted audits of the Bayview facility between February and April 2022, documenting "adverse regulatory findings" and noting "that contamination issues are still present and are not under control"—confirming FDA's findings that Emergent had not remediated issues and was not operating in compliance with quality standards.[397]

Following the release of the Committees' May 10, 2022, staff report, Johnson & Johnson notified Emergent on May 31, 2022, that it intended to send a notice terminating its contract, effective July 6, 2022. Johnson & Johnson representatives told Committee staff that they were alarmed by the Committees' findings that Emergent employees hid evidence of potential quality issues in order to deceive FDA inspectors. According to one senior Johnson & Johnson representative, this "signaled a shift from capability to misconduct," explaining that being "unable to manufacture something" is different than "withholding information."[398] In total, Emergent received $330 million in taxpayer dollars under the contract awarded by the Trump Administration as well as millions from its private contracts with Johnson & Johnson and AstraZeneca.[399] Despite repeated claims that it had addressed concerns, the company's unacceptable and irresponsible business practices ultimately led to the destruction of 420 million Johnson & Johnson and 105.2 million AstraZeneca coronavirus vaccine doses.[400]

2. One Medical failed to follow vaccine prioritization guidelines, manipulating distribution to benefit its bottom line and those with connections.

After the first coronavirus vaccines were authorized in December 2020, federal, state, and local public health departments worked with health care providers to rapidly distribute vaccines and administer vaccinations. Due to limited supplies in late 2020 and early 2021, CDC and local public health departments recommended prioritizing vaccinations for certain high-risk populations such as senior citizens, long-term care facility residents and staff, health care workers, and other essential workers. During the early vaccine roll out, reports emerged that some health care providers disregarded vaccine eligibility requirements and sought to profit from the public sense of urgency surrounding vaccines.

As the Select Subcommittee revealed in a December 2021 report, One Medical, a nationwide membership-based primary care practice in which members pay an annual fee for access to its platform in addition to the cost of services provided,[401] took advantage of its access to scarce coronavirus vaccines to promote the company's business interests and push vaccine seekers toward paying for One Medical memberships. In an internal chat message, one senior One Medical executive said, "maybe i'm being too opportunistic, but we should be really focused on how to capitalize on this visibility … how can we take advantage of the vacinne [sic] interest to conver [sic] to our other company objectives." Another senior executive suggested that "the only way people can get a vaccine is if they are a member….so we need to make it easy to sign up….and cheap possibly." The Select Subcommittee's investigation found that some users who attempted to make a vaccination appointment with One Medical were required to enter credit card information and subscribe to a $199 per year membership plan, despite the fact that vaccines were free, having been purchased by the federal government.[402]

The Select Subcommittee's investigation found that One Medical and its employees gave priority access to coronavirus vaccinations to friends and family of executives and non-patient-facing employees, including remote staff. Instead of going to those with the greatest need, One Medical helped VIPs, paying members and enterprise clients, business contacts, and friends and family members of One Medical employees get through the vaccination gate ahead of others. One Medical also enabled a flood of patients, some of whom were ineligible, to get early access

to vaccinations. Despite repeated complaints, internal messages obtained by the Select Subcommittee showed that One Medical's leadership was slow to act and inconsistent in upholding vaccine eligibility guidelines, with one employee remarking about the company's policy: "[W]e turn nobody away. We aren't gate keeping."[403]

One Medical's failure to administer coronavirus vaccines equitably reflects broader struggles to reach vulnerable communities that plagued the early vaccine rollout. The Company's willful disregard of proper vaccination prioritization contributed to a delay in vaccination of members of vulnerable communities—leaving them at heightened risk from the coronavirus in the early months of 2021 while vaccines remained in short supply. Upon receipt of complaints and reports of One Medical's conduct, several local governments terminated their vaccine distribution agreements with the company.[404]

2. Misinformation and distrust of public health expertise has contributed to the unnecessary loss of life.

Misinformation and disinformation about the coronavirus undermined the nation's pandemic response and cost American lives. Throughout the pandemic, nefarious actors spread false information about risks posed by the coronavirus, public health measures proven to curb transmission, and the safety and effectiveness of coronavirus vaccines and treatments. While some of the figures pushing false information masked their identities by operating online, prominent politicians and well-known media figures played a significant role in disseminating and amplifying misinformation. Misinformation led some Americans to endanger their own lives by refusing coronavirus vaccines and proven treatments in favor of alternative drugs that cannot prevent or cure coronavirus infections.[405] The rampant spread of coronavirus misinformation also led to distrust, harassment, and even violence against public health officials, doctors and nurses, store clerks, flight attendants, and other Americans who have been tasked with preserving public health during the pandemic.[406]

The Biden Administration has made efforts to combat misinformation and politicization, pledging early on to let scientists lead and elevated scientists and public health experts in leadership roles, and working to remove partisanship from vaccine messaging.[407] But these insidious forces have been difficult to dislodge.

a. <u>Fueled by the former President and other right-wing public figures, science-based public health expertise and guidance has been under attack.</u>

Much of the phenomenon of coronavirus misinformation can be traced to President Trump and his efforts to politicize the pandemic. In addition to treating the coronavirus crisis as a political problem, the former President pushed lies about risks posed by the virus and took steps to undermine the scientists who were working to address America's worst public health crisis in a century. From the earliest weeks of the crisis, President Trump made false promises about the virus's spread and the country's preparedness. Two days after a February 25, 2020, CDC telebriefing "angered" President Trump by warning Americans about the coming disruption, he inaccurately claimed: "It's going to disappear. One day, it's like a miracle—it will disappear."[408]

While the nation was experiencing severe shortages in coronavirus tests, President Trump falsely asserted during a March 6, 2020, visit to the CDC: "Anybody that wants a test can get a test."[409]

The former President's spread of falsehoods became even more insidious as the pandemic continued. On April 23, 2020, President Trump suggested that disinfectant or ultraviolet light could be used to treat the coronavirus, saying, "I see the disinfectant that knocks it out in a minute, one minute. And is there a way we can do something like that by injection inside or almost a cleaning?"[410] In October 2020, President Trump falsely asserted that a CDC study had shown "that 85% of the people wearing masks catch" the coronavirus.[411] The former President repeatedly advocated for the use of hydroxychloroquine to treat the coronavirus and claimed at one point that a study finding hydroxychloroquine ineffective as a coronavirus treatment was authored by "people that aren't big Trump fans."[412] He frequently attacked those who were willing to contradict his lies—increasingly targeting Dr. Anthony Fauci, a career scientist, as the pandemic dragged on. In October 2020, he stated: "People are tired of hearing Fauci and all these idiots."[413]

These falsehoods and attacks on scientists were not limited to the former President himself. The Select Subcommittee's investigations uncovered extensive evidence revealing how top advisors to the former President sought to amplify his lies while attacking scientific experts. Mr. Navarro published an op-ed in July 2020 arguing that Dr. Fauci "has been wrong about everything I have interacted with him on."[414] As detailed in an August 2022 Select Subcommittee report, Mr. Navarro and his top scientific advisor Dr. Stephen Hatfill went on to conduct a furtive campaign seeking to discredit Dr. Fauci.[415] A Select Subcommittee investigation also revealed that top HHS officials took steps to further the President's preferred narrative about coronavirus treatments. In early July 2020, Dr. Alexander and other political appointees sought to publish an op-ed rebutting a CDC study on hydroxychloroquine, which had its EUA revoked by FDA on June 15, 2020, due to its inefficacy as a coronavirus treatment and potential safety issues.[416] In an internal email to Dr. Hahn on July 19, 2020, previously released by the Select Subcommittee, Dr. Alexander pushed a study purporting to show the benefits of hydroxychloroquine, asserting: "I want to help the administration," and "we are being fought by the other side and media which is horrendous."[417]

Fox News and other conservative media outlets parroted the former President's lies. Fox Business anchor Trish Regan said on March 9, 2020, that concerns over the emerging virus were "yet another attempt to impeach the President."[418] Fox's top rated host, Tucker Carlson, repeatedly attacked Dr. Fauci and other scientific experts on his program, telling viewers in August 2022 that Dr. Fauci had committed "very serious crimes" and "apparently engineered the single most devastating event in modern American history."[419] Another Fox host, Laura Ingraham, repeatedly touted ivermectin—a disproven coronavirus treatment—on her program, saying on one occasion, "And you never hear Fauci talk about that, or D3 or ivermectin, because they haven't even given emergency use authorization for ivermectin, haven't even put out anything about that. They're way behind all these other countries."[420] Nationally syndicated conservative radio host Phil Valentine expressed skepticism about coronavirus vaccines and told his listeners he had begun taking ivermectin after becoming infected with the virus.[421] He later expressed regret after he was hospitalized for his infection, from which he later died.[422]

Misinformation about the pandemic has become ubiquitous. A November 2021 poll found that 78% of adults had heard at least one of eight different false statements about the coronavirus

and either believed one to be true or were unsure if the statement was true or false.[423] Nearly a third of adults surveyed said that they believed or were uncertain about at least four false statements about the pandemic.[424] Consumers of Fox News, Newsmax, and One America News were found to be significantly more likely to believe falsehoods than consumers of CNN, NPR or MSNBC.[425]

Research has also found direct causal links between the former President's lies about the pandemic and the spread of misinformation. A study at Cornell University analyzed 38 million articles about the pandemic in English-language media around the world and concluded that President Trump was the single largest driver of coronavirus misinformation between January 1 and May 26, 2020.[426] The researchers found that President Trump's promotion of "miracle cures" like hydroxychloroquine significantly contributed to the spread of misinformation.[427] By feeding the public falsehoods about the coronavirus and coronavirus treatments, the former President made it more difficult for Americans to distinguish between legitimate and illegitimate sources of health information. This also made it harder for Americans to know how to protect themselves and their loved ones from the coronavirus, ultimately threatening the health of the American people.

b. Misinformation has led to harassment, threats, and attacks on public health officials.

Misinformation and the politicization of public health not only undermined public health but also threatened the safety—and at times the lives—of those charged with protecting it. During a Select Subcommittee hearing in September 2021, state and local public health officials testified about their personal experiences dealing with threats during the pandemic. For example, Dr. Jennifer Bacani McKenney, Health Officer of the Wilson County Health Department in Kansas, testified about an incident where her home was filmed, and the footage posted on social media. Louisiana State Health Officer and Medical Director of the Louisiana Department of Health Dr. Joseph Kanter said that he had experienced "increased anger and threats made to me personally, some very ugly and with obvious intent to track down my family's personal identifying information." Dr. Mysheika Roberts, Health Commissioner of Columbus Public Health, similarly testified about threats to multiple state health officers in Ohio, including an assistant medical director who "had shots fired at her home."

c. Right-wing extremists contributed to and profited from the spread of misinformation.

In October 2021, the Select Subcommittee initiated an investigation into two prominent purveyors of misinformation—America's Frontline Doctors (AFLDS) and SpeakWithAnMD.com—that used telemedicine to prescribe disproven and potentially hazardous coronavirus treatments across the United States.[428] Since at least the spring of 2021, SpeakWithAnMD.com and its parent company, Encore Telemedicine, collaborated with AFLDS to provide paid telehealth consultations and sell off-label prescriptions for hydroxychloroquine and ivermectin, seeking to capitalize off the spread of coronavirus misinformation to market and sell these disproven and potentially hazardous treatments.[429] AFLDS's website referred patients to SpeakWithAnMD.com to provide patients seeking these treatments with telemedicine consultations with "AFLDS-trained and licensed physicians."[430]

New information obtained by the Select Subcommittee shows that, in the five-month period between April 2021 and September 2021, more than 480,000 prospective patients registered for accounts on SpeakWithAnMD.com's telemedicine platform seeking consultations.[431] According to press reports, AFLDS referred over 255,000 individuals to SpeakWithAnMD.com between July 16, 2021, and September 12, 2021. Approximately 72,000 of these prospective patients paid $90 for initial phone consultations, and many also had follow-up consultations for an additional $60.[432] One investigation found that some individuals were charged for consultations that never occurred. In total, prospective patients appear to have paid more than $6.7 million for consultations from July 2021 to September 2021.[433]

These two entities also teamed up with fringe operatives to promote their businesses and increase their reach. SpeakWithAnMD.com entered a contract with prominent conspiracy theorist Dr. Jerome Corsi to steer prospective patients to their website in return for lucrative referral fees. Dr. Corsi was to receive between $5 to $20 for each patient that he referred to SpeakWithAnMD.com.[434] As described earlier in this report, Trump White House officials engaged with Dr. Corsi to generate support for and exert inappropriate pressure on FDA to reauthorize hydroxychloroquine as a coronavirus treatment.

Following these telemedicine consultations, SpeakWithAnMD.com-affiliated medical providers reportedly prescribed thousands of doses of potentially hazardous coronavirus treatments, including ivermectin and hydroxychloroquine.[435] FDA, CDC, and NIH recommend against taking ivermectin and hydroxychloroquine to prevent or treat coronavirus infections because they are ineffective and can cause severe illness.[436] By encouraging the use of questionable treatments and discouraging coronavirus vaccination, these entities—along with others that have spread misinformation—put American lives at risk and threatened our nation's ability to overcome the coronavirus crisis.

d. Politicization of the pandemic fueled deadly anti-vaccine sentiment.

Misinformation has made vaccine refusal a core tenet of the far right. While anti-vaccine sentiment was once relegated to the fringe, prominent right-wing figures and Republican members of Congress distorted the life-saving benefits of coronavirus vaccines in order to portray them as mechanisms of government overreach and threats to freedom. While President Trump himself did not actively push anti-vaccine rhetoric, his attacks on scientists and scientific institutions had the effect of making the apolitical experts who urged the public to get vaccinated seem like partisans to be distrusted. Many of the President's supporters and political acolytes attacked coronavirus vaccines as experimental, potentially dangerous, or simply unnecessary.

For example, Congresswoman Marjorie Taylor Greene tweeted false information about coronavirus vaccines in July 2021, writing: "Thousands of people are reporting very serious life changing vaccine side effects from taking covid vaccines. 5,946 deaths are reported on the CDC website. Social media is censoring their stories & the media is silent. Biden is going to homes to push shots. Just say NO!"[437] Congressman Matt Gaetz echoed this false claim several months later, tweeting in October 2021: "Post-vaccine breakthrough infection kills more people than Iraq's WMD's ever did."[438] Senator Ron Johnson similarly said in May 2021, "I'm talking to

doctors who have, since day one, been concerned about vaccinating people who've already had Covid, because you die, not of Covid, you die of the immune system overreaction to Covid."[439] Similar lies and distortions were repeated by state-level Republican officials.[440]

These sentiments were also echoed in conservative media. In May 2021, Tucker Carlson used his platform to assert inflammatory information about deaths after coronavirus information, stating: "Between late December of 2020 and last month, a total of 3,362 people apparently died after getting the COVID vaccine in the United States … The actual number is almost certainly higher than that, perhaps vastly higher … It's clear that what is happening now, for whatever reason, is not even close to normal."[441] Mr. Carlson's false connection between coronavirus vaccines and unrelated deaths appeared to be designed to stoke fear among the unvaccinated. The One America News Network took this claim even further, falsely claiming in an October 2022 segment that people vaccinated against the coronavirus are suffering from a "strange new illness."[442] Numerous other conservative media figures used their platforms to advocate against coronavirus vaccines for children.[443]

Despite the widespread availability of lifesaving coronavirus vaccines, approximately 20% of eligible Americans have failed to get vaccinated, resulting in tens of thousands of preventable hospitalizations and deaths.[444] An October 2021 analysis conducted by The Johns Hopkins' Center for Health Security estimated that millions of Americans were unvaccinated because of coronavirus misinformation and disinformation. This analysis found that misinformation and disinformation caused between $50 and $300 million of harm each day since May 2021, based on the costs of hospitalizations, valuation of lives lost, and long-term morbidity due to coronavirus infections among the unvaccinated.[445]

A May 2022 analysis conducted by researchers at Brown University and Microsoft AI Health estimated that nearly half of all coronavirus deaths between January 2021 and April 2022 could have been averted—assuming every eligible adult over the age of 18 had gotten vaccinated during that time. In other words, if the United States had reached 100% vaccination coverage, nearly 319,000 adult coronavirus deaths could have been avoided as of April 30, 2022.[446] Even 85% vaccination coverage could have prevented 178,000 deaths between January 1, 2021 and April 30, 2022.[447] A separate analysis conducted by the Kaiser Family Foundation and Peterson Center on Healthcare in April 2022 estimated at least 234,000 adult coronavirus deaths between June 2021 and March 2022 could have been prevented with a primary vaccination series—roughly 60% of all adult coronavirus deaths during that time.[448]

Vaccine hesitancy has increasingly followed traditional political divides.[449] Belief in coronavirus misinformation has been demonstrated to be linked to both vaccination status and partisanship—with unvaccinated adults and Republicans more likely to believe or be unsure about false statements. A November 2021 analysis found that unvaccinated adults are three times more likely to lean Republican than Democrat, and counties with a higher Republican vote share in the 2020 presidential election experienced greater numbers of coronavirus deaths, compared to those that voted for Democrats.[450] A September 2022 analysis by the National Bureau of Economic Research identified political affiliation as a risk factor for the coronavirus, finding that registered Republicans in Ohio and Florida died at higher rates than registered Democrats, after all adults were eligible for vaccines.[451] Similar research demonstrated that Republican-leaning states—led

by West Virginia, Wyoming, Tennessee, and Kentucky—had the most vaccine-preventable deaths in the nation.[452] Compounding the potential harm, misinformation about the effectiveness of and risks posed by coronavirus vaccines has also fostered skepticism about other routine vaccinations, like childhood immunizations and flu shots.[453]

4. Long COVID continues to afflict millions of Americans.

Increasing vaccine and booster uptake is critically important as a preventative measure for Long COVID, which can develop from a coronavirus infection of any severity.[454] Although most Americans who contract the coronavirus recover from their infections without lingering issues—especially if they were vaccinated before being infected—millions of Americans have been affected by Long COVID.[455] This number will only continue to grow as the coronavirus continues to circulate.[456] Long COVID disproportionately impacts women, Hispanic, Black, bisexual, and transgender adults, and those who have disabilities, and experts warn that longstanding gaps in access to health care may drive disparities in diagnosis and treatment among communities of color, rural, and low-income communities.[457]

Many individuals with Long COVID also experience severe employment and financial consequences, which has significant implications for the broader economy. The country faces up to $3.7 trillion in economic losses from Long COVID, in the form of approximately $997 billion in lost earnings by patients who cannot work, approximately $528 billion in increased medical spending to address symptoms of and conditions created by Long COVID, and an estimated $2.195 trillion in loss of quality of life.[458] Long COVID is also likely to impose disproportionately high financial harms on women—particularly Hispanic and Black women—as these groups are also disproportionately represented in low wage jobs that are least likely to provide the support needed to allow workers to deal with Long COVID.[459]

President Biden has initiated a whole-of-government approach to address the impacts of Long COVID, taking important steps to advance the nation's understanding and treatment of the condition, deliver high-quality medical care to patients, and ameliorate the economic and labor consequences of Long COVID and strengthen support for affected Americans.[460]

II. The Economic Crisis Caused by the Pandemic—Disproportionately Impacting Those Already Struggling—Was Ameliorated by Aggressive Congressional Action, but the Trump Administration's Poor Implementation of Emergency Programs Limited Their Effectiveness, Efficiency, and Equity While Contributing to Waste, Fraud, and Abuse

As the coronavirus spread nationwide in the spring of 2020, its economic effects—and its health consequences—were immediate and devastating. Tens of millions of Americans lost their jobs, millions more lost work hours and income, and nearly half the nation's small businesses closed their doors. Tens of millions of American families were rapidly thrown into economic precarity as the nation struggled with an unprecedented public health crisis. At the same time, many workers who retained their jobs faced serious increased health risks from the virus.

The hardships of both job losses and work that involved increased health risks were concentrated among lower wage, hourly workers whose jobs had to be performed in person. These workers were the most likely to either be cut by industries hard-hit by the pandemic or to be essential workers facing heightened coronavirus risks with in-person work that had to continue. These jobs were disproportionately held by women, people of color, and people with lower levels of education, meaning that the pandemic's economic impacts exacerbated preexisting inequities, with much of the economic harm falling on those who were already vulnerable.

Existing worker benefits and relief programs were not adequate to address these hardships. State unemployment insurance systems were not equipped to effectively deliver aid to workers who lost their jobs, and these systems often failed to include many workers or provide sufficient relief. The lack of paid sick and medical leave put many essential workers at increased risk of catching the coronavirus and therefore more financially vulnerable when they or family members contracted the virus. The rapid rise in unemployment also led to millions of Americans falling behind on housing payments. Small businesses that required in-person interactions, including those in vital sectors like child care, also faced catastrophic consequences.

Congress expeditiously passed fast-acting, aggressive economic relief measures to alleviate these hardships during the crisis. In March 2020, Congress enacted FFCRA and the CARES Act. These laws expanded and enhanced protections that many Americans lacked, such as medical leave and unemployment benefits, and provided unprecedented direct payments to all Americans under designated income thresholds. In late December 2020, Congress enacted the Consolidated Appropriations Act, 2021, which briefly extended some of these measures months after they lapsed. In March 2021, Congress enacted the American Rescue Plan Act, which provided significant additional relief.

Although these programs were very successful at ameliorating the suffering Americans faced during the crisis, the Trump Administration's poor implementation of the early measures weakened the pandemic response. The Trump Administration consistently failed to prioritize the needs of working Americans and failed to guard against waste, fraud, and abuse. These failures prevented Americans from getting desperately needed relief and allowed unscrupulous private actors to profit from the pandemic.

Congress and the Biden Administration acted to remedy the Trump Administration's earlier failures and improved the equity and effectiveness of relief programs while reducing their fraud vulnerabilities. These steps, with the support provided by the American Rescue Plan and the Biden Administration's successful vaccination campaign, have powered a robust jobs recovery that has added 10 million jobs and reduced unemployment to near record lows.

A. As the Coronavirus Crisis Upended the U.S. Economy, Longstanding Inadequate Protections for Workers Put America's Families at Increased Risk.

1. The onset of the coronavirus crisis caused an unprecedented economic crisis.

The onset of the pandemic caused an unprecedented economic crisis. More than 20 million people lost their jobs in April 2020 alone, and the unemployment rate surged from 3.5% to 14.7% in two months—the highest rate recorded since the federal government began keeping such data in 1948.[461] At least 2.2 million more people lost hours and were pushed into involuntary part-time work at the onset of the pandemic, increasing the number of underemployed people to an all-time high of 10.2 million.[462] In weeks, the pandemic erased more than 10 years of job gains.[463]

The service sector and the leisure and hospitality sector were particularly hard-hit, losing 22% and 48% of their respective workforces in April 2020, as many Americans avoided non-essential in-person activities.[464] Further reflecting the severity of the pandemic's impact, in late March and early April 2020, approximately 43% of the nation's small businesses reported that they had closed down, at least temporarily.[465] The U.S. economy contracted at a nearly 30% annual rate in the second quarter of 2020—a larger drop in economic activity than any other quarter recorded in the last 75 years and likely the largest decline since the Great Depression.[466]

2. The economic pain fell hardest on low-income workers and their families, who were disproportionately women and people of color, as they were more likely to work in hard-hit sectors that experienced closures and disruptions as a result of the pandemic.

The Select Subcommittee's oversight work, through investigations and hearings, consistently highlighted how this economic pain exacerbated existing inequities, causing the most harm to those who were already struggling and vulnerable. As Federal Reserve Chair Powell testified to the Select Subcommittee in June 2021, the impact of this crisis did not fall "equally on all Americans, and those least able to shoulder the burden" were "the hardest hit."

A major cause of this unequal impact was that "only 20% of Black workers and 16% of Latinx workers" were "able to work from home," according to Rose Godinez, a racial justice expert who testified to the Select Subcommittee during an October 2021 hearing on the meatpacking industry.[467] As a result, many lost their jobs as the industries they worked in experienced closures and business declines. Federal Reserve Chairman Jerome Powell testified to the Select Subcommittee in June 2021 that pandemic-related unemployment fell "disproportionately on lower-wage workers in the service sector and on African-Americans and Hispanics."[468] For

example, more than a third of workers in the child care sector—who are disproportionately women of color—lost their jobs in the first two months of the pandemic.[469] These low wage workers were already vulnerable to economic emergencies, as they were paid less than employees in 98% of other occupations.[470]

The disparate impacts of the pandemic on service sector workers also resulted in dramatic gender inequities in pandemic job losses. Dr. C. Nicole Mason of the Institute for Women's Policy Research testified to the Select Subcommittee in May 2022, "During the early months of the pandemic, women lost four times as many jobs as men."[471] The early recovery of lost jobs did not remedy the gender inequity of initial losses. By the end of 2020, women still had lost over one million more jobs during the crisis than men on a net basis. For the month of December 2020, losses of jobs held by women accounted for all net job loss suffered as a surge in coronavirus infections led to employers to shed additional jobs.[472] Contributing to and compounding these unequal impacts, the contraction of the child care sector led to an increased child care burden that fell disproportionately on mothers, forcing many women out of the workforce.[473]

The Select Subcommittee's investigations confirmed that the brunt of the pandemic's economic impacts were unequally borne by women and people of color. In December 2021, by which point women's labor force participation had declined by 1.5 million (compared to a male labor force decline of 900,000), the Select Subcommittee initiated an investigation into 12 of the largest employers in America across multiple industries.[474] The Select Subcommittee sought demographic data on various employment outcomes (e.g., layoffs, furloughs, terminations, reductions in hour or pay, and quits or resignations), as well as information regarding the companies' workplace policies.[475] In May 2022, the Select Subcommittee released an initial analysis of the survey data showing that among hourly workers, women disproportionately experienced negative employment outcomes during the first year of the pandemic as compared to their male coworkers—discrepancies that were amplified by but predated the pandemic, and that also impacted racial minorities. Data obtained from the surveyed companies showed at least 25 instances in 2020 in which a company's female hourly workforce disproportionately experienced given negative employment outcome compared to their male counterparts, while the reverse occurred in only 12 instances.[476] The investigation further found that hourly workers of color had worse outcomes than their white peers and salaried workers, with Black workers being fired at higher rates and promoted at lower rates than white workers.[477]

3. Before the pandemic, American workers and families, particularly those with low incomes, lacked the financial protections needed to cope with job losses.

Before the onset of the pandemic, many lower-income Americans lacked the resources to weather a crisis without emergency relief. Pre-pandemic data showed that nearly 40% of Americans reported that they could not cover an unexpected expense of just $1,000.[478] Were these Americans to lose their jobs, they would be heavily reliant on unemployment insurance. Yet state unemployment insurance systems, suffering from underinvestment and, in some states, overly restrictive eligibility requirements and low benefit levels, were not equipped to meet the unprecedented job loss inflicted by the pandemic.

States weakened and failed to invest in unemployment insurance systems for decades, particularly since the 2007-2009 financial crisis.[479] Antiquated technological systems and lack of administrative capacity for processing unemployment claims harmed state effectiveness in distributing badly needed relief, prevented state and local governments from effectively adjusting benefit levels to reflect lost earnings, made it difficult to pay benefits in a timely manner during the crisis, and left programs vulnerable to fraud.[480]

Before the pandemic, as Indivar Dutta-Gupta of the Center on Poverty and Inequality at Georgetown Law testified to the Select Subcommittee in September 2021, many states also cut eligibility for and benefit payments from unemployment insurance to such an extent that fewer than three in 10 workers were actually eligible for benefits when unemployed. Benefits became so low in some states that workers fell below the poverty line even when they received benefits.[481] Indeed, in some states, as few as 9% of unemployed workers received unemployment insurance when unemployed due to increasingly stringent eligibility rules regarding the number of quarters of previous earnings required in traditional employment and the high earnings required to receive eligibility.[482] For those who did receive benefits, those benefit levels averaged below 50% in the majority of states.[483] Gig workers and self-employed individuals were ineligible to receive any unemployment insurance at all, even as the number of workers in such roles surged dramatically in the years leading up to the pandemic.[484]

Many working Americans and their families also lacked health insurance, which created a critical vulnerability during the pandemic for the uninsured, who may have been forced to choose between avoiding badly-needed care or falling into debt after contracting the virus. At the end of 2019, 28.9 million nonelderly people were uninsured, even as 85% of those uninsured lived in households where someone was employed and working.[485] Upon losing employment, even those workers who previously had health insurance would be unable to continue to pay for insurance while unemployed.[486] This vulnerability was caused, in significant part, by the refusal of 12 states to expand Medicaid to cover low-income workers and families.[487]

4. Many workers who avoided immediate job losses—often lower-income workers who were disproportionately people of color—faced increased health risks and lacked critical workplace benefits and protections.

Even workers who avoided losing their jobs immediately with the onset of the coronavirus crisis and its resulting layoffs often faced significant hardships. This was particularly true for essential workers who had to perform their roles in person at the height of the crisis. Many of these workers also lacked the sick, medical, and family leave necessary to cope with the illness and caregiving responsibilities caused by the pandemic, and many also lacked affordable health insurance necessary to ensure health care access during a public health emergency.

Essential workers who needed to work in person, and their family members, were significantly more likely to contract the coronavirus early in the crisis.[488] These essential workers disproportionately earned low wages and were more likely to be people of color.[489] Black and Latina women were particularly "overrepresented as essential workers" at greater risk of coronavirus infection "with Latina women making up 22% of women grocery store workers and

Black women making up 27% of women home health aide workers," according to the October 2021 testimony from Godinez.[490]

Many of these workers also lacked critical benefits that would have allowed them to better cope with the illnesses and caregiving responsibilities caused by the pandemic, and which would have made their workplaces safer. Professor Dutta-Gupta testified in September 2021 that "[u]nlike other wealthy nations, we had no national paid family and medical leave program, no sick leave guarantee, no child allowance or robust cash assistance, no unemployment assistance for new job seekers or returning workers, and no health coverage guaranteed."[491] Dr. Mason testified in May 2022 that vulnerable workers in "the hardest hit sectors did not have health insurance, paid family and sick leave, job security, predictable scheduling, or flexibility."[492]

The lack of paid sick, medical, and family leave took a particularly large toll on American workers' finances and health during the coronavirus crisis. Before the pandemic, 24% of all American workers had no paid sick leave and 81% had no paid family or medical leave for extended medical problems.[493] That limited flexibility and leave for workers contributes to negative health outcomes. Paid leave expert Vicki Shabo of New America explained to the Select Subcommittee during a May 2022 hearing:

> [W]hen workers have access to paid sick time, they are more likely to take themselves out of the workforce for a shorter period of time. They're more likely to get healthcare they need in an acute way. They're more likely to get preventative healthcare.[494]

Indeed, Census data shows that during the early months of the pandemic, only 12% of low-income workers were able to use paid leave upon contracting the coronavirus or while caring for a family member with the virus. Even for workers with incomes over $100,000, less than half were able to use paid leave for these absences caused by the coronavirus.[495] These workers not only experienced increased health risks, but also saw sharp increases in food insecurity after being forced to miss work without paid leave, with almost 50% of low-income workers without paid leave lacking enough food to eat after missing work for coronavirus illness.[496]

A Walmart worker, Cynthia Murray, testified in a May 2022 hearing about how a lack of paid leave had affected herself and her colleagues, and explained: "We need to stop pushing workers to come to work sick because they get penalized for missing a day."[497] Similarly, at an October 2021 hearing on pandemic-related infections and deaths at meatpacking plants, Martin Rosas, President of District Union Local Two, United Food and Commercial Workers, testified about the impact of limited leave and flexibility on meatpacking workers and their communities:

> They were afraid to miss work because they do not have sufficient leave benefits and indeed in some plants were penalized for missing work. They were afraid to go to work and be exposed to the virus and bring home the disease to their family members, especially those family members who were most vulnerable. Sadly, those fears became a reality.[498]

He called for universal paid leave, including sick leave, adding that all workers "benefit when those who are sick stay home and do not circulate viruses in the workplace."[499]

The lack of paid leave was a significant cause of women leaving the workforce disproportionately. Rev. Dr. Starsky Wilson, President of the Children's Defense Fund, explained to the Select Subcommittee during a September 2021 hearing, "Most parents and caregivers who are in low-income families don't have paid leave to care for their children or older adults at all, and never have had access. And this, of course, disproportionately impacts Black and brown parents."[500] Dr. Mason similarly testified in May 2022: "Black and Latina women, because of caretaking responsibilities and demands and the lack of paid sick and family leave, were more likely than other women to exit the workforce."[501]

5. The lack of critical workplace protections—particularly paid leave—harmed the broader economy as well as the workers directly impacted.

The Select Subcommittee's oversight work, investigative findings, and hearings consistently made clear that the absence of guaranteed paid leave, in addition to harming the workers directly affected, also harms the economy as a whole. Paid leave improves worker retention, making the economy stronger and more resilient, and more extensive paid leave could have increased the economy's resilience in facing the pandemic. Ms. Shabo testified at the May 2022 hearing: "We know from states that have paid family and medical leave programs in place … that women are better able to stay employed, they have wages that go up over time …. We know that women who are caregivers to older people or disabled adults are able to come back to work."[502]

The Select Subcommittee's investigation into the employment practices of 12 large corporations also found that paid sick, medical, and caregiving leave was valuable not only to individual workers, but to their employers and, by extension, the economy as a whole. It showed that paid sick, medical, and caregiving leave, where available, likely helped workers stay in their jobs during the pandemic. Employers who offered those benefits saw reduced turnover. By contrast, workers whose employers failed to provide paid sick leave quit their jobs at significantly higher rates than workers with access to such leave.[503]

Dr. Yana van der Meulen Rodgers, Professor of Labor Studies and Employment Relations at Rutgers University, explained how the increase in pandemic departures from the workforce impacted the economy as a whole: "One of the fundamental inputs into economic growth is the input of workers…. So when women are withdrawing from the labor force because of constraints that they face, that … puts a damper on economic growth."[504] Professor Dutta-Gupta, Co-Director of the Georgetown Center on Poverty & Inequality, testified in September 2021 that medical and family leave increase productivity to the benefit of employers:

> Offering protections for workers to be able to prioritize their own health and the health of their loved ones as well, including potentially sick kids and others they care for, can absolutely allow people to focus more on productive economic activity

and avoid some of those substantial health costs that we have been facing in this country.[505]

The Select Subcommittee's more than two years of oversight work consistently showed that, had universal paid leave been in effect during the crisis, the policy would have reduced inequities, improved workplace safety, and increased employee retention—benefiting workers, their families, employers, and the nation as a whole.

B. Congress Passed Rapid, Aggressive Federal Relief to Save Lives and Reduce Economic Damage, Which Compensated for Structural Weaknesses.

At the onset of the coronavirus crisis, Congress swiftly enacted legislation to address the economic impacts of the pandemic, mitigate the suffering caused by the pandemic's economic fallout, and partially compensate for weaknesses in the existing safety net and benefits available to working Americans. In March 2020, Congress enacted the Coronavirus Preparedness and Response Supplemental Appropriations Act, the FFCRA, and the CARES Act, unprecedented relief measures that were signed into law on March 6, March 18 and March 27 respectively. FFCRA and the CARES Act expanded and enhanced protections that many Americans lacked, such as sick leave and unemployment benefits, and provided unprecedented direct payments to help Americans meet their financial needs.

The FFCRA included a limited temporary paid leave policy, which prevented an estimated 15,000 cases of COVID per day nationwide early in the crisis.[506] The CARES Act relief provisions immediately reduced economic hardship and suffering. Data collected by the Urban Institute showed that household food insecurity declined by nearly 20% between March and May of 2020 (although increasing the maximum Supplemental Nutrition Assistance Program (SNAP) benefit would have alleviated it significantly more).[507] CARES Act measures supported Americans for much of the year: an Urban Institute survey found that despite substantial job losses, the share of adults reporting material hardships in 2020 actually dropped below pre-pandemic levels, with significant declines between December 2019 and December 2020 in food insecurity (from 23.9% to 20.5%), utility shutoffs (from 3.8% to 2.6%), and problems paying medical bills (from 18.8% to 14.9%).[508] The CARES Act's enhanced unemployment benefits, which increased benefit levels substantially and extended eligibility to impacted gig workers, were particularly impactful in relieving hardships, despite states' administrative delays in disbursing the benefits. In the spring and summer of 2020, these benefits delivered relief to tens of millions of newly unemployed workers and kept at least 5.5 million people from falling into poverty.[509] In testimony before the Select Subcommittee in September 2021, Professor Dutta-Gupta explained: "The $600 weekly CARES Act [unemployment] supplement supported 30 million workers, helped keep poverty from rising, and prevented hunger . . . and even death."[510] Testifying at the same hearing, Professor Luke Shaefer of the University of Michigan's School of Public Policy described his research into hardship rates following the CARES Act's passage:

> [W]e found that despite historically high unemployment, rates of hardship were stable—and in some cases declining—following the roll-out of the CARES Act. That hardship did not spike during the summer months of 2020 is remarkable.[511]

By the closing months of the Trump Administration, however, many of the direct relief measures in the CARES Act had expired, and food insecurity rates began to climb.[512] Although House Democrats had passed two different versions of the Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act), which included the resources necessary to meet the ongoing challenges, Republican opposition delayed further relief. This delay in emergency congressional action, while Americans increasingly suffered, underscored the need for a durably improved permanent system to provide needed assistance. In late December 2020, Congress ultimately agreed on a significantly smaller relief package in the Consolidated Appropriations Act, 2021, which extended expanded unemployment insurance benefits for several months, included additional direct payments to Americans, extended other relief for small businesses, and provided $25 billion for emergency rental assistance.[513]

After the Biden Administration assumed office, congressional Democrats promptly enacted the American Rescue Plan. The ARP rapidly relieved suffering across America, immediately decreasing hunger and other hardships. One analysis found that between early March and late April—as the bulk of the ARP's relief payments were distributed—the percentage of Americans that lacked sufficient food declined from 10.7% to 8.1%, with sharp declines for families with children. The share of Americans reporting difficulty paying basic expenses declined from 14.4% to 9.8%, and those behind on rent or mortgage payments declined from 9.5% to 7.4%. This analysis also found that the share of people reporting anxiety, depression, or hopelessness dropped significantly following the ARP's enactment.[514] The ARP also replenished the pandemic unemployment relief program with increased benefits and expanded eligibility, keeping at least 2.3 million people out of poverty as the job market began to recover.[515]

The ARP also provided critical relief by making health insurance more affordable for low- and middle-income Americans. Supported by the American Rescue Plan's expansion of premium tax credits for the purchase of health insurance on Affordable Care Act (ACA) exchanges, nearly three million people gained health insurance during the 2021 special enrollment period opened by the Biden Administration.[516] The expanded premium tax credits lowered premiums and out-of-pocket health costs for individuals across the income spectrum. An increased share of middle-income Americans bought health insurance as the tax credits were expanded to those making above 400% of the federal poverty line for the first time. This expansion was designed to prevent middle class Americans from spending over 8.5% of their income on health coverage.[517] This expansion led to a decline in the uninsured rate to a historic low by 2022, filling part of the critical gap in benefits faced my many workers.[518]

The American Rescue Plan also provided housing assistance, including $21 billion additional in rental assistance, which helped keep millions of people in their homes. In total, pandemic rental assistance funds allocated by the American Rescue Plan and the Consolidated Appropriations Act, 2021 delivered aid to more than 6.5 million American families.[519] In combination with eviction moratoriums, this aid contributed to as many as 1.55 million fewer eviction cases than would have occurred at pre-pandemic eviction filing rates, keeping families housed during a health and economic crisis.[520] The American Rescue Plan also created an Emergency Housing Voucher program that prevented 35,000 at-risk households—including domestic violence and human trafficking victims—from becoming homeless during the

pandemic.[521] The pandemic also included a homeowners' assistance fund that, along with emergency mortgage forbearance and foreclosure moratoriums, appears to have aided in preventing the pandemic from causing homeowners from falling into foreclosure.[522] This success may have sustained increases in Black and Hispanic homeownership levels, as pandemic emergency measures and ARP relief prevented the coronavirus crisis from causing vulnerable families to lose their homes as a result of pandemic disruptions that would have wiped out the progress other Black and Hispanic families made in purchasing homes.[523]

The broad, wide-ranging success of the pandemic relief legislation in reducing poverty, alleviating economic distress, and improving health care access amidst an unprecedented crisis demonstrated the ability of a strengthened safety net to reduce vulnerabilities in future crises.

C. The Trump Administration Failed to Prioritize and Effectively Deliver Relief for Working Americans.

Congress's aggressive efforts to relieve economic hardship and to fill gaps in the safety net early in the coronavirus crisis were critical, but their effectiveness was hampered by the Trump Administration's poor implementation of emergency programs. Many early relief programs were less effective at preserving jobs, delivering aid, and serving the most vulnerable than they could have been with better implementation. In some cases, these failures to prioritize working American families were caused by a focus on aiding corporations or gaining political benefits. These implementation failures show both the need for a more durable, improved permanent support structure to assist Americans during times of crisis, and the need for effective oversight of relief programs.

1. The Trump Administration left millions of vulnerable Americans without access to vital Economic Impact Payments in 2020.

Given the gaps in the safety net, particularly in state unemployment insurance programs, one key relief measure in the CARES Act were EIPs of up to $1,200 per person. As millions of Americans faced delays or eligibility hurdles in receiving unemployment, these payments were intended to keep people out of poverty and desperation early in the crisis. Following an oversight letter from the Select Subcommittee, however, the Trump Administration revealed that approximately 9 million Americans eligible for EIPs had not yet received them nearly six months after the CARES Act's passage. Those who experienced delays in receiving these vital relief funds were disproportionately those who needed them most: low-income people who generally earned too little to be required to file tax returns.[524] After repeated calls from Chairman Clyburn to Treasury Secretary Mnuchin to quickly send notices to those eligible for EIPs and to extend the deadline for eligible individuals to claims their benefits, the Trump Administration ultimately extended the deadline to claim these benefits to November 21, 2020.[525] The day after assuming office, President Biden issued an executive order directing Treasury and the Internal Revenue Service to redouble their efforts to ensure additional eligible Americans received EIPs.[526]

2. The Trump Administration failed to ensure that payroll support funds for businesses were equitably distributed and actually saved workers' jobs.

When implementing programs designed to support companies in order to keep workers employed, the Trump Administration similarly failed to ensure that programs were effective. For example, the CARES Act authorized the Trump Administration to preserve aviation jobs by providing up to $32 billion in funds to air carriers and their contractors to pay employees' wages, salaries, and benefits through the Payroll Support Program (PSP).[527] The Select Subcommittee found, however, that more than 16,000 workers at eligible companies were laid off due to the Trump Administration's delays in delivering the funds. Moreover, the Trump Administration allowed PSP recipient companies to lay off workers right up to the day they executed the PSP agreement, which allowed companies with pending PSP applications to lay off workers and still receive federal relief funds.[528] The Trump Administration's failure to ensure that PSP funds were used to maintain employment may not only have cost workers their jobs, but may also have contributed to flight delays due to diminished capacity in the pandemic recovery despite the provision of billions of dollars in taxpayer-funded aid.[529]

The Trump Administration also implemented the PPP in a manner that deprived underserved businesses, disproportionately minority- and women-owned, of access to desperately needed aid. The CARES Act directed SBA to issue guidance to ensure that PPP lenders prioritized small businesses in underserved markets, including businesses owned by women and socially and economically disadvantaged individuals.[530] The Trump Administration's Treasury Department, however, directed lenders to "go to their existing customer base" when issuing PPP loans, even though this created a substantial risk that underserved small businesses would be left without access to the program. Defying the Cares Act's urgings, the Trump Administration also failed to issue meaningful guidance to lenders on how to prioritize these underserved businesses.[531] And under the Trump Administration's implementation of PPP, some lenders processed PPP loans substantially faster for wealthier businesses than for the neediest small businesses applying for relief.[532]

3. The Trump Administration also failed to ensure large-scale financial relief programs served small- and mid-sized businesses, rather than just large corporations.

Pandemic relief programs that the Treasury Department under the Trump Administration jointly implemented with the Federal Reserve similarly failed to effectively deliver aid where it was needed, while large corporations received significant relief. Through the first seven months of the coronavirus crisis, the Trump Administration and the Federal Reserve made only 252 loans under the Main Street Lending program that Congress authorized to aid small-to-medium sized businesses, totaling less than $3 billion of the $600 billion available.[533] Treasury Secretary Mnuchin ultimately directed that the program be closed when the program had lent only 3% of its capacity.[534] The Trump Administration and the Federal Reserve similarly made little use of the available funds authorized to aid states and municipalities through the Municipal Liquidity Facility because the Federal Reserve required distressed local governments to pay relatively high interest rates on unfavorable terms, including a short repayment period.[535] By the time Secretary Mnuchin directed that the program wind down, the Municipal Liquidity Facility had only delivered financing to one state and one local government entity that totaled less than 2% of the $500 billion in available funds.[536]

In contrast with programs for state and local governments and small-to-medium-sized businesses, the Trump Administration Treasury Department and the Federal Reserve acted to provide robust support for large corporations through an unprecedented program—the Secondary Market Corporate Credit Facility—which bought the corporate bonds of large companies. In total, the Federal Reserve purchased approximately $14 billion worth of corporate debt of about 500 large companies, easing those firms access to affordable credit.[537] The Select Subcommittee found, however, that the Federal Reserve's method of providing this relief did not provide guardrails to protect workers and taxpayers. Companies that benefited from the program laid off more than a million workers in the first six months of the pandemic, and 383 of the companies that benefited paid dividends to shareholders during that period.[538]

4. The Trump Administration also failed to take effective action to prevent vulnerable Americans from losing their housing during the crisis.

The Trump Administration also failed to take prompt action to effectively protect Americans from losing their homes as a result of the coronavirus crisis. The economic dislocations caused by the pandemic pushed millions of Americans to the brink of homelessness, with as many as 12 million Americans falling behind on rent by December 2020.[539] These hardships were preventable, as House Democrats passed bills with tens of billions of dollars in emergency rental assistance in both May and September of 2020, but the Trump Administration did not support any such measures until the end of December 2020.[540] Even after eventually agreeing to allocate $25 billion for emergency rental assistance in the Consolidated Appropriations Act, 2021, the Trump Administration seriously hindered the distribution of those vital funds. The Select Subcommittee heard testimony that the Trump Administration's guidance on the disbursement of this assistance to state and local governments was unnecessarily restrictive, discouraged eligible families from seeking assistance, and laid out timeline and documentation requirements that made distribution difficult and slow.[541] The Biden Administration rescinded this guidance and issued improved guidance, but the Trump Administration's delays in agreeing to allocate rental assistance and initial missteps in implementing the program left millions impacted by the crisis in danger of losing their housing for many months.[542]

D. Poor Implementation and Oversight of Federal Aid Programs, Combined with Unscrupulous Private Actors, Led to Significant Waste, Fraud, and Abuse and a Less Effective Pandemic Response.

Oversight and implementation of federal pandemic relief programs in many cases failed to safeguard taxpayer funds and ensure that those in need received aid. The Select Subcommittee's investigations and hearings identified numerous instances where the Trump Administration's early pandemic response involved insufficient oversight or poor execution, which made programs particularly vulnerable to fraud in 2020. In other cases, private companies exploited a lack of sufficient oversight by state or federal agencies to profit from the pandemic at the expense of suffering Americans and the broader public. These implementation failures underscore the need to develop a durable permanent infrastructure for delivering relief, one that would not need to be

created on short notice and that would not promptly become overwhelmed by a surge in crisis-driven need for relief.

1. Substantial fraud was committed against pandemic relief programs.

Government watchdogs and independent researchers alike have identified potential fraud against pandemic programs ranging from tens to hundreds of billions of dollars. Data provided to the Select Subcommittee by the Small Business Administration Office of Inspector General (SBA OIG) identified more than $86 billion in potentially fraudulent EIDL loans and grants made during the pandemic. SBA OIG similarly estimated that the PPP had "strong indicators of widespread potential abuse and fraud,"[543] and independent researchers at the University of Texas have estimated that that between $64.2 billion and $117.3 billion worth of PPP loans were questionable and potentially fraudulent, in light of fraud indicators such as multiple loans to the same address or missing business registry data.[544] The Department of Labor OIG (DOL OIG) has estimated the amount of pandemic Unemployment Insurance fraud was also significant with potentially improper payments totaling $163 billion or more.[545] The Select Subcommittee heard testimony from Inspectors General and prosecutors responsible for identifying and tracking pandemic relief fraud, who acknowledged that it was difficult to assess the full extent of pandemic relief fraud, but agreed that the amount of fraud has been substantial.[546]

2. SBA failed to prevent widespread fraud against its pandemic programs, as the Trump Administration failed to implement basic safeguards.

A Select Subcommittee investigation uncovered evidence that the Trump Administration's implementation of the PPP and EIDL programs made them vulnerable to substantial fraud and overpayment. The vital funds allocated to these programs to provide aid to struggling small businesses were prematurely exhausted partly as a result of the administration's failure to effectively guard the funds against misuse and fraud.

a. <u>The Trump Administration's operation of the Economic Injury Disaster Loan program made it vulnerable to substantial fraud.</u>

The SBA OIG has identified $86 billion in potential fraud committed against the EIDL program.[547] A Select Subcommittee investigation found that the Trump Administration failed to implement basic safeguards against fraud during the early operation of the program, which likely contributed to the high level of potential fraud.[548] The failure of the Trump Administration SBA to plan for the demand that would be created by a nationwide disaster contributed to this failure, as SBA lacked the technology and trained staff necessary to quickly deliver relief at the beginning of the pandemic without unacceptable fraud risk.

Through the CARES Act, the American Rescue Plan Act, and other pandemic relief legislation, Congress directed SBA to provide EIDLs and EIDL advance grants to small businesses harmed by the pandemic, which SBA refers to as its "COVID-19 EIDL" program.[549] In total, the COVID-19 EIDL program approved more than 3.9 million COVID-19 EIDL applications and a

total of over $378 billion in EIDLs for American businesses.[550] 5.8 million EIDL advance grants and one million targeted and supplemental targeted EIDL advance grants totaling $27.5 billion were also disbursed.[551]

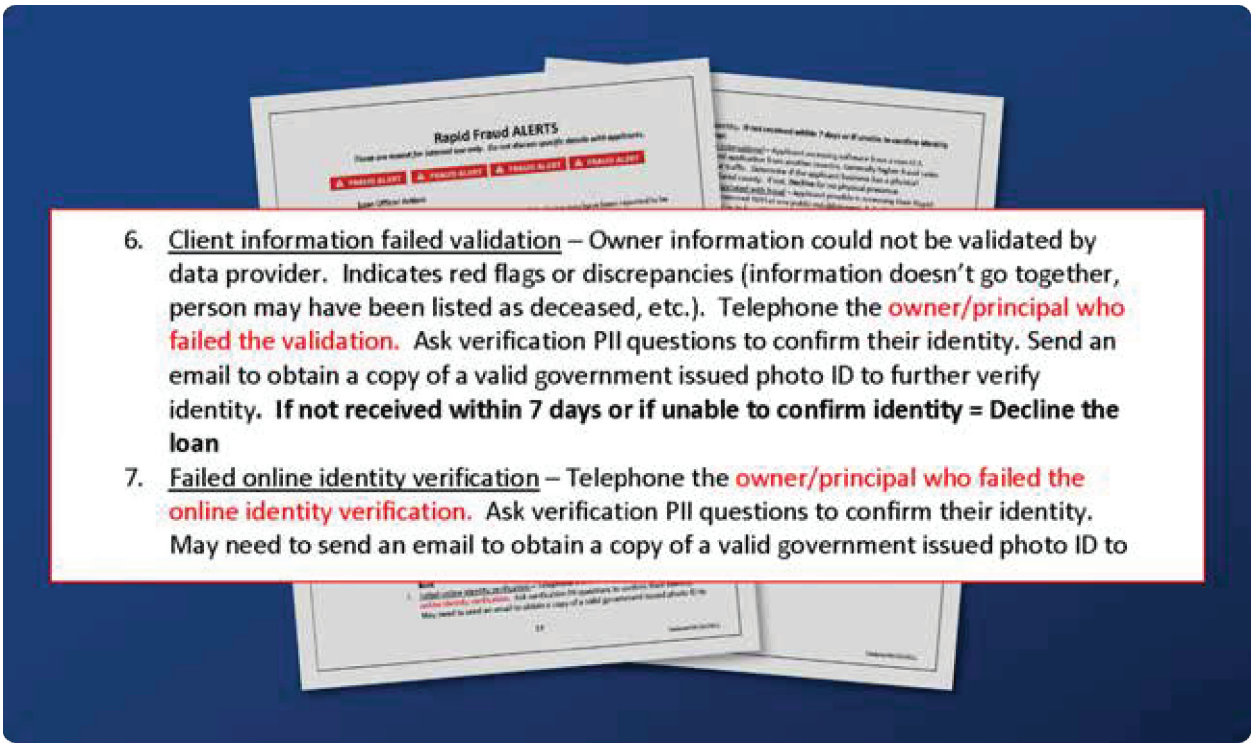
In addition to the SBA OIG's estimate that $86 billion of these funds were potentially disbursed to fraudulent applicants, there are other significant indications that fraud against the COVID-19 EIDL program was widespread. GAO found that financial institutions filed more than 20,000 suspicious activity reports (SARs) related to COVID-19 EIDL transactions.[552] SBA also disbursed more than 112,000 COVID-19 EIDL loans and 98,000 advance grants that it later referred to SBA OIG as being related to an identity theft complaint. As of January 2021, SBA estimated that it had received over 150,000 returned loan statements related to incorrect or fraudulent addresses, indicating that COVID-19 EIDL identity theft fraud may have been even more extensive.[553] SBA OIG also found that, in 2020, SBA distributed approximately $4.5 billion in up to 10,000 EIDL advance grants to sole proprietors and independent contractors that they were categorically ineligible for given the $1,000 per employee advance grant limit.[554] These findings taken together show that the Trump Administration likely permitted the COVID-19 EIDL program to disburse billions of taxpayer dollars in response to fraudulent applications.

The Trump Administration SBA created the conditions for this widespread fraud by failing to implement basic safeguards in its early operation of the COVID-19 EIDL program. The administration created a "batch" approval mechanism that allowed SBA team lead loan reviewers to approve dozens of loan applications at once "with little to no vetting of the loan information" or "with little to no additional review by the team leaders."[555] SBA specifically requested that its contractor add this "batch" functionality, which did not previously exist in the contractor's software.[556]

In practice, applications in batches received no review at all from any SBA employee. SBA's Processing and Disbursement Center Director told the Select Subcommittee that the EIDL application processing system did not even allow SBA Team Leads to open individual EIDL application files in batches recommended for approval[557]—making approval without review essentially automatic without any human review of application details. Data from SBA's contractor obtained by the Select Subcommittee shows that as many as 1.6 million EIDL applications may have been included in "batches" recommended for approval and received no actual review by an SBA employee in the COVID-19 EIDL program's early months.[558] Additionally, there are strong indications that some EIDL applications included for "batch" approval without review contained fraud alerts—including emails that failed to pass validation, phone numbers that weren't associated with the relevant business or owner, international locations, and businesses whose registration could not be confirmed. SBA instructed a subcontractor (Rapid, discussed below) to include applications in batches even when they contained as many as two indicators of potential fraud.[559]

Even when EIDL applications were not included in "batches," and were manually reviewed by staff, SBA directed loan reviewers to simply approve applications with serious indications of fraud. Specifically, SBA's Guide for loan officers directed them to simply "Approve" applications that "failed online identity verification," and directed loan reviewers to "Approve" applications where the "Owner/Client information failed validation (info doesn't go together, person is listed

as deceased, etc.)" without taking action to address the fraud flag.[560] During the Biden Administration, SBA included more detailed instructions that also directed the loan reviewer to call the applicant and further confirm their identity by asking for personally identifying information.[561]



The Select Subcommittee analyzed DOJ prosecutions of COVID EIDL fraud and found that the overwhelming majority of prosecutions involved fraud committed against the program during the Trump Administration. 95% of the prosecutions involved EIDL applications submitted between March 2020 and August 2020, and 98% of prosecutions involved EIDL applications submitted during the Trump Administration.[562] These findings accord with the Select Subcommittee's findings that the Trump Administration failed to employ basic safeguards to protect the COVID-19 EIDL program from fraud.

b. In addition to failing to prevent fraud, the Trump Administration awarded a $750 million Economic Injury Disaster Loan (EIDL) processing contract to a company that relied on a subcontractor for nearly all the work required, yet still accrued windfall profits.

The windfall reaped by a small contractor that did little actual work to support the EIDL program illustrates another way in which existing weaknesses in emergency infrastructure allowed private actors to profit at the public's expense. The Trump Administration awarded the $750 million COVID-19 EIDL loan recommendation contract—the largest individual contract across the entire federal government to respond to the pandemic's economic impact—to small company RER Solutions without a competitive process or an adequate assessment of the reasonable cost of

the services provided.[563] SBA modified RER's much smaller pre-pandemic contract without competitive bidding. Contractor RER, through subcontractor Rapid, primarily provided automated services that required relatively little labor, and which reviewed COVID-19 EIDL application information in less than a second to provide fraud alerts, credit checks, and approval or denial recommendations.[564] Despite this, SBA agreed to pay RER more than $40 per EIDL application reviewed without assessing whether this price was reasonable in light of the actual costs the contractor would incur.[565] RER then assigned only six employees to work on the contract but netted more than $340 million after paying its subcontractors and vendors.[566] Documents produced to the Select Subcommittee indicate the company provided merely "contractual administrative duties,"[567] and hundreds of millions of dollars of taxpayer funds were wasted in a contract that provided a windfall to a company that contributed little actual work to a vital government program.

This windfall was partly the consequence of SBA's pre-pandemic decision to award the processing contract for a vital disaster relief program to a small company that could not handle a catastrophic surge in applications without relying extensively on a subcontractor. This decision created a weakness in the program by relying on a small firm that would have to act as an inefficient middleman and that received, under federal regulations, around 50% of the contract's value for very little work. Here, the preexisting weakness in the relief infrastructure resulted in a private windfall at taxpayers' expense.

c. <u>The Paycheck Protection Program was highly vulnerable to fraud because of poor oversight and heavy delegation to unvetted private companies.</u>

The PPP was intended to give small businesses impacted by the pandemic forgivable loans, with forgiveness contingent on maintaining workers on their payrolls for specific periods of time. The Select Subcommittee's early analysis of loans made under PPP raised serious concerns about the effectiveness of program controls and the potential level of waste, fraud, and abuse under the Trump Administration. The Select Subcommittee's subsequent investigation fintech companies and lenders that assisted in disbursing a substantial share of the loans under PPP revealed that these private companies enriched themselves with taxpayer fees while failing to guard effectively against fraud risks.

The Select Subcommittee's September 2020 analysis of PPP loans identified more than 10,000 that were made to likely ineligible companies or were otherwise potentially improper, due the Trump Administration's failure to effectively implement the program. The Select Subcommittee identified 10,856 loans in which the same borrower received multiple loans despite SBA's guidance stating that one business could not apply "for more than one loan."[568] More than 600 PPP loans were also made to businesses that were suspended or debarred from doing business with the federal government, and 353 loans were approved for businesses with a history of performance and integrity issues when operating as government contractors.[569] The Select Subcommittee also found indications that substantial numbers of PPP loans were approved despite indications that they were potentially fraudulent, with over 11,000 applications totaling nearly $3 billion showing through the federal System for Award Management (SAM) database that companies had presented inconsistent identifying information, provided only a P.O. box, or

contained indications that the companies were not eligible because they were not in operation before February 15, 2020.[570]

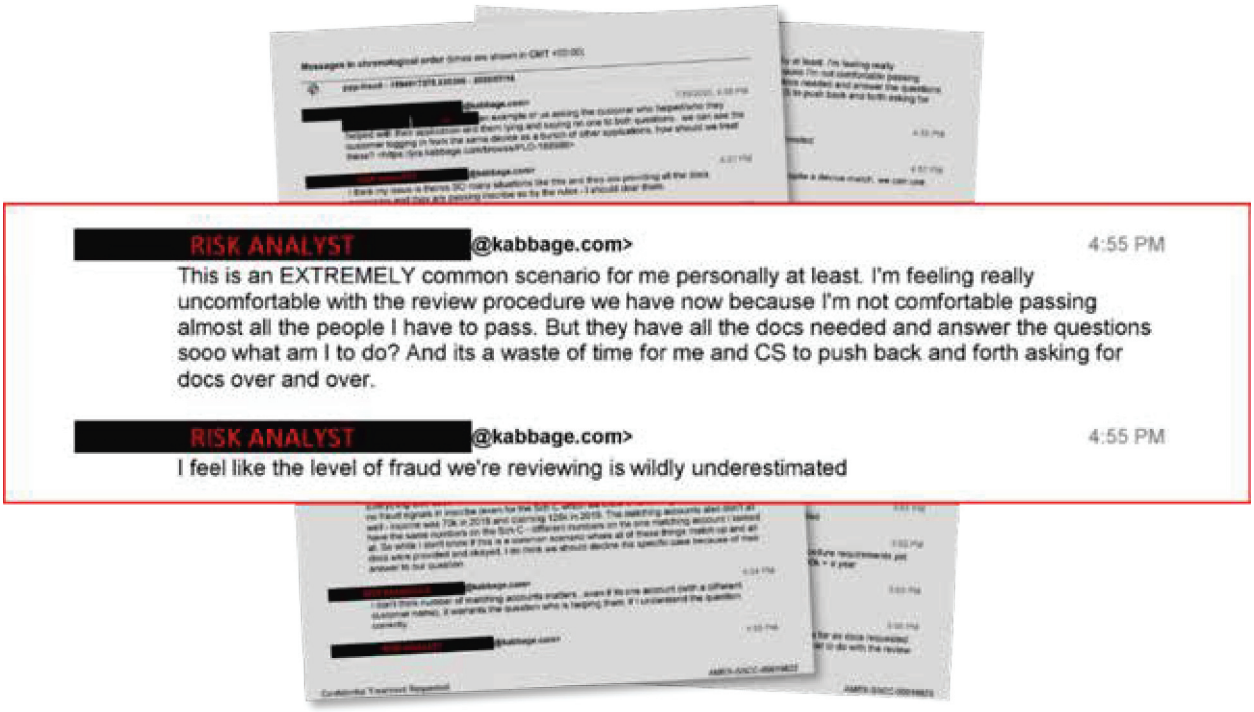
The Select Subcommittee's findings regarding the role of fintech companies in facilitating PPP loans, released in December 2022, identified significant vulnerabilities in the government's reliance on unvetted, underregulated private-sector companies to implement the program.[571] The Select Subcommittee's investigation found that fintechs were given extraordinary responsibility in administering the nation's largest pandemic relief program, as certain SBA lenders heavily delegated applicant screening to companies that claimed to employ effective and innovative fraud control technology.[572] However, many of these companies appear to have failed to stop obvious and preventable fraud, leading to the needless loss of taxpayer dollars. The Select Subcommittee's investigation found that several fintechs, largely existing outside of the regulatory structure governing traditional financial institutions and with little to no oversight, took billions in fees from taxpayers while becoming easy targets for those who sought to defraud the PPP.[573]

Two fintechs investigated by the Select Subcommittee—Womply and Blueacorn—together facilitated nearly one in every three PPP loans funded in 2021.[574] Blueacorn received over $1 billion in taxpayer-funded processing fees, while Womply had a 2021 net revenue of over $2 billion.[575] Several Blueacorn loan reviewers, who spoke to the Select Subcommittee on condition of anonymity, reported receiving poor training and of being pressured to "push through" PPP loans, even if the reviewers doubted the authenticity of the loan's supporting documentation.[576] Multiple Womply lending partners criticized Womply's fraud prevention practices, in one case describing its systems as "put together with duct tape and gum" and accusing Womply of allowing "rampant fraud" to infiltrate the PPP.[577] Womply's CEO Toby Scammell—who was convicted of insider trading in 2014 and has been permanently barred from participating

in the securities industry—led Womply's fraud prevention efforts and instructed his company not to cooperate with federal investigators who were attempting to identify PPP fraud in real time.[578] Multiple lenders who had subcontracted with these entities described their oversight as being limited to "spot checks" conducted at random on a small percentage of fintech-referred applications.[579]

These companies also appear to have abused their positions of public trust to benefit themselves and their executives. For example, Blueacorn executives gave priority and reduced scrutiny to high-dollar loans, while instructing contractors regarding smaller-value loans: "delete them … who fucking cares."[580] Despite their companies receiving billions of dollars in taxpayer-funded loan fees, both Blueacorn and Womply executives also obtained PPP loans to benefit themselves and their companies.[581] The Select Subcommittee identified questionable details in some Blueacorn executives' loan applications that may be indicative of fraud, and a Blueacorn loan reviewer informed the Select Subcommittee that at least one executive directed a family member to submit a fraudulent PPP loan application.[582] The Select Subcommittee also uncovered evidence that Womply may have transferred the sensitive personal and financial data of hundreds of thousands of PPP borrowers to a new business, for unclear purposes.[583]

The investigation determined that the PPP lacked sufficient incentives for fintechs to implement strong fraud prevention controls. For example, although employees of fintech Kabbage—which facilitated over 310,000 PPP loans—expressed that they were "really uncomfortable with the review procedures" for PPP loans and that "the level of fraud … [was] wildly underestimated," a Kabbage supervisor told his team that the level of diligence for PPP loans differed from Kabbage's standard lending program because "the risk here is not ours—it is SBA[']s risk."[584] However, another fintech known as Bluevine initially approved outsized quantities of fraudulent loans, but improved its controls over the course of the PPP under pressure from its federally-regulated bank partners.[585]



The conduct of these program participants make clear that minimally-regulated entities should not have been permitted to participate in administering a federal program of the PPP's magnitude without strong oversight mechanisms to safeguard taxpayer funds.

3. The Trump Administration USDA also failed to guard taxpayer dollars and effectively deliver aid in operating the Food Box Relief program, awarding contracts to unqualified companies and failing to monitor their performance for potential fraud.

In operating a critical program designed to alleviate hunger and suffering at the beginning of the coronavirus pandemic, the Trump Administration failed to guard taxpayer dollars and ensure that funds were used efficiently and effectively to aid those in need, while also using the program for political advantage.[586] In the early months of the pandemic, the Trump Administration's USDA administered the Food Box Program to provide food for families in need, but directed substantial contracts to implement the new program to unqualified companies that did not deliver relief effectively and efficiently. These failures did not stop Trump Administration officials from attempting to use the program for political gain. These failures only further demonstrate the need to build an established, durable relief infrastructure to ensure families in need have enough to eat in a crisis without wasting funds and resources on ineffective companies.

a. The Food Box program was intended to purchase food from American farmers for distribution to those in need.

At the beginning of the coronavirus crisis, more than 20 million Americans lost their jobs and food prices surged as grocery supply chains were disrupted.[587] Tens of millions of Americans, including nearly 13.9 million children, lived in households without enough food to eat in June 2020.[588] In response to these critical hunger needs, Congress authorized the Secretary of Agriculture to "purchase commodities for emergency distribution in any area of the United States during a public health emergency designation," and appropriated funds for that purpose.[589] Secretary Perdue exercised this authority nearly a month later to create the Farmers-to-Families Food Box Program. Under the Program, USDA's Agricultural Marketing Service (AMS) would select regional and local distributors to purchase agricultural products at market rates, package them into family-sized boxes, and deliver them "to food banks and other nonprofits . . . that can receive, store and distribute food items."[590]

The Food Box Program was significant in size and scope. In May 2020, the Trump Administration announced contracts worth more than $1.2 billion with 198 food providers through the Food Box Program.[591] These contracts covered delivery of food boxes across the country from May 15, 2020, through June 30, 2020.[592] The program was extended for four additional rounds for deliveries through the end of May 2021.[593] According to a GAO analysis of the federal government's contract obligations through the end of February, purchases of fruits and vegetables "made primarily in support of the USDA's Farmers to Families Food Box Program" represented the third-largest set of contract obligations made in response to the coronavirus pandemic, exceeded only by "drugs and biologicals" and "medical equipment and supplies."[594] In total, the federal government entered into Food Box Program contracts worth approximately $6 billion.[595]

b. The Trump Administration awarded Food Box contracts to unqualified companies and failed to monitor the contractors' performance for fraud.

The Select Subcommittee initiated an investigation of the Food Box Program in August 2020, after the first round of the program had concluded, in light of reports that the Program had been mismanaged.[596] In conducting this investigation, the Select Subcommittee conducted and intensive review of three of the companies that had received among the largest contracts in the first round of the program—Yegg, CRE8AD8, and Ben Holtz Consulting which respectively received the 19th, seventh, and sixth largest overall contract awards.[597] While Ben Holtz Consulting had its contract terminated approximately two weeks after it was awarded, Yegg and CRE8AD8 were ultimately paid $16.5 million and $31.5 million respectively by USDA. Reviewing these companies' contract awards and performance allowed the Select Subcommittee to examine the design and operation of the Food Box Program.

The Select Subcommittee's investigation found that the Trump Administration USDA awarded contracts worth tens of millions of dollars to contractors that were unqualified to carry out program demands. The Trump Administration awarded a contract worth over $39 million to CRE8AD8, a company focused on wedding and event planning without significant food distribution experience,[598] and whose owner reportedly compared coordinating the Program to his

usual work of "stuffing little tchotchkes into bags."[599] CRE8AD8 was ultimately paid $31.5 million of this contract. The Trump Administration also awarded contracts worth $16.5 million to Yegg, a self-described "Export Management, Trading, and Trade Finance company"[600] that had listed its most recent annual sales as $250,000 and limited relevant experience.[601] The Trump Administration awarded a $40 million contract[602]—which was later canceled before any payments were made—to Ben Holtz Consulting.[603] In its references section, Ben Holtz's bid proposal had stated: "I don't have any."[604]

After awarding these substantial contracts to unqualified companies, the Trump Administration failed to adequately monitor them for fraud and allowed the firms to obtain windfall profits. The Trump Administration continued payments to one contractor—Yegg—despite troubling business practices and evidence suggesting that the company submitted false records to USDA and may have engaged in self-dealing during its performance of the contract. For example, the administration reimbursed Yegg for more than $2.85 million worth of milk and dairy boxes purportedly delivered to "Helping Feet," a nonprofit operated by the wife of the company's CEO, who was also Yegg's majority shareholder.[605] Records for that nonprofit raise serious questions about its suitability to handle dairy shipments as it operated out of office space rented by Yegg.[606] Its stated mission was "to provide Debt Consolidation, Educational and Recreational Purpose," and to engage in "Acquisition of Vacant Land for Construction of Residential Dwellings and Subsequent Sale or Rent to Low-Income Persons."[607] The Trump Administration also paid Yegg for $1.3 million in deliveries that were not supported by proper documentation and $584,400 for deliveries to a nonprofit organization that the Select Subcommittee confirmed were not received by the recipient organization.[608]

The Select Subcommittee also found that the Trump Administration did not structure or administer the Food Box Program to meet its stated goal of feeding hungry Americans and eliminating food waste. Although then-Secretary of Agriculture Perdue promised that the Food Box Program would distribute food "to communities across the country where it's needed most,"[609] the initial design of the program heavily prioritized the needs of the food industry and neglected to prioritize hungry Americans. Emails from the agriculture industry show the National

Chicken Council proposed USDA create "a special purchase of chicken in light of COVID-19," and subsequent distribution of such chicken products to "worthy recipients," to Secretary Perdue's office on April 6, 2020.[610] The Trump Administration USDA decided to run the program through its Agricultural Marketing Service (AMS) which specializes in "marketing opportunities for U.S. producers of food, fiber, and specialty crops," rather than the Food and Nutrition Service, which focuses on reducing hunger and food insecurity.[611] The Trump Administration did not have a process in place to evaluate whether nonprofit organizations that received the food boxes had the necessary operational and financial capacity to store and distribute them to people in need, and failed to meaningfully screen first-round contractors for their ability to safely and competently deliver food in the amounts awarded. Recipient nonprofits of food from the companies examined, told the Select Subcommittee, for example, that some contractors delivered "rotten food and wet or collapsing boxes," provided large amounts of commercially-packaged meat inappropriate for family consumption, or delivered produce at temperatures that the nonprofits identified as presenting a "food safety issue."[612] Another recipient nonprofit described its experience with Yegg, one of the contractors examined by the Select Subcommittee, as "a disaster" with wasteful practices by Yegg, which "did a horrible job."[613]

c. The Trump Administration allowed unqualified contractors to reap windfall profits.

In operating the new Food Box program ineffectively, the Trump Administration also allowed private contractors to reap windfall profits and waste taxpayer dollars on excessive margins. One significant Food Box program contractor, event planning company CRE8AD8, was ultimately paid $31.5 million in taxpayer funds. CRE8AD8 acknowledged to Select Subcommittee staff that it collected profits of between 10% and 25%—a total of anywhere from $3.1 million to $7.75 million—for just one month's worth of food deliveries.[614] CRE8AD8 confirmed that contractors in the Food Box Program sometimes paid well above market prices, with farmers and producers receiving from CRE8AD8 up to 10 times the price they would normally get from grocery stores.[615] Another contractor that received a contract in excess of $16 million, Yegg Inc., repeatedly charged taxpayers a 50% markup on the amount that it paid to a dairy. For example, Yegg charged USDA $20,979 for one delivery of 2,100 two-gallon boxes of milk to the Liberian American Community Organization of Southern California (LACOSC) in early June, representing $9.99 per box of milk.[616] These milk boxes had been purchased from and delivered by the dairy for $13,272, or $6.32 apiece.[617] Yegg made $7,707, or $3.67 per box, on that single delivery. Because the deliveries were being made—and at times arranged—by the dairy itself, Yegg appears to have been paid for acting as little more than a middleman. If sufficient existing food relief infrastructure existed to link food suppliers with those in need—such as through a longstanding program with standards, controls, and oversight—it likely would have been more difficult for unqualified contractors to profit handsomely at taxpayer expense.

c. The Trump Administration also manipulated the Food Box Program for political advantage.

Even as the Select Subcommittee's investigation found that the Trump Administration failed to effectively implement the Food Box program to serve the needs of those harmed by the pandemic, the Trump Administration sought to use the program for political advantage.

Most conspicuously, the Trump Administration used taxpayer dollars to include a letter signed by President Trump in food boxes, in which the President took credit for feeding hungry families.[618] Emails show that the chief of staff to Ivanka Trump, the President's daughter and advisor, contacted Secretary Perdue's chief of staff on the day before Secretary Perdue announced initial extensions for Food Box vendor contracts: "Ivanka touched base with me this morning about the letter [sic] idea of getting a letter from POTUS in every food box that's delivered—she had raised this previously with the Secretary I believe. Can we get that going?"[619] While a White House official later suggested the letter was meant to highlight public health guidance, the email implied that this health justification originated from a separate source and later in time: "Dr[.] Birx also had an idea about putting COVID guidance in each box as the people that are receiving these boxes are the most vulnerable."[620] The resulting letter read, in part: "As part of our response to the coronavirus, I prioritized sending nutritious food from our farmers to families in need throughout America."[621] Six weeks before the presidential election, USDA emailed all active Food Box Program contractors to reinforce that the letter was mandatory: "[T]he attached letter must be included in all food boxes being distributed."[622] Nonprofit organizations distributing the boxes informed Select Subcommittee staff that the letters, in which President Trump credited himself for the program, created frustration among the people they served.[623]

In addition to distributing President Trump's letter, President Trump and Secretary Perdue appear to have planned major program developments based on electoral strategy, rather than policy considerations. On August 24, 2020, the opening day of the Republican National Convention, President Trump announced $1 billion in additional funding for the third round of the Food Box Program from the battleground state of North Carolina.[624] An email from Ivanka Trump's assistant laying out the schedule for the event noted: "The President's letter will be featured during the packaging [of the food boxes]."[625] The event was promoted both on official government accounts and on the Trump campaign's Twitter account.[626] USDA later informed Select Subcommittee staff that the former President's announcement was made without notifying USDA in advance of his determination.[627]

At this announcement event, despite appearing in his official capacity, Secretary Perdue gave a speech encouraging viewers to "get[] out and vote[] for this man, Donald J. Trump" for "four more years."[628] The Office of Special Counsel (OSC) subsequently found that Secretary Perdue's comments were illegal under the Hatch Act, explaining, "if confidence in the system of representative Government is not to be eroded to a disastrous extent," Secretary Perdue and other government officials must avoid "giving the impression that the government itself has a preference for one candidate over another."[629] In this event, purportedly about a government-sponsored program to feed hungry Americans, Secretary Perdue's "first words were not about USDA, but about the president's 2016 and 2020 campaigns."[630] As OSC concluded: "[I]t is hard to imagine a better example of campaign rhetoric."[631]

4. Senior Trump Administration political appointees overrode career officials' recommendation—likely with President Trump's involvement—to approve a $700 million CARES Act national

security loan to a company of questionable eligibility facing a DOJ lawsuit for defrauding the government.

Trump Administration political appointees also interfered in the nation's economic response to the pandemic, seemingly motivated by perceived political benefits. Even as millions of small businesses struggled to get relief and millions of low-income Americans had not yet received payments to which they were entitled, senior Trump Administration officials prioritized pushing a substantial loan on generous terms for a corporation that likely should not have received taxpayer funds. The CARES Act created a loan program for companies "critical to maintaining nation security." 95% of the funds disbursed by the Trump Administration Treasury Department went to a single trucking company—a $700 million loan to the Yellow Corporation (Yellow). A Select Subcommittee investigation found that Trump Administration political appointees overrode career officials' assessment that the company was not eligible for a national security loan and made the loan on interest rate, risk, and use of funds terms that violated CARES Act requirements.[632]

a. <u>The National Security Loan Program, designed to protect the viability of businesses critical to national security, provided a significant majority of all its funds to a single company.</u>

Congress created the national security loan program in the CARES Act to ensure that companies critical to America's national security had access to funds necessary to offset losses caused by pandemic disruptions. Specifically, the CARES Act directed Treasury to make national security loans and loan guarantees available to "provide liquidity" to "businesses critical to maintaining national security" that were experiencing "losses incurred as a result of coronavirus."[633] Treasury guidance stated that companies could be determined by the Treasury Secretary to be eligible for national security loans if they secured a "recommendation and certification by the Secretary of Defense or the Director of National Intelligence" that "the applicant business is critical to maintaining national security."[634]

On July 1, 2020, the Trump Administration announced that Yellow would receive a $700 million loan through this program.[635] No other company received a national security loan until late October 2020. The loan to Yellow constituted over 95% of the $725.9 million total loaned under the program.[636] In support of its decision to approve this substantial loan to Yellow, Treasury asserted that its "determination was based on a certification by the Secretary of Defense that YRC is critical to maintaining national security" and that Yellow "provides 68% of less-than-truckload services to the Department of Defense."[637]

Treasury's loan to Yellow was made at an interest rate of 3.5% plus LIBOR, with $300 million to be used for "near-term contractual obligations and non-vehicle capital expenditures" and $400 million to be used for long term capital investments in its truck and trailer fleet.[638] Treasury took a third-priority security interest in Yellow's existing collateral assets, putting taxpayers behind Yellow's bank creditors in an Asset-Backed Lending (ABL) facility and a group of private creditors led by Apollo Global Management (Apollo).[639]

b. White House officials—likely with President Trump's involvement—intervened as Yellow's application for a national security loan was being evaluated.

The Select Subcommittee obtained evidence suggesting that political pressure from the Trump White House may have contributed to Treasury and DOD's decisions to support and approve the loan to Yellow, despite career DOD officials' recommendation that Yellow not be certified as eligible to receive a loan, and despite the fact that Yellow failed to comply with CARES Act loan term requirements. Documents obtained by the Select Subcommittee show that senior White House officials,[640] including White House Chief of Staff Mark Meadows,[641] repeatedly communicated with Treasury on Yellow's behalf as Treasury evaluated Yellow's application for a national security loan. Emails obtained by the Select Subcommittee also indicate that President Trump personally discussed Yellow's loan application with a union leader coordinating with the company in its efforts to obtain relief, and that the fact of President Trump's call concerning Yellow's loan application was relayed to Secretary Mnuchin and Secretary Esper.[642] Secretary Mnuchin's subsequent emails to President Trump's closest aides, highlighting praise for the issuance of the loan, appear to confirm the President's involvement.[643]

c. Trump Administration political appointees overrode the recommendation of career officials in certifying that Yellow was "critical" to national security.

Senior career DOD officials concluded, after collecting and analyzing information about the services that Yellow provided to DOD, that Yellow should not be certified as "critical to maintaining national security" for the purposes of obtaining a CARES Act loan. Yet within a day of receiving the recommendation of career officials, senior political appointees—including Treasury Secretary Mnuchin, Defense Secretary Esper, and Defense Under Secretary Ellen Lord—conferred about Yellow and quickly decided to certify that the company was "critical" to national security and eligible for a national security loan.[644] This certification overrode the recommendations of career officials who found that Yellow should not be certified because the trucking services the company provided to DOD could be carried out by "plenty of other trucking companies" and because the company was being sued for fraudulently overcharging DOD for the very services that Yellow argued made it critical to national security.[645] Secretary Esper's certification that Yellow was "critical" to national security contained no data or analysis,[646] and Treasury's announcement that Yellow would receive a national security loan asserted, in a repetition of the company's own talking points, that Yellow provided 68% of DOD's less-than-truckload [LTL][647] shipments—twice the share found by DOD career officials.[648] Without the intervention of political appointees, Yellow would not have been deemed eligible to receive a national security loan.

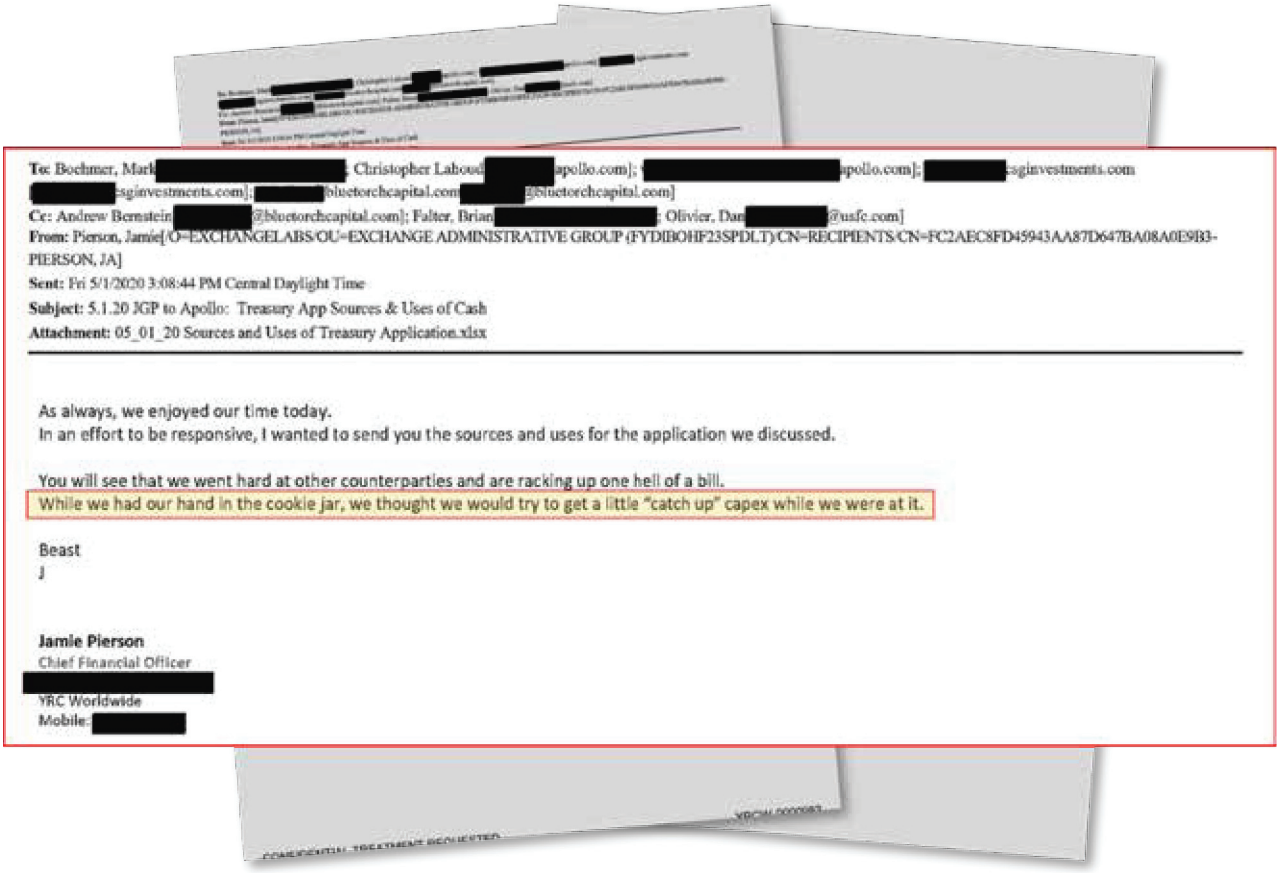
d. The Trump Administration approved the loan to Yellow on terms that violated CARES Act risk and use of funds requirements.

The Trump Administration's loan to Yellow violated CARES Act requirements intended to protect taxpayers and ensure that loan funds only went to aid companies in coping with the

impacts of the coronavirus crisis. The Trump Administration agreed to loan terms that allowed Yellow to use more than half its pandemic loan funds for long-term capital investments in replacing an aging truck and trailer fleet, despite the CARES Act specification that loans were to offset "losses incurred as a result of the coronavirus."[649] Further, despite CARES Act requirements that national security loans either be "sufficiently secured" or made at an interest rate reflective of the risk and comparable to pre-pandemic market rates, the loan to Yellow was made at an interest rate well below that charged to Yellow by private creditors led by Apollo only six months before the onset of the pandemic, even though Apollo received higher-ranking collateral interests than Treasury.[650] Before Treasury agreed to such generous terms, Yellow's own counsel had concluded that Yellow would likely be required to pay a higher interest rate and give a higher-priority collateral interest to Treasury because of the CARES Act risk and interest rate requirements.[651]

Yellow's application for the national security loan included a request for $365 million for capital investment and justified the request's connection to pandemic losses with the vague statement that Yellow had "cut a significant portion of its capital plan for 2020."[652] Moreover, Yellow's application made plain that these funds were largely being sought to remedy an existing problem—an aging truck and trailer fleet—that pre-dated the pandemic, stating that Yellow's "average age for tractors is ~11 years; industry average is 5 years."[653] The application further emphasized the financial benefits to Yellow of increased capital expenditures, but did not substantiate the claim that the funds would be used for losses caused by the pandemic.[654]

Yellow executives knew they were seeking to take advantage of American taxpayers. Yellow's CFO made clear to Yellow's existing creditors, including Apollo Global Management, that the company's request for a $710 million national security loan went beyond what was needed to offset pandemic losses and included a request for additional capital funds. In a May 1, 2020 email titled "Treasury App Sources & Uses of Cash," Yellow CFO Jamie Pierson sent the company's existing creditors a summary of its $710 million loan request, with $365 million of the request designated for capital investments in new tractors, trailers, and technology.[655] Pierson explained: "While we had our hand in the cookie jar, we thought we would try to get a little 'catch up' capex [capital expenditures] while we were at it."[656]



To: Boehmer, Mark; Christopher Laboud; apollo.com]; apollo.com]; sginvestments.com
sginvestments.com]; bluetorchcapital.com; @bluetorchcapital.com]
Cc: Andrew Bernstein; @bluetorchcapital.com]; Falter, Brian; Olivier, Dan; @usfc.com]
From: Pierson, Jamie[/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC2AEC8FD45943AA87D647BA08A0E9B3-PIERSON, JA]
Sent: Fri 5/1/2020 3:08:44 PM Central Daylight Time
Subject: 5.1.20 JGP to Apollo: Treasury App Sources & Uses of Cash
Attachment: 05_01_20 Sources and Uses of Treasury Application.xlsx

As always, we enjoyed our time today.
In an effort to be responsive, I wanted to send you the sources and uses for the application we discussed.

You will see that we went hard at other counterparties and are racking up one hell of a bill.
While we had our hand in the cookie jar, we thought we would try to get a little "catch up" capex while we were at it.

Beast
J

Jamie Pierson
Chief Financial Officer
YRC Worldwide
Mobile:

Although Yellow represented that its capital investment funds request would merely allow it to fulfill its pre-pandemic investment plan,[657] the company's *actual* capital expenditures preceding the pandemic were far lower than the amount the company sought and received for capital investment through the Treasury loan.[658] After receiving the Treasury funds earmarked for capital investments, Yellow's capital expenditures increased dramatically.[659] Ultimately, the Trump Administration approved this significant taxpayer loan of funds—meant for companies that were critical to national security—to a company that intended to use most of its funds for its long-term profitability.[660]

5. Technology company ID.me subjected Americans in need to extraordinary wait times for pandemic relief benefits, while the company used exaggerated claims to secure contracts with dozens of states and the federal government.

Existing weaknesses in the safety net and relief infrastructure that made vital programs vulnerable to fraud also gave private actors an opportunity to profit from federal and state agencies' desperate need to implement fraud controls on an emergency basis. Even before the pandemic, unemployment insurance systems had suffered from decades of underinvestment and utilized antiquated technology that was both too slow and vulnerable to fraud.[661] To fill these gaps, dozens of state unemployment agencies, as well as the Internal Revenue Service, turned to ID.me—a company that purported to offer a quick, high-tech solution to verify identities remotely and

thereby prevent fraud through identity theft. ID.me used facial recognition technology that required a phone or computer camera to compare the face of a person seeking benefits to their government identification photo. A Select Subcommittee investigation found, however, that ID.me ultimately subjected many citizens to endure exorbitant wait times as they sought funds necessary to sustain themselves after being laid off, while inaccurately downplaying those wait times as it sought to provide services to the IRS in connection with the ARP's Child Tax Credit payments. Meanwhile, ID.me made self-serving claims that the extent of pandemic fraud in unemployment programs was much higher than other expert estimates, without employing any underlying methodology or analysis, in an apparent attempt to increase demand for its services.

a. ID.me downplayed its wait times to the IRS while it forced Americans who could not automatically verify their identities to wait for up to nine hours to provide evidence of their identity in video chats.

ID.me contracted with at least 25 states' unemployment insurance agencies to provide identity verification using facial recognition technology, which purported to verify that an individuals' appearance by phone or computer camera matched to their photo identification card, in order to guard against identity theft fraud being committed against pandemic unemployment relief and other programs. [662] The company received contracts worth nearly $45 million from state workforce and labor agencies for these services.[663] ID.me informed the Select Subcommittee that 10% to 15% of users were unable to verify their identities with the company's automated facial recognition technology. These individuals were directed to show proof of their identities to ID.me employees through video chats.[664] Given that more than 22 million Americans lost their jobs during the crisis and that ID.me provided services to approximately half the country, a substantial share—potentially hundreds of thousands—of unemployed workers during the pandemic were routed to verify their identities through video chats with ID.me employees.[665]

Data obtained by the Select Subcommittee shows that people who were unable to verify their identities automatically with facial recognition technology were regularly forced to wait for multiple hours to have a video chat to verify their identities. In late April 2021, when the IRS was considering using ID.me's services in connection with the enhanced Child Tax Credit (CTC), a group of ID.me representatives that included multiple executives met with representatives of IRS's Secure Access Digital Identity team and informed them that its current wait times were "about 2 hours as of today." The company also noted that its "users have to wait online" as it had removed the "callback feature" it had previously offered. The company attributed its decision to stop offering a callback option to the perceived inefficiency of offering appointments.[666]

In describing how users were forced to wait online for an average of two hours, ID.me inaccurately minimized the difficulty Americans seeking vital benefits were facing when using ID.me. According to data from ID.me, users actually had to wait more than four hours on average in 14 of 21 states where the company provided unemployment benefit verification services in April 2021. Sixteen of 21 states had wait times exceeding 3.5 hours. For those seeking verification in North Dakota, average wait times were nearly 10 hours that month.[667] This affected a significant share of the population as those states where individuals faced wait times in excess of four hours included the nation's three most populous: California, Texas, and Florida.[668] These long average

wait times also fail to capture additional delays for applicants who had to leave the lines prematurely due to lack of steady internet access or commitments like caregiving. It is unclear why ID.me failed to hire adequate staff or infrastructure to decrease wait times as it elected to enter a high number of new contracts during the pandemic.

These wait times are particularly concerning given the equity concerns that ID.me's technology raises. Many individuals with low incomes, who need support urgently when they lose employment, cannot afford the necessary devices and internet access in the first place or must share devices with other family members using them for work, job applications or school. As of 2021, approximately 15% of American adults did not own a smart phone, and 23% did not own a desktop or laptop computer.[669] These individuals already faced significant barriers in verifying their identities while lacking the necessary technology, which may have been impossible without the ability to access borrowed or public technology for long durations.

b. ID.me's CEO provided estimates of pandemic unemployment fraud that dramatically exceeded figures assessed by experts and were not supported by evidence, in an apparent attempt to increase demand for ID.me's services.

Even as ID.me was unable to handle the programs it was already providing identification services for without excessive delays for Americans seeking pandemic relief, the company's CEO made claims about the extent of pandemic unemployment fraud that far exceeded the estimates of state and federal agencies and watchdogs in an apparent effort to increase demand for ID.me's services. In June 2021, *Axios* reported: "Blake Hall, CEO of ID.me, a service that tries to prevent this kind of fraud, tells Axios that America has lost more than $400 billion to fraudulent claims. As much as 50% of all unemployment monies might have been stolen, he says."[670] This asserted total lost to fraud is nearly 10 times higher than the $45.6 billion in potential unemployment fraud DOL OIG assessed through an analysis of the data associated with unemployment claims.[671] ID.me's assertion is nearly three times larger than the DOL OIG's broader assessment of all potential improper pandemic unemployment payments, which encompasses fraud as well as non-fraudulent payments made due to compliance failures (largely reflecting inaccurate earnings, separation, or work search information regarding bona fide unemployed workers).[672] ID.me subsequently promoted the press coverage of this estimate on its own news page, alongside ID.me's press releases.[673]

The Select Subcommittee repeatedly asked ID.me to explain its methodology for its public assertions in June 2021 that "more than $400 billion," and up to "as much as 50%" (which would be about $414 billion), of pandemic unemployment benefits were lost to "fraudulent claims."[674] ID.me did not identify any method for calculating its assessment of pandemic unemployment fraud. Instead, ID.me stated that it relied on federal, state, and independent assessments and its own "observations":

> ID.me's understanding of the extent of improper payments for pandemic-related UI claims draws on a number of sources, including public statements by state and federal officials responsible for administering and overseeing UI programs,

> estimates put forward by third-party analysts assisting state governments in detecting potential fraud, and the company's own observations . . . .[675]

But the sources ID.me cited simply do not support ID.me's $400 billion fraud total. ID.me cited DOL OIG's March 2022 estimate of $163 billion in improper payments (about 19% using a measure broader than "fraud"), Arizona's September 2021 estimate that between $4.3 and $4.4 billion was lost to fraud (about 27%), California's October 2021 estimate that $20 billion was lost to fraud (about 11%), Michigan's December 2021 estimate that between $8.4 and $8.5 billion was lost to fraud (about 22%), and the Heritage Foundation's July 2021 estimate that $357 billion was lost to fraud, which itself cited ID.me's own assessment.[676] Each of the assessments ID.me referenced as having been used to support its assessment were made *after* ID.me's June 2021 assertion that more than $400 billion had been lost to fraud.[677]

ID.me's inability to articulate any methodology for its $400 billion fraud estimate and its representation that it relied on federal, state, and independent estimates that both post-dated ID.me's assertion and reflected lower levels of fraud demonstrate that the company had no reliable foundation for the exaggerated estimates of fraud it offered publicly.

6. Some large corporate landlords aggressively filed to evict tenants despite eviction moratoriums, even as federal rental assistance programs began to disburse billions in aid.

A Select Subcommittee investigation found that some large corporate landlords were among the corporate actors that exacerbated the impacts of the pandemic on American families and undermined pandemic response efforts. Despite the protections of CDC's eviction moratorium and Congress's appropriation of more than $46 billion in emergency rental assistance, four large landlord companies investigated by the Select Subcommittee continued to file thousands of eviction actions—nearly 15,000 during the pandemic's first 16 months—even as many struggling tenants waited for pending rental assistance applications to be approved. The Select Subcommittee's investigation found troubling practices at some companies and a widespread practice of filing to evict even tenants who were only a month behind on rent or who had pending rental assistance applications. These findings demonstrate the need to invest in a relief infrastructure that can more effectively help people keep their homes and avoid evictions in the next crisis.

a. Congress and the federal government took unprecedented measures to prevent the pandemic's economic fallout from causing an eviction crisis, including the appropriation of billions in rental assistance and eviction moratoriums.

The onset of the coronavirus pandemic resulted in enormous economic dislocation as 22 million Americans lost their jobs.[678] This crisis put tens of millions of people at risk of losing their homes through eviction.[679] In response to this potential catastrophe, which threatened to further exacerbate the spread of and deaths from the coronavirus, Congress enacted an eviction moratorium in the CARES Act that applied to properties with federally backed mortgages and tenants with federally supported housing vouchers from March 27, 2020 through July 24, 2020.[680] After the expiration of the CARES Act moratorium, CDC issued a moratorium on evictions for nonpayment of rent for those impacted by the pandemic that applied to all residential rental properties and was in force from September 4, 2020 through July 31, 2021.[681]

To further prevent a housing crisis while also ensuring landlords were still paid, Congress appropriated $46.5 billion in rental assistance to pay back rent of tenants impacted by the pandemic, including $21.5 billion in the American Rescue Plan.[682] State and local governments, charged with disbursing these funds to aid renters, required significant time to create the necessary infrastructure and were initially slow to distribute funds.[683] The CARES Act had also previously provided states with funds that could be used for rental assistance earlier in the pandemic, and state and local governments devoted at least $3.9 billion to rental assistance between March 2020 and October 2020, with at least $2.9 billion of those funds coming from the CARES Act.[684]

Despite the difficulties state and local governments faced in creating new infrastructure to disburse rental assistance funds, the CARES Act and CDC eviction moratoriums, rental assistance programs, and other sources of pandemic financial assistance were ultimately successful at keeping millions of families in their homes. Even with the economic crisis faced by many Americans, pandemic eviction filings were significantly lower than their historic averages in most metropolitan areas where data was available, resulting in as many as 1.55 million fewer eviction cases than would have occurred at pre-pandemic eviction filing rates.[685] Pandemic rental assistance funds have delivered aid to more than 6.5 million American families.[686] Still, during the first 16 months of the pandemic, estimates suggest households faced approximately 1.3 million eviction filings, putting millions of people at risk of homelessness during a national health and economic crisis.[687] Consistent with these figures, a Select Subcommittee investigation found that some large corporate landlords employed aggressive eviction filing practices throughout the coronavirus crisis.

b. Some large corporate landlords continued to file to evict tenants in large numbers even as rental assistance began to roll out and CDC's eviction moratorium was in place.

At the time the Select Subcommittee initiated its investigation, publicly available data from select jurisdictions showed that Pretium Partners (through its companies Progress Residential and Front Yard Residential, hereafter Pretium), Invitation Homes, Ventron Management (Ventron), and the Siegel Group (Siegel) had collectively filed 5,413 eviction actions from March 2020

through July 2021.[688] The Select Subcommittee obtained evidence showing that these companies in fact filed at least 14,744 eviction actions during this period—nearly three times the previously reported total.[689] Pretium filed 6,264 eviction actions, compared to the 1,730 actions previously identified.[690] Invitation homes filed 3,305 actions, compared to 932 previously identified.[691] Ventron Management filed 4,401 eviction actions, compared with 2,178 that were previously identified.[692] Siegel filed at least 774 actions compared with 573 that were previously identified.[693] These data show that the four corporate landlords that were the subject of the Select Subcommittee's investigation filed eviction cases at a substantial rate from March 15, 2020, through July 31, 2021, as Americans faced the health and economic crisis brought by the coronavirus pandemic. Most of these companies' eviction filings took place while CDC's eviction moratorium was in place, and the filings continued even after Congress appropriated $46 billion in rental assistance funds and state and local governments began working to create the infrastructure to distribute this relief.[694]

CDC's moratorium did not bar all evictions and included specific substantive and procedural requirements for tenants to gain protection, including declaring that tenants had suffered an adverse impact as a result of the pandemic and were undertaking efforts to obtain assistance.[695] Nevertheless, Pretium, Invitation Homes, Siegel, and Ventron filed eviction cases against many tenants who almost certainly met these criteria, putting them at risk of losing their housing, particularly if they did not understand available protections or did not have access to counsel.

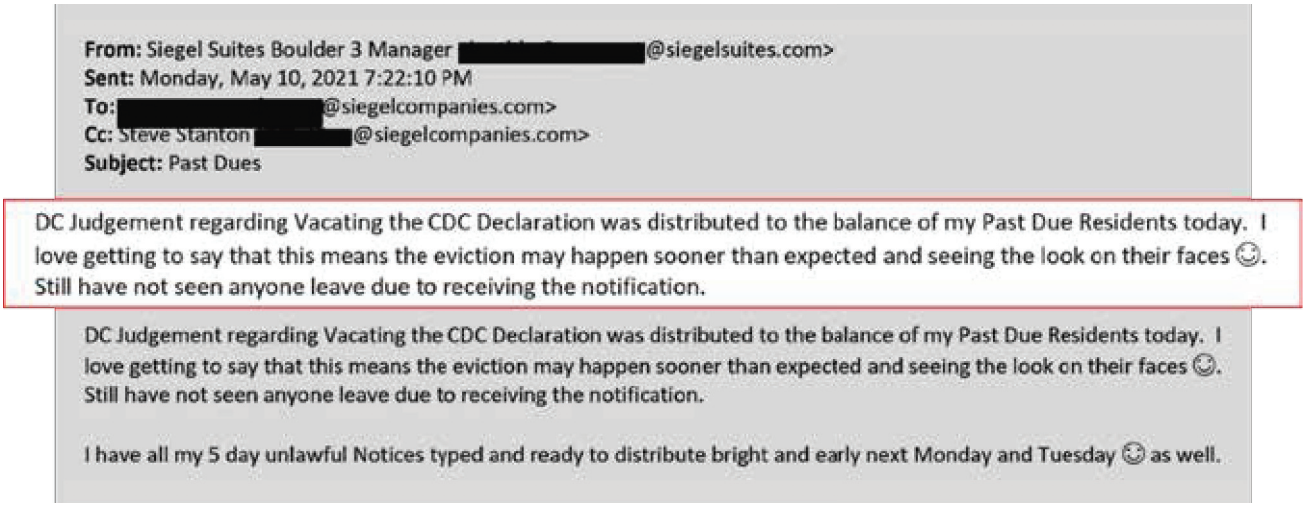
c. Investigated companies filed to evict tenants with pending rental assistance applications, and sometimes used misleading or potentially unlawful tactics to force renters out of their homes during the crisis.

All of the corporate landlords the Select Subcommittee investigated had policies or practices of filing to evict tenants with pending rental assistance applications, and the companies employed other troubling practices during the first 16 months of the coronavirus crisis. Siegel was uniquely egregious, as executives directed employees to deceive tenants about protections under the CDC eviction moratorium. The other companies used low thresholds before initiating eviction filings, downplayed the impact of pandemic eviction filings, and sometimes refused to accept rental assistance, even as these companies thrived financially or received millions in government aid.

i. *Siegel used uniquely egregious tactics to evict tenants during the crisis*

Siegel engaged in deceptive and potentially unlawful practices to prevent tenants from understanding their protection from eviction under CDC's eviction moratorium. Documents obtained by the Select Subcommittee show that executives aimed to "bluff" tenants out of their apartments by ordering that subordinates post and distribute copies of a court order holding that CDC lacked authority to impose the eviction moratorium—deliberately hiding the fact that the court had also ordered that the moratorium's protections would remain in effect as the case was appealed.[696] A Siegel executive specifically directed that the stayed order be brought to a tenant

"after 5pm" on a Friday "so the courts and constable office are closed and she cannot call to verify anything" and "see if she vacates over the weekend."[697] The executive followed up with the company's regional managers to ensure that the deceptive strategy of distributing the order was being followed, writing that "properties [] have been using this order to bluff people out," and "I hope you all are doing the same."[698] Property managers carried out this directive with evident glee, with one writing to an executive and a regional manager that he "love[d] getting to say that this means the eviction may happen sooner than expected and seeing the look on their faces 😊."[699] A regional manager similarly reported to executives that his region had been distributing the order and was "seeing positive results," indicating that people were leaving their homes as a result, which he described as "to our advantage."[700] These practices may have been unlawfully deceptive under federal laws governing business and collection practices in light of CFPB and FTC guidance and CFPB's regulation requiring landlords' agents make tenants affirmatively aware of their rights under CDC's moratorium, and the Select Subcommittee referred Siegel for further investigation.[701]



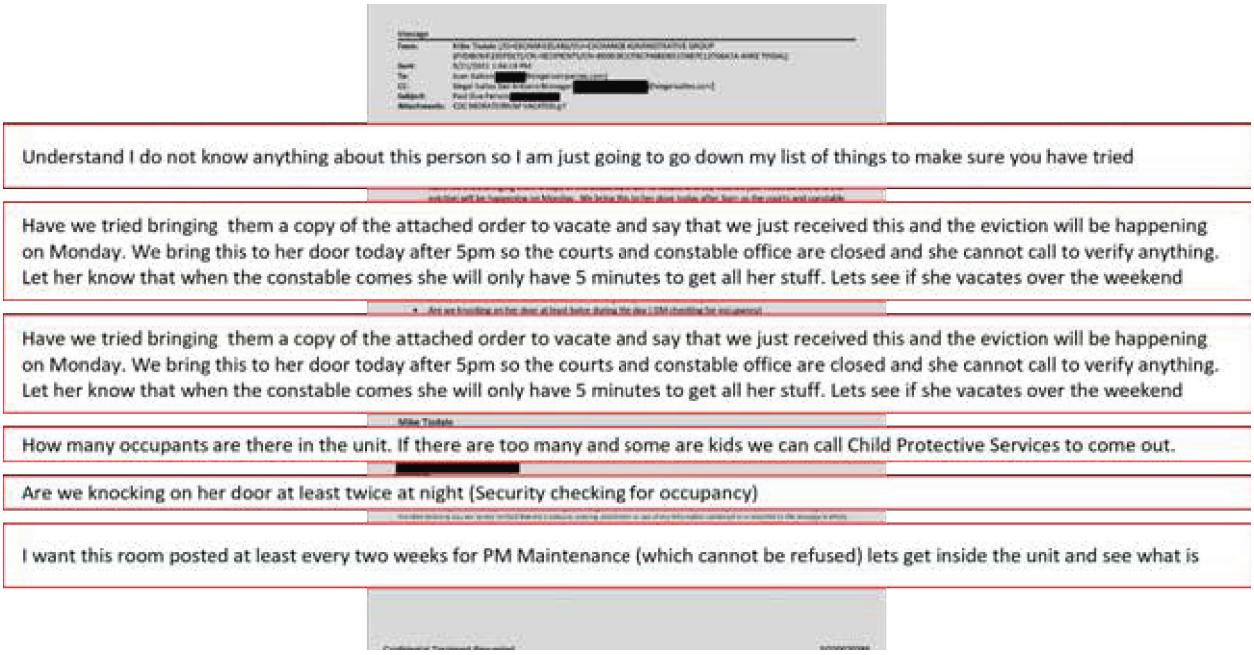
From: Siegel Suites Boulder 3 Manager [redacted]@siegelsuites.com>
Sent: Monday, May 10, 2021 7:22:10 PM
To: [redacted]@siegelcompanies.com>
Cc: Steve Stanton [redacted]@siegelcompanies.com>
Subject: Past Dues

DC Judgement regarding Vacating the CDC Declaration was distributed to the balance of my Past Due Residents today. I love getting to say that this means the eviction may happen sooner than expected and seeing the look on their faces ☺. Still have not seen anyone leave due to receiving the notification.

DC Judgement regarding Vacating the CDC Declaration was distributed to the balance of my Past Due Residents today. I love getting to say that this means the eviction may happen sooner than expected and seeing the look on their faces ☺. Still have not seen anyone leave due to receiving the notification.

I have all my 5 day unlawful Notices typed and ready to distribute bright and early next Monday and Tuesday ☺ as well.

In addition to Siegel's deceptive practices regarding CDC's eviction moratorium, the Select Subcommittee obtained an email showing that a Siegel executive also directed employees to use harassing and unlawful tactics to evict or otherwise push out at least one tenant. The Siegel executive's May 21, 2021, directive to bring a copy of the court order suggesting CDC's moratorium was no longer in effect to a tenant after the courts and constable office had closed for the weekend, discussed above, also articulated the executive's "list" of strategies for coercing the tenant to leave without obtaining a legal eviction order. The list includes directions to call "Child Protective Services to come out" if children were present in a crowded apartment, threatening to call "animal control to come pick up her abandoned pet" if the tenant was not present in the apartment, and having security "knock[] on her door at least twice at night." The executive's preface to this list said, "I do not know anything about this person so I am just going to go down my list of things to make sure you have tried everything possible to get rid of them." This statement suggests that the executive may have directed employees to use these strategies on other occasions.[702]



As Siegel used these abusive tactics to force people from their homes during the crisis, Siegel benefited significantly from government aid. Company documents show Siegel also received $1.785 million in rental assistance funded through the CARES Act in 2020 for tenants behind on rent, even before Congress authorized $46.5 billion additional dollars to aid in paying tenant rental arrears.[703] Company records also show that Siegel received at least an additional $1.44 million in rental assistance funds through July 2021, with approximately $87,000 in additional payments approved as of that time and approximately $769,000 in additional pending applications for assistance.[704] In total, Siegel received at least $5.5 million in federal assistance to offset pandemic costs and tenant rental arrears as it flouted tenant protections.

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ii. *Pretium, Invitation Homes, and Ventron filed to evict tenants aggressively during the crisis despite the increasing availability of rental assistance*

Investigated companies were quick to file eviction cases against tenants during the first 16 months of the pandemic, even as states and localities began to roll out rental assistance programs distributing tens of billions of dollars in rental assistance intended to compensate landlords and prevent people from losing their homes. Ventron and Pretium, for example, applied a low threshold for initiating eviction filings. Ventron documents show that 91% of the eviction actions Ventron filed during the first 16 months of the pandemic involved tenants who were only one month behind on rent.[705] Pretium's policies, similarly, placed tenants into its eviction filing process after they fell as little as $500 behind on rent.[706] Both Pretium and Invitation Homes, moreover, decided not to accept rental assistance as an alternative to eviction filings if the companies determined that the rental assistance programs were not offering to pay a sufficient portion of a tenant's rental arrears or otherwise imposed conditions the companies deemed unacceptable (such as funding premised on the landlord agreeing not to evict the tenant for a period of time).[707]

7. Nationwide consumer reporting agencies (NCRAs) failed to protect Americans' credit reports from errors during the crisis.

The Select Subcommittee's investigation of credit reporting companies identified longstanding problems with nationwide consumer reporting agencies' (NCRA) responsiveness to consumers disputing inaccurate information in their credit reports.[708] Errors in credit reports are often quite serious, as they can reduce consumers' credit scores, potentially blocking access to loans, housing, and employment, among other harmful consequences. However, these errors become even more significant during crises like the pandemic, when Americans may need access to credit more than ever to weather difficult economic circumstances.[709]

Data provided to the Select Subcommittee revealed that consumers have disputed a massive amount of information in their credit reports, yet the top three NCRAs—Equifax, Experian, and TransUnion—have often failed to investigate. Between 2019 and 2021, consumers disputed nearly 336 million items—such as names, addresses, and credit information—in their credit reports.[710] However, this does not include the 13.8 million or more dispute submissions—containing an unknown number of disputed items—that the NCRAs discarded without investigation during this time period.[711] The NCRAs disregard these disputes on the suspicion that they have not been authorized by the consumer, but the Select Subcommittee found that they use such speculative criteria to reach this conclusion that they may also be throwing out legitimate, authorized disputes—meaning consumers may find themselves stuck with an inaccurate credit report and penalized by lenders when they seek credit. Even when the NCRAs did investigate, they made no change at all to the consumer's credit report around half the time (53-57% each year for Equifax, around 48% each year for Experian, and 47-51% each year for TransUnion).[712] While some disputes are likely meritless, the Select Subcommittee's investigation also identified potential issues with the NCRAs' investigations, calling into question whether such a high percentage of disputes should have resulted in no change.

To help address long-standing issues with the NCRAs' error resolution and prevent more needless economic harm, Chairman Clyburn requested that the Consumer Financial Protection Bureau (CFPB) further review the NCRAs' dispute investigation processes.[713] Following this request, the CFPB issued new industry guidance "to emphasize that certain practices involving the failure to conduct a reasonable investigation of disputes can violate" the Federal Credit Reporting Act in light of data showing apparent failures to conduct reasonable investigations.[714] This guidance is an important first step. To build a more resilient, equitable economy and to reduce Americans' vulnerabilities to harmful shocks in future crises, continued scrutiny of NCRAs' practices is essential.

8. Social media company Telegram facilitated fraud against critical relief programs, threatening the effectiveness of government aid.

The Select Subcommittee found that one large social media company—Telegram—with more than 500 million users, and a reported valuation of more than $30 billion,[715] acted as a platform for sharing information to aid the commission of fraud against pandemic relief programs in light of the company's bare content moderation policies and scant interventions to prevent the facilitation of criminal activity. Telegram's platform served as a hub for people to discuss ways

to commit large-scale criminal fraud against numerous federal and state relief programs.[716] Individuals used Telegram channels to advertise the sale of detailed instructions—often referred to as "methods" or "sauces"—for successfully submitting fraudulent relief claims to numerous relief programs.[717] These channels—which can reach thousands of members at a time—were used to disseminate what some reports have called "step-by-step playbook[s]" that scammers follow to commit fraud.[718] Telegram's strikingly limited terms of service raise further concerns that the company does not intend to undertake serious efforts to prevent its platform from being used for illegal activity. Telegram's very brief terms of service only prohibit users from "scam[ming]" other Telegram users, appearing to permit the use of the platform to conspire to commit fraud against others.[719] The terms also only bar users from promoting illegal content on "publicly available" channels even though "private" channels are often far from private, permitting up to 200,000 users. The company explicitly says it "do[es] not process any requests related to [illegal content on "private" group chats]."[720]

Following an inquiry from the Select Subcommittee, Apple reported that it identified "content on the Telegram app related to potentially fraudulent activity directed toward pandemic relief and other government programs," and "communicated with Telegram about this content, and Telegram committed to remove it from the app." Apple reported that it "subsequently searched the app to confirm Telegram's actions."[721] Although the Select Subcommittee's inquiry did prompt remedial action, interventions to prevent large scale facilitation of fraud against relief programs will be vital to protecting program integrity in future crises.

E. Congress and the Biden Administration Improved the Federal Implementation of Pandemic Programs, Addressed Earlier Failures, and Supported a Robust and Equitable Jobs Recovery.

1. Following Trump Administration failures to equitably deliver relief and guard taxpayer funds, Congress and the Biden Administration improved the federal implementation of pandemic programs, making the distribution of relief more equitable and reducing fraud vulnerabilities.

The Biden Administration and Congress undertook significant measures to improve the federal response to the pandemic's economic impact by ensuring that relief programs were available to vulnerable and marginalized communities and by taking steps to reduce the vulnerabilities of critical programs to fraud. Following reports, including from the Select Subcommittee, that federal relief programs in 2020 prioritized large businesses and failed to reach small, minority-owned businesses[722] and very low-income people,[723] the Biden Administration took action to improve the equity of the federal response. Within a month of assuming office, the Biden Administration removed barriers to smaller businesses receiving PPP loans.[724] The American Rescue Plan subsequently authorized EIDL supplemental targeted grants specifically to support small businesses in low-income communities.[725] The Biden Administration also prioritized vulnerable and marginalized communities in other programs, including the Restaurant Revitalization Fund (RRF). GAO determined that 72% of businesses supported by the RRF self-reported as being "owned by women, veterans, or members of socially and economically disadvantaged groups."[726]

At the same time, the Biden Administration took crucial steps to protect critical relief programs from fraud and to ensure that taxpayer dollars were protected. Shortly after assuming office, President Biden moved to protect the PPP program from fraud by directing that loan approval be "contingent on passing SBA fraud checks, Treasury's Do Not Pay database, and public records."[727] Similarly, in the EIDL program, the Biden Administration strengthened fraud controls by requiring that fraud indicators be addressed by loan officers (including with detailed directions to loan officers on actions that must be taken when identity theft indicators are present), validating applications against Treasury's Do Not Pay List, obtaining Internal Revenue Service tax transcripts to verify EIDL applicant information, and checking Employer Identification Numbers (EINs).[728]

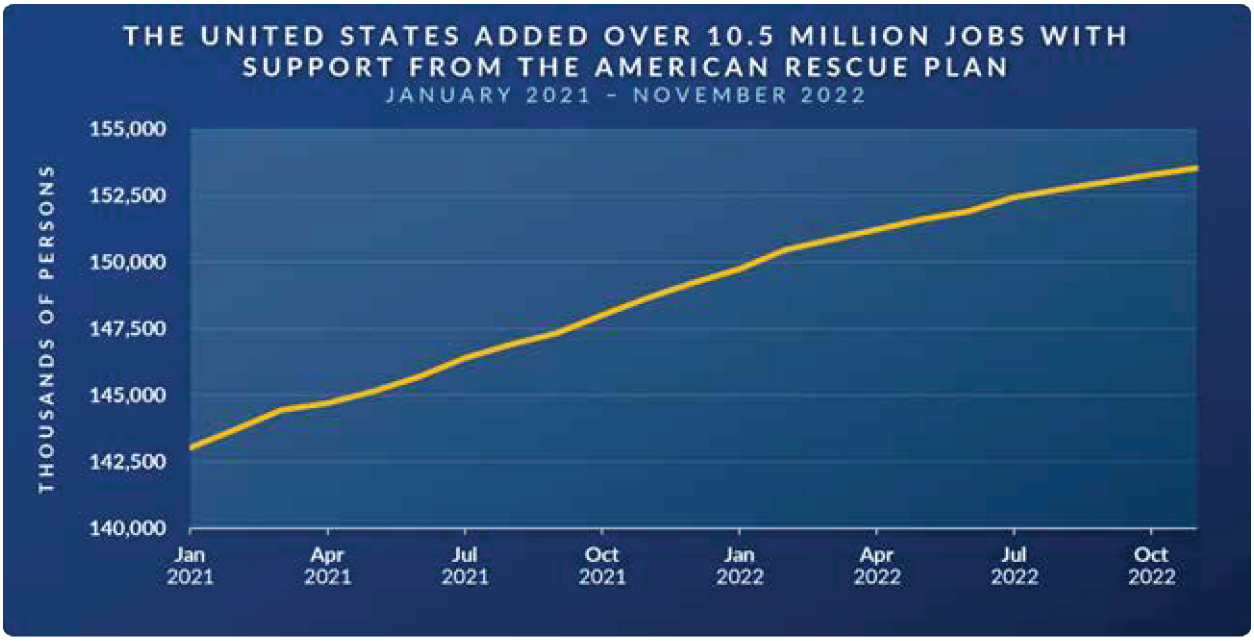
The Biden Administration and Congress also prioritized combating fraud in the American Rescue Plan, appropriating more than $204 million to combat waste, fraud, and abuse, including $25 million to SBA OIG for necessary expenses including PPP and EIDL oversight and $40 million to the PRAC.[729] The ARP further included $2 billion to improve state Unemployment Insurance systems, and the Biden Administration Department of Labor (DOL) has announced grants of hundreds of millions of dollars to states to upgrade their technology to deliver better service with less fraud risk. DOL has deployed teams of experts to states to provide assistance and make recommendations on fraud, equity, technology, and payment timeliness, has awarded grants to states to help address potential fraud, and has awarded purchase agreements to vendors that states can use to combat identity-theft related fraud.[730]

The Biden Administration and Congress have also taken action to hold those who committed fraud against relief programs to account. President Biden directed DOJ to appoint a chief prosecutor for pandemic relief fraud, and in a June 2022 Select Subcommittee hearing that prosecutor testified that DOJ had charged approximately 1,481 individuals with pandemic fraud and was conducting civil investigations of more than 2,300 additional individuals and entities in connection with pandemic fraud, with additional confidential investigations ongoing beyond.[731] In August 2022, Congress passed and President Biden signed the Paycheck Protection Program and Bank Fraud Enforcement Harmonization Act and the COVID-19 Economic Injury Disaster Loan Fraud Statute of Limitations Act, which extended the statutes of limitations for DOJ to investigate and prosecute fraud against the PPP and EIDL programs.[732]

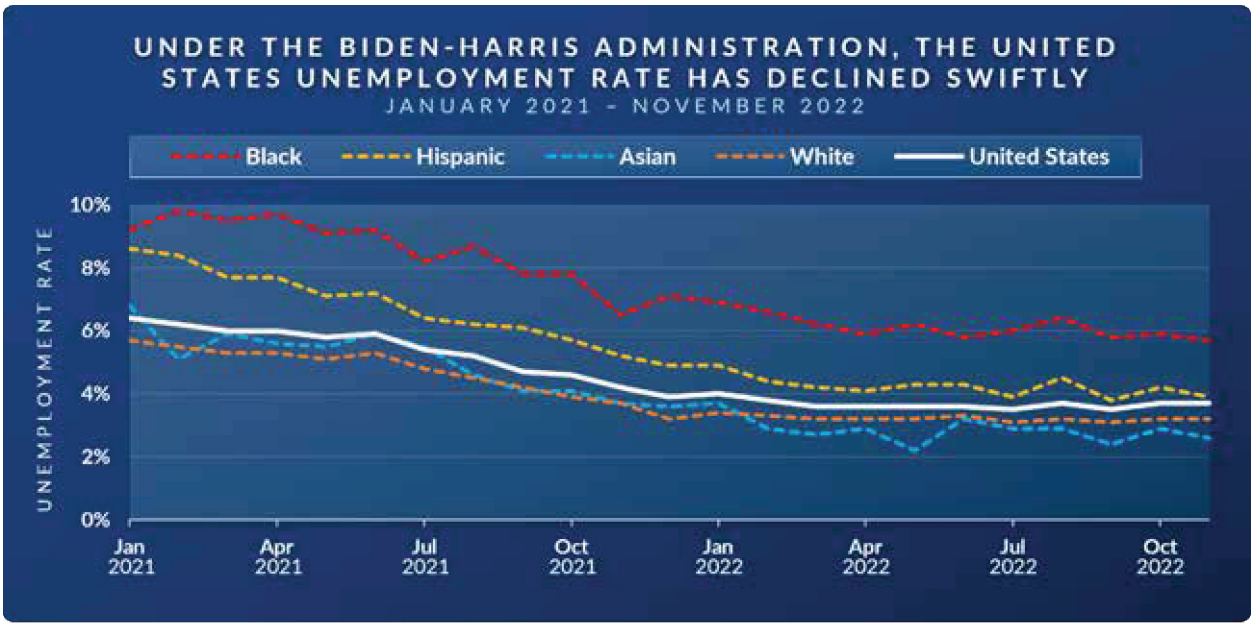
2. The Biden Administration's vaccine rollout and the American Rescue Plan supported a historically rapid jobs recovery that dramatically reduced unemployment and regained all the jobs lost at the onset of the pandemic.

In addition to providing desperately needed relief to reduce hardship, the Biden Administration and Congress also acted to ensure a rapid and equitable recovery of the millions of jobs lost during the coronavirus crisis. When the American Rescue Plan was enacted in March 2021, there were still 8 million fewer jobs than there had been at the onset of the pandemic a year prior.[733] But with the accelerated vaccine rollout led by the Biden Administration supported with ARP funds, and the ARP's relief and investment provisions, the United States has experienced a robust job recovery. Since January 2021, the country has added more than 10 million jobs,

surpassing the pre-pandemic total and regaining a historically low unemployment rate of 3.7%.[734]



This recovery has been particularly strong for Black and Hispanic Americans. The unemployment rate for Black Americans dropped from 10% in December 2020 to 5.7% in November 2022, and Hispanic Americans saw a similar decline from 9.4% to 3.9% in November 2022.[735] This rapid job growth has nearly returned the United States to full employment and has been widely credited with increasing worker power and affording more vulnerable Americans, including people with disabilities and prior criminal convictions, job opportunities.[736]



After shrinking by 3.4% in 2020, the economy grew by 5.7% in 2021.[737] Positive trends have generally continued, with real Gross Domestic Product estimated to have increased at an annual rate of 2.9% in the third quarter of 2022.[738]

III. Moving Forward: Recommendations for Continuing Ongoing Management of the Coronavirus and Preventing and Addressing Future Public Health and Economic Crises

A. Critical Investments Are Needed to Sustain the Ongoing Response to the Coronavirus, Reinvigorate a Chronically Underfunded Public Health Infrastructure, and Bolster the Nation's Ability to Prevent and Respond to Future Public Health Emergencies.

Decades-long underinvestment and longstanding health disparities left the nation's health care system and public health workforce inadequately prepared to respond to the coronavirus, exacerbating the pandemic's impact, particularly among communities of color, rural communities, and low-income communities. As the coronavirus continues to spread, it is important for the federal government to invest in new tests, treatments, and vaccines, help combat misinformation, and accelerate research and treatment into Long COVID. Policy changes and sustained investments are also critically needed to strengthen the nation's ability to prevent and respond to future public health crises. These measures include safeguarding scientific integrity, reinvigorating core public health programs, modernizing public health infrastructure, and addressing persistent health inequities.

1. A targeted bivalent booster campaign could prevent thousands of deaths and hospitalizations and save billions of dollars.

Despite the resounding evidence that the coronavirus vaccines authorized in the United States are safe and effective, millions of Americans are currently not up to date with their vaccines, including many who are only partially vaccinated or vaccinated but not yet boosted.[739] Earlier this year, FDA authorized updated mRNA bivalent booster shots developed by Pfizer and Moderna to target the Omicron BA.4/BA.5 subvariants.[740] According to FDA and CDC, these bivalent boosters offer better protection against Omicron subvariants than the original monovalent vaccines.[741] Yet uptake of these bivalent boosters has lagged with only 13% of adults having received a bivalent booster as of late November 2022.[742] With waning population immunity and the threat of new variants, surges in hospitalizations and deaths during the upcoming winter are increasingly likely.[743]

Recommendation: Increase bivalent booster uptake. Research shows that an aggressive booster campaign could prevent tens of thousands of deaths and hundreds of thousands of hospitalizations as well as generate billions of dollars in savings in direct medical costs by the end of March 2023.[744] The Biden Administration has dedicated significant resources to offer free bivalent booster shots at tens of thousands of locations across the country, including by standing up new community vaccination centers, focusing outreach to older Americans and immunocompromised individuals, and launching a comprehensive public education campaign with national and local organizations.[745]

2. Congress should act to accelerate next-generation coronavirus countermeasures.

Sustained investment in research and development of next-generation coronavirus vaccines and treatments will allow the country to pre-emptively combat a constantly evolving virus, rather than reactively respond to the newest variants or the effects of waning immunity.[746]

Recommendation: Accelerate the development of pan-coronavirus vaccines and nasal vaccines. Variants of the coronavirus have become more transmissible and immune evasive since the first strain reached the United States in early 2020.[747] While bivalent boosters perform well against currently circulating strains of the coronavirus, this effectiveness may wane over time as the virus continues to evolve. Experts have therefore called for a concerted mobilization to develop true next-generation vaccines, such as pan-coronavirus vaccines that target a wide range of variants and nasal vaccines that may better prevent transmission than intramuscular shots.[748] In recent months, China and India have approved and begun deploying nasal coronavirus vaccines. U.S. researchers have created several promising nasal vaccines that have been tested in animals, but these are still several years away from being deployed in the United States. Continued investments in vaccine research and development are necessary to decrease infections and reduce the spread of the coronavirus.[749]

Recommendation: Accelerate the development of new anti-viral treatments. The Biden Administration took significant action to accelerate the highly effective oral antiviral treatment Paxlovid to market by approximately seven months and to make the drug widely available for free. Although Paxlovid continues to serve as a powerful therapeutic, the overall number of effective treatment options has dwindled as the coronavirus mutated. FDA authorized six monoclonal antibody treatments for the coronavirus, but emerging strains of the Omicron variant have rendered these drugs less effective. FDA has rescinded each of these authorizations, meaning no more monoclonal antibody treatments remain available in the United States. FDA also recently announced that Evusheld, the monoclonal antibody prophylaxis used to prevent infection in immunocompromised individuals, may not be effective against circulating Omicron variants.[750] While immunocompromised patients who cannot take Paxlovid have other options, such as the antiviral drug remdesivir or convalescent plasma, these treatments are more complicated to administer and oversee, leaving some increasingly vulnerable.[751] Further, the coronavirus may continue to develop resistance to antiviral treatments like Paxlovid over time, underscoring the need to cultivate a robust pipeline of new effective treatment options without delay.[752]

Recommendation: Maintain testing capacity while developing better tests. The Biden Administration made investments that helped bring hundreds of millions of rapid at-home tests to households nationwide—offering Americans a convenient and efficient way to test themselves for the coronavirus, rather than traveling to testing sites and waiting for laboratory results to be processed and returned.[753] However, there is significant risk of backsliding on this progress. Without continued support from Congress, the nation's pandemic response will shift away from public countermeasures and instead rely on the commercial market for manufacturing, procurement, and pricing. This could lead to challenges if sufficient supplies are not available, likely curtailing access for those with limited resources.[754] The federal government should also

invest in and support the development of at-home tests that can detect a range of common respiratory viruses in addition to the coronavirus, like influenza and RSV.[755]

Recommendation: Promote ventilation and filtration systems. Improved ventilation and filtration systems—if deployed at scale—could contribute significantly to mitigating the spread of the coronavirus and other respiratory viruses, particularly during cold-weather seasons when people spend more time indoors.[756] The American Rescue Plan provided hundreds of billions of dollars for state and local governments and schools nationwide that could be used to improve indoor air quality.[757] Earlier this year, the Biden Administration launched the Clean Air in Buildings Challenge, a key component of President Biden's National COVID-19 Preparedness Plan. Recently, the Administration solicited public comments on actions, strategies, tools, and approaches that will lead to sustainable, systems-based improvements in the nation's building stock that can reduce disease transmission over the longer term.[758] The federal government must continue to support these efforts and ensure that the resources provided by Congress are used appropriately and expeditiously.

3. The federal government must evaluate its domestic manufacturing capabilities and investment in the nation's Strategic National Stockpile.

The Select Subcommittee's investigations have identified pre-pandemic lapses in infectious disease preparedness, which contributed to the federal government's inability in the early months of 2020—and beyond—to procure and distribute PPE and medical supplies vital to protecting Americans against the coronavirus.[759] The coronavirus pandemic highlighted challenges hindering the country's ability to mobilize domestic supply chains and maintenance of the SNS during a public health emergency. Ensuring that the United States is adequately prepared for a future public health crisis will require ongoing examination of and investment in the country's domestic manufacturing capabilities and operation of the SNS.

Recommendation: To ensure that the United States is adequately prepared for the next public health emergency, federal agencies must continue to evaluate the proper role of the SNS, including additional responsibilities related to emerging and infectious disease outbreaks. This may require incorporating new responsibilities to shape SNS operations, including managing the contracts, storage, and inventory requirements of new PPE, pharmaceuticals, and other products; rethinking the role of the SNS, especially areas outside its traditional work responsibilities such as supply chain management; hiring new staff with specific medical countermeasures and supply chain expertise; and improving coordination between government entities, domestic manufacturers, and public health experts to decide what is stocked in the SNS.[760]

By March 2020, as the virus spread around the world, numerous governments had placed export restrictions on PPE, which in turn contributed to higher costs and greater supply shortages. The United States—as the world's largest importer of PPE—was highly susceptible to, and acutely felt, the harm caused by these supply shortages.[761] Severe shortages of PPE and other medical supplies throughout 2020 underscore the need for significant changes and corrective actions to ensure that Americans have access to needed supplies in the event of a future public health

emergency. The pandemic also served as a catalyst for examining SNS operations moving forward. The near depletion of PPE in the SNS inventory early in the pandemic response raised questions about the role, transparency, and inventory of the SNS during a nationwide public health threat.

Recommendation: Congress should ensure that sufficient funds are allocated to adequately stock necessary supplies in the SNS, cover the costs of ongoing responsibilities such as maintenance and replenishment for medical countermeasures, and allow for shifting investments and resources as appropriate. To better protect health care workers and all Americans in the event of another crisis, policymakers should consider strategic industrial policy to increase domestic manufacturing of PPE and medical supplies, reduce the nation's dependence on the global supply chain for PPE, and generate effective institutional capacity to quickly mobilize domestic supply chains in the event of a public health threat.[762] The bipartisan Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act (or the PREVENT Pandemics Act), introduced in March 2022, focuses on strengthening the nation's public health and medical preparedness and response systems in the wake of the coronavirus pandemic. Of particular importance, the PREVENT Pandemics Act seeks to strengthen supply chains and government stockpiles of medical products and improve coordination among public health preparedness agencies.

The Select Subcommittee's investigations found that, due to the urgent need to obtain life-saving PPE during the pandemic and the widespread competition to obtain limited supplies, federal agencies expedited multimillion-dollar contracts to unvetted suppliers with minimal diligence—leading to greater risk of waste, fraud, and abuse of taxpayer resources. An effective medical supply chain—delivering the right item or service, at the right time, to the right place, at the right cost—would help ensure that federal agencies are prepared for future public health emergencies and positioned to carry out mission critical work.[763]

Recommendation: Federal agencies must review and close gaps in their diligence processes so they can more effectively identify bad actors before awarding procurement contracts. Federal agencies with significant needs for PPE and other critical medical supplies must be well prepared and have supplies stockpiled in advance of future public health emergencies so that they are not vulnerable to supply shortages and the heightened risk of waste, fraud, and abuse that follows. Federal agencies should also address longstanding supply chain management issues. For example, GAO added VA's acquisition management to its High-Risk list in 2019, yet the agency has made limited progress in addressing these challenges in the intervening years.[764] The vetting of any prospective federal contractors should include a careful consideration of a company's ability to perform under a contract. The Select Subcommittee's investigations into private companies like FGE and Emergent demonstrated how significant lapses in performance can waste millions of taxpayer dollars and raises questions as to whether additional federal contracting controls could have prevented such loss. Federal agencies must ensure they are adequately monitoring companies' compliance with and performance on government contracts. Congress must ensure that federal agencies have sufficient resources to address these challenges and prevent such widespread abuse in future crises.

4. Sustained, long-term investments are necessary to bolster the nation's public health infrastructure, modernize public health data collection, expand the public health workforce, and protect public health officials from attacks.

The Select Subcommittee's September 29, 2021, hearing on "Upgrading Public Health Infrastructure: The Need to Protect, Rebuild, and Strengthen State and Local Public Health Departments" made clear that the United States has failed to adequately invest in the nation's public health infrastructure and workforce for decades.[765] Chronic underfunding of core public health programs slowed the response to the coronavirus pandemic and exacerbated its impact among low-income communities, communities of color, and other populations with fewer resources needed during health emergencies. This resulted in a public health system with a declining workforce stretched thin long before the pandemic that could not address the nation's health security needs or its persistent health inequities.[766]

a. The federal government must invest in core public health infrastructure.

Recommendation: Congress should increase funding for federal, state, local, tribal, and territorial public health agencies, ensuring that it is predictable from year to year. Billions of dollars in relief funding have been made available during the pandemic, but most of it has been geared toward stemming the emergency, rather than building long-term capabilities. Government funding for core public health functions is grossly insufficient. Many experts agree that $4.5 billion of new and permanent annual funding—an investment of $32 per person—is needed to ensure equitable and sustained foundational public health services for all.[767]

Substantially increasing core public health funding would give public health departments the tools they need to control outbreaks of infectious diseases, reduce injuries, prevent chronic illness, enhance access to the health care system, protect the health of families and children, and respond to emergencies.[768] Increased funding would reinvigorate key public health and emergency preparedness programs that have experienced budget cuts over the years, such as the Prevention and Public Health Fund, the Hospital Preparedness Program, and the Public Health Emergency Preparedness Cooperative Agreement.[769] Additional funding from Congress could also support the expansion and modernization of state and local public health laboratories, which would improve testing and response capacity, genomic sequencing of pathogens, and biosecurity capacity.[770] Experts testified to the Select Subcommittee during its September 29, 2021, hearing that sustained, predictable, and robust investments—decoupled from disease-specific program lines—are critical to achieving federal public health goals.[771]

c. The federal government must modernize public health data collection and improve the nation's disease surveillance infrastructure.

Recommendation: Invest in modernizing public health data systems to make them more flexible, dynamic, and interoperable. Public health requires modernized data systems that

both communicate with other systems and include sufficiently detailed and actionable information. Congress should grant CDC the authority to require standardized data collection within and across localities and to coordinate and compel data-sharing.[772] Both federal and state governments need sufficient, ongoing funding to ensure they have the technology and data systems necessary to carry out critical functions.

Accurate and timely data and a robust public health surveillance infrastructure are critical to monitoring the spread of infection and disease progression and responding to health emergencies. CDC, for example, uses numerous surveillance systems to collect, analyze, share, and publish data on coronavirus cases, deaths, test results, hospitalizations, and vaccinations from hospitals, health care providers, and laboratories. However, CDC relies on health departments and health care facilities to collect and voluntarily report this data.[773] As a result, the nation's response to the coronavirus crisis was weakened by fractured and outdated public health data infrastructure.[774]

GAO has identified numerous longstanding challenges in the federal government's management of public health data, including: the lack of common data standards, which leads to inconsistent data and challenges in identifying or analyzing trends; the lack of interoperability among different public health data systems, which slows down decision-making when health officials and hospitals must manually input data into multiple systems; and the complete lack of a public health IT infrastructure, which forced some states in the early stages of the pandemic to manually collect, process, and transfer data from one place to another—sometimes by fax machine.[775] HHS OIG has also identified limitations in how CDC collected racial, ethnic, and socioeconomic data during the pandemic, which could make understanding and addressing disparities more difficult.[776] Public health surveillance systems lack timely and reliable data to protect against health threats.[777]

Congress has provided $1.1 billion to CDC in support of the agency's Data Modernization Initiative, which will improve data collection and sharing, strengthen data reporting and analytics, and advance surveillance to monitor the spread of the coronavirus and other public health threats. One goal of this initiative is to make important data, including racial and ethnic data, more complete. Similarly, CDC's newly created Center for Forecasting and Outbreak Analytics will improve the government's ability to forecast and model emerging health threats, expand collaboration by increasing capacity for data-sharing and interoperability, and support policymakers by communicating forecasts to inform decisions.[778]

Wastewater surveillance is a promising infectious disease surveillance tool that can help scientists track how viruses evolve and mutate and inform the location of testing and vaccination sites as well as the distribution of resources to areas of need.[779] Yet some experts have observed that the national reporting system for collecting and testing samples from wastewater treatment systems for the coronavirus remains limited, uncoordinated, and insufficiently standardized for a robust national surveillance system.[780]

Both GAO and HHS OIG have recommended actions CDC must take to ensure its data modernization efforts reach their full potential. Health departments need access to affordable, standardized software and data. The United States needs to fully modernize its public health data

systems not just at the federal level, but all the way down to the local health department level, so that officials can use timely, comprehensive data to educate the public and inform policymaking.[781]

c. The federal government must invest in the public health workforce.

Recommendation: Make sustained investments to grow a culturally competent workforce trained in surveillance and detection, risk communications, laboratory science, data systems, and disease containment. Experts testified to the Select Subcommittee during its September 29, 2021, hearing that state and local health departments often struggle to attract competitive candidates and fresh talent in today's job market. Further, the provision of short-term, emergency funding leads to boom-and-bust cycles, where public health agencies and departments hire staff but then do not have the funds to keep them permanently and cannot invest or plan for long-term challenges.[782]

It is important to incentivize public health workers to join and remain in the workforce as well as to build strategic partnerships and training pathways that can be leveraged during emergencies to meet surging demand for workers.[783] These recruitment and retention efforts must recognize that communities will typically be best served by public health workers who are from those communities; it is therefore important to raise awareness and interest in public health professions among underrepresented groups, expand recruitment, and create pipeline programs in underserved communities. Experts testified to the Select Subcommittee in September 2021 that increased funding should support training for those with an interest in public health careers as well as those at risk for leaving for other sectors of the economy.[784]

Congress and the Biden Administration have made strong investments in the nation's public health workforce through the American Rescue Plan. For example, the Administration invested $7.4 billion from the American Rescue Plan to train and recruit public health workers to respond to the pandemic and prepare for future public health challenges.[785] The American Rescue Plan also provided a total of over $1.1 billion for community health, outreach, and health education workers—the largest ever one-time investment in the nation's community health workforce.[786] While these funds were critical in addressing acute workforce shortages after years of budget cuts, emergency funding cannot replace or address systemic weaknesses created by 20 years of underinvestment in state and local public health departments across the country.[787] Rather than continuing to deprioritize public health funding in normal times and then scrambling during a crisis, the federal government should make forward-looking investments to strengthen public health infrastructure and the public health workforce.[788]

4. *The federal government must take action to protect public health institutions from political interference.*

The Select Subcommittee's investigations found extensive evidence that the Trump Administration engaged in a persistent pattern of political interference in the nation's pandemic response, prioritizing politics over protecting American lives. The Select Subcommittee also held a number of hearings to explore these issues. For example, the Select Subcommittee's April 29, 2022, hearing on "Ensuring Scientific Integrity at Our Nation's Public Health Agencies" detailed

how political interference by the Trump Administration led to the suppression and alteration of accurate scientific information. Witnesses from GAO, including the Honorable Gene L. Dodaro, Comptroller General of the United States, testified that career scientists feared retaliation and doubted whether appropriate action would be taken. Other witnesses, including a former Editor-in-Chief of CDC's MMWR series, testified that this assault on science undermined Americans' trust in public health institutions—leaving the nation vulnerable to misinformation and future public health threats.[789]

Dr. Birx also testified before the Select Subcommittee on June 23, 2022, on how President Trump's failure to accurately and effectively communicate the severity of the coronavirus hampered the country's ability to prepare for and respond to the pandemic. Dr. Birx testified that the former President's reelection campaign and efforts to overturn the election results distracted the White House and detracted from the pandemic response, and that the Trump Administration justified its disastrous handling of the pandemic response by relying on misinformation, rather than sound science.[790] More must be done to protect science from political interference and restore public trust in public health institutions.

Recommendation: Federal agencies must ensure that scientific decision-making is protected from political interference. During the Select Subcommittee's April 29, 2022, scientific integrity hearing, witnesses discussed multiple recommendations for how HHS can improve its response to public health emergencies, strengthen public trust, ensure scientific integrity, and safeguard against political interference. Numerous career scientists at CDC, FDA, and NIH reported that political interference in scientific decision-making resulted in the alteration or suppression of scientific findings during the coronavirus pandemic, but that they did not report these incidents because they "feared retaliation," "thought leadership was already aware," or were "unsure how to report issues."[791] To prevent a future recurrence, HHS can develop procedures and train staff on reporting and addressing political interference. If officials contemplating political interference within scientific decision-making are aware that it will be reported, they will be less likely to engage in it.

6. Combating health misinformation requires dedicated federal resources and a multi-pronged approach that supports public health officials and emphasizes oversight and accountability.

The Select Subcommittee's hearings and investigations highlighted how the spread of misinformation regarding the coronavirus and coronavirus vaccines undermined the nation's response to the pandemic and cost American lives. Government officials, social and traditional media companies, public health officials, and other stakeholders must work together to identify and limit the spread of misinformation while also maintaining flexible policies that are not overly restrictive, change as new information emerges, and balance the rights of individuals to express themselves.

Recommendation: Modernize public health communications to ensure critical information is accessible to all Americans, including communities that are often missed or ignored.[792] Americans must have access to and trust in accurate public health information. However, during the pandemic, public health messages did not resonate with certain communities,

particularly those whose trusted voices were spreading misinformation. Federal agencies must increase resources and technical assistance to state and local public health agencies to help better address misinformation, increase investment in research on misinformation, and expand efforts to educate the public on how to recognize misinformation as well as how it spreads.[793]

Expert testimony provided to the Select Subcommittee described how misinformation "seeds doubt and skepticism in the minds of people that may be less likely to understand or believe reputable research" and "can cause direct patient harm."[794] Rebuilding an infrastructure of trust is vital for many Americans who feel like they have no trusted messengers. Surgeon General Dr. Vivek Murthy issued a formal advisory in July 2021 declaring misinformation a serious public health threat and recommending that the federal government convene federal, state, local, territorial, tribal, private, nonprofit, and research partners to explore the impact of misinformation, identify best practices to prevent and address it, issue recommendations, and find common ground on difficult questions.[795] Similarly, the Presidential COVID-19 Health Equity Task Force issued a report in November 2021 highlighting the threat posed by coronavirus misinformation and recommending that the federal government "lead a multipronged, public-private awareness, education, and communications campaign focused on clarifying misinformation associated with vaccines and rebuilding trust in government," particularly in communities of color and other underserved populations.[796]

Recommendation: Examine opportunities to protect the public health workforce, including by establishing a national reporting system for incidents of violence against public health officials and providing legal protections for workers facing harassment and violence. Johns Hopkins Bloomberg School of Public Health identified 1,500 incidents of harassment and violence against public health workers across the nation between March 2020 and January 2021. Dr. Resnick, Senior Scientist at Johns Hopkins, elaborated on this research during a September 29, 2021, Select Subcommittee hearing, testifying that many public health officials were leaving their jobs in the wake of these attacks and harassment. Dr. Resnick noted that her research team had identified over 300 leadership departures from state and local health departments during the same time frame.[797] These threats—and other efforts to delegitimize officials' expertise during health emergencies—erode confidence in public health professionals and will make it harder to control the spread of illness and disease in the future. Congress may consider requiring state and local monitoring and mandatory reporting of incidents of violence against state and local public health workers for performing their official duties. The federal government could also implement legal strategies and fund incentives to support strong public health authorities at the state and local levels, and support state and local prosecutors to use existing statutes and legal protections, as appropriate, to prosecute those who threaten violence against state and local public health workers.[798] State and local public health workers need more support from local, regional, and federal leaders—borne out in policies that recognize their expertise and provide enhanced resources to continue to combat the coronavirus and prepare for future pandemics.[799]

Recommendation: Explore opportunities to limit the spread of misinformation. Experts testified to the Select Subcommittee during a November 17, 2021, hearing on "Combating Coronavirus Cons and the Monetization of Misinformation" that the federal government should strengthen consumer protections within the virtual world to protect against fraud victimization and recommended investigations and possible repercussions for those who consistently propagate viral

vaccine misinformation, especially those who do so for personal gain.[800] As one expert testified, the pandemic created "an opportune environment for fraud to proliferate" and that "the harms that come from [coronavirus-related] fraud … are not equally distributed throughout society and the focused nature of them can create disproportionate harms within those marginalized communities."[801] Of course, when misinformation is spread in furtherance of fraud, the fraud is illegal and should be prosecuted.

In the absence of fraud, using governmental action to combat misinformation is rightly limited by the First Amendment, but the misinformation can still cause significant harm. Opportunities may exist for the federal government to act to protect Americans without infringing First Amendment rights. Most major platforms utilize algorithms that manipulate what people see online—often feeding misinformation to users without their seeking it out purposely.[802] The Protecting Americans from Dangerous Algorithms Act, introduced in 2021, would remove platforms' existing liability protections for the algorithmic promotion of content (while maintaining the liability protections for hosting non-promoted content).

Social media companies are not bound by the First Amendment and should act responsibly to minimize the spread of misinformation on their platforms. Dr. Murthy's July 2021 health advisory also recommended that technology platforms strengthen the monitoring of misinformation; prioritize early detection of misinformation super-spreaders and repeat offenders; evaluate the effectiveness of internal policies and practices in addressing misinformation and be transparent with findings; and amplify communications from trusted messengers and subject matter experts.[803] Additional oversight and enforcement is needed to understand and address the substantial impact of misinformation.[804]

7. The federal government should take urgent action to mitigate the health and economic impacts of Long COVID.

Recommendation: Congressional action is needed to ensure that individuals with Long COVID can access the care they need. Multiple pieces of legislation have been introduced in both the House and the Senate that would authorize funding and programs to help public health officials and providers better understand Long COVID and provide critical services for affected individuals. For example, the Targeting Resources for Equitable Access to Treatment (TREAT) for Long COVID Act would support and expand Long COVID clinics that are stretched to maximum capacity—alleviating long wait times and increasing access to care. Dr. Monica Verduzco-Gutierrez testified to the Select Subcommittee during a July 17, 2022, Select Subcommittee hearing on "Understanding and Addressing Long COVID and Its Health and Economic Consequences" that the "multidisciplinary, organized care" offered by Long COVID clinics is vital to patients suffering from Long COVID but that accessing these clinics can be difficult, expensive, and "a barrier for many." Ms. Hannah Davis, Co-founder of the Patient-Led Research Collaborative, also testified that "Long COVID clinics are extremely necessary," but that "the vast majority of patients who can't get into these clinics are socioeconomically disadvantaged patients and women." According to Dr. Verduzco-Gutierrez, "the most vulnerable with the most barriers to access to care will be at increased risk of disability and poor outcomes" from Long COVID.[805]

If enacted, the TREAT Long COVID Act would also: authorize funding to establish new multidisciplinary clinics; prioritize funding for providers that engage with medically underserved populations and those disproportionately impacted by the coronavirus; ensure Long COVID treatment; and encourage ongoing medical training for physicians in Long COVID clinics and other health care providers. Other legislation, such as the Comprehensive Access to Resources and Education (CARE) for Long COVID Act, would advance critical research, authorize a patient registry developed by HHS, collect data through Medicaid on items and services furnished to beneficiaries with Long COVID, and authorize a grant program to support legal and social service assistance for individuals with Long COVID.

Recommendation: In addition to expanding and improving clinical care access and quality, the federal government should expedite and fund clinical treatment trials and educate health care providers and the public on Long COVID. Ms. Katie Bach testified to the Select Subcommittee that the federal government must also work to better understand and reduce the economic burden of Long COVID, stating that "there is essentially no way this could not have a significant impact on the economy." Both Ms. Bach and Ms. Davis recommended critical interventions the federal government could support, including paid sick leave, greater access to Social Security Disability Insurance, related Medicare benefits, and financial assistance, improved employer accommodations, and better data collection to fully assess the labor market and public health impacts of Long COVID and to track the efficacy of any interventions.[806]

8. The federal government must collaborate with global partners and make sustained investments to be better prepared to prevent and respond to future global health emergencies.

Recommendation: The federal government should increase its collaboration with international partners to strengthen its ability to protect people from future threats and mount a coordinated, effective, and equitable response to major global health crises when they do occur. The coronavirus pandemic has demonstrated just how crucial multilateral institutions and worldwide cooperation are to our collective health, prosperity, and security. In response to the coronavirus pandemic, several international initiatives have been proposed to strengthen and reform the global architecture for pandemic preparedness and response, including suggestions for a pandemic treaty, a global pandemic fund, and mechanisms for equitable access to medical countermeasures. These initiatives seek to make use of crucial lessons gleaned from the ongoing pandemic by addressing gaps in health security and traditional public health functions. The Biden Administration recently requested funding from Congress to combat the virus globally by supporting vaccine uptake and expanding access to treatments and testing, stating that a failure to provide more funding "would lead to needless infections and deaths across the nation and around the world."[807]

Dr. Krishna Udayakumar, founding Director of the Duke Global Health Innovation Center, testified before the Select Subcommittee in December 2021 that there is a continuing need for "bold American leadership" in response to the coronavirus, stressing that the global pandemic has been "both an international humanitarian crisis and also a threat to our own nation's security, health, and economic interests."[808] One fact remains certain: pandemics know no borders. While significant progress has been made in the fight against the coronavirus, sustained Congressional

support is critical to a full domestic and global recovery. The United States cannot fully emerge from the coronavirus pandemic until the whole world emerges.

Recommendation: Congress must pass legislation to ensure government institutions and public health agencies are fully equipped to prevent and respond to future challenges. Many provisions contained in the PREVENT Pandemics Act represent necessary and important steps for preventing and responding to future public health crises and would improve capabilities to detect and monitor emerging infectious diseases and other threats; enhance the development and review of tests, treatments, and vaccines; improve public health communication and address misinformation; and address disparities that make public health emergencies harder on at-risk populations and communities.[809]

B. Critical Changes Must Be Made to Ensure that Responses to Future Crises Assist Working Americans Equitably, to Decrease Our Economic Vulnerabilities to Future Crises in the First Place, and to Guard the Integrity of Relief Programs.

The coronavirus crisis exposed and exacerbated vulnerabilities and inequities in our economy. Even though the robust relief delivered by pandemic legislation compensated for these weaknesses to reduce suffering and foster a rapid recovery, long-term structural changes are necessary to make our economy more equitable and resilient. From strengthening unemployment insurance systems and programs that deliver crisis relief, to improving the sustainability and affordability of key sectors like child care and housing, to ensuring broad and equitable access to paid sick and medical leave and credit, long-term changes are required to allow our economy to weather future crises and to support working families. These changes will also strengthen program integrity and ensure that aid goes to Americans in need rather than to bad actors seeking ill-gotten gains.

1. The federal government must take proactive steps to ensure equitable access to relief programs.

The Select Subcommittee's work has identified significant underlying inequities in access to federal relief programs through traditional pathways, such as IRS processes and private financial institutions. Both in advance of and then during any future crisis, the government must take proactive steps to reach already underserved individuals and businesses who may not be reached by traditional means.

a. <u>The federal government must maintain means of reaching non-filers, who are likely to be the lowest-income and most needy Americans.</u>

Recommendation: In advance of future emergencies, the federal government should assess and improve its ability to distribute emergency federal relief equitably, particularly to the lowest-income Americans who are extraordinarily vulnerable to disasters. These efforts should include plans for emergency information-sharing across federal and state benefit programs and databases that typically do not interact. When emergencies arise, the federal

government must also prioritize clear and rapid communication to underserved Americans to ensure they are aware of their eligibility, regardless of their tax filing status. Among other improvements, universal access to broadband internet would help to facilitate rapid contact with Americans in rural areas and less-wealthy urban areas, who may then access online tools similar to those created by the IRS for non-filers to apply for and receive EIPs. The investments included in the Bipartisan Infrastructure Investment and Jobs Act will enable significant progress in this area.

Expert analyses and testimony provided to the Select Subcommittee indicate that CARES Act and American Rescue Plan relief provisions—particularly direct payments such as EIPs and the Child Tax Credit—dramatically and immediately reduced household food insecurity rates during a period of economic crisis.[810] However, millions of low-income Americans who do not file taxes and do not access certain other federal benefit programs may have missed out on timely payments, if not failed entirely to receive relief for which they were eligible.[811] At the Select Subcommittee's urging, the IRS identified nine million non-filers who had not yet received an EIP in September 2020, and agreed to notify them on an accelerated timeframe of their eligibility.[812] It is nevertheless virtually certain that many Americans were passed over for much-needed relief payments. Such exclusion must never be repeated.

b. <u>When the government relies on private actors to manage relief programs, it must structure relief programs to maximize equity and conduct rigorous program oversight.</u>

Recommendation: If the federal government continues to leverage private-sector institutions to implement relief programs, it must tailor such programs more effectively from the outset to prioritize businesses or workers who lack other means of accessing credit. So long as inequities persist in the private sector, the government should pair any delegation to private actors with rigorous oversight to ensure that profit motives do not interfere with the primary goals of the program. Outside of any crisis, the government should also conduct ongoing work to improve equitable access to credit across the financial sector.

The Select Subcommittee's examination of SBA programs illuminated how systemic inequities in the financial system created obstacles to aiding workers and small businesses at risk. For example, contrary to the intent of many of its proponents, the Paycheck Protection Program initially benefited mostly larger businesses, which had the inherent advantage of being established banking customers, and which banks appeared to prefer due to the program fee structure (which initially awarded higher fees for larger loan values).[813] The Trump Administration also failed to push banks to administer the program more equitably, and even originally encouraged them to serve larger businesses first.[814] At least some lenders accordingly delivered PPP relief faster for wealthier businesses than for the neediest small business applicants.[815] An independent study by the National Community Reinvestment Coalition (NCRC) further found that black small business owners and women received less assistance and information from lenders to aid in accessing PPP loans than white male business owners.[816] A Federal Reserve Bank of New York study similarly found that areas with high concentrations of black-owned businesses received disproportionately little PPP relief in the early months of the pandemic.[817] Meanwhile, 75% of loans in PPP's first phase went to businesses in majority-white census tracts (where only 8% of the population

lives).[818] The Biden Administration took aggressive action to remedy these inequities in pandemic relief programs, including with supplemental EIDL grants for disadvantaged communities and a PPP priority period for the smallest businesses.[819] PPP fee structures were also later adjusted to incentivize lending to smaller businesses.[820] However, SBA did not pair these improvements with sufficient oversight of new, unregulated loan facilitators, which ostensibly entered the program to help underserved markets.[821] Limited and inequitable access to traditionally regulated sources of capital in the financial sector therefore contributed to significant waste of taxpayer dollars through unvetted newcomers.[822]

2. It is essential to improve and maintain the infrastructure to deliver critical relief effectively, efficiently, and equitably in a crisis.

The Select Subcommittee's hearings, investigations, and briefings have repeatedly made clear that it is important for Congress, as well as state and local governments, to support the improvement and maintenance of the infrastructure needed to deliver critical relief in a crisis. Unemployment insurance, newly created emergency rental assistance programs, and Small Business Administration relief programs like EIDL are vital components of this infrastructure and must be maintained and strengthened.

a. Congress should support state and local governments' maintenance of the emergency rental assistance programs created with pandemic assistance, while also making other crucial investments in housing security.

Recommendation: Now that state and local governments have created the infrastructure for distributing emergency rental assistance, Congress should support its permanent maintenance so that in future crises aid can be delivered in a timely manner, and to provide a consistent, effective lifeline to prevent evictions and homelessness. To prevent millions of Americans from losing their homes as a result of the economic fallout of the coronavirus crisis, Congress took decisive action to appropriate more than $46 billion in emergency rental assistance to help impacted tenants. Unfortunately, because state and local rental assistance programs had to be created from scratch to distribute the assistance in early 2021, it took many tenants far too long to receive needed assistance.[823] Permanent programs would provide the infrastructure to prevent such delays in future crises.

The National Low-Income Housing Coalition (NLIHC), which has studied the functioning of emergency rental assistance programs, explained to Select Subcommittee staff during a briefing that Congress could effectively build on the progress made during the pandemic by providing ongoing funding to the rental assistance programs that have been created with pandemic relief funds. NLIHC also offered that a permanent program could also provide centralized technical support to state and local programs, including in the form of standard technology, forms, and basic policies.[824] To prepare for future crises, a permanent program could contain provisions that allow for increased eligibility and larger benefits during times of crisis, with assistance targeted to the lowest income renters under normal conditions.

State and local governments could also be encouraged to continue innovative strategies to improve the effectiveness of rental assistance programs, such as through outreach and the

development of eviction diversion programs. The Select Subcommittee's pandemic evictions investigation identified the troubling practice of large landlords filing to evict tenants with pending rental assistance applications.[825] NLIHC noted that some courts handling evictions had required landlords to confirm that tenants had not applied for rental assistance before filing to evict, a requirement that a permanent program could encourage state and local governments to adopt.[826]

b. Congress should make additional investments in housing to reduce Americans' vulnerability to losing their homes in future crises.

Recommendation: Congress can reduce Americans' vulnerabilities to losing their homes in a crisis by investing in housing affordability for lower-income American families—ensuring they have access to housing without having to pay more than 30% of their income. Congress should expand the number of Housing Choice Vouchers, which provide assistance so that renters only pay 30% of their income in rent, as current funding levels only allow about 25% of those eligible to receive assistance.[827] Congress should also invest in supporting more affordable housing construction for people at lower incomes, and in rehabilitating and preserving public housing units, because these forms of housing also reduce rent burdens and have rents that adjust downward when renters' incomes fall in a crisis.[828] Further, in light of abuses the Select Subcommittee identified in its investigation of corporate landlords' pandemic eviction practices, Congress should also consider increasing funding to provide tenants at risk of eviction with access to counsel by building on the $20 million it has appropriated annually for that purpose in recent years.[829]

Making these investments would reduce the number of families vulnerable to losing their homes in an economic downturn and would consequently reduce the strain on emergency rental assistance programs during a crisis. Existing vulnerabilities in our economy are one reason that as many as 12 million Americans were pushed to the brink of homelessness during the pandemic, and why such significant rental assistance was needed to avoid an eviction crisis.[830] Even before the pandemic, 48% of renter households were cost-burdened (paying more than 30% of their income in rent), putting the more than 50 million Americans at serious risk of losing their homes with an economic shock.[831] With the onset of the pandemic, tens of millions of American families experienced such a shock at once, threatening a systemic eviction crisis. In addition to direct investments in housing affordability, providing access to counsel has been associated with significantly lower eviction rates and improved success in obtaining emergency rental assistance.[832]

c. Congress should enact reforms to strengthen the unemployment insurance systems and continue investments to improve those systems.

Recommendation: Congress should take action to require or encourage states to reform their unemployment systems to reduce Americans' vulnerability in future crises. Congress can support these efforts by building on its $2 billion in funding in the American Rescue Plan for modernization and improvement of unemployment insurance systems, including by supporting the Biden Administration's request that Congress significantly increase grant funds to

support for state administration of unemployment insurance.[833] With this funding support, states must invest in creating programs that can more quickly deliver benefits to the unemployed while guarding against fraud. In light of GAO's finding that some states have significant racial disparities in approving benefits, Congress should consider requiring states to report additional data about claim processing. Congress should also encourage states not to impose overly strict eligibility requirements, provide a full 26 weeks of benefits, and increase minimum benefits so they are not so low that workers are pushed into poverty upon job loss. Congress should also consider how "gig economy" workers can be included in the unemployment insurance system so that quickly created programs like pandemic unemployment compensation are not required in the next crisis. Taking these steps would strengthen one of the most important systems for crisis response and would ensure a more rapid and equitable delivery of relief in the next crisis.

The Select Subcommittee's oversight work explored weaknesses in the unemployment systems operated at the state level, which required pandemic relief legislation to create a pandemic unemployment insurance program and to supplement state payments. Many states' unemployment insurance systems have very strict eligibility requirements that leave large shares of the workforce unprotected. Many also have outdated technical systems and a lack of administrative capacity that slows the processing of benefits in a crisis. Some states have significantly shortened the duration of benefits, and some states pay such small benefits that unemployed workers receive benefits below the poverty line. As the number of individuals working in the "gig economy" has grown, these weaknesses affect the economic security of millions of working Americans. Improvement and reforms are necessary to ensure adequate unemployment insurance benefits are delivered effectively, efficiently, and equitably in the next crisis.

d. Congress should consider action to improve the capacity of the EIDL program to handle large surges in a crisis.

Recommendation: Congress should provide SBA with resources to expand its capacity for a surge during a national crisis or catastrophe. This could include maintaining a larger staff trained in evaluating EIDL applications, as well as maintaining technological systems capable of handling enormous surges in loan application volumes. Improving this infrastructure would allow SBA to provide relief more quickly in the next crisis, with less fraud risk. SBA should plan for nationwide disasters and crises on an order of magnitude greater than the one million EIDL applications in a catastrophe that it planned for prior to the pandemic. This would include ensuring that it had trained staff, training materials, technological systems, and contractors capable of quickly surging capacity to handle millions of EIDL applications on a monthly basis.

The Select Subcommittee found that the EIDL program relied on a contractor that did not have capacity to scale dramatically in a crisis without relying on a subcontractor for almost all substantive work. Further, the Select Subcommittee found that EIDL application reviewers had minimal training, which increased the program's fraud vulnerabilities. SBA documents also revealed that the anticipated surge in applications in a crisis, only one million in 60 days, was much lower than occurred early in the pandemic.[834] SBA's original EIDL portal and processing system simply could not handle the influx, and a new system was constructed during the crisis.[835] Congress and SBA must work to ensure that these delays and fraud vulnerabilities do not recur in a future nationwide crisis.

3. Congress should take steps to protect and support workers.

The Select Subcommittee's hearings and investigations concerning worker well-being identified higher turnover and other clear disadvantages for the hourly workers, female workers, and workers of color who were most likely to serve as essential workers during the pandemic. They also confirmed that the pattern of workplace inequities that occurred during the height of the economic crisis largely predated the pandemic.[836] Achieving an equitable and more resilient economy will require permanent protections to ensure working Americans can support themselves and their families through times of personal or economic upheaval without being forced to leave the labor force.

a. Congress should enact a program guaranteeing universal paid sick, medical, and family leave.

Recommendation: Congress should advance economic recovery, equity, and public health preparedness by enacting a program of universal paid sick, medical, and family leave. Ensuring all working Americans have access to these forms of paid leave would improve the lives of the essential workers who were so vital during the coronavirus crisis, and would also promote a robust, equitable economic recovery. Moreover, expanding these forms of paid leave would also reduce vulnerabilities in future public health crises.

The Select Subcommittee consistently found that lack of access to paid sick, medical, and caregiving leave put workers in a position of economic precarity, while also making workplaces less safe as working people could not take time off when they were infected with or exposed to the coronavirus. This was the case for meatpacking workers, who the Select Subcommittee found suffered significant risks during the crisis, as well as workers in other industries.[837] The Select Subcommittee's survey of 12 major corporations found that workers without paid sick leave quit their jobs at far higher rates than workers with such leave during the first two years of the pandemic, indicating that the absence of sick leave harms workers forced to leave their jobs as well as the broader economy.[838] Workers who had access to and used paid family and caregiving leave also weathered the economic challenges without an increase in adverse employment outcomes and, benefiting employers, had higher retention rates than workers without such leave.[839] It is possible that these forms of leave during a public health crisis—where the need to take time for illness, the illness of a family member, or to care for children was significantly increased—reduced burnout and increased productivity.[840] Expanding paid sick and medical leave to ensure all workers have access to these critical benefits is a necessary step in building a more equitable economy that is resilient to crises and public health emergencies like the coronavirus pandemic.

A universal paid sick leave program would be particularly beneficial to essential lower-paid hourly workers, who often lack the ability to stay home when they or their family members are sick—even during a global pandemic. Ensuring that all American workers have access to these benefits would also enhance the nation's preparedness for any future health crises.

b. Congress should make sustained investments in the child care sector.

Recommendation: Congress should make a permanent investment in the child care sector to improve affordability for families, increase wages for caregivers and early educators, and expand the sector's capacity so child care challenges are not a barrier for parents' participation in the labor market.

The coronavirus pandemic has showed that women, who are most likely to have disproportionate caregiving responsibilities and be concentrated in low-wage and hourly jobs, are extremely vulnerable to job loss during a public health crisis and economic downturn. The Select Subcommittee's survey found that, in 2020, women working for hourly wages tended to experience worse employment outcomes than their male colleagues.[841] This was likely attributable in part to a steep reduction in the availability of child care, which created significant obstacles for working parents, particularly the mothers of young children.

The American Rescue Plan, and earlier the CARES Act and Consolidated Appropriations Act, 2021, provided tens of billions of dollars in critical relief to support the child care sector during the coronavirus crisis. These funds have provided crucial support for a sector that is unaffordable for many parents, but that also pays very low wages to its heavily female workforce that is disproportionately made up of women of color.[842] As Lynnette Fraga of Child Care Aware testified to the Select Subcommittee, these relief funds have provided a "lifeline" to the child care sector, supporting tens of thousands of child care providers.[843] But American Rescue Plan child care funds will run out after 2024, and child care will remain unaffordable for parents and unsustainably poorly compensated without further investment. As Dr. Lea Austin testified to the Select Subcommittee, child care workers have been "among the lowest-paid workers in every state with an average wage of about $12 an hour."[844] It is critical for parents, child care workers, and our economy as a whole that we expand investments in child care to ensure it is both affordable and high-quality so that a lack of child care does not prevent parents from participating in the labor force or children from receiving a strong start in life. As Professor Betsey Stevenson testified to the Select Subcommittee, investing quality, affordable child care both results in "higher lifetime earnings for the children," and counters "low labor force participation" of parents which is part of "the biggest economic problem the U.S. currently faces."[845]

Sustained investments are critical to an equitable economy today and in the future. Significant federal investment will allow parents who wish to participate in the workforce to do so, while also ensuring their children receive high-quality care and education that prepares them to contribute to the economy in the future. The same investments will also help remedy serious inequities by raising the wages in a critical sector predominantly employing women, and disproportionately women of color, at very low wages.

5. The federal government should build on improvements to its economic data collection tools.

Recommendation: Federal agencies should expand and improve their economic data collection tools and methods, building on advances in highlighting economic vulnerabilities and inequities.

The U.S. Census Bureau has obtained rapid, real-time data samples through the Household Pulse Survey in order to collect critical data during the pandemic, beginning in April 2020 and continuing today. Among other government and expert groups that leveraged this data to track the recovery, the Select Subcommittee monitored Pulse Survey data to assess the success of various federal relief programs in real time.[846] The data also helped to identify significant systemic inequities across race and gender lines in terms of the economic impacts of, and recovery from, the pandemic-induced economic downturn.

Other work by the Select Subcommittee highlighted the need for updates to federal data collection practices to monitor such inequities more effectively. For example, a number of companies surveyed by the Select Subcommittee did not track data on workers with certain protected characteristics, because such reporting was not required by the Equal Employment Opportunity Commission.[847] The lack of data on various protected demographic characteristics likely limits EEOC's ability to enforce civil rights law. By collecting data on additional protected characteristics—such as disability, sexual orientation, and gender identity—EEOC could better enforce the full range of federal laws protecting Americans from discrimination in the workplace, and help private companies identify areas where they may be falling short.

Additionally, if employers were required to report outcomes data—such as terminations, raises, and promotions—on data collection instruments (or even if employers were simply required to track and maintain such outcomes data in case of potential investigations), then EEOC, researchers, and employers would be better able to ensure not just that workplaces are hiring a representative number of people from various protected classes, but also that workplaces are treating protected employees equitably. Such data would also be helpful to employers who may better understand the impact of their workplace policies and practices by collecting and reviewing such data.

5. Future emergency programs must require that agencies implement reasonable fraud safeguards.

a. Congress, SBA, and the IRS must ensure that tax transcripts can be processed quickly in a crisis to provide a vital fraud control.

Recommendation: Congress must, as it has with the Inflation Reduction Act, continue to ensure the IRS has the resources to maintain the ability to surge the processing of partial tax transcripts for SBA's use to prevent fraud and ensure integrity in the EIDL program. SBA and the IRS should maintain the relationship and process they created during the

operation of pandemic programs so the EIDL program can effectively use partial tax transcripts in another crisis that results in a dramatic surge in the number of applicants for relief.

Both SBA and independent watchdogs have credited SBA's use of tax transcripts to verify EIDL applicants' information is not fraudulent as a critical change that reduced fraud against the program. In a briefing with the Select Subcommittee, SBA explained that it took time to work with the IRS to create a streamlined process for sharing these tax transcripts in partial form, which allowed SBA to both verify the existence of a business applicant and its recent revenues.[848] Congress and the Biden Administration have taken an important step to strengthen the IRS's ability to respond in a crisis by providing $33 billion for operations support, taxpayer services, and system modernization over the next decade, and continued support for the IRS's administrative capacity through the next crisis is vital.[849] Ensuring that SBA can quickly access partial tax transcripts from the IRS in a future emergency will allow the agency to deliver relief quickly with significantly lower fraud risks.

b. Rigorous oversight must be conducted of any private-sector entities involved in safeguarding taxpayer dollars from criminal actors.

Recommendation: Future relief programs must include proactive fraud controls, and to the extent that the federal government continues to delegate responsibilities for safeguarding taxpayer dollars to the private sector, rigorous vetting and oversight must be conducted of all entities acting in a position of public trust. The Select Subcommittee determined that unvetted and underregulated companies were given extraordinary responsibility in administering public relief programs, then either failed in effectively preventing fraud or abused the relief programs for personal gain.[850] Companies acting in a capacity that involves stewardship of taxpayer funds should be thoroughly reviewed to ensure that they have appropriate conflict-of-interest policies and procedures, well-developed mechanisms to identify and report fraud to law enforcement, management with appropriate qualifications and a history of business integrity, adequately developed governance structures, and sufficient capitalization and capabilities to achieve satisfactory performance.

Despite widespread reports of fraud in PPP loans, including concerns identified by the Select Subcommittee, [851] the SBA forgave many loans before reviewing them for eligibility and fraud. SBA OIG has previously "expressed concerns regarding the impact this change will have on SBA's ability to recover funds for forgiven loans later determined to be ineligible."[852] In any future relief programs involving forgivable loans, the SBA must ensure that loans are fully reviewed for eligibility and fraud before granting forgiveness so that taxpayer dollars are safeguarded, and fraudulent loans are identified for investigation and possible prosecution.

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[2] International Society for Infectious Diseases, COVID-19 (online at https://isid.org/2019-novel-coronavirus/) (accessed Dec. 7, 2022); How ProMED Crowdsourced the Arrival of Covid-19 and SARS, Wired (Mar. 23, 2020) (online at https://wired.com/story/how-promed-crowdsourced-the-arrival-of-covid-19-and-sars/).

[3] Centers for Disease Control and Prevention, CDC Museum COVID-19 Timeline (online at www.cdc.gov/museum/timeline/covid19.html); A Timeline of the Coronavirus Pandemic, New York Times (Mar. 17, 2021) (online at www.nytimes.com/article/coronavirus-timeline.html); U.S. Officially Surpasses 1 Million COVID-19 Deaths, Johns Hopkins Coronavirus Research Center (May 22, 2022) (online at https://coronavirus.jhu.edu/from-our-experts/u-s-officially-surpasses-1-million-covid-19-deaths).

[4] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Nancy Messonnier (Oct. 8, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.10.08%20SSCC%20Interview%20of%20Nancy%20Messonnier%20-%20REDACTED.pdf).

[5] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Anne Schuchat (Oct. 1, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.10.01%20SSCC%20Interview%20of%20Anne%20Schuchat%20-%20REDACTED.pdf).

[6] Id.

[7] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Robert Redfield (Mar. 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.03.17%20SSCC%20Interview%20of%20Robert%20Redfield%20-%20REDACTED.pdf).

[8] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Daniel Jernigan (Dec. 13, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.12.13%20SSCC%20Interview%20of%20Daniel%20Jernigan%20-%20REDACTED.pdf).

[9] Id.

[10] Id.

[11] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Robert Redfield (Mar. 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.03.17%20SSCC%20Interview%20of%20Robert%20Redfield%20-%20REDACTED.pdf).

[12] Id.; The Plague Year, New Yorker (Dec. 28, 2020) (online at https://newyorker.com/magazine/2021/01/04/the-plague-year).

[13] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Robert Redfield (Mar. 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.03.17%20SSCC%20Interview%20of%20Robert%20Redfield%20-%20REDACTED.pdf).

[14] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Robert Redfield (Mar. 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.03.17%20SSCC%20Interview%20of%20Robert%20Redfield%20-%20REDACTED.pdf); Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Nancy Messonnier (Oct. 8, 2021) (online at

https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.10.08%20SSCC%20Interview%20of%20Nancy%20Messonnier%20-%20REDACTED.pdf).

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[16] Id.

[17] Id.

[18] Id.

[19] Id.

[20] Id.

[21] Centers for Disease Control and Prevention, CDC Museum COVID-19 Timeline (online at www.cdc.gov/museum/timeline/covid19.html) (accessed Dec. 7, 2022).

[22] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Robert Redfield (Mar. 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.03.17%20SSCC%20Interview%20of%20Robert%20Redfield%20-%20REDACTED.pdf).

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[29] See, e.g., China Builds Hospital in 5 Days After Surge in Virus Cases, Associated Press News (Jan. 16, 2020) (online at https://apnews.com/article/beijing-health-coronavirus-pandemic-wuhan-china-c555525ecdaea032b6d1bc1ec2894513).

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https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.06.21%20The%20Trump%20Administration%E2%80%99s%20Embrace%20of%20a%20Dangerous%20and%20Discredited%20Herd%20Immunity%20via%20Mass%20Infection%20Strategy.pdf).

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[292] Id.

[293] Id.

[294] Id.

[295] Memorandum from Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis, to Members, Select Subcommittee on the Coronavirus Crisis, Issuance of Subpoena to Dr. Steven J. Hatfill (Sept. 23, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.09.23%20Memorandum%20from%20Chairman%20Clyburn%20re%20S.%20Hatfill%20Subpoena.pdf).

[296] Select Subcommittee on the Coronavirus Crisis, Transcribed Interview of Deborah Birx (Oct. 13, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.10.13%20Birx%20TI%20Transcript%20%2B%20Errata.pdf).

[297] Memorandum from Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis, to Members, Select Subcommittee on the Coronavirus Crisis, Issuance of Subpoena to Dr. Steven J. Hatfill (Sept. 23, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2021.09.23%20Memorandum%20from%20Chairman%20Clyburn%20re%20S.%20Hatfill%20Subpoena.pdf).

[298] Select Subcommittee on the Coronavirus Crisis, The "Atlas Dogma": The Trump Administration's Embrace of a Dangerous and Discredited Herd Immunity via Mass Infection Strategy (June 21, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.06.21%20The%20Trump%20Administration%E2%80%99s%20Embrace%20of%20a%20Dangerous%20and%20Discredited%20Herd%20Immunity%20via%20Mass%20Infection%20Strategy.pdf).

[299] Select Subcommittee on the Coronavirus Crisis, Press Release: Clyburn Launches Sweeping Investigation into Widespread Coronavirus Deaths in Nursing Homes (Jun. 16, 2020) (online at https://coronavirus.house.gov/news/press-releases/clyburn-launches-sweeping-investigation-widespread-coronavirus-deaths-nursing).

[300] Id. Two of these companies have made significant changes to their corporate structures since the Select Subcommittee's investigation began in June 2020. Sava owned or operated approximately 174 long-term care facilities in June 2020 but has since divested most of its facilities and retained operations over only 18 as of June 2022 and 12 as of November 1, 2022. Email from Executive Vice President for Compliance, Ethics and Customer Experience, SavaSeniorCare Administrative and Consulting, LLC to Majority Staff, Select Subcommittee on the Coronavirus Crisis (Nov. 1, 2022). Consulate's management company was dissolved after the company filed for bankruptcy in 2021. Six Nursing Home Entities File for Bankruptcy Following $258M FCA Ruling, McKnights Long-Term Care News (Mar. 4, 2021) (online at www.mcknights.com/news/six-nursing-home-affiliates-file-for-bankruptcy-following-258m-fca-ruling/). Consulate facilities that were initially the subject of the Select Subcommittee's investigation were dispersed across four different management companies as of August 2022, with some facilities having been divested to entirely different companies outside of the legacy Consulate corporate family. Post-bankruptcy data in this report includes data from facilities owned by four management companies. Letter from Counsel for Consulate Health Care, to Chairman James E. Clyburn, Chair, Select Subcommittee on the Coronavirus Crisis (Aug. 12, 2022).

[301] Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State, Kaiser Family Foundation (May 14, 2015) (online at www.kff.org/medicare/issue-brief/reading-the-stars-nursing-home-quality-star-ratings-nationally-and-by-state/); Atul Gupta, et al., Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes, New York University Stern School of Business (Nov. 2020) (online at

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3537612); Kai You, et al., Do Nursing Home Chain Size and Proprietary Status Affect Experiences with Care?, Medical Care (Mar. 1, 2016) (online at https://doi.org/10.1097%2FMLR.0000000000000479); Charlene Harrington, et al., Nurse Staffing and Deficiencies in the Largest For-Profit Nursing Home Chains and Chains Owned by Private Equity Companies, Health Services Research (Aug. 30, 2011) (online at https://doi.org/10.1111%2Fj.1475-6773.2011.01311.x).

[302] Centers for Disease Control and Prevention, National Center for Health Statistics, Long-term Care Providers and Services Users in the United States, 2015-2016 (Feb. 2019) (online at www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf).

[303] As Sava had divested all but 18 of its facilities by June 2022, selections were based on the company's remaining ownership.

[304] 'A National Disgrace': 40,600 Deaths Tied to US Nursing Homes, USA Today (June 1, 2020) (online at www.usatoday.com/story/news/investigations/2020/06/01/coronavirus-nursing-home-deaths-top-40-600/5273075002/); Centers for Medicare and Medicaid Services, COVID-19 Nursing Home Data as of Week Ending: May 31, 2020 (online at https://data.cms.gov/covid-19/covid-19-nursing-home-data); 10 Things About Long-Term Services and Supports (LTSS), Kaiser Family Foundation (Sept. 15, 2022) (online at www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/). See also Ram Gopal, et al., Compress the Curve: A Cross-Sectional Study of Variations in COVID-19 Infections Across California Nursing Homes, BJM Open (Jan. 5, 2021) (online at https://doi.org/10.1136%2Fbmjopen-2020-042804) (finding that as of May 1, 2020, the size of coronavirus outbreaks was 12.7 times larger in for-profit nursing homes in California than in their non-profit counterparts).

[305] Data on Coronavirus Infections and Deaths at Consulate Facilities as of June 2022 (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/Consulate%20COVID%20Incident%20Data%20%28Feb.%202021%29%20-%20SSOCC%20016132.xlsx and https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000002.xlsx) (Consulate data through February 2, 2021 may also include COVID-19 positive patients transferred from other facilities or hospitals to Consulate facilities.); Data on Coronavirus Infections and Deaths at Ensign Facilities as of June 2022 (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/ENSIGN-COVID-00009850.xlsx and https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/ENSIGN-COVID-00012403.xlsx); Data on Coronavirus Infections and Deaths at Genesis Facilities as of June 2022 (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/GEN_SSCC_0004663.xlsx and https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/GEN_SSCC_0004686.xlsx) (Genesis data includes coronavirus infections and death counts for all Genesis long-term care facilities, not limited to skilled nursing facilities, from the onset of the pandemic through October 22, 2020, and for skilled nursing facilities only from October 23, 2020, through June 30, 2022. Genesis' tally of coronavirus cases and deaths excludes those at facilities owned in part by Genesis but operated by other companies, or facilities not owned by Genesis but for which it has a consulting or management agreement.); Data on Coronavirus Infections and Deaths at Life Care Facilities as of June 2022 (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/LCCA-Congress010927_Confidential%20Commercial%20or%20Financial%20Information.ods); Data on Coronavirus Infections and Deaths at Sava Facilities as of June 2022 (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/COVID-19%20Cases%20and%20Deaths%20%28Item%208%269%29%20final%2011.1.22.pdf and https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/SAVA_00076811.xlsx).

[306] Email from Executive Vice President for Compliance, Ethics and Customer Experience, SavaSeniorCare Administrative and Consulting, LLC to Majority Staff, Select Subcommittee on the Coronavirus Crisis (Nov. 3, 2022).

[307] Consulate facilities that were initially the subject of the Select Subcommittee's investigation were dispersed across four different management companies as of August 2022, with some facilities having been divested to entirely different companies outside of the legacy Consulate corporate family. Post-bankruptcy data in this report

includes data from facilities owned by four management companies. Letter from Counsel for Consulate Health Care to Chairman James E. Clyburn, Chair, Select Subcommittee on the Coronavirus Crisis (Aug. 12, 2022).

[308] Centers for Medicare and Medicaid Services, COVID-19 Nursing Home Data (online at https://data.cms.gov/covid-19/covid-19-nursing-home-data) (accessed Dec. 7, 2022); Select Subcommittee on the Coronavirus Crisis, Press Release: Ahead of Hearing, Select Subcommittee Releases New Evidence of Dire Conditions at For-Profit Nursing Home Chains in 2020 (Sept. 21, 2022) (online at https://coronavirus.house.gov/news/press-releases/clyburn-corporate-nursing-home-pandemic-analysis).

[309] National Academies of Sciences, Engineering, and Medicine, The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff (Apr. 2022) (online at https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our).

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[311] 42 U.S.C. § 1395i–3(C)(i).

[312] Centers for Medicare & Medicaid Services, Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report (Dec. 24, 2001) (online at https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf). See also Charlene Harrington, et al., Appropriate Nurse Staffing Levels for U.S. Nursing Homes, Health Services Insights (June 29, 2020) (online at https://doi.org/10.1177%2F1178632920934785).

[313] Charlene Harrington, et al., The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes, Health Services Insights (Apr. 12, 2016) (online at https://doi.org/10.4137/hsi.s38994); Charlene Harrington, Nursing Home Staffing Standards in State Statutes and Regulations, University of California San Francisco (Jan. 2008) (online at www.justice.gov/sites/default/files/nursing_home_staffing_standards_in_state_statutes_and_regulations.pdf).

[314] Covid-19 Exposed the Devastating Consequences of Staff Shortages in Nursing Homes. But the Problem Isn't New, CNN (July 6, 2021) (online at www.cnn.com/2021/06/27/us/nursing-homes-staff-shortages/index.html).

[315] National Academies of Sciences, Engineering, and Medicine, The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff (Apr. 2022) (online at https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our).

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[317] Centers for Medicare & Medicaid Services, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Overview of the Phase II Report: Background, Study Approach, Findings, and Conclusions (Dec. 2001) (online at www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf).

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[320] Is Your Loved One's Nursing Home Staffed Well on Weekends? The Feds Want to Know, Tampa Bay Times (Dec. 3, 2018) (online at www.tampabay.com/health/is-your-loved-ones-nursing-home-staffed-well-on-weekends-the-feds-want-to-know-20181204/).

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[322] Weekends Are a Nursing Home Danger Zone. A Syracuse Home's Staffing Is Among NY's Worst, Syracuse.com (Feb. 14, 2022) (online at www.syracuse.com/health/2022/02/notorious-syracuse-nursing-homes-weekend-staffing-level-among-worst-in-new-york.html).

[323] Id.

[324] Fangli Geng, et al., Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations, Health Affairs (July 2019) (online at https://doi.org/10.1377/hlthaff.2018.05322).

[325] Ensign provided staffing data showing combined ratios for RNs and Licensed Practical Nurses (LPNs). As the training, certification, and skill sets of LPNs is lower than that of RNs, the combined data for these two categories does not present an accurate picture of RN-level resident care at Ensign facilities. CMS's 2001 study recommends different staffing ratios for LPNs than RNs, so measuring both of those categories against the benchmark for RNs alone presents a misleading picture of the quality of staffing at Ensign's nursing homes. See Centers for Medicare & Medicaid Services, Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report (Dec. 24, 2001) (online at https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf); Fangli Geng, et al., Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations, Health Affairs. (July 2019) (online at https://doi.org/10.1377/hlthaff.2018.05322). As a result, Ensign data was excluded from the analysis of RN staffing.

[326] Staffing Data at Sava Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/SAVA_00128296-SAVA_00128313_Redacted.pdf). An average staffing ratio of zero does not necessarily indicate that there were no RNs on staff over the relevant time period. Rather, it may be that there were so few RNs staffed in relation to the number of residents that the ratio of RNs to residents was less than 0.005, and thus would round to zero.

[327] Id.

[328] Staffing Data at Consulate Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000008%20Consulate%20Staffing%20Data_Redacted.pdf).

[329] Id. An average staffing ratio of zero does not necessarily—though may—indicate that there were no RNs staffed over the relevant time period. Rather, it may be that there were so few RNs staffed in relation to such a high number of residents that the ratio of RNs to residents was less than 0.005, and thus would round to zero.

[330] Staffing Data at Life Care Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/LCCA-Congress010739_CONFIDENTIAL_Redacted.xlsx).

[331] Staffing Data at Consulate Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000008%20Consulate%20Staffing%20Data_Redacted.pdf).

[332] Staffing Data at Consulate Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000008%20Consulate%20Staffing%20Data_Redacted.pdf); Staffing Data at Genesis Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/GEN_SSCC_0004688.xlsx); Staffing Data at Life Care Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/LCCA-Congress010739_CONFIDENTIAL_Redacted.xlsx); Staffing Data at Sava Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/SAVA_00128296-SAVA_00128313_Redacted.pdf).

[333] Ensign provided the Select Subcommittee staffing data showing ratios for RNs and Licensed Practical Nurses (LPNs) combined. See Staffing Data at Ensign Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/ENSIGN-COVID-00012402.xlsx). However, as the training, certification, and skill sets of LPNs are not interchangeable with those of RNs, the combined staffing for these two categories does not present an accurate picture of the level of staff dedicated to RN-level resident care at Ensign facilities. Moreover, CMS's 2001 study recommends different staffing ratios for LPNs than RNs, so measuring both of those categories against the benchmark for RNs alone presents a misleading picture of the quality of staffing at nursing homes. See, e.g., Centers for Medicare & Medicaid Services, Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II Final Report (Dec. 24, 2001) (online at https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf); Fangli Geng, et al., Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations, Health Affairs (July 2019) (online at www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.05322).

[334] Staffing Data at Consulate Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000008%20Consulate%20Staffing%20Data_Redacted.pdf); Staffing Data at Ensign Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/ENSIGN-COVID-00012401.xlsx); Staffing Data at Genesis Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/GEN_SSCC_0004688.xlsx); Staffing Data at Life Care Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/LCCA-Congress010739_CONFIDENTIAL_Redacted.xlsx); Staffing Data at Sava Facilities (Jan. 2020 - June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/SAVA_00128296-SAVA_00128313_Redacted.pdf).

[335] Pauline Karikari-Martin, Centers for Medicare & Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes (Aug. 22, 2020) (online at www.cms.gov/blog/centers-medicare-medicaid-services-staffing-study-inform-minimum-staffing-requirements-nursing-homes).

[336] The White House, Fact Sheet: Biden-Harris Administration Announces New Steps to Improve Quality of Nursing Homes (Oct. 21, 2020) (online at www.whitehouse.gov/briefing-room/statements-releases/2022/10/21/fact-sheet-biden-harris-administration-announces-new-steps-to-improve-quality-of-nursing-homes/).

[337] Inside the 'Staffing Apocalypse' Devastating U.S. Nursing Homes, AARP (June 9, 2022) (online at www.aarp.org/caregiving/health/info-2022/labor-shortage-nursing-homes.html),

[338] Bureau of Labor Statistics, National Industry-Specific Occupational Employment and Wage Estimates (May 2021) (online at www.bls.gov/oes/current/naics4_623100.htm#31-0000) (accessed Dec. 7, 2022); Nursing Homes Bleed Staff as Amazon Lures Low-Wage Workers with Prime Packages, Kaiser Health News (Dec. 23, 2021) (online at https://khn.org/news/article/nursing-homes-staff-shortages-amazon-lures-low-wage-workers/).

[339] Select Subcommittee on the Coronavirus Crisis, Briefing on "The Devastating Impact of the Coronavirus Crisis in America's Nursing Homes" (June 11, 2020) (online at https://coronavirus.house.gov/subcommittee-activity/briefings/devastating-impact-coronavirus-crisis-america-s-nursing-homes).

[340] PHI National, Direct Care Workers in the United States: Key Facts (Sept. 7, 2021) (online at www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2/).

[341] Employees Who Work at Multiple Nursing Homes May Have Helped Spread the Coronavirus, National Public Radio, (Oct. 24, 2020) (www.npr.org/2020/10/24/927384339/employees-who-work-at-multiple-nursing-homes-may-have-helped-spread-the-coronavi).

[342] Center for Medicare Advocacy, CDC's Report on Coronavirus in a Seattle Nursing Facility: What It Tells Us About Staffing Problems Nationwide; What We Must Do to Address Lessons Learned (Apr. 9, 2020)

(online at https://medicareadvocacy.org/cdcs-report-on-coronavirus-in-a-seattle-nursing-facility-what-it-tells-us-about-staffing-problems-nationwide-what-we-must-do-to-address-lessons-learned/).

[343] The Crisis Facing Nursing Homes, Assisted Living and Home Care for America's Elderly, Politico (July 28, 2022) (online at www.politico.com/news/magazine/2022/07/28/elder-care-worker-shortage-immigration-crisis-00047454); Inside the 'Staffing Apocalypse' Devastating U.S. Nursing Homes, AARP (June 9, 2022) (online at www.aarp.org/caregiving/health/info-2022/labor-shortage-nursing-homes.html).

[344] Pay data may not distinguish between direct employees and workers who are contractors or otherwise employed by nursing home staffing agencies. Agency-contracted staff do not necessarily get paid the same rates as full-time employees. Worker shortages during the pandemic have reportedly led to agency contract staff receiving substantially higher wages than their full-time facility employee counterparts. See Beyond the Byline: Providers Accuse Staffing Agencies of Price Gouging, Modern Healthcare (Mar. 17, 2022) (online at www.modernhealthcare.com/labor/beyond-byline-providers-accuse-staffing-agencies-price-gouging); Pressures Mount for Staffing Agencies Accused of Price Gouging Long-Term Care Operators, McKnight's Senior Living (Jan. 31, 2022) (online at www.mcknightsseniorliving.com/home/news/pressures-mount-for-staffing-agencies-accused-of-price-gouging-long-term-care-operators/). Genesis wage data begins in June 2020; wage data for all other companies begins in January 2020.

[345] Centers for Medicare and Medicaid Services, COVID-19 Nursing Home Data (online at https://data.cms.gov/covid-19/covid-19-nursing-home-data) (accessed Dec. 7, 2022). See also Select Subcommittee on the Coronavirus Crisis, Press Release: Ahead of Hearing, Select Subcommittee Releases New Evidence of Dire Conditions at for-Profit Nursing Home Chains in 2020 (Sept. 21, 2022) (online at https://coronavirus.house.gov/news/press-releases/clyburn-corporate-nursing-home-pandemic-analysis).

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[347] Wage Data at Consulate Facilities (Jan. 2020 – June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000011_Redacted.pdf); Wage Data at Ensign Facilities (Jan. 2020 – June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/ENSIGN-COVID-00012400.xlsx); Wage Data at Genesis Facilities (June 2020 – June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/GEN_SSCC_0004684_Redacted.xlsx); Wage Data at Life Care Facilities (Jan. 2020 – June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/RedactedLCCA-Congress010662_SENSITIVE%20PERSONAL%20INFORMATION%20AND%20CONFIDENTIAL%20COMMERCIAL%20OR%20FINANCIAL%20INFORMATION.xlsx and https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/RedactedLCCA-Congress010916_Confidential%20Commercial%20or%20Financial%20Information.xlsx); Wage Data at Sava Facilities (Jan. 2020 – June 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/Congressional%20Inquiry%20Regular%20Wage%20Trends2_Redacted.xlsx).

[348] Id.

[349] Letter from Counsel for SavaSeniorCare, to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Aug. 9, 2022); Letter from Counsel for Consulate, to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Aug. 12, 2022).

[350] Email from Executive Vice President, Compliance, Ethics and Customer Experience, SavaSeniorCare Administrative and Consulting, LLC, to Majority Staff, Select Subcommittee on the Coronavirus Crisis (Nov. 7, 2022).

[351] Letter from Counsel for Consulate, to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Aug. 12, 2022).

[352] Letter from Counsel for Genesis to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Oct. 31, 2022); Letter from Counsel for Ensign to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Aug. 30, 2022).

[353] Sick Leave Policies of Life Care Facilities reviewed by Select Subcommittee staff.

[354] Primary vaccination series is defined as receipt of two primary doses of an mRNA vaccine (Pfizer-BioNTech or Moderna) or one primary dose of Ad26.COV2 (Johnson & Johnson) vaccine. A booster dose is defined as any additional installment of the coronavirus vaccine beyond the primary series. Data regarding booster doses do not include bivalent boosters, which were authorized by the FDA in October 2022. See Food and Drug Administration, COVID-19 Vaccines (online at www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines#authorized-vaccines).

[355] Vaccination Data for Consulate Residents and Staff (as of July 3, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/BSLLP%20SSOCC%20000006-07_Redacted%202.pdf); Vaccination Data for Ensign Residents and Staff (as of July 31, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/ENSIGN-COVID-00012399.xlsx); Vaccination Data for Genesis Residents and Staff (as of July 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/GEN_SSCC_0004685_Redacted.xlsx); Vaccination Data for Life Care Residents and Staff (as of July 31, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/LCCA-Congress010740_CONFIDENTIAL_Redacted.xlsx); Vaccination Data for Sava Residents and Staff (as of July 22, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/SAVA_00128314-SAVA_00128315_Redacted.pdf).

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[566] RER Solutions, Inc. Invoices to SBA Office of Disaster Assistance, Contract 73351019D0001 (May 11, 2020 - Feb. 1, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/RER%20Rocket%20invoices%20redacted.pdf); Rocket Loans Invoices to RER Solutions, Inc., Task Order 2 (May 11, 2020 - Feb. 4, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/RER%20Rocket%20invoices%20redacted.pdf); Rapid Financial Services, LLC Invoices to Rocket Loans (July 2, 2020 - Feb. 2, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/Rocket%20and%20Rapid%20Invoices_Redacted.pdf); Letter from Counsel, RER Solutions, Inc., to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis, and Chairwoman Nydia Velazquez, Committee on Small Business (Mar. 11, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/Letter%20Counsel%20RER%20to%20Chairman%203.11.21_Redacted.pdf); Small Business Administration, Office of Inspector General, Evaluation of SBA's Contract for Disaster Assistance Loan Recommendations Services (Apr. 14, 2022) (online at www.sba.gov/sites/default/files/2022-04/SBA%20OIG%20Report%2022-10.pdf).

[567] Letter from Counsel, Rocket Loans, to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis, and Chairwoman Nydia Velazquez, Committee on Small Business (Nov. 24, 2020) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2020-11-24%20Rocket%20Ltr%20to%20Committees%20from%20Rocket%20Loans%20highlighted.pdf); Letter from Counsel, RER Solutions, Inc., to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis, and Chairwoman Nydia Velazquez, Committee on Small Business (Oct. 2, 2020) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2020-10-02%20Ltr%20N%20Eggleston%20to%20Chairpersons%20and%20Committee%20Members%20-%20signed%20highlighted.pdf).

[568] Memorandum from Majority Staff to Members of the Select Subcommittee on the Coronavirus Crisis, Preliminary Analysis of Paycheck Protection Program Data (Sept. 1, 2020) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2020-09-01.PPP%20Interim%20Report.pdf).

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[571] Select Subcommittee on the Coronavirus Crisis, "We Are Not the Fraud Police": How Fintechs Facilitated Fraud in the Paycheck Protection Program (Dec. 1, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.12.01%20How%20Fintechs%20Facilitated%20Fraud%20in%20the%20Paycheck%20Protection%20Program.pdf).

[572] Id.

[573] Id.

[574] How Two Start-Ups Reaped Billions in Fees on Small Business Relief Loans, N.Y. Times (June 27, 2021) (online at www.nytimes.com/2021/06/27/business/ppp-relief-loans-blueacorn-womply.html?action=click&module=Top%20Stories&pgtype=Homepage).

[575] Blueacorn Group January 1, 2021 – February 28, 2022, Simplified Cash Flow Statement (BA-SSCC-0000121-22); Letter from Womply, Inc. to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Apr. 14, 2022).

[576] Conversation between former Blueacorn employee and Majority Staff, Select Subcommittee on the Coronavirus Crisis; Conversation between former Blueacorn employee and Majority Staff, Select Subcommittee on the Coronavirus Crisis.

[577] Call between Staff, Fountainhead Commercial Capital, and Majority Staff, Select Subcommittee on the Coronavirus Crisis Conversation (May 2, 2022); Emails Between Toby Scammell, Founder and Chief Executive Officer, Womply, Inc., and Cory Capoccia, Womply, Inc, and Bernie Navarro, Benworth Capital Partners, LLC (Apr. 8, 2021 – May 10, 2021) (BWSSCCResp0000034-52).

[578] Opinion of the Commission, In the Matter of Toby G. Scammell, No. 3-15271 (S.E.C. Oct. 29, 2014); see, e.g., Email from Toby Scammell, Womply, Inc., to Michael Bland, Fountainhead Commercial Capital (June 10, 2021) (House_Select_000006066-69); Email from Staff, Small Business Administration, to Toby Scammell, Womply, Inc. (June 16, 2021) (House_Select_000006750-51).

[579] Letter from Prestamos CDFI to Chairman James E. Clyburn, Select Subcommittee on the Coronavirus Crisis (Apr. 25, 2022); Briefing by Adam Seery, Chief Operating Officer, Harvest Small Business Finance, LLC, to Staff, Select Subcommittee on the Coronavirus Crisis (Apr. 4, 2022).

[580] Slack Messages Between Stephanie Hockridge and Kristen Spencer (ELEV8_00000717).

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[582] See Select Subcommittee on the Coronavirus Crisis, "We Are Not the Fraud Police": How Fintechs Facilitated Fraud in the Paycheck Protection Program (Dec. 1, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.12.01%20How%20Fintechs%20Facilitated%20Fraud%20in%20the%20Paycheck%20Protection%20Program.pdf) at 38-42; Conversation between former Blueacorn employee and Majority Staff, Select Subcommittee on the Coronavirus Crisis.

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[829] Office of Rep. David E. Price, Press Release: Chairman Price, Whip Clyburn, Rep. Clarke and Rep. Khanna Secure Funding for Eviction Prevention Demonstration Program in FY21 Government Funding Package (Dec. 22, 2020) (online at https://price.house.gov/newsroom/press-releases/chairman-price-whip-clyburn-rep-clarke-and-rep-khanna-secure-funding).

[830] Millions of Americans Are Heading into the Holidays Unemployed and Over $5,000 Behind on Rent, Washington Post (Dec. 7, 2020) (online at https://washingtonpost.com/business/2020/12/07/unemployed-debt-rent-utilities/).

[831] Center for Economic and Policy Research, Housing Affordability and Insecurity Before and During the Pandemic (Sept. 29, 2020) (online at https://cepr.net/housing-affordability-and-insecurity-before-and-during-the-pandemic/).

[832] STOUT, Cleveland Eviction Right to Counsel Annual Independent Evaluation, January 1 to December 31, 2021 (Jan. 31, 2022) (online at https://freeevictionhelpresults.org/wp-content/uploads/2022/01/Stouts-2021-Independent-Evaluation-of-RTC-C_FINAL_1.31.22.pdf).

[833] Biden's Budget Would Significantly Improve Delivery of Unemployment Benefits, The Century Foundation (Sept. 9, 2022) (online at https://tcf.org/content/commentary/biden-budget-would-significantly-improve-delivery-of-unemployment-benefits/?agreed=1).

[834] Select Subcommittee on the Coronavirus Crisis, Idle on EIDL Fraud: How the Trump Administration Wasted Taxpayer Dollars by Leaving the COVID-19 EIDL Program Vulnerable to Fraud (June 14, 2022) (online at https://coronavirus.house.gov/news/reports/select-subcommittee-report-details-trump-administration-s-failure-prevent-fraud).

[835] Id.

[836] Memorandum from Majority Staff to Members of the Select Subcommittee on the Coronavirus Crisis, New Finding of Disproportionate Impact of Coronavirus Pandemic on Working Women (May 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/22.05.17%20SSCC%20Gender%20Equity%20Analysis.pdf); Select Subcommittee on the Coronavirus Crisis, Hearing on Recognizing and Building on the Success of Pandemic Relief Programs (Sept. 22, 2021) (online at https://coronavirus.house.gov/subcommittee-activity/hearings/hybrid-hearing-recognizing-and-building-success-pandemic-relief).

[837] Select Subcommittee on the Coronavirus Crisis, Testimony of Martin Rosas, United Food and Commercial Workers Local Union 2, Hearing on How the Meatpacking Industry Failed the Workers Who Feed America (Oct. 27, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/Rosas%20Testimony.pdf).

[838] Select Subcommittee on the Coronavirus Crisis, America's Pandemic Workforce: Persistent Structural Inequities Harm Workers and Threaten Future Crisis Response (Oct. 25, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.10.25%20Persistent%20Structural%20Inequities%20Harm%20Workers%20and%20Threaten%20Future%20Crisis%20Response.pdf).

[839] Id.

[840] Id.

[841] Memorandum from Majority Staff to Members of the Select Subcommittee on the Coronavirus Crisis, New Finding of Disproportionate Impact of Coronavirus Pandemic on Working Women (May 17, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/22.05.17%20SSCC%20Gender%20Equity%20Analysis.pdf).

[842] University of California-Berkeley, Center for the Study of Child Care Employment, Early Childhood Workforce Index 2020 (online at https://cscce.berkeley.edu/workforce-index-2020/) (accessed Dec. 7, 2022); 'Crashing Down': How the Child Care Crisis Is Magnifying Racial Disparities, Politico (July 22, 2020) (online at www.politico.com/news/2020/07/22/coronavirus-child-care-racial-disparities-377058) ("Ninety-three percent of child care workers are women, and 45 percent are Black, Asian or Latino, according to Labor Department data.").

[843] Select Subcommittee on the Coronavirus Crisis, Testimony of Dr. Lynette M. Fraga, Child Care Aware of America, Hearing on COVID Child Care Challenges: Supporting Families and Caregivers (Mar. 2, 2022) (online at https://coronavirus.house.gov/subcommittee-activity/hearings/hybrid-hearing-covid-child-care-challenges-supporting-families-and).

[844] Select Subcommittee on the Coronavirus Crisis, Testimony of Dr. Lea J.E. Austin, Center for the study of Child Care Employment, University of California, Hearing on COVID Child Care Challenges: Supporting Families and Caregivers (Mar. 2, 2022) (online at https://coronavirus.house.gov/subcommittee-activity/hearings/hybrid-hearing-covid-child-care-challenges-supporting-families-and).

[845] Select Subcommittee on the Coronavirus Crisis, Testimony of Dr. Betsey Stevenson, University of Michigan, Hearing on COVID Child Care Challenges: Supporting Families and Caregivers (Mar. 2, 2022) (online at https://coronavirus.house.gov/subcommittee-activity/hearings/hybrid-hearing-covid-child-care-challenges-supporting-families-and).

[846] Memorandum from Majority Staff to Members of the Select Subcommittee on the Coronavirus Crisis, The Pandemic Recovery: The American Rescue Plan's Impact on Alleviating Hardship and Supporting Economic Recovery (Sept. 22, 2021) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/Staff%20Memo%20-%20The%20American%20Rescue%20Plan%27s%20Impact%20on%20Alleviating%20Hardship%20and%20Supporting%20Economic%20Recovery.pdf).

[847] Select Subcommittee on the Coronavirus Crisis, America's Pandemic Workforce: Persistent Structural Inequities Harm Workers and Threaten Future Crisis Response (Oct. 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.10.25%20Persistent%20Structural%20Inequities%20Harm%20Workers%20and%20Threaten%20Future%20Crisis%20Response.pdf).

[848] Briefing by Staff, Small Business Association to Staff, Select Subcommittee on the Coronavirus Crisis (July 29, 2021).

[849] Congressional Research Service, IRS-Related Funding in the Inflation Reduction Act (Oct. 20, 2022) (online at https://crsreports.congress.gov/product/pdf/IN/IN11977).

[850] See, e.g., Select Subcommittee on the Coronavirus Crisis, "We Are Not the Fraud Police": How Fintechs Facilitated Fraud in the Paycheck Protection Program (Dec. 1, 2022) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2022.12.01%20How%20Fintechs%20Facilitated%20Fraud%20in%20the%20Paycheck%20Protection%20Program_0.pdf).

[851] Memorandum from Majority Staff to Members of the Select Subcommittee on the Coronavirus Crisis, Preliminary Analysis of Paycheck Protection Program Data (Sept. 1, 2020) (online at https://coronavirus.house.gov/sites/democrats.coronavirus.house.gov/files/2020-09-01.PPP%20Interim%20Report.pdf).

[852] Small Business Administration, Office of Inspector General, SBA's Handling of Potentially Fraudulent Paycheck Protection Program Loans (May 26, 2022) (Rept. No. 22-13) (online at www.oversight.gov/sites/default/files/oig-reports/SBA/SBA-OIG-Report-22-13.pdf).

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ONE HUNDRED SEVENTEENTH CONGRESS

Congress of the United States

House of Representatives

SELECT SUBCOMMITTEE ON THE CORONAVIRUS CRISIS

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Select Subcommittee on the Coronavirus Crises

Business Meeting Summary – 12-14-2022

Convened: 4:40 p.m.
Adjourned: 5:00 p.m.

Committee Report entitled: Preparing for and Preventing the Next Public Health Emergency: Lessons Learned from the Coronavirus Crisis

1) **Amendment in the Nature of a Substitute (ANS)** offered by Mr. Clyburn. The Amendment was agreed to by Voice Vote.

The Committee Report entitled: Preparing for and Preventing the Next Public Health Emergency: Lessons Learned from the Coronavirus Crisis, as amended, was ordered favorably reported to the House by Voice Vote.

Mr. Jordan requested to be recorded as a NO vote on the report's final passage.

MINORITY VIEWS

The Select Subcommittee on the Coronavirus Crisis (Subcommittee) was formed on April 23, 2020, with Chairman James Clyburn (D-SC) promising the Subcommittee would be "forward looking" and would "look at the totality of the current response." The Subcommittee failed on both accounts.

Instead, Congressional Democrats used the Subcommittee as a hatchet against political adversaries and the former Trump Administration. The most prominent example of this is the fact that the Subcommittee held five hearings with Trump Administration officials in 2020, compared to two with Biden Administration officials in 2021 and only two in 2022. Further, the Subcommittee sent 31 public letters to Trump Administration officials in 2020, compared to 10 letters to Biden Administration officials in 2021 and only three in 2022. Subcommittee Democrats failed to hold the Biden Administration accountable.

Specifically, Subcommittee Democrats refused to investigate: (1) the origins of COVID-19, (2) President Biden's politically motivated decision making, (3) the Biden Administration's decision not to purchase more rapid, at-home COVID-19 tests leading up to the holidays in 2021, and (4) the Food and Drug Administration's (FDA) and Centers for Disease Control and Prevention's (CDC) actions sideling scientific experts regarding vaccine booster shots.

While Democrats sat idly by, Subcommittee Republicans uncovered: (1) the United States likely funded gain-of-function (GOF) research on novel coronaviruses at the Wuhan Institute of Virology (WIV), (2) the scientific establishment, including Drs. Anthony Fauci and Francis Collins, worked to suppress the lab leak hypothesis, (3) the Biden Administration provided uncommon access to teachers unions to draft and edit official CDC guidelines so they could make it easier to keep schools closed, causing devastating learning loss for America's young people, and (4) the governors of certain Democrat-led states, particularly New York, violated CDC and Centers for Medicare and Medicaid Services (CMS) guidance to force potentially COVID-19 positive patients into nursing homes, causing thousands of unnecessary deaths.

These minority views detail the efforts from Subcommittee Republicans to uncover the truth and hold bad actors accountable. It also addresses the failures stemming from Subcommittee Democrats inaction. Simply, Republicans acted while Democrats failed.

I. The United States likely funded gain-of-function research on novel coronaviruses at the Wuhan Institute of Virology.

On June 1, 2014, EcoHealth Alliance, Inc. (EcoHealth) received a $3.7 million dollar grant from the National Institute of Allergy and Infectious Diseases (NIAID), entitled "Understanding the Risk of Bat Coronavirus Emergence."[1] Through this grant, EcoHealth sent more than $600,000 to the WIV in Wuhan, China. Also pursuant to this grant, EcoHealth was required to report to the National Institutes of Health (NIH) and "immediately stop all experiments" if it created a virus that showed evidence of viral growth 1,000 percent that of the

[1] Project Grant, Understanding the Risk of Bat Coronavirus Research, EcoHealth Alliance, Inc. (June 1, 2014).

original virus.[2] Even if EcoHealth did not immediately report an experiment that met these parameters as required by the grant, EcoHealth would have to submit its annual progress report by September 30, 2019.

On October 20, 2021, the House Committee on Oversight and Reform received a letter from Dr. Lawrence Tabak, Principal Deputy Director of the NIH. According to Dr. Tabak, EcoHealth "failed" to properly and promptly report an experiment that violated the terms of the grant.[3] In one experiment, EcoHealth created a virus which showed evidence of viral growth over the stated threshold, but subsequently failed to report it. This experiment qualified as GOF research since the virus gained enhanced transmissibility.

This is further complicated by the NIH's revolving and changing definition to GOF to fit their preferred narrative. Prior to October 20, 2021, GOF was defined as, "research that modifies a biological agent so that it confers new or enhanced activity to that agent."[4] EcoHealth's experiment would clearly fit this definition. However, after October 20, this definition was stripped from NIH's website. The only viable explanation for this is to shield NIH from scrutiny and accountability since Drs. Fauci and Collins have long been proponents of GOF research stating, "important information and insights can come from generating a potentially dangerous virus in the laboratory."[5]

II. The scientific establishment, including Drs. Anthony Fauci and Francis Collins, worked to suppress the lab leak hypothesis.

Despite Dr. Fauci claiming otherwise on multiple occasions, he was, in fact, aware of the monetary relationship between the NIAID, the NIH, EcoHealth, and the WIV by January 27, 2020.[6] Dr. Fauci also knew that NIAID worked with EcoHealth to craft a grant policy to sidestep the gain-of-function moratorium at the time.[7] This new policy, designed by EcoHealth and agreed to by NIAID, allowed EcoHealth to conduct dangerous experiments on novel bat coronaviruses—with very little oversight—that would have otherwise been blocked by the moratorium.[8] In January 2020, Dr. Fauci was also aware that EcoHealth was not in compliance with the terms of its grant that funded the WIV.[9] EcoHealth was required to submit an annual progress report to NIAID by September 30, 2019, and failed to timely submit the report.[10]

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[2] Letter from Hon. Francis Collins, Dir., Nat'l Insts. Of Health, to Hon. James Comer, Ranking Member, H. Comm. on Oversight & Reform (July 28, 2021) [hereinafter Collins Letter].
[3] Letter from Lawrence Tabak, Deputy Dir., U.S. Nat'l Insts. Of Health, to Hon. James Comer, Ranking Member, H. Comm. on Oversight & Reform (Oct. 20, 2021) [hereinafter Tabak Letter].
[4] *Gain-of-Function Research Involving Potential Pandemic Pathogens,* U.S. NAT'L INSTS. OF HEALTH (last updated July 12, 2021) (*archived at* https://web.archive.org/web/20211019065407/https:/www.nih.gov/news-events/gain-function-research-involving-potential-pandemic-pathogens.)
[5] Anthony S. Fauci, Gary J. Nabel, & Francis S. Collins, *A flu virus risk worth taking,* WASH. POST (Dec. 30, 2011).
[6] Email from Greg Folkers to Anthony Fauci, et. al. (Jan. 27, 2020) (On file with Comm. Staff); Zachary Basu, *Fauci and Rand Paul clash over NIH funding for Wuhan Institute of Virology,* AXIOS (May 11, 2021).
[7] Sharon Lerner & Mara Hvistendahl, *NIH Officials Worked with EcoHealth Alliance to Evade Restrictions on Coronavirus Experiments,* INTERCEPT (Nov. 3, 2021).
[8] *Id.*
[9] Letter from Lawrence Tabak to James Comer (Oct. 20, 2021).
[10] *Id.*

On February 1, 2020, Dr. Fauci, Dr. Collins, and at least eleven other scientists convened a conference call to discuss the origins of COVID-19.[11] It was on this conference call that Drs. Fauci and Collins were first warned that COVID-19 may have leaked from the WIV and, further, may have been intentionally genetically manipulated:

- Dr. Kristian Andersen said, "The unusual features of the virus make up a really small part of the genome (<0.1%) so one has to look really closely at all the sequences to see that some of the features (potentially) look engineered . . . Eddie [Holmes], Bob [Garry], Mike [Farzan], and myself all find the genome inconsistent with expectations from evolutionary theory."[12]

- Dr. Robert Garry said, "I really can't think of a plausible natural scenario . . . I just can't figure out how this gets accomplished in nature . . . Of course, in the lab it would be easy . . ."[13]

- Dr. Michael Farzan said he was "bothered by the furin site and ha[d] a hard time explain[ing] that as an event outside the lab . . . I am 70:30 or 60:40 [lab]."[14]

- Dr. Andrew Rambaut said, "[f]rom a (natural) evolutionary point of view the only thing here that strikes me as unusual is the furin cleavage site."[15]

- Dr. Edward Holmes indicated that he was "60-40 lab . . . ."[16]

- Dr. Jeremy Farrar said, "I am 50-50 [lab]."[17]

Only three days later, on February 4, 2020, four participants of the conference call authored a paper entitled "The Proximal Origin of SARS-CoV-2" and sent a draft to Drs. Fauci and Collins.[18] Prior to final publication in *Nature Medicine*, the paper was sent to Dr. Fauci for editing and approval.[19] It is unclear what, if any, new evidence was presented or if the underlying science changed in those three days, but after speaking with Drs. Fauci and Collins, the authors abandoned their belief COVID-19 was the result of a laboratory leak. It is unclear if Drs. Fauci or Collins edited the paper prior to publication.

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[11] Email from Jeremy Farrar to Anthony Fauci, et. al. (Feb. 1, 2020) (On file with Comm. Staff).
[12] E-mail from Dr. Kristian Andersen to Dr. Anthony Fauci & Dr. Jeremy Farrar (Jan. 31, 2020) (On file with Comm. staff).
[13] Letter from Hon. James Comer, *supra* note 2.
[14] *Id;* "Furin" refers to COVID-19's Furin Cleavage Site. Generally, Furin is a protease enzyme that breaks down proteins into single amino acids, to then form new proteins. This is done by cleaving bonds within specific proteins. COVID-19's unique Furin Cleavage Site enhances transmissibility and ability to infect other tissue types in the body.
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] Email from Jeremy Farrar to Anthony Fauci & Francis Collins (Feb. 4, 2020) (On file with Comm. Staff)
[19] Email from Kristian Andersen to Anthony Fauci, Francis Collins, & Jeremy Farrar (Mar. 6, 2020) (On file with Comm. staff).

On April 16, 2020, more than two months after the original conference call, Dr. Collins emailed Dr. Fauci expressing dismay that the *Nature Medicine* article—which they saw and were given opportunity to edit prior to publication—did not squash the lab leak hypothesis.[20] Dr. Collins asks if the NIH can do more to "put down" the lab leak hypothesis.[21] The next day—after Dr. Collins explicitly asked for more public pressure—Dr. Fauci cited the *Nature Medicine* paper from the White House podium likely in an effort to further stifle the hypothesis COVID-19 leaked from the WIV.[22]

The Biden Administration continues to hide, obfuscate, and shield the truth. By continuing to refuse to cooperate in the Republican investigation into the origins of COVID-19, the Administration is choosing to hide information that will help inform the origins of the pandemic, prevent and respond to future pandemics, inform the United States' current national security posture, and restore confidence in our public health experts. This continued obstruction is likely to cause irreparable harm to the credibility of these agencies.

III. The Biden Administration provided uncommon access to teachers unions to draft and edit official Centers for Disease Control and Prevention guidelines so they could make it easier to keep schools closed, causing devastating learning loss for America's young people.

On May 11, 2021, after public reports of political interference by American Federation of Teachers (AFT) in the school re-opening policymaking process, Subcommittee Republicans wrote to CDC Director Rochelle Walensky to request documents and information regarding the formulation of the "Operational Strategy for K-12 Schools through Phased Prevention" (Operational Strategy).[23] On July 19, 2021, Director Walensky responded and asserted CDC's consultation with AFT was routine and consistent with the agency's customary process for issuing guidance.[24] Documents and testimony show, however, that Director Walensky downplayed the degree to which CDC departed from past practice to allow AFT to influence the policymaking process. In fact, CDC allowed AFT to insert language into the Operational Strategy that made it more likely schools across the country would remain closed after February 2021.

Contrary to the CDC's long-standing practice of keeping draft guidance documents confidential Republicans learned through documents and testimony that senior CDC officials shared a draft copy of the Operational Strategy with the AFT, a political union with no scientific expertise but an extensive record of providing financial support to the Biden campaign and other elected Democrats. After reviewing the draft, AFT staff asked Director Walensky to install a

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[20] Email from Kristian Andersen to Anthony Fauci, Francis Collins, & Jeremy Farrar (Mar. 6, 2020) (On file with Comm. staff).
[21] Email from Francis Collins to Anthony Fauci, et. al. (Apr. 16, 2020) (On file with Comm. Staff).
[22] John Haltiwanger, *Dr. Fauci throws cold water on conspiracy theory that coronavirus was created in a Chinese lab,* BLOOMBERG (Apr. 18, 2020).
[23] Letter from Hon. Steve Scalise, Ranking Member, Select Subcomm. on the Coronavirus Crisis, H. Comm. on Oversight & Reform, et. al., to Dr. Rochelle Walensky, Director, U.S. Cents. For Disease Control & Prevention (May 11, 2021).
[24] Letter from Dr. Rochelle Walensky, Director, U.S. Cents. For Disease Control & Prevention, to Hon. James Comer, Ranking Member, Comm. on Oversight & Reform (July 19, 2021).

"trigger" in the guidance that would cause schools to close automatically if COVID-19 positivity rates reached a certain threshold.[25] The CDC obliged, and thousands of schools across the country remained closed throughout the 2020-2021 school year.

On February 18, 2022, Subcommittee staff interviewed Dr. Henry Walke, a career CDC scientist and medical doctor. Dr. Walke testified this level of coordination between the CDC and an outside organization was "uncommon."[26] In fact, according to Dr. Walke, the CDC does not typically share draft guidance outside the agency for any reason, even with other federal partners.[27]

The actions by the AFT and the Biden Administration led to more school closures. Virtual school and school closures will be one of the biggest failures during the pandemic and they were largely perpetuated by teachers unions and Democrats nationwide. According to University of Harvard professor Thomas Kane, "…the closures came at a stiff price—a large decline in children's achievement overall and a historic widening in achievement gaps by race and economic status."[28] Further according to Brown University professor Emily Oster, "[t]he past two years have seen enormous test score declines for kids…these declines were caused, at least in significant part, by school closures."[29] Professor Oster continued, "…the lack of resumption of in-person learning was a significant contributing factor to test score declines."[30] Compared to the academic decline, the mental health toll on America's youth is vast but more difficult to ascertain.

Because lawyers for the Biden Administration prevented a key witness from explaining why the CDC allowed AFT to write key portions of its guidance for re-opening schools, there are still several unanswered questions.[31]

IV. The governors of certain Democrat-led states, particularly New York, violated Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services guidance to force potentially COVID-19 positive patients into nursing homes, causing thousands of unnecessary deaths.

On March 13, 2020, the Center for Medicare & Medicaid Services (CMS) issued guidance "For Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes."[32] This guidance is a blueprint for individual states to follow when determining how to best control outbreaks of COVID-19 in nursing homes and long-term care facilities. This

[25] Email from Ms. Kelly Trautner, American Fed. Of Teachers, to Dr. Rochelle Walensky, Dir., U.S. Cents. for Disease Control & Prevention, et. al. (Feb. 11, 2021).
[26] Transcribed Interview of Dr. Henry Walke, Director, Cent. for Preparedness & Response, U.S. Cents. For Disease Control & Prevention, by H. Comm. on Oversight & Reform Staff (Feb. 18, 2022) [hereinafter Walke TI].
[27] *Id.*
[28] Thomas Kane, *Kids Are Far, Far Behind in School,* THE ATLANTIC (May 22, 2022).
[29] Zachary Rogers, *Sharpest learning loss occurred in school districts that stayed remote longer, study says,* CBS (Sept. 15, 2022).
[30] *Id.*
[31] *Id.*
[32] Memorandum from David R. Wright, Director, Quality, Safety & Oversight Group, U.S. Centers for Medicare & Medicaid Services, to State Survey Agency Directors (Mar. 13, 2020) (on file with Comm. Staff).

guidance does not direct any nursing home to accept a COVID-19 positive patient if they are unable to do so safely. In fact, it says "nursing homes should admit any individual ***that they would normally admit to their facility***, including individuals from hospitals where a case of COVID-19 was/is present" ***only if*** the nursing home can follow Centers for Disease Control (CDC) quarantining guidance.[33]

CMS Administrator Seema Verma said, "[u]nder no circumstances should a hospital discharge a patient to a nursing home that is not prepared to take care of those patient's needs."[34]

The most infamous violation of this guidance came from former New York Governor Andrew Cuomo. On March 25, 2020, the New York Department of Health posted, on their website, a now deleted directive entitled "Hospital Discharges and Admissions to Nursing Homes."[35] This directive said "[n]o resident ***shall be denied*** re-admission or admission to the [nursing home] solely based on a confirmed or suspected diagnosis of COVID-19" and "[nursing homes] are ***prohibited*** from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or re-admission."[36] For clarity, this advisory mandated nursing homes accept known COVID-19 positive patients andmandated that nursing homes not even test patients for COVID-19 prior to admission.

On October 13, Subcommittee staff interviewed former White House COVID-19 Coordinate Dr. Deborah Birx. When asked about Governor Cuomo's infamous March 25, 2020, nursing home order, Dr. Birx testified that the order violated CMS guidance and that admitting potentially positive COVID-19 nursing home residents back into the nursing home could have led to unnecessary deaths.[37]

Because the former Cuomo Administration and the current Administration of Governor Kathy Hochul have refused to share any information with the Subcommittee, several unanswered questions remain.

V. Subcommittee Democrats failed to investigate the origins of COVID-19.

Select Subcommittee Democrats affirmatively declined to investigate the origins of COVID-19; a never-before-seen virus that has now killed more than six million people worldwide. On three occasions, Subcommittee Republicans requested Subcommittee Democrats investigate the origins of COVID-19. On each occasion, they refused. Finally, on June 11, 2021, Chairman Clyburn responded to Republicans' request. He stated, "[w]e are concerned that your request may be designed…to deflect accountability from the Trump Administration."[38] He

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[33] *Id; (emphasis added)*.
[34] Charles Creitz, *Medicare chief Verma blasts Cuomo for trying to deflect blame onto White House fo NY nursing home deaths*, Fox News (May 28, 2020).
[35] Memorandum from the New York State Department of Health to Nursing Home Administrators, et. al. (Mar. 25, 2020) (on file with Comm. Staff).
[36] *Id; (emphasis added)*.
[37] Oct. 13 Birx TI at 119-121.
[38] Letter from hon. James E. Clyburn, Chairman, Select Subcomm. On the Coronavirus Crisis, H. Comm. On Oversight & Reform, & Hon. Carolyn B. Maloney, Chairwoman, H. Comm. On Oversight & Reform, to Hon. Steve

continued, "[y]our apparent effort to use the issue of the origin of the virus in order to shift accountability from President Trump…is an irresponsible gambit that we urge you to abandon."[39]

Unfortunately for Subcommittee Democrats, investigating the origins of COVID-19 is not a political pursuit. In fact, on May 14, 2021, Dr. Jesse Bloom and 17 other respected scientists called for the origins to be investigated. They wrote, "[k]nowing how COVID-19 emerged is critical for informing global strategies to mitigate the risk of future outbreaks."[40] The authors continued, "[w]e must take hypothesis about both natural and laboratory spillovers seriously…"[41] Additionally, on September 17, 2021, another 16 scientists writing in *The Lancet*, said, "[o]verwhelming evidence for either zoonotic or research-related origin is lacking: the jury is still out."[42]

On September 14, 2022, *The Lancet* COVID-19 Commission said, "[i]dentifiying these origins would provide greater clarity into not only the causes of the current pandemic but also vulnerabilities to future outbreaks and strategies to prevent them."[43] The Commission continued, "…hypothesis about both natural and laboratory spillovers are in play and need further investigation."[44]

Despite these calls from numerous respected scientists for further investigation into the origins of COVID-19, Subcommittee Democrats chose to play politics and ignore them. Understanding the origins of COVID-19 is not only about accountability but also about preparing for and defending against future viral pandemics.

VI. Subcommittee Democrats failed to investigate President Biden's politically motivated decision making.

Select Subcommittee Democrats refused to investigate the Biden Administration's routine decisions that followed the political science instead of the medical science. For instance, while campaigning, President Biden promised there would be no vaccine mandate but on September 9, 2021, through executive order, he imposed a vaccine mandate.[45] The Biden Administration went so far as to blame the pandemic on Republicans and the unvaccinated without any evidence.[46]

J. Scalise, Ranking Member, Select Subcomm. On the Coronavirus Crisis, H. Comm. On Oversight & Reform, & Hon. James R. Comer, Ranking Member, H. Comm. On Oversight & Reform (June 11, 2021).

[39] *Id.*

[40] Jesse D. Bloom, et. al., *Investigate the origins of COVID-19,* SCIENCE (May 14, 2021).

[41] *Id.*

[42] Jacques van Helden, et. al., *An appeal for an objective, open, and transparent debate about the origin of SARS-CoV-2,* THE LANCET (Sept. 17, 2022).

[43] Jeffrey D. Sachs, et. al., *The Lancet Commission on lessons for the future form the COVID-19 pandemic,* THE LANCET (Sept. 14, 2022).

[44] *Id.*

[45] *See* Jacob Jarvis, *Fact Check: Did Joe Biden Reject Idea of Mandatory Vaccines in December 2020?,* NEWSWEEK (Sept. 10, 2021); Bloomberg Quicktake (@Quicktake), Twitter (July 23, 2021 02:16 p.m.), https://mobile.twitter.com/Quicktake/status/1418636102643167235; Zeke Miller, *Sweeping new vaccine mandates for 100 million Americans,* ASSOC. PRESS (Sept. 9, 2021).

[46] Remarks, The White House, Remarks by President Biden on Fighting the COVID-19 Pandemic (Sept. 9, 2021).

Further, on February 24, 2022, polling firm Impact Research argued in a now-public memoranda that the Democrats need to "declare the crisis phase of COVID over and push for feeling and acting more normal."[47] The next day, the CDC ended their masking restrictions in most places despite the fact that just two weeks prior CDC Director Walensky said it was not yet time.[48]

In addition, the Biden Administration has repeatedly renewed the COVID-19 public health emergency, and thus the extension of social welfare programs, despite President Biden declaring the pandemic over.[49] Select Subcommittee Democrats' have refused to investigate any of these politically based decisions by the Biden Administration.

VII. Subcommittee Democrats failed to investigate the Biden Administration's decision not to purchase more rapid, at-home COVID-19 tests leading up to the holidays in 2021.

Select Subcommittee Democrats ignored reports that the Biden Administration refused to purchase more rapid, at-home tests for Americans headed into the 2021 holiday season which corresponded with a dramatic surge in cases. In July 2020, during the Trump Administration, Chairman Clyburn said, "[w]ithout widely available, rapid testing, it is nearly impossible to control the spread of the virus…"[50] The Chairman went on to say that the Trump Administration was "warned" about testing and "failed."[51]

However, the Biden Administration was not only warned about a lack of available testing but flatly rejected an October 22, 2021 proposal to ramp up manufacturing and deliver tests to Americans prior to Christmas.[52] This plan detailed the need for about 400 million tests.[53] Ironically, exactly two months later, President Biden said, "I wish I had thought about ordering" 500 million at-home tests "two-months ago."[54] Yet no investigation was launched by the Select Subcommittee Democrats.

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[47] Julie Hamill, @hamill_law, Twitter (Feb. 25, 2022), https://twitter.com/hamill_law/status/1497205184790872065.
[48] Julie Hamill, @hamill_law, Twitter (Feb. 25, 2022), https://twitter.com/hamill_law/status/1497205184790872065; Mitch Smith & Shawn Hubler, *Masks Come Off in More States, but Not Everyone is Grinning*, THE N.Y. TIMES (Feb. 9, 2022).
[49] Declaration, Administration for Strategic Preparedness & Response, U.S. Dep't of Health & Human Serv., Renewal of Determination that a Public Health Emergency Exists (Oct. 15, 2022); Adam Cancryn & Krista Mahr, *Biden declared the pandemic 'over.' His Covid team says it's more complicated*, POLITICO (Sept. 19, 2022).
[50] *The Urgent Need for a National Plan to Contain the Coronavirus, Hearing Before the Select Subcomm. on the Coronavirus Crisis, H. Comm. on Oversight & Reform,* 117th Cong. (July 31, 2020).
[51] *Id.*
[52] Katherine Eban, *The Biden Administration Rejected an October Proposal for "Free Rapid Tests for the Holidays",* VANITY FAIR (Dec. 23, 2021).
[53] *Id.*
[54] Ben Gittleson, *President Biden to ABC's David Muir on at-home COVID testing: 'Nothing's been good enough',* ABC NEWS (Dec. 23, 2021).

VIII. Subcommittee Democrats failed to investigate the Food and Drug Administration's and Centers for Disease Control and Prevention's actions sidelining scientific experts regarding vaccine booster shots.

Select Subcommittee Democrats disregarded the fact that President Biden's FDA and CDC intentionally sidelined or ignored outside vaccine experts that did not support the Biden Administration's vaccine only strategy. On August 18, 2021, without evidence and data, President Biden announced that booster doses of the mRNA vaccines would be available for Americans starting September 20, 2021.[55] Top scientists and researchers were stunned by this decision—particularly because the CDC and the FDA had not yet conducted their independent review of the data.[56] In fact, two vaccine manufacturers have not yet submitted the relevant data to the government agencies.[57] This political manipulation and pressure to interfere with the science by President Biden's White House reportedly contributed to the decision of two top career scientists, Marion Gruber and Phill Krause, who were key in the vaccine process, to leave the FDA.[58] They felt that the FDA was being sidelined by the Biden Administration and according to press reports "what finally did it for them was the White House getting ahead of FDA on booster shots."[59]

We now know that those same FDA scientists disagreed with the Biden Administration on the need for booster shots. In a paper published September 13, 2021, both Krause and Gruber argued that "[c]urrent evidence does not, therefore, appear to show a need for boosting in the general population, in which efficacy against severe disease remains high."[60] Despite this blatant disregard of scientific process, Select Subcommittee Democrats refused to investigate allowing the Biden Administration to engage in politicization of the vaccine approval process.

IX. Conclusion

Subcommittee Republicans will work to uncover the facts in the next Congress and ensure that America is ready for the next pandemic.

Steve Scalise
Ranking Member
Select Subcommittee on the Coronavirus Crisis

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[55] Bob Herman, *FDA's top vaccine leaders are leaving*, Axios (Aug. 31, 2021); Erin Banco, Sarah Owerwohle & Adam Cancryn, *Tensions mount between CDC and Biden health team over boosters*, POLITICO (Sept. 13, 2021).
[56] Caitlin Owens, *The bureaucracy pushes back on Biden's booster plan*, AXIOS (Sept. 1, 2021).
[57] Erin Banco, Sarah Owerwohle & Adam Cancryn, *Tensions mount between CDC and Biden health team over boosters*, POLITICO (Sept. 13, 2021).
[58] Caitlin Owens, *The bureaucracy pushes back on Biden's booster plan*, AXIOS (Sept. 1, 2021).
[59] *Id.*
[60] Phillip R Krause, *et.al*, *Considerations in boosting COVID-19 vaccine immune responses*, LANCET (Sept. 13, 2021).