That we appreciate wind and we make the equipment or the kind of technology right here in the United States. Solar, that we make all of our panels. Natural gas, that we do it safely and securely, and that we create jobs that way. That we bring down the cost of energy. That we stop calling upon the American people to take $5 out of their pocket and put a few ounces, if you will, of gas in their car.

That we begin to recognize the pain of America, and the way that we recognize the pain of America is that we begin to go aggressively toward the American people with solutions. And the demagoguery of raising the debt ceiling, and I'm not going to vote on it unless you burden it down with draconian cuts that will end Medicare as we know it on all seniors, eliminate Social Security, destroy Medicaid and throw it to the winds so that disabled children suffering from autism or those who have other diseases cannot be taken care of, that's not the America that has made us so great.

It is one that pulls up our pants and puts on our shoes, pulls up our skirts and gets empowered by the joy of work and helping others. And when we did that, we were able to invest in this Nation.

I will not vote on a debt ceiling increase that destroys Medicare as we know it. And I will not vote on a debt ceiling increase that destroys Social Security, or Medicaid, or violates the premise that this country owes a debt of gratitude to veterans and returning soldiers. That's what my friends on the other side of the aisle are trying to sell the American people, a bill of goods. A bill of goods that the philosophy that is anti to President Reagan, who asked for the increase in the debt ceiling himself, that we cannot count and speak at the same time. I believe America is greater than that.

We can bring down the debt with a very meticulous plan over a period of time, the same way you save for college or plan to bring down your debt, or stop using credit cards. We can do that. But at the same time, we can pay America's bills. And we cannot leave one American alongside of the road, languishing and reaching out for help, and we say there is no room at the inn.

Where is the America that is a Good Samaritan? Where is America that sent young men to war, World War II, and if you talk to any of that generation they say, I didn't know all the facts, but I was glad to be part of what America was standing for, helping those who were languishing alongside the road.

We have had any number of conflicts, and some that I have agreed or disagreed with; but the premise was, whether we had the agreement of the American people on the premise of that conflict, it was to help someone along the road.

I am now calling in a clarion cry for Americans to help America. I am calling on this Congress for this Congress to help America. I am calling on the President, as a friend of the American people, to help America. And to do that, whatever is heard that will now come behind me, and disjangled chords will sound attractive, and it will be about who is going to burden our grandchildren and the long-term debt, but it will not be infused with values by many of our faiths.

Those of us of a Christian faith and many other faiths have an element of the document under which they worship that talks about the Good Samaritan and charity and love. And albeit that you are asking why on the floor of the House, it is because the infusion of those tenets were part of the design of this Nation when we organized around the concept of forming a more perfect Union. And when the Declaration of Independence said that we seek to pursue happiness, we hold these truths self-evident that all of us are created equal, we don't abandon that just because it happens to be June 3, 2011. We are able to keep those values, and those values have kept this country on a straight and productive path.

All the noise that comes sometimes in a confused sound to the ears of the American people, if as Members of Congress we can declare our commitment to helping the American people and keeping the values of the American people in place, and that of our faith, that is to help, to love, and to present charity to those who are in need, there is no limit to the greatness of America. And there is no limit to the restoration of making it in America, both in terms of our success and survival, and then in terms of making things that we need and putting America back to work.

Madam Speaker, I am grateful for being yielded this time by the Speaker of the House, and I am grateful for the opportunity to live in a Nation where disagreement does not result, in this century and even in the past century, of taking up arms against each other. I am grateful that maybe in the debate that we have on the floor of the House at some point my colleagues can hear not disjangled sounds of discord and disrespect and dislike, but they can actually hear the chords of reason, my friends, that to pay for our bills as you pay for yours, we must do the right thing: raise the debt ceiling, and to be able to preserve Medicare as we know it, and not to destroy it as it is being destroyed by the budget proposals of the Republican Party.

It is necessary, if you will, to be able to come together and to listen in one voice, finally, that we act to help America.

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

□ 1450

HEALTH CARE

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

Mr. BURGESS. This afternoon, the Congressional Health Care Caucus wants to talk a little bit about the future of the government's role in health care in this country.

I recognize, for those of you studying your Constitution as of this very moment, you don't find the government's role for controlling health care in this country, but we will do our best to help you understand why we are where we are and perhaps where we are going with some of the Federal programs that are run by the Federal Government. Again, the Congressional Health Care Caucus, the Web site healthcaucus.org.

This hour, I am grateful to the leadership of the Republican Party for the use of this hour. I and my cochair, Mr. G.T. THOMPSON from Pennsylvania, will be leading the discussion.

We have had a lot of talk over the past 4 weeks about the future of Medicare in this country. Certainly, if you look at the three plans that are on the table right now—and I understand you may be scratching your head and saying, Wait a minute. I thought there was only one plan out there. I thought there was only the Republican plan. But the Medicare Trustees Report that was issued some 2, 2½ weeks ago, came forward and articulated how the Medicare trust fund would be exhausted in the year 2023 or 2024. This is a significant fact that right now this Congress and the White House are trying to ignore, but it can't be ignored, and that's why the responsible Republican budget passed in April would deal with this fact.

One plan would be to continue on the current course and make no change at all, and that is what the trustees' report articulated. The trust fund is exhausted by 2023 or 2024. That means, then, all funds to pay for part A, part B, and part D of Medicare, hospitalizations, physician payments, and pharmaceutical payments would all come from the Federal Treasury. The trust fund would be depleted at that point.

What are the implications for that? As we sit here even now and talk about things like expansion of the debt limit, the implications are that all of the funding for Medicare for the hospitalizations, for the physicians part, for the pharmaceutical part, all of the funding would come strictly out of the general revenues, that part that is paid by the taxpayers every year.

Are there things that could be done under the trustees' report to prevent this from happening? There are. And one of those things would be to raise the tax on the payroll tax that is paid by individuals for their Medicare. All of us pay a 1.2 percent tax. The employer matches with a similar amount, so that comes out of our paychecks every 2 weeks or every month. However we are paid, there would be a way to increase that tax to perhaps sustain Medicare farther into the future.

But I must remind the Speaker that this law, which was signed by the President in March of 2010, the Patient Protection and Affordable Care Act, already had a Medicare tax increase included therein. So there is a .9 percent Medicare payroll tax that is included in the Patient Protection and Affordable Care Act, which leaves us very little room to maneuver unless the payroll tax goes up even further.

Many people argue that the payroll taxes are some of the least progressive and most regressive taxes in this country because they are administered across the board without regard to income, so this is a potential problem. It is one that perhaps could have been solved with a payroll tax increase, but that payroll tax increase has already occurred. You say, well, but okay, if there is a payroll tax increase in the Medicare trust fund, that's good news, because that means that Medicare goes on farther.

Unfortunately, under this law, the money that is taxed on the payroll, collected by the Medicare trust fund, makes a very short stop in the Medicare trust fund and then goes to fund a very different program, a program that, in fact, does not exist today but will start in 2014, a program of subsidies for entitlement for people to purchase private health insurance in the non-Medicare years in what are called the State exchanges.

So the money goes from the Medicare trust fund to fund a new entitlement. That money will have to be paid back to the Medicare trust fund, make no mistake about it. It is money that we are borrowing from ourselves, but it is not money that is there to save Medicare today.

But as the administration argues that, hey, within the Affordable Care Act we have already done some things to sustain Medicare into the future, nothing could be further from the truth. In fact, they have probably poured gasoline on the fire that was already in existence.

One of the other things the trustees' report suggested was that benefits could be cut in the future. And I daresay that if nothing else happens and we get to the point where the trust fund is exhausted, those benefit cuts will be enacted not by this Congress, not by the next Congress, but by some Congress in the future, because of the intergenerational strife that will occur because of the inability to keep pace with the problems that were made by generations before, with generations yet to come. The unfunded liabilities in the Medicare trust fund will soon begin to outstrip every other activity of the Federal Government. That is, there will be no money left for defense, no money left for transportation, no money left for education. All of it will go into health care in some way, shape, or form.

Well, did the President have a plan for sustaining Medicare? Well, yes. You heard about the tax that he already enacted in the Patient Protection and Affordable Care Act, but that may not have been so helpful. In fact, that may have been more detrimental.

What other things has the President put out there on the table as a plan for saving Medicare?

Now, bear in mind, there is no Presidential plan to save Medicare. We have encouraged the White House to provide us with such a framework. We would like to see such a framework. They could send it over to the Congressional Budget Office and have it scored, have it compared to Republican proposals that are out there, but this ask has not yet been honored. So, as a consequence, what we are left with are the bits and pieces that the White House has articulated, the administration has articulated: Here is our plan for Medicare.

One of the big plans they have for Medicare is contained within the pages of the compilation of the Patient Protection and Affordable Care Act, on page 423, where it talks about a new board that is created that is going to administer Medicare costs. This is the Independent Payment Advisory Board.

Who will these individuals be? Well, they will be 15 in number. They will be nominated by the President. They will be confirmed by the Senate. They are to be made up of academics, of people who have worked in government, people who have expertise in health finance and economics and actuarial science, health facility management, health plans, and integrated delivery systems. And way, way down at the bottom of the page, yes, you might get a doctor or nurse on that board as well. Fifteen people that are paid by the government to do nothing but identify cuts in the Medicare system. Well, perhaps that's a good thing. Perhaps that's something that's necessary.

Now, look, I am a Member of the United States Congress. The Speaker is a Member of the United States Congress. We are the people's House. It is our job to deal with the people's money, to tax the people, to raise the money, to spend the money and be good stewards of the people's money. It is not our job to hand off that obligation to the executive branch or, worse yet, to a board that is appointed by the executive branch and is accountable to no one. It is not our job to do that. It is our job to have the oversight over the Federal agencies and boards so that we can ensure that things are done properly with the people's money.

In this case, the Independent Payment Advisory Board will be just that. It will be absolutely independent of the legislative branch. Once an action is taken by the Independent Payment Advisory Board, it becomes very, very difficult for Congress to impact the decisions that are thereby made.

Now, true enough, their job is to deliver back to the House and the Senate their recommendations for cuts in the Medicare system, and it's very detailed in here on those pages as to just how much they are required to cut. It's very detailed as to the procedure for bringing those cuts to the House and the Senate and which committees they go to for evaluation.

But here's the deal. At the end of the day, Congress either votes up or down on this menu of cuts that's provided by the Independent Payment Advisory Board. And, yes, we can vote ''no.'' Yes, we can turn down the recommendation of the Independent Payment Advisory Board.

What happens then? According to statute, we are not finished. Congress then is required to produce the same level of cuts that was recommended by the board, maybe taking it from different places. But still the same amount of money has to come out of the same Federal program, that is, the Medicare program.

□ 1500

Well, what if Congress gets together and says, ''We don't like what the board has delivered to us. We're going to produce a different menu of cuts''? But then, wouldn't you know it; Congress can't agree on what those cuts should be.

I know, I know, Madam Speaker, you'll find that hard to believe that Congress could ever get to a point where it didn't agree with itself on very much, but it could happen at some point in the future that things could be so contentious in Washington and so contentious in the House and the Senate that we couldn't agree with each other on what those cuts would be. Well, what happens then?

What happens then is the cuts recommended by the Independent Payment Advisory Board are, in fact, delivered to the Secretary of Health and Human Services; and that person, whoever he or she may be, the following April, will enact those cuts. There is no getting away once those cuts are recommended. Again, they are dictated in statute. Once they are recommended, they are going to be enacted. There is almost no way around that.

We've got kind of a similar situation today with a different formula that deals with only part B. That's only the part that reimburses physicians. It's called the sustainable growth rate formula. It is a very complex set of figures and numbers that deals with some Federal targets, that deals with conversion factors, and that deals with update adjustment factors. But suffice it to say that it requires a reduction in reimbursement for patients' visits to doctors, and it does this every year.

Now, Congress, historically, has come in at the last minute and rolled those cuts back and said that we won't enact those cuts. The problem is, with the formula as written, every year that we come in and say, ''okay, doctors and patients, we're not going to actually cut reimbursement rates this year,'' that aggregate number that should have been cut is added to the sum that ultimately must be cut.

So, right now, we are existing on a gift, if you will, done in the lame-duck

session of the last Congress where the cuts in Medicare were given a 13-month reprieve. But, if Congress doesn't act by December or January, December of this year or January of 2012, an almost 30 percent cut goes to physicians who practice in the part B part of Medicare.

Now, I know you can say, well, doctors probably make too much money anyway and the government needs to save money, so what could that hurt? Where that hurts is that doctors are having a tough enough time keeping up with their expenses. When we cut them 30 percent, the nurse that works in the front office or the company that delivers the electricity that keeps the lights on in their practice doesn't say, ''Gee, Doc. We know you're having a tough time and the government cut your reimbursement, so we're going to give you a break on your electricity bill.'' That does not happen. The good people in the municipality that allow the doctor to practice don't come up and say, ''Doctor, we know this is tough on you. We're going to give you a 30 percent reduction in your school taxes this year on your business property.'' That does not happen. Those fixed overhead expenses occur, and the Federal reimbursement rate for Medicare in the part B program reduces year over year. That is why you have doctors leaving the Medicare program.

As a consequence, that is why you have people who are entering the Medicare program, turning 65 or older, who move to a new location, call up a doctor's office and say, ''I need to be seen for my whatever,'' and the answer is, ''We are not taking new Medicare patients.''

That unfortunate reality is hitting people today. The Independent Payment Advisory Board is theoretical. That's in the future. The SGR is the ''here and now'' that Congress is dealing with even this year.

Now, I'm very fortunate to have been joined by my counterpart on the Congressional Health Care Caucus. Again, healthcare.org is the Web site.

GLENN THOMPSON from Pennsylvania, thank you for being with us this afternoon. Let me yield to you such time as you might consume.

Mr. THOMPSON of Pennsylvania. I thank my good friend, Dr. BURGESS from Texas, for yielding and also for being able to work with him in terms of our Congressional Health Care Caucus. We cover the health care industry from both important aspects—you as a physician and all of your experience specifically in the medical field.

My background came up through therapy. Most of my almost 30 years of working in nonprofit community health care was really on the administration side; some as a therapist, but largely in administering programs in hospitals, in comprehensive rehab centers, and nursing homes. I was licensed as a nursing home administrator towards the end of my career there. And, frankly, I dealt very, very closely with Medicare out of necessity because Medicare is, on the in-patient side, at least 60 percent in terms of market share, in terms of payment. So Medicare is very important.

I have to say to my good friend, I was pretty naive when I came to Washington in January 2009. That's when I was sworn in. I won election in 2008. I thought everybody knew that one of the impending crises had to do with the insolvency and the eventual bankruptcy of the Medicare program, only to get here and find out that that was not on the agenda under the previous leadership. And, frankly, it has emerged because it is a truth.

When you look at the situation today with the Medicare system, Medicare is in jeopardy. And what we're trying to do, what the Republicans are trying to do, is to save Medicare. The thing that would hurt Medicare the most is to do nothing, to further kick that can down the road.

Just by coincidence, I was off the Hill and stopped by, and I picked up a prescription earlier today. The only prescription to save Medicare is a Republican prescription. I have to tell you, on the Democratic side, they're just willing to pull the plug and let it die, because if you don't make changes to the Medicare program, that's exactly what happens. And that's not political rhetoric. That's coming from some pretty credible sources that you talked about.

Last Friday, the Medicare trustees' report confirmed that the Medicare program is already contributing to the Federal deficit and will continue to do so for the next decade and that, since 2008, the program has run a cash flow deficit. That's a fact that has been largely ignored in Washington. Still there are those of our colleagues who choose to pretend it's not true, but it is the truth. In fact, in 2011, it exceeds $32 billion. That's a program that, if we don't make the necessary reforms to save, will go bankrupt.

And what an injustice that will be for all of us, all the people across this Nation who have paid into that program, who are looking forward to hitting those retirement years to be able to access and utilize that benefit. If we allow it to go insolvent, if we don't reform it, if we don't save it, it goes bankrupt.

The only thing keeping the program afloat financially, really, is the sale of Treasury bonds in the Medicare trust fund. And when those bonds are cashed, that increases the deficit.

The President's plan, I guess, is to let it go insolvent, because I read today he's restated he doesn't want to do anything about Medicare, leave Medicare alone, which essentially says let's let it go bankrupt, and let's let it go away.

In fact, the measures—and you did a great job of, I think, talking about one in particular, the Independent Payment Advisory Board, which essentially takes the decision-making out of the hands of those of us who are accountable, of those of us who are elected every 2 years to make decisions about Medicare. Those decisions will not be about what benefits to expand in this financial situation. This will be about where to make cuts, where to ration care.

The Federal Government already does that. Under part B, if you are in a nursing home and you need to receive rehabilitation therapy, the Federal Government has already put a cap on how much therapy that you're able to receive. It has nothing to do with what your need is. It has to do with how many dollars have been spent. So if Americans think the Federal Government would not do rationing, it already happens. It already happens.

You talked about the board. What the President has done, I think, in his plan, which really is going to pull the plug on Medicare, a program that is already financially insolvent and challenged, is cut $575 billion from the Medicare program to fund his health care initiative. He cuts over $200 billion for Medicare Advantage and forces over 7 million seniors out of their current Medicare plans. The projection from the CMS actuary—this is the person who is responsible for really crunching the numbers for the Medicare agency—Richard Foster, in April 22, 2010, said that 15 percent of hospitals, nursing homes and home health will close because Medicare pays less under ObamaCare.

We have an opportunity here to do the right thing and to reform Medicare and to save Medicare. The President has an obligation to do that. Under the Medicare trust fund—and what a lot of folks don't know—is there is a requirement, a statutory requirement, that at whatever point the Medicare trust fund reaches a 45 percent level for more than 2 years, the President is required—is required—to put forth a plan essentially to save Medicare, to be able to address Medicare.

We are way past that trigger, and President Obama knows that. I assume he knows it. It's part of his job. So he has chosen to ignore his responsibilities to really put a plan forward. In fact, when we were at the White House just earlier this week, the President said that he was not going to put a plan forward for dealing with Medicare.

□ 1510

He was going to just not take the leadership on that issue. We have, and I am very pleased with the plan we have put forward. It has to do with putting premium supports. Our plan would direct Medicare to go out and to bid out for many different vendors health care plans that seniors could then shop through. Medicare sets the standards, and these companies that would put these products forward would have to meet Medicare requirements. It is not a new concept. It is what we do under Medicare part D today, and Medicare part D is probably one of the few government programs which has actually

come in under budget. Most government programs come in way over budget, but Medicare part D has come in under budget. It also will put an emphasis on prevention and wellness. We are keeping people well. That is what we need to do. Obviously, that is the best thing for individuals, for folks to remain as healthy as possible.

We are not talking about voucher programs. We are not talking about privatizing Medicare. Those are concepts. That is just not true when people claim that we are. We are talking about providing people the choice of quality products that meet minimum standards and that the Medicare agency will ensure are there, because they are the ones who will bid this out and manage the process.

Then we're going to provide premium supports that allow our seniors—and we're talking about just impacting people that are younger than 55 years of age. If you are 55 years or older, there won't be any change. Although, I have bumped into a few who wonder why they can't have this opportunity. They think that it sounds like a really good thing. We are holding those harmless aged 55 and older. I think it is important that we have this debate, and it is a debate that brings forward all of the facts and the realities of what we are talking about.

We are talking about doing something that will improve Medicare, just like Medicare part C, which is Medicare Advantage. It has been shown that seniors on that, because of the emphasis on prevention and wellness, have been hospitalized for fewer days and smaller length of stays, which has saved money in the long run. So we are talking about a positive investment in the health care of our seniors, in saving the country money and, frankly, in saving Medicare.

So I appreciate the opportunity to join my good friend from Texas. This is a conversation that I think is going to be very important that we continue throughout the rest of the spring and well into the summer.

Mr. BURGESS. Well said, because that is exactly the point of this exercise this afternoon. These are difficult concepts. They are very easy to demagogue; they are very easy to demagogue against the Republican plan. The President himself may choose to do this. Certainly the Democratic leadership in this House has chosen to do that. They do that in the absence of putting forward their own plan.

But let's be realistic. We talk about things like premium support. Now, in the 1990s, I'm just a regular guy practicing OB–GYN in Texas, and President Clinton recognizes that Medicare is going to be headed for difficulty in a few years. He convenes a big commission, the bipartisan Medicare commission that is going to save Medicare.

Senator Frist, who at the time was relatively new in the Senate, was a heart surgeon from Tennessee. At that time, he was recognized as one of the thought leaders and forward thinking in health care reform. So Senator Frist was on that commission. Senator Breaux from Louisiana, a well-respected conservative Democrat, was on the commission; Bill Thomas, who subsequently became chairman of the Ways and Means Committee in the House, was on the commission. The Breaux-Frist Commission came up with a series of recommendations to the Clinton administration on how to sustain Medicare into the future.

The Breaux-Frist Commission had a number of recommendations, but the centerpiece of what they recommended to President Clinton was this concept of premium support. It was not necessarily new with them. It had previously been described by the Brookings Institute, certainly not a conservative think tank, probably regarded more as a moderate to somewhat left of center think tank, but the Brookings Institute had come up with the concept of premium support. People liked to try to describe what the Republican budget produced as a voucher system. That is, in fact, incorrect.

I will tell you, I was a little bit surprised that members of the administration, when the Republican conference was called down to the White House earlier this week and had a discussion with the administration, required some instruction as to what premium support actually was and what the history of premium support actually represented: that it was in fact developed by a moderate think tank, that it was embraced by a centrist to center left Democratic administration in the Clinton administration, and that the Clinton administration essentially took this idea, evaluated it and put it on the shelf and said we are not going to consider it because there were too many special interest groups on the left who did not like the concept of Medicare moving away from central Federal control.

But what premium support represents is, in this case a purchaser, in this case the United States Government, going out and negotiating with insurers, saying we have a bank of patients that is going to require care, i.e., our seniors on Medicare, and this is the type of claims history they have had for the last several years, and we would like to see if you would be interested in developing a proposal for what you can do for our patients.

So it is essentially a request for proposals that goes out from the Federal Government—yes, to private health insurance companies, some for-profit, some not-for-profit. The only requirement is that they be able to show that they can take care of the patients where the government needs help with its seniors and produce a product that is going to be cost effective and is going to deliver quality care to the patients.

A voucher system—and, again, I was somewhat startled that members of the administration required instruction in this regard. A voucher system would be essentially giving a check to someone and saying: Go out and negotiate and cut your best deal with an insurance company. A premium support system is the government going out, negotiating with the insurance companies and then saying: Come to us with your best proposals for taking care of Medicare patients.

Some people would say: That is preposterous. That would never work. Congressman THOMPSON, you were not here when Medicare part D was passed. I was. Part D was built on that premise. It was let's see if there is an interest out there in providing a prescription drug benefit for seniors. Since we were criticized that no one in their right mind would provide such insurance for seniors, we had a fallback position.

It was a Medicare prescription drug program exclusively, not one run through a private intermediary. The fear was there would be parts of the country that no insurance company would show up to make a proposal. What we got was, indeed, a surprise. After being criticized for several months that no one was going to show up to participate, we were criticized by the other side because people said there are too many plans out there from which seniors have to choose. In the State of Texas, there were 45 plans available subscribing at different rates. You could pick the one that most consistently met your needs for a prescription drug program. But it really was a pleasant surprise.

Because of the competition between so many plans, the prices were vastly under what had been projected by both the Congressional Budget Office and the Office of Management and Budget, and one of those few programs that came in on time and under budget where the satisfaction rate is in excess of 94 percent. Very few seniors today would be willing to give up their part D coverage under the Medicare prescription drug program.

Yes, it has had some bumps and bruises along the way, but a lot has been learned in the process. Now the concept of premium support is much more developed in 2011 than it was in 2003 when the Medicare Modernization Act passed.

So premium support—and again, I was surprised that members of the administration required sort of remedial learning on this. But at the end of the morning, I hope they understood better that it is not necessary to demagogue against the Republican plan because, after all, it is a reasonable plan that has been tested with Medicare part D satisfaction rates high and the cost of delivering the care under what was projected. Why in the world wouldn't we draw on that worthwhile experience?

Now, what do you do about someone who is between the ages of 55 and the end of their life? What do you do with someone who has reached that point where they have basically made all of

their assumptions and plans based around what the government promised they were going to do? For that individual aged 55 or older, nothing changes. I happen to fall into that age group. As Mr. THOMPSON alluded to, I would happily opt into the group that is going to have choices because I would rather have choices than a prescribed benefit.

□ 1520

Nevertheless, those individuals who are 55 and older will see no change, the thought being that they have already structured their lives and their retirements based on the fact that this promise had been made. For individuals who are younger than that, when there is still time to make some adjustments in your post-work years, your retirement years, there will be a different program.

Now you ask: For people who are 54 years of age and younger, is that fair to do this?

Well, I think both Mr. THOMPSON and I have articulated what ''fair'' will look like if you don't do something. What ''fair'' will look like if you don't do something is either vastly restricted benefits, as has been recommended by the Medicare trustees, vastly restricted benefits as dictated by the Independent Payment Advisory Board, or perhaps no Medicare program at all. After all, the makeup of the voting public in 10- to 15-years' time is going to be different than what it is today, and the makeup of the voting population in 10- to 15-years' time may feel significantly different about paying 60, 65, 70, 75 percent of their paychecks in order to continue benefits that were promised by a Congress 60 years before.

This type of intergenerational anxiety is just around the corner, and if we don't deal with it head on, if we don't take it as a serious responsibility, then it, indeed, could set the stage for some significant strife down the road between today's children and tomorrow's grandparents. That is why it is so important that we address this situation today.

G.T., I have said what I had intended to say today. If you have any additional comments or closing thoughts, we'll wind down this hour a little early.

Mr. THOMPSON of Pennsylvania. I appreciate that. Thanks again for hosting this hour.

Whether we're talking about addressing the deficit or whether we're talking about saving Medicare—frankly, both of those issues are intertwined—we've got to save the country, and we've got to save the Medicare program. What we cannot do is allow the politics of 2012 to affect the problem-solving of critical problems in 2011. That's what we have seen so far. Where the facts are evident and clear that this country is facing a critical deficit that could bankrupt it and where the numbers for Medicare are such that its insolvency is impending and bankruptcy occurs and it goes away, these are critical problems, and they shouldn't be demagogued as we bring solutions to the floor to debate. That's what has been happening. So there is no way we should allow the politics of 2012 to affect the critical problem-solving of 2011.

After the Balanced Budget Act of 1997, I had the privilege as a health care professional to be recruited to serve on a technical expert panel for Medicare. At the time, it was the Health Care Finance Administration. Today, it's the Centers for Medicare and Medicaid Services. Based on that experience, this is necessary. This is a necessary debate. This is necessary in order to save Medicare, and it's an opportunity for us.

We have had previous reforms. The most recent one I saw was under President Bush where he created the waiver program. That was a reform to an entitlement program that actually increased the quality of life and decreased the costs of many people who were institutionalized, living in nursing homes. Frankly, I like nursing homes. I think they can be very quality facilities, and I was an administrator at one time. Yet people should have the choice of where they live if they're living with a significant disability. It was President Bush's waiver program, a reform actually, that allowed that to occur.

So ''reform,'' I think, can be a word used to scare people, but we need to talk about the specifics of why it is necessary and the opportunities that we have, I believe, to increase the quality of care, to decrease costs, to even increase access—all those—and certainly choice since the health care consumers are making decisions. Those are four principles that we share as a caucus as to whatever we do in health care. In looking at Medicare reform, I think that our plan, which is really the only viable plan, honors all four of those qualities.

So I look forward to continuing this debate. We need to have a good, transparent debate, but it needs to be a debate that is not based on demagoguery. It's a debate that needs to be based on the facts. I thank my colleague for hosting this Special Order time.

Mr. BURGESS. I think we'll look forward to having similar discussions in the future, probably frequently, because it's important that we not just have the debate with both sides of the Chamber. It's also important that we have the conversation with the American people.

I would remind people that the Republican budget that was passed in April was an aspirational document. It wasn't terribly long. If you look at something that becomes an actual law, it can get fairly long and intricate, but the budget was an aspirational document that set the goals. In 10-years' time, we want to see Medicare on a sustainable path. We want to preserve, protect and defend it for the future, and this aspirational document sets the pathway for achieving that goal.

All of the work that will be done to actually develop the legislative product will be done in the committees that Mr. THOMPSON and I are on in the House and that Members of the other body are on in the Senate. The actual work will be done on those committees, and there will be ample opportunity for people to comment, for people to contact their legislators. There will be periods of open comment at the Federal agencies as those laws are written. They won't be written in the next couple of months. They will be written over the next several years.

The point I would end with is that we are entering a phase of a long conversation with the American people about what the future of this program is, which arguably has been a good program in the past but, left untouched, is headed for some significant problems in the future.

So what is the forward-looking path for our Medicare system and for our seniors of both today and tomorrow? It will be a long conversation, but we are both up to it, and we can talk for a long time without pausing. I look forward to working with you on many afternoons on this very subject.

Madam Speaker, I yield back the balance of my time.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. BASS of New Hampshire (at the request of Mr. CANTOR) for today on account of attending the funeral of former Congressman Peter Frelinghuysen.

ADJOURNMENT

Mr. BURGESS. Madam Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 3 o'clock and 27 minutes p.m.), under its previous order, the House adjourned until Tuesday, June 7, 2011, at 10 a.m.

OATH FOR ACCESS TO CLASSIFIED INFORMATION

Under clause 13 of rule XXIII, the following Members executed the oath for access to classified information:

Gary L. Ackerman, Sandy Adams, Robert B. Aderholt, W. Todd Akin, Rodney Alexander, Jason Altmire, Justin Amash, Robert E. Andrews, Steve Austria, Joe Baca, Michele Bachmann, Spencer Bachus, Tammy Baldwin, Lou Barletta, John Barrow, Roscoe G. Bartlett, Joe Barton, Charles F. Bass, Karen Bass, Xavier Becerra, Dan Benishek, Rick Berg, Shelley Berkley, Howard L. Berman, Judy Biggert, Brian P. Bilbray, Gus M. Bilirakis, Rob Bishop, Sanford D. Bishop, Jr., Timothy H. Bishop, Diane Black, Marsha Blackburn, Earl Blumenauer, John A. Boehner, Jo Bonner, Mary Bono Mack, Madeleine Z. Bordallo, Dan Boren, Leonard L. Boswell, Charles W. Boustany, Jr., Kevin Brady, Robert A. Brady, Bruce L. Braley, Mo Brooks, Paul C. Broun, Corrine Brown, Vern Buchanan, Larry Bucshon, Ann Marie