PERSONAL EXPLANATION

HON. LOUISE McINTOSH SLAUGHTER

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 27, 2017

Ms. SLAUGHTER. Mr. Speaker, I was unavoidably detained and missed Roll Call vote numbers 224, 225, 226, 227 and 228. Had I been present, I would have voted ''aye'' on votes 226 and 227. I would have voted ''nay'' on votes 224, 225, and 228.

TRIBUTE TO PUNAHOU SCHOOL NATIONAL SCIENCE BOWL TEAM

HON. COLLEEN HANABUSA

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 27, 2017

Ms. HANABUSA. Mr. Speaker, I rise today to celebrate Punahou School's win in the Hawaii Regional Science Bowl and for earning the opportunity to compete in the National Science Bowl for the second year in a row.

Created by the Department of Energy's Office of Science in 1991, the National Science Bowl is one of the largest and most prestigious academic competitions in the United States. Over 265,000 students have participated throughout the National Science Bowl's 26 years. This year, over 14,000 students competed for a coveted spot in the National Science Bowl. Each team completed a series of daunting hands-on challenges that tested their knowledge. This meeting of some of the brightest student minds has encouraged thousands to expand their understanding of mathematics and science and pursue careers in such fields.

This week, Punahou School will compete against 62 other high schools in the National Science Bowl. To the Punahou School team—John Winnicki, Andrew Winnicki, Anna Kimata, Deborah Wen, Conrad Newfield, and Coach Warren Huelsnitz—all the best in this year's competition. They are a great example to their peers and I wish them continued success in their education and careers.

Mr. Speaker, I am honored to represent these students and their families in the United States Congress and I know all my colleagues in the House will join me in congratulating them on competing in the National Science Bowl Finals 2017.

COMMEMORATING NATIONAL MINORITY HEALTH MONTH

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 27, 2017

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, I am here to recognize the month of April as National Minority Health Month. The Affordable Care Act is a transformative piece of legislation that has helped millions of uninsured people to acquire affordable health insurance who otherwise would not have access to quality patient-centered care. This legislation was not just relegated to help the poor and the needy but also the 177 million employer sponsored insured employees with additional health benefits that never existed before the Affordable Care Act. For instance, ACA prohibited insurance companies from discriminating individuals with pre-existing conditions, and imposing lifetime cost caps on patients. Under ACA, parents can keep their children on their insurance plan up to the age of 26. Also, insurance companies are required to spend 80 percent of all premium dollars toward direct medical expenses and 20 percent toward insurance companies' administrative costs. Otherwise, they must reimburse the customer some of their money back. Currently, ACA has allowed more than 20 million U.S. residents to have health insurance coverage, which has improved the racial and ethnic disparities among minority population.

The purpose of the Affordable Care Act consisted of five basic goals:

1. Expand health insurance coverage for nearly 50 million uninsured people in the United States, which consist of 44 percent Whites, 32 percent Latinos, 16 percent African Americans, 6 percent Asians, 2 percent Native Americans and 0.4 percent Native Hawaiian and other Pacific Islanders.

2. Reduce health care costs by establishing marketplaces called exchanges where federal and state-based marketplaces will have a single process to determine whether someone is eligible for tax credits to reduce the cost of premiums, in the form of cost sharing, Medicaid, or Children's Health Insurance Program. ACA requires a minimum standard of essential health benefits to include ambulatory patient services, prescription drugs, emergency services, rehabilitative and facilitative services, hospitalization, laboratory services, maternity and newborn care, preventive and wellness services and chronic disease management, mental health and substance use disorder services (including behavioral health treatment), and pediatric services (including oral and vision care). Whereas before, ACA's essential benefits did not exist, thus leaving the prospective patients without quality access to care.

3. Reduce health care fraud and abuse

4. Improve health care quality through several initiatives: (1) a national quality strategy; increased reliance on value-based purchasing; expansion of meaningful use of electronic health records (EHRs); better care coordination; development of quality measures for Medicaid and Medicare; and measures of quality in the marketplace.

5. Improve population health that includes reducing racial and ethnic disparities among the minority population. One aspect of the ACA helping people of color to reduce disparities is by requiring health plans to cover certain preventative services such as blood pressure and cholesterol screening, mammograms and Pap smears, and vaccinations, with no cost-sharing. The ACA increased funding for community health centers, which provide quality primary and comprehensive services to underserved communities. They served approximately 25 million people in rural and urban centers where more than half of the patients were members of various ethnic and minority groups.

We need more doctors and allied health professionals to assist a healthcare system that for decades was not adequately addressing health disparities among millions of racial and ethnic minority Americans. Many of our minorities are disproportionately more likely to suffer deleterious health disparities just because they are low-income wage earners, poorer in health and suffer worse health outcomes, and are more likely to die prematurely and often from preventable causes compared to their White counterparts. Some of the examples of these health disparities include the following:

The infant mortality rate for African Americans and American Indian/Alaska Natives are more than two times higher than that for whites;

African Americans with heart disease are three times more likely to be operated on by ''high risk'' surgeons than their White counterparts with heart disease;

Hispanic/Latina women have the highest incidence rate for cancers of the cervix; 1.6 times higher than that for white women, with a cervical cancer death rate that is 1.4 times higher than for white women;

Puerto Ricans have an asthma prevalence rate over 2.2 times higher than non-Hispanic whites and over 1.8 times higher than non-Hispanic blacks;

Together, African Americans and Hispanics account for 28 percent of the total U.S. population, yet account for 62 percent of all new HIV infections;

American Indian/Alaska Natives have diabetes rates that are nearly 3 times higher than the overall rate; and

Of the more than one million people infected with chronic Hepatitis B in the United States, half are Asian-Americans and Pacific Islanders.

In addition to the unacceptable costs of human suffering and premature death, there are significant economic repercussions of allowing health disparities to persist. A 2010 study from the Health Policy Institute at the Joint Center for Political and Economic Studies found that the total costs of health disparities were $1.24 trillion over a three-year period. This same report found that eliminating racial and ethnic health disparities would have reduced direct medical care expenditures by $229.4 billion over the same three-year period.

Many analysts over the past several years have reported that investments through the Affordable Care Act and the American Recovery and Reinvestment Act of 2009 have helped double the number of clinicians in the National Health Service Corps by providing scholarships and loan repayments to medical students and primary care physicians and other healthcare professionals as incentives for them to practice in underserved communities. The ACA helped bridge some of the gap in workforce diversity to include dentists and other primary oral health care providers.

Increasing the proportion of African-American dentists is critical because studies show that they are more likely to serve in underserved communities than their white cohort. In 2010, underrepresented minority (URM) Black or African American, Hispanic/Latino of any race, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander-students composed 13 percent of the overall applicant pool for dental school programs. For the 639 URM applicants who enrolled in 2010, the enrollment rate increased only by 1 percent since 2009. A statistic that shows that progress is needed. Dental schools today are graduating 300 Black dentists out of 5,000 each year. Today, 5 percent of dentists are African-American. Black dentists treat nearly 62