Joyce (PA)	Mucarsel-Powell	Sherman
Kaptur	Mullin	Sherrill
Katko	Murphy (FL)	Sires
Keating	Murphy (NC)	Slotkin
Keller	Nadler	Smith (MO)
Kelly (IL)	Napolitano	Smith (NE)
Kelly (MS)	Neal	Smith (NJ)
Kelly (PA)	Neguse	Smucker
Kennedy	Newhouse	Soto
Khanna	Norcross	Spanberger
Kildee	Norman	Spano
Kilmer	Nunes	Speier
Kim	O'Halleran	Stanton
Kind	Ocasio-Cortez	Stauber
King (NY)	Omar	Stefanik
Kinzinger	Palazzo	Steil
Kirkpatrick	Pallone	Steube
Krishnamoorthi	Palmer	Stevens
Kuster (NH)	Panetta	Stewart
Kustoff (TN)	Pappas	Stivers
LaHood	Pascrell	Suozzi
LaMalfa	Payne	Swalwell (CA)
Lamb	Pence	Takano
Langevin	Perlmutter	Taylor
Larsen (WA)	Perry	Thompson (CA)
Larson (CT)	Peters	Thompson (MS)
Latta	Peterson	Thompson (PA)
Lawrence	Phillips	Tiffany
Lawson (FL)	Pingree	Timmons
Lee (CA)	Pocan	Tipton
Lee (NV)	Porter	Titus
Levin (CA)	Posey	Tlaib
Levin (MI)	Pressley	Tonko
Lieu, Ted	Price (NC)	Torres (CA)
Lipinski	Quigley	Torres Small (NM)
Loebsack	Raskin	
Lofgren	Reed	Trahan
Long	Reschenthaler	Trone
Loudermilk	Rice (NY)	Turner
Lowenthal	Rice (SC)	Underwood
Lowey	Riggleman	Upton
Lucas	Rodgers (WA)	Van Drew
Luján	Roe, David P.	Vargas
Luria	Rogers (AL)	Veasey
Lynch	Rose (NY)	Vela
Malinowski	Rose, John W.	Velázquez
Maloney, Carolyn B.	Rouda	Visclosky
	Rouzer	Wagner
Maloney, Sean	Roy	Walden
Marshall	Roybal-Allard	Walker
Mast	Ruiz	Walorski
Matsui	Ruppersberger	Wasserman Schultz
McAdams	Rush	
McBath	Rutherford	Waters
McCarthy	Ryan	Watkins
McCaul	Sánchez	Watson Coleman
McClintock	Sarbanes	Weber (TX)
McCollum	Scalise	Webster (FL)
McEachin	Scanlon	Welch
McGovern	Schakowsky	Wenstrup
McKinley	Schiff	Westerman
McNerney	Schneider	Wexton
Meeks	Schrader	Wild
Meng	Schrier	Williams
Meuser	Schweikert	Wilson (FL)
Mfume	Scott (VA)	Wilson (SC)
Miller	Scott, Austin	Wittman
Moolenaar	Scott, David	Womack
Mooney (WV)	Sensenbrenner	Woodall
Moore	Serrano	Yarmuth
Morelle	Sewell (AL)	Yoho
Moulton	Shalala	Zeldin

NOT VOTING—35

Abraham	Holding	Roby
Aderholt	Huizenga	Rogers (KY)
Amodei	King (IA)	Rooney (FL)
Bishop (NC)	Lamborn	Shimkus
Blunt Rochester	Lesko	Simpson
Brooks (IN)	Luetkemeyer	Smith (WA)
Buchanan	Marchant	Thornberry
Calvert	Massie	Walberg
Cleaver	McHenry	Waltz
Collins (GA)	Mitchell	Wright
Gallego	Olson	Young
Gianforte	Richmond	

□ 2007

So (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MEMBERS RECORDED PURSUANT TO HOUSE RESOLUTION 965, 116TH CONGRESS

Barragán (Beyer)	Hastings (Wasserman Schultz)	Napolitano (Correa)
Blumenauer (Beyer)	Higgins (NY) (Sánchez)	Payne (Wasserman Schultz)
Bonamici (Clark (MA))	Jayapal (Raskin)	Peterson (McCollum)
Boyle, Brendan F. (Jeffries)	Johnson (TX) (Jeffries)	Pingree (Kuster (NH))
Brownley (CA) (Clark (MA))	Keating (Kuster (NH))	Pocan (Raskin)
Bustos (Kuster (NH))	Khanna (Gomez)	Porter (Wexton)
Carson (IN) (Cleaver)	Kind (Beyer)	Price (NC) (Butterfield)
Castro (TX) (Garcia (TX))	Kirkpatrick (Stanton)	Rose (NY) (Golden)
Clay (Cleaver)	Langevin (Courtney)	Roybal-Allard (Bass)
Cohen (Beyer)	Lawrence (Kildee)	Ruiz (Dingell)
Costa (Cooper)	Lawson (FL) (Demings)	Rush (Underwood)
DeGette (Blunt Rochester)	Lieu, Ted (Beyer)	Ryan (Kildee)
DeSaulnier (Matsui)	Lipinski (Cooper)	Schrier (Kilmer)
Doggett (Raskin)	Lofgren (Jeffries)	Serrano (Jeffries)
Escobar (Garcia (TX))	Lowenthal (Beyer)	Speier (Scanlon)
Evans (Brown (MD))	Lowey Tonko)	Takano (Chu, Judy)
Frankel (Clark (MA))	Lynch (McGovern)	Titus (Connolly)
Garamendi (Sherman)	McEachin (Wexton)	Vargas (Correa)
Gonzalez (TX) (Gomez)	Meng (Kuster (NH))	Watson Coleman (Pallone)
Grijalva (García (IL))	Moore (Beyer)	Welch (McGovern)
	Nadler (Jeffries)	Wilson (FL) (Hayes)

HONORING KOREAN WAR VETERANS

(Mr. KELLER asked and was given permission to address the House for 1 minute.)

Mr. KELLER. Mr. Speaker, last week I had the honor of presenting Korean Ambassador of Peace Medals to Korean war veterans and their families in Towanda, Pennsylvania. The Korean Ambassador of Peace Medal is an honor from the Embassy of the Republic of Korea for American veterans who served in the Korean war.

One of the greatest parts of representing Pennsylvania's 12th Congressional District is hearing our veterans' stories of service and sacrifice for our Nation. As the names of these heroes are read on the House floor, it is my hope that their legacies echo through these Halls and across America for generations to come:

Glen Ellis, United States Navy;

Silas Mills, United States Army;

Charles Miller, United States Army;

Kent Edsell, United States Marine Corps;

Nicholas Williams, United States Navy;

Edward Moritz, United States Army;

Earl Mayo, United States Army;

Carlton Repsher, Jr., United States Army; and

Keith Haight, Sr., United States Marine Corps.

It is incumbent upon us to honor these individuals and reflect on their heroism in the name of liberty and our American way of life.

RECOGNIZING THE RETIREMENT OF LARSEN JAY

(Mr. BURCHETT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BURCHETT. Mr. Speaker, during the coronavirus pandemic, community organizations in east Tennessee stepped up to help our neighbors in need. I rise today to highlight the efforts of Random Acts of Flowers, which recently delivered its 500,000th bouquet; and to recognize the retirement of its founder, my good friend, Larsen Jay.

In 2007, Larsen Jay was in the hospital recovering from an accident, and he noticed many patients weren't receiving visitors or flowers. He reflected on the amount of support he received and wanted others to have that encouragement, too. Larsen founded Random Acts of Flowers in 2008 to deliver repurposed flowers to local hospital patients and seniors in nursing homes.

The nonprofit recycles arrangements donated from events like weddings and makes them into beautiful floral bouquets. Since opening its doors in Knoxville, the nonprofit has grown to serve folks in Indianapolis and Tampa Bay, Florida.

Random Acts of Flowers has safely resumed operations after a pause during the coronavirus pandemic. Isolation continues to be a serious problem for seniors and those in poor health during this crisis, but outstanding organizations like Random Acts of Flowers are here to let our neighbors know they are loved and supported.

Mr. Speaker, after reaching the milestone of delivering half a million bouquets, Larsen Jay announced his retirement from Random Acts of Flowers. He has long been active in community service, currently serving as chairman of the Knox County Commission.

I know he will continue to find ways to make an impact in our community. I thank him for his efforts to make Random Acts of Flowers a successful and meaningful organization in east Tennessee and I congratulate the nonprofit on its 500,000th delivery.

□ 2015

CORONAVIRUS' IMPACT ON MINORITY COMMUNITIES

The SPEAKER pro tempore (Mr. CASTEN of Illinois). Under the Speaker's announced policy of January 3, 2019, the gentlewoman from California (Ms. LEE) is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Ms. LEE of California. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the subject of our Special Order tonight.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

Ms. LEE of California. Mr. Speaker, first, I thank the chair of our Congressional Black Caucus. I thank Chairwoman BASS, who has helped us organize this tonight, for her leadership of the Congressional Black Caucus.

I join with my colleagues to speak on the impact of COVID–19, the pandemic which has had an especially disparate impact on communities of color.

First, again, let me thank Chairwoman BASS, Chairwoman CHU, and Congressman CASTRO of the Tri-Caucus, as well as Representatives KELLY, HAALAND, and DAVIDS, for working together to ensure that we address the disproportionate effects of the COVID–19 pandemic on communities of color—also, Congresswoman SYLVIA GARCIA.

It is really very imperative that our strategy to crush COVID intentionally includes provisions to support the specific needs of our communities.

I also want to take a moment to thank Speaker PELOSI and Chairman PALLONE for negotiating some of the provisions of our COVID Community Care Act, that is H.R. 8192, in our Heroes bill, which further strengthens efforts to engage medically underserved communities in the latest version, again, of the Heroes bill.

I thank Chairman SCOTT and, of course, our subcommittee chair, ROSA DELAURO, for their support, their input, and their assistance in getting this bill, the COVID Community Care Act, really very targeted, very focused, and something that all of us could support as a Tri-Caucus, also—and, of course, Speaker PELOSI, again, for her steadfast understanding and support for this issue.

Now, millions of people have suffered incomprehensible grief and hardship due to the COVID pandemic. Just in the United States, we now have over 10.3 million cases of COVID–19 and over 240,000 deaths. That is mind-boggling.

We are here today to insist that any coronavirus response addresses the needs of people of color. This is because the impacts of the pandemic and the economic fallout have had a disproportionate impact on African Americans, Latinx, Indigenous, Asian Pacific Islander, and immigrant communities. We have witnessed the horrific result of how longstanding inequities stemming from structural racism has exacerbated COVID's threats to people of color.

Black people are dying at more than twice the rate of White people in the United States. Indigenous and Latinx people are both 50 percent more likely to die from COVID than White Americans. Between January and July, the AAPI death rate rose 35 percent compared to an increase of 9 percent for White Americans.

The Federal Government must address the vicious cycle of disparities that drive these unequal impacts on communities of color, especially during the COVID–19 crisis. That is why we introduced, together, H.R. 8192, the COVID Community Care Act, legislation to ensure that any effort to fight the pandemic engages local communities as partners in crushing the virus.

This bill, supported by our Tri-Caucus colleagues, ensures that any testing and tracing efforts engage communities of color where they live with trusted messengers who speak their language and know their unique challenges.

Speaker PELOSI and Chairman PALLONE worked with us to add language to Chairman PALLONE's $75 billion CONTACT plan. This is included in the revised version of the Heroes Act passed October 1, which will further strengthen efforts to engage communities of color.

The strengthened CONTACT plan mandates that community-based organizations and nonprofits in medically underserved communities play an important role to reach those communities that public health agencies have difficulty engaging. It ensures the people hired to conduct the outreach have experience and relationships with people living in the communities that they serve.

Turning a blind eye to the American people's desperate need for culturally rooted contact tracing and testing will result in increased deaths and illnesses that we could have prevented.

We must build a relief package that addresses the needs of millions, especially Black and Brown people, who are suffering disproportionately from this virus.

Mr. Speaker, we thank our Speaker for her persistence, leadership, and fighting spirit to ensure that lawmakers acknowledge and respond to the racial and ethnic disparities that have plagued our Nation for centuries.

Mr. Speaker, I yield to the gentlewoman from Texas (Ms. GARCIA), who played an important role in making sure that the Latinx community and all the Hispanic issues, as it relates to COVID, were included as a part of this bill.

Ms. GARCIA of Texas. Mr. Speaker, I thank Representative LEE and the caucuses involved for putting this Special Order together.

Today in America, there is not one State that has the pandemic under control. My own State of Texas became the first State to surpass 1 million cases.

Let me repeat that: 1 million cases.

These cases represent many of our neighbors, our friends, and our own family. I personally have self-quarantined once and have already been tested four times for different times I have been exposed to someone with the virus.

Thank God all tests have come back positive—I am sorry, negative. I meant to say, ''not come back positive.'' Little misspeaking there.

Mr. Speaker, this pandemic is affecting everyone, but it is not affecting everyone in the same way. Black and Latino communities are bearing the weight of this pandemic. While Black and Latino people are being hospitalized and dying at higher rates than White people, they are also the ones most likely to be working jobs that put them more at risk.

They have always been essential workers. Now more than ever, this is sadly more true. They are meatpacking workers, farmworkers, sanitation workers, custodians, restaurant workers, grocery clerks, postal workers, police officers, firefighters, longshoremen. These aren't jobs you can do from home. If you don't show up, you just don't get paid.

Black and Latino families have had to go into work even when it meant they may get sick. And many of them have gotten sick. Even worse, many infected a loved one with the virus.

America depends on these workers to put food on our tables and keep us safe. Because our leaders didn't take any steps to prepare us for this pandemic, we can't even offer the protective gear needed to keep essential frontline workers safe.

So while we are asking these communities to go to work every day without the proper protections, we also know that Latino and Black Americans are more likely to have health conditions, like asthma and diabetes, that make the virus even more dangerous.

Nationwide, Latinos make up 55 percent of the COVID cases and 24 percent of the overall deaths. Yet, we are only 18.5 percent of the total U.S. population. In Texas, Latinos are about 40 percent of the population, but we are nearly 55 percent of the deaths—more than half, Mr. Speaker. In Houston, sadly, Latinos account for 54 percent of the deaths caused by this virus—again, more than half.

My district, which is nearly 80 percent Latino, was one of the hardest hit areas in the Houston region. But despite these numbers, many of my constituents are still scared of getting tested or even seeing the doctor. Many don't have health insurance. Others don't trust our healthcare system. Many more are undocumented and fear deportation.

Mr. Speaker, now, I am optimistic about the future, given some of the news about vaccine trials. However, we must make sure, once we have a safe and effective vaccine, that it is distributed fairly and equitably and that no one is left behind.

We do not need to repeat the disparate mistakes of the past. As elected officials, we must work together to keep all of our constituents safe.

Right now, with the virus rapidly spreading, we are losing precious time if we don't act. People will get sick, and even more people will die, if we wait any longer.

Legislation like the Heroes Act provides protections that working families and frontline workers need now. It would provide rent relief for families who are afraid of losing their homes. It would help our schools keep kids healthy and safe for in-person learning.

It would give local and State governments much-needed relief to retain frontline workers on payroll. It would give hardworking families another stimulus check. It would also reinstate the supplemental weekly $600 in unemployment benefits, a lifeline that helped many families stay afloat.

Lastly, we need to earn the trust of these communities and let them know that, yes, they are a part of us. People of color know and must know that we are working for them. We cannot save the economy if we don't save people first.

Saving many lives must be our top priority. It will take all of us to crush this virus, but I know that we will get together to make sure that we are all working together to get past this pandemic, and if we do, it will be for all of us. Todos juntos.

Mr. Speaker, I thank the gentlewoman for this Special Order.

Ms. LEE of California. Mr. Speaker, I thank Congresswoman GARCIA very much for her input in helping to write the COVID Community Care Act.

Mr. Speaker, I yield to the gentlewoman from Connecticut (Ms. DELAURO), my good friend, the chair of the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the House Appropriations Committee.

Ms. DELAURO. Mr. Speaker, I thank my colleague for yielding to me this evening and being here with other colleagues because we know, and we have said over and over again, that we face public health and economic crises unlike any that our country has seen in a generation.

More than 245,000 Americans have died of COVID–19. Tens of millions are out of work. And we know how communities of color have suffered acutely and disproportionately.

While we have known about some of these issues in the past, about the inequities in our healthcare system, in our economy, this virus has exposed and shone a light on the depths of the injustices and inequities that exist for communities of color. While we need to fight the virus, we need to fight the virus of injustice.

In my home State of Connecticut, as of last Thursday, Black people accounted for more than 14.5 percent of Connecticut's COVID-related deaths when they are just 12 percent of the population.

Mr. Speaker, 18 percent of COVID cases are Hispanic, outpacing the 17 percent they make up of our State's population.

Yet, this data is not perfect, which is why I have been so proud to work with my friend and my colleague, Congresswoman BARBARA LEE, to require the Health and Human Services agency and the Centers for Disease Control and Prevention to provide Congress with the data on which communities are bearing the worst impacts so that we can make sure that testing—once we have an administration that takes testing strategy seriously—is focused on those communities and that they get the resources they need going forward.

My colleague from California, Congresswoman LEE, has been indefatigable in questioning the issue of the data that we have on communities of color, and she did this long before we probably could spell ''coronavirus.'' To be frank, it is frustrating that we even had to put this requirement into law.

The CDC is complying with the reporting, but we keep a vigilant eye on that information. We have more work to do to ensure that we have complete data.

Through November 12, 47 percent of cases had unknown race and ethnicity in the CDC's surveillance system. That is just not good enough. This moment demands the boldest possible efforts to secure affordable healthcare, to address the deep racial disparities exposed by this virus, to help families.

I am proud to chair this subcommittee, which has been central to our response to this pandemic and the disparities that it has exposed. Together, my colleagues on the committee and on this subcommittee, we have appropriated $280 billion in emergency funding for education, for health, for working people throughout the pandemic. Through the good offices of my colleagues, Congresswoman LEE and Congresswoman BASS, we inserted language that would focus on the issue of disparities and how we address them. We could add $400 million in the latest iteration of The Heroes Act.

□ 2030

Yet the United States Senate has refused to do anything to help struggling Americans and get us to a place where we can test everyone, that we can do contact tracing, and that we can provide treatment.

We know more is needed. So, as I mentioned, the House has passed two additional relief packages, and we looked at boosting SNAP benefits by 15 percent; expanding access to paid leave and paid sick days; and expanding and improving the child tax credit for one-third of our children, which includes half of Black and Hispanic children, who are currently left behind because their families earn too little. If we do not address the virus, we will not be able to do anything about turning our economy around.

Let me say a thank-you to Congresswoman BARBARA LEE, who has been a tireless champion for communities of color, for organizing this Special Order. She and I, along with others, are committed to bringing to bear the full weight of the Federal Government for the communities of color, not only in my district, but around the country, because together we can and we must do better. People's lives are depending on it.

We know what we need to do to save lives. It is incomprehensible that we can't get to a protocol which allows us to save people's lives and those in communities of color, which are affected the most.

Ms. LEE of California. Thank you, Chairwoman DELAURO, for your statement and for reminding us that we have to address the health and economic impacts at the same time. One does not supersede the other. Thank you for helping us move our COVID Community Care Act forward with your leadership on the subcommittee.

Mr. Speaker, I yield to the gentlewoman from California (Ms. JUDY CHU), the chair of the Congressional Asian Pacific American Caucus, someone who contributed to crafting our COVID Community Care Act but also whom I have had the pleasure to serve with as co-chair of the Healthcare Task Force for CAPAC, a true leader on so many issues.

Ms. JUDY CHU of California. Mr. Speaker, as chair of the Congressional Asian Pacific American Caucus, I am here to say that we have reached another terrible milestone. Just yesterday, the number of COVID–19 cases in our country surpassed 11 million. One million of those cases came in just the last week alone.

The coronavirus is spreading at a rapid rate, and while hospitals and healthcare providers in all 50 States are overwhelmed, there is still no plan to contain it. The failure to contain the coronavirus has let it spread within every State and community.

Almost one-third of Americans know someone who has died from COVID–19, and yet we are still hearing false claims, including from some of my colleagues on the other side of this Chamber, that masks don't work and that gathering in large groups indoors is safe.

The message that we can or should live with this virus is a denial of the hundreds of thousands of Americans who are sick or who have died from this virus already, and it is condemning thousands more to die as well.

But not everyone is impacted equally. While all of us are susceptible to the virus, communities of color have been disproportionately impacted by the Trump administration's inaction. Now that we know more about this virus, we can see who is paying more for it.

Native Hawaiians and Pacific Islanders have seen cases surge in their communities and continue to face some of the highest COVID–19 infection and mortality rates out of any of the racial groups in several States, including in my own State of California.

And new data shows that Asian Americans are also dying from COVID–19 at a disproportionate rate, with deaths in the Asian-American community nationwide increasing by 35 percent this year compared with the average over the last 5 years. This is compared to a 9 percent increase in deaths for White Americans.

For other communities of color, there are equally high rates: for

Blacks, a 31 percent increase compared to 5 years ago; 44 percent for Hispanics; and a 22 percent increase for Native Americans.

Downplaying this virus is also downplaying the reality of healthcare inequality and minority health disparities in this country. That is why we crafted an urgently needed COVID–19 response bill: to make us sure we can combat the disproportionate effects of coronavirus on communities of color.

That is precisely what the House did in May, with the passage of The Heroes Act, and again in October, with the updated Heroes Act, which ensured that we collect disaggregated race and ethnicity data related to COVID–19 and that we restore Medicaid coverage for citizens of the Freely Associated States of the Pacific islands and include provisions like Congressmember BARBARA LEE's COVID–19 Community Care Act.

It is so important because it would provide targeted COVID–19 testing, treatment, and contact tracing for communities of color that have been devastated by the pandemic. What is so crucial is that it would include culturally and linguistically competent outreach for contact tracing that is so critical to the AAPI community.

Communities of color cannot wait any longer. Americans cannot wait any longer. We need the outgoing President and Republicans in Congress to stop playing games with American lives. We can't ignore the fact that Americans are dying and the economy is struggling because of a refusal to take this virus seriously. It is time to face facts and work together to pass a coronavirus relief package now.

Ms. LEE of California. Thank you very much, Chairwoman CHU, and thank you for being with us tonight, but also for your consistently sounding the alarm to all of us about the necessity for culturally and linguistically appropriate services, testing, contact tracing, as well as the importance of disaggregating the data based on race and ethnicity. Thank you for input into helping to write this bill.

Mr. Speaker, I yield to the gentlewoman from Illinois (Ms. KELLY), who is the chair of the Congressional Black Caucus' Health Braintrust, someone who is a member of the House Energy and Commerce Committee and also a member of the Oversight and Reform Subcommittee on National Security and Subcommittee on Civil Rights and Civil Liberties.

Congresswoman ROBIN KELLY has helped put together this bill and helped make sure that we put provisions in for data collection and all of the information that we know we need to be able to target these resources.

So thank you, Congresswoman ROBIN KELLY, for being here tonight and for helping us.

Ms. KELLY of Illinois. Mr. Speaker, I rise today to challenge this Congress to act to end the shocking health disparities that COVID–19 has put on display. To date, nearly 250,000 Americans have lost their lives to COVID–19 and more than 10 million have been infected. And these numbers are still rising.

Shocking, but not surprisingly, a disproportionate number, as you have heard, of those who fought and those who fought and lost battles with COVID–19 have been people of color. Once again, another public health crisis has taken an oversized toll on Black Americans, Latinx Americans, Asian and Pacific Americans, and Native Americans.

COVID–19 is simply the latest in a long list of diseases, including cancer, addiction, HIV/AIDS, maternal mortality, diabetes, cardiovascular conditions, and on and on and on, with a disproportionate impact on communities of color.

Why does this continue to be the case in America, the greatest, richest, most powerful country in the history of our world?

The answer is simple: health disparities.

In America, despite all of our technology and pledges to equity, the ZIP Code in which you are born is nearly inescapable as a determinant of your life, your health, and, yes, even your death.

In Chicago, part of my district, life expectancy varies up to 30 years by neighborhood. The pattern is the same across most American communities.

But what are the social determinants of health, or, as I like to say, the social determinants of life?

In short, they are all of the nonmedical factors that impact your health, the things you don't necessarily see a doctor for, such as not having ample fresh food and vegetables in your diet because there aren't any grocery stores in your community; missing routine preventive care, such as cancer screenings, because seeing the doctor means getting up at 4 a.m., taking two buses, and missing a day of work or school.

It means worrying about manganese or lead poisoning in the air you breathe, the water you drink, or the playground where your child plays.

It means dealing with stress, anxiety, and depression from housing instability on top of a recession and pandemic.

All of these factors decide our lives, our health, and, tragically, again, our death. So many of these factors are out of one's individual control, including environmental factors, the location of medical facilities, discriminatory housing policy, and discrimination and so forth.

We all know these factors have been with us for a long time. They have been undermining our health and the health of generations of Americans for centuries.

As we work on these issues, I am continuously reminded of a quote from Dr. King: ''Of all of the forms of inequality, injustice in healthcare is the most shocking and inhumane.''

Despite 70 years passing and amazing technological and societal advancement since he spoke these words, injustice in healthcare, of all of the forms of inequality, still remains the most shocking and inhumane.

Right now, we are seeing parallel COVID–19 pandemics: one in wealthier, whiter communities, and a much harsher one in vulnerable communities of color.

But this is America. There shouldn't be a two-tiered system, because when it comes to public health, we are all in this together.

The only solution is to root out health disparities at their source. We must end systemic racism and a lack of opportunities for low-income and minority communities.

To address these issues in healthcare, my colleague and mentor, Congresswoman BARBARA LEE, has introduced the COVID Community Care Act, H.R. 8192. This legislation, which I am proud to support and my office helped develop, will provide grants for community-based organizations and nonprofits to conduct testing, tracing, and outreach activities in communities.

Given the number and rates of COVID–19, we know that these resources are most urgently needed in communities of color. I believe this legislation is central to making health equity a cornerstone of our Nation's immediate pandemic response. I am proud to be an original cosponsor of this important and immediate-acting legislation.

Additionally, I have introduced the Ending Health Disparities During COVID–19 Act, H.R. 8200, which provides a sweeping approach to addressing the widening health disparities from COVID–19. It tackles the immediate-term needs of testing, tracing, and public awareness from COVID–19.

But just as crucially, the bill makes long-term investments to build a stronger system to reduce and eliminate health inequities in the future via investments in the social determinants of health, technology, research, workforce diversity, and community health centers and workers.

Lastly, H.R. 8200 makes our government accountable for progress on health equity by creating a Federal task force with oversight over health disparities during COVID–19 and beyond and protects the Office of Minority Health. That is a long list to do, but it is all desperately needed.

I truly feel that this long-term approach, combined with strict accountability for health disparities, is exactly what this moment calls for. For the first time, many Americans are waking up to the reality faced by communities of color, a reality that the Tri-Caucus and our fellow Members of Congress, such as champions like Representative BARBARA LEE, are working to address.

We need to harness this rightful outrage and catalyze it into action. We need to make this the last pandemic to have a disproportionate impact on any

American community, because the fact is Americans deserve a public health system that works for all Americans. We deserve to live in one America, not an unequal America with worse health outcomes for Black and Brown people.

We all deserve healthcare because healthcare is a human right, yet it is not easily won. It must be fought for. As Frederick Douglass taught us: ''Power concedes nothing without a demand. It never did and it never will.'' The only path forward is for us to demand it.

□ 2045

We demand action to end health disparities once and for all. We must do this by passing the COVID Community Care Act, H.R. 8192; and Ending Health Disparities during the COVID–19 Act, H.R. 8200.

Ms. LEE of California. Mr. Speaker, I thank Congresswoman KELLY for laying out actually what the social determinants of healthcare are. Oftentimes, we see that as separate from healthcare, but you laid it out perfectly, so thank you for educating us tonight.

Mr. Speaker, I yield to the gentlewoman from Texas (Ms. JACKSON LEE), who is a member of the Judiciary Committee, but also is a member of the Congressional Black Caucus and the Congressional Native American Caucus. I know Congresswoman JACKSON LEE's district in Texas is ravaged by this COVID pandemic, so I want to thank her for helping us with our COVID Community Care Act and for being here tonight.

Ms. JACKSON LEE. Mr. Speaker, I thank very much the distinguished manager, the honorable BARBARA LEE. I am most grateful for her yielding to me. Also, let me acknowledge the very important work that she has done over the years in disparities and racial equity. I thank her for being my partner in H.R. 40, and me her partner in H. Res. 100, that really also speaks to the pain and the issues of disparities.

We look forward to reconciliation and we look forward to repair with those two initiatives. Let me also acknowledge the chair of the Congressional Black Caucus for gathering us all together, and my colleagues that are here, and my colleague that has just joined us, Congresswoman ADAMS.

Let me try to address where we are nationwide and how disparities weaves its way into this phenomenon of the transfer of power—the peaceful transfer of power—and how the President's status of the President-elect and Vice President-elect is interwoven in how to best respond to one of the disparities in healthcare, and that is COVID–19.

Mr. Speaker, first to take note of the fact that the stability of the United States electoral system is remarkable, it first involved the election of 1800, which marked the first time in United States history that power was transferred. The second was the 1876 election, which the President was chosen, who won neither the absolute majority popular vote nor the necessary electoral votes, but it was resolved by the infamous Hayes-Tilden Compromise. The third instance involved the 2000 election, which sought the Supreme Court effectively deciding the Presidency. But in each of those moments there was an end. In each of those moments there was a transfer of power.

We find ourselves now in a quandary. Believe it or not, there are people who are on ventilators. There are people in El Paso and Dallas who are in hospitals, who are being negatively impacted by the idea of the lack of peaceful engagement, specifically because the President-elect and Vice President-elect definitively need to be able to secure information to have their COVID–19 task force speak with the White House task force to understand prospectively how vaccines will be transferred or implemented throughout the Nation.

So as people are languishing on hospital beds, as loved ones are saying goodbye over telephones, we have this inability to transfer power. Our history has shown the transfer of power in the Nation. It was designed as a benefit. It can be harmed when the transition is not smooth and transparent, which can be invariably attributed to one or more of the following reasons.

The outgoing President is still engaged in the building of his or her legacy in the final months of the administration; two, there are sharp differences in philosophy or style between the outgoing and incoming administration; or the current or future President actively makes trouble for his or her successor.

In this timeframe, I hope my colleagues, Republicans and Democrats, will find a way, as we come back to Washington, to be able to look to the transition of Dwight D. Eisenhower and John F. Kennedy, for example, and speak to the idea of how this should go; or maybe even from Lyndon Baines Johnson and Richard Nixon, opposite parties, but yet they found a way to come together in the wake of the importance of the Constitution and democracy.

Why would I start a health disparities discussion on the transfer of power?

As I indicated, it is very important for the work that is going to be part of containing COVID–19 to really start now, to really start now with a new attitude about wearing masks, socially distance, washing your hands, and yes, testing, testing, testing.

That is what I have found as a chair of the bipartisan Congressional COVID Task Force where we have been working on doing the work of implementing and talking about the diagnostic testing and all its gradations over the past couple of months.

Our first testing site in Houston was opened on March 19. We have opened 41 test sites. The most recent was this past Saturday. We open the 42nd on this coming Saturday. The question in disparities is very, very real. The pandemics dealing with racial disparities indicates that there are 74 Black or African-American persons out of 100,000 impacted by COVID; Alaska Native and American Indian, 40; Hispanic or Latino, 40; Asian, 31; White, 30; Native Hawaiian, 29; others, 29.

We can see that there are large numbers of African Americans, Hispanic, and American Indian. We just heard that the Navajo community will be shutting down for a period of time. That is how devastating COVID–19 is. That is how much the disparities in healthcare are evident.

Let me share with you this question of disparities and underlying conditions. Those are numbers of the number of deaths. So the number of deaths is much higher among African Americans and Hispanics.

Why?

Thirty percent more likely to die of CVD—that is cardiovascular disease—that is Black Americans. Latin Americans, 40 percent more likely to die from stroke. And then it goes on. Two times as likely to die as an infant, two times more likely to die of asthma, three times more likely to develop ESRD, two times more likely to die from prostate cancer, two times on cervical cancer, three times in pregnancy. There is still a high level of maternal mortality among African Americans.

As it relates to Latin Americans and Hispanics, two times more likely to die of liver cancer, two times more likely to die of asthma, 1.7 more times to have diabetes, and two times more likely to die of HIV-AIDS. Which is why we see this increasing number of those on that ethnic backgrounds, African Americans, Hispanics and, of course, Native Americans and Alaskans, because of the underlying conditions and the lack of access to healthcare.

We are on this floor today because, as members of the Tri-Caucus, we have made it our constructive business, starting from the Affordable Care Act, to deal with the question of health disparities. As a Member of Congress many years back, I authored legislation to create an Office of Health Disparities in the Health and Human Services Department, knowing that there was a lack of recognition of different clinicals that African Americans were not participating in, men and women. Hispanic men and women were not participating in those as well.

In the course of the work that we are doing right now, we are seeing a high number of deaths. Texas hit 1 million cases on November 6. We were the first State to hit 1 million cases. Now, in Dallas and El Paso, my sister cities, my colleagues who are there working very hard, our hospitals are being oversaturated. The same thing that happened to Houston, Texas, in July of 2020.

And so it is crucial to do three things: One, we must pass the Heroes

Act. We are desperate for that money in testing, desperate for PPPs, desperate for PPEs. We are now running out of PPEs in some of these saturated towns. We are desperate, as I said, for testing. We are desperate for economic dollars that are needed.

Every testing site that I have had—most of them, let me clarify that, we have had full distribution by our Houston Food Bank, because people need food. And as evidenced with lines in my sister State, just a day or two ago in Los Angeles, we saw cars and cars and cars of individuals recognizing that testing was crucial.

I believe that we cannot ignore anymore. There must be cooperation with our Republican friends, I will call them, to deal with providing this financial relief to our cities and to all of our constituents who are desperately in need. We must acknowledge the health disparities. It is important both in the White House task force, we know that it is happening in the COVID task force under the President-elect and Vice President-elect, that health disparities can kill.

And we can see that the lack of a transition of power right at this time, the continued denial of who has been the victor, so that the General Services Administration can stop violating the administrative procedure code in not allowing the resources necessary for the team that is now in place looking to transition to power with the existing Presidency being stopped, not by law, not by any determination that you did not meet the standard of victory in terms of the Electoral College, but by an individual administrator who indicates that they refuse to certify and to allow that transfer of funds for them to work on.

So I thank the gentlewoman for allowing me to present today, to speak both on the disparities and the needs for response, but also on the devastating impact of COVID–19 impacting now several States.

Mr. Speaker, I want to close on this. I want to say it to America. We are coming on our holidays, and many different faiths celebrate their holidays during this time, from Thanksgiving to, in the Christian faith, Christmas, but many different faiths. I am not here to judge how and which faith will be celebrating this very special time of the year. We beg of you, on the basis of science, to realize that because someone is your family member does not mean that they are immune or that they cannot transfer COVID to you, or they are not asymptomatic. My message is that we must test, test, test.

Today, I had a press conference in Houston, and I want to read these words as I close. I would encourage all cities and States to follow what was utilized in Los Angeles. It was effective. And that is a public safety alert. A public safety alert that is simple, that goes out to the text of all citizens.

COVID–19 cases are increasing. Please wear a mask and social distance. Get tested if you have symptoms or might have been exposed. I would add to that, get tested because you may be asymptomatic. That simple note to the text of people in that State allowed thousands of individuals to see the importance of getting tested, and they went to the testing sites. That is going to help contain and stop the community spread.

So my message is, as you get into Thanksgiving, please do your events outside. If you are inside, doing them 10 or less. Please ask all of your relatives and loved ones to get tested, tested, tested, so that we can contain this preceding the vaccine, which we know is coming, but is not coming as soon as we would like.

We also know that we will be addressing the question of implementation and distribution as it relates to people of color and those who suffer disparities, along with the elderly and those underlying conditions.

You will not get a vaccine tomorrow. While we are waiting for that process, we need to do what is right. And that is to continue to social distance, wearing the mask and getting tested.

Mr. Speaker, I thank the gentlewoman for her kindness and her leadership.

Mr. Speaker, today I rise to join my colleagues during this Special Order to shed light on the impact of COVID–19 on communities of color.

I want to recognize and thank Congresswoman KAREN BASS and the Congressional Black Caucus for hosting this hour, so that we may not only speak about the disproportionate impact of the coronavirus on communities of color but also call upon the federal government to address these devastating inequities.

Mr. Speaker, before addressing the devastating impact of the COVID–19 crisis on communities of color, I wish to speak briefly on the important subject of presidential transitions and the peaceful transfer of power for which the United States is justly celebrated around the world.

The stability of the United States electoral system is remarkable, but this does not mean it has never been tested; it has—three times—and weathered each crisis.

The first involved the election of 1800, which marked the first time in United States history that power had transferred peacefully between political parties.

The second involved the 1876 election, in which a president was chosen who won neither the absolute majority popular vote nor the necessary number of electoral votes and was resolved by the infamous 'Hayes-Tilden Compromise,' which effectively ended Reconstruction.

The third instance involved the 2000 election which saw the Supreme Court effectively decide the presidency by ordering the cessation of ballot counting in the state of Florida.

Mr. Speaker, what enabled the country to weather these crises is that all parties, including the victor and the vanquished, understood and accepted the primacy of the rule of law and the bedrock democratic value that power is only legitimately conveyed by the people through their votes and is held in trust and to be used exclusively to protect and advance the national interest.

A peaceful transfer of power implies also a smooth and seamless transition from outgoing administration to the incoming one, which has usually but not always been the case.

Our history has shown how the transfer of power, and the nation it was designed to benefit, can be harmed when the transition is not smooth and transparent, which can invariably be attributed to one or more of the following reasons: (1) the outgoing president is still engaged in the business of building his or her legacy in the final months of the administration; (2) there are sharp differences in philosophy or style between the outgoing and incoming administrations; or (3) the current or future president actively makes trouble for his successor or predecessor.

The transition between President Dwight D. Eisenhower and the newly elected John F. Kennedy is an example of the dangers of presidential legacy building post-election because Eisenhower authorized covert programs for regime change in what is today the Democratic Republic of the Congo, in the Dominican Republic, and, most famously, against Fidel Castro's Cuba but none of these programs were completed by the time Kennedy took the oath of office.

The second form of trouble can come from the soon-to-be-powerful people on the receiving end of a transition, as when incoming President George W. Bush failed to pay due heed to the warnings received from then President Bill Clinton about the dangers of Osama Bin Laden and Al Qaeda.

But far the most serious harm to be avoided stems from the failure of the outgoing administration to prioritize and expedite the sharing of vital information and resources with the incoming administration.

This is the danger we currently face in the aftermath of President-elect Biden's resounding victory in the Electoral College and the popular vote.

Mr. Speaker, the federal government is perhaps the most complex organization in the world because it involves a $5 trillion-plus budget, four million person workforce, including the military and reservists, who are stationed all over the globe, and two million career civil servants in hundreds of operating units of the Executive Branch, not to mention the 4,000 political appointments made by the President.

So, a presidential transition of this enterprise is a massive operation that requires a lot of work, time, and cooperation in three important areas.

The first is access to the agencies themselves—there are over 100 operating in the government—and the incoming team needs to understand what's happening inside them because each and every one of them have different urgent issues that they are addressing and deciding, including for example, the approval and distribution of any vaccine for COVID–19 and dealing with the economic damage caused by the pandemic.

The second area is the processing of personnel, 1,200 of whom require Senate confirmation and who will need security clearances and financial agreements with the Office of Government Ethics to make sure there are no conflicts.

Third, the incoming President must have access to the President's Daily Brief, to ensure it has awareness and understanding of the most current threats and challenges facing our nation.

The final area is providing funding needed to pay the salaries and expenses of the incoming administration's transition personnel.

I call upon the current President to honor his oath of office to defend, protect, and preserve the Constitution and America's sacred tradition of peaceful transfers of power and begin the full and seamless transition to the Biden Administration.

Turning to the immediate subject at hand, we must recognize the impact of COVID–19 on people of color and its devastating consequences on the communities we represent.

As a Founding Member of the Bipartisan Congressional Coronavirus Task Force, I call upon my fellow Members of Congress to not only recognize the disproportionate impact of this virus on communities of color but also to come together to redress this reality.

I first saw news reports on the rapid spread of the coronavirus in early January.

As the numbers of infected increased, I knew this was not something to be taken lightly, so I began to monitor the situation more closely.

On February 10, 2020, I held the first press conference on the issue of the novel coronavirus at Houston Intercontinental Airport, where I was joined by public health officials, local unions, and advocates to raise awareness regarding the virus, the implications it might have for travel to the United States from China, and the need to combat early signs of discrimination targeting Asian businesses in the United States.

From the onset of this pandemic, I have actively worked to address the negative and unequal affects of this disease on people of color.

I have facilitated the opening of 41 COVID–19 testing sites, which have collectively provided over 200,000 tests to residents in Harris County, one of the most diverse counties in the state of Texas.

Across the United States, Black individuals comprise thirteen percent of the population.

Yet, we experience a higher rate of incarceration and health disparities, are more vulnerable to economic slowdowns, and are even more likely to get COVID–19 and face significantly worse health outcomes from the disease.

Disparities tell the story of living while Black in America, and there are disparities in every aspect of African American life and death.

Right now, Black people are dying at 2.2 times the rate and Latinx people at two times the rate of white people.

Whereas American Indian and Alaska Native people are 5.3 times more likely than white people to be hospitalized due to COVID–19.

My district of Harris County has reported over 175,000 total cases of coronavirus, of which over 17,300 identify as Black and over 37,700 identify as Hispanic or Latinx.

From a high prevalence of preexisting conditions to limited employment opportunities to additional structural inequities that are the result of implicit bias and racial discrimination, there are several factors at play for why communities of color are disproportionately affected by the coronavirus,

For example, the African American community is known to be highly affected by preexisting conditions, such as diabetes, heart disease, hypertension, lung disease, and obesity.

With these underlying health conditions, many African Americans suffer from an impaired immune system, thereby dramatically increasing the risk of being infected with and the fatality of the coronavirus.

Limited employment opportunities also play a role in understanding why people of color are most affected by this disease.

According to the Center for Economic and Policy Research, Black workers make up about one in nine workers overall, but they represent about one in six front-line-industry workers, further increasing the disproportionate likelihood of being exposed to and contracting the virus.

These disparities cannot be separated from the history of enslavement of Black people and subsequent periods of segregation, racialized violence, pervasive racial discrimination and their ongoing impacts.

With that in mind, I urge my colleagues to support my bill, H.R. 40, the Commission to Study and Develop Reparation Proposals for African-Americans Act, as it is the most comprehensive legislative solution to begin repairing the legacy of systemic racism and accounting for the harms of past and present.

Mr. Speaker, it is abundantly clear that people across the United States are struggling in the face of this epidemic.

As Members of Congress, we have a duty to our constituents to address this vicious cycle of socioeconomic disparities that further the inequities facing communities of color, especially during the COVID–19 crisis.

We must come together to ensure that COVID–19 relief extends to all members of our communities.

Ms. LEE of California. Mr. Speaker, I thank the gentlewoman from Texas for using this opportunity to deliver a very powerful public health message also. I also would just note a personal privilege. I was born and raised in El Paso, Texas, and my heart goes out to all of those who are suffering from this terrible deadly pandemic.

Mr. Speaker, I want to salute our colleague, Congresswoman VERONICA ESCOBAR, for being such a tremendous leader in El Paso in trying to help on the ground with taking care of people and preventing the transition of the virus.

I thank Congresswoman JACKSON LEE again.

Mr. Speaker, I now yield to the gentlewoman from North Carolina (Ms. ADAMS), a member of the Committee on Education and Labor, whose mission in life, I think, is to make sure that our young people are educated and receive the best quality education through the Historically Black Colleges and Universities, and at the same time make sure that their health and safety is a top priority issue for their health and their safety.

□ 2100

Ms. ADAMS. Mr. Speaker, I thank the gentlewoman for yielding and for her leadership. I thank, as well, the Chair of the Congressional Black Caucus for getting us together tonight.

Mr. Speaker, I rise today as the founder and co-chair of the Black Maternal Health Caucus.

I want to take this time to speak briefly about the impact of COVID–19 on the Black community, communities of color, and pregnant women.

For the past 8 months, our country has been battling this incredibly deadly virus. It is a national public health crisis unlike any we have experienced. And it has highlighted the existing racial health disparities that our communities were already facing.

The data does not lie. We know that people of color are experiencing significantly higher rates of infections and deaths compared to White individuals.

Black people are more than twice as likely to die from COVID–19 as White people, and the mortality rate for Native Americans is nearly two times that of White persons.

Researchers have also found that Black and Hispanic people are nearly three times as likely to contract COVID–19 and nearly two times as likely to die from COVID–19.

This month, a CDC morbidity and mortality weekly report found that pregnant women are at increased risk for severe illness from COVID–19.

Since January 22, more than 38,000 pregnant women have been diagnosed with COVID–19 in the United States, of which 51 have died.

The study found that pregnant women are more likely to be admitted to the intensive care unit, receive invasive ventilation, and are at increased risk of death compared to White, nonpregnant women.

But much remains unknown.

But what we do know is that before the pandemic Black and Brown mothers were already dying at alarming and unacceptable rates.

In particular, Black women from all walks of life were three and four times more likely to die from pregnancy-related complications than White women.

According to the CDC data, Latina women account for nearly 50 percent of COVID–19 cases among pregnant women.

And these numbers indicate the devastating effects of the pandemic on the minority community.

A recent study also showed that Black and Latina women in Philadelphia who are pregnant were five times more likely to be exposed to the new coronavirus than White pregnant women.

Physicians in Washington, DC, said that anecdotally they were also seeing similar patterns, according to an August report in the Washington Post.

As Congresswoman LEE and I have continued to say since the start of the pandemic, we are facing a crisis within a crisis. And that is why I have been working closely with healthcare providers, stakeholders, to provide a comprehensive plan for eliminating these racial health disparities, especially during the pandemic.

We must improve access to screening and treatment for women at risk for preterm birth;

Ensure that all women have access to high quality maternity care, no matter where they live;

And provide access to midwives or doulas that can advocate for families' needs throughout pregnancy, labor, and delivery.

This summer I introduced the COVID–19 Bias and Anti-Racism Training Act to provide grants for hospitals and healthcare providers for implicit bias training, particularly in light of COVID–19.

We all have our unconscious bias, and it is important for our healthcare providers to be more aware of those issues as they are providing care to patients during the pandemic.

We need to invest in programs that help families meet their basic needs, including nutrition assistance, housing assistance, and other social supports.

Last, but certainly not least, we must improve the quality of the data being collected and ensure diversity among stakeholders that serve on mortality review committees.

If we don't stand together to address these inequities, Black and Brown mothers, our families, our friends, and our communities will continue to suffer.

I hope this Congress will stand together to ensure that our communities, our mothers, our babies have the resources they need—not only to survive this pandemic, but to thrive and truly build back stronger.

Mr. Speaker, I thank the gentlewoman from California for her leadership.

Ms. LEE of California. Mr. Speaker, I thank Congresswoman ALMA ADAMS for that very clear statement and I thank her for outlining the interconnection and the intersection between systemic racism and the social determinants of healthcare and how they impact the underlying conditions and exacerbate it now as seen in COVID–19. I thank Congresswoman ADAMS again for her leadership.

Mr. Speaker, I yield to the gentlewoman from Pennsylvania (Ms. SCANLON), who certainly knows the serious and devastating impact of this COVID pandemic in her district. I visited her district and understand how close she is to her nonprofits and her community-based organizations who are doing phenomenal work.

Mr. Speaker, I thank Congresswoman SCANLON very much for being here.

Ms. SCANLON. Mr. Speaker, I thank the gentlewoman for arranging this Special Order hour.

I stand before you today frustrated by the lack of Federal relief as COVID–19 surges across the country. With each day that we don't have relief for families, businesses, our frontline workers, and the State and local governments that have borne the brunt of the pandemic response, its impact grows that much more disastrous—and disproportionately so for our communities of color.

More than a quarter of my constituents are Black, and we now know that Black individuals are almost three times as likely to become infected with COVID–19 as White individuals and twice as likely to die of the virus. So over the past 9 months my district has seen families and neighborhoods devastated by this virus.

My district is also home to our Nation's poorest and hungriest major city. When you live paycheck to paycheck, one missed shift or even missing an hour's worth of work forces families to make impossible decisions between putting food on the table or keeping a roof overhead, and it makes quarantining impossible.

For the most part these are not new challenges caused by COVID–19, these are challenges that have been plaguing our most marginalized communities and communities of color for decades. But the pandemic has exacerbated and laid bare these inequities for all who care enough to see. It is why we must provide relief to help our communities survive the pandemic and commit to closing the gaps preexisting the pandemic that have been holding families back for far too long.

Our families are in crisis. They need stimulus checks to pay their rent and mortgages. They need access to free testing to protect themselves and their families. They also need food and childcare and access to equitable education, housing, healthcare, and wages.

This pandemic has shown us there is a roadmap to improving the lives of millions of Americans, especially our communities of color, but we must have the courage to follow it.

Ms. LEE of California. Mr. Speaker, I thank Congresswoman SCANLON for joining us tonight with our Tri-Caucus and Congressional Black Caucus, because so many of the issues that you are talking about in your district as it relates to COVID and health disparities and the social determinants we all are dealing with in our districts, and so thank you for your leadership and for continuing to help us get this Heroes Act passed so that we can do some of the things that you laid out that our communities deserve.

Mr. Speaker, I include in the RECORD the following statements from the Leadership Conference on Civil and Human Rights, the National Indian Health Board, the Asian Health Services, and UnidosUS.

STATEMENT FOR THE RECORD: LEADERSHIP CONFERENCE ON CIVIL AND HUMAN RIGHTS

On behalf of the Leadership Conference on Civil and Human Rights, I submit this testimony for the record.

No matter what we look like, where we live, or what is in our wallets, getting sick reminds us that at our core we are all the same. But we cannot ignore the pandemic's disproportionate and devastating impact on Black and Brown people, Native Americans, low-income people, people with disabilities, the elderly, women, and immigrant communities. Through health and education disparities, income inequality, discrimination in voting and housing, unequal treatment within the legal system, and the digital divide, communities of color have been routinely locked out and left behind—and sadly, as we have seen in increased hate violence and in far worse health outcomes for people of color, this pandemic is no different.

This pandemic calls for the enactment of policies and sufficient funding to protect low- and moderate-income people from economic disaster and to meet the urgent needs of the most vulnerable people in our nation. Communities that have already been marginalized by structural barriers to equal opportunities and who have low levels of wealth are particularly vulnerable during this current emergency. While many working people have been sidelined, many others are still providing essential services during the crisis—working at our grocery stores, delivering mail and packages, and providing care to vulnerable people—putting their lives at risk, often at reduced hours and wages, to keep our country running. The ongoing crisis has laid bare the structural racism and barriers to opportunity that are entrenched in our society, and our collective actions now must not worsen them.

STATEMENT FOR THE RECORD: NATIONAL INDIAN HEALTH BOARD

On behalf of the National Indian Health Board (NIHB) and the 574 sovereign Tribal Nations we serve, I submit this testimony for the record.

American Indian and Alaska Native (AI/AN) Tribal communities have been disproportionately impacted by the COVID–19 pandemic. No sector of Tribal economies or health systems have been spared from the devastation this crisis has unleashed. We are now, as of this writing, seven months in the throes of an unparalleled pandemic. While we may not have been able to prevent the outbreak of COVID–19, we absolutely could have mitigated the worst of its impacts—especially in Indian Country. But unfortunately, our Tribes are, once again, battling a catastrophic, unprecedented, once-in-a-lifetime disease without the necessary federal relief funds and resources to protect and preserve life.

Since June of this year alone, NIHB has submitted seventeen letters to Congress urging immediate action and passage of emergency stimulus funds for the Indian health system to better respond to COVID–19. We solemnly await congressional action. We have consistently urged long-term reauthorization of the Special Diabetes Program for Indians (SDPI), vital to Tribal efforts to mitigate the spread of COVID–19 by preventing, treating, and managing one of the strongest risk factors for a more serious COVID–19 illness: type II diabetes. We solemnly await congressional action. We have demanded that Congress work to fulfill Treaty obligations to Tribal Nations and Native people by ensuring congressional COVID–19 relief funds are on par with the recommendations outlined by Tribal leaders and health experts. We solemnly await congressional action. We have urged that burdensome administrative requirements for accessing federal grants and programs be eliminated to ensure expeditious delivery of relief resources. We solemnly await congressional action. We have urged that Congress not subject the Indian health system to a destabilizing continuing resolution (CR) as it continues to combat against an unparalleled pandemic; or to, at the least, attach emergency COVID–19 appropriations for IHS to the CR to mitigate the pain and disruption. Again, we solemnly await congressional action.

To be clear, we continue to appreciate the commitment and leadership of members of Congress in working to advance Tribal health priorities in response to COVID–19. But the Tribes require action from all of Congress on those commitments. On September 10, NIHB was joined by the National

Congress of American Indians and the National Council of Urban Indian Health in a letter to congressional leadership urging immediate action on the priorities listed below. These priorities have remained intact since early summer, as Indian Country continues to bear the brunt of this extraordinary crisis. In short, these priorities have not changed because the situation in Indian Country remains just as dire. Once again, we solemnly await congressional action.

TRIBAL COVID–19 PRIORITIES

Minimum $2 billion in emergency funds to IHS for immediate distribution to I/T/U system.

$1.7 billion to replenish lost 3rd party reimbursements across the I/T/U system.

Prioritize equitable distribution of a safe and effective COVID–19 vaccine across Indian Country, including a minimum 5 percent set-aside in vaccine funds for the I/T/U system.

Minimum $1 billion for water and sanitation systems across IHS and Tribal communities.

Long-term reauthorization (5 years), higher funding, and expansion of self-determination and self-governance for the Special Diabetes Program for Indians.

COVID–19 UPDATES

The last time NIHB appeared before this Subcommittee was June 10, 2020. Since that time, the number of AI/AN COVID–19 case infections reported by IHS have nearly quadrupled. Similarly, the Centers for Disease Control and Prevention (CDC) reported a roughly 22 percent increase in COVID–19 hospitalization rates among AI/ANs—increasing from a rate of 272 per 100,000 in mid-July to 347.7 per 100,000 as of September 12, 2020. Rates of death from COVID–19 among AI/ANs have more than doubled since the last time NIHB testified before the Subcommittee—from a rate of 36 per 100,000 on June 9 to 81.9 per 100,000 as of September 15.

In August, the Centers for Disease Control and Prevention (CDC) reported that across 23 states, cumulative incidence rates of lab-confirmed COVID–19 cases among AI/ANs are 3.5 times higher than for non-Hispanic Whites. Also, according to CDC, age-adjusted rates of COVID–19 hospitalization among AI/ANs from March 1, 2020, through August 22, 2020, were 4.7 times higher than for non-Hispanic Whites. Without sufficient additional congressional relief sent directly to I/T/U systems, these shocking upward trends will more than likely continue as COVID–19 restrictions are eased, schools and businesses reopen, and the potential threat of a more severe flu season coincides with this pandemic. State-specific data further demonstrate the vast inequities in COVID–19 deaths between AI/ANs and the general population. Below are a few examples of these state-specific disparities based on NIHB's analysis of state-specific data.

In Arizona, AI/ANs account for 5.5 percent of the population, but 13.4 percent of COVID–19 deaths.

In New Mexico, AI/ANs account for 10.7 percent of the population, but nearly 57 percent of COVID–19 deaths.

In Montana, AI/ANs account for 8.2 percent of the population, but 27 percent of COVID–19 deaths.

In South Dakota, AI/ANs account for 10.4 percent of the population, but nearly 23 percent of COVID–19 deaths.

In North Dakota, AI/ANs account for 6.5 percent of the population, but 13.3 percent of COVID–19 deaths.

In Mississippi, AI/ANs account for less than 1 percent of the population, but 3 percent of COVID–19 deaths.

Even more alarming is the lack of complete data on COVID–19 outcomes among AI/ANs. Available COVID–19 data already highlight significant disparities between AI/ANs and the general population; shockingly, true estimates of disease burden and death resulting from COVID–19 in Indian Country are likely much higher. In CDC's own August 2020 report on COVID–19 in Indian Country, the authors noted the following:

This analysis represents an underestimate of the actual COVID–19 incidence among AI/AN persons for several reasons. Reporting of detailed case data to CDC by states is known to be incomplete; therefore, this analysis was restricted to 23 states with more complete reporting of race and ethnicity. As a result, the analysis included only one half of reported laboratory-confirmed COVID–19 cases among AI/AN persons nationwide, and the examined states represent approximately one third of the national AI/AN population. In addition, AI/AN persons are commonly misclassified as non-AI/AN races and ethnicities in epidemiologic and administrative data sets, leading to an underestimation of AI/AN morbidity and mortality.

Indeed, there are multiple states that still have a significant percentage of COVID–19 cases missing critical demographic data. In California for instance, a whopping 31 percent of cases are still missing race and ethnicity. The State of New York has failed to report AI/AN data altogether—listing only Hispanic, Black, White, Asian, or Other on their COVID–19 data dashboards.

Meanwhile, the Special Diabetes Program for Indians (SDPI)—instrumental for COVID–19 response efforts in Indian Country because it is focused on prevention, treatment, and management of diabetes, one of the most significant risk factors for a more serious COVID–19 illness—has endured four short-term extensions since last September, placing immense and undue strain on program operations. Under the House-passed CR for FY 2021 H.R. 8337, SDPI is extended for a mere eleven days—its shortest reauthorization on record. A national survey of SDPI grantees conducted by NIHB found that nearly 1 in 5 Tribal SDPI grantees reported employee furloughs, including for healthcare providers, with 81 percent of SDPI furloughs directly linked to the economic impacts of COVID–19 in Tribal communities. Roughly 1 in 4 programs have reported delaying essential purchases of medical equipment to treat and monitor diabetes due to funding uncertainty, and nearly half of all programs are experiencing or anticipating cutbacks in the availability of diabetes program services—all under the backdrop of a pandemic that continues to overwhelm the Indian health system.

Now, with the inevitability of a continuing resolution (CR) through at least December 11, 2020—and the possibility of another CR thereafter—it is even more imperative that Congress provide emergency appropriations to better stabilize the Indian health system. This Subcommittee knows full well that IHS is the only federal healthcare system that is subject to government shutdowns and CRs. This Subcommittee is also acutely aware of the devastating impacts that endless CRs have had, and will continue to have, on the Indian health system. We commend Chair McCollum's leadership in introducing H.R. 1128 and Ranking Member Joyce's strong support for H.R. 1135—both of which would authorize advance appropriations for IHS and permanently insulate it from the volatility of the annual appropriations process. But in the interim, Congress must ensure a funding fix that protects and preserves life in Indian Country and delivers critical pandemic relief in recognition of federal Treaty obligations. If Congress fails to provide sufficient emergency appropriations for the Indian health system, a stopgap measure will force a healthcare system serving roughly 2.6 million AI/ANs to operate during a pandemic without an enacted budget or even adjustments for rising medical and non-medical inflation. In short, that is a recipe for even more disaster, death, and despair.

We patiently remind you that federal Treaty obligations for healthcare to Tribal Nations and AI/AN Peoples exist in perpetuity and must be fully honored, especially in light of the current pandemic and its unparalleled toll in Indian Country. While we appreciate the roughly $1 billion to IHS under the CARES Act and the $750 million testing set-aside under the Paycheck Protection Program and Health Care Enhancement Act; these investments have been necessary but woefully insufficient to stem the tide of the pandemic in Tribal communities.

We thank you for your continued commitment to Indian Country, and as always, stand ready to work with you in a bipartisan fashion to advance the health of all AI/AN people.

Sincerely,

NATIONAL INDIAN HEALTH BOARD.

STATEMENT FOR THE RECORD: ASIAN HEALTH SERVICES

On behalf of the One Nation Commission, Co-Chairs Sherry Hirota, CEO of Asian Health Services, and former Congressman Mike Honda, I submit this testimony for the record.

The information shared, is documented in the One Nation Commission 2020 Report: One Nation AAPIs Rising to Fight Dual Pandemics COVID–19 and Racism, which was delivered to every member of Congress and the Senate in October 2020.

The COVID–19 pandemic has hit communities of color, including AAPIs, the hardest. In the 13th Congressional District, Alameda County in California, AAPIs are the largest population subgroup, comprising a diverse and varied population, spanning every economic stratum; essential workers and corporate CEOs, Nobel Laureates and students on the broken side of the digital divide, researchers and doctors, janitors and food servers, and new immigrants all contributing to society in this time of crisis.

By the time COVID–19 was declared a global pandemic and national emergency, the Asian American and Pacific Islander (AAPI) Community had already gone underground. Fear of the virus was compounded by a sudden and virulent rise in hate and violence against Asians. Racist taunting by our country's top leader calling Covid–19 ''Kung Flu,'' and ''China Virus,'' used the pandemic and its economic destruction to scapegoat Asian Americans across the country. Congresswoman Lee's own staffer was called, ''COVID'' and pelted with rocks while riding his bike through Rock Creek Park in D.C. Despite calls from every sector of the AAPI Community for the president to retract his dangerous words, the hate speak continued. The result was a tsunami of attacks on Asian Americans.

As COVID–19 cases spiked around the country, AAPIs were not only blamed but appeared missing from the news coverage, data, and charts. The twenty-five-year-old health advocacy battle to ''disaggregate data'' reared its ugly head again and was now a matter of life and death. Lumping together information about ethnic and language groups obstructs effective epidemiology and care. In the big picture, the absence of data ensures invisibility for AAPIs as a whole, and each subpopulation within that designation. Missing are the number of AAPIs who have been tested, how many tested positive, how many are sick, or hospitalized, or have died. We must expand the frame—to ask, what is the impact of COVID–19 on AAPI communities? To fill the gap a self-organized

work group of nationally renowned AAPI researchers pulled data from multiple cities and states revealing higher death rates among Asian Americans who were Covid positive.

Nine months into the dual pandemic of COVID–19 and racism, the AAPI community is fighting back against being both blamed and ignored. The One Nation Commission is honored to join forces with Congresswoman Barbara Lee, Congresswoman Karen Bass, and the Congressional Black Caucus, Congressional Asian Pacific Islander American Caucus, and individuals and organizations to defeat COVID–19, bring back our communities stronger and healthier, combat hate crimes against AAPIs, and work in solidarity with the Black, Latinx and Indigenous People to fight systemic racism.

Hidden disparities undermine effective and just health policy and outcomes. COVID vaccine allocation, for example, based prioritization in part on inaccurate information of disparities and vulnerabilities. Recently the National Academy of Sciences released recommendations on vaccine allocation but did not name Asian Americans as a vulnerable group. This must be immediately rectified.

Critical to health, justice, equity, and the opportunity for our communities to emerge stronger than before from these dual pandemics:

(1) Mandate disaggregated data collection and reporting;

(2) Require linguistically and culturally competent outreach and care;

(3) Strengthen and resource the community health center and nonprofit safety net; and

(4) Reverse unfair and un-American anti-immigrant policies that endanger the public health and public good, including Public Charge.

Immediate next steps:

(1) Protecting and further investing in trusted community-based organizations to implement new programs and preserve proven programs,

COVID community testing,

COVID contact tracing,

Cultural and linguistic competency,

Addressing misinformation that creates fear and chilling effects (e.g., public charge rule change).

(2) Expanding beyond COVID–19 outcomes (cases and deaths) to understand full impacts

Anti-Asian hate crimes à physical and mental health,

Mental health,

Immigration status affecting access and utilization of services (e.g., public charge rule change),

Other social determinants of health (occupation/essential workers, living conditions, language barriers).

(3) Data disaggregation is paramount to identifying and addressing hidden disparities. Encourage immediate disaggregated data collection at the local levels—testing, cases, comorbidities, deaths,

Do not let the perfect be the enemy of the good: Reinforce disaggregated data reporting in public communications to create this paradigm shift, even with small numbers,

An example of hidden disparities: Filipinos having even more striking death rates. In the U.S., Filipino nurses make up 4 percent of workforce but nearly 31.5 percent of deaths among registered nurses.

STATEMENT FOR THE RECORD: UNIDOSUS

On behalf of UnidosUS, I submit this testimony for the record.

Communities of color are putting life and limb on the line every day to help our nation through the COVID–19 crisis yet continue to be overwhelmingly and disproportionately impacted by the dire health and economic repercussions of this pandemic.

These unprecedented and devastating times continue to expose the appalling and deeply unjust fault lines in our nation's health care system and labor force. Despite the fact that Latinos are overrepresented in ''essential'' occupations where they are most at risk of exposure to the coronavirus infection and are also bearing the brunt of the economic fallout from the pandemic, they have been consistently excluded from much needed COVID–19 relief legislation.

Any further delay in COVID–19 relief legislation will be particularly devastating to the health and well-being of our nation's 58 million Latinos, far too many of whom have been left out of the four coronavirus relief packages enacted so far. Failure to respond urgently to the human suffering we are witnessing is deeply objectionable and, from a public health and economic perspective, wholly indefensible.

Latinos have long suffered from health disparities—being more likely to develop chronic health conditions such as diabetes, heart disease, and obesity. Another disparity is emerging, Latinos are contracting and dying from COVID–19 disproportionately and are nearly three times more likely to die compared to non-Hispanic Whites.

These disparities are a result of multiple preexisting structural and societal factors, including a health care system that leaves coverage out of reach of millions of Latinos. Before the pandemic, more than 10 million Latinos (including 1.6 million Latino children) were uninsured, and preliminary data now show that the Latino uninsured rate increased over the course of 2020. Latinos have also long struggled with food insecurity and increased stressors and mental health issues, and the pandemic has only exacerbated these challenges.

Ms. LEE of California. Mr. Speaker, let me take a moment to thank all of our colleagues who joined us this evening laying out the pandemic upon pandemic upon pandemic in communities of color.

In all past public health crises one recurring lesson stands out: That is, success depends on the willingness of people to trust the health information that they are getting. We learned this from the HIV and AIDS pandemic, Ebola, H1N1, and now we are learning it again during COVID. So this is especially true for communities of color.

This year millions of Americans have taken to the streets to demand racial justice. This is because the system that exists today has failed them. We must acknowledge the centuries old racial and ethnic disparities, and intentionally build culturally and community-minded policies to move forward for a stronger and unified country.

We must act swiftly. The longer communities suffer from COVID–19, the greater the long-term impact and disparities. States project that their shortfall for 2021-fiscal year will be much deeper than the shortfalls faced in any year of the Great Recession.

Federal Reserve economists project that unemployment will be at 6.5 percent at the end of 2021. Of course, it is higher in communities of color. The Congressional Budget Office projects an even higher rate at 6.7 percent; again, for communities of color more than likely it is double that.

Our Nation's workforce is disproportionately composed of communities of color and some of the most marginalized communities and groups. Many are essential workers. These workers and their families are being put at greater risk during the coronavirus pandemic due to the conditions of their jobs and their socioeconomic realities and, mind you, the lack of Federal response. We must pass a COVID relief bill.

I am proud to stand before you joined by my colleagues because I know that this change is on the horizon. From the sidewalks to the ballot boxes, people are fully engaged and are courageously advocating to be heard. It is our job that every community is ensured coronavirus relief and that we negotiate what is needed, including funding to provide relief for every community and with community stakeholders.

Our bill, H.R. 8192, the COVID Community Care Act, does just that. We cannot afford to leave anyone behind.

Mr. Speaker, once again, I thank our Speaker; Chairwoman BASS, for sharing this CBC Special Order hour; and I thank our Tri-Caucus chairs, Congresswoman CHU and Representative CASTRO, Representatives HAALAND, DAVIDS, of course, Representative GARCÍA. And I thank all of our colleagues for being here tonight to really sound the alarm.

This is an emergency in the entire country. It is a deep and broad emergency pandemic as it relates to COVID–19, and we need relief right away.

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

Ms. JOHNSON of Texas. Mr. Speaker, I rise today to speak on the impact of the coronavirus (COVID–19) pandemic on our communities of color across this nation. This virus has deeply impacted every segment of our society, but the harms that have befallen certain populations have been disproportionate and devastating.

For our Black, Latino, Indigenous, Asian, and immigrant families, COVID–19 has exacerbated longstanding inequities in our health care and economic systems, and our communities of color have been burdened with higher rates of comorbidities, more barriers in accessing medical care, and worse health outcomes due to this virus. This has been devastating to observe, as many of these same communities have also been dealing with significant economic turmoil in these recent months.

Never has our society faced a challenge such as this. These are truly unprecedented times, and it merits our relentless efforts to lessen the damages of this pandemic, which is expected to worsen during this upcoming winter season. It is our responsibility as members of this chamber to prevent the imminent disparate harms of COVID–19 on communities of color. We must also address the systematic issues of structural racism in our society, which affects the health and economic wellbeing of our families.

Everyday, our nation sees the need for further action to combat this public

health crisis. I urge my colleagues to join me in supporting additional federal assistance to fight this pandemic and protecting our communities of color.

Mr. CARSON of Indiana. Mr. Speaker, I rise today in support of the Tri-Caucus' Special Order to highlight the disproportionate impact of COVID–19 on communities of color. Our nation is currently overwhelmed by unprecedented numbers of COVID–19 cases, hospitalizations and deaths. After more than eight months of suffering, the COVID–19 pandemic continues to ravage our communities, creating incalculable pain, massive economic disruption, and immense strain on our public health system. As of this moment, more than 246,000 Americans have lost their lives from this deadly disease. More than eleven million have been infected, and nearly 70,000 are currently hospitalized with severe cases of COVID–19. While all Americans are suffering from this pandemic, communities of color are experiencing acute and disproportionate pain.

From the beginning of this pandemic, it was clear that the phrase ''when white America catches a cold, Black America gets pneumonia'' would be particularly true with COVID–19's devastating consequences. In fact, the COVID–19 pandemic disproportionately harms Black and Brown communities with dramatically unequal infection rates, hospitalizations, and deaths. Specifically, Black people are three times more likely to become infected with COVID–19 than whites. Moreover, Black people die from COVID–19 at around twice the rate of white people. These aren't just statistics. They represent our friends, neighbors, and loved ones. They are people like my cousin who died from COVID–19 earlier this year, and so many others who are no longer with us.

Like past disease outbreaks and natural disasters, the COVID–19 pandemic lays bare the consequences of systemic injustices suffered by communities of color. Institutional racism, compounded by environmental and economic injustices, have resulted in severe health disparities for communities of color which make the COVID–19 pandemic so uniquely devastating. Despite the disproportionate harm the COVID–19 pandemic has caused among communities of color, many states still do not provide transparency regarding racial and ethnic demographic data for COVID–19 cases and deaths. For example, in my state of Indiana, the State only provides an aggregate breakdown of the racial and ethnic demographics for cases and deaths during the entire pandemic. This results in a profoundly incomplete picture of the disproportionate sickness, death, fear and tragedy this virus is inflicting on communities of color.

As Congress considers much-needed, additional measures to combat COVID–19 and provide relief for businesses, hospitals and workers, one thing is clear: Communities of color must receive substantial relief and support that matches the devastation they've suffered from this pandemic. In addition, states and public health departments must provide updated and daily demographic information, including a racial and ethnic breakdown, for the daily numbers of COVID–19 cases and deaths. This data transparency is essential to fully understand how the pandemic is affecting different communities and how we can best respond. With this data, we can better target our COVID–19 relief funds and support to ensure that communities of color get all the help we need to weather the storm of this pandemic and combat the underlying inequities in our health care system that this pandemic has exacerbated.

I am committed to work with my colleagues on both sides of the aisle to act now and to act boldly to implement a national plan that will save lives from this terrible disease.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. ADERHOLT (at the request of Mr. MCCARTHY) for today and the balance of the week on account of quarantining as precautionary measure as recommended by the Office of Attending Physician.

CERTIFICATION SUBMITTED PURSUANT TO SECTION 5(a) OF HOUSE RESOLUTION 965, 116TH CONGRESS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOUSE ADMINISTRATION,
Washington, DC, November 10, 2020.

Hon. NANCY PELOSI,
Speaker, of the House of Representatives, Washington, DC.

DEAR MADAM SPEAKER: Pursuant to section 5(a) of House Resolution 965, following consultation with the Ranking Minority Member, I write to notify you that that operable and secure technology exists to conduct remote voting in the House of Representatives.

Sincerely,

ZOE LOFGREN,
Chairperson.

NOTICE OF PROPOSED RULEMAKING

U.S. CONGRESS,
OFFICE OF CONGRESSIONAL WORKPLACE RIGHTS,
Washington, DC, November 16, 2020.

Hon. NANCY PELOSI,
Speaker of the House, House of Representatives, Washington, DC.

DEAR MADAM SPEAKER: Section 202(d) of the Congressional Accountability Act (CAA), 2 U.S.C. 1312(d), requires the Board of Directors of the Office of Congressional Workplace Rights (''the Board'') to issue regulations implementing Section 202 of the CAA relating to sections 101 through 105 of the Family and Medical Leave Act of 1993 (''FMLA''), 29 U.S.C. 2611 through 2615, made applicable to the legislative branch by the CAA. 2 U.S.C. 1312(a)(1).

Section 304(b)(1) of the CAA, 2 U.S.C. 1384(b)(1), requires that the Board issue a general notice of proposed rulemaking by transmitting ''such notice to the Speaker of the House of Representatives and the President Pro Tempore of the Senate for publication in the Congressional Record on the first day of which both Houses are in session following such transmittal.''

On behalf of the Board, I am hereby transmitting the attached notice of proposed rulemaking to the Speaker of the House of Representatives. I request that this notice be published in the House section of the Congressional Record on the first day on which both Houses are in session following receipt of this transmittal. In compliance with Section 304(b)(2) of the CAA, a comment period of 30 days after the publication of this notice of proposed rulemaking is being provided before adoption of the rules.

Any inquiries regarding this notice should be addressed to Susan Tsui Grundmann, Executive Director of the Office of Congressional Workplace Rights, Room LA–200, 110 Second Street, S.E., Washington, D.C. 20540–1999; 202–724–9250.

Sincerely,

BARBARA CHILDS WALLACE,
Chair of the Board of Directors,
Office of Congressional Workplace Rights.

Attachment.

NOTICE OF PROPOSED RULEMAKING FROM THE BOARD OF DIRECTORS OF THE OFFICE OF CONGRESSIONAL WORKPLACE RIGHTS AND REQUEST FOR COMMENTS FROM INTERESTED PARTIES.

MODIFICATIONS TO THE RIGHTS AND PROTECTIONS UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA), NOTICE OF PROPOSED RULEMAKING, AS REQUIRED BY 2 U.S.C. 1312, CONGRESSIONAL ACCOUNTABILITY ACT OF 1995, AS AMENDED (CAA).

Background:

The purpose of this Notice is to propose modifications to the existing legislative branch FMLA substantive regulations under section 202 of the CAA (2 U.S.C. 1302 et seq.), which applies the rights and protections of sections 101 through 105 of the FMLA to covered employees. On December 20, 2019, Congress enacted the Federal Employee Paid Leave Act (subtitle A of title LXXVI of division F of the National Defense Authorization Act for Fiscal Year 2020, Public Law 116–92, December 20, 2019) (FEPLA). FEPLA amended the FMLA to allow most civilian Federal employees, including eligible employees in the legislative branch, to substitute up to 12 weeks of paid parental leave (PPL) for unpaid FMLA leave granted in connection with the birth of an employee's son or daughter or for the placement of a son or daughter with an employee for adoption or foster care. These modifications are necessary in order to bring existing legislative branch FMLA regulations (issued April 19, 1996) in line with these recent statutory changes.

What is the authority under the CAA for these proposed substantive regulations?

Section 202(a) of the CAA provides that the rights and protections established by sections 101 through 105 of the FMLA (29 U.S.C. 2611–2615) shall apply to covered employees in the legislative branch. Section 202(d)(1) and (2) of the CAA require that the Office of Congressional Workplace Rights Board of Directors (the Board), pursuant to section 304 of the CAA, issue regulations implementing the rights and protections of the FMLA and that those regulations shall be ''the same as substantive regulations promulgated by the Secretary of Labor to implement the statutory provisions referred to in the subsection (a) [of section 202 of the CAA] except insofar as the Board may determine, for good cause shown . . . that a modification of such regulations would be more effective for the implementation of the rights and protections under this section.'' The modifications to the regulations proposed by the Board herein are on all matters for which section 202 of the CAA requires regulations to be issued.

Are there currently FMLA regulations in effect?

Yes. On January 22, 1996, the OCWR Board adopted and submitted for publication in the Congressional Record the original FMLA final regulations implementing section 202 of the CAA, which applies certain rights and protections of the FMLA. On April 15, 1996, pursuant to section 304(c) of the CAA, the House and the Senate passed resolutions approving the final regulations. Specifically,