

## STATE CHILDREN'S HEALTH INSURANCE PROGRAM EQUITY ACT

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

Mr. BURGESS. Mr. Speaker, later this week, in our Committee on Energy and Commerce's Subcommittee on Health, we will be having a hearing called "Covering the Uninsured Through the Eyes of a Child, Part Two." Now, having sat through part one of this hearing, a hearing dealing with the reauthorization of CHIP funding this year, I really think the title of the hearing should be "Covering the Uninsured Through the Guise of a Child" because if some deception is implied in that title, indeed, I believe some deception is taking place within the SCHIP program.

Now, most of my colleagues in this body, having heard from medical professionals and hospital groups this past month up here on the Hill, are aware of the need for reauthorizing the Children's Health Insurance Program this year. It is a good program. It has provided needed health insurance to millions of needy children across our country. And both the House and the Senate are discussing funding options. And we are concerned about the rising cost of health care in general but in particular, specifically, the rising cost for the SCHIP program.

Fourteen States are going to expect budgetary shortfalls in their SCHIP program. For some of those States, they are their own worst enemy. They are the reason for their own problem. They are using children's funding to cover adults.

In fiscal year 2005, the adult enrollment in the SCHIP program exceeded the number of children enrolled in the program in four States: in Arizona we had over 113,000 adults in the program and just over 88,000 children; in the State of Michigan, over 101,000 adults and under 90,000 children; in Minnesota 35,000 adults and just over 5,000 children; in Wisconsin 108,000 adults, just over 57,000 children.

Now, why does this matter? Well, if you look at what it costs to cover a child versus what it costs to cover an adult, for every dollar you spend on the adult, you only need to spend about 60 cents on the child. They are generally healthier. A dollar spent on children's health insurance goes a lot farther because children tend to be a healthier population, and if you provide them a modicum of preventative care, they are going to be healthier still. And after all, if we can attenuate a disease in its early stages in childhood, we will avoid the larger expenditures of allowing that disease to go on unchecked over years.

I can think of a number of diseases that would fall into this category. Childhood obesity immediately comes to mind, an area where we need to devote significant time, energy, and resources. But if we are spending the

money elsewhere, we are not going to be able to spend it on the children.

And the real deception, in my mind, is that this is a method of expanding a single-payer government-run health care system through the SCHIP program. And, again, that subverts the entire concept of why this program was created in the first place almost 10 years ago.

I would ask my colleagues to remember a dollar spent on a nonpregnant adult is a dollar that is not spent on a needy child. Indeed, States should prioritize spending on needy children and live within their annual allocations instead of looking to other States from which to take their moneys when their programs run a shortfall.

To ensure that States are not using children-specific funding for nonpregnant adults, I have introduced H.R. 1013, the SCHIP Equity Act. There are four principles to the bill:

It prohibits future HHS approval of any State waiver submitted by a State for SCHIP coverage of nonpregnant adults.

The bill terminates portions of State waivers that HHS has approved that extend coverage to nonpregnant adults.

States must eliminate coverage of nonpregnant adults by January 1, 2008.

And if the coverage of a nonpregnant adult was part of a multipurpose waiver, those components not dealing with the coverage of the nonpregnant adult will remain in effect for the duration of the waiver.

SCHIP has been a success story for so many States, for so many children. I am asking you to consider supporting my bill, H.R. 1013.

I want to remind all Members of Congress that "C" in CHIP stands for "children." Let's keep it that way.

## AMERICAN HEART MONTH

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California (Ms. MILLENDER-McDONALD) is recognized for 5 minutes.

Ms. MILLENDER-McDONALD. Mr. Speaker, let me first offer my warmest thanks to my dear friend and colleague, the gentlewoman from Illinois, who led the debate on the floor today in my absence on my bill that is recognizing this month as American Heart Month. I was told that she did a great job, and I am very grateful to her for that. Traveling from California to Washington sometimes is quite a task, and we appreciate our friends for standing in for us.

Mr. Speaker, I would like to speak briefly in support of this resolution, as heart disease is an issue of great importance to our Nation's health, especially women who many have felt for years that breast cancer was the number one killer for women.

For over 40 years, the Federal Government has recognized February as American Heart Month, and during this time we have made great strides in

fighting heart disease in this country. New medical innovations have improved the treatment of heart disease, and public education campaigns have made Americans more aware of the importance of prevention.

Nonetheless, heart disease is still the number one killer of Americans, both men and women. One in three Americans has some form of heart disease, whether it be high blood pressure, coronary heart disease, heart failure, stroke, or congenital cardiovascular defects. And while men are more likely to suffer from heart disease in their lives, women are not far behind.

While women may have a lower incidence of heart disease than men, women with heart disease are less likely to receive the proper preventative, diagnostic, and treatment interventions. This could be due to the fact that medical professionals consider heart disease to be primarily an affliction of men and are therefore slower to recognize it in women.

Additionally, women suffering from a heart attack or angina are more likely to have atypical symptoms. In fact, women with atypical heart attack symptoms who are sent home undiagnosed from the hospital are about twice as likely to die from a heart attack as individuals who are admitted.

Another problem with managing heart disease in women is that most of the research on coronary heart disease has been exclusively or primarily done on men. As a result, test and treatments developed from these studies may be less effective in women. This is why there is an urge to test more women and do more research on coronary heart disease with women.

Mr. Speaker, American Heart Month is a time to remember how far we have come, as well as how far we need to go. Heart disease is not just a man's disease, and one of the next big frontiers in battling heart disease involves improving its management in women. Additionally, men and women alike need to remember that preventing heart disease early is preferable to treating it later. A healthy diet, regular exercise, and avoidance of smoking all reduce a person's risk for heart disease. By enhancing both treatment and prevention of heart disease, we will go a much further way, a long way, to improving the health and the hearts of all Americans.

I urge all of my colleagues to support this legislation when it comes to the floor tomorrow for a vote.

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

## CELEBRATING THE LIFE AND LEGACY OF THE HONORABLE GENE SNYDER

The SPEAKER pro tempore (Mr. ALTMIRE). Under a previous order of