

116TH CONGRESS
2D SESSION

S. 3850

To require the Centers for Disease Control and Prevention to collect and report certain data concerning COVID–19.

IN THE SENATE OF THE UNITED STATES

JUNE 1, 2020

Ms. WARREN (for herself, Ms. HARRIS, Mr. BOOKER, Mr. MARKEY, Mr. MERKLEY, Mr. DURBIN, Mr. VAN HOLLEN, Ms. BALDWIN, Mr. CARPER, Mr. KAINE, Mr. CARDIN, Ms. KLOBUCHAR, Mr. SANDERS, Mr. WHITEHOUSE, Mr. BLUMENTHAL, Mr. BROWN, Mr. WARNER, Ms. STABENOW, Mr. PETERS, and Mr. WYDEN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To require the Centers for Disease Control and Prevention to collect and report certain data concerning COVID–19.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Equitable Data Collec-
5 tion and Disclosure on COVID-19 Act”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

1 (1) The World Health Organization (WHO) de-
2 clared COVID–19 a “Public Health Emergency of
3 International Concern” on January 30, 2020. By
4 late March 2020, there have been over 470,000 con-
5 firmed cases of, and 20,000 deaths associated with,
6 COVID–19 worldwide.

7 (2) In the United States, cases of COVID–19
8 have quickly surpassed those across the world, and
9 as of April 12, 2020, over 500,000 cases and 20,000
10 deaths have been reported in the United States
11 alone.

12 (3) Early reporting on racial inequities in
13 COVID–19 testing and treatment has renewed calls
14 for the Centers for Disease Control and Prevention
15 and other relevant subagencies within the Depart-
16 ment of Health and Human Services to publicly re-
17 lease racial and demographic information to better
18 inform the pandemic response, specifically in com-
19 munities of color and in Limited English Proficient
20 (LEP) communities.

21 (4) The burden of morbidity and mortality in
22 the United States has historically fallen dispropor-
23 tionately on marginalized communities (those who
24 suffer the most from great public health needs and
25 are the most medically underserved).

1 (5) Historically, structures and systems such as
2 racism, ableism and class oppression, have rendered
3 affected individuals more vulnerable to inequities
4 and have prevented people from achieving optimal
5 health even when there is not a crisis of pandemic
6 proportions.

7 (6) Significant differences in access to health
8 care, specifically to primary health care providers,
9 health care information, and greater perceived dis-
10 crimination in health care place communities of
11 color, individuals with disabilities, and LEP individ-
12 uals at greater risk of receiving delayed, and per-
13 haps poorer, health care.

14 (7) Stark racial inequities across the United
15 States, including unequal access to stable housing,
16 quality education, and decent employment, signifi-
17 cantly impact the ability of individuals to take care
18 of their most basic health needs. Communities of
19 color are more likely to experience homelessness and
20 struggle with low-paying jobs or unemployment. To
21 date, experts have cited that 2 in 5 Latino residents
22 in New York City, the current epicenter of the
23 COVID–19 pandemic, are recently unemployed as a
24 direct consequence of COVID–19. And at a time
25 when sheltering in place will save lives, less than 1

1 in 5 Black workers and roughly 1 in 6 Latino work-
2 ers are able to work from home.

3 (8) Communities of color experience higher
4 rates of chronic disease and disabilities, such as dia-
5 betes, hypertension, and asthma, than non-Hispanic
6 White communities, which predisposes them to
7 greater risk of complications and mortality should
8 they contract COVID–19.

9 (9) Such communities are made even more vul-
10 nerable to the uncertainty of the preparation, re-
11 sponse, and events surrounding the pandemic public
12 health crisis, COVID–19. For instance, in the recent
13 past, multiple epidemiologic studies and reviews have
14 reported higher rates of hospitalization due to the
15 2009 H1N1 pandemic among the poor, individuals
16 with disabilities and preexisting conditions, those liv-
17 ing in impoverished neighborhoods, and individuals
18 of color and marginalized ethnic backgrounds in the
19 United States. These findings highlight the urgency
20 to adapt the COVID–19 response to monitor and act
21 on these inequities via data collection and research
22 by race and ethnicity.

23 (10) Research experts recognize that there are
24 underlying differences in illness and death when
25 each of these factors is examined through socio-

1 economic and racial or ethnic lenses. These socially
2 determinant factors of health accelerate disease and
3 degradation.

4 (11) Language barriers are highly correlated
5 with medication noncompliance and inconsistent en-
6 gagement with health systems. Without language ac-
7 cessibility data and research around COVID–19,
8 these communities are less likely to receive critical
9 testing and preventive health services. Yet, to date,
10 the Centers for Disease Control and Prevention does
11 not disseminate COVID–19 messaging in critical
12 languages, including Mandarin Chinese, Spanish,
13 and Korean within the same timeframe as informa-
14 tion in English despite requirements to ensure lim-
15 ited English proficient populations are not discrimi-
16 nated against under title VI of the Civil Rights Act
17 of 1964 and subsequent laws and Federal policies.

18 (12) Further, it is critical to disaggregate data
19 further by ancestry to address disparities among
20 Asian American, Native Hawaiian, and Pacific Is-
21 lander groups. According to the National Equity
22 Atlas, while 13 percent of the Asian population over-
23 all lived in poverty in 2015, 39 percent of Burmese
24 people, 29 percent of Hmong people, and 21 percent
25 of Pacific Islanders lived in poverty.

1 (13) Utilizing disaggregation of enrollment in
2 Affordable Care Act-sponsored health insurance, the
3 Asian and Pacific Islander American Health Forum
4 found that prior to the passage of the Patient Pro-
5 tection and Affordable Care Act (Public Law 111–
6 148), Korean Americans had a high uninsured rate
7 of 23 percent, compared to just 12 percent for all
8 Asian Americans. Developing targeted outreach ef-
9 forts assisted 1,000,000 people and resulted in a 56-
10 percent decrease in the uninsured among the Asian,
11 Native Hawaiian, and Pacific Islander population.
12 Such efforts show that disaggregated data is essen-
13 tial to public health mobilizations efforts.

14 (14) Without clear understanding of how
15 COVID–19 impacts marginalized racial and ethnic
16 communities, there will be exacerbated risk of en-
17 dangering the most historically vulnerable of our
18 Nation.

19 (15) The consequences of misunderstanding the
20 racial and ethnic impact of COVID–19 expound be-
21 yond communities of color such that it would impact
22 all.

23 (16) Race and ethnicity are valuable research
24 and practice variables when used and interpreted ap-
25 propriately. Health data collected on patients by

1 race and ethnicity will boost and more efficiently di-
2 rect critical resources and inform risk communica-
3 tion development in languages and at appropriate
4 health literacy levels, which resonate with historically
5 vulnerable communities of color.

6 (17) To date, there is no public standardized
7 and comprehensive race and ethnicity data reposi-
8 tory of COVID–19 testing, hospitalizations, or mor-
9 tality. The inconsistency of data collection by Fed-
10 eral, State, and local health authorities, and the in-
11 ability to access data by public research institutions
12 and academic organizations, poses a threat to anal-
13 ysis and synthesis of the pandemic impact on com-
14 munities of color. However, research and medical ex-
15 perts of Historically Black Colleges and Universities,
16 academic health care institutions which are histori-
17 cally and geographically embedded in minoritized
18 and marginalized communities, generally also pos-
19 sess rapport with the communities they serve. They
20 are well-positioned, as trusted thought leaders and
21 health care service providers, to collect data and con-
22 duct research toward creating holistic solutions to
23 remedy the inequitable impact of this and future
24 public health crises.

1 (18) Well-designed, ethically sound research
 2 aligns with the goals of medicine, addresses ques-
 3 tions relevant to the population among whom the
 4 study will be carried out, balances the potential for
 5 benefit against the potential for harm, employs
 6 study designs that will yield scientifically valid and
 7 significant data, and generates useful knowledge.

8 (19) The dearth of racially and ethnically
 9 disaggregated data reflecting the health of commu-
 10 nities of color underlies the challenges of a fully in-
 11 formed public health response.

12 (20) Without collecting race and ethnicity data
 13 associated with COVID–19 testing, hospitalizations,
 14 morbidities, and mortalities, as well as publicly dis-
 15 closing it, communities of color will remain at great-
 16 er risk of disease and death.

17 **SEC. 3. EMERGENCY FUNDING FOR FEDERAL DATA COL-**
 18 **LECTION ON THE RACIAL, ETHNIC, AND**
 19 **OTHER DEMOGRAPHIC DISPARITIES OF**
 20 **COVID–19.**

21 To conduct or support data collection on the racial,
 22 ethnic, and other demographic implications of COVID–19
 23 in the United States and its territories, including support
 24 to assist in the capacity building for State and local public
 25 health departments to collect and transmit racial, ethnic,

1 and other demographic data to the relevant Department
2 of Health and Human Services agencies, there is author-
3 ized to be appropriated—

4 (1) to the Centers for Disease Control and Pre-
5 vention, \$12,000,000;

6 (2) to State and territorial public health agen-
7 cies, distributed proportionally based on the total
8 population of their residents who are enrolled in
9 Medicaid or who have no health insurance,
10 \$15,000,000;

11 (3) to the Indian Health Service, Indian Tribes
12 and Tribal organizations (as defined in section 4 of
13 the Indian Self-Determination and Education Assist-
14 ance Act), and urban Indian organizations (as de-
15 fined in section 4 of the Indian Health Care Im-
16 provement Act), \$3,000,000;

17 (4) to the Centers for Medicare & Medicaid
18 Services, \$5,000,000;

19 (5) to the Food and Drug Administration,
20 \$5,000,000;

21 (6) to the Agency for Healthcare Research and
22 Quality, \$5,000,000; and

23 (7) to the Office of the National Coordinator
24 for Health Information Technology, \$5,000,000.

1 **SEC. 4. COVID-19 DATA COLLECTION AND DISCLOSURE.**

2 (a) DATA COLLECTION.—The Secretary of Health
3 and Human Services (referred to in this Act as the “Sec-
4 retary”), acting through the Director of the Centers for
5 Disease Control and Prevention and the Administrator of
6 the Centers for Medicare & Medicaid Services, shall make
7 publicly available on the website of the Centers for Disease
8 Control and Prevention data collected across all surveil-
9 lance systems relating to COVID-19, disaggregated by
10 race, ethnicity, sex, age, primary language, socioeconomic
11 status, disability status, and county, including the fol-
12 lowing:

13 (1) Data related to all COVID-19 testing, in-
14 cluding the number of individuals tested and the
15 number of tests that were positive.

16 (2) Data related to treatment for COVID-19,
17 including hospitalizations and intensive care unit ad-
18 missions.

19 (3) Data related to COVID-19 outcomes, in-
20 cluding total fatalities and case fatality rates (ex-
21 pressed as the proportion of individuals who were in-
22 fected with COVID-19 and died from the virus).

23 (b) APPLICATION OF STANDARDS.—To the extent
24 practicable, data collection under this section shall follow
25 standards developed by the Department of Health and
26 Human Services Office of Minority Health and be col-

1 lected, analyzed, and reported in accordance with the
2 standards promulgated by the Assistant Secretary for
3 Planning and Evaluation under title XXXI of the Public
4 Health Service Act (42 U.S.C. 300kk et seq.).

5 (c) TIMELINE.—The data made available under this
6 section shall be updated on a daily basis throughout the
7 public health emergency.

8 (d) PRIVACY.—In publishing data under this section,
9 the Secretary shall take all necessary steps to protect the
10 privacy of individuals whose information is included in
11 such data, including—

12 (1) complying with privacy protections provided
13 under the regulations promulgated under section
14 264(c) of the Health Insurance Portability and Ac-
15 countability Act of 1996; and

16 (2) protections from all inappropriate internal
17 use by an entity that collects, stores, or receives the
18 data, including use of such data in determinations of
19 eligibility (or continued eligibility) in health plans,
20 and from inappropriate uses.

21 (e) INDIAN HEALTH SERVICE.—The Indian Health
22 Service shall consult with Indian Tribes and confer with
23 urban Indian organizations on data collection and report-
24 ing for purposes of this Act.

1 (f) REPORT.—Not later than 60 days after the date
 2 on which the Secretary certifies that the public health
 3 emergency related to COVID–19 has ended, the Secretary
 4 shall make publicly available a summary of the final statis-
 5 tics related to COVID–19.

6 (g) REPORT.—Not later than 60 days after the date
 7 on which the Secretary certifies that the public health
 8 emergency related to COVID–19 has ended, the Depart-
 9 ment of Health and Human Services shall compile and
 10 submit to the Committee on Health, Education, Labor,
 11 and Pensions and the Committee on Finance of the Senate
 12 and the Committee on Energy and Commerce and the
 13 Committee on Ways and Means of the House of Rep-
 14 resentatives a preliminary report—

15 (1) describing the testing, hospitalization, mor-
 16 tality rates, and preferred language of patients asso-
 17 ciated with COVID–19 by race and ethnicity; and

18 (2) proposing evidenced-based response strate-
 19 gies to safeguard the health of these communities in
 20 future pandemics.

21 **SEC. 5. COMMISSION ON ENSURING HEATH EQUITY DUR-**
 22 **ING THE COVID–19 PUBLIC HEALTH EMER-**
 23 **GENCY.**

24 (a) IN GENERAL.—Not later than 30 days after the
 25 date of enactment of this Act, the Secretary shall establish

1 a commission, to be known as the “Commission on Ensuring
 2 ing Heath Equity During the COVID–19 Public Health
 3 Emergency” (referred to in this section as the “Commis-
 4 sion”) to provide clear and robust guidance on how to im-
 5 prove the collection, analysis, and use of demographic data
 6 in responding to future waves of the coronavirus.

7 (b) MEMBERSHIP AND CHAIRPERSON.—

8 (1) MEMBERSHIP.—The Commission shall be
 9 composed of—

10 (A) the Director of the Centers for Disease
 11 Control and Prevention;

12 (B) the Director of the National Institutes
 13 of Health;

14 (C) the Commissioner of Food and Drugs;

15 (D) the Administrator of the Federal
 16 Emergency Management Agency;

17 (E) the Director of the National Institute
 18 on Minority Health and Health Disparities;

19 (F) the Director of the Indian Health
 20 Service;

21 (G) the Administrator of the Centers for
 22 Medicare & Medicaid Services;

23 (H) the Director of the Agency for
 24 Healthcare Research and Quality;

25 (I) the Surgeon General;

1 (J) the Administrator of the Health Re-
2 sources and Services Administration;

3 (K) the Director of the Office of Minority
4 Health;

5 (L) the Director of the Office of Women's
6 Health;

7 (M) the Chairperson of the National Coun-
8 cil on Disability;

9 (N) at least 4 State, local, territorial, and
10 Tribal public health officials representing de-
11 partments of public health, who shall represent
12 jurisdictions from different regions of the
13 United States with relatively high concentra-
14 tions of historically marginalized populations, to
15 be appointed by the Secretary; and

16 (O) racially and ethnically diverse rep-
17 resentation from at least 3 independent experts
18 with knowledge or field experience with racial
19 and ethnic disparities in public health appointed
20 by the Secretary.

21 (2) CHAIRPERSON.—The President of the Na-
22 tional Academies of Sciences, Engineering, and Med-
23 icine, or designee, shall serve as the chairperson of
24 the Commission.

25 (c) DUTIES.—The Commission shall—

1 (1) examine barriers to collecting, analyzing,
2 and using demographic data;

3 (2) determine how to best use such data to pro-
4 mote health equity across the United States and re-
5 duce racial, Tribal, and other demographic dispari-
6 ties in COVID–19 prevalence and outcomes;

7 (3) gather available data related to COVID–19
8 treatment of individuals with disabilities, including
9 denial of treatment for pre-existing conditions, re-
10 moval or denial of disability related equipment (in-
11 cluding ventilators and CPAP machines), and data
12 on completion of DNR orders, and identify barriers
13 to obtaining accurate and timely data related to
14 COVID–19 treatment of such individuals;

15 (4) solicit input from public health officials,
16 community-connected organizations, health care pro-
17 viders, State and local agency officials, and other ex-
18 perts on barriers to, and best practices for, collecting
19 demographic data; and

20 (5) recommend policy changes that the data in-
21 dicates are necessary to reduce disparities.

22 (d) REPORT.—Not later than 60 days after the date
23 of enactment of this Act, and every 180 days thereafter
24 until the Secretary certifies that the public health emer-
25 gency related to COVID–19 has ended, the Commission

1 shall submit a written report of its findings and rec-
2 ommendations to Congress and post such report on the
3 website of the Department of Health and Human Services.

4 Such reports shall contain information concerning—

5 (1) how to enhance State, local, territorial, and
6 Tribal capacity to conduct public health research on
7 COVID–19, with a focus on expanded capacity to
8 analyze data on disparities correlated with race, eth-
9 nicity, income, sex, age, disability status, specific ge-
10 ographic areas, and other relevant demographic
11 characteristics, and an analysis of what demographic
12 data is currently being collected about COVID–19,
13 the accuracy of that data and any gaps, how this
14 data is currently being used to inform efforts to
15 combat COVID–19, and what resources are needed
16 to supplement existing public health data collection;

17 (2) how to collect, process, and disclose to the
18 public the data described in paragraph (1) in a way
19 that maintains individual privacy while helping di-
20 rect the State and local response to the virus;

21 (3) how to improve demographic data collection
22 related to COVID–19 in the short- and long-term,
23 including how to continue to grow and value the
24 Tribal sovereignty of data and information con-
25 cerning Tribal communities;

1 (4) to the extent possible, a preliminary anal-
2 ysis of racial and other demographic disparities in
3 COVID–19 mortality, including an analysis of
4 comorbidities and case fatality rates;

5 (5) to the extent possible, a preliminary anal-
6 ysis of sex, gender, sexual orientation, and gender
7 identity disparities in COVID–19 treatment and
8 mortality;

9 (6) an analysis of COVID–19 treatment of indi-
10 viduals with disabilities, including equity of access to
11 treatment and equipment and intersections of dis-
12 ability status with other demographic factors, includ-
13 ing race, and recommendations for how to improve
14 transparency and equity of treatment for such indi-
15 viduals during the COVID–19 public health emer-
16 gency and future emergencies;

17 (7) how to support State, local, and Tribal ca-
18 pacity to eliminate barriers to COVID–19 testing
19 and treatment; and

20 (8) to the extent possible, a preliminary anal-
21 ysis of Federal Government policies that disparately
22 exacerbate the COVID–19 impact, and recommenda-
23 tions to improve racial and other demographic dis-
24 parities in health outcomes.

1 (e) AUTHORIZATION OF APPROPRIATIONS.—There is
2 authorized to be appropriated such sums as may be nec-
3 essary to carry out this section.

○