I am pleased to join the congregation of St. Paul's Lutheran Church in recognizing Mr. Hearn's service to his church and contributions to our community as he begins a well deserved retirement.

INTRODUCING THE MEDIKIDS HEALTH INSURANCE ACT OF 2007

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 17, 2007

Mr. STARK. Madam Speaker, it is with great pride that I rise today to introduce the MediKids Health Insurance Act of 2007, legislation to provide universal health coverage to our Nation's children.

In February, I was appalled when the Washington Post reported that 12-year-old Deamonte Driver passed away because his mother could not afford a basic dental procedure. An untreated infection in Deamonte's molar had spread to his brain. By the time he was brought to an emergency room, no amount of money could save him.

Deamonte Driver did not have to die. He would be still alive today if his mother had been insured, if more dentists accepted Medicaid, or if his family had not lost their Medicaid coverage.

This tragic story speaks to the shortcomings of our fragmented health care system. Millions of children are covered by their parents' health insurance plans. Medicaid and SCHIP provide care to millions of kids in families that meet their eligibility standards. Unfortunately, both programs have unnecessarily complex enrollment and review processes. Nearly 9 million children slip through the cracks of this incomplete system and go without health insurance each year.

Enough is enough. The wealthiest nation in the world can and should guarantee quality health care to all of our children. With insurance costs skyrocketing and employers dropping care, an overwhelming majority of Americans agrees. According to a February 2007 New York Times/CBS News poll, 84 percent favor expanding public programs to cover all uninsured children. If that's not a mandate for Congressional action, I don't know what is.

Rather than reinvent the wheel to provide care to our children, we should build on what works in our health care system. When Congress created Medicare more than 40 years ago, our Nation's seniors were more likely to be living in poverty than any other age group. Most senior citizens were unable to afford needed medical services and unable to find health insurance in the private 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 or to go without needed health care.

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 has grave consequences for the future of our country. Our future rests on our ability to provide our children with the basic conditions to thrive and become healthy, educated, and productive adults.

Poor children are often malnourished and have difficulty succeeding in school. Untreated illnesses only worsen their chance for success. Providing these children with guaranteed health care would help realize their potential as individuals and our potential as a Nation.

The MediKids Health Insurance Act would create a new Federal health insurance program for children called MediKids. Modeled after Medicare, MediKids would provide comprehensive benefits appropriate to children, simplified cost sharing, prescription drug coverage and mental health parity.

Every child in America would be automatically enrolled in MediKids at birth and maintain that eligibility until age 23. Parents would retain the choice to enroll their kids in private plans or government programs such as Medicaid or SCHIP. However, if a lapse in other insurance coverage occurs, MediKids automatically fills in the gap.

MediKids doesn't have complicated enrollment and eligibility hoops. Instead, it assures that families will always have access to affordable health insurance for their children.

I can think of no better use of Congress' time—or our Nation's money—than to enact MediKids and provide health insurance to every child. 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, including the American Academy of Pediatrics and the Children's Defense Fund to enact the MediKids Health Insurance Act.

Below is a summary of MediKids that provides additional details.

MEDIKIDS HEALTH INSURANCE ACT OF 2007

BILL SUMMARY

The MediKids Health Insurance Act provides health insurance for all children in the United States regardless of family income level by 2014. 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 December 31, 2008 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 card, 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.

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 percent 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 percent of AGI.

FINANCING

Initial funding to be determined by Congress. In future years, the Secretary of the 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.

PHASE-IN

MediKids is phased-in over a 5-year period according to the following schedule: 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.

SUPPORTING ORGANIZATIONS

American Academy of Family Physicians; American Academy of Pediatrics; American Medical Student Association; 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; and NETWORK: A National Catholic Social Justice Lobby.

PERSONAL EXPLANATION

HON. MADELEINE Z. BORDALLO

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 17, 2007

Ms. BORDALLO. Madam Speaker, I was absent from the Chamber during the early morning hours of Friday, May 11, 2007, and was therefore unable to record my vote on three postponed votes that were taken in the Committee of the Whole House on the State

of the Union. Had I been present for those votes on amendments to H.R. 2082, the Intelligence Authorization Act for Fiscal Year 2008, I would have voted as follows: ''no'' on rollcall No. 337; ''no'' on rollcall No. 338; and ''yea'' on rollcall No. 339.

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2008

SPEECH OF

HON. BRUCE L. BRALEY

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 16, 2007

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 1585) to authorize appropriations for fiscal year 2008 for military activities of the Department of Defense, to prescribe military personnel strengths for fiscal year 2008, and for other purposes:

Mr. BRALEY of Iowa. Mr. Chairman, I rise today in support of my amendment to H.R. 1585, the Fiscal Year 2008 National Defense Authorization Act. My amendment represents a crucial first step in enhancing and expanding critical family support and mental health services for our National Guard and Reserve troops and their families.

I commend Chairman SKELTON and the Armed Services Committee for their work on this bill. I'm glad the committee has recognized the great contributions of our National Guard and Reserve soldiers, and has recognized that readjusting to civilian life can be especially challenging for members of the reserve component. I believe that the establishment of the Yellow Ribbon Reintegration Program in the bill is a good first step in enhancing family support services for these soldiers, but I believe that more needs to be done for the families of National Guard and Reserve troops, who have too often and for too long been forgotten and left behind.

Members of the National Guard and Reserve are serving our country more than ever in the world's most dangerous places, including Iraq and Afghanistan, and many of them are facing multiple and extended deployments, causing considerable hardships for them and for their families. To cite just one example, in January 2007, members of the Iowa National Guard's 1–133rd Infantry Battalion learned that their tour of duty in Iraq would be extended from April of this year until August.

My amendment, which requires the Secretary of Defense to conduct a study into establishing a pilot program for family-to-family support for members of the National Guard and Reserve, and conduct a study on improving support services for the children of members of the National Guard and Reserve who are undergoing deployment, will help ensure that our reserve component troops and their families receive all of the family support and mental health services they need as they continue to serve our country.

My amendment is consistent with the goals of the Armed Services Committee to enhance support services for our National Guard and Reserve troops and their families, and I urge my colleagues to support it.

HONORING JAMES C. HAGUE, JR.

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 17, 2007

Mr. UDALL of Colorado. Madam Speaker, I am pleased to recognize the life-long accomplishments of a Coloradan who has served as a role model for achievement and made a substantial impact on our State, Mr. James C. Hague, Jr. On Saturday, February 25, 2007, a group of family and friends met to celebrate the 98th birthday of this truly wonderful and special person.

Jim was born on February 24, 1909 in Plainview, Texas and moved to Dallas, Texas in 1912. After working in the oil refining industry as a helper in 1927, he became a chemist. During the Hoover Administration he worked for the government and was initiated into Pipefitters Local 195 in Beaumont, Texas on May 31, 1937.

In 1939, Jim married his wife Ethel, a union which lasted for 58 years. He has two stepsons, 2 grandsons and 1 granddaughter. He and Ethel moved to Denver in October 1951 at which time Jim transferred his union card to Pipefitters Local 208, a membership still active today. Jim worked at the Rocky Flats Weapons Plant as a pipefitter in the initial construction of the facility.

Jim has always been active in the civic arena. He became a member of the Westminster City Charter Convention in 1957 and, as a result of his participation, Westminster established a City Manager/Home Rule government. Jim assisted in writing the Charter for Westminster which was approved by the voters in 1958. Jim was also instrumental in establishing the Central Colorado Library District for Arapahoe, Adams, Boulder, Denver, Clear Creek, Gilpin and Jefferson Counties. He remained a member of the Library District for 14 years and was Chairman for 12 years.

Jim is an active member of the Adams County Democratic Party; he has walked many miles in precincts and made many phone calls for candidates and was even featured in several commercials for former Senator Tim Wirth. Jim is well known by Democrats throughout the State of Colorado.

Jim is a truly interesting and fascinating person. He has tales to tell of yesterdays and always makes a contribution to today. Our future is much brighter for having Jim Hague in our lives. I ask my colleagues to join me in wishing him the very best and a long healthy life with much happiness.

AFRICA'S WATER CRISIS

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 17, 2007

Mr. SMITH of New Jersey. Madam Speaker, yesterday the House Subcommittee on Africa and Global Health held a briefing and hearing on the important issue of Africa's water crisis. We tend to take for granted this basic necessity for human existence, and yet we are told by the United Nations Development Programme that over 1.1 billion people in developing countries do not have adequate access to safe water. Access to water is closely correlated to basic sanitation, and there too the world is facing a crisis. Some 2.6 billion people live without this second essential aspect of good health.

In its Human Development Report for 2006, the UNDP presents a heavy indictment against the international community, noting that every year 1.8 million children die from causes related to unclean water and poor sanitation. This is equivalent to 4,900 deaths every day, and diarrheal disease is the second highest cause of death in the world for children under 5. This occurs despite the fact that we now have oral rehydration therapy. These numbers dwarf the number of deaths resulting from violent conflict, and yet the UNDP points out that water and sanitation are rarely highlighted as an international concern.

In sub-Saharan Africa—the focus of the hearing—over 300 million people lack access to safe water, and some 460 million do not have access to proper sanitation. These overwhelming numbers hide the even deeper tragedy that it is the poor, both poor individuals and poor countries, who carry the greatest burden. Sub-Saharan Africa loses about 5 percent of its GDP, or about $28.4 billion each year, to the water and sanitation deficit. This figure exceeds the total amount of aid and debt relief provided to the region in 2003. And most of this loss is suffered by those households that are below the poverty line, those who can least afford to pay the cost. The lack of water also unduly affects women and girls, who in many societies have the responsibility of collecting and transporting water, which can occupy their energy and time for several hours each day.

Beyond the apparent costs in human suffering and loss of life, there are broader social and economic costs as well. Improper water management impacts agricultural and industrial development, economic growth, and the preservation of land, coastal and marine ecosystems. Equitable access to sufficient quantities of safe water is necessary for a secure, peaceful society, and threats to such access can become a source of conflict and even violence.

It is worthwhile to note that, according to the UNDP, the scarcity of water worldwide is not the result of physical availability. The Human Development Report states that household water requirements represent a very small fraction of water use, often less than 5 percent of the total. Instead the UNDP asserts that the source of the problem lies in power, poverty and inequality. Households in high-income urban areas of Asia, Latin America and Sub-Saharan Africa have access to several hundred liters of water each day through public utilities, while slum dwellers and poor households in the rural areas of those same countries have access to far less than the 20 liters a day per person required to meet the most basic human needs. The same analysis is said to apply to the areas of agriculture and industry. Income levels and access to water and sanitation systems are key elements. UNDP explicitly rejects the notion that the global water shortage is due to population increases.

Fortunately, the United States Government is acting to provide more safe water and proper sanitation to the poor of the world. Thanks to the Senator Paul Simon Water for the Poor