trained or funded many of the leading MS researchers creating these life-changing breakthroughs.

Mr. Speaker, I also want to thank Lori and Tommy Straub for inviting me to be a part of Team ''Walk a Myelin My Shoes.'' Together, we will continue to work towards a world free of MS.

STOP CLOSING PUBLIC SCHOOLS IN AMERICA

(Ms. JACKSON LEE asked and was given permission to address the House for 1 minute.)

Ms. JACKSON LEE. Mr. Speaker, I want to congratulate and thank the community of North Forest and the North Forest Independent School District.

This has been a tumultuous week. This school district, undeserving, has fallen prey and victim to the closing of public schools in a public school system—this district that has acceptable schools; this district that has homeowners who have taxed themselves to ensure excellence in the teaching of these children, 7,500 students that are happy to be in a small pond and be a big fish. It is sad that the TEA administrator has undeservedly offered to close this school district without accepting an offer of compromise.

This is time for the Secretary of Education to act on the massive closings of public schools throughout America. This is time for the U.S. Department of Justice to act on preventing the elimination of elected school board members and utilizing section 5.

But more importantly, I want to thank the ombudsman coalition headed by Dr. Ken Campbell and President Robinson, the presidents of the Ministers Alliance who carried on a prayer vigil this last week. I do believe that prayers will be answered, the children will be saved, and we'll stop closing public schools in America.

□ 1930

PETSMART PROMISE

(Mr. SCHWEIKERT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SCHWEIKERT. Mr. Speaker, this is actually one of those moments when you get to stand in front of the House with sort of a happy story. There's an organization out there called Family Promise. They are in 41 States with, I believe, about 160,000 volunteers, and they've had an issue for years now. They bring in homeless families, but often those homeless families would have a pet, a furry family member.

Just this week, PetSmart set up PetSmart Promise. I actually got to see this firsthand in Scottsdale, Arizona, where they actually are taking care of that furry friend of that homeless family that needs to get their life back in order. So PetSmart gets a real call out from us. Family Promise is doing amazing things, and this is just one of those moments where you're very proud of a corporate entity like this, stepping up and working with Family Promise to help homeless families around the country.

CBC HOUR: ELIMINATING HEALTH DISPARITIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2013, the gentleman from Nevada (Mr. HORSFORD) is recognized for 60 minutes as the designee of the minority leader.

Mr. HORSFORD. Mr. Speaker, thank you.

We are pleased to come to this body at this time for this hour of power with the Congressional Black Caucus. This evening, we'd like to focus on eliminating health disparities in America.

Health is a cornerstone of equal opportunity, which is why access to quality, affordable care is so important. Sickness not only decreases individual and social productivity, but without access to health resources, many get sick and never truly recover. Over this next hour, members of the Congressional Black Caucus will discuss our priorities, working together with the President, our colleagues on the other side and throughout this body, and in the other Chamber, to address the needs of health care for all Americans, and specifically to eliminate the health disparities in the African-American communities.

I'd like to recognize the chair of the Congressional Black Caucus. Under her leadership, the CBC is advancing a number of priorities during this 113th Congress. I yield to the gentlelady from Ohio, Chairwoman FUDGE.

Ms. FUDGE. I thank the gentleman for yielding, and I want to thank my colleagues, both Congressmen HORSFORD AND JEFFRIES, again for leading the Congressional Black Caucus Special Order hour. This hour is to discuss health disparities. You both have done an incredible job carrying the message of the CBC on the House floor each week, and I thank you.

Mr. Speaker, the health disparities between African Americans and other racial and ethnic populations are striking. When compared with the country as a whole, African Americans are three times more likely to die from diabetes. We account for about 44 percent of all new HIV infections among adults and adolescents, despite representing only about 13 percent of the U.S. population. African-American men can expect to live approximately 6 years less than White men. African-American women are twice as likely to give birth to low-weight infants, and our children are almost five times more likely to be hospitalized for asthma.

Though health disparities manifest in life-threatening ways, such as lower life expectancy and higher disease rates, the root cause is poverty. Where you live and how you live have a direct effect on how long and how well you live. Until we address the persistent poverty that plagues our communities, the debilitating cost of health disparities will continue to rise.

According to the Joint Center for Political and Economic Studies, health disparities collectively cost minorities more than $1.24 trillion from 2003 to 2006. We must create and maintain a path toward greater health equity in America. We can't afford the status quo.

Thankfully, a path to equity has begun to take shape, a path that reduces the rates of illness and premature death and increases access to quality health care. The solution was and is the Affordable Care Act—or, as it is known to many, ObamaCare. We are proud to call it ObamaCare because it proves that the President and many in this Congress really do care about the health of Americans.

ObamaCare has already begun to lower the cost of health care by providing financial relief for consumers, increasing insurance options, investing in preventative and primary care, and placing a focus on minority health. The ACA helps decrease health disparities by collecting data, strengthening cultural training, and increasing diversity in the health care field. These investments are critically important and will strengthen America's financial future.

Some on the other side of the aisle believe the status quo is sufficient, that health disparities are not real. Some don't believe that the impact of disparities on families is devastating. That's why a number of Republicans are again calling for the repeal of the ACA. How many times do we have to play this game?

The CBC will continue to stand up, speak out and defend the Affordable Care Act against all of those who oppose it for political or ideological reasons. Attaining health equity is to the benefit of all Americans, and is not only consistent with the American promise of opportunity, but it is critical to the future of Black America.

Mr. HORSFORD. At this time I would like to recognize the vice chairman of the Congressional Black Caucus, a leader on a number of key issues that the Congressional Black Caucus is facing this 113th Congress, the gentleman from North Carolina (Mr. BUTTERFIELD).

Mr. BUTTERFIELD. Let me thank you, Mr. HORSFORD, for yielding time this evening, and thank you for your leadership not only here in the Congress but in the Congressional Black Caucus. You have come to this Congress, and you've done so much in such a short period of time. Thank you, Mr. JEFFRIES and Ms. FUDGE as well, for your leadership.

But, Mr. Speaker, I want to start this conversation this evening by talking about a 1985 report. President Ronald Reagan was President at the time, and the U.S. Department of Health and

Human Services issued a statement. They called health disparities in the United States of America ''an affront both to our ideals and to the ongoing genius of American medicine.''

It's disgusting, Mr. Speaker, that in this year, 2013, health disparities still exist in the richest and most powerful country in the world. African Americans are disproportionately less healthy. Life-threatening diseases like high blood pressure, diabetes, and heart disease are ravaging our population.

Oftentimes African Americans that live in rural communities, like the one that I represent in North Carolina, don't have insurance, and they have difficulty finding a regular primary care doctor, and so they go without an annual physical or regular checkups. Sometimes their only interaction with a health care provider is when they call 911 because their unchecked blood pressure resulted in a heart attack or stroke. By then it's too late. If that same person suffering from a stroke would have had access to care, their high blood pressure may have been diagnosed early.

□ 1940

They may have been put on medication meant to regulate their condition, making a heart attack or stroke less likely.

Many African Americans do play an active role in their health care, but the quality of the care they receive can be much worse than their white counterparts, further widening the gulf of disparities.

A significant driver of these disparities is the lack of health insurance, and that's what the gentlelady spoke about a moment ago. African Americans make up 13 percent of the entire population, but account for more than 50 percent of all people who are uninsured.

African Americans are also likely to have disproportionately lower access to primary care and often receive poorer quality care and face more barriers in seeking treatment for chronic-disease management.

The Affordable Care Act that we're all so proud of was designed to put a premium on quality of care, increase access, and encourage and reward good health care outcomes. I am a strong supporter of the Affordable Care Act, and my constituents in North Carolina are as well.

Every person should have access to affordable quality health care, regardless of who they are, where they come from, or how much money they have in their bank accounts.

Before the Affordable Care Act was signed into law, 50 million people lived without health insurance. An additional 38 million people had insurance, but it was woefully inadequate and charged them exorbitant coinsurance payments and huge copays and completely unmanageable out-of-pocket expenses, essentially making them uninsured too. That means nearly one-third of all Americans were without the very basic insurance needed to see a health care professional and receive care at an affordable price.

When President Barack Obama proposed, and Congressional Democrats introduced, the Affordable Care Act, Republicans stirred up for a battle. And they would scream in the town hall meetings all across the country, and even right here on this House floor, about how the bill would create death panels that would decide if a person was worthy of receiving treatment for a particular disease. That was not correct.

They would insist that the bill would cut hundreds of millions of dollars from Medicare. Not correct. In fact, the Affordable Care Act specifically prohibits cuts to the guaranteed Medicare benefits.

They would bring out charts on this floor and graphs that showed how the Affordable Care Act will be a ''job killer'' worse than we have ever experienced before. That turned out to be a lie.

The cost of health care has risen each year, insurance coverage has decreased each year, and the amount of uncompensated care has increased every year.

Mr. HORSFORD, here's a statistic that really stands out with me: in 1970, the United States spent $75 billion on health care. That was 7.2 percent of GDP. In 2010, health care spending represented 17.9 percent of GDP and, if not for the Affordable Care Act, was expected to reach 20 percent by the year 2020.

The U.S. spends more of its dollars for health care-related expenses than any other country in the world, and the uncontrolled rise in the cost of health care would have been completely unsustainable if not for ObamaCare.

President Obama signed the Affordable Care Act into law and, with the stroke of a pen, revolutionized health care in America. Insurance companies can no longer deny coverage to people with preexisting conditions or charge them more than anyone else. There is now no lifetime dollar limit on what insurers will pay for claims.

Preventative visits to health care providers are now free, yes, free, and even include some free vaccinations. Young adults can now stay on their parents' policy until they're 26 years old. And all new group health plans now have to cover all recommendations by the U.S. Preventative Services Task Force.

Now, millions of people in our country, and in my congressional district and, Mr. HORSFORD, in your congressional district, who were living without the most basic health insurance can benefit from the most advanced health care technology in the world.

My only disappointment, Mr. Speaker, is that some of our Republican Governors and State legislatures across the country are refusing to participate in the expansion of Medicaid. Shame on them.

Mr. Speaker, in closing, I am confident that because of the Affordable Care Act the delta of health disparities in America will begin to shrink. No matter the color of your skin or the amount of money you have, each and every American deserves high-quality health care so they can live long and prosperous lives.

Mr. HORSFORD, I thank you so very much for yielding time.

Mr. HORSFORD. Thank you, Mr. Vice Chairman, and thank you for your leadership and commitment on these issues. And I know we will continue to fight and advocate for the preservation of the Affordable Care Act and, as you indicate, the proper implementation of that act with the expansion of Medicaid and the other key provisions of the law which we need our local and State partners to work with us in providing quality health care for all Americans.

GENERAL LEAVE

Mr. HORSFORD. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks on the subject of this Special Order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Nevada?

There was no objection.

Mr. HORSFORD. At this time I'd like to yield to the chair of the Congressional Black Caucus' Health Brain Trust, the doctor in the House, the person who knows more about health care than most, the honorable gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Thank you, Mr. HORSFORD. Thank you and our other colleague, Mr. JEFFRIES, for hosting these Special Orders every week. It's been with great pride that we've watched our young new Members come to the floor and present the case so forcefully and so effectively to the American people and the disparities in all areas that African Americans and other people of color and the poor are facing.

Before I start, Representative BARBARA LEE of California could not be with us this evening, but her work on HIV and AIDS, and other areas in health care, but specifically in HIV and AIDS, both here in the United States and across the globe, is worthy of recognition; and I know that she'll be entering a statement for the RECORD on some of the issues around HIV and AIDS.

I want to just go back a little bit and present a little bit of historical context on just how long this battle to eliminate health disparities has been going on. I'm going to go back—of course, it goes back to slavery, but I want to go back to W.E.B. DuBois in 1899, when he said, and I'm quoting:

> There have been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference.

And then 25 or so years later, and this was mentioned by Congressman

BUTTERFIELD, in 1985, the Heckler Report, where it was said, and I'm quoting here:

There was a continuing disparity in the burden of dealt and illness experienced by blacks and other minority Americans as compared with our Nation's population as a whole.

And as he said:

The stubborn disparity remained. The stubborn disparity remained an affront to both our ideals and the genius of American medicine.

Surgeon General Heckler was very surprised by what that report found, but when she asked her researchers, well, why is this, the only answer that they could give her is, it's always been that way.

And so that stubborn indifference that W.E.B. DuBois mentioned in 1899 continued into as far as 25 years later.

Almost 20 years later, the IOM issued its unequal treatment report which said:

In unassailable terms, the report found that even when insurance and income are as the same as those of whites, minorities often receive fewer tests, less sophisticated treatment for a panoply of ailments, including heart disease, cancer, diabetes and HIV/AIDS.

So even when you have insurance, even when your educational level, even when your income is the same, you are still not getting the same treatment. And so it's no wonder that African Americans and other people of color have suffered from disparities for so long.

So in 2003, led then by Jesse Jackson, Jr., we insisted that there be a report every year on health disparities, a national report. And the very last one, so we're in our 11th year now, well, we're in our 10th year now, and the very last report shows very little change.

□ 1950

It showed that blacks received worse care—it talks about quality—than whites for 41 percent of quality measures. Hispanics receive worse care than non-Hispanic whites for 39 percent of measures. Asians and American Indians and Alaskan Natives receive worse care than whites for nearly 30 percent of quality measures. And in terms of access, blacks had worse access to care for 32 percent of access measures, Asians for 17 percent, American Indians and Alaskan Natives for 62 percent, and Hispanics 63 percent of the measures.

So as we look over the years from 1899 to 2011, which is what this report is on, there has been very, very little change. Among the themes that emerge from the report, health care quality and access are suboptimal, especially for racial and ethnic minorities, and this is in 2011. I'm sure the report this year is not going to be any different. Quality is improving, but disparities are not improving.

There are several areas where disparities are worsening over time between minorities and whites. Those are maternal deaths in the black population and breast cancer diagnosed at an advanced age for women in the black population. Children zero to 40 pounds—their families are not getting advice in the Asian population about seatbelts. Adults over 50 not receiving colonoscopy, sigmoidoscopy or anything in the American Indian and Alaskan Native populations.

So when looking at these reports coming back the same way year after year, the Tri-Caucus, the Black, Hispanic and Asian Caucus, when we began to debate the Affordable Care Act and to write the Affordable Care Act, we came together and said health equity had to be a major and core goal of health care reform. We were able to insert into the bill many of the provisions that we had worked on for many years to create health equity and to begin to eliminate health disparities. So we call on all people across the country to support us and make sure that all of those attempts to repeal the Affordable Care Act, which would close the door that we have been able to open for so many who have not had access to quality health care for so long—that door would not be closed again.

Mr. HORSFORD. Thank you again to the gentlelady from the Virgin Islands and the chair of the Congressional Black Caucus' health brain trust for laying out, again, the hard work that the Congressional Black Caucus has been involved with for many years in getting to the point with the Affordable Care Act now on the cusp of being fully implemented in January of 2014. So when our colleagues on the other side spend time bringing up legislation to repeal the Affordable Care Act now more than 30 times after this legislation has been approved by Congress, it has been upheld by the courts, it has been signed by the President, and the American public are desperate for quality health care—that is why we are coming here today to say enough is enough. Thirty times to repeal the Affordable Care Act—how many more times will we waste the people's, House's and our time bringing these issues forward when we need to be working together to implement the Affordable Care Act in the way that it is intended?

At this time, I would like to yield to the second vice chair of the Congressional Black Caucus. She is a strong leader for her constituents, the gentlelady from New York (Ms. CLARKE).

Ms. CLARKE. Thank you, very much, Congressman HORSFORD, and I thank you for your leadership along with Congressman JEFFRIES in leading the Special Order hour for the Congressional Black Caucus.

Mr. Speaker, I rise today to join my colleagues in the Congressional Black Caucus to raise awareness about health disparities that continue to affect racial and ethnic minorities in the United States of America. Despite medical advances that save many lives in our country, there has been very limited progress in ending the racial and ethnic disparities in health. In a 1985 report, the United States Department of Health and Human Services called health disparities in this country ''an affront both to our ideals and to the ongoing genius of American medicine.'' Now, decades later, health disparities still exist between black and white and rich and poor.

A primary reason for these disparities is, quite frankly, the lack of health insurance that has been a problem for all these many years. For instance, African Americans make up 13 percent of the entire population but account for more than half of all people who are uninsured. Blacks also have disproportionately lower access to primary care and face more obstacles in seeking treatment.

Across our Nation, health disparities continue to persist and widen in communities historically marginalized as a result of poverty and other social, economic and environmental barriers. These communities are experiencing a high burden of life-threatening diseases and poor health outcomes.

Population-based approaches such as recent efforts to reduce childhood obesity rates, while showing evidence of success, have been primarily focused on white children in affluent communities. For example, in a report released in 2012 by the CDC, New York showed an overall decline of as much as 10 percent in obesity rates for kindergartners. However, for poor black children, the decline was only 1.9 percent, and for Hispanic children it was 3.4 percent.

In my district in Brooklyn, New York, I represent a very large number of immigrants. Close to 40 percent of the residents are first- and second-generation Americans. Culturally significant and linguistically tailored education is required to address health disparities. This education is one of the building blocks upon which improvements in early detection and screening in these communities have been built.

Health disparities are a serious matter. According to the National Urban League's State of Urban Health report, in 2009, health disparities cost the United States economy $82.2 billion. I firmly believe in prevention and addressing health disparities, and that it will go a long way in bringing these costs down. It is important that we fully engage in a full implementation of the Affordable Care Act. This will lead us to closing these disparities, this health disparity gap.

I look forward to working with my colleagues in the Congressional Black Caucus and, quite frankly, all Members of goodwill to find solid solutions to addressing health disparities in communities of color across this Nation.

Having said that, Mr. Speaker, I thank you for the time.

Mr. HORSFORD. Thank you to the gentlelady from New York, and I appreciate, again, all of her hard work and her commitment on these issues and her willingness to, again, reach across

the aisle as you said. We are here to work with anybody who wants to work with us to find solutions to the health care crisis that exists in America. But we need them to understand that voting to repeal the Affordable Care Act is not that solution. There are many more things that we can do together to provide access to health care than we can by repealing this very important legislation.

At this time, I would like to recognize, Mr. Speaker, the gentleman from Illinois (Mr. DAVIS).

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, I want to first of all commend our colleagues for coming here every week raising issues and promoting awareness. Tonight it is health care, health care disparities.

I believe that the big problem with the eradication of the disparities is the fact that we, as a nation, have not committed ourselves to the concept that health care ought to be a right and not a privilege. As the most technologically proficient nation on the face of the Earth, as the wealthiest nation with a quality of life for large numbers of people—that is commendable—we still have not reached the point where we take the position that every person, no matter what their status or circumstance, deserves the highest quality of health care that our Nation can afford for them.

□ 2000

So until we reach that point, we will continue to have studies and reports and we will continue to look at disparities, and we'll keep doing it and doing it and doing it and doing it again.

We will have legislation like the Affordable Care Act that is designed to close some of the gaps. And it does, in fact, close some of the gaps, and it's commendable that we have done that.

But I maintain that we have a health care system that really is a sickness care system. We do a good job of treating illnesses and sickness when people can get to the places where they get the treatment.

I had a call yesterday from a person who suggested that they had gone to the emergency room at the hospital and were given two Tylenol and sat in a room for a good period of time. When they inquired of the hospital why they had done that, they told them, Well, it's because of the ObamaCare; that ObamaCare is causing this to happen to you.

Now, the person actually has been on Social Security disability for a long time, before there was any ObamaCare and there was a way to pay for their health care, and somebody took the opportunity to misrepresent ObamaCare. I would hope that people would not, especially people in the industry, people in the business, would not do that.

But I also urge individual citizens to take more responsibility for our health. You know, there's still disparities in smoking, still disparities in drinking too much alcohol, still disparities in not having the appropriate diet or the exercise that is needed. So we've got to tack on several fronts. We've never put enough resources into the systems to make sure that they work properly and appropriately. We need to put more money into health education, health promotion, health awareness, so that individual citizens have a greater understanding of what it is that they individually can do.

Of course, people who know me know that I promote community health centers as the best way of providing ambulatory health care to large numbers of low-income people more effectively than anything else we've come up with, with the exception of Medicare and Medicaid, in a long time. I still promote these institutions as being one of the best ways in local communities of having health care delivery where people themselves are involved. These centers provide jobs and work opportunities and help keep the money in the neighborhood so that the impact of poverty is not as great as it would be.

So, Mr. HORSFORD, again, I want to thank you; I want to thank Mr. JEFFRIES; and I want to commend the caucus for raising the issues, promoting awareness, and helping, hopefully, to develop a different level of understanding. Health care ought to be a right and not a privilege.

Mr. HORSFORD. I'd like to thank the gentleman from Illinois and, again, just to highlight, as you indicated, the community health centers as an important provision of support within the health care delivery system.

Both rural and urban communities suffer from the disproportionate distribution of health care resources and access to care. Community health care centers play an important component in overcoming that care, providing millions of health care services, particularly to people of color, access to high-quality and affordable care in both rural and urban areas.

I know in my own district, in Nevada's Fourth Congressional District, we have 14 health centers throughout our region. From my rural parts to the urban parts, these are very important areas. But unfortunately, under the sequester, Mr. Speaker, these are still areas that are under attack because cuts to these health care centers are still being imposed because of the uncertainty of the sequester.

In my district, Nevada health centers, they're looking at over $700,000 worth of reductions between now and September; elimination of nursing positions and elimination of services for children and seniors at a time when people are sick and they need it the most.

So I would hope that, again, we can work together with Members on the other side to come up with solutions to replace the sequester and to fully fund community health centers, who are providing such good care to our citizens at this time.

I would like to yield now, Mr. Speaker, to the gentlelady from Texas, Congresswoman SHEILA JACKSON LEE.

Ms. JACKSON LEE. I thank the conveners of this Special Order and express my appreciation to Mr. HORSFORD and to Mr. JEFFRIES for continuing to educate our colleagues on extremely important issues. And I'm delighted to join the Congressional Black Caucus as it proceeds continuously to ensure that we advocate for those who cannot speak for themselves.

I want to take up an issue that has struck home and is being confronted by many States, some of which are in the South and some are in other places throughout the Nation. I was very pleased to stand with my fellow Democrats and support the Affordable Care Act. I could go through the journey of 2009 and 2010, when many of us spread out across the country and confronted misinformation through town hall meetings, controversy, and conflictedness.

I think that what should be continuously emphasized as the President's leadership on one single point: that although health care was not listed, per se, in the Constitution, it should be a constitutional right. If you read the words or quote the words of the Declaration of Independence, we hold these truths to be self-evident, that we have certain unalienable rights of life, liberty, and the pursuit of happiness, one might argue that education and health care fall into those provisions of life, liberty, and the pursuit of happiness.

It was in the context of that framework in the original words of the Constitution that, as you open the book that has the provisions of the Constitution, the opening phraseology indicates that we have come together to create a more perfect Union. I think the Affordable Care Act was intended to try and lift the boats of all people.

Interestingly enough, major hospitals across America were clamoring for the passage of this legislation to really do what we're speaking about, which is to cut into the health disparities, because our hospitals across America were suffering from not being reimbursed on uncompensated care for those people who came without insurance. Many of them included African Americans, who suffered in larger numbers from the difficulties with diabetes, for example.

Texas, which is now in the eye of the storm, is one of those States that has rejected the expansion of Medicaid, which goes to the very point of increasing opportunities for those who suffer disparities so they can have access to health care. That is largely the problem in Texas. Federal funding for the adult expansion far exceeds current local expenses for unreimbursed health care costs, having 3 years without any match whatsoever and then having the ability to have a very small match later on.

It is estimated that Medicaid expansion would generate more than 231,000

jobs in 2016, a 1.8 percentage point reduction in the State's current unemployment from 6.1 percent to 4.3 percent, and it would directly address the disparities in diabetes, heart disease, and HIV/AIDS, in partnership with our federally qualified health clinics, which many States have seen expanded because of the Affordable Care Act. And now in my home State, my city in particular, Central Care has now put more community health clinics in areas where disparities were severe and lives were being lost.

It benefits children as well. I'd like to cite some numbers here for my colleagues to indicate what we would benefit from by the expansion of Medicare.

□ 2010

Unreimbursed health care costs for charity care in 2010, for an estimated $4.4 billion in unreimbursed expenses. We would be covering that.

We would also get off the number one list. Texas, number one, ranking among States with the greatest share of uninsured residents at 23.8 percent in 2011, more than 6 million people, compared with the national average of 15.7 percent.

And then, as I indicated, we would, again, eliminate the opportunity for low-income adults to be able to secure care. When low-income adults don't get care, the children don't get care.

So I am suggesting that the rejection by Governor Perry, along with other Governors, to not accept expanded Medicaid has a direct impact on the increase, not only of the uninsured, but the increase in the numbers of those suffering from certain diseases who cannot get care and, therefore, rather than have preventative care, which an expansion of Medicaid would provide, allowing for doctor visits, then the only time that we are able to secure health care for them is when they arrive in the cities and the counties and the States' emergency rooms, where we see a surge in emergency room costs, health care costs, and we eliminate the good will and the good intentions of a very good bill that answers the question, are we attempting to form a more perfect union by establishing a framework of insurance for all Americans, hardworking Americans, Americans of Asian descent and African descent and Hispanic descent, who have different DNA and cultural indices that would lead them to have certain diseases more than others.

Let me also take note of the fact that one of those particular diseases that impacts the African American woman in a more devastating manner than in others, and that is triple negative breast cancer that impacts Hispanic women, African American women and Anglo women, but more so in the African American community. That kind of diagnosis gives in this current phrase of time a short and almost devastating diagnosis, one that is difficult to recover from, one that sees an increase in the loss of life.

So I would make the argument to Governor Perry and to Governors across the Nation who have rejected the expanded Medicaid as a budget issue, as a political issue, as a ''I'm going to stand up to the President'' issue, you are wrong, you are absolutely wrong, because this is not a political issue; this is a life and death question. And I want to applaud Governors like those in Florida, who certainly, obviously, may not welcome the applause. But I think it's important when people stand on principle or what is good for others, that they should be applauded.

So I applaud the Governor of Ohio and the Governor of Florida for moving forward on Medicaid expansion. And I would say to my good friend, who is leading this very important Special Order, that we need to begin to work with the President to find ways to substitute the rejection of the Medicaid expansion so that individuals that are in these States who cannot speak for themselves, who in actuality have a head of State Governor that is making a political decision, a simple political decision, will not lose out on the benefits intended by the Affordable Care Act, which is to give comfort and to give help and aid to those who need health care.

I finish on this note. I want to thank Dr. CHRISTENSEN, because when we began to write this legislation with the Congressional Black Caucus that, one, talked about the health care disparity, which was the premise of the fact of expanding health care, it would be a shame if after all this work and passage of this bill there would be innocent persons in our respective States like Texas that could not benefit from something that could save lives.

I thank the gentleman for yielding.

WHY TEXAS SHOULD EXTEND MEDICAID COVERAGE TO LOW-INCOME ADULTS

LOCAL BENEFITS

Local savings from the expansion would offset much if not all of the state match in 2016 and 2017. According to reports that cities, counties, hospital districts and local hospitals submit to the state, unreimbursed local health care spending in Texas that local property taxes largely support, totaled $2.5 billion in 2011. In addition, Texas hospitals reported at least $1.8 billion in conservatively estimated unreimbursed health care costs for charity care in 2010, for an estimated total of $4.4 billion in unreimbursed expenses

The math is simple—federal funding for the adult expansion far exceeds current local expenses for unreimbursed health care costs. Although the impact of the Medicaid expansion and ACA subsidized insurance would not entirely offset total local expenses, since not everyone currently receiving charity care, such as undocumented immigrants, would be eligible for these programs and since some services may not be covered, much of it would.

If necessary, the state could use some portion of these savings to fund the required match through an intergovernmental transfer arrangement. Local governments and hospitals would still realize a net gain over current costs from the federal funds the match would generate.

It is estimated that the Medicaid expansion would generate more than 231,000 jobs in 2016, equivalent to a 1.8 percentage point reduction in the state's current unemployment rate—from 6.1 percent to 4.3 percent.

STATE BENEFITS

In numerous programs, the state pays 100 percent for adult health care that Medicaid would cover under an expansion. For example, the Texas Department of Criminal Justice requested $186.5 million in state appropriations for hospital inpatient and clinical care for its inmates for 2014.

The federal federal government contributes nothing toward this purpose now, but with a Medicaid expansion, the state would spend nothing on in-patient hospital care for eligible inmates from 2014 through 2016, and a maximum of just 10 percent of these costs by 2020. Similarly, the expansion would cover eligible adults in state mental institutions and juvenile facilities that need non-psychiatric hospital in-patient care.

The state also spends unmatched general revenue for community primary care services, mental and behavioral health services and, soon, women's health care delivered to low-income individuals who are not eligible for Medicaid. Other programs include the breast and cervical cancer program, the kidney health care program and the HIV Medication assistance and STD program. Furthermore, the state supplements funding for the County Indigent Health Care (CIHC) program, much of which would be unnecessary under a Medicaid expansion. The state also pays the regular state match for medically needy adults that currently qualify for Medicaid. Under an expansion, the state would be able to use the high federal match rate for newly eligible individuals not covered by Medicare.

The Comptroller's office estimates that larger caseloads from a Medicaid expansion would net increased revenues from the insurance premium tax due to the large number of persons who will buy health insurance under the exchange, as well as those covered in the expansion. The Comptroller estimates the increased insurance premium tax revenue due to ACA implementation and the Medicaid expansion at $1.3 billion from 2015 through 2019, or an average of $250 million a year.

In addition to these savings and new revenue that could offset the required state match, the expansion would generate an additional $1.8 billion in new tax revenue from 2014 through 2017, assuming moderate enrollment—enough to offset nearly half of the required state match from 2014 through 2017. These jobs, many of them in health care, would provide substantial benefits and increased economic security to families and local communities. As employees spend their wages on taxable items, state and local governments benefit from increased tax collections, and the increased economic activity in turn creates other jobs.

BENEFITS TO CHILDREN

According to the Census Bureau, in 2011 Texas had about 900,000 or 16.7 percent of the nation's 5 million uninsured children, and nearly 600,000 of the nation's 3.5 million uninsured children with family incomes below 200 percent FPL, again a 16.7 percent share. About 13.2 percent of all Texas children are uninsured, compared to a national average of 7.5 percent.

Bringing Texas up to the national average would require the state to insure an additional 393,000 children, less than the 550,000 expected to enroll in Medicaid under a Moderate scenario. After 2014, the national average will increase significantly since most states will expand Medicaid, which means that, without the expansion, the disparity between Texas and other states will grow.

Studies conducted in the 1980s found that expanding Medicaid to children reduced child mortality by 5.1 percent and infant mortality by 8.5 percent. Assuming the lower 5.1 percent rate, the expansion would save the lives of 2,700 Texas children every year after full implementation.

BENEFITS TO ADULTS

Our children also need healthy parents to provide for their care. Many low-income individuals and families simply cannot afford basic living expenses, health insurance and out-of-pocket health care expenses, making a Medicaid expansion imperative.

The Kaiser Family Foundation estimates that about 41 percent of adults covered under the expansion would be parents. Many of them work, but lack health insurance. According to the Census Bureau, 59.9 percent of uninsured adults in Texas work, a higher labor force participation rate than the total population's. According to Kaiser, about 1.2 million adults who would be covered under the expansion in Texas are working, about 60 percent of them in agriculture or service industries that tend toward smaller firms and are less likely to offer insurance to employees.

Only 28.4 percent of the 320,334 Texas private firms with fewer than 50 employees insured their employees in 2011, versus 92.3 percent of the 132,109 larger private firms. And besides working for low wages in firms that do not offer health insurance, many low-income individuals find work only on a part-time or seasonal basis, resulting in poverty-level incomes.

The Medicaid expansion would cover a person employed in a full-time, minimum-wage job paying $7.25 per hour, which equates to $15,080 per year, just below the 138 percent FPL cutoff. It also would cover a single parent earning $10 per hour (annual wages of $20,800). These wages are generally insufficient to cover basic living and working expenses as well as health insurance.

The high cost of health insurance affects both employers and workers, but high premiums as well as out-of-pocket medical expenses make it impossible for most low-income workers to afford health care. The 2012 average cost of single coverage was $5,615, and family coverage was $15,745, a 30 percent increase since 2007, according to a recent study by the Kaiser Family Foundation and the Health Research and Educational Trust. Employees paid an average of $951 for single coverage and $4,316 for and $11,429 for family coverage per employee, it is unsurprising that most small employers find it difficult to provide insurance.

Although the ACA provides subsidized health insurance for individuals above 100 percent of FPL, about 1.4 million uninsured Texas adults aged 18 to 64 who are below 100 percent of FPL will not be eligible. Covering most of these adults through Medicaid would mean a healthier workforce and would reduce absenteeism, job loss and unemployment insurance costs to employers. It also would increase income for families with children, thus reducing stress and providing more opportunities.

And, it would save lives. The Harvard School of Public Health recently compared three states (New York, Arizona and Maine) that expanded Medicaid to childless adults aged 20 to 64 between 2000 and 2005 with neighboring states that did not (New Hampshire, Pennsylvania, Nevada and New Mexico). They found not only a higher insured rate in the expansion states, but a 6.1 percent drop in the death rate for adults under age 65, or about 2,840 deaths prevented each year for every 500,000 persons newly insured. This translates into one life saved per year in the five-year follow-up period for every 176 newly insured. In Texas, that would amount to about 5,700 lives saved per year under the Moderate enrollment scenario once fully implemented.

BENEFITS TO EMPLOYERS

Only 36 percent of U.S. workers in firms with fewer than 25 workers have insurance.36 In a Kaiser Family Foundation survey, 48 percent of small employers indicated that the cost of insurance was too high for them to offer it to employees.

On the other hand, when their uninsured employees become sick, they are more likely to be absent from work longer, creating a burden to their employer and fellow employees. Frequent or prolonged absences for common untreated conditions such as asthma, diabetes, heart disease, allergies and flu can lead to terminations and the costs of recruiting, hiring and training new employees. Expanding Medicaid to adults aged 18 through 64 who are making marginal wages or working in part-time or seasonal positions is an effective way to assist small businesses and their employees alike.

Finally, we estimate that the Medicaid expansion would generate nearly 71,500 jobs in Texas in 2014, rising to 231,100 jobs in 2016, the first year of full implementation. Many of these jobs would be in health care, an industry that pays well and provides good job security and benefits, including health insurance, and wages would average $50,818 during the 2014–2017 period—the same as the statewide average for all industries.

Texas already has the highest rate of uninsured for adults aged 18 to 64 of any state—31 percent compared to a national average of 21 percent in 2011.45 If Texas does not expand Medicaid, and Wal-Mart and other companies implement their intended policies, the number of uninsured in Texas will grow as it shrinks in states that acted, leaving Texas still at the bottom and digging a deeper hole.

FINDINGS IN OTHER STATES

Recent studies in other states have also found that states can finance their share of the expansion using funds already spent on state and locally funded health care for adults and new revenues generated from the expansion. After further study and considering revised trends, several states besides Texas have also substantially reduced their estimates of the state funds required for the expansion.

Some governors that previously expressed opposition to the expansion have changed their minds. In particular, Arizona's governor, Jan Brewer, initially in opposition, has recently announced that she will support it as long as Arizona includes an automatic trigger reducing Medicaid optional coverage should the federal government reduce its match rate in the future, a concern expressed by several state governors.46 After reviewing a new study that identified sufficient existing revenue sources, New Mexico's governor, Susana Martinez, also announced her support for the expansion.

California. A recent study by the University of California at Berkeley and the University of California at Los Angeles on the California expansion found that increased state tax revenues and savings would largely offset additional spending. It also found that savings in other areas of the budget, including other state health programs, mental health services and state prisons due to the expansion ''would likely be more than enough to offset the $46 to $381 million in annual state General Fund spending for the newly eligible population through 2019.''

Florida. Florida has recently reduced its estimate of state costs from $26 billion to $5.066 billion over 10 years from 2013–14 to 2022–23, including costs for newly eligible adults ($1.767 billion), children who are currently eligible but not enrolled ($3.012 billion) and the cost of shifting, called ''crowd out,'' of currently insured individuals to Medicaid ($0.287 billion). The state now estimates that the expansion would generate $37 billion in federal funds over the ten-year period, of which about $30 billion is for newly eligible adults.

Ohio. Estimates just published by Ohio State University compare the state's match requirements with the net savings the state would receive from moving adults from state-funded programs to Medicaid over a nine-year period from 2014 through 2019, concluding that savings in these programs would provide 41.2 percent of the state match necessary for the expansion. The study estimated that the state would receive net savings of about $1 billion on:

Better match rate for medically needy adults of $709 million.

Breast and Cervical Cancer Program costs of $48 million.

Inpatient prison health care costs of $273 million.

In addition, the study pointed out that there would also be savings on non-Medicaid substance abuse treatment, family planning, pregnant women and other state health care programs for uninsured adults. The study identified other areas of savings as well, including reduced criminal justice costs due to better access to substance abuse treatment.

The study also found net increases in state revenue from taxes of $2,898 million on: managed care plans ($1.823 billion), general revenue ($857 million) from increased economic activity and increased drug rebates to the state from pharmaceutical companies ($218 million). The study estimates that the state will need about $2.5 billion for state match, which would leave a net state fiscal gain of $1.4 billion.

Wyoming. The Wyoming Department of Health issued a report in November 2012 that also looked for offsets to pay for the Medicaid expansion. The department found that ''participating in the optional expansion of the Medicaid program would result in a projected cost savings for the State General Fund throughout the first 6 years of the ACA implementation (fiscal years 2014–2020).''

OBJECTIONS TO MEDICAID EXPANSION

The ACA and the Medicaid expansion have raised concerns in Texas and some other states about its long-term costs for state and local budgets, as well as other concerns. Objections to expansion in Texas primarily revolve around three arguments:

Medicaid is ''socialized medicine'' like that practiced in western Europe and expanding it would spread it further;

The federal government should abandon Medicaid and move to a system of block grants to states, to provide them with more ''flexibility'' in meeting their citizens' health care needs; and

The added cost burden of expansion, despite extremely favorable federal matching rates, is too much for a program that has already overburdened the state financially.

Socialized medicine: Medicaid is not socialized medicine. Socialized medicine as practiced in Western Europe, and specifically Great Britain, is a system under which the government not only funds but also operates hospitals, hires health care providers and controls every aspect of health care. Medicaid does not do these things; patients and their health care providers make health care decisions. Medicaid in no way meets the definition of ''socialized medicine.''

Medicaid is a federal insurance program that matches state funding to provide health care to eligible, low-income citizens who cannot afford private health insurance. States receive federal matching funds and

administer the program under federal rules that limit eligibility to certain groups and services and that provide states with flexibility within certain eligibility and service requirements. Texas participates in many similar federal programs that require state matching funds, including transportation, historic preservation and homeland security programs, among others.

Block grants: Some Texas lawmakers suggest that Medicaid is a ''one-size-fits-all'' program that fails to meet the state's unique demographic and industry needs. They are petitioning the federal government to convert federal Medicaid funding to a block grant, with each state receiving a fixed amount to establish its own state-specific program that might or might not include all the features of the current program. Even for lawmakers who favor a block-grant approach, however, this argument should not affect the decision to extend Medicaid coverage under the ACA. In fact, lawmakers who favor a Medicaid block grant in particular should support extending Medicaid to low-income adults: the government typically bases block grants on historical funding levels, so maximizing federal funding now would better position Texas in the event of any future conversion to block grants.

Cost burdens: As noted above, state and local governments currently fund all of our expenditures for indigent care and in-patient hospital costs for eligible incarcerated individuals, while the state supplies 100 percent of funding for some adults served in state health care programs that would be eligible for Medicaid. These, combined with hospital charity costs, far exceed the amount Texas would be required to contribute to expand Medicaid. New revenue from insurance premium taxes and economic growth from the infusion of $100 billion in federal funds would provide additional revenue sources. Furthermore, opting out of the expansion will not reduce Texans' federal tax burden, nor will expanding Medicaid increase it.

Concerns that the federal government will not be able to maintain high match rates in the future are unlikely to become reality given that Congressional representatives and senators represent their states. To ensure against this event, however, Texas could build in an automatic ''trigger,'' such as Arizona is doing, to reduce Medicaid optional populations and services should Congress reduce the match rate in the future.

Governor Rick Perry has described extending Medicaid to low-income adults as ''adding more passengers to the Titanic.'' It would be closer to the case to say that failing to cover adults will doom them like those hapless travelers. Experience in other states indicates that the death rate would fall by 6.1 percent for adults under age 65 if the state expands Medicaid, preventing premature deaths of 5,700 Texas adults in each of the five years following the implementation year, or 28,500 Texans over five years. Previous studies also have found reductions of 5.1 percent in the child mortality rate and 8.5 percent in the infant mortality rate attributable to Medicaid coverage.

Such studies led one author from the Harvard study, Arnold M. Epstein, to conclude: Sometimes the political rhetoric is at odds with the evidence, such as claims that Medicaid is a 'broken program' or worse than no insurance at all; our findings suggest precisely the opposite.

CONCLUSION

Extending Medicaid to low-income adults will save tens of thousands of lives and improve millions more over the next decade and beyond. The jobs created will support hundreds of thousands of people and boost the economy. The additional tax revenue will benefit state and local governments and important public purposes such as education, infrastructure and public safety. Businesses will benefit from healthier employees and lower employer insurance costs.

State and local government and the state's hospitals collectively spend far more on piecemeal health care for low-income Texans than the state's expected match for the expansion. Expanding Medicaid would move thousands of people into managed care from these programs and significantly reduce the use of expensive emergency room treatment for routine care.

Without expanding Medicaid to adults, Texas will still have to find additional state match for many of the eligible but unenrolled children identified in this report—but without the benefit of the additional state funds that an expansion would free up and without the new revenues that the additional federal funding would generate.

The decision to expand Medicaid—or not—will affect the lives of millions of Texans for years into the future and is arguably one of the most important decisions that the Legislature has had to make in decades. If politics are set aside, the right decision is obvious.

Mr. HORSFORD. I thank the gentlelady from Texas. We stand with you and your colleagues here on the floor to continue to put pressure on leaders, not only in Texas but throughout the country, who do not see the value of expanding Medicaid.

I'm fortunate in Nevada—we have a Republican Governor, but he has agreed to provide the expansion for Medicaid, because he understands that in Nevada a third of our population is currently uninsured, and with the expansion of Medicaid that's going to make sure that fewer people turn up in the emergency rooms through uncompensated care, which all of us as taxpayers end up paying for.

So this is an issue where Republicans who understand the bottom line in terms of health care and cost can work together with us to implement good policy for the American people. We'll continue to work with Governors that have not seen the light, but we believe that this is a plan that will work very effectively.

Mr. Speaker, can I ask how much time we have remaining?

The SPEAKER pro tempore. The gentleman has 18 minutes.

Mr. HORSFORD. Thank you, Mr. Speaker.

At this time, I would like to turn to several of our new Members of the 113th Congress. I'm very pleased and honored to be serving with them. I've learned so much from all the Members here, but particularly have enjoyed getting to know the new Members of the Congressional Black Caucus. There are five new Members.

I would now like to recognize my good friend, the gentleman from New Jersey, the man with the great legacy, who's carrying on the legacy of the late Congressman Payne, Representative PAYNE, Jr., at this time.

Mr. PAYNE. Mr. Speaker, I thank the gentleman.

Let me first thank my colleagues, Congressman HORSFORD from Nevada and Congressman JEFFRIES of New York, for anchoring tonight's CBC's Special Order on eliminating health disparities.

I would also be remiss if I did not acknowledge our leader on health issues in the Congressional Black Caucus, Dr. CHRISTENSEN.

Mr. Speaker, I would also like to take the opportunity to acknowledge a young person on the floor, the gentlelady from Nevada, the young Miss Horsford, who is here tonight. This is truly unique quality time to spend with your daughter.

There are numerous factors that contribute to the growing health disparities in New Jersey's 10th District—poverty, environmental threats, inadequate access to health care, and educational inequities. These issues are so interconnected that a piecemeal approach to fixing them just will not work. A comprehensive approach that focuses on providing access to quality care to all, creating good jobs that provide a decent living and increasing educational opportunities for low-income communities, is the only way to eliminate health disparities once and for all.

Even in the 21st century, health disparities are stark, especially in the African American community, in which life expectancies are lower and infant mortality rates are higher. Children of color who live at or below the poverty line are much more likely to have asthma, develop ADHD and contract diseases because they cannot afford vaccinations.

So we have a moral obligation to eliminate health disparities. Our children and our future generations are depending on us. But narrowing the health disparities that exist is not only good for our Nation's health, it's good for our Nation's pocketbook.

Research tells us that access to quality health care could eliminate or reduce the onset of many chronic illnesses and disproportionate health outcomes that add to astronomical health care costs every year. Yet many of my colleagues won't rest until they repeal ObamaCare. The fact is, the Affordable Care Act will now provide health care to 9 million African Americans who are uninsured or underinsured. ObamaCare ensures that everyone has access to lifesaving care such as preventative cancer screenings, as well as coverage for children with preexisting conditions.

□ 2020

We know that ObamaCare's preventative services will help save lives and save money. So why are my Republican colleagues so set on repealing it? We have to protect ObamaCare just like we have to protect Medicare and Medicaid.

Sequestration is a direct attack on these already limited health resources. Sequestration is an irresponsible, across-the-board cut approach that will only contribute to the widening health disparity gap. Because of sequestration, Medicare has been cut by $11 billion; cancer patients are being turned

away from clinics, and they cannot get access to the life-saving treatments they need to live; millions in funding have been cut from community health centers.

Furthermore, the effects are very real for the people in New Jersey. In my State, nearly 4,000 fewer children will receive vaccines for diseases such as measles, mumps, rubella, tetanus, whooping cough, influenza, and hepatitis B. There will be millions in cuts to grants that would help prevent and treat substance abuse. New Jersey will lose nearly $4.9 million in environmental funding that ensures clean air and clean water.

We live in a first world country, and you want me to go back home and tell my constituents that we cannot provide them with clean water and clean air? This is absolute insanity.

And to make matters worse, the New Jersey State Department of Health and Senior Services will be forced to provide 19,000 fewer HIV tests to low-income communities. Sequestration is directly contributing to the spread of this fatal disease. In essence, it is providing a death sentence to those who are poor and who can't afford the testing.

So I say to my colleagues tonight: addressing health disparities in this country is both a moral obligation and a financial imperative. If we are going to truly eliminate disparities, we must start by eliminating sequestration, which does nothing but further the burden of our distressed citizens. Finally, we must maintain and strengthen our investments in health care access and resources for the disadvantaged populations that we serve.

In closing, just as Medicaid and Medicare and Social Security have become common threads and fibers of this great Nation, one day ObamaCare will be looked at in the same manner.

Mr. HORSFORD. Thank you very much to the gentleman from New Jersey.

I would like to now turn to the gentlelady from Ohio. She has come to Congress, providing great perspective as a member of the Financial Services Committee specifically, but also in her background of higher education and in her working on a number of these issues, one of which being the need to create a workforce that's trained and ready, particularly in the health care sector. I would like to yield to the gentlelady from Ohio, Congresswoman BEATTY.

Mrs. BEATTY. First, let me join my other colleagues in thanking my freshman class members, Mr. HORSFORD and Mr. JEFFRIES, for leading the Congressional Black Caucus' important discussion tonight on eliminating health disparities in America.

Tonight, you are hearing a lot of statistics because it is so important for us to let America know that low-income Americans, racial and ethnic minorities and other underserved populations often have a higher rate of disease and fewer treatment options and reduced access to health care. So you will hear facts tonight.

The facts are that African Americans have the highest rate of high blood pressure of all population groups and tend to develop it earlier in life; African Americans are twice as likely to have diabetes than Whites; African Americans are twice as likely to die from stroke than Whites; African Americans are more than twice as likely to die from prostate cancer than White men; and African American women younger than 40 years of age are more likely to develop breast cancer than White women; infants born to Black women are 1.5 to 3 times more likely to die than those born to women of other races or ethnicities; African Americans are estimated to be 44 percent of all new HIV infections despite representing only 13 percent of the U.S. population.

These disparities are shocking, and the Congressional Black Caucus will not let us ignore them. In 2009, health disparities cost the United States economy $82.2 billion. We have to continue to bring awareness to this issue within our communities and develop strategies to eliminate these disparities in a cost-effective way.

On March 23, 2010, President Obama signed the Affordable Care Act, which is a monumental step that helps us address these overwhelming statistics in health disparities within our communities. We now have in place comprehensive health care reform that improves access to affordable care and guarantees that millions of our most at-risk citizens will finally be able to receive care. By improving access to quality health care for all Americans, the Affordable Care Act actually reduces health disparities.

We share this information so citizens will know that this law invests in prevention and wellness, that it gives individuals and families more control over their own care, that it expands initiatives to increase racial and ethnic diversity in health care professionals by strengthening cultural competency training for all health providers, and that it improves communications between providers and patients.

As a lifelong health care advocate and as a stroke survivor and as an African American woman, I know the importance of protecting access to affordable health care coverage for all Americans, particularly for those who are most in need. We need to continue to move forward with this legislation and with initiatives that eliminate health disparities in America, and I look forward to continuing to work with all of my colleagues to improve our health care system. In order to have a successful Nation, we must have a healthy Nation. So this is my clarion call to all my colleagues—Democrats and Republicans—to help us make progress on this critical issue.

Mr. HORSFORD. I thank the gentlelady from Ohio.

At this time, I would like to turn to the gentleman from Texas, Congressman VEASEY, and I would like to thank him again for his hard work and contributions to this new 113th Congress.

Mr. VEASEY. Thank you.

I would also like to thank the gentleman from the Sagebrush State, STEVEN HORSFORD, and from the Empire State, HAKEEM JEFFRIES, for all of their work on this very important issue and also in talking about the importance of the Affordable Care Act and everything that it's going to bring to our country. I also want to talk about the health care crisis that is ongoing in America today.

Unfortunately, obesity and the long-term effects associated with this condition are all too prevalent in our country. When you look at the health statistics, it's quite astounding to say the least. Today in America, nearly two-thirds of adults and one in three children are overweight. In my own home State of Texas, we have one of the highest obesity rates in the country. According to the Centers for Disease Control and Prevention, 30 percent or more of Texans are obese.

The high obesity rate has contributed to the pervasiveness of diabetes, heart disease, and other chronic diseases that drain resources from our health care system. Increases in food intake, a lack of physical activity, and environments that make nutritious choices more difficult have all played a role in this obesity epidemic.

Many children and adults do not have much control over the choices of foods they are able to get. Across this country, we are laden with food deserts or places where residents may not be able to get to a nutritious food option because they do not own a car or have access to public transportation, or maybe they don't live along walkable roads. This forces families to outsource their daily eating to more accessible and sometimes cheaper alternatives, such as fast food, to get their daily nutrients. A steady diet with high fat, salt and sugar-based products has led to unhealthy lifestyles.

Diabetes is one of the more commonly known effects of being overweight or obese.

□ 2030

The disease affects 25.8 million Americans, roughly 8 percent of our population. The effects and complications of diabetes can include stroke, high blood pressure, blindness, kidney disease, and amputations.

Studies have shown that people with prediabetes who lose weight or increase their physical activity can prevent or delay type 2 diabetes and in some cases even return their blood glucose levels to normal.

Each of these statistics is more exacerbated when you look specifically at the minority population in our country such as Latinos and African Americans and our special-needs population.

When you break down obesity by race, African Americans have the highest rates of obesity at roughly over 35

percent; Latinos, a little over 28 percent as compared to the non-Hispanic White population of 23.7 percent. Individuals with disabilities also have higher rates of obesity at 31.2 percent. This is why I introduced House Resolution 195 designating May as Health and Fitness Month.

We need to correct our course as a country and get on the path to healthier lifestyles. The numbers are clear. We cannot sustain this unhealthy path we are on. Not only is it cutting the lives of too many Americans short, but it's also costing our country. In 2008, medical costs associated with diabetes were estimated to be at $147 billion. The medical costs for people who were obese were over $1,400 higher than those of normal weight.

We need to show our children that we can make healthy, nutritious choices and increase our physical activity. We must also not forget that this must be spread throughout all aspects of our population. While tremendous resources have been employed to help combat the growing obesity epidemic amongst children, markedly fewer have been used to address specific issues regarding how to best help obese children with disabilities.

So, today, let's declare a more nutritious and healthy lifestyle with better food choices and more active lives.

Mr. HORSFORD, thank you very much.

Mr. HORSFORD. I thank the gentleman from Texas.

I know we are wrapping up on our hour, Mr. Speaker.

I'd like to recognize the co-anchor for this hour, my good friend and colleague from New York (Mr. JEFFRIES), who will provide a bit of a synopsis.

Mr. JEFFRIES. Thank you, Mr. HORSFORD, for once again co-anchoring this Special Order and for your tremendous leadership, and also thanks to Dr. CHRISTENSEN. We are thankful for all that you have done in chairing the CBC Brain Trust on Health Care.

The Affordable Care Act is the law of the land; the President has been elected and reelected; the Supreme Court has ruled it constitutional. Let's move forward and address the health care disparities that have been set forth so eloquently here today, come together and deal with the ailments that are facing the American people.

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

The SPEAKER pro tempore (Mr. DESANTIS). Members are reminded not to refer to persons on the floor as guests of the House.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today to recognize the contributions of the Affordable Care Act to eliminating health disparities. Health disparities refer to the unequal health outcomes, ability to access health care, and rates of disease that impact certain Americans based on their income, race, ethnicity, or other identities. These disparities not only have devastating impacts on communities of color in my district, but they undermine health in historically marginalized communities across the Nation.

The disparities are staggering. For instance, in 2006, the infants of African American women had death rates over twice as high as infants of white American women. In 2009, the average American could expect to live 78.5 years, but the average African American could only expect to live to 74.5 years. African Americans also have significantly higher rates of hypertension and HIV than white Americans.

The impacts are financial as well as human. Eliminating health disparities would prevent approximately one million hospital stays per year, saving $6.7 billion in health care costs alone. Even more stunning, from 2003 to 2006, the direct and indirect costs of racial and ethnic health disparities totaled $1.24 trillion in the United States.

Insurance coverage is strongly related to better health outcomes, and African Americans have substantially higher uninsured rates than white Americans. Beginning in 2014, the Affordable Care Act will expand health insurance coverage to millions of Americans who are currently uninsured, and will provide subsidies to make coverage affordable for low-income Americans. The Affordable Care Act will mandate that Medicare and some private insurance plans cover essential preventive services at no additional cost, so that more people will be able to prevent illness and stay healthy.

The Affordable Care Act invests in community health centers, which offer primary health care to patients regardless of income, and in coordinated care measures, such as providing care teams to help patients manage chronic diseases and funding home visits for pregnant mothers and infants. Patients may be more likely to visit the doctor and receive quality care if physicians are able to understand their cultural background, so the Affordable Care Act also devotes resources to increasing the racial and ethnic diversity of health care providers and improving cultural competency training for all providers.

These are just some of the important ways in which the Affordable Care Act is working to eliminate health disparities. I look forward to collaborating with my colleagues to support the successful implementation of the Affordable Care Act and eliminate health disparities for future generations.

CURRENT EVENTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2013, the gentleman from Texas (Mr. GOHMERT) is recognized for 60 minutes as the designee of the majority leader.

Mr. GOHMERT. Mr. Speaker, it's always an honor to come to the floor of the House of Representatives, especially when there's so much of great importance occurring in our Nation at this time.

We do need health care reform, and I appreciate my friends across the aisle talking about the importance of good health care.

I've continued to hear people find that they are going to lose their health insurance. I was talking to numerous employers this past week who say, I want to compete and have been notified insurance is going up higher next year. I heard from a small business employer, I'm not going to be able to carry insurance. I love my employees. I provide them good insurance. But come January, too many of my competitors have said they can't afford to keep the insurance for their employees, and so they're going to drop it and pay the $2,000 fine because $2,000 is so much cheaper than the cost of health insurance.

The reason we were told for pushing through the ObamaCare bill in a very partisan way was because there were 30 million or so who did not have insurance; and as some have indicated, there may be that many who lose their insurance as a result of ObamaCare. So I'm very concerned.

I, like my friends across the aisle, want to make sure not that people have insurance necessarily, but that they have affordable health care. And I'm hearing from health care providers that they're hearing from people who are no longer going to carry insurance for their employees, that it's going to be more and more expensive to provide health care since they made money off those who had insurance; and without people having the insurance they had in the past, as the President promised and has been made very clear was not true, there will be more pressure on those who are paying for their health care to pay substantially more, which means there are more people who will not be able to afford it, and it will break the system. Of course, with health insurance companies complaining that because of the things they're forced to cover, their insurance is going to necessarily have to go up.

There will likely be insurance companies that will have to give up the health insurance business, and then the administration can complain that, Well, we thought we were going to be able to work with the greedy health insurance companies; but as it turns out, they've gone out of business and doctors have abandoned their practices and retired early. So it looks like the government is going to have to take over the health care business.

Under ObamaCare, the Federal Government is already going to have everybody's health records. Their most private and personal secrets between them and their health care provider will then be available to the Federal Government and, as I understand it, to General Electric, who this administration, because of their great support of General Electric in this administration and their cozy working relationship, they'll have the contract to take care of everybody's health care records. So that will be just delightful.

The tragic thing, just as the one lady asked during the town hall that the President had at the White House when she asked about her elderly mother getting a pacemaker, though she was of late years—I believe 95—and that she's had the pacemaker for 10 or 11 years, would the panel that decided who would get what treatment, would they consider the quality of life of an individual in determining whether or not