lengthened shadow of one person, then the Agape International Spiritual Center, the Association for Global New Thought, and the Season for Nonviolence are all indeed extensions of Dr. Beckwith. Furthermore, they are distinctly an emblem of his vision of one human family united on a foundation of peace based on the spiritual origin of every man, woman and child.

Mr. Speaker, I rise today to acknowledge an extraordinary human being. Rev. Dr. Michael Beckwith, an outstanding man, an emissary of peace, and a humanitarian for all people, who has made a profound and lasting impact on our world through his distinctive stand for peace and harmony in our community.

Having known ''Reverend Michael,'' as his community affectionately refers to him, since he was a child, I can unequivocally say that his life is a testament to building community. In the 1970's he began a journey that to this day embraces the major religions, philosophies and cultures of East and West. One significant manifestation of this vision began in 1986 when Dr. Beckwith founded Agape, a trans-denominational community with over 9,000 members currently devoted to the study and practice of the New Thought—Ancient Wisdom tradition of spirituality.

If it is so, as Emerson has stated, that, ''every institution is but the lengthened shadow of one person,'' then the Agape International Spiritual Center, the Association for Global New Thought and the Season for Nonviolence are all indeed extensions of Dr. Beckwith. Furthermore, they are distinctly emblematic of his vision of one human family united on a foundation of peace based on the spiritual origin of every man, woman and child.

One of the largest churches of its kind, the Agape church is a portrait of multiculturalism. The diversity you will find attending service on Sunday can be compared to the diversity that would be found by walking into the United Nations. Further, Agape's unique outreach ministry reaches deep into the heart of the community to care for city, country and world citizens who need it most.

But Dr. Beckwith's impact is even greater. His entire life, being dedicated to serving his community and creating harmony in our world, has attracted the movement's most influential visionaries, leaders and teachers including Arun Gandhi and his Holiness the Dalai Lama of Tibet. Coretta Scott King wrote in a personal letter to Reverend Michael upon his election as an assembly member of the Parliament of the World's Religions, ''I greatly admire what you are doing to bring about the Beloved Community, which is certainly what my dear husband worked for an ultimately gave his life.''

Whether it's through his leadership as president of the Association of Global New Thought where he stands with co-creative leaders on the threshold of an evolutionary leap that dares to call an end to human suffering, as the author of Forty Day Mind Fast-Soul Feast and A Manifesto of Peace, or as co-founder of the Season for Nonviolence, a grassroots effort expanding the power and truth of non-violence, Reverend Michael stands before us as an exemplary guide to living in a world united by humankind's highest spiritual, philosophical, educational and scientific expression.

ON THE HEALTH CARE EQUALITY AND ACCOUNTABILITY ACT OF 2003

(Ms. JACKSON-LEE of Texas asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, in the backdrop of just returning from Iraq and seeing the challenges of our soldiers, might I offer to their families and those who lost their lives in the Black Hawk incident of just about 3 days ago my deepest sympathy.

I rise today because I am very proud to be joining with my colleagues in the offering of the Health Care Equality and Accountability Act of 2003, I believe one of the singular legislative initiatives of this century. I congratulate the gentleman from Maryland (Mr. CUMMINGS), chair of the Congressional Black Caucus; the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), chair of the Congressional Black Caucus Health Brain Trust; House Democratic leader NANCY PELOSI; Senate Democratic leader TOM DASCHLE; Senator EDWARD KENNEDY; as well as leaders of the Congressional Hispanic Caucus, the gentleman from Texas (Mr. RODRIGUEZ); Congressional Asian Pacific American Caucus; and the Native American Caucus. This has been a tremendous coming together recognizing the need for curing disparity in health care in America.

I am very proud that this bill improves the diversity of our health workforce, improves data collection on health disparities, and helps to reduce the disparities by promoting accountability and strengthening the institutions that serve minority communities.

I am glad to have been the author of two particular pieces of this legislation, one that will create the Center for Cultural and Linguistic Competence in Health Care so that individuals who speak a different language, who have a different culture will be able to be treated by those health professionals who understand; and a piece to be able to give visas to those who will come and to treat those in the inner city areas and rural communities.

Mr. Speaker, this is a great bill. I hope my colleagues on both sides of the aisle will help to see this bill passed immediately to save lives here and abroad.

Mr. Speaker, across this great Nation the health disparities between minority and majority populations are staggering. As the economy continues to falter and as the unemployment rate spikes, millions of Americans are losing their health insurance. That state of affairs will only make the health disparities worse. Therefore, the introduction and movement of this legislation is imperative.

I commend my colleagues: Representatives ELIJAH E. CUMMINGS, chair of the Congressional Black Caucus (CBC), Delegate DONNA CHRISTENSEN, chair of the CBC Health Braintrust, House Democratic Leader NANCY PELOSI, Senate Democratic Leader TOM DASCHLE, and Senator EDWARD KENNEDY, as well as Leaders from the Congressional Hispanic Caucus, the Congressional Asian Pacific American Caucus, and the Native American Caucus. This has been a tremendous effort, and has truly resulted in a landmark piece of legislation.

This bill will expand health coverage, improve the diversity of our health workforce, improve data collection on health disparities and then help reduce those disparities by promoting accountability and strengthening the institutions that serve minority communities. Truly, this bill represents years of intense thought and discussion, and 9 months of hard work on both the House and Senate sides. It is the comprehensive approach that this important issue deserves. The Healthcare Equality and Accountability Act is a solid foundation upon which we can build a strong healthcare system that will bring quality affordable healthcare to all Americans.

I am also pleased to be the author of two pieces in this landmark legislation. First, this act will create the Center for Cultural and Linguistic Competence in Health Care. Too often, even people who can afford to pay for quality care receive second-rate services because healthcare providers cannot speak their language or relate to their cultural health backgrounds. Good medicine is more than dispensing pills; it is about communication and an understanding relationship between doctor and patient. The center will help foster that kind of relationship.

Also, drawing on my expertise as ranking member on the House Subcommittee on Immigration and Claims, I was gratified to contribute a piece that will provide appropriate visas for healthcare providers to come to the U.S. to work in underserved areas as needed.

It is a misconception that minority health care is just about helping minorities. Keeping Americans healthy ensures that children can stay in school and that their parents can go to work. It ensures that our emergency rooms are not glutted. It ensures that our hospitals are not wasting time and money chasing the uninsured with massive bills they cannot afford to pay anyway. Keeping Americans healthy ensures that all of our friends, neighbors, and loved ones can have longer, more productive lives to contribute to our communities and to our economy.

We all pay the cost of leaving people in America without health coverage. We cannot afford to pay that high cost any longer. The time for health equality is now.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

BAD DEAL FOR AMERICA'S SENIORS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. DEFAZIO) is recognized for 5 minutes.

Mr. DEFAZIO. Mr. Speaker, there is a lot of confusion from the debate earlier tonight about what the so-called pharmaceutical benefit for seniors is or is not. Let us just clarify things a little bit.

First off, there are two bedrock principles in this provision of law. It prohibits the Federal Government of the United States from negotiating lower drug prices on behalf of Medicare beneficiaries. It prohibits the government from doing that.

We heard a discussion from the gentlewoman from New Mexico (Mrs. WILSON) about people who will be put together in groups and they will negotiate lower prices as much as 15 or 20 percent. Well, the government has done that with our veterans and they have lowered prices up to 60 percent for those drugs and the veterans group is much smaller than the Medicare group. So if we were to aggregate all of seniors voluntarily into a group without them paying a penny or premium of any sorts and have the government negotiate on their behalf for price reductions, one could expect that they might even exceed those of Veterans Administration. Maybe we would see prices even lower than in Canada.

That is the second bedrock principle of this legislation. Not only does this legislation at the behest of the pharmaceutical industry prohibit the government from negotiating lower prices in the extortionate cost of prescription drugs, the highest in the world here in the United States, secondly, it actually would say that not only can you not do that but it is going to stop the importation or really restrain the importation of less expensive drugs from Canada and other countries because it has a provision that says the Secretary of Health and Human Services will have to say that those drugs are safe, in his opinion.

Well, he has already rendered an opinion. He has already said they are not safe in his opinion. Now, there is a little problem with that. Actually, the supply chain in Canada has more integrity than the supply chain in the United States. In the United States we have a whole host of people who are out there. We have these closed-door pharmacies. We have unregulated middle men and wholesalers. The drugs really are not tracked and a whole lot of counterfeit drugs are getting injected into the system in the United States. But in Canada the Government of Canada negotiates on the behalf of the Canadian people very substantial price cuts from U.S. manufacturers of FDA-approved drugs; and when the drugs go to Canada, they are always within the purview of the government there. They track them much more carefully than in the United States.

So arguably you could say that FDA-approved, U.S.-manufactured pharmaceuticals returning to the United States from Canada directly to a consumer would be less likely to be adulterated or counterfeit than many of those in the supply chain in the United States of America. That is very well documented. It was particularly well documented in a recent series in The Washington Post.

So what is really at risk here? If it is not the health of seniors, which is suddenly of tremendous concern to the majority party here at the behest of the pharmaceutical and insurance industries, what is really at risk? Well, what is really at risk is the extortionate price they are able to extract from the American people for pharmaceuticals. Americans pay far more than any other developed nation in the world for pharmaceuticals. This bill will do nothing to help that. In fact, this bill will guarantee that price gouging will be continued.

The other big benefit is that seniors would be allowed under this bill to go and buy private insurance at a price that is not yet totally determined but with substantial deductibles. And under the optimistic estimates, and these are only estimates because God forbid the government even after giving a $20 billion subsidy under this bill to the private insurance industry should mandate they do anything, we are hoping that they would offer an affordable benefit; and the estimates, optimistic, are that a person who has a drug bill of $1,000 a year would get a benefit of $109 a year after they pay their premiums, copayments, and deductibles. A person with a drug bill of $5,000 a year would get a benefit of $1,024. They would pay 80 percent of the cost. The person at $1,000 a year would pay 77 percent of the cost.

If those same people were just allowed to purchase their drugs from Canada, the price would be 50 percent or less. If the government negotiated on their behalf using the market power of the people in Medicare to reduce the price, it would likely be 50 or 45 percent. So what we are really doing here is providing a huge subsidy to the private insurance industry setting up the pharmaceutical industry to continue price gouging and setting up seniors for a very big fall; and this is such a great benefit, it will not even begin until year 2007.

This is really not a good deal for America's seniors, and AARP should be ashamed that they have lent their endorsement to this. I do not know what they got in return. I know what that side got and that was huge contributions from the pharmaceutical and insurance industries.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska (Mr. OSBORNE) is recognized for 5 minutes.

(Mr. OSBORNE addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

(Mr. BROWN of Ohio addressed the House. His remarks will appear hereafter in the Extensions of Remarks.)

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from the District of Columbia (Ms. NORTON) is recognized for 5 minutes.

(Ms. NORTON addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

STATUS REPORT ON CURRENT SPENDING LEVELS OF ON-BUDGET SPENDING AND REVENUES FOR FY 2004 AND THE 5-YEAR PERIOD FY 2004 THROUGH FY 2008

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Iowa (Mr. NUSSLE) is recognized for 5 minutes.

Mr. NUSSLE. Mr. Speaker, I am transmitting a status report on the current levels of on-budget spending and revenues for fiscal year 2004 and for the 5-year period of fiscal years 2004 through 2008. This report is necessary to facilitate the application of sections 302 and 311 of the Congressional Budget Act and section 501 of the conference report on the concurrent resolution on the budget for fiscal year 2004 (H. Con. Res. 95). This status report is current through November 14, 2003.

The term ''current level'' refers to the amounts of spending and revenues estimated for each fiscal year based on laws enacted or awaiting the President's signature.

The first table compares the current levels of total budget authority, outlays, and revenues with the aggregate levels set forth by H. Con. Res. 95. This comparison is needed to enforce section 311(a) of the Budget Act, which creates a point of order against measures that would breach the budget resolution's aggregate levels. The table does not show budget authority and outlays for fiscal years 2004 through 2008, because appropriations for those years have not yet been considered.

The second table compares the current levels of budget authority and outlays for discretionary action by each authorizing committee with the ''section 302(a)'' allocations made under H. Con. Res. 95 for fiscal year 2004 and fiscal years 2004 through 2008. ''Discretionary action'' refers to legislation enacted after the adoption of the budget resolution. A separate allocation for the Medicare program, as established under section 401(a)(3) of the budget resolution, is shown for fiscal year 2004 and fiscal years 2004 through 2013. This comparison is needed to enforce section 302(f) of the Budget Act, which creates a point of order against measures that would breach the section 302(a) discretionary action allocation of new budget authority for the committee that reported the measure. It is also needed to implement section 311(b), which exempts committees that comply with their allocations from the point of order under section 311(a).

The third table compares the current levels of discretionary appropriations for fiscal year 2004 with the ''section 302(b)'' suballocations of discretionary budget authority and outlays among Appropriations subcommittees. This table also compares the current level of total discretionary appropriations with the section 302(a) allocation for the Appropriations Committee. These comparisons are needed to enforce section 302(f) of the Budget Act because the point of order under that section equally applies to measures that would breach either the section 302(a) allocation or the applicable section 302(b) suballocation.