

Opening Statement
Chairwoman Anna G. Eshoo
Subcommittee on Health
Committee on Energy and Commerce
Hearing on “Health Care Inequality: Confronting Racial and Ethnic Disparities in COVID-19
and the Health Care System”
June 17, 2020

Our country is in pain. Our country is grieving. And our country is angry.

Over 2 million Americans are sick. 44 million workers are jobless. Most tragically, we have lost over 115,000 of our fellow Americans.

And this pain falls most heavily on communities of color.

The COVID mortality rate for Black Americans is 2.3 times higher than the rate for White Americans. Other groups are disproportionately impacted as well. For example, near my district in Santa Clara County, 24 percent of the county’s population is Latino, but Latinos represent nearly 32 percent of all COVID deaths.

While this virus is new to our country, the plague of racism is not.

According to the CDC, Black Americans are more likely to die at early ages from all causes. Black Americans are more likely to die from heart disease or stroke at a young age. As we know from our Subcommittee’s work, Black mothers are 3.5 times more likely to die during childbirth, even when they have higher incomes and more education than their white counterparts.

In the wake of the murder of George Floyd we must acknowledge the public health impact of police brutality. According to the National Academy of Sciences, 1 in every 1,000 Black men can expect to be killed by police. Black men are about 2.5 times more likely to be killed by police over the course of their life than are white men.

Our expert witnesses, Dr. Boyd and Dr. Brooks describe the interaction of racism with COVID-19 as a “pandemic within a pandemic.”

Sadly, the Administration has failed to anticipate, track, and respond to the pandemic’s effect on communities of color.

The latest example of this failure is a final rule issued last week by the Department of Health and Human Services that repealed nondiscrimination protections for individuals with limited English proficiency, LGBT people, people with disabilities, and women.

Another example is that two months after Congress passed a law requiring the Administration to provide COVID racial analysis, the CDC finally announced that it will require COVID testing

labs to report demographic data. However, that demographic data will not be required until August 1st, eight months after we first learned of this disease.

My colleagues on the Subcommittee, led by Congresswoman Robin Kelly, Chair of the Congressional Black Caucus Health Braintrust, have introduced the *Equitable Data Collection and Disclosure on COVID-19 Act* in response to the Administration's failure to act.

Until a vaccine or therapy is available, intensive testing will be necessary to safely reopen. However, systemic barriers, such as lack of insurance and paid leave, keep Americans from seeking COVID-19 testing and treatment. The *HEROES Act* breaks down those barriers by creating a national testing strategy, extending eligibility for paid sick leave, covering the uninsured for COVID treatment, and strengthening the Medicaid program.

There's so much more Congress needs to do to deliver on the belief that "Black Lives Matter" in health care and our society and I look forward to hearing suggestions from our witnesses.

A vital part of this work will be the newly-formed Energy and Commerce Racial Disparities Working Group, and I'm please to yield the remainder of my time to its Co-leader, Representative Yvette Clarke, to announce that work.