Our goal in the area of science and technology is improve the level and quality of technical assistance provided to the Caribbean region, to support improvements in the access, development and use of science and technology across all sectors, and the increased access of disadvantaged communities in the Caribbean to information technology. Our current agenda is the support of Computer centers in disadvantaged centers in the Caribbean and the development of exchange and linkages programs to support science education in the Caribbean such as support for the establishment of children's science centers.

Our goals in education and health include increasing transfer of technology to the Caribbean region; ensuring Caribbean Americans equity in health care; and supporting the provision of increased educational opportunities to disadvantaged populations in the Caribbean. This includes assisting in the establishment of linkage programs between historically Black colleges and universities.

Our goal in sociology and culture include: assisting the Caribbean-American community to participate in U.S. democratic processes; promoting the conservation and development of Caribbean arts and culture, and promoting an understanding of Caribbean culture in the U.S. Our current focus in this area is the establishment of June as Caribbean Heritage Month in the Washington, DC metropolitan region and the production of the DC Caribbean Film Festival.

THE CONVICTION OF EDGAR RAY KILLEN ON JUNE 21, 2005, IN NESHOBA COUNTY, MISSISSIPPI

HON. JOHN LEWIS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 23, 2005

Mr. LEWIS of Georgia. Mr. Speaker, it is so strange. It is so ironic. It is almost eerie that Edgar Ray Killen was convicted today exactly 41 years to the day that James Chaney, Mickey Schwerner, and Andy Goodman were found missing in Philadelphia, Mississippi. I knew these three young men, these brave and courageous fighters for freedom. They did not die in Vietnam. They did not die in the Middle East. They did not die in Eastern Europe. They did not die in Africa or South America; they died right here in the United States. And they were killed simply for helping Americans exercise their constitutional right to vote.

They were killed, not just by vicious members of the Ku Klux Klan, but they were also killed by an evil system of tradition and government that perpetuated segregation, racial discrimination, and deliberately and methodically denied African Americans the right to vote. Their murder was a sad and dark hour for the whole Civil Rights Movement, and especially for those of us who participated in the Mississippi Summer project. When we realized that these three young men were missing, it broke our hearts, but it did not destroy our determination to continue the struggle to gain the right to vote.

For more than a thousand young people who risked their lives in Mississippi that summer, and for the mothers and the families of James Chaney, Mickey Schwerner, and Andy Goodman, maybe, just maybe, what happened today will offer some degree of closure. It took a long time to bring some resolution to this case, but justice is never too late. I hope that this conviction will have a cleansing effect on our nation's dark racial past.

I also hope that the state of Mississippi and the American people will do more. I hope that we will seek and find appropriate ways to honor the sacrifices of these three young men. I hope that as a nation and as a people we will always remember that the struggle for civil rights in America is littered by the battered and broken bodies of countless men and women who paid the ultimate price for a precious right—the right to vote. We must not take that right for granted. We have a mandate from these three young men who gave their lives for our freedom in the red clay of Mississippi. We must continue the struggle for justice in America and around the world.

INTRODUCTION OF THE MEDIKIDS HEALTH INSURANCE ACT OF 2005

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 23, 2005

Mr. STARK. Mr. Speaker, it is with great pride that I join my colleagues in the House today to introduce the MediKids Health Insurance Act of 2005. This bill is also being introduced in the Senate by my good friend, Jay Rockefeller.

Mr. Speaker, this year we are honoring the 40th anniversary of Medicare, our nation's health insurance program for the elderly and people with disabilities. At the time we created Medicare, our nation's seniors were more likely to be living in poverty than any other age group. Most were unable to afford needed medical services and unable to find health insurance in the market even if they could afford it. Today, as a result of Medicare's success, seniors are much less likely to be shackled by the bonds of poverty.

Now it is our nation's children who are most likely to be poor. Kids in America are nearly twice as vulnerable to poverty as adults. This travesty is not only morally reprehensible, it also denotes grave consequences for the future of our country. Poor children are often malnourished and have difficulty succeeding in school. Untreated illnesses only worsen the chance for success. The future of our country rests in our ability to provide our children with the basic conditions to thrive and become healthy, educated, and productive adults. Guaranteeing continuous health coverage is a critical component of realizing this potential.

The MediKids Health Insurance Act of 2005 assures that every child in the United States has health insurance by 2012. Modeled after Medicare—with benefits appropriate to children, simplified cost sharing, and comprehensive prescription drug coverage—MediKids covers America's kids from birth until age 23.

MediKids assures that families will always have access to affordable health insurance for their children. Parents retain the choice to enroll their kids in private plans or government programs such as Medicaid or S–CHIP. However, if a lapse in other insurance coverage occurs, MediKids automatically fills in the gap. MediKids is the ultimate safety net, available nationwide, with maximum simplicity, stability, and flexibility.

Many children's advocates and health care professionals who care for children are united in their support for MediKids, including: the American Academy of Pediatrics, the Children's Defense Fund, the American Academy of Family Physicians, the American Academy of Child and Adolescent Psychiatry, the American Nurses Association, Consumers' Union, FamiliesUSA, the March of Dimes, the National Association of Children's Hospitals, the National Association of Community Health Centers, National Association of Public Hospitals and Health Systems, and the National Health Law Program. I am submitting a sampling of letters from these groups along with my statement.

I can think of no better use of Congress' time than to provide health insurance to every child. While some are fixated on flag burning, Terri Schiavo and banning gay marriages, my colleagues and I are offering solutions to real problems facing American families. Providing a simple, stable, and flexible health insurance option will afford millions of parents the peace of mind of knowing that their children will be cared for when they are sick. Our nation's priorities should be centered on creating a bright future for our children, and MediKids helps to achieve this goal.

I look forward to working with my colleagues and the many endorsing organizations to enact the MediKids Health Insurance Act of 2005.

MEDIKIDS HEALTH INSURANCE ACT OF 2005—BILL SUMMARY

The MediKids Health Insurance Act provides health insurance for all children in the United States regardless of family income level by 2012. The program is modeled after Medicare, but the benefits are improved and targeted toward children.

MediKids is the ultimate safety net, with maximum simplicity, stability, and flexibility for families. Parents may choose to enroll their children in private plans or government programs such as Medicaid or S–CHIP. However, if a lapse in other insurance coverage occurs, MediKids automatically picks up the children's health insurance. MediKids follows children across state lines when families move, and fills the gaps when families climbing out of poverty become ineligible for means-tested programs.

ENROLLMENT AND ELIGIBILITY

Every child born after 2007 is automatically enrolled in MediKids. Older children are enrolled over a 5–year phase-in as described below. Children who immigrate to the U.S. are enrolled when they receive their immigration cards. Materials describing the program's benefits, along with a MediKids insurance care, are issued to the parent(s) or legal guardian(s) of each child. Once enrolled, children remain enrolled in MediKids until they reach the age of 23. There are no re-determination hoops to jump through because MediKids is not means tested.

PHASE-IN

Year 1 = the child has not attained age 6;
Year 2 = the child has not attained age 11;
Year 3 = the child has not attained age 16;
Year 4 = the child has not attained age 21;
Year 5 = the child has not attained age 23.

BENEFITS

The benefit package is based on the Medicare and the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits for children, with simplified cost sharing mechanisms and comprehensive prescription drug coverage. The benefits will be reviewed annually and updated by the Secretary of Health and Human Services to reflect age-appropriate benefits as needed with input from the pediatric community.

PREMIUMS, DEDUCTIBLES, AND COPAYS

MediKids assures that families will always have access to affordable health insurance for their children. Families below 150 percent of poverty pay no premiums or cost sharing. Families between 150 percent and 300 percent of poverty pay reduced premiums and cost sharing. Parents above 300 percent of poverty are responsible for a small premium equal to one fourth of the average annual cost per child. Premiums are collected at the time of income tax filing. Premiums are not assessed during periods of equivalent alternative coverage. Families will never pay more than 5% of their adjusted gross income (AGI) for premiums.

Cost sharing is similar to the largest plans available to Members of Congress. There is no cost sharing for preventive and well childcare for any children. A refundable tax credit is provided for cost sharing above 5% of AGI.

FINANCING

Initial funding to be determined by Congress. In future years, the Secretary of Treasury would develop a package of progressive, gradual tax changes to fund the program, as the numbers of enrollees grows.

STATES

Medicaid and S–CHIP are not altered by MediKids. States can choose to maintain these programs. To the extent that the states save money from the enrollment of children into MediKids, states are required to maintain current funding levels in other programs and services directed toward the Medicaid population. This can include expanding eligibility or offering additional services. For example, states could expand eligibility for parents and single individuals, increase payment rates to providers, or enhance quality initiatives in nursing homes.

SUPPORTING ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry (AACAP); American Academy of Family Physicians; American Academy of Pediatrics; Children's Defense Fund; Consumers' Union; Families USA; March of Dimes; National Association of Children's Hospitals; National Association of Community Health Centers; National Association of Public Hospitals and Health Systems; National Health Law Program.

Contact Deborah Veres at 225–4021 or deb.veres@mail.house.gov if you have any questions.

HONORING THE TEN TOWNS GREAT SWAMP WATERSHED MANAGEMENT

HON. RODNEY P. FRELINGHUYSEN

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 23, 2005

Mr. FRELINGHUYSEN. Mr. Speaker, I rise today to honor the Ten Towns Great Swamp Watershed Management Committee of Morris County, New Jersey, a vibrant organization I am proud to represent! On June 24, 2005 the Trustees and Friends of the Committee are celebrating its Tenth Anniversary.

The Great Swamp Watershed is a 55 square mile region in Morris and Somerset Counties and includes portions of Bernardsville Borough, Bernards Township, Chatham Township, Harding Township, Long Hill Township, Borough of Madison, Mendham Borough, Mendham Township, the Town of Morristown, and Morris Township.

The Ten Towns Great Swamp Watershed Management Committee was formed in 1995 through an Inter-municipal Cooperative Agreement among the ten municipalities that have lands within the Great Swamp Watershed. Developed under the auspices of the Morris County leadership group, Morris 2000 (now Morris Tomorrow), the Ten Towns Committee was formed for the specific purpose of developing and implementing a watershed management plan for the watershed in the Upper Passaic River basin of northern New Jersey.

Since its formation, the Ten Towns Committee has developed a full range of programs to protect water quality and water resources in the Great Swamp, including: a water quality monitoring program, development of environmental ordinances, and construction of ''Best Management Practices'' improvements to correct existing non-point source pollution conditions.

The Ten Towns Committee has been recognized as a model in the State of New Jersey and has received awards for its work from the U.S. Environmental Protection Agency and from the New Jersey Department of Environmental Protection.

Mr. Speaker, I urge you and my Colleagues to join me in congratulating the members of the Ten Towns Great Swamp Watershed Management Committee on the celebration of the Committee's ten years of service to the Great Swamp Watershed area. Special praise is due to their dedicated staff and active volunteers who work tirelessly to protect and enhance the Great Swamp National Wildlife Refuge and Wilderness Area.

INTRODUCTION OF THE ''SOUTHERN NEW JERSEY VETERANS COMPREHENSIVE HEALTH CARE ACT''

HON. FRANK A. LoBIONDO

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 23, 2005

Mr. LoBIONDO. Mr. Speaker, I rise today to introduce the ''Southern New Jersey Veterans Comprehensive Health Care Act''. I am proud to have Representatives JIM SAXTON, CHRIS SMITH, and ROB ANDREWS join me as original cosponsors of this legislation. My colleagues and I all share a serious concern that South Jersey veterans are not currently having their health care needs adequately served by the Veterans' Administration. In order to increase health care accessibility in our area, this bill directs the Secretary of the Department of Veterans' Affairs to expand the capability of the VA to provide for the medical care needs of vets in Southern New Jersey.

The issue of improved access to health services from the Department of Veterans' Affairs, is especially important with the growing number of veterans in Southern New Jersey. Many of our older veterans from World War II and other conflicts are in need of more frequent health care services and inpatient care. As a result of the continued fight in the Global War on Terror, there will be many new veterans in our area who need care in the coming years, as over 62 percent of the New Jersey National Guard is currently deployed, deploying, or has been deployed in support of the Global War on Terror. This percentage of Reserve Component forces from our State who will be eligible for veterans' status is growing rapidly.

As it relates to Southern New Jersey, I have serious reservations about the VA's access model for health care access, which currently says that adequate access is being provided if a veteran lives within 60 to 90 mile radius of a VA Medical Center. Today, despite falling within the VA's access model, veterans residing in Southern New Jersey must often travel several hours away, either to the neighboring states of Pennsylvania or Delaware, or to Northern New Jersey, in order to receive inpatient medical care and some outpatient services.

Although transportation is provided to the Wilmington, DE facility via a new handicapped-accessible van, these veterans often face a ten-hour round trip. Veterans riding a van from Southern New Jersey must board the van early in the morning, making several stops before reaching the VA facility, stay all day until each veteran has completed their appointment and then return home. This means that a veteran with a 4 p.m. appointment boards the bus at 8 a.m. and waits at the facility until 4 or 5 p.m. And, the veteran whose appointment is at 9 a.m. must wait to return home until the last appointment is completed, resulting in a 10 hour day of travel.

Of equal concern is that veterans have told me they simply do not use the services at these three facilities because of the transportation hardship. Southern New Jersey is a prime example of suppressed demand for VA health care.

The Southern New Jersey Veterans Comprehensive Health Care Act gives an overview of the VA health care access situation veterans are facing Southern New Jersey and proposes a choice of two workable solutions to this growing problem. The bill cites that the current and future health care needs of South Jersey veterans are not being met by the VA, travel times to existing VA facilities in Philadelphia and Wilmington may fall within VA's access parameters, but that these parameters fail to take into account that the area is rural, and that routes to the two VAMCs are congested, leading to a ''suppressed demand'' for care. It also outlines that the number of vets in the area is increasing as more retire in the area and new vets come back from being deployed in support of the War on Terrorism. States that 62 percent of the NJ Guard will have been deployed on active duty by the end of 2004.

This bill defines ''Southern New Jersey'' as the counties of: Atlantic, Cape May, Cumberland, Salem, Gloucester, Camden, Burlington, and Ocean and requires the VA Secretary to determine and notify Congress no later than March 15, 2006 as to how he will provide for the full service health care needs of South Jersey vets.

The Secretary of the Department of Veterans' Affairs is given two options for providing this improved access to health care for veterans in Southern New Jersey. The Secretary is given the choice of establishing a public-private partnership between the VA and an existing hospital (private-sector entity) in South Jersey—a ''VA Wing'', or construction of a full-service, 100 bed VA Medical Center (VAMC). If the VAMC option is chosen, the bill authorizes $120 M for the construction of the facility.

I am proud to introduce the Southern New Jersey Comprehensive Health Care Act with my New Jersey colleagues Congressman