with an issue. Whether it was an appropriations issue, whether it was an internal issue, whether it was an issue for Ohio, he's a guy who would give great advice, and he would work to get an answer for the problem.

So whether it was the Appropriations Committee or—the Transportation Committee, where he served much of his career, was an area where he knew more about transportation, and transportation issues, then anybody in this town. He was just a walking encyclopedia on transportation issues.

It's pretty hard for a Buckeye to talk about a University of Michigan graduate this way, Mr. Speaker, but it's going to be a big void for this House for all five, but especially for STEVE LATOURETTE, who has really given his heart and his soul for 18 years to trying to make this body and our Nation a better place for our kids and for our grandkids.

It really didn't matter who you were or what you were about or if you had an ''R'' or a ''D'' by your name with respect to STEVE. If he believed in your cause, he was your partner, and he was going to do everything within his power to make sure that cause, that issue was going to be solved. He didn't always win, but he surely went down swinging every time he took that cause up.

This place will not be as good as it has been without STEVE LATOURETTE, JEAN SCHMIDT, STEVE AUSTRIA, DENNIS KUCINICH, and BETTY SUTTON.

Mr. Speaker, it has been great knowing these folks. I am pretty sure that all of them we will see again in one capacity or another. I know, STEVE, that we will see you and Jen and Henry and Emma soon.

Mr. Speaker, with that, I think our hour is up. We have no more speakers. It's been a pleasure. It's been a privilege, an honor to serve with all five of these men and women.

I yield back the balance of my time.

## THE IMPENDING FISCAL CLIFF

The SPEAKER pro tempore. Under the Speaker's announced policy of January 5, 2011, the gentleman from California (Mr. GARAMENDI) is recognized for 60 minutes as the designee of the minority leader.

Mr. GARAMENDI. Mr. Speaker, thank you for the opportunity. We're going to spend a good portion of this hour talking about something that is on everybody's mind, the fiscal cliff. Oh my goodness, the fiscal cliff is now just, well, 20 days away. So what are we going to do?

Some have suggested that we really have to deal with entitlements, and I'm here to agree that we can and we should deal with entitlements. Certainly, two of those issues, which I really don't think we ought to call entitlements, but they happen to be fundamental programs here in America for Americans, should be dealt with. One that some people want to put on the table really doesn't deal with the deficit at all, and that's Social Security.

So before we even get into this discussion tonight, let's just understand, for anybody that cares to take on this issue, that in dealing with the fiscal cliff, Social Security is not the problem. The deficit is not caused by Social Security. Social Security has never been and in its present form will not be part of the deficit issue. It's separate and apart. It is a special program, has its own source of revenue, has its own trust fund, and frankly, is not even running a deficit at all and has not run a deficit.

So let's put Social Security to the side and say, yes, in the years ahead, maybe even next year, but probably 3 to 4 years out, Social Security will be dealt with, as it must, because we will have to make adjustments. But that is really not the debate about the deficit, sequestration, or the fiscal cliff.

Coming back to the fiscal cliff, let's take up one of the very big programs, and I'm not talking here about the Department of Defense, which is one of the major expenditure items, but that's not the subject for tonight. Tonight the subject is Medicare and Medicaid.

The Medicare program is a big one, and it certainly is a program that is expensive. It's a program that, over the years, has grown on the average faster than inflation. But, in the last 2 years, that's not the case, and we'll discuss that in more detail later. In fact, Medicare has fallen below the general rate of health care inflation.

Let's talk about what we can do about Medicare. Instead of saying what we ought not do, we're going to start this discussion, at least my portion of it, talking about what we can do. And the President has put out several ideas that deserve the attention of the 435 Members of this House and the 100 Senators, because there are things that really can be done immediately to significantly reduce the cost of Medicare.

Just in listening to my colleagues here on the floor discuss the departure of some extraordinary Members from the Ohio delegation, I came across an article in one of the local Hill newspapers, and this article says, ''GAO hits Medicare and Medicaid wasteful spending.'' Turns out that the GAO just issued a report, came out just this week, that Medicare had, in their estimation, $28 billion in fraud and wasteful spending in the year 2011—$28 billion. And in Medicaid, some $21 billion.

Now, the President has suggested that one of the things we ought to do to reform the Medicare system and the Medicaid system is go after waste, fraud, and abuse. Well, there you have, what, 50-plus billion dollars of annual fraud, waste, and expenditure in the Medicare system. That goes a long way to solving the Medicare problem. And we ought to do that. And, in fact, a lot of that was done in the Affordable Health Care Act, and systems were put in place and they're working today.

But there's even more that can be done, according to the GAO. And if we're going to start dealing with Medicare, why don't we start right there with that issue and perhaps some $50 billion, or if you want to be a little conservative, let's just say 40 or $30 billion that we can reduce immediately.

By the way, this is going to take a few Federal employees to do that. Interestingly, in the Affordable Health Care Act there was a provision that added several thousand, a couple of thousand employees to the IRS for the specific purpose of going after Medicare and Medicaid fraud. Well, they were added, and then our Republican colleagues, in a fit of—well, just in a fit, decided that they would somehow save a lot of money by eliminating the men and women that were supposed to be hired to go after fraud.

□ 2010

They tried to do it. Fortunately, they were not successful.

I'm going to just name a couple of other ways in which we can reduce the cost of Medicare, and then I want to turn to my colleague from Illinois to expand on some of these issues.

Very quickly, how about drugs? Would you believe that the Federal Government has no power to negotiate the price of drugs for seniors in the Medicare program? It's true. Congress passed a law back in the 2003–2004 period that denied the Federal Government the ability to negotiate prices. We could save a pile of money right there.

There's some other things we can do—and some of this is already underway. We could penalize hospitals that have high infection rates; readmission to hospitals. Well, the Affordable Health Care Act is already doing that. And it's having an effect. We could also deal with the issues that occur with unnecessary payments. We can reform the system in the way in which payments are made so that they are more efficient and more effective. And those have been proposed by the President.

In fact, there are many, many things that can be done to significantly reduce the cost of Medicare without doing the onerous, damaging proposals that have been made by many of our colleagues on the Republican side, such as increasing the age to 67 when you could apply for Medicare—and we'll discuss that in much more detail in a few moments—and such as going after the privatization of Medicare.

Some really bad ideas are out there. And we don't need those bad ideas. What we need are some really good, solid ideas.

Let me turn to my colleague from Illinois, JAN SCHAKOWSKY. This is a woman who's been deeply involved in this issue. She was on the Simpson-Bowles Committee. That's not the formal name but that's how we know it—the Simpson-Bowles Committee. And she's focused specifically on Social Security and Medicare. She's joining us tonight with extraordinary background and information on this.

JAN, let's talk for a few minutes about your experiences and what you think we can do.

Ms. SCHAKOWSKY. Thank you so much, Congressman GARAMENDI, for leading this hour where, hopefully, we can get just some of the facts out about Medicare and Social Security. I, too, want to concentrate on Medicare.

First of all, I want to ask this fundamental question: do we really think that the United States of America is poorer today than we were 70 years ago, when Social Security came into being; that the United States is really poorer as a country today than 50 years ago, when Medicare and Medicaid came into being? The answer is simply, no. The economy has grown 15 times over since Social Security was enacted. And it was enacted because this country decided that it was really important for us to not have poorhouses for our elderly in this country, and that when Medicare and Medicaid came in, that insurance companies really didn't want to ensure old people, and that they weren't able to get the health care that they needed, and that the right thing to do for the richest country in the world, which we still are, is to set a priority that we're going to address the needs of the elderly—not for free, by any means.

People pay every paycheck that they're working into Social Security, and we created an insurance company for Americans, an insurance policy for Americans, that if you pay in, when you retire, that money will be there for you. And as you pointed out, we have $2.7 trillion in the Social Security Trust Fund right now. If we didn't have that, that means that our deficit would look $2.7 trillion worse than it does. Thank goodness for Social Security and its Trust Fund.

So you're right, Social Security should be off the table. Medicare, too. Every single paycheck people pay in. But the difference is when you get Medicare, you continue to pay. And I want to talk a little bit about the truth of what's going on in Medicare today, and the myths.

Talk about means-testing Social Security. Guess what? We do. We already means-test Social Security. I want everybody to understand that. We means-test Social Security. Medicare part D premiums—that's for doctor outpatient—and part D—that's for prescription drug premiums—are already higher for individuals with incomes over $85,000 a year. Now let's remember we're calling middle class for everyone else up to the $250,000. But we're saying, for Medicare purposes, people who make $85,000 or more, they're going to pay extra costs ranging from $504 a year to $2,270 a year for part B and $139 to $797 more a year for part D. We means-test Medicare. By 2020, with no changes in current law, annual means-tested part B premiums are projected to range from almost $2,700 to $6,000 more. We means-test Medicare.

Higher income households pay more for future Medicare benefits during their working lives as well. There's no cap on the tax that you pay into Medicare. A person with $2 million in wages pays $58,000 into Medicare. So during their working lives, and when they retire and take Medicare benefits, we means-test Medicare.

Mr. GARAMENDI. Let me just interrupt for a second. You started to discuss Social Security. I think what you meant was Medicare, which is where you have been taking the discussion. Medicare part B is means-tested—and has been since its inception.

Ms. SCHAKOWSKY. We means-test Medicare, exactly. We do.

Mr. GARAMENDI. Exactly. The amount that you pay into Medicare is higher as your income goes up.

Ms. SCHAKOWSKY. Yes. So during your working life and when you start on Medicare, you are paying more if you make $85,000 or more.

Mr. GARAMENDI. So the argument that you've got to means-test this program is, Yes. And we do.

Ms. SCHAKOWSKY. Now we means-test Medicare for 5 percent of beneficiaries. Under proposals to cover 25 percent of beneficiaries, call them higher income, means-testing would start at $47,000 in income. Really? These are rich seniors? Covering 10 percent of Medicare beneficiaries would hit individuals with $63,000 in income. Are those wealthy seniors? No. We means-test Medicare right now for people who earn income over $85,000.

Here's the other thing. A couple more points I want to make. There is no cap right now on out-of-pocket costs in Medicare, which today average $4,500 for people over 65 years old. So the out-of-pocket costs for Medicare beneficiaries are very high. The average amounts to about 20 percent of their income, out-of-pocket, already. So Medicare costs are already high. The idea now of going further down in income levels to means-test Medicare beneficiaries makes no sense whatsoever.

The other thing I wanted to point out is half of all seniors live in households with less than $22,000 in income. So here's the part I don't get about the fiscal cliff proposals. It seems as if the trophy that the Republicans want in exchange for asking people whose income is above $250,000, even though they'll get a tax break on that first $250,000, to ask them to pay a little more, the trophy in return is to ask senior citizens, whose median income is $22,000, to pay more?

□ 2020

Why is this a quid pro quo? Why is this fair? Why is that the trophy? Why is that the exchange that makes sense? The American people say no.

Medicare, Social Security, Medicaid, these are programs that keep people healthy. Raising the age of Medicare; really? That's why we have Medicare in the first place; insurance companies don't want to insure people. The Center for American Progress says that if we did that, in a single year, almost 435,000 seniors would be at risk of becoming uninsured. Is this the goal?

I am really confused about these proposals that somehow equate really the wealthiest top 2 percent in our country with extracting something from the poorest adults in our country: seniors and persons with disabilities.

Mr. GARAMENDI. Your points are so very, very well taken. It seems as though—you call it a trophy. The argument made by some is that we ought not raise this top tax rate, but you ought to hit the Medicare program, the beneficiaries, and make them pay more. As you've said, they're mostly middle class and poor. So what's that all about? And raising the age to 67 is really stupid. There is no other way to describe that.

I was the insurance commissioner in California for 8 years, and let me tell you, you raise that age to 67, a lot of very, very bad things are going to happen. First of all, people between 65 and 67 are not likely to get insurance at all, let alone affordable, for the reason you said. That's the population that is almost uninsurable under the present system. Even with the Affordable Health Care Act, they're going to wind up paying a huge amount of money, and you're shifting the cost to them, to their employers, and to their State and local governments. You've saved no money. In fact, you've probably increased the cost because the benefits that go to seniors in the Affordable Care Act are not available to them, such benefits as annual checkups, medical services keeping people healthy.

I'd like to come back to that in a little while, but I noticed our colleague from the great State of Texas is with us. Thank you for joining us once again to talk about something that I know you've spent your career here in Congress working on: Social Security, Medicare, and Medicaid.

Ms. JACKSON LEE of Texas. I thank the gentleman from California, and I thank the gentlelady from Illinois for her persistence on this issue of seniors and Medicare.

Congresswoman SCHAKOWSKY, along with Congresswoman MATSUI, co-chaired a task force that was very effective on making sure that the Democratic Caucus—and, really, Members of Congress—had an understanding of the safety net, but also the issue around the word ''earned.''

For some reason or another, when you put the benefits of individuals on the altar of sacrifice, it's because they didn't earn anything. You can sacrifice them. One thing that the Congresswoman emphasized is the idea that Social Security is earned, Medicare is earned, and, to a certain extent, Medicaid, though it's on a different structure.

To the gentleman from California, I want to speak directly to what you've said as insurance commissioner. We value your experience, because here's my point that I want to make. I want to stay narrowly focused.

First of all, let me say that there are enough bipartisan voices right now to pass the Senate bill. I want to thank Congressman WALZ, whom we have a petition with 178 Democratic names. We welcome our colleagues, Republicans, to get on. But the point I want to make is that—and I want to change my vernacular, I want to change my language—100 percent of the American people will get a tax cut. If we pass the Senate bill, 100 percent——

Mr. GARAMENDI. Let's describe the Senate bill.

Ms. JACKSON LEE of Texas. The Senate bill is $250,000 and below. The income up to $250,000—whatever you make—receives the continuation or a tax cut, and the remaining obviously expire. Simple premise. That means 97 percent of our businesses today, that means all the businesses on Main Streets in everybody's cities and towns will be protected going into the 2013 tax year or the 2012 tax year. But what it means is that middle class Americans will not have a $2,200 per family of four going into January 2013. I just want to lay that on the table, because now I want to move to this question of entitlements, but specifically the eligibility as it relates to age. That's been batted around.

I really wanted to come here today. I was home over the weekend, and I said, I have to get to Washington to convey the thoughts in the minds of my constituents, not only the average citizen, but doctors whom I sat down with yesterday to ask about this question. But here's my point. Now, you can look at it globally, and then I'm going to narrow it down.

Globally, one would say that we're living longer. Of course women are. This is the actuarial genius here, you know, the actuarial tables that you deal with. So women are living longer. It's always been a tradition, et cetera, but the body politic is living longer, maybe because they're healthier. That is not the case in the span of what we're speaking of, because what we're talking about globally, or nationally, are people whose beginnings are different, whose lifestyles are different.

Now, I don't know, but the family farmers—and I'm not picking on that group of people—have worked with their hands. Of course they work with their minds—they have to have a budget and make things work—but they're in the outdoors, foresters. Some would say, well, that's a healthy lifestyle. I don't know until you walk a mile in their shoes. Those who work in the coal mines in West Virginia; those who are in the sanitation department of our municipal cities; those who work in concrete and the building trades; those individuals who work in the energy industry in all shapes, forms, and sizes; those who may be in the vocational trades, maybe even nurses and nurses aids who are lifting patients all day long, thank God for them. We see them all the time when we're visiting the sick and our relatives or even we're in the hospital. So what I'm saying is you cannot have a cookie that fits all. You cannot immediately jump to entitlement reform between now and December 31.

Here's a solution: The bipartisan voices have said pass the Senate bill or pass the elimination of the tax cuts on the top 2 percent—but I, frankly, believe that 100 percent of Americans will get it. We cannot then jump to entitlement reform now. It would not be wise. It is not prudent. It does not work.

When you talk about 65 to 67, that is a lifetime. Because what you do, as the gentleman has said, you throw seniors into the marketplace. You save a buck, and they have to spend two bucks, three bucks, four bucks. And then on top of the four bucks, they will have doors slammed in their face.

The Affordable Care Act was premised on a 65-year-old Medicare admission, if you will—except for those who are disabled—and therefore, now, you want to skew it. You've already claimed that ObamaCare is going to raise prices. Look at the projection of cost to the seniors, trillions of dollars that they will pay in the open marketplace. But more importantly, how many of the poor seniors not having the money to go into the open marketplace will drop dead? I'm being colorful because, in terms of your lifestyle, some people struggle to get to 65. It makes no sense that they should be on the altar of sacrifice.

I'm passionate about this because I just don't understand why we jump so far. I say, Members, let's be deliberative. You cannot throw it out and say, oh, that's what we're going to do, when you don't know the numbers, you don't know the ultimate results, you have not done an analysis on what seniors of this age, what are their particular work histories. Maybe we will have, 40 years from now—let me go 20 years from now, we'll have all white collar seniors. I don't know what we have now, and therefore I can't judge that 65 for one person is 65 for everybody.

Let me say this to my good friends that are here: Let's take raising the Medicare age off the table. I'm delighted to see people here who are 65, 72, 80, 42, fine, but sometimes we do not represent a microcosm of America.

Let me finish on this note. I sat down with doctors and I posed a question. Doctors have a sense of pride. They like their work and they think they can keep us healthy. They could have said a number of things to me: Well, if we stay on a nutritious diet and if we do our exercise, I can see that in the future. They did not say that.

□ 2030

They shook their heads, and they said it is unbelievable. It won't work. It doesn't work. It's not a good answer. They were against raising it on the basis of medical grounds.

So let me just say this: I hope that we stand firm, our caucus. I hope we will work with the White House. I know they are speculating over a number of opportunities and options, but my perspective is you go for this tax relief, and you put on the table for deliberative consideration what is the best approach to have Medicare savings and to provide for the American people. But I can't fathom burdening seniors with raising the eligibility age for Medicare.

Mr. GARAMENDI. I thank you for bringing this issue back. And I don't want to leave it right yet. Our colleague from Illinois started her discussion with the values, the values that we Americans possessed back in the 1960s when Medicare began. That was the value of caring for each other, particularly caring for those seniors who at that time had 50 percent in poverty, I think 70 percent without insurance, and a very bad situation.

I remember when I was a youngster, not even a teenager yet, my father took me to the county hospital. You mentioned the word poorhouse. That's what it was. And that is etched in my mind to this day, what was happening in that county hospital. It was just row after row of beds down a long ward. The cries, the sounds, and the odors were unbelievable. That was the only care available. And then Medicare came in. And we have moved to a different place, fortunately. Our values as Americans expressed in the most meaningful way, taking care of seniors, the issues of poverty, largely eliminated—no, that's not true. The issue of poverty among seniors substantially changed. We still have too much poverty. But medical services available, quality medical services that have extended the life of many.

The point you were making about not everybody is so very, very true. As you were talking, I was just thinking, I read something about this, though increasing overall life expectancy at 65 has not increased equally across the social economic status, from 1977 to 2007, life expectancy for the top half of earners increased by 5 years, but only 1 year for the bottom half of earners. So, once again, you have this disparity class, if you would. White men without a high school diploma have a life expectancy of 67.5 years as compared to 80.4 years for those with a college degree. Once again, two different societies in America.

Since 1990, life expectancy for the least educated whites has decreased—decreased—by 4 years. And now the argument is that we can increase the Medicare eligibility age to 67 because people are living longer. Hello? Who is living longer? Those who have higher incomes. Those who don't—and you said it so very well—those who work with their hands, whether they are a maid cleaning a hotel room or a farmer or a coal miner or any other task which is labor intensive, and that's physical labor intensive—by the time they get to 65, they're broken. Their body is broken. And to deny them the opportunity, I can tell you everybody I

meet who is not 65 wants to live long enough to get to 65 and Medicare.

So for our Republican friends, their principal negotiator has put on the table, the Speaker of the House has put on the table let's raise the eligibility age.

JAN, you were talking about this earlier—let's go back at this—this is a fundamental dichotomy in how we value our seniors, how we value each other and how we are compassionate.

Ms. JACKSON LEE of Texas. Could I say one thing before the gentlelady, and then I will finish on that and then step away.

Mr. GARAMENDI. Sure.

Ms. JACKSON LEE of Texas. I'm so glad you used the statistic of a white male because I want this to be holistic. You did it on income. There are other disparities between African Americans, Asians, and Hispanic based upon a number of factors, a number of factors. So, there is a population that you've just mentioned, I assume there are numbers for white women, and then there are what we call health disparities because of various ethnic differences and distinctions, nothing that would make them different as Americans, but it would make you want to think more closely about a cookie-cutter approach to how Medicare can be. And to raise it to 67 is dangerous for the diversity of this country. And remember what we said. We want to be for the 100 percent.

I thank you for allowing me just to say that point. Thank you, Congresswoman, because I think our fight is a noble fight, and it is not against anybody, it is for something, and I would like our friends to join us and recognize that this is not a good idea. I thank the gentleman.

Mr. GARAMENDI. SHEILA JACKSON LEE, thank you very much. I hope you are able to stick around.

Jan.

Ms. SCHAKOWSKY. Thank you. I wanted to also make the point that there are many people who throughout their life have not been able to afford health care, and so they really are in need of health care when they turn 65. I have people coming into my office every day, or at least once a week—I bet this happens to you and to most Members—who say, I just hope I make it until I'm 65. Then I can have this fixed or that fixed or all these things that are really debilitating me and causing such a loss in lifestyle.

Mr. GARAMENDI. Pain, serious pain.

Ms. SCHAKOWSKY. Yes. I finally am going to be able to take care of it. So a couple of things I want to reiterate that I think are just myths. One, I already said that we already means-test Medicare. Number two, that raising the age of eligibility—and our Democratic leader wrote on December 11 the ''Truth About Medicare Age.'' She wrote an excellent USA Today article. And in it she says:

As one expert, Paul N. Van de Water of the Center for Budget and Policy Priorities, has noted, raising the age 'would not only fail to constrain health care costs across the economy, it would increase them.'

And our leader points out that the Kaiser Family Foundation estimates that higher State and private sector costs that result from raising the age would be twice as large as the total Federal savings. So we aren't even doing ourselves a favor when it comes to expenditures, the cost of health care, if we raise the age. It's, as you said, a really bad idea.

Another thing, I do think that a lot of people, especially younger people, do think that once you get to 65 you just get this health care benefit without realizing that it is an insurance policy that seniors are paying dearly for. It is a good insurance policy, Medicare. In fact, it is far more efficient, with an overhead of about 3 percent, compared to private insurance, which can have as much as, well, you would know better, it is reaching up into 20 percent overhead costs. So Medicare works very well. And it's popular for very good, good reasons.

As you pointed out, we can control the cost of Medicare. I'm not up here saying don't do anything about Medicare. We aren't going to touch Medicare. Yes, we can, as we did through ObamaCare. And you remember the numbers, $716 billion, Democrats were hit over the head with that number, saying that we funneled that kind of money, we stole that money from Medicare, implying that we took it from beneficiaries. The opposite happened.

□ 2040

We were able to create more efficiencies in Medicare, stopping our subsidies of private insurance companies, beefing up our fraud division, even though, as you pointed out, we can do better. We saved $716 billion from Medicare and improved benefits. That was just the beginning.

I was here when we passed Medicare part D. The truth is, the pharmaceutical companies, the drug companies got language written into the bill that said Medicare, unlike the Veterans Administration, shall be prohibited from negotiating for better prices with the drug companies. That cost us about $250 billion over 10 years, the fact that we cannot negotiate for lower prices with the drug companies, who are making money hand over fist from Medicare part D.

If we were to make a change like that, as the Veterans Administration does, drug prices would be lower for the government and for Medicare beneficiaries, as well. It would be a win-win in terms of lowering prices. Yes, the pharmaceutical companies aren't going to like it, but most countries already negotiate for lower drug prices. Why shouldn't we do the same, especially for Medicare?

Mr. GARAMENDI. Only in a free-market system would Congress pass a law to prohibit negotiating prices, which, I think, is kind of the essence of a market system.

You raised a couple of points, and I just want to use a chart to expand on those points. The Affordable Health Care Act—ObamaCare—really significantly enhanced benefits to Medicare recipients 65 and older. They got some really important benefits. You mentioned the drug benefit, benefit part D, the doughnut hole that is being closed. That's worth, I think, some $55 billion a year to seniors. There's other things that are in the Affordable Health Care Act that have already saved vast amounts of money to the Medicare program. For example, annual wellness visits for seniors. Why is it important? Well, you find out certain things, like you've got high blood pressure. And you take a pill—we ought to be negotiating that price—but you take a pill, and suddenly you're able to reduce your blood pressure and avoid a stroke, avoid some other kind of medical incident. You may find that you're on the path towards diabetes or other kinds of long-term, very expensive illnesses. So that wellness visit becomes exceedingly important, and also some treatments are available.

Here's what's happened. Because of ObamaCare, the inflation rate in Medicare has been dramatically reduced. If you take a look at this particular chart, over the years it shows that beginning in 2005 and now in 2012, the annual increase in cost, the inflation rate in Medicare—it peaked in 2005, and then it began to come down. Here is the Affordable Health Care Act, or ObamaCare, and we have seen a decline to about 2½ percent inflation, which is actually less than the general health care inflation rate in the economy. This has occurred because of multiple factors, perhaps—and it's arguable, but we think one of the major factors is the advent of ObamaCare, or the Affordable Health Care Act, and the kinds of programs that are in the Affordable Health Care Act for Medicare recipients that reduce the cost of medical services.

Ms. SCHAKOWSKY. I think it's important to point out too that the full provisions of ObamaCare haven't even rolled out yet, although these preventive services are in place. And look at what's already happened.

Mr. GARAMENDI. Exactly.

As those other services roll out, they will affect not only the Medicare portion of the health care system, but they will also affect the general population and should, because of the availability of insurance and the availability of the ability therefore get to a doctor, to get the continuation of care, should bring down the overall inflation rate for health care, which will dramatically affect Medicare, as well.

What we are on is a track that is reducing what they call ''bending the inflation curve.'' It's happening. Here's the most dramatic chart that I've seen on this issue, that we are, in fact, bending the cost curve. And perhaps even

more important, senior citizens are healthier. They're healthier. They're getting better care. They're getting more care.

Ms. SCHAKOWSKY. Let me just say on that point, though, on the cost savings, that's why when the Affordable Health Care Act passed, the Congressional Budget Office estimated that it saves—people said, How are we going to afford that? How are we going to pay for that? But it actually saved a $1 trillion over 20 years in costs to the government.

Mr. GARAMENDI. That's a very good point, but let me interrupt.

They were calculating an inflation rate that continued at this level. They did not calculate a reduction in the inflation rate. And in the more recent estimates of cost savings, they're now looking at this difference here. They're looking at a lower inflation rate. This saves billions upon billions of dollars in the Medicare system. So we are seeing that.

I don't want to let a point go by that you raised, and that is, yes, all of us Democrats were whacked over the head in the elections about the $720 billion. I was, you were, and I suspect the rest of us were also. The $720 billion of savings reductions in Medicare did not come from benefits. In fact, the benefits were increased just as you said. I don't know how many times I said that over the last several months, but I'm going to say it again: it didn't come from there. It came from three areas. You said this earlier, and it bears repetition.

First of all, it came out of the pockets of the insurance companies that were providing the additional Medicare insurance coverage; secondly, it came out of fraud and abuse; and, thirdly, it came out of payments to medical providers that were not performing good services. Specifically, one of the biggest were hospitals that had high infection rates. The Affordable Health Care Act said, we are not paying for the second admission when there is an infection acquired in the hospital. This is really good news to every Medicare beneficiary because suddenly the hospital goes, Oh, you mean we are going to have to pay for the cost of a readmission because of an infection? The government's not going to pay for it any more? Maybe we ought to clean up our act. Maybe we ought to have a little bit of hygiene in this hospital.

We are now seeing a significant decline in the hospital infection rates. It's not expensive for hospitals to do, but extremely important for every individual that goes into a hospital, whether you're on Medicare or otherwise. Hospitals are now paying attention to hygiene, cleaning up, washing hands, other kinds of very simple, inexpensive things that keep people healthy and reduce the cost of Medicare and general health care.

Ms. SCHAKOWSKY. Exactly.

The real benefit of the Affordable Care Act and it's effect on Medicare and everything else is that we are making this system more efficient. The health care system in the United States of America is very inefficient. We are going to be rewarding outcomes, we are going to be rewarding value and good performance, rather than just getting—you know, a doctor sends a bill or the hospital sends a bill, Medicare sends off a check. We are going to be rewarding efficiency and good practices now in the health care system. I think that that is what everybody wants. You want better results for a lower cost. That's what we are getting.

Mr. GARAMENDI. There are some very simple things in the Affordable Health Care Act that do reduce the cost, and this is the continuity of care. This is the kind of thing you're talking about. It is the management of a debilitating illness, for example, diabetes. If diabetes is properly managed, the kinds of extraordinarily damaging and expensive things that occur to individuals are either delayed or not happening at all. So management systems are put in place that dramatically reduce the overall costs. They cost a little bit up front because people are keeping in touch with the patient. It's not necessarily a doctor. It may be a case worker keeping in touch with the patient and making sure they're taking their medications, making sure they're doing the checkups that they need on a regular basis, getting that kind of thing. How about right now?

□ 2050

I don't know. There are a whole bunch of people in this room—435. They're not here today, but how many have gotten their flu shots? If you want to reduce the costs of health care, get your flu shot. I think I'll go do that tomorrow.

Ms. SCHAKOWSKY. I did that. You should do it, too.

Mr. GARAMENDI. I know. I've got to do it tomorrow. I'll get my flu shot.

So these are the kinds of things that reduce costs, and the Affordable Care Act does that, not just for seniors but all the way down the board.

Go ahead. You were about to make a comment. Then I want to turn to some of the pernicious things that are being proposed to Medicare and to seniors.

Ms. SCHAKOWSKY. I just want to say that this is not about party. This is about people who know the realities of life—Democrats, Republicans, Independents and, I'm sure, some people who are identified with the Tea Party. They don't want to see this Congress cut Medicare, Medicaid, Social Security benefits, and this is overwhelming in every single poll. It's not because people are greedy; it is because they need these bedrock programs—these treasures of our American system—in order to live a decent quality of life. Americans are willing to work hard, to pay into these programs, to follow the rules—to do everything they're supposed to do. Then when they're either disabled or when they're past 65 years old or, in the case of Social Security, 67 years old, they want the fruits of their labor to be there for them. Again, continuing when they get Medicare, they pay dearly for those services. I think it's really important to remember that.

Mr. GARAMENDI. I guess, as politicians—all 435 of us—what happens when we get elected is we often read the polls. Hmm, let's see here: 67 percent of Americans are opposed to increasing the age from 65 to 67—71 percent of Democrats, 68 percent of Republicans, and 62 percent of Independents. That's pretty overwhelming.

So, just to back up to what you were saying a few moments ago about the American public, they viscerally, internally, understand how important Medicare is. It's not just for themselves. They have parents, many of whom are now 65. My mother is 92. She's a Medicare recipient, and she depends upon Medicare for her hospitalization. Fortunately, she hasn't had an incident for more than 2 years now, but when she did, Medicare was there to provide the necessary services for her, and so it is for all of us who have parents who are in the Medicare system.

We understand this, and we really want to make it quite clear that, as Democrats, we are in synchronization with the President on this issue. He has put forward specific proposals that over time will reduce the cost of Medicare without taking away the benefits, without changing the eligibility age.

However, there are proposals—and I spoke earlier about one that has been put forth by the Speaker of the House—to increase the age to 67. No, that's a nonstarter. I'm not going to go into all the actuarial issues—which I could easily do—about why that makes no sense at all for employers, who would wind up paying more. It makes no sense at all for an individual, who is going to wind up paying more. It makes no sense to the Medicaid program, which you've already talked about, and it makes no sense in saving money. The total cost to the system would actually increase. The costs would be shifted, to be sure. No, not so. I guess I will do a little actuarial work here.

Those people who are 65 to 67 years of age are more healthy than people who are 67 and above. You eliminate the healthy people from the risk pool, and guess what happens to those who are left—it's more expensive per person in that smaller risk pool. So what you want to do in all insurance programs is to increase the size of the risk pool so that the cost is shared among a larger population of people. What this proposal does is exactly the opposite. It shrinks the risk pool. It keeps in that risk pool less healthy people; it's more expensive; and those who are more healthy are outside. Yet they are now shifted on to the new exchanges that are going to be created, so the cost in the exchange is increased, and the cost

for the per-person in Medicare is increased. So what's going on here? You've got to think this through. Bad idea. Bad concept.

Ms. SCHAKOWSKY. Your 92-year-old mother, when she goes into the hospital, if she didn't have—she probably does have—a supplemental insurance policy, the copayment on the first day in the hospital, which some seniors have to pay out-of-pocket, is well over $1,000. Medicare, let's remember, does not cover most vision, hearing, or dental, so seniors are still left with not only their premiums and their copayments and their deductibles but lots of things that still aren't covered by Medicare.

With the cost of health care to seniors today, this is no entitlement, which makes it sound like they're getting a freebie here. It's very, very expensive. We want to make Medicare better. We want to make it efficient and actually enhance some of those benefits.

Mr. GARAMENDI. The word ''entitlement'' is really misused for both Social Security and Medicare. Basically, the word means that, when you reach a certain age, the program is available to you. It's not a freebie. Men and women in America who work, even those who are 65 and over, continue to pay what amounts to a health care premium. It's the payroll tax. They're paying that from the first paycheck they get until the last one that they receive. Then when they're no longer working, as you so correctly stated, Medicare does not cover the total cost, so they're going to continue to pay. They're probably going to be paying for a supplemental insurance program, and they're certainly going to be paying out-of-pocket and the like.

There are a couple of other things that have been proposed, and I want to just cover those because they're very important. It has been proposed that the cost of the Medicare system can be reduced by giving every senior a voucher or—a different word but exactly the same thing—premium support, which basically says that the Medicare system, as we have known it for nearly 50 years, is terminated—gone—and that seniors who are 65—or 67 if they get their way—would be thrown into the private health insurance market. I cannot imagine a worse situation for a senior. The private health insurance market is not interested in caring for seniors.

Ms. SCHAKOWSKY. That's why we have Medicare.

Mr. GARAMENDI. They don't want those people because they get sick and they're expensive. They want Medicare, but the voucher program is the privatization of Medicare. It is nothing other than that. It's the termination of this guarantee, and seniors have to go out and negotiate on their own for a health insurance policy.

Good luck, Mom. You're 92 years old. Good luck in getting a health insurance policy from any private health insurance company. It won't happen. It won't happen.

So, with those proposals, they are wrongheaded; they are cruel; they are expensive to the individual; and they ultimately will lead to a system in which health insurance will not be available to seniors. That's a proposal that has been given life and that has actually passed the House of Representatives.

Ms. SCHAKOWSKY. It's part of the Ryan budget.

Mr. GARAMENDI. Indeed, it is. It has passed the House of Representatives twice—not once but twice.

So this is not just some idea floating in the ethereal. This is a real proposal that is sitting in the Senate. Fortunately, it's going nowhere there, but these kinds of programs are there.

The other program—and we've talked around this issue—is just a flat-out assault on the benefits. We're going to cut out drugs. We're going to cut out one or another of the benefits that are in Medicare. The package of benefits in Medicare is designed to provide a continuity of care so that something that is common is going to get covered—hospitalization, a doctor's care, and now, with the Affordable Care Act, annual visits to the doctor. It's very, very important.

Let me be clear that, as Democrats, we understand the necessity of reducing the cost of Medicare. We understand that. In fact, we have done it. The Democrats have done it. We have taken action to reduce the cost of Medicare and to simultaneously maintain the benefits and improve the benefits to seniors.

□ 2100

That is what we have done, and we'll continue to do it. Things I talked about at the very outset are very real. We can take additional steps. We can do more. The President has proposed it, and the Democrats stand ready today to take up those issues and pass them out of the House, give them to the Senate and say we can do more to reduce the cost of Medicare and simultaneously maintain quality care for seniors and the benefits that they have spent their lifetime paying for, paying for those benefits. We can do it. We've done it.

Ms. SCHAKOWSKY. We can do it. And I hope that everyone will stand with our President who has said that we're not going to raise the age of Medicare and that the Republicans now first have to agree that we're going to ask the wealthiest people in our country to pay a bit more, and not to begin with the least able to pay more, the poorest adults, seniors, and persons with disabilities.

Mr. GARAMENDI. Our colleague, SHEILA JACKSON LEE, before she left, she brought this issue up. In the House today is the tax program that would continue the tax reductions for the middle class.

Ms. SCHAKOWSKY. And for the first $250,000 for everyone.

Mr. GARAMENDI. Exactly so. All we need to do is pass that.

The other alternative, which has been proposed, is to keep the taxes low for the superwealthy and to pay for that out of the pockets of seniors. We're not going there, and we shouldn't.

JAN, thank you for sharing this evening with us. This is an important issue.

Ms. SCHAKOWSKY. Thank you.

Mr. GARAMENDI. Mr. Speaker, I yield back the balance of my time.

## LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CULBERSON (at the request of Mr. CANTOR) for today on account of illness.

Mr. REYES (at the request of Ms. PELOSI) for today on account of medical reasons.

## ENROLLED BILL SIGNED

Karen L. Haas, Clerk of the House, reported and found truly enrolled a bill of the House of the following title, which was thereupon signed by the Speaker:

H.R. 6156. An act to authorize the extension of nondiscriminatory treatment (normal trade relations treatment) to products of the Russian Federation and Moldova an to require reports on the compliance of the Russian Federation with its obligations as a member of the World Trade Organization, and for other purposes.

## BILLS PRESENTED TO THE PRESIDENT

Karen L. Haas, Clerk of the House, reported that on December 6, 2012, she presented to the President of the United States, for his approval, the following bill:

H.R. 6634. To change the effective date for the Internet publication of certain financial disclosure forms.

Karen L. Haas, Clerk of the House, further reported that on December 7, 2012, she presented to the President of the United States, for his approval, the following bill:

H.R. 6156. To authorize the extension of nondiscriminatory treatment (normal trade relations treatment) to products of the Russian Federation and Moldova and to require reports on the compliance of the Russian Federation with its obligations as a member of the World Trade Organization, and for other purposes.

## ADJOURNMENT

Ms. SCHAKOWSKY. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 9 o'clock and 2 minutes p.m.), under its previous order, the House adjourned until tomorrow, Wednesday, December 12, 2012, at 10 a.m. for morning-hour debate.