have seen a lot of the mainstream media try to claim that these price increases are due to Russia's attack on Ukraine, not the Biden administration's anti-energy agenda. If that were true, how has the gas price per gallon increased by $1.60 over the last year, not just the last two weeks of the Ukraine conflict.

Since taking office, the Biden administration has frozen all new oil and gas projects on Federal lands and implemented extreme financial barriers on domestic oil and gas production. On day one, of course, we all know he killed the Keystone pipeline, which could be supplying 830,000 barrels of oil from Canada to U.S. refineries, more than what Russia imports to us.

In his first week, we had an executive order stopping new leases on Federal lands, so we need to replace Russian energy with our own production.

STANDING AGAINST ANTI-SEMITISM

(Mr. VEASEY asked and was given permission to address the House for 1 minute.)

Mr. VEASEY. Madam Speaker, I rise today to stand in solidarity with Congregation Beth Israel in Colleyville, Texas, and stand against anti-Semitism and other forms of religious bigotry.

On January 15 of this year, Congregation Beth Israel, in our North Texas area, endured a preplanned terrorist attack with the explicit purpose of targeting Jews.

This attack was personal to me, because I know the rabbi of that congregation, Charlie Cytron-Walker, and his wife, Adena, very well. I met them when they first moved to the North Texas area.

That is why I am here today, because no community should have to endure that type of attack while they are trying to worship. It doesn't matter what religion they happen to be. It has absolutely no place in our houses of worship.

Tomorrow, in the House, we will vote on a bipartisan resolution that my fellow colleague from North Texas, BETH VAN DUYNE, and I are leading. This resolution condemns the actions taken in Colleyville in January and underscores our commitment to fighting anti-Semitism. I ask everybody to support it, because we must root out hate.

RACIAL DISPARITIES IN HEALTHCARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2021, the gentlewoman from Texas (Ms. JACKSON LEE) is recognized for 60 minutes as the designee of the majority leader.

Ms. JACKSON LEE. Madam Speaker, it is my pleasure to co-anchor this Congressional Black Caucus Special Order and to be joined by my co-anchor, the distinguished gentleman from New York, Congressman TORRES. I thank him so very much for his presence here today.

Let me acknowledge the chair of the Congressional Black Caucus as well and thank her for helping to organize this Special Order as well as to be able to discuss health equity and the Black family and the reasons why the CBC strongly urges and supports substantial investments for healthcare in the budget for fiscal year 2023. I also want to especially acknowledge my friend and colleague, the Honorable DONALD PAYNE, whose office initiative has always focused us on the enormity of health disparities in the African-American community.

Let me start with a few comments to be made regarding the work of the Congressional Black Caucus. Let me acknowledge and express my appreciation to the President of the United States for hosting the members of the Congressional Black Caucus this afternoon who serve on the executive committee and for the concern and interest that the President has expressed on a number of issues that I think are important to where we are today in America.

Let me borrow this picture from Congresswoman KAPTUR, who heads the Congressional Ukrainian Caucus, and just remind everyone, because the Congressional Black Caucus has been at the forefront of persons fleeing persecution.

□ 1945

We have been a leader. Whether it is Haiti or whether it is places in Africa or the Caribbean or Europe, African Americans have been at the forefront.

This happens to be the mass of people that are trying to escape Ukraine because of the bloody and immoral and purposeless and vicious and vile actions of Vladimir Putin.

We stand here today as well, recognizing the humanitarian crisis and recognizing as well that we, as Americans, are going to be supporting any people who are fighting for democracy. As we fight for those people, we will also recognize that we will ensure that we are protecting democracy and the freedom of all people.

With that in mind, we had a number of issues that we discussed, and I think it is important that healthcare was certainly a part of it. And the disparities, disparities dealing with African-American boys and African-American men and recognize that we need to focus on eliminating those stark disparities that would result in less of a future for these young boys, for their lives turning around even before they enter school, that there is an intervention to ensure that they become the best of what they can be. That is a crucial element of what we talked about as well.

I am very grateful that we were also in discussions on H.R. 40, the Commission to Study and Develop Reparation Proposals for African Americans Act; and, of course, the very positive discussion that we had, breaking news is that progress will be made on the idea of healing and repairing and reparations, and we are certainly grateful for that discussion.

I would also like to mention as I begin, in the immediacy of the news of the day, we are well aware of my constituent that is now being held in Russia, that is Brittney Griner, an Olympian, a double-honors WNBA player. Unfortunately, we don't have the proof of the allegations. We are disturbed, but we know that she has the possibility of being held for 10 years because of the alleged charges that they are making against her. We are grateful to have had the opportunity to bring this to the attention of the President of the United States, and we expect that hopefully this situation will be looked at as closely as possible and that help will be coming.

I mention this because our Chairwoman has always said, Our Power, Our Message. We speak of a multitude of messages that we will have tonight, focused in particular on the issue of healthcare.

As a member of the United States Congress and the Congressional Black Caucus, we can't start this without talking about the COVID–19 pandemic that has laid bare for the Nation to see the stark racial and ethnic inequalities exacerbated by the virus.

In my home State of Texas as of the end of September 2020, there had been more than 760,000 cases of COVID–19 and 16,000 deaths. According to the Texas State Department of State healthcare services, 70 percent of the confirmed fatalities are people of color.

In Texas, COVID–19 mortality rates are 30 percent higher for African Americans and 80 percent higher for Hispanics. One factor in the Hispanic and African-American populations being more likely to contract COVID–19 is employment in occupations associated with public contact that cannot be done remotely.

We saw that in the early stages of COVID–19, when testing was not at its peak, that the numbers were so high in New York, New Orleans, Detroit, and, yes, in Houston, Texas, because African Americans, in particular, were in jobs that they had hands on, that they were encountering people, whether they were metro bus drivers or TSA workers in the Federal system, whether they were retailers in the grocery store, whether they were firefighters and first responders or police officers, we were finding out that they were being confronted by these particular issues.

The idea of health disparities in the African-American community lends itself to the very reason why this Special Order is crucial. Health coverage as it relates to African Americans in 2017:

10.6 percent of African Americans were uninsured compared with 5.9 percent of non-Hispanic Whites;

89.4 percent of African Americans had healthcare coverage in 2017 compared with 93 percent of White Americans;

44.1 percent of African Americans had government health insurance coverage in 2017; and

12.1 percent of African Americans under the age of 65 reported having no health insurance coverage.

Chronic health conditions are prevalent in our community. 13.8 percent of African Americans reported having fair or poor health. We are prone to diabetes; cancer, particularly breast cancer, prostate cancer, lung cancer, brain cancer; and the leading causes of death among African Americans are heart disease, cancer, and accidents.

There are 11 infant deaths per 1,000 births among Black Americans. This is almost twice the national average of 5.8. Of course, we have a serious problem with Black maternal mortality, which I am very glad the Congressional Black Caucus has taken on as an important issue.

I know that there are also the different kinds of cancer that impact African-American males, and I know my colleagues will spend their time discussing that.

I think the point that is most important is that we realize that all of the indicia indicating disparities in healthcare unfortunately fall on African Americans.

One I forgot to mention is obesity. African-American women have the highest rates of obesity or being overweight compared to other groups in the United States, about four out of five African-American women are overweight or obese.

As we have this discussion tonight, there are several things that I think we should be reminded of. Twelve States refused to take the expanded Medicaid when the Affordable Care Act was finalized and signed by the President of the United States. I was here; we were fighting. In fact, we had included expanded Medicaid as a response to the public option, that we were fighting for. I was in support of the public option, but we compromised, and lo and behold, if I may use that terminology, didn't it get taken out. Didn't we have States refusing to accept expanded Medicaid, and they are in the worst dire straits which includes the State that is a poster child for uninsured, and that is the State of Texas.

But in this Build Back Better Act, we created, with the work of the Congressional Black Caucus, a Federal Medicaid process that we could opt into so that whatever State you lived in—the 12 horrific States that did not accept it who suffer every single day, not the States, not the State government, but the people suffer every day, the children suffer every day—we provided this in Build Back Better.

I was so excited because we were pushing and working and sending letters saying you had to fix this issue of not having the expanded Medicaid. We were able to secure that, and here we are with Build Back Better stalled in the United States Senate, after we worked so hard to get a bill that has so many elements to it that deals with the disparities in healthcare.

As I conclude, let me indicate that the idea of these disparities fall right into the umbrella of H.R. 40, the Commission to Study Slavery and Develop Reparation Proposals for African Americans Act, but the idea is to track slavery and its trajectory to 2021, why these stark disparities in healthcare and education and science and housing and the criminal justice system. But healthcare is life or death, and we can see it in a glaring panorama of any community you go into, of hospitals that you go into, hospice that you are in, that you see this disproportionate proportion of African Americans who either did not have access to healthcare in the early stages of their disease or either suffered from diseases that were, in fact, inherited from families down through the generations because of diet, living conditions, or lack thereof.

We stand here today on the floor of the House to say it is imperative that we work together as Americans to find a way to provide an even playing field for all of our children, if it takes legislation that focuses specifically on diseases that we have, that falls on our shoulders.

I am a breast cancer survivor, and I have introduced over the years triple-negative breast cancer legislation that I hope I will see in the next few months passing, for triple-negative breast cancer is more deadly in our African-American populations and Hispanic populations. I know the cancer clusters that are in the Fifth Ward, Texas, in my district, or Kashmere Gardens, because living in conditions where there are toxic chemicals that these people are breathing or they are eating them because they are in the soil that they plant their gardens in.

Can you imagine, Madam Speaker? This is what we are confronting. That is why the Congressional Black Caucus rises on the floor today to be able to address these serious questions of health disparities, which I believe is at this time a crucial moment in history for us to speak about.

Madam Speaker, as a senior member of the Committees on the Judiciary, on Homeland Security, and on the Budget, and the Congressional Black Caucus, I am pleased to co-anchor this Congressional Black Caucus Special Order with my colleague, the distinguished gentleman from New York, Congressman RITCHIE TORRES.

I thank the Chair of the CBC, Congresswoman BEATTY of Ohio, for organizing this Special Order to discuss the health equity and the Black Family and the reasons why the CBC strongly urges and supports substantial investments for healthcare in the budget for FY 2023.

Before I do, however, let me note for the record that today is March 7, the 57th anniversary of ''Bloody Sunday,'' when hundreds of heroic souls risked their lives in Selma, Alabama, for freedom and to secure the right to vote for all Americans.

Those ''foot soldiers'' of Selma, who were led by our beloved colleague, the late Congressman John Lewis of Georgia, were brave and determined men and women, boys and girls, persons of all races and creeds, who loved their country so much that they were willing to risk their lives to make it better, and to bring it even closer to its founding ideals.

The foot soldiers marched because they believed that all persons have dignity and the right to equal treatment under the law, and in the making of the laws, which is the fundamental essence of the right to vote.

I am Congresswoman SHEILA JACKSON LEE of Texas, and I proudly hail from the great city of Houston, which has been on the front lines since the beginning of the COVID–19 pandemic and paid more than its share in death, heartbreak, and suffering, especially among communities and healthcare workers of color, but has also seen the best our nation has to give in the selfless and courageous service of black nurses who were among the very first to answer the call and have never left or retreated from the field of battle.

The COVID–19 pandemic has laid bare for the nation to see the stark racial and ethnic inequalities exacerbated by the virus.

In my home state of Texas, as of the end of September 2020, there have been more than 760,000 cases of COVID–19 and 16,000 deaths.

According to the Texas Department of State Health Care Services, 70 percent of the confirmed fatalities were people of color.

In Texas, COVID–19 mortality rates are 30 percent higher for African Americans and 80 percent higher for Hispanics overall.

The differences become much larger when accounting for age; for example, in the 25 to 44-year-old age group, African American mortality rates are more than four times higher than White rates, and the Hispanic rates are more than seven times higher.

One factor in Hispanic and African American populations being more likely to contract COVID–19 is employment in occupations associated with public contact and that cannot be done remotely.

The sad fact is that most workers in these occupations are less able to be absent from their job or to have paid time off.

In Texas, people of color are more than 40 percent of cashiers, retail salespersons, child care workers, licensed practical nurses, more than 50 percent of bus drivers and transit workers, medical and nursing assistants, personal care aides, and home health aides, and more than 60 percent of building cleaners and housekeepers.

In addition, Hispanic and African American populations in Texas are less likely to have health insurance and to have a regular health care provider, so less likely to seek or receive early care for symptoms, especially in the first months of the epidemic.

And African American and Hispanic populations are also more likely to have an underlying health condition that makes them more vulnerable to the effects of COVID–19.

To respond and mitigate the devastation wrought by COVID–19 on Americans, and especially marginal and vulnerable communities of color, I have introduced H.R. 330, the ''Delivering Covid–19 Vaccinations to All Regions and Vulnerable Communities Act'' or ''COVID–19 Delivery Act,'' which I invite all Members to join as sponsors.

Under the COVID–19 Delivery Act, FEMA will be authorized and directed to lead the effort for vaccine delivery from the receipt from

manufacturing facilities to delivery to designated inoculation sites (hospital, clinic, doctors' offices, school, places of worship, community centers, parks, or neighborhood gathering locations.

The legislation directs FEMA to develop and deploy a fully staffed and resourced 24-7 advanced real-time tracking system that allows FEMA to monitor shipments of vaccine units that can provide end-to-end transparency on the temperature, real-time location, origin, and destination data, anticipated time of arrival, and report on changes and update recipients on the progress of their delivery and report on changes that may impact expected delivery or the viability of the vaccine while in transit.

I see the disparities in the lives of so many of my constituents who suffer disproportionately from medical conditions that make COVID–19 deadly.

They work low wage or no wage jobs to make ends meet, and they have no health insurance and rely on community health centers or public health services for routine care.

I call them friends and neighbors because they are that to me.

That is why I strongly support CBC's legislative agenda for the 117th Congress to address the many social justice and health equity issues that are related to how the COVID–19 pandemic has manifested and amplified healthcare racial disparities in our communities.

Specifically, I support:

1. Expanded access to testing for all essential workers.

2. Setup a comprehensive vaccination campaign targeting communities of color and ensuring free vaccination for all.

3. Expanded SNAP food benefits.

4. Direct relief payments of $2,000 a month until the end of the pandemic.

5. Continue rent and mortgage payment suspension.

6. Cancellation of student loan debt as students of color have the highest debt loads.

I support legislation that will ensure that all essential workers have access to free PPE for the duration of the pandemic.

I also support legislation to raise the minimum wage to $15 dollars an hour and to develop and support legislation that promotes the ethnic, racial and gender diversification of the health care workforce aimed at increasing overall cultural competence.

Most importantly, I support legislation like H.R. 40 that directly augments the underlying social determinants of health (e.g., socioeconomic factors, education, employment, housing) that historically have disproportionately impacted black and other communities of color that have made them more vulnerable to the COVID–19 pandemic.

Madam Speaker, the CBC strongly supports comprehensive efforts to reduce maternal and infant mortality and its devastating effects.

Maternal and infant mortality disproportionately impacts the Black community in comparison to other communities and this is unacceptable.

700 women die each year in the United States as a result of pregnancy or delivery complications.

Black women are shown to have a disproportionate fatality rate during pregnancy or within 42 days after giving birth.

In 2018, the national maternal mortality rate was 17.4 deaths per 100,000 births in 2018, 37.1 black women died per 100,000 births.

Black infants have 2.3 times the infant mortality rate as white infants.

African American infants are 3.8 times as likely to die from complications related to low birthweight as compared to non-Hispanic white infants.

Black infants are at three times greater risk of accidental death than are white babies, and at more than four times the risk of developing SIDS.

For these reasons, I strongly support and am working for:

1. President Biden's Budget that proposes $31.9 million for the Program for Treatment for Pregnant and Postpartum women;

2. legislation that will increase the diversity of the perinatal health care workforce;

3. investment in digital tools like telehealth to improve maternal health outcomes, especially in underserved areas; and

4. Establishment of an Office of Sexual and Reproductive Health & Wellbeing in the White House to align federal policies and programs so they promote sexual and reproductive health and wellbeing through a human rights, reproductive justice, and racial equity lens.

The CBC supports comprehensive efforts to endorse actions to address the health effects of systemic racism, such as H.R. 379, Improving Social Determinants of Health Act of 2021, which will authorize the CDC to set up a program to improve health outcomes and reduce health inequities by coordinating CDC social determinants of health (SDOH) activities and improve capacity of public health agencies and community organizations to address SDOHs.

We also support the passage of legislation focused on ways to increase the diversity of the U.S. health care workforce (especially nurses, physicians, dentists, and mental health workers) to include enhanced tuition and student loan repayment programs for those from Black communities and other communities of color.

CBC supports as well the passage of legislation to combat institutional racism in all governmental health related agencies and programs.

I am also the lead sponsor of legislation, H.R. 40, which will establish a commission on restorative justice to investigate the ramifications of reparations that includes the acknowledgment of historic health related atrocities.

I support comprehensive efforts to ensure action to improve urban green spaces, public health, environmental health justice and global warming and support clean air/water protections and initiatives that ensure healthy environments for all people because the most recent data reveal that people of color compared to their white counterparts are disproportionately affected by poor socio-ecosystems that affect their physical, mental and social well-being.

Poor socio-ecosystem services translate to disparities in health risks so innovative and multifaceted strategies aimed at reversing the following issues are critical to improve the health and well-being of all Americans and specifically people of color.

The CBC supports comprehensive efforts to reduce cancer inequities and its devastating effects.

According to the American Cancer Society, Blacks have the highest mortality and poorest survival rate of any racial—ethnic group in the U.S.

Experts are concerned that the COVID–19 pandemic will exacerbate disparities in cancer care among Blacks, Hispanics, and other people of color.

Accordingly, I agree with NBNA's call for the 117th Congress to:

1. Support (H.R. 8845), the Multi-Cancer Early Detection Screening Coverage Act which would ensure prompt access to FDA-approved multi-cancer screening tests and fuel innovation in cancer screening.

2. Support legislation that would provide ongoing research and education for minorities impacted by cancer.

3. Support legislation that limits and reduces the cost of cancer medications and medical treatment for all populations with an emphasis on disproportionately impacted Black and other communities of color.

4. Support legislation (H.R. 1570) to Remove Barriers to Colorectal Cancer Screening and to modify cost-sharing requirements for colorectal cancer screening tests, and drug manufacturer reporting requirements under Medicare medical services.

5. Support legislation (H.R. 113) to provide for research and education with respect to triple negative breast cancer and for other purposes.

More than 600,000 uninsured African Americans with incomes below the poverty line are among the 2.2 million adults who have no access to affordable health coverage simply because they live in one of 12 states that have refused to take up the Affordable Care Act's Medicaid expansion.

Permanently closing the Medicaid coverage gap is essential to remedy this racial health inequity.

It has been over a decade since the passage of the Affordable Care Act. Of the 12 remaining states that have stubbornly declined to expand coverage to adults with low incomes, eight are in the South: Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

Fully 60 percent of those in the coverage gap in 2019 were people of color, even though people of color represent just 41 percent of the adult population of the 12 states.

Most live in Florida, Georgia, or Texas; more than 100,000 African Americans in each state fall into the coverage gap.

In Alabama, Mississippi, North Carolina, and South Carolina, a majority of those without a pathway to coverage are African American.

In Texas, more than half of those in the coverage gap—422,000 people—are Latinos.

Who are the people in the coverage gap?

They are parents, often with young children.

They are working people.

Many are essential workers who have kept our nation going during the pandemic by working in grocery stores and health care jobs.

Yet they have no health coverage and no way to get it.

By permanently closing the Medicaid coverage gap, Congress can improve the financial security of African Americans and Latinos as well as their health.

Medicaid expansion is a powerful tool against financial hardship and bankruptcy because it prevents catastrophic out-of-pocket medical costs.

Providing this safeguard is particularly critical for African Americans, given the substantial racial wealth gap.

Closing the Medicaid gap will also help address the Black maternal health crisis.

States that expanded Medicaid have seen improved access to preconception and prenatal services that make pregnancy and birth safer for parents and babies.

Medicaid expansion is associated with reduced rates of maternal death, particularly for Black women.

Yet 235,000 Black women of reproductive age with incomes below the poverty line remained uninsured in 2019 without any pathway to affordable health coverage.

Almost all of them live in the Southern states that have refused to expand Medicaid.

Consider these stark and persistent racial disparities in health coverage, chronic health conditions, mental health, and mortality between black and white Americans.

An African American or Black person is any individual with total or partial ancestry from any of the Black racial groups of Africa.

In 2017, 10.6 percent of African Americans were uninsured compared with 5.9 percent of non-Hispanic whites.

89.4 percent of African Americans had health care coverage in 2017 compared with 93.7 percent of white Americans.

44.1 percent of African Americans had government health insurance coverage in 2017.

12.1 percent of Africans Americans under the age of 65 reported having no health insurance coverage.

13.8 percent of African Americans reported having fair or poor health compared with 8.3 percent of non-Hispanic whites.

Eighty percent of African American women are overweight or obese compared to 64.8 percent of non-Hispanic white women.

In 2017, 12.6 percent of African American children had asthma compared with 7.7 percent of non-Hispanic white children. Forty-two percent of African American adults over age 20 suffer from hypertension compared with 28.7 percent of non-Hispanic white adults.

In 2018, 8.7 percent of African American adults received mental health services compared with 18.6 percent of non-Hispanic white adults.

6.2 percent of African American adults received prescription medication for mental health services compared with 15.3 percent of non-Hispanic white adults.

In 2018, 3.8 percent of African American adults reported serious psychological distress.

These disparities are not a result of individual or group behavior but decades of systematic inequality in American economic, housing, and health care systems.

Alleviating health disparities will require a deliberate and sustained effort to address social determinants of health, such as poverty, segregation, environmental degradation, and racial discrimination.

Madam Speaker, in 2019, I introduced a Jackson Lee Amendment to the National Defense Authorization Act, which was adopted to address the issue of Maternity Mortality.

I am pleased to report that the National Defense Authorization Act for Fiscal Year 2020 did include the adoption of a maternity mortality amendment that I offered.

This Jackson Lee Amendment directs the Secretary of Defense to produce a report on maternity mortality rates among members of the Armed Forces and their dependents, which will include the Coast Guard to draw attention to the incident maternal mortality.

Between 1990 and 2015 it is reported that maternal mortality rates around the world fell by 30 percent, while at the same time in the US, the ratio went up nearly 60 percent.

A 2012, Pentagon report states that mothers delivering at military hospitals are more likely to hemorrhage after childbirth than mothers at civilian hospitals.

More than 50,000 babies are born at military hospitals each year, and they are twice as likely to be injured during delivery as newborns nationwide.

In the United States, black women are 2 to 6 times more likely to die from complications of pregnancy than white women, depending on where they live.

Dating back from 1979 to 1992 maternity mortality was analyzed, the overall pregnancy-related mortality ratio was 25.1 deaths per 100,000 for black women, 10.3 for Hispanic women, and 6.0 for non-Hispanic white women.

These numbers did not improve between 1987 and 1996.

During 2011–2015, the pregnancy-related mortality ratios were—

42.8 deaths per 100,000 live births for black non-Hispanic women;

32.5 deaths per 100,000 live births for American Indian/Alaskan Native non-Hispanic women;

14.2 deaths per 100,000 live births for Asian/Pacific Islander non-Hispanic women;

13.0 deaths per 100,000 live births for white non-Hispanic women; and

11.4 deaths per 100,000 live births for Hispanic women.

Black women in the United States experience unacceptably poor maternal health outcomes, including disproportionately high rates of death related to pregnancy or childbirth.

African American women have the highest rates of obesity or being overweight compared to other groups in the United States.

About 4 out of 5 African American women are overweight or obese.

Obesity in the African American community has been a growing concern in recent decades and can be attributed to a multitude of societal elements.

Contributing factors include but are not limited to inequities in stable and affordable housing, risks of living in food deserts, income, and access to quality education.

Each one of these factors has the potential to directly or indirectly influence an individual's chance to live a longer and healthier life.

In addition, if one combines those circumstances with disparities in access to affordable and healthy food or safe places to be physically active, the picture of obesity in the African American community begins to take shape.

Among African American adults, nearly 48 percent are clinically obese (including 37.1 percent of men and 56.6 percent of women, compared to 32.6 percent of whites (including 32.4 percent of men and 32.8 percent of women).

The Centers for Disease Control and Prevention found that among 148,494 U.S. adults with COVID–19, a nonlinear relationship was found between body mass index (BMI) and COVID–19 severity, with lowest risks at BMIs near the threshold between healthy weight and overweight in most instances, then increasing with higher BMI.

Overweight and obesity were risk factors for invasive mechanical ventilation.

Obesity was a risk factor for hospitalization and death, particularly among adults aged <65 years.

Using data from the Premier Healthcare Database Special COVID–19 Release the CDC assessed the association between body mass index (BMI) and risk for severe COVID–19 outcomes as defined by hospitalization, stays in intensive care units and the use of invasive mechanical ventilation, and death.

Among 148,494 adults who received a COVID–19 diagnosis during an emergency department (ED) or inpatient visit at 238 U.S. hospitals during March–December 2020, 28.3 percent had overweight and 50.8 percent had obesity.

Overweight and obesity were risk factors for invasive mechanical ventilation, and obesity was a risk factor for hospitalization and death, particularly among adults aged <65 years.

Risks for hospitalization, ICU admission, and death were lowest among patients with BMIs of 24.2 kg/m2, 25.9 kg/m2, and 23.7 kg/m2, respectively, and then increased sharply with higher BMIs.

Risk for invasive mechanical ventilation increased over the full range of BMIs, from 15 kg/m2 to 60 kg/m.

Madam Speaker, I include in the RECORD three publications relating to racial health disparities.

[From USA Today]

FAMILY RAVAGED BY CORONAVIRUS BEGGED FOR TESTS, HOSPITAL CARE BUT WAS REPEATEDLY DENIED

(By Kristen Jordan Shamus)

DETROIT—The man who raised Keith Gambrell, who loved him like a son and married his mother, died in a blue recliner of novel coronavirus in his Michigan home.

Gary Fowler, 56, went to the emergency rooms of three metro Detroit hospitals in the weeks leading up to his death, begging for a coronavirus test, begging for help because he was having difficulty breathing, but he was repeatedly turned away, Gambrell said.

''My dad passed at home, and no one tried to help him,'' Gambrell, 33, said through tears. ''He asked for help, and they sent him away. They turned him away.''

In the hours before his death, breathing was so difficult, Fowler slept sitting up in the bedroom chair, while his wife, Cheryl, dozed in the bed by his side. When she woke, her husband of nearly 24 years was gone.

Before he took his last breaths, Fowler scrawled on a piece of paper, ''Heart beat irregular . . . oxygen level low.''

''My little brother called me, screaming, 'Daddy won't wake up!' '' Gambrell said.

By the time Gambrell got across town to their house on the morning of April 7, police and emergency medical workers had arrived.

His dad was still in the recliner. A bluish tinge had settled on his lips and fingers.

''I went up and talked to him,'' Gambrell said, his voice breaking. ''I told him I love him and that I'll see him again one day and that I'm sorry we couldn't even have a funeral for him.

''I just felt so bad because he was begging for his life, and medical professionals did nothing for him.''

The virus has brought renewed attention to health disparities for people of color.

''About 33 percent of the cases of COVID–19 in this entire state of Michigan are in African Americans, and about 40 percent . . . of the deaths,'' Dr. Joneigh Khaldun, the chief medical executive for the Michigan Department of Health and Human Services, said during a Facebook Live interview Thursday with Detroit's Civil Rights, Inclusion and Equal Opportunity Department. ''And that's incredibly concerning. We know that African

Americans are only about 14 percent of the entire population.''

Gambrell lives in Detroit's 48235 ZIP code, a coronavirus hot zone with the highest infection rate per capita—162 cases per 10,000 residents—and the highest number of confirmed cases of the virus at 724, according to data released Friday by the city.

Denise Fair, Detroit's chief public health officer, said coronavirus testing remains a barrier for many in the community, as does access to care.

''It's estimated that there are upwards of 10 people with undetected infections for every confirmed case, and in some communities, the estimates are even higher,'' she said.

Dozens of factors feed the health disparities for people of color, said Khaldun, who formerly worked as the director and health officer for the Detroit Department of Health.

[From the American Cancer Society]

CANCER DISPARITIES IN THE BLACK COMMUNITY

African Americans have a higher cancer burden and face greater obstacles to cancer prevention, detection, treatment, and survival. In fact, Black people have the highest death rate and shortest survival of any racial/ethnic group for most cancers in the U.S. Research has shown that:

African Americans experience more illness, worse outcomes, and premature death compared to whites.

African Americans have the highest death rate and shortest survival of any racial/ethnic group for most cancers. African American men also have the highest cancer incidence.

Cancer death rates in black men is twice as high as in Asians and Pacific Islanders, who have the lowest rates.

Prostate cancer death rates in black men are more than double those of every other racial/ethnic group.

Black women are 40 percent more likely to die of breast cancer than white women and are twice as likely to die if they are over 50.

About a third of Africa American women reported experiencing racial discrimination at a health provider visit.

Living in segregated communities and areas highly populated with African Americans has been associated with increased chances of getting diagnosed with cancer after it has spread, along with having higher death rates and lower rates of survival from breast and lung cancers.

HEALTH DISPARITIES IN THE UNITED STATES

AFRICAN AMERICANS OR BLACK AMERICANS

An African American or Black person is any individual with total or partial ancestry from any of the Black racial groups of Africa.

HEALTH COVERAGE

In 2017, 10.6 percent of African Americans were uninsured compared with 5.9 percent of non-Hispanic whites.

89.4 percent of African Americans had health care coverage in 2017 compared with 93.7 percent of white Americans.

44.1 percent of African Americans had government health insurance coverage in 2017.

12.1 percent of Africans Americans under the age of 65 reported having no health insurance coverage.

CHRONIC HEALTH CONDITIONS

13.8 percent of African Americans reported having fair or poor health compared with 8.3 percent of non-Hispanic whites.

Eighty percent of African American women are overweight or obese compared to 64.8 percent of non-Hispanic white women.

In 2017, 12.6 percent of African American children had asthma compared with 7.7 percent of non-Hispanic white children. Fortytwo percent of African American adults over age 20 suffer from hypertension compared with 28.7 percent of non-Hispanic white adults.

MENTAL HEALTH

In 2018, 8.7 percent of African American adults received mental health services compared with 18.6 percent of non-Hispanic white adults.

6.2 percent of African American adults received prescription medication for mental health services compared with 15.3 percent of non-Hispanic white adults.

In 2018, 3.8 percent of African American adults reported serious psychological distress.

LEADING CAUSES OF DEATH

The leading causes of death among African Americans are heart disease, cancer. and accidents.

African Americans have the highest mortality rate for all cancers combined compared with any other racial and ethnic group.

There are 11 infant deaths per 1,000 live births among Black Americans. This is almost twice the national average of 5.8 infant deaths per 1,000 live births.

11.4 per 100,000 African American men and 2.8 per 100,000 of African American women die by suicide.

Ms. JACKSON LEE. Madam Speaker, I would like to express my appreciation, and I yield back the balance of my time.

RACIAL HEALTH DISPARITIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 4, 2021, the gentlewoman from Ohio (Ms. BROWN) is recognized for the remainder of the hour as the designee of the majority leader.

Ms. BROWN of Ohio. Madam Speaker, I want to thank the gentlewoman from Texas (Ms. JACKSON LEE) and also the gentleman from New York (Mr. TORRES) for hosting this Special Order hour. I would like to thank my sister Chair BEATTY and all my Congressional Black Caucus colleagues for their continued work to shine a spotlight on racial health disparities.

Dr. Martin Luther King once said, ''Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.'' Madam Speaker, what was true in Dr. King's time continues to be true in our own. Communities of color have long experienced inadequate access to healthcare, housing, healthy food, and economic opportunity.

These inequalities independently, and working together, increase the prevalence of a host of dangerous health conditions, including diabetes, asthma, obesity, heart disease, and high blood pressure.

One of the most shocking examples of health inequity is our Nation's maternal and infant mortality crisis. Infants born to Black mothers are nearly twice as likely to die compared to those born to White mothers. Continuing after birth, minority Americans face far higher rates of illness and death from an array of conditions.

And what does this lead to, you might ask? Well, I am glad you did. Black Americans have a life expectancy that is 4 years—I repeat, 4 years—shorter than White Americans.

The COVID pandemic's disproportionate impact on minority Americans exacerbated and exposed these disparities and the underlying inequalities driving them. Black and Brown Americans have faced far higher rates of hospitalization and death during the pandemic, and a growing body of research confirms what we have suspected—no, what we have known, what we have known for years—and that is there is an undeniable link between historical racism and the present-day medical health problems Black Americans face.

Health disparities that disproportionately impact Black Americans, from heart disease to maternal and infant mortality, are not merely an aberration. No, they are a direct result of structural, systemic, and institutional racism that has been passed down from generation to generation.

To build a healthier America for all, we must address the generational injustices that drive the racial inequities we continue to see today. That is why I was proud to declare racism as a public health crisis as a county council member, and that is why I am proud to work today with my Congressional Black Caucus colleagues to improve health outcomes for minority Americans and to address injustice in healthcare and throughout our society.

As Dr. King said, injustice anywhere is a threat to justice everywhere. That is our power and our message.

Madam Speaker, I yield to the gentleman from New Jersey (Mr. PAYNE), my friend.

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Mr. PAYNE. Madam Speaker, I thank the gentlewoman from Ohio for those wonderful remarks and her continued leadership here in the House of Representatives.

Madam Speaker, I rise today to discuss health equity disparities in America. Today, American minorities do not get the same quality of healthcare as our White counterparts, and it causes too many of them to die needlessly every single day. It is a problem that we must solve immediately.

The numbers tell the story. African Americans are 24 percent more likely to die in this country than White Americans.

The average life expectancy for a White American male is 75. For Black American males, it is about 71.

African Americans between 18 and 49 years old are twice as likely to die from heart disease than our White counterparts.

African Americans between 35 and 64 years old are 50 percent more likely to have high blood pressure than our counterparts.

One out of every five African-American deaths could have been prevented if they received the same level of healthcare as White Americans.

This should not be a surprise to anyone. Research shows that Black Americans receive less and lower quality care