large numbers the first election, and it appears that they will participate fully in the December 15 elections.

As far as an exit strategy, you often hear that there is none. Yet at the present time 210,000 Iraqi security forces have been trained and equipped as of this date. The goal is 270,000 total, so we are more than three-fourths of the way toward our goal. There is no shortage of recruits. Every time they put out a call, more people volunteer than they have room for in the Iraqi army.

Some areas of Iraq are totally controlled at the present time by Iraqis with no American backup. The intent is to draw down U.S. troops as Iraqis are prepared to control their own destiny. That is the exit strategy. We are moving in that direction. It is certainly not done yet, and we will be there for some time.

The next few weeks will be violent before the elections. It will be a very difficult time. Some agree and some disagree that we should have gone into Iraq, but we are there, and this is an irrefutable fact. The observation from a soldier in Kuwait is something I would like to pass on at this time. He said this: We pull out and we pull out prematurely, three things are going to happen.

Number one, every soldier who died or was wounded will have been sacrificed in vain. Currently the morale of our troops is generally very good. They do not want to leave prematurely. Many of them have reenlisted.

Secondly, if we pull out early, Iraqis will die in large numbers. Tens of thousands and possibly hundreds of thousands will die. We will have broken a promise, and this is what happened after the first Gulf War. We cannot let the Iraqi people down at this point.

Thirdly, if we pull out prematurely, at this point terrorists will be encouraged worldwide. They will be shown that terrorism does work. The U.S. will become an even bigger target, and our population will be under a greater threat.

This is a difficult and a dangerous process. Nothing is certain at this point. It is difficult, but many positive things have happened. I think it is important that the American people be aware of these issues.

BUDGET RECONCILIATION: BALANCING THE BUDGET ON THE BACKS OF MEDICAID BENEFICIARIES

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

Mr. GENE GREEN of Texas. Madam Speaker, I rise tonight to speak out against the budget reconciliation bill, which we will consider soon. The bill contains a number of harmful provisions, but my primary opposition to this legislation stems from its $11.9 billion in cuts to the Medicaid program. This reconciliation process has been flawed from day one.

The Energy and Commerce Committee was given an arbitrary budget number and was forced to mold the policy to achieve that number. Without doubt, there are certainly ways that we can improve the Medicaid program, but sound public policy, not budget targets, must be the driving force behind any Medicaid reform.

This quest to meet budget targets superseded Congress's responsibility to ensure that the Medicaid program continues to provide comprehensive and quality health care to our Nation's most vulnerable. Unfortunately, the bill the House will consider takes away that assurance and further frays the safety net that Medicaid beneficiaries depend on.

While the Senate's bill largely shielded the beneficiaries from any cuts to Medicaid, the House bill places a bull's-eye squarely on the backs of Medicaid beneficiaries and aims Medicaid cuts directly at them. In fact, $8.8 billion of these cuts in this bill are achieved through cost-sharing and benefit reductions for beneficiaries. The increased cost-sharing allowed for in the bill exposes Medicaid beneficiaries to new premium requirements and copays that many beneficiaries simply cannot afford. The reason you are on Medicaid is because you are poor.

What is more, Medicaid beneficiaries already pay a higher percentage of out-of-pocket health care costs than higher-income individuals who can better afford out-of-pocket costs. In 2002, higher-income adults with private insurance paid 0.7 percent of their income on the out-of-pocket medical expenses. Yet during the same year low-income, nondisabled adults on Medicaid spent more than three times as much, 2.4 percent of their income on out-of-pocket expenses.

Low-income disabled adults on Medicaid fared even worse, forced to spend 5.6 percent of their income on out-of-pocket medical expenses. Unfortunately, the growth of out-of-pocket health care spending is more than double that of the income for Medicaid adults, with income growing at 4.6 percent annually, out-of-pocket increases increasing by 9.4 percent annually.

This bill is only going to make worse a problem we already know is occurring. Faced with increased out-of-pocket costs, Medicaid beneficiaries are less likely to seek health care, which is exactly the result that proponents of this bill are looking for. The problem is, health care conditions worsened for these folks, and they will only seek care when their health problems reach emergency portions and the cost of care is exponentially greater.

While we do not want to encourage overutilization, we also do not want to cut off our nose to spite our face by discouraging preventive care. To make matters worse, the bill takes an extremely heavy-handed approach to the enforcement of those with cost-sharing measures. The bill will allow health care providers to refuse to treat sick Medicaid patients if they do not have the copay on hand.

The State can also drop Medicaid beneficiaries altogether if they cannot afford the premium for the Medicaid. A recent study of cost-sharing on Medicaid beneficiaries in Oregon foreshadows what will happen under these circumstances. Less than a year after Oregon implemented premium increases through a waiver process, its Medicaid population decreased by one-half.

Make no mistake about it, the Medicaid program is the health insurer of last resort. Without health insurance through Medicaid, it is safe to say that these folks in Oregon joined the growing ranks of the uninsured, a trend we will likely see continued if we enact this bill to allow every State in the Nation to follow Oregon's lead.

□ 2015

Not only does the bill make Medicaid beneficiaries pay more for health care; it also reduces the health care benefits they receive under Medicaid.

The bill allows States to reduce benefits as long as the Medicaid package mirrors private coverage or SCHIP coverage.

The flaw in that policy lies in the fact that the Medicaid program was always intended to provide benefits that low-income individuals could not afford to purchase through private coverage, such as an array of benefits needed by disabled individuals.

This reduction in benefits flies in the face of the goal shared by Democrats and Republicans alike to remove the institutional bias inherent in the Medicaid program by providing the necessary tools to keep disabled individuals in the community.

Without these benefits, low-income disabled individuals will have no option other than to enter a nursing home setting.

This bill also eliminates a benefit that has long served as the cornerstone of the Medicaid program's approach toward children's health.

If Medicaid costs are truly growing at an unsustainable rate, there is no way increased costs can be attributed to children.

Health care for pregnant women and children is arguably the most cost-beneficial aspect of the Medicaid program, with pregnant women or children accounting for nearly 70 percent of all Medicaid enrollees, but only 30 percent of the program's costs.

The bill's elimination of the Early, Periodic, Screening, Detection and Treatment program for children above the poverty level means that childhood illnesses will not be detected as early, and more low-income children will lack the good health that puts them on the path of learning and productivity.

According to the March of Dimes, the situation would be even more dire for children with significant physical and developmental conditions.

In a recent analysis of Medicaid coverage in all 50 States, the March of Dimes found that each State would significantly restrict coverage for services needed by children with physical and developmental disabilities, States that were exempt from the mandates of the Early, Periodic, Screening, Detection and Treatment program.

Unfortunately, this bill puts the wheels in motion for States to deny necessary health care benefits to disabled children.

Madam Speaker, the light has been shined on this process. This is not a process to reduce the deficit. This is a process to finance additional tax cuts.

There is no way to deny this fact when the same budget that protects $34.7 billion in decreased mandatory spending allows for $70 billion in tax cuts that will decrease revenues used to fund government programs.

It is inconceivable Congress would balance this budget on the backs of low-income Americans, but to finance tax cuts on the backs of America's most vulnerable, that is downright shameful.

The SPEAKER pro tempore (Mrs. DRAKE). Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

(Ms. JACKSON-LEE of Texas addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

ORDER OF BUSINESS

Mr. BURGESS. Madam Speaker, I ask unanimous consent to go out of order and claim the unclaimed time of the gentlewoman from Texas (Ms. JACKSON-LEE).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

PANDEMIC PLAN—AVIAN INFLUENZA

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

Mr. BURGESS. Madam Speaker, we heard the chairman of the Appropriations Committee come to the floor and speak about his bill that he has introduced to fund preparation for a possible pandemic flu outbreak, and I thought it might be useful to come down to the floor and just review some of the reasons that scientists are concerned about this outbreak of avian flu in the world and some of the reasons why we need to be concerned and some of the reasons why we need to be prepared and some of the good news to share as well.

Madam Speaker, the influenza virus with which we are all familiar undergoes a continuous process of change. It is constantly changing its genetics. It drifts from one genetic makeup to another.

For the past several years, the flu type known as H3N2 has been the type for which we commonly receive inoculations; and because of this genetic drift, a new inoculation is required each and every year.

With the absence of a flu vaccination last year, I did not take a flu shot; but there is still some immunity that carries over from year to year; but about every 30 years, there is a major change in the genetics of the flu virus. These major changes took place during the last century in 1957 when 170,000 people in this country died from an outbreak of what was called Asian flu and in 1968 when 35,000 people in this country died from the Hong Kong flu.

The term pandemic applies when there is a big, big animal reservoir of the virus and no underlying immunity, and those conditions exist today.

The assumptions and the knowledge of prior pandemics certainly have become part of the pandemic plan that was revealed by the Department of Health and Human Services last week; but the important thing is the study of prior pandemics tells us that this virus, if it were to achieve pandemic status, could overwhelm almost all of the available resources that we would have at our disposal in this country, not to mention what would happen in the rest of the world.

The virus that is under consideration for this pandemic, the so-called H5N1 virus, has some similarities with the Spanish flu from the 1918 pandemic. Both of these illnesses cause lower respiratory tract symptoms, high fever, muscle aches and pains, and extreme, extreme fatigue. That fatigue can persist for 6, 8, 10 weeks after recovery. If the patient recovers from the illness, that fatigue may persist for many, many weeks thereafter; and that, of course, could have implications for people returning to the workforce. The virus can cause a primary or a secondary pneumonia. The pulmonary tree is unable to clear itself of secretions and debris. The vast majority do recover, but the potential to kill is certainly related to the virulence of the microbe.

Some of the trouble signs that are on the horizon, things that have gotten the Secretary of Health and Human Services and the chairman of the Committee on Appropriations concerned, some of the trouble signs include the wide geographic setting with involvement of not only birds but now other mammals. Bird-to-human transmission has occurred. It has not been easy for the virus to go from bird to human, but it has happened; and it appears in some instances, although it has not been an easy transmission, there has been transmission from human to human.

If the virus undergoes that last step that allows it to have efficient human-to-human transition, that is what would signify the onset of a worldwide pandemic. It is also entirely possible, and I do need to stress this, that efficient human-to-human transition will never be developed and that the pandemic will never occur.

So the chairman is quite right. We need to devote resources to this problem, but we must also recognize that the problem that we are concerned about today may not be the problem that we face. One of the very important aspects of the legislation that has been introduced by Chairman LEWIS and legislation that will be taken up by my committee, the Energy and Commerce Committee, is how do we facilitate the ramp up, the surge capacity, the production of antiviral or the production of antiviral vaccines if an entirely different virus or somewhat different virus from this avian flu is actually the one that causes the outbreak.

There are other antiviral medications available, medications such as Tamiflu and Relenza have activity against the H5N1 virus, and they are going to be one of our first lines of defense.

Again, some good news is that a vaccine has been developed, and it was developed in a relatively short period of time. It was undergoing trials. It appears to be safe. One of the troubles, though, is since we have no underlying immunity to that virus, it takes a lot of that vaccination for us to develop immunity.

Some of the things we are going to have to consider, and the chairman appropriately referred to these, the Federal Government will have to share some of the risks with companies that are manufacturing the vaccines. That means not only some of the liability risks but the risks of guaranteeing purchase of these products if they ramp up production and the pandemic does not materialize. Some guarantee of purchase will have to be there and to allow drug companies to communicate with each other to discuss among themselves what are some of the techniques for producing some of these medications. So perhaps some antitrust reform will have to be included in whatever our preparation and our response is to the flu.

Madam Speaker, I wanted to bring these facts to the floor tonight because I know this is important legislation that this House will be considering in the next couple of weeks, and it is imperative that we all do have accurate and timely information.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2005, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY. Madam Speaker, tonight, a number of the members of the Republican Conference are going to speak on an issue we know all Americans are concerned about and Members