village in Syria, they stayed until they were told to move again. She remembers, ''An order came from all the General Headquarters that all Armenians either be killed or deny their religion and become Muslims.'' Many people converted to save their lives, while others died to preserve their faith.

The Armenians were forced to relocate from village to village. They were left with no money and no supplies, and had to find ways to survive. She said, ''You couldn't get in touch with anybody. You didn't know what to do. We were hungry. It was terrible. We were all dying. We were just skeletons, no food, no nothing.''

Unlike much of Mrs. Hanessian's family who died or disappeared in the genocide, she survived and was able to relocate to the United States and rebuild her life in Syracuse, New York. She has since passed away, but not before she left her story behind, and I am proud to be able to retell her memories, which must never be forgotten.

Mr. Speaker, I wish to express my support this evening for swift passage of H. Resolution 106, reaffirming the Armenian Genocide. The resolution now has a majority of the Members of the House as cosponsors on a bipartisan basis.

As the first genocide of the 20th century, it is morally imperative that we remember this atrocity and collectively demand reaffirmation of this crime against humanity. By properly affirming the Armenian genocide, we can also help ensure its legacy and rightfully honor its victims and survivors like Mrs. Hanessian.

REVISIONS TO THE 302(a) ALLOCATIONS AND BUDGETARY AGGREGATES ESTABLISHED BY THE CONCURRENT RESOLUTIONS ON THE BUDGET FOR FISCAL YEARS 2007 AND 2008

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

Mr. SPRATT. Mr. Speaker, pursuant to section 207(d) of S. Con. Res. 21, the Concurrent Resolution on the Budget for Fiscal Year 2008, I hereby submit for printing in the CONGRESSIONAL RECORD revised 302 (a) allocations for the House Committee on Appropriations for Fiscal Years 2007 and 2008. Section 207 (d)(2) directs the Chairman of the Committee on the Budget to adjust the discretionary spending allocations for three program integrity initiatives: Continuing Disability Reviews and Supplemental Security Income Redeterminations, Health Care Fraud and Abuse Control, and Unemployment Improper Payment Reviews as provided in section 207 (d)(1)(A), (C) and (D) of S. Con. Res. 21, respectively.

DISCRETIONARY APPROPRIATIONS: Appropriations Committee 302(a) Allocation

[In millions of dollars]

	BA	OT
Current allocation:		
Fiscal Year 2007	950,316	1,029,465
Fiscal Year 2008	953,459	1,028,780
Change for H.R. 3043 program integrity initiatives:		
Fiscal Year 2007	0	0
Fiscal Year 2008	636	317
Revised allocation:		
Fiscal Year 2007	950,316	1,029,465
Fiscal Year 2008	954,095	1,029,097

□ 2000

PROVIDING FOR INDIVIDUALS A SECOND CHANCE

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

Mr. DAVIS of Illinois. Mr. Speaker, as I was leaving a friend of mine's home on Sunday morning, a young fellow was across the street on the other side and he flagged me down and said, ''Can I talk to you for a moment?'' And so I waited for him to come across the street, and he did. And I asked what I could do for him, and he says, ''Well, I am trying to find a job.'' And I inquired as to his educational background, what kind of things that he could do, and what kind of jobs that he had. And he says, ''Well, I had a job, but then my employer discovered that I also had a felony conviction and he didn't know that when I got hired.'' And, ''Of course,'' he says, ''I have lost my job, lost my house, lost my car, lost my wife, and I am in the process of losing my children.'' And as I listened to him on Sunday morning, it reinforced for me how important it is that we try and provide for individuals like this young man a second chance.

As a matter of fact, our country is the most imprisoned nation on the face of the Earth. More than 2 million people languish in our jails and prisons across the country.

More than 650,000 of them come home every year, and, like this young man, oftentimes find every avenue blocked that prevents them from leading normal lives. Of course, many of them do what we call recidivate, that is, if they don't get any help within 3 years, 67 percent of them will have done what we call re-offend; that is, committed another offense against society. More than 50 percent of them will be re-incarcerated, costing our taxpayers enormous sums of money.

And so I felt compelled to come to the floor and urge my colleagues to support the Second Chance Act, to urge the leadership to bring that legislation to the floor, so that this young man and thousands of others like him can, indeed, experience a second chance.

CONGRESSIONAL BLACK CAUCUS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentlewoman from Ohio (Mrs. JONES) is recognized for 60 minutes as the designee of the majority leader.

Mrs. JONES of Ohio. Mr. Speaker, tonight I'm joined by members of the Congressional Black Caucus on the first of what will be many CBC message hours. This evening we will be discussing health care disparities, as well as the SCHIP program, which is the State insurance health program.

But before I get into it, I need to ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include extraneous material on the subjects that I just mentioned, that of health care disparity and the State Children's Health Insurance Program.

For the past few Congresses, the CBC has made confronting health disparities one of its major initiatives. We have been champions for access to affordable health care, meaningful coverage for prescription medications for every American, and increased representation of African Americans across all health care professions.

The health care statistics are staggering in the African American community. While African Americans comprise approximately 12 percent of the U.S. population, in 2000 they represented 19.6 percent of the uninsured. The African American AIDS diagnosis rate was 11 times that of the White diagnosis rate, 23 times more for women and nine times more for men.

African Americans are two times more likely to have diabetes than whites, four times more likely to see their diabetes progress to end-stage renal disease, and four times more likely to have a stroke. And African Americans are only 2.9 percent of the doctors, 9.2 percent of the nurses, 1.5 percent of dentists, and 0.4 percent of health care administrators. Yet African Americans comprise 12 percent of our population.

These problems are just the tip of the iceberg. Tonight, along with my colleagues, we will outline some of the various health issues that currently impact the African American community. Additionally, many of us have legislation that we are working to have passed to provide necessary care and resources to the African American community.

I want to thank the Chair of the Congressional Black Caucus, Congresswoman CAROLYN CHEEKS KILPATRICK, and our executive director, Dr. Joe Leonard, for their assistance and work in this effort, and for the record, my communications director Nicole Williams.

At this point I'd like to yield 5 minutes to the gentleman from Virginia, Mr. BOBBY SCOTT.

Mr. SCOTT of Virginia. Mr. Speaker, I rise today to stress the importance of health care to the well-being of our children and to our Nation. In 2003, a report was released by the National Academy of Science entitled ''Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.'' It

confirmed what many of us have known for a long time, that even when African Americans and other minorities have equal insurance and equal access to physicians, their outcomes are different.

Minority populations just don't get the same health care and are not offered the same treatments. Unfortunately, we're foundering under the constraints of a profit-driven, multi-tiered health care where racial and ethnic stereotypes often distort the decision-making process by many health care providers.

The situation becomes even more critical when we realize that over 20 percent of all African Americans do not have health insurance. Those who do are more likely to have public insurance or Medicaid, which, unfortunately, often does not command the full measure of services available in private insurance.

Every day, more and more African Americans are diagnosed with life-threatening illnesses which can be avoided with proper care and prevention. The diagnosis of illnesses such as diabetes, high blood pressure, heart disease and HIV/AIDS continues to increase among African Americans in the African American culture as access to health care becomes more and more elusive.

It is no surprise that when it comes to taking care of our medical needs, many of us and our Hispanic, Native American and Asian Pacific Islanders are slipping through the safety nets available to other Americans.

Mr. Speaker, the total number of uninsured has actually increased from 41 million, just a few years ago, to 46 million by the most recent numbers. In the country where we pride ourselves as being the world's leading and most prosperous democracy, we have millions of children and young adults walking around without health insurance.

A sad reflection of how ominous the absence of health care insurance can be is the death of a 16-year-old boy in Maryland who died from infections caused by an abscessed tooth because his family had no health insurance to seek medical care.

Mr. Speaker, in the next few weeks, we'll address the reauthorization of the State Children's Health Insurance Program, or SCHIP, which is a vital Federal program which allows States to target and cover low-income children with no health insurance and families with incomes above the Medicaid eligibility levels.

Almost 90 percent of these children live in households with a working parent. More than half live in two-family households. Many of these children are actually eligible for coverage under SCHIP or Medicaid but are not enrolled due in large part to barriers to enrollment in programs and complex eligibility rules that make it difficult to obtain or keep coverage. Millions more children are underinsured or at risk of losing coverage if their parents change jobs or if employers drop health coverage for families.

Mr. Speaker, we need to do more than just renew SCHIP. We need to expand it so that it adequately covers every uninsured child living in the United States.

Early and preventive screening, diagnosis and treatment, EPSDT, which would include services such as dental, vision and mental health services should be available to all children. EPSDT is the current requirement under Medicaid to make sure that the health needs of children are being met, and we should bring this requirement to SCHIP.

Coverage for low-income pregnant women. We need to make sure that women are receiving the necessary prenatal care needed to ensure that infants have a healthy start in life.

Presumptive eligibility. We need a unified application system for SCHIP. There are many social services programs, such as reduced or free school lunch, that have eligibility requirements clearly more restrictive than SCHIP. So if a child is eligible for such a program, it is a virtual certainty that he's also eligible for SCHIP.

The problem arises that States do not presume eligibility, and parents are required to fill out different applications in different offices, often with the exact same information, just to access the services they obviously qualify for.

A commonsense solution would be to streamline the application process for SCHIP and other programs so that if you're enrolled in another social service program, you should not have to fill out another application just to get health care benefits. Money to promote the streamlining of this process should be included in the reauthorization of SCHIP.

Mr. Speaker, there is an urgent need for expanded health care coverage for children, and that's why I introduced H.R. 1688, the All Healthy Children's Act. That act has been endorsed by the Children's Defense Fund. It's a logical, smart, and achievable incremental next step to close the child coverage gap and guarantees that all children will have access to health care coverage that they need to survive, thrive, and learn.

This proposal will ensure that all children are covered by expanding the coverage of both Medicaid and SCHIP programs, while eliminating the procedural red tape that currently prevents children from being covered by either program. The comprehensive program would include all basic health care, as well as coverage for mental health and prenatal care.

Mr. Speaker, the United States health care system has yet to solve the fundamental challenge, delivering health care coverage to all Americans at an affordable price. The tragedy is that we know what to do to fix the problem once and for all. And what is required is a national health care system with universal access to comprehensive prevention-oriented benefits. And it is time to take action, and we should start with our children by passing the All Healthy Children's Act.

Mrs. JONES of Ohio. Mr. SCOTT, thank you very much for your leadership on that issue.

Let me speak for a moment about another piece of legislation that I've introduced with regard to health care disparities. About 7 years ago, one of my staffers approached me with an idea for a piece of legislation. He told me a story of one of his female friends who had been suffering from uterine fibroids. Her condition had taken a tremendous toll on both her and her family, mainly because she was unsure of her options.

This young lady is not alone. There are many women across this country who are silently dealing with this painful, sometime deadly, disease.

Uterine fibroids are noncancerous tumors that form within a woman's uterine lining. It is estimated that three in every four American women have uterine fibroids, with one in four women seeking medical care for the condition. African American women are three to nine times more likely to develop uterine fibroids.

Uterine fibroids can be hard diseases to combat, given the fact that women are diagnosed with the disease at various stages and physical conditions. While the fibroids may develop slowly in some women, others may develop more aggressively.

Right now, hysterectomy is the most common treatment for uterine fibroids, accounting for 200,000, or 30 percent, of all hysterectomies in the United States. It is for this reason that I have reintroduced the Uterine Fibroid Research and Education Act to find new and better ways to treat, or even cure, uterine fibroids.

The Uterine Fibroid Research and Education Act would double Federal funding for uterine fibroid research and fund a public education campaign on the condition. Senator Barbara Mikulski of Maryland introduced companion legislation in the Senate, and we introduced identical legislation in the 109th Congress, but neither received a floor vote.

Even though an estimated three-quarters of all reproductive-age women have uterine fibroids, little is known about them, and there are still few good treatment options available. Women deserve better. I have made it a priority to make sure women are not left out or left behind when it comes to health care.

This legislation would authorize $30 million in Federal funding for uterine fibroid research each year for 5 years, doubling the budget from last year's $15 million. Research is needed to find out what causes uterine fibroids, why African American women are disproportionately affected, and what can be done to prevent and treat the condition.

It is time that we put the health of the women of America in the forefront of our agenda. Therefore, I'm asking all to be supportive on this crucial issue.

Right now I'd like to yield such time as she may consume to Representative DONNA CHRISTENSEN, who is, in fact, a medical doctor; and she chairs the Congressional Black Caucus Health Disparities Health Brain Trust. And this weekend in the Virgin Islands you're hosting a health care health disparities conference, correct?

Mrs. CHRISTENSEN. Yes. Not only that, but Congressman CLYBURN's district will be hosting a disparities conference, as well as the Tri-Caucus, the Hispanic, Black and Asian Pacific Caucus this weekend.

Mr. Speaker, I'm pleased to join my colleagues to call attention to some critical unmet health care needs that this 110th Congress is called upon to address.

And I also want to applaud our chairwoman, CAROLYN CHEEKS KILPATRICK, for making this hour available to us and to thank Congresswoman STEPHANIE TUBBS JONES for her leadership as well.

Before I speak about the children's health insurance program, which is up for reauthorization, I want to remind this body that we have not yet appropriated the level of funding that would make a dent in the health disparities that result in 100,000 unnecessary deaths every year because of our country's failure to address them. We worry more about a few dollars that may be less than necessary than we worry about the unnecessary loss of life that happens every day in this country, although we have the wherewithal to stop them.

□ 2015

Until our country funds disparity elimination adequately, people of color will continue to get to health care services late, if at all, and become disabled or die prematurely from preventable causes.

This Congress will have the opportunity to do just that by passing the Healthcare Equity and Accountability Act, introduced by the Black, Hispanic, and Asian Pacific Caucus last week. That is the way to improve health for everyone and to begin to drive down the skyrocketing cost of health care.

Mr. Speaker, I also want to call our attention to the now chronic underfunding for the AIDS Drug Assistance Program, or ADAP. As we have underfunded it every year, the gaps have grown and the waiting lists for lifesaving medicines have grown longer. Some of those waiting in line have died because of our neglect. This Congress, led by Democrats who have always understood the challenges faced by the HIV/AIDS community, more than half of which are people of color, needs to correct this deficiency in funding for this important program.

And, also, Mr. Speaker, very soon we will be reauthorizing the State Children's Health Insurance Program. We need to do so fully. Now when we have the opportunity to do the right thing for America's children with whose welfare we are charged, we are poised to shortchange them, to let them down, and to leave them without access to health care. That is unbelievable. There are 9 million uninsured children, of which 6 million are at or below 200 percent of poverty and eligible for SCHIP. I think we should cover all of them, but current proposals don't even cover one-third of those who are eligible.

This Congress should do nothing less than cover all 6 million eligible children, and we must do so with robust programs to foster their mental, dental, and nutritional health. Investing in our children is investing in our future.

The CBO has said that it would cost at least $60 billion to cover all of those eligible children. We are told there are not enough offsets, not enough money to cover the costs.

Well, there are no offsets for the civil war in Iraq, which we are funding while our children are being caught in the crossfire, and there were no offsets for the tax cuts to the wealthiest individuals in this country, both of which are funded in part with money borrowed from Communist China. If we can go into bad debt for those, then we can certainly go into good debt for our children because it is an investment that pays back invaluable dividends. I am willing to bet, Mr. Speaker and colleagues, that we will have to set PAYGO aside for some measure that is deemed important, probably even before this Congress adjourns. So let's do it now for America's children. There is no one and nothing more important than they.

There is one other alternative, and that would be to provide funding to cover all 6 million children for a shorter period of time and revisit that program 2 or 3 years from now when we should be out of Iraq and the tax cuts for the rich would expire. That, I think, is another viable alternative.

We know that the President has said that he will veto a bill if it costs what he considers too much and even the modest proposals from the House and Senate fit that bill. I think that that is a fight the American people would want us to take on because our children are just that important. And so using his own words, I would say ''bring it on.''

Let's not let there be any more Deamonte Drivers, the 11-year-old who died because he could not get an $80 tooth extraction. We are a better country than that.

Thank you, Congresswoman TUBBS JONES.

Mrs. JONES of Ohio. Thank you, Dr. CHRISTENSEN, for your leadership not only this year but every year that I have been in Congress on the health disparities issue and health care on behalf of all Americans while particularly focused on African Americans.

Mr. Speaker, it gives me great pleasure at this time to yield to my colleague and good friend DANNY DAVIS from Illinois.

Mr. DAVIS of Illinois. Mr. Speaker, I want to commend and thank the gentlewoman from Ohio for not only her leadership on this but her leadership on many issues that affect not only African Americans but people all over America.

Although we are talking about health disparities, let it be known that we don't believe that merely dealing with the disparities is going to get us where we need to be relative to health care in this country. I am firmly convinced that the only way that we will address adequately all of the health care needs that exist in this country is to have a national health plan where everybody is in and nobody is out; where everybody will have access to quality, comprehensive health care without regard to their ability to pay.

I have spent a great deal of my time over the last 2 or 3 years dealing with the particular needs of young African American males. And if we look at that population group, nearly four out of 10 young African American men lack health insurance. The percentage of uninsured African American men, while higher than that of whites, is lower than that of Hispanics, American Indians, and Native Hawaiians. Young men, regardless of race or ethnicity, are more likely to be uninsured than any other age group.

People without health insurance are more likely than those with health insurance to delay needed care, less likely to fill prescriptions, and more likely to be diagnosed at a later stage when they do finally seek care. They are also less likely to have a usual or regular source of care.

Young African American men die at the rate that is at least 1.5 times that of young white and Hispanic men and almost three times the rate of young Asian men. While the death rate drops for men ages 25 to 29 for most groups, it continues to rise among African Americans. The leading causes of death for all young men ages 15 to 29, regardless of race or ethnicity, are unintentional injuries such as car accident, firearm, or drowning, suicide and homicide. For young African American men, more deaths are caused by homicide than any other cause.

Additionally, HIV is the sixth leading cause of death for young African American and Hispanic men. Yet for other racial groups, HIV is not among the top 10 causes of death.

When I hear my colleagues talk about what we need to do and when Representative CLARKE was here a few minutes ago talking about the need for gun control legislation that would make it more difficult to acquire and make use of handguns, that is so real. Not only are those tragedies taking place in New York, but I also take this

opportunity to commend Reverend Jessie Jackson and a coalition of individuals, including Reverend Gregory Livingston, who every Saturday morning have been picketing gun shops outside the City of Chicago. Fortunately, you cannot purchase a handgun in Chicago, but you can go right outside and purchase all that you want.

So I commend them for their efforts to make real the notion that change can occur, but it only comes as we are activated, motivated, stimulated, and involved.

So, again, Representative JONES, I thank you for your leadership. Thank you for giving us the opportunity to put a face on this problem that is plaguing African Americans all over America.

Mrs. JONES of Ohio. I want to say to you, Mr. DAVIS, also your leadership on the Second Chance Act, you and I have been working on that issue for several years, and, hopefully, it will come to fruition in the next couple, 3 weeks. I look forward to working with you on that and discussing that issue with you.

Mr. DAVIS of Illinois. I must tell you, I was in Detroit at the NAACP convention last week, and there were some folks there from Ohio. And as we talked about what needed to happen, I know I don't have to ask you, but I just know that my representative, Representative Stephanie TUBBS JONES, is up on this, as in my man, you got it right. You're on it; stay on it. We appreciate you so much.

Mrs. JONES of Ohio. Thank you very much.

Mr. Speaker, it gives me great pleasure at this time to have the opportunity to yield to the awesome Chair of the Congressional Black Caucus. She has shown such great leadership not only in this role but as Chair of so many other events that the Congressional Black Caucus has done.

I yield to my sister, the Congresswoman from the great State of Michigan, CAROLYN CHEEKS KILPATRICK.

Ms. KILPATRICK. I thank you, Madam Chair, for yielding. I certainly appreciate your leadership and all that you do for this body. I thank you for being the coordinator for this Special Order as we move through this 110th session. We thank you for your leadership, delta woman. We appreciate you.

Mr. Speaker, I am honored to stand here tonight as chairperson of the Congressional Black Caucus. We are from 26 States. We are 43 Members. We represent over 40 million Americans. Eighteen of our Members have less than 50 percent populations of African Americans. The highest percentage that any Member represents is 61 percent African Americans. So we represent all ethnicities of America: Latino Americans, Asian Americans, Native Americans, Arab Americans, Italian Americans, European, and the whole conglomerate. So we call ourselves the conscience of the Congress because we are they, 43 of us, 26 States, representing over 40 million Americans who can speak and represent all ethnicities in America.

Disparities in health care is real. It's alive. And it is really determined by how you live, where you live, what economic standards are you able to afford with you and your family, from generations yet unborn. So we are here tonight to talk about how do we close that gap? What ought to be the policies of our United States government to take care of American citizens, 300 million of us, from disparate backgrounds? What can we do to close the gap?

One thing we can do is to make sure that education, quality education, is had for every American; that they may compete not against Ohio or Michigan or California and New York, but to compete in the world, China, India, other countries of the world who revere, and in knowing that education is the key not only to a successful life but a key to adequate health care opportunities.

Number two, that we invest in those communities so that we put the dollars where they are necessary, so that we don't have underserved communities as we have today across America, underserved as it relates to health care, their access to quality health care. Can they really participate in programs that make their lives better?

When we have a healthy America, then we have healthier families, we have healthier cities, and then, of course, our country is one of health.

We talk about disparities of health care, and it refers to the difference between two or more population groups, the outcomes and the prevalence of certain illnesses, heart disease, diabetes, access to quality health care, are we really providing what is necessary for America's families? And we, the members of the Congressional Black Caucus, don't believe that we do.

Our Federal budget is 2.9 trillion of your tax dollars. We round that off and say $3 trillion in this 2008 budget that we are dealing with. Of that budget three entitlements: Medicare, health insurance for 44 million American seniors; Medicaid, over 40 million low-income, disabled, and children's programs; and then our veterans, our proud veterans, who have fought in our wars ever since the beginning, some in battle, some in theater, some not, but defending our country.

□ 2030

When you take out the main three entitlements, our Appropriations Committee handled 600 to $800 billion. Two-thirds of those monies goes to the entitlements, as was mentioned, and a few others handled by the Ways and Means Committee, where some of those health programs were had. And the other, what we call discretionary funding, is what is handled in the Appropriations Committee.

Of the $800 billion in 2008, $600 billion of that is going to defense, to defense. Proud that we are of our Defense Committee, but never is it intended that two-thirds of that budget, three-fourths in many instances, will go to defend the country. We have to end the war. We've got to bring our soldiers home. We have to invest in American families.

I believe that health care, education, housing, environment and access to capital are those things that this Congress must fund. That's why we have disparities, because many families start at a disadvantage; low income, poor schools, health crisis, unable to get quality health care.

So as we come to you tonight as members of the Congressional Black Caucus, we ask you, America, stand up for what you believe. If you want a strong family, if you want strong opportunities, if you want investment in your children and in your families, speak to that.

Our theme for the Congressional Black Caucus is ''Change Course.'' Do something different, America. Join. Speak out. Donate. Volunteer. Be a part of something that you believe in that will make America stronger. Health care, we believe, is one of those things that you will find yourself participating in.

Change course and then confront the crisis. Confront the crisis of education. Why is it that our schools can't compete with schools around the world? Confront the crisis of the war. And yes, confront the crisis of the disparities in health that we find ourselves in today. We can do better. We can be better. Make sure you're a part of that equation.

And then let us all rise up and continue the legacy. Change course, confront crises, and continue the legacy that all of us have put together as members of the African American Congressional Black Caucus, Latino Caucus, Tri-Caucus, the Asian Caucus as well. We work together to make sure that we begin to address some of the disparities that we see.

So, Madam Chair, thank you for your leadership. Thank you as we try to talk to America to become involved, to change course, to confront crises, to continue the legacy that so many have given their lives and time that we might be on this floor tonight.

This is the greatest country in the world. Let's eliminate the health disparities. Let's make our families stronger. Provide better education opportunities, better work opportunities and, yes, access to capital. When we do that, we will eliminate the disparities that we find now in our health system.

With that, Madam Chair, I yield back the balance of my time.

Mrs. JONES of Ohio. Thank you, Madam Chair, for that great presentation and for your leadership.

Being uninsured means going without needed care. It means minor illnesses become major ones because care is delayed. Tragically, it also means that one significant medical expense can wipe out a family's life savings.

There are millions of working uninsured Americans who go to bed worrying about what will happen to them and their families if a major illness or injury strikes.

In my home State of Ohio, there are currently 1,362,000 uninsured, an increase of 18,000 people since 2003. We've also seen the strain on many of the local hospitals in my district when people are forced to use emergency rooms as their source of primary care. The problem is getting worse. As the price of health care continues to rise, fewer individuals and families can afford to pay for the coverage. Fewer small businesses are able to provide coverage for their employees, and those that do are struggling to hold on to the coverage they offer. It is a problem that affects all of us, and we cannot sit idly by while the people of this country continue to go without health insurance.

I am pleased at this juncture to yield such time as she may consume to my colleague and good friend from the great State of Texas, Congresswoman SHEILA JACKSON-LEE.

Ms. JACKSON-LEE of Texas. Let me thank my distinguished colleague from Cleveland, Ohio, the chairwoman of the Ethics Committee, and as well the first African American woman, only African American woman on the Ways and Means Committee. These two distinctive positions are so important, one, for the health of this body, the Ethics Committee, and two, for the great city that she represents. And I might compete with her, she has the Cleveland Clinic; I have the Texas Medical Center. And I know that we have had the opportunity to work with each other, and I want to thank her for what I think is an enormously important Special Order.

I want to begin, as many of my colleagues have begun, and I want to acknowledge the chairwoman of the Congressional Black Caucus, Congresswoman KILPATRICK, for the importance of putting a face on the issue of disparities in health care.

In doing that, I'm reminded of the language in the beginning of the Constitution that the Founding Fathers organized to create a more perfect Union. But as they struck out on faith to establish this fledgling United States of America, only 13 colonies, feeling the redcoats breathing down their backs, afraid that at any moment this very fragile government might be toppled, they had enough courage to declare some words that I believe, if this Congress would use it as a moral compass, these issues of Congresswoman STEPHANIE TUBBS JONES would be very clear, and those are the words of the Declaration of Independence that said we all are created equal with certain inalienable rights; the right to pursue life, liberty and the pursuit of happiness. We are all created equal with certain inalienable rights; the rights of life, liberty and the pursuit of happiness.

Clearly, health care is intimately involved in life and the pursuit of happiness. And so in actuality, the Founding Fathers put down a marker of what kind of Nation they wanted this to be. Tragically, over the last years, when our good friends were involved, many of the serious issues of health care were diminished in terms of care and funding. And so it is important that we stand here tonight to be able to lay down the challenge and the charge that we are here to fix it up. We are here to make it right. We are here to correct some of the ills, governmental ills, budgetary ills that have caused health care to be diminished.

And let me cite some important statistics that represent the districts of individuals in this body coming from the south, coming from the midwest, coming from the far west, next to Texas, and parts of the mountain area.

The cost of the war in one district is costing $1 million. And out of that waste of money in the Iraq war, we would be able to provide people with health care: 336,000 adults and 527,000 children, plus, with health care.

Another district, the war is costing them $1.2 million, plus. We would be able to provide 420,000 people with health care if that war was ended, 758,000 children.

Another district, the war is costing them $1.1 million—755,000 people would be able to have health care and 633,000 children. Another district, $812,000 it's costing them, and we would be able to provide 310,000 adults with health care, and children, 502,000.

So, we can already see that we would be able to provide thousands, hundreds of thousands of Americans with health care and hundreds of thousands of children with health care if we, first of all, brought our troops home and ended the Iraq war.

Now, why should we be concerned with that? And the Congressional Black Caucus has gone on the record on questions of disparities in health care. And I might say that this whole issue of disparities is not just an issue of race; it's an issue of dealing with economics. It is the kind of health care that poor people are able to manage to get versus those who are covered, who have means. Some people have means where they pay outright for the care. The Texas Medical Center, for example, has long-time hosted international patients who outright pay for good care. We don't have that luxury here in the United States for many of those who are struggling.

And I might give you just a real-life example, Mr. Speaker, having left my home district and had the challenge and the desire to visit constituents who were ailing. They are now surviving because they happen to be individuals who had the care and the sophistication of family members who could get them to a spot that would, in fact, determine what was the final need of their care. Mr. Speaker, they had a disastrous cancerous organ that was not initially found, and they could have died. But because they had the means, they were able to go through test after test, and one expensive test that is rarely given, an MRI, was able to find that cancerous organ, their life has been saved. Another person with a severe injury or severe disease was able to be cared for and is in the best of care because of means. They live today. But that is not the case in the question of disparities on economics, what you make, and also on race.

I'm very glad to be part of the CBC effort and Health Task Force to focus on ensuring that the Ryan White CARE Act is passed with language that emphasizes minority HIV organizations.

I believe in fixing health care disparities on the ground. I have organized a series of testing activities or actions to engage the community in being tested. Our first effort with a church, 245 persons were tested. And our message is that HIV testing is not a one-shot deal. Just recently, a good friend, Representative Borris Miles, was able to get 7,000, or thousands of persons tested, possibly 7,000 persons, for HIV. We are going to launch another effort of testing and a campaign that says ''HIV testing is not a one-shot deal.''

I am a strong supporter of believing in the Health Centers Renewal Act of 2006. For the time that I have been here, I have emphasized that we have not enough community-based health clinics that were privately owned in neighborhoods accessible to grandmothers and young mothers with children. And we have worked hard to ensure that more community health centers come to Houston, Texas.

I'm proud that in my own congressional district we've opened one in Fifth Ward. We've opened two that are under the auspices of the Martin Luther King Community Center that I worked with and kept their doors open with a $400,000 grant from HHS in the early years of my congressional career. This is a stopgap to the disparities in health care, allowing those in the community to have immediate access to health care.

Then, of course, one of the largest, if I might use the term, Mr. Speaker, ''elephants'' in the room, is the question of obesity in America. As the cochair of the Congressional Children's Caucus, we have worked on the issue of obesity in children. I was very proud to join Congressman DONALD PAYNE for a very thoughtful, forward-thinking session on obesity in New Jersey, and providing remarks dealing with the question of obesity in our children. And it is a disparity in health care as it relates to Hispanic and African American children who are victimized, if you will, in large numbers by the lack of nutritious food that generates an overweight child. That turns into hypertension as an adult, type II diabetes, coronary heart disease, stroke, gallbladder disease, asthma, bronchitis, sleep apnea, and other respiratory diseases.

There are also increases in overweight among children and teens. For

children age 2 to 5, the prevalence of overweight increased from 5 percent to 13 percent; 6 to 11 years, prevalence increased from 6.5 percent to 18.8 percent; and for age 12 to 19 years, 5 percent to 17.4 percent.

We're working to ensure in the agricultural reauthorization bill that's coming forward that school lunches and school breakfasts are nutritious. That has to be for those children who are poor and are dependent upon those meals as sometimes their only meal.

I passed legislation that involved the creation of an Office of Minority Populations that still stands today, and the idea is to keep the question of disparities in health care before Health and Human Services regardless of who the Secretary is. We can do better in this Congress.

And there are issues dealing with our veterans. I'm very pleased that my VISTA bill was marked up in the veterans which provides added resources for visually impaired veterans in order to assist them in the care of those who are impaired by their recent, if you will, deployment to Iraq and those who are veterans who have suffered injury or have lost their sight.

But we come now to the issue of the SCHIP, which is in the process of being reauthorized. And the difficulty, of course, is that we need to emphasize the crucialness of SCHIP in the Nation and in our States. I believe that the work of the Congressional Black Caucus and all of us in our respective States is a telling answer to health care for children who are at a certain economic level.

Tragically, the State of Texas, after the passage of the 1997 budget resolution which created SCHIP, was one of those States that turned back $400 million because they could not enroll the children. As we move forward, I want to make sure that we move forward on the package that will cover 6 million children. I would like to see us go up to 9 million, but I think we need to look at process. I hope that we do not privatize and make this a market-based program so that people can stuff their pockets with money.

□ 2045

This should be a program that goes directly to these families. Any State that fails to enroll should be penalized by the State's having to refund their own tax dollars, not the money sent for the children. Let us not penalize the children, but let us cause those States to pay fines for their inertia and their inability to enroll these children. I hope that we will have that kind of reform.

Let me close by suggesting that we have an enormous road to take on health care. I am gratified that I hear more African Americans and Hispanics and others of a certain economic level who are prone to these disparities in health care talking about eating right, talking about an intake of less red meat. For those who are on the ranches, and I am from Texas, a good steak is a good thing to have. But to focus on vegetables, and some people have become vegetarians and are drinking water. These are elements that can encourage good health care.

For those of us who have our schedule here in Washington, D.C., a little walking, a little exercise would be good as well. We should probably look at ourselves in the mirror and try to improve our own health status. We have the capability and capacity if and when some health matter would come to our attention, that is a personal matter, but we must speak for the millions of Americans, 44 million, that are uninsured, that do not have access to health care. I do believe that it is time to move for universal access to health care.

So as we move in the 110th Congress and complete this session, I would say to all of my colleagues, be reminded of the Declaration of Independence; we all are created equal with certain inalienable rights of life, liberty and the pursuit of happiness. Health care has to be a constitutional issue and a right for Americans.

Certainly for the least of those we must stand ready to provide them with a strong and forceful statement and action on health care in America. We should have the SCHIP passed without hindrance and without a market-based approach. We should pass universal access to health care so that all Americans, all Americans, can have the ability to be blessed with the virtues of the pursuit of happiness and have good health care.

Mr. Speaker, let me thank my colleague for yielding. Might I also suggest that we have our marching orders at this point, that we will not take a ''no'' on passage of the SCHIP out of this House. We want to see universal access to health care come to the floor.

On the disparity question, I am looking forward to the Congressional Black Caucus and the Tri-Caucus health disparity bill being made in regular order and being brought to this floor as soon as possible.

Mr. Speaker, we must save lives. We must.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in support of Special Order to recognize the importance of closing the racial and ethnic health disparities in this country. It is crucial that we continue to bring awareness to the many health concerns facing minority communities and to acknowledge that we need to find solutions to address these concerns. My colleagues in the Congressional Black Caucus and I understand the very difficult challenges facing us in the form of huge health disparities among our community and other minority communities. We will continue to seek solutions to those challenges. It is imperative for us to improve the prospects for living long and healthy lives and fostering an ethic of wellness in African-American and other minority communities. I wish to pay special tribute to my colleague, Congresswoman DONNA CHRISTENSEN, the Chair of the CBC Health Braintrust, for leading the Congressional Black Caucus in its efforts to bring attention to the health challenges facing minority communities. I thank all of my CBC colleagues who have been toiling in the vineyards for years developing effective public policies and securing the resources needed to eradicate racial and gender disparities in health and wellness.

Let me focus these brief remarks on what I believe are three of the greatest impediments to the health and wellness of the African-American community and other minority communities. The first challenge is to provide everyone access to healthcare. This includes supporting the reauthorization and expansion of the State Children's Heath Insurance Program (SCHIP) so that all of our children who need health insurance will receive it. The second challenge is combating the scourge of HIV/AIDS. The third challenge is to reverse the dangerous trend of increasing obesity in juveniles and young adults.

DIFFERENTIAL ACCESS MAY LEAD TO DISPARITIES IN QUALITY; SUPPORT FOR HEALTHCARE LEGISLATION—H.R. 676

Across this great Nation the health disparities between minority and majority populations are staggering. Most major diseases—diabetes, heart disease, prostate cancer, HIV/AIDS, low-birth weight babies—all hit minority communities harder. As minorities, we constantly have had to endure decreased access to care, and often of lesser quality care, than do members of the majority race in America.

H.R. 676, ''THE UNITED STATES NATIONAL HEALTH INSURANCE ACT''

Earlier this year, I was proud to be an original cosponsor of H.R. 676, ''The United States National Health Insurance Act.'' This Act would allow for every American to receive heath insurance. You, the American people called for universal health care, as it was one of the most prominent issues for Americans in the 2006 election.

The need for a high-quality, accessible and affordable health care system has never been more urgent. There are currently 47 million uninsured Americans, 8 million of whom are children. Another 50 million are underinsured. Although the U.S. spends twice as much on health care per capita as countries with universal coverage, the World Health Organization ranks us 37th in overall health system performance. Major American corporations such as General Motors bear the brunt of an outdated health care system because they are at a competitive disadvantage relative to their international counterparts who pay less for health care. A Harvard study found that almost half of all bankruptcies are partially or fully related to health care bills.

Our plan, H.R. 676, ''The United States National Health Insurance Act,'' guarantees every resident of the United States access to a full range of medically necessary services, including primary care, prescription drugs, mental health care and long term care. The role of the government would be limited to collecting revenues and disbursing payments; care would continue to be delivered privately. Patients could continue to use the same hospital, physician or health clinic from which they currently receive services. H.R. 676 is supported by over 210 labor unions and more than 100 grassroots groups across the country. The former editor of the New England Journal of Medicine, two former U.S. Surgeons General and 14,000 physicians support national health insurance.

HEALTH EQUITY AND ACCOUNTABILITY ACT OF 2007

I also strongly support the Health Equity and Accountability Act of 2007, an important bill that my colleague Congresswoman DONNA CHRISTENSEN has crafted to address the health disparities we face in our community. This bill will provide for:

Creation of Regional Minority Centers of Excellence Programs in medically underserved regions of the country

Creation of Health Information Technology Zones

Data Collection and Analysis Grants for Historically Black Colleges and Universities, Hispanic Services Institutions, and Tribal Colleges and Universities, and Asian American and Pacific Islander-serving institutions with accredited public health, health policy or health services research programs

Reauthorization of the National Center for Minority Health and Health Disparities

Expansion of funding the Minority AIDS Initiative ($610 million)

Grants for Racial and Ethnic Approaches to Community Health

Access to programs and activities and establishes support center to those with limited English proficiency and ensures antidiscrimination provisions and sets standards for these services, such as hiring bilingual staff and informing patients of their rights in their primary language.

Federal agencies that carry out health related activities are mandated to adopt a guidance model on language services.

The Secretary is required to conduct a demonstration project in no less than 30 states or territories showing the impact of costs and health outcomes to those with limited English proficiency.

Grants to improve healthcare for those with communities with low functional literacy.

The preparation and publication of a report that describes government efforts to provide access to culturally and linguistically appropriate healthcare services including an evaluation of activities and an explanation of best practices and models.

DHHS will be responsible for submitting a report on health workforce diversity with descriptions of any grant support provided for workforce diversity initiatives.

Establishment of a technical clearinghouse for health workforce diversity with statistical information, model health workforce programs, admissions policies, etc.

Evaluation of workforce diversity initiatives, data collection and reporting by health professional schools, and supporting institutions committed to workforce diversity.

Providing career development for scientists and researchers and for those non-research health professionals.

Provide cultural competence training for health care professionals.

To increase the number of individuals from disadvantaged backgrounds in health professions by enhancing their academic skills and supporting them in training.

Examination of providers and the delivery of culturally and linguistically appropriate services in geographic areas

Makes public the data collected and analyzed.

Grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

Such a bill will go a long way in providing for the healthcare needs of minorities and will help to narrow the health disparity gap.

There is no reason why this country should continue down a dreadfully deleterious road of denying healthcare to any citizen of this country who needs it. Many of the health conditions, such as diabetes, obesity, kidney failure, cancer, hypertension and HIV/AIDS, the prevalence of which plagues our community the most, could be curtailed or even prevented if everyone had access to health insurance. I will continue to fight hard for the most effective policy measures that aim to narrow the racial health disparity gap.

It is a misconception that minority healthcare 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. We need to work to improve access to care for people, in general, but there are also areas where more specific interventions are necessary.

I have worked to improve awareness on prostate cancer, and have worked with MD Anderson to help start clinics in Houston that will open access to quality affordable prostate screening and care. I have worked with Hepatitis C advocates in Houston, and across the Nation, to spread the word that Hep C is a silent killer that is cutting down our minority communities and our veterans. There is so much misinformation out there about Hep C. I am pushing the Government Accountability Office to do a full report on the Hep C problem so that we can work to stop this epidemic.

There is also a significant shortage of minority doctors, dentists, and health professionals of all sorts; a shortage that contributes significantly to quality healthcare access. It has been shown that people tend to seek care from people who look like them, and share similar backgrounds. So, the lack of diversity is not just a civil rights issue, it is an issue of health access. We need to boost minority enrollment in health professional programs.

Success will require young people to redouble their efforts to pursue their scholarly pursuits with a renewed commitment to health and medical research. I am very bullish on academic achievement. That is one reason why I was so interested in securing increased funding for science, technology, engineering, and mathematics education and research.

There are so many areas in which we need to work together and address the critical needs of the people who are being left out of our health care system. Putting energy and resources into decreasing health disparities is a solid investment, one that will reduce unnecessary suffering, and make our workforce and our society stronger. I pledge to you that I will continue to do my part. By your presence here today, I have no doubt you will continue to do yours. And together, we will see the eradication of serious health inequalities in our lifetimes.

We must ensure that all Americans have access to healthcare. Access to healthcare is an important prerequisite to obtaining quality care. Some access barriers, whether perceived or actual, can result in adverse health outcomes. Patients may perceive barriers to delay seeking needed care, resulting in presentation of illness at a later, less treatable stage of illness. For example, a usual source of care can serve as a navigator to the healthcare system and an advocate to obtain needed evidence-based preventive and health care services. Of the major measures of access, the lack of health insurance has significant consequences. Avoidable hospitalizations are a good example of the link between access and disparities in quality of care. These hospitalizations may reflect, in part, the adequacy of primary care. When health care needs are not met by the primary health care system, rates of avoidable admissions may rise. Many racial and ethnic minorities and individuals of lower socioeconomic status are less likely to have a usual source of care. As a result:

Hispanics and people of lower socioeconomic status are more likely to report unmet health care needs.

While most of the population has health insurance, racial and ethnic minorities are less likely to report health insurance compared with whites. Lower income persons are also less likely to report insurance compared with higher income persons.

Higher rates of avoidable admissions by blacks and lower socioeconomic position persons may be explained, in part, by lower receipt of routine care by these populations.

Many of these circumstances are the direct result of lack of heathcare coverage.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Until we have a healthcare system that covers all Americans, it is crucial that we reauthorize the State Children's Health Insurance Program, SCHIP. We know that the lack of healthcare contributes greatly to the racial and ethnic health disparities in this country, so we must provide our children with the health insurance coverage to remain healthy. SCHIP, established in 1997 to serve as the healthcare safety net for low-income uninsured children, has decreased the number of uninsured low-income children in the United States by more than one-third. The reduction in the number of uninsured children is even more striking for minority children.

In 2006, SCHIP provided insurance to 6.7 million children. Of these, 6.2 million were in families whose income was less than $33,200 a year for a family of three. SCHIP works in conjunction with the Medicaid safety net that serves the lowest income children and ones with disabilities. Together, these programs provide necessary preventative, primary and acute healthcare services to more than 30 million children. Eighty-six percent of these children are in working families that are unable to obtain or afford private health insurance for their Meanwhile, health care through SCHIP is cost effective: it costs a mere $3.34 a day or $100 a month to cover a child under SCHIP, according to the Congressional Budget Office. There are significant benefits of the State Children's Health Insurance Program when looking at specific populations served by this program.

CHILDREN IN RURAL AREAS

SCHIP is significantly important to children living in our country's rural areas. In rural areas:

One in three children has healthcare coverage through SCHIP or more than half of all children whose family income is under $32,180 received healthcare coverage through Medicaid or SCHIP.

Seventeen percent of children continue to be of the 50 counties with the highest rates of uninsured children, 44 are rural counties, with many located in the most remote and isolated parts of the country. Because the goal is to reduce the number of uninsured children, reauthorizing and increasing support for SCHIP will be crucial to helping the uninsured in these counties and reducing the 17 percent of uninsured.

MINORITY CHILDREN

SCHIP has had a dramatic effect in reducing the number of uninsured minority children and providing them access to care:

Between 1996 and 2005, the percentage of low-income African-American and Hispanic children without insurance decreased substantially.

In 1998, roughly 30 percent of Latino children, 20 percent of African-American children, and 18 percent of Asian American and Pacific-Islander children were uninsured. After enactment, those numbers had dropped by 2004 to about 12 percent, and 8 percent, respectively.

Half of all African Americans and Hispanics are already covered by SCHIP or Medicaid.

More than 80 percent of uninsured African-American children and 70 percent of uninsured Hispanic children are eligible but not enrolled in Medicaid and SCHIP, so reauthorizing and increasing support for SCHIP will be crucial to insuring this population.

Prior to enrolling in SCHIP, African-American and Hispanic children were much less likely than non-Hispanic White children to have a usual source of care. After they enrolled in SCHIP, these racial and ethnic disparities largely disappeared. In addition, SCHIP eliminated racial and ethnic disparities in unmet medical needs for African-American and Hispanic children, putting them on par with White children.

CHILDREN IN URBAN AREAS

SCHIP is also important to children living in urban areas of the country. In urban areas: One in four children has healthcare coverage through SCHIP. More than half of all children whose family income is $32,180 received healthcare coverage through SCHIP.

HIV/AIDS

Ensuring that everyone has healthcare coverage will also help to combat HIV/AIDS in this country, and in particular in African-American and minority communities. In 1981, HIV/AIDS was thought by most Americans to be a new, exotic, and mysterious disease which seemed to inflict primarily gay white males in New York City and San Francisco. But since then we have learned that in the America of 2006, AIDS is overwhelmingly a black and brown disease. And that means that we have to assume the major responsibility for finding the solutions to rid our communities of this scourge. Consider the magnitude of the challenge confronting us:

HIV/AIDS is now the leading cause of death among African Americans ages 25 to 44—ahead of heart disease, accidents, cancer, and homicide.

The rate of AIDS diagnoses for African Americans in 2003 was almost 10 times the rate for whites.

Between 2000 and 2003, the rate of HIV/AIDS among African-American males was seven times the rate for white males and three times the rate for Hispanic males.

African-American adolescents accounted for 65 percent of new AIDS cases reported among teens in 2002, although they only account for 15 percent of American teenagers.

Billions and billions of private and federal dollars have been poured into drug research and development to treat and ''manage'' infections, but the complex life cycle and high mutation rates of HIV strains have only marginally reduced the threat of HIV/AIDS to global public health.

Although the drugs we currently have are effective in managing infections and reducing mortality by slowing the progression to AIDS in an individual, they do little to reduce disease prevalence and prevent new infections. It simply will not suffice to rely upon drugs to manage infection. We can make and market drugs until we have 42 million individually tailored treatments, but so long as a quarter of those infected remain detached from the importance of testing, we have no chance of ending or even ''managing'' the pandemic.

Currently, the only cure we have for HIV/AIDS is prevention. While we must continue efforts to develop advanced treatment options, it is crucial that those efforts are accompanied by dramatic increases in public health education and prevention measures.

Learning whether one is infected with HIV before the virus has already damaged the immune system represents perhaps the greatest opportunity for preventing and treating HIV infection. According to the Centers for Disease Control, CDC, between 2000 and 2003, 56 percent of late testers—defined as those who were diagnosed with full-blown AIDS within 1 year after learning they were HIV-positive—were African Americans, primarily African-American males.

African Americans with HIV have tended to delay being tested because of psychological or social reasons, which means they frequently are diagnosed with full-blown AIDS soon after learning they are infected with HIV. This is the main reason African Americans with AIDS do not live as long as persons with HIV/AIDS from other racial/ethnic groups.

Researchers have identified two unequal tracks of HIV treatment and care in the United States. In the first, or ''ideal track,'' a person discovers she or he is HIV-infected, seeks medical care, has regular follow-ups, and follows a regimen without complications. Persons in this track can now in most cases lead a normal life.

But some individuals follow a second, more-dangerous track. These individuals come to the hospital with full-blown AIDS as their initial diagnosis. They may have limited access to care because of finances or because other social or medical problems interfere. The vast majority of deaths from HIV/AIDS are among this second group. And the persons making up this group are disproportionately African-American males.

I have strongly supported legislation sponsored by CBC members and others to give increased attention and resources to combating HIV/AIDS, including the Ryan White CARE Act. I support legislation to reauthorize funding for community health centers (H.R. 5573, Health Centers Renewal Act of 2006), including the Montrose and Fourth Ward clinics in my home city of Houston, and to provide more nurses for the poor urban communities in which many of these centers are located (H.R. 1285, Nursing Relief Act for Disadvantaged Areas). I have also authored legislation aimed to better educate our children (H.R. 2553, Responsible Education About Life Act in 2006) and eliminate health disparities (H.R. 3561, Healthcare Equality and Accountability Act and the Good Medicine Cultural Competency Act in 2003, H.R. 90).

Twenty-five years from now, I hope that we will not be discussing data on prevalence and mortality of HIV/AIDS among African Americans, but rather how our sustained efforts at elimination have come into fruition. But for us to have that discussion, we must take a number of actions now. We must continue research on treatments and antiretroviral therapies, as well as pursue a cure. We absolutely have to ensure that everyone who needs treatment receives it. And we simply must increase awareness of testing, access to testing, and the accuracy of testing. Because we will never be able to stop this pandemic if we lack the ability to track it.

African Americans are 11 times as likely to be infected with HIV/AIDS, so we must make 11 times the effort to educate them until HIV/AIDS becomes a memory. We simply do not have any other alternative but to work continuously to eliminate HIV/AIDS in our community.

When it comes to the scourge of HIV/AIDS, the African-American community is at war. It is a war we absolutely have to win because at stake is our very survival. With HIV/AIDS we need not wonder whether the enemy will follow us. The enemy is here now. But so is the army that can vanquish the foe. It is us. It is up to us. For if not us, who? If not now, when? If we summon the faith of our ancestors, the courage of our great grandparents, and the determination of our parents, we will march on until victory is won.

OBESITY

The obesity epidemic in the African-American and other minority communities is also of great concern. Although the obesity rates among all African Americans are alarming, as Chair of the Congressional Children's Caucus, I am especially concerned about the childhood obesity epidemic among African-American youth. More than 40 percent of African-American teenagers are overweight, and nearly 25 percent are obese.

Earlier this year, my office in concert with the office of Congressman TOWNS and the Congressional Black Caucus Foundation, held a widely-attended issue forum entitled, ''Childhood Obesity: Factors Contributing to Its Disproportionate Prevalence in Low Income Communities.'' At this forum, a panel of professionals from the fields of medicine, academia, nutrition, and the food industry discussed the disturbing increasing rates of childhood obesity in minority and low-income communities, and the factors that are contributing to the prevalence in these communities.

What we know is that African-American youth are consuming less nutritious foods such as fruits and vegetables and are not getting enough physical exercise. This combination has led to an epidemic of obesity, which directly contributes to numerous deadly or life-threatening diseases or conditions, including

the following: hypertension; dyslipidemia (high cholesterol or high triglyceride levels), Type 2 diabetes; coronary heart disease; stroke; gallbladder disease; osteoarthritis; asthma; bronchitis; sleep apnea; and other respiratory problems; and cancer (breast, colon, and endometrial).

When ethnicity and income are considered, the picture is even more troubling. African-American youngsters from low-income families have a higher risk for obesity than those from higher-income families. Since the mid-1970s, the prevalence of overweight and obesity has increased sharply for both adults and children. According to the Centers for Disease Control and Prevention (CDC), among African-American male adults aged 20–74 years the prevalence of obesity increased from 15.0 percent in 1980 survey to 32.9 percent in the 2004.

There were also increases in overweight among children and teens. For children aged 2–5 years, the prevalence of overweight increased from 5.0 percent to 13.9 percent; for those aged 6–11 years, prevalence increased from 6.5 percent to 18.8 percent; and for those aged 12–19 years, prevalence increased from 5.0 percent to 17.4 percent.

As the debate over how to address the rising childhood obesity epidemic continues, it is especially important to explore how attitudes, environmental factors, and public policies influence contribute to obesity among African Americans and other minorities. Some of these contributing factors are environmental, others are cultural, still others are economic, and others still may be lack of education or information. But one thing is clear: we must find ways to remove them.

Mr. Speaker, I urge my colleagues to continue to support initiatives and programs that close the racial and health disparities gaps. It is imperative that we continue to seek workable solutions to the health and wellness challenges facing our communities. I look forward to working with all of my colleagues to achieve these goals.

Mrs. JONES of Ohio. Mr. Speaker, the State Children's Health Insurance Program is one of the most important priorities for the Congressional Black Caucus. Let me give you some information about SCHIP.

Of children living in rural areas, one in three children have health care coverage through SCHIP or Medicaid. More than half of all those whose family income is under $32,180 receive health care coverage through Medicaid or SCHIP. Of the 50 counties with the highest rate of uninsured, 44 are rural counties, with many located in the most remote and isolated parts of the country. Because SCHIP's goal is to reduce the number of uninsured children, reauthorizing and increasing support for this program will be crucial to helping the uninsured in these counties and reducing the 17 percent of uninsured.

Let's talk about children living in urban areas. One in four children have health care coverage through SCHIP or Medicaid. More than half of all the children whose family income is under $32,180 receive health care coverage through Medicaid or SCHIP. Nineteen percent continue to be uninsured. Because SCHIP's goal is to reduce the number of uninsured children, reauthorizing and increasing the support will be crucial in this area.

Let me talk about minority children just for a moment. SCHIP had a dramatic effect in reducing the number of uninsured minority children and providing them access to health care. Between 1996 and 2005, the percentage of low-income African American and Hispanic children without insurance decreased substantially. In 1998, roughly 30 percent of Latino children, 20 percent of African American children, and 18 percent of Asian American and Pacific Islander children were uninsured. After SCHIP's enactment, those numbers have dropped by 2004 to about 21 percent, 12 percent, and 8 percent.

Half of all African American and Hispanic children are already covered by SCHIP or Medicaid. More than 80 percent of the uninsured African American children and 70 percent of the uninsured Hispanic children are eligible but not enrolled in Medicaid and SCHIP, so reauthorizing and increasing support will be crucial to insuring this population.

One of the discussions that we have been having about the program is apparently the difficulty in getting young children enrolled in the program, whether they are African American, Hispanic, low-income, rural, or urban. One of the things that we have been talking about with the reauthorization is implementing new ways in which we can enroll children and get parents on board with providing health care to their children. The beauty of the program, as we have talked about previously, is the preventive arm of the program, so that children who have injuries or conditions can get treatment early in the process so that their problems will not escalate.

One of the exciting things that is going on this weekend is the fact that the Congressional Black Caucus is going to be participating in health care disparity events all over the country. In South Carolina, Congressman CLYBURN will be hosting a health and wellness event in Charleston this coming weekend. The 5th Annual Tri-Caucus Minority Health Summit will be held in San Diego, California. As I said previously, Representative DONNA CHRISTENSEN will be hosting an event in St. Croix, Virgin Islands.

We continue to be concerned about the SCHIP program. We are supportive of reauthorization. We are not only supportive, we are demanding reauthorization and requiring that the amount of money that is put into the program be extended such that it will cover most of the young men and women, or children, excuse me, in America. There is some debate about whether or not pregnant women ought to be included in this process. But the reality is, if we don't take care of pregnant women, the children will suffer as a result. So we are moving forward with those issues, as well.

I want to close with just a few more additional facts in and around the issue of health care disparities, because we can never say enough about the impact that it has. Let me talk to you for a moment about amputation. The differences in amputation rates reveal one of the many treatment disparities that exist between racial and ethnic minorities. In general, African Americans and Latinos have higher rates of lower extremity amputation than non-Hispanic whites. It brings to my mind an aunt that I have. Her name is Evelyn Shelton. She is in a nursing facility, having lost both of her legs as a result of a condition of diabetes. Among Medicare beneficiaries, the rate of amputation of all or part of the lower limb was 6.7 percent per 1,000 for African Americans and 1.9 percent per 1,000 for whites.

Let's talk about asthma care. Asthma rates are disproportionately high among racial and ethnic minorities, particularly among the African American community. Moreover, disparities also appear to exist in how asthma is treated in minority populations, with racial and economic minorities often receiving inadequate asthma care. Insured African Americans with asthma are more likely than insured whites to be hospitalized for asthma-related health conditions and are less likely to be treated by an asthma specialist.

African American children are about three times more likely to be hospitalized for asthma than their white peers, and about five times more likely to seek care at an emergency room. Among families in which parents lack any postsecondary education and do not have access to a primary care physician, African American and Latino children with asthma are more likely than white children to underuse routine medications, such as anti-inflammatory agents.

There are other facts that I would like to go on and discuss at the moment, but I don't have the time. There are issues around cancer care, there are issues around, cardiovascular care, there are issues around HIV treatment.

But I am pleased to stand this evening with my colleagues from the Congressional Black Caucus to discuss the issue of health disparity and to bring attention to those State Children's Health Insurance Program. This is the first of future hours that the Congressional Black Caucus will be hosting on issues that affect the African American community, and particularly but often affect the entire community of our Nation.

Mr. Speaker, my colleague BARON HILL, we came to Congress at the same time, and I thank you for having the opportunity to speak out on these issues.

Mr. CONYERS. Mr. Speaker, I rise today in strong support for the continuation of the State Children's Health Insurance Program (SCHIP). Since 1997, this program has served as a safety net for our Nation's low-income uninsured children. Today, the number of uninsured low-income children participating in SCHIP has fallen by more than one-third. The

number of minority children that participate in the program has decreased even more drastically.

In 2006, 6.7 million of America's children received health care benefits through SCHIP; of these, 6.2 million came from families whose income was less than $33,200 a year for a family of three. SCHIP working in conjunction with Medicaid through State programs provides necessary preventive, primary and acute health care services for the lowest income children and those with disabilities. Overall, these programs service more than 30 million children.

Children living in both rural and urban areas benefit from the SCHIP program. In rural areas, one in three children is covered either through SCHIP or Medicaid. In spite of this statistic, 17 percent of the children living in these areas remain uninsured. In urban areas one in four children has healthcare coverage through SCHIP or Medicaid, but 19 percent continue to be uninsured.

SCHIP also helps to reduce the number of uninsured minority children. The percentage of low-income African-American and Hispanic children without insurance decreased between 1996 and 2005 because of this program. Prior to SCHIP's enactment, approximately 30 percent of Latino children, 20 percent of African-American children, and 18 percent of Asian-American and Pacific Islander children were uninsured. By 2004, those numbers had dropped to 21 percent, 12 percent, and 8 percent respectively.

Mr. Speaker, let's not undermine the purpose of the SCHIP program. We have a responsibility to our children to provide them with one of the most basic needs in our society, equal access to health care. Let us not ignore the great strides that SCHIP has made in reducing the number of uninsured children. Reauthorize the SCHIP program and keep our children insured.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, members of the Congressional Black Caucus wish to call greater attention upon the disparities that exist in health care.

Chilren of color suffer disproportionately from a lack of health insurance.

In my State of Texas, the problem is severe.

Texas has the highest rate of uninsured children in the Nation, with over 21 percent of children—that's 1.4 million—lacking health care coverage.

Across the nation, more than 9 million American children lacked health care coverage in 2005.

The State Children's Health Insurance Program, called SCHIP, is critically important to prevent low- and moderate-income minority children from slipping through the cracks of our health care system.

One problem is that eligible children are not enrolling in SCHIP.

Nearly three-quarters of uninsured children were eligible for health coverage through SCHIP or Medicaid in 2004.

A disproportionate number of those eligible, but uninsured, were either Black or Hispanic.

Without insurance, children living in poverty are likely to have poorer health compared to children with insurance.

Uninsured kids are more likely to lack a regular source of health care, delay or have unmet health care needs, use less preventive care, and receive poorer quality care than children with insurance.

I urge my colleagues to remember our uninsured—especially the children—and have compassion on our Nation's most vulnerable.

Mrs. JONES of Ohio. Mr. Speaker, I yield back the balance of my time.

SPEAKING THE TRUTH: OPPOSING UNTRUE STATEMENTS ABOUT THE BUDGET

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from North Carolina (Ms. FOXX) is recognized for 5 minutes.

Ms. FOXX. Mr. Speaker, this weekend I noticed one of my colleagues in the majority on the Senate side on Fox News Sunday discussing our Nation's Iraq policy. In his conversation with Brit Hume he asserted that our Iraq policy was a failure because of limited progress on the political front in Iraq.

Mr. Hume challenged him on this point by pointing out that progress has been made recently in other areas of Iraq. Mr. Hume noted that if a lack of political progress in Iraq was the only thing that mattered, then couldn't people call the Democrats a failure because of their dismal record on enacting their priorities this session of Congress? The Senator from Michigan responded by drumming up a list of Democrat success, the first of which I find to be entirely dubious.

He attempted to prove that the majority party has not been a complete failure by first saying the Democrats have adopted a budget for the first time in years.

Mr. Hume had asked him, ''My understanding is that you got the minimum wage increase, but nothing else passed. Does that make you a failure?''

The Senator responded, ''Well, no, because it is not true. There is a lot of things that have passed. For the first time in years we have adopted a budget.''

I am not sure if he has been in the same Congress that I have been serving in. He makes it look like it has been years since we passed a budget, and that is simply not true. In 2005, a budget resolution passed the House and the Senate as well as a conference report. In 2006 a budget resolution also passed the House and the Senate without an accompanying conference report.

So I am a little confused as to where the Senator is getting his facts. Unfortunately, Mr. Hume did not catch the untrue statement. As a result, the millions of Americans watching the popular Sunday news program were led to believe that somehow the fact that the majority has adopted a budget resolution was an unusual feat, unseen for years in Congress. I wish to set the record straight.

Some people might wonder why I call attention to this. My reasoning is simple: The truth matters. When we allow untrue statements to enter the public record, we have allowed the public to be led astray. Those to whom we are accountable deserve so much better. The American people deserve the whole truth, the whole picture, not half truths or dodgy statements intended to cloud a less than stellar record of accomplishment.

I will give the Senator from Michigan the benefit the doubt. Maybe he really thought that it has been years since Congress adopted a budget. But if that is the case we have an equally large problem; he can't keep his facts straight. Both problems serve to mislead the American people.

Fortunately, at this point I don't think the American people have been too misled. They know that this majority has quickly established itself as the party of broken promises. Recent polls tell the whole story. Since taking office, the majority's job approval ratings have taken a nosedive. It is not a temporary dip either. Ever since January, their approval ratings have consistently trended negative, dropping from 37 percent to a low of 23 percent. These sorts of ratings are so low that they have even turned heads in Washington, where unpopularity in the polls seems to be a way of life. I will submit for the RECORD a chart showing the plummeting of the Democrat job approval.

But I am concerned about the public dialogue at stake. If Congressional leaders can't be trusted with the basic facts and insist on creating a track record of truth distortion and promise breaking, I see it as my duty to voice opposition. Even if I am the only one raising the alarm, I will continue to call for integrity in all aspects of public life, and especially in that most important of arenas, communicating with the American people.

The facts are important. The American people deserve the respect that comes with not taking liberties with the facts.

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AMNESTY

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Georgia (Mr. GINGREY) is recognized for 60 minutes as the designee of the minority leader.

Mr. GINGREY. Mr. Speaker, I come to the well this evening to talk about a very, very important subject that we just went through some very contentious debate on, and my colleagues are familiar with that, and it is the immigration issue. The American people are familiar with it. And the people in the great State of Georgia, the 11th Congressional District that I serve, are familiar with it as well.

And the big concern was to not do something in a, quote, ''comprehensive way'' that resulted in granting amnesty to up to 12 million people, possibly more than that, that have over the last 20 years, since 1986, the last time we granted amnesty to 3 million at that time, we have not secured our borders and because of porous borders,