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TIMELINE OF LEGISLATIVE ACCOMPLISMENTS

1985	• You cosponsored the Maternal and Child Health Preventative Care Amendments of 1985, and a related bill, which provided pregnant women enrolled in Medicaid with pregnancy related services. • You cosponsored a bill to improve access to mental health services in rural health clinics.
1986	• You cosponsored the Medicare Quality Protection Act to improve the flawed Medicare physician payment system; a prelude to later efforts.
1987	• You joined the Senate Finance Committee and also joined the Subcommittee on Health. • You cosponsored the Medicare Catastrophic Loss Prevention Act of 1987 to require that Medicare cover long-term hospital stays and extended care services.
1988	• Debate began over Medicare Catastrophic Coverage Act of 1988, which passed into law with your vote. • You cosponsored the Medicaid Infant Mortality Amendments which would have increased coverage for pregnant women and children under

	• You cosponsored the Long-Term Care Assistance Act to help people with dementia who needed assistance with activities of daily living. Although this bill did not become law, its contents were the subject of Finance Committee hearings in 1988 and 1989.
1989	• You became chairman of the Finance Committee's Subcommittee on Medicare and Long-Term Care. • You joined the Finance Committee's Subcommittee on Health for Families and the Uninsured. • **November**- Congress repealed the Medicare Catastrophic Coverage Act of 1988 but upheld the provision of the law creating a commission to study long-term care and health reform, which would come to be known as the Pepper Commission. • You were elected chairman by your fellow Commissioners of the new Pepper Commission. • You authored the Medicare Physician Payment Reform Act to adjust Medicare payments based on the value of the work, overhead, malpractice risks associated with each physician. After intense negotiations, this legislation was passed in to law during Reconciliation.

	• You authored a bill that provided Medicare reimbursement for services performed by psychologists. The enactment of this legislation was a major victory for mental health access as well as one of your first major accomplishments in the health care space. • You authored the Rural Health Clinic Improvement Act to help entities seeking certification as rural health clinics and inform rural residents about the services provided by these clinics. • You introduced (and twice brought before the Finance Committee) the Medicaid Home and Community Care Options Act so that Medicaid would cover home and community care for dual eligibles. • You cosponsored the Medicaid Children's Health Improvement Act of 1989 to increase the number of children under age 7 eligible for Medicaid.
1990	• **September-** The Pepper Commission published its report on the need for long-term care and health reform. • You authored the Better Health Protection for Mothers and Children Act to require states to extend Medicaid coverage to all children under age 19 and eliminate asset testing in Medicaid for

	pregnant women and children. • You cosponsored three measures--the Medicaid Child Health Act, the Children's Health Access and Prevention Act, and the Primary Pediatric Outreach and Care for Disadvantaged Children Act —which would have otherwise improved coverage of low-income children (including foster children) and pregnant women.
1991	• You founded the Alliance for Health Reform, a nonprofit group which provides thoughtful, nonpartisan background on current health reform issues for policymakers. • You and Congressman Waxman introduced the Pepper Commission Health Care Access and Reform Act to provide universal access to health insurance for basic health services for all. • You introduced the Medicare Physician Payment Reform Implementation Act to further adjust the physician payment schedule in Medicare. • You authored the Medicare Cancer Coverage Improvement Act which would to improve Medicare coverage of cancer treatments. • You cosponsored the Long-Term Care Insurance Consumer Protection Act which would have created Federal consumer protections for

	purchasers of long-term care insurance policies.
1992	• You cosponsored the Rural Health Care Protection and Improvement Act to increase rural access to both general health and mental health services.
1993	• You began your efforts with the White House in developing the Clinton Health Care reform package and served as a critical advisor for the administration's bold legislation. • You authored the Primary Care Workforce Act to prioritize the development of primary care providers. You included a similar provision in the Clinton health reform plan. • You authored the Medicaid Nurse Midwives Bill to expand Medicaid coverage for services provided by nurse midwives. • You re-introduced your Medicare Cancer Coverage Improvement Act. • **January 25, 1993** - President Clinton names wife Hillary as head of task force on health care reform. • **September 23, 1993** - Health care reform proposal presented to Congress. • **October 27, 1993**- You go on NewsHour to

	discuss Clinton's health reform plan. • **November 3, 1993**- Finance Hearing held about Health Reform
1994	• **Sept. 1994** - Clinton health care reform plan voted down by Congress.
1995	• You became a ranking member in the Finance Committee's Medicare, Long-Term Care and Health Insurance Subcommittee. • You joined the Finance Committee's subcommittee on Medicaid and Health Care for Low-Income Families. • You introduced the Medicare Commission Act which established the National Commission on the Long-Term Solvency of the Medicare program to provide analyses of recommendations with respect to the current and long term financial condition of the Medicare trust funds. • You cosponsored the Family Health Insurance Protection Act which would have prohibited health plans from denying coverage based on pre-existing conditions, a prelude to the Affordable Care Act.
1996	• You played a vital role in the passage of the Health Insurance Portability and Accountability Act (HIPAA) which created key patient privacy

	protections and improved the portability of health coverage, a prelude to even greater protections in the Affordable Care Act. • You authored an amendment to require 12-month continuous eligibility for Medicaid coverage, similar to the Medicaid and CHIP Continuous Quality Act you would introduce in 2013, to prohibit people from churning in and out of coverage due to small fluctuations in income.
1997	• **August**: You were the primary author of the Children's Health Insurance Program and fought to make sure it was included in the Balanced Budget legislation when signed into law by President Clinton. • You authored an amendment to the Balanced Budget Act of 1997 to extend premium protection for low-income Medicare beneficiaries. • You authored an amendment to a budget resolution protecting the Medicare Health Insurance Trust fund from cuts. • You and Senator Frist introduced the Provider Sponsored Organization Act to give Medicare beneficiaries greater choice in Medicare plans. While this bill did not pass out of the Finance Committee, hearings were held on the topic.

	• You cosponsored a bill to increase the excise taxes on tobacco products. The enactment of this bill in to law, was yet another major victory for fully funding the Children's Health Insurance Program and made certain it immediately fulfilled its promise to America's children. • You cosponsored the Medigap Portability Act to ban exclusions for preexisting conditions and waiting periods for eligible Medicare beneficiaries.
1998	• You authored an amendment to the Balanced Budget Act of 1997, which would have require balanced billing protections in Medicare. • You cosponsored the Healthy Kids Act which was aimed at curbing tobacco use by children and also offered states bonus payments for increasing enrollment of children in Medicaid.
1999	• You authored the Advance Planning and Compassionate Care Act to develop outcome standards and measures to evaluate and improve end of life care. • You cosponsored the Immigrant Children's Health Improvement Act of 1999 to give States the option to extend Medicaid or CHIP eligibility to certain lawful resident alien pregnant women and children. It did not pass this year, but ultimately became

	law.
2000	• You fought to pass the Balanced Budget Act which restored more than $2 billion in funding to rural health providers. • You authored the MediKids Health Insurance Act which would have guaranteed access to health coverage for every child born in the United States after 2001 whose parents had no other means of obtaining coverage for them. • You introduced the Medicare Early Access and Tax Credit Act which would have allowed beneficiaries not yet 65 to buy into the program. • You cosponsored the State Children's Health Insurance Program (SCHIP) Preservation Act which would have required amounts allotted to a state for FY 1998 and 1999 to remain available through FY 2001. • You cosponsored an amendment which would have amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage. This legislation is also reflective of your concern for consumers, and was a precursor to your Medical Loss Ratio (MLR) legislation in the ACA and the newly introduced

	Medicaid MLR bill.
2001	• You introduced the Rural Health Care Improvement Act of 2001 which would have corrected the disparity between Medicare payments to hospitals in rural areas in order to secure equal treatment for all Medicare recipients. • You authored a bill which would have amended the Economic Growth and Tax Relief Reconciliation Act of 2001 to delay the reduction of the top income tax rate individuals until a real Medicare prescription drug benefit is enacted. • You introduced the Medicare Remote Monitoring Services Coverage Act which would have increased access to new technologies that would have collected, analyzed, and transmitted clinical health information in order to give doctors better information on the patient's condition. • You cosponsored an amendment to the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act which provides for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits. This amendment passed via voice vote. • You received the distinguished Jimmy and

	Rosalyn Carter Award for Humanitarian Contributions to the Health of Humankind.
2002	• You successfully led a bill to temporarily increase the Federal Medical Assistance Percentage for the Medicaid program. • You fought to extend the availability of allotments for FY 1998 through 2001 under the State Children's Health Insurance Program (SCHIP). • You authored the Children's Health Improvement and Protection Act which would have modified the rules for redistribution and extended availability of FY2000 and subsequent fiscal year funding under the Children's Health Insurance Program. • You introduced the Medicare Incentive Payment Program Act (MIPPRA) to provide physicians providing primary care services a bonus if they served in a federally designated health professional shortage area. • You introduced the First Step to Long-Term Care Act which would have improved access to long-term care services under the Medicare and Medicaid programs. • You introduced legislation to reauthorize the Rural Hospital Flexibility Grant Program (Flex grant) which would have helped rural hospitals to qualify

	as a Critical Access Hospital and receive better reimbursements under Medicare and Medicaid. • You authored the Consumer Access to Prescription Drugs Improvement Act.
2003	• **August**- the Senate unanimously passed your bill to preserve $2.7 billion in funding for CHIP**.** • You authored a bill which extended the availability of state funding for fiscal years 1998 through 2001 under the Children's Health Insurance Program. This passed the Senate; however, the House version became law. • You announced that the Senate Committee on Finance approved the Family Opportunity Act which extends Medicaid services to West Virginia families with disabled children who meet federal criteria for disability coverage. • You fought for and passed legislation to provide states with financial assistance with the Federal Assistance Medical Percentage (FMAP) in order to avoid future cuts to Medicaid by offering $20 billion to states with $125 million going to West Virginia. FMAP is the program that provides federal funds to Medicaid, and increased funding would keep states like West Virginia from cutting money from essential health care program to balance their budgets.

	• You introduced an amendment to the Medicare Prescription Drug Improvement, and Modernization Act to move dual eligibles into the new Medicare drug benefit. While this was ultimately successful, it had the unintended consequence of higher prices for these drugs.
2004	• You authored the Children's Health Protection and Improvement Act which would have extended the period of time states had access to their unused CHIP funds and distributed funds to states in dire need to additional funding. • You introduced legislation, the State Fiscal Relief Act of 2004 which provided $6 billion in temporary fiscal relief to states facing ongoing budget crises.
2005	• You supported a successful Senate Budget amendment which restored the $15 billion in Medicaid cuts proposed for next five years. • You announced that $4 million in redistributed CHIP funding would be made available to West Virginia to increase health care coverage for children throughout the state. • You shared your expertise on Medicaid during annual National Governors Meeting where you urged Governors to stand together to prevent cuts

	to Medicaid. • You introduced the Medicare Dual Eligible Coverage Act which would have given dual-eligible consumers time and resources to transition to Medicare prescription drug coverage and would have required states to continue to provide Medicaid medical assistance for prescription drugs if coordination requirements had not been enacted.
2006	• You introduced the Keep Children Covered Act of 2006 which would have eliminated funding shortfalls for the State Children's Health Insurance Program. • You authored a bill to amend the Federal Food, Drug, and Cosmetic Act which would have prohibited the marketing of authorized generic drugs.
2007	• You fought to secure a 15-month extension for the CHIP and to extend a number of Medicare services important to West Virginians. • You introduced the Keep Children Covered Act which would have eliminated funding shortfalls for the CHIP program in certain state for FY2007. • You introduced the Preexisting Condition Exclusion Patient Protection Act which was similar

	to past attempts to protect consumers from exclusion for health care based on pre-existing conditions; this applied to both individual and group markets.
2008	• You cosponsored the Paul Wellstone Mental Health Parity Law which passed in to law and helped 735,000 West Virginians get greater access to affordable mental health care paid by their insurance plans. • You introduced the Economic Recovery in Health Care Act of 2008, which would have implemented a one year moratorium on proposed regulatory changes to Medicaid and CHIP and provide states in need with federal relief.
2009	• You secured an improvement and extension of CHIP that undid several harmful provisions that President Bush enacted during his presidency. • You authored the Affordable Access to Prescription Medications Act which, if it had not failed to pass Finance Committee, would have improved prescription drug coverage under Medicare part D and improved prescription drug coverage under private health insurance. • You offered an amendment which would have

	created a permanent fix for the doughnut hole in Medicare prescription drug coverage, and would have enhanced access to affordable prescription coverage. Similar legislation was included in the Affordable Care Act. • **March 10, 2009-** Finance Committee Hearing: The President's Fiscal Year 2010 Health Care Proposals. • **Sept. 16, 2009-** Baucus released his Chairman's Mark of the Finance Committee health care reform bill, The America's Healthy Future Act, for the American people and members of Congress to review • **Sept. 22, 2009-** Baucus released his Modified Chairman's Mark of the America's Healthy Future Act, which incorporated a number of amendments submitted by you and other Finance Committee Members on both sides of the aisle. • **Sept. 22 to Oct. 13, 2009**- Seven Day markup of the Finance Health Reform legislation. This was the longest markup in 22 years. On the final day, the Committee passed the legislation. • **December 24, 2009-** The Full Senate passed the merged Finance and Health, Labor and Pension Committees version of health reform legislation

	called The Patient Protection and Affordable Care Act. • **March 21, 2010-** The House passed the Patient Protection and Affordable Care Act . • **March 23, 2010**- President Obama signs the ACA in to law. This is nearly twenty years after the last major health reform effort during the Clinton Administration and contained many of your hard-fought beneficiary protections. • **<u>THE FOLLOWING ARE KEY PROVISIONS IN THE ACA AUTHORED BY YOU:</u>** • You authored the Fairness in Health Insurance Act which requires all health insurers to spend at least 90 percent of premium dollars on actual medical care. • You authored the Informed Consumer Choices in Health Care Act which helps consumers obtain the information they need to make informed choices about health insurance coverage. • You authored the Annual and Lifetime Health Care Limit Elimination Act which prohibits insurers from imposing annual or lifetime limits as part of any individual or group health insurance policy.

	• You authored the Pre-existing Condition Patient Protection Act which eliminates the ability of insurance companies to deny or drop coverage based on pre-existing conditions. • You introduced the National Health Care Quality Act which improves the Federal infrastructure for health care quality improvement in the United States. • You authored and successfully passed an amendment in the Senate Finance Committee to preserve CHIP in health care reform and also secured language in the final bill passed by the senate to extend full federal funding for CHIP through fiscal year 2015.
2010	• You authored a bill which would have extended the increase in the FMAP provided in the American Recovery and Reinvestment Act of 2009 for an additional 6 months.
2011	• You vowed to fight against any Republican effort to end health care coverage for CHIP and sent a letter to Senator Hatch addressing the possible impact on children and other Medicaid recipients. • You introduced the Prescription Drug Abuse Prevention and Treatment Act which would have amended the Public Health Service Act to award grants to states and nonprofit entities for consumer education about opioid abuse. Unfortunately, this

	did not pass out of the Health, Labor and Pensions Committee. • **July:** You reintroduced the Medicare Drug Savings Act which would have amended part D of voluntary Prescription Drug Benefit Program in Medicare to require drug manufacturers to pay the Secretary of Health and Human Services drug rebates for rebate eligible (low-income) individuals. Although this did not gain traction, you reintroduced it in both the 112th and 113th Congress. • Despite your tireless efforts to protect any remaining long-term care legislation, the House Energy and Commerce Committee passed a Republican bill to repeal the CLASS Act during budget negotiations.
2012	• You urged HHS to overhaul a Duals Demonstration project on Care over Costs. • You cosponsored, and played a pivotal role in authoring the Medicare Diabetes Prevention Act which would have amended Medicare to cover items and services furnished under a diabetes prevention program to an eligible individual. • You supported funding to enable solutions such as the Prescription Drug Monitoring Project to help end prescription drug abuse in West Virginia.
2013	• You authored the Medicaid Managed Care

	Responsibility and Equity Act which, if enacted, will apply Medical Loss Ratio requirements to Medicaid and CHIP. Given the rising use of managed care in Medicaid, this is of great importance to you and you feel that it will provide greater protection to low-income beneficiaries. • Although the CLASS Act was repealed in 2011, Congress retained a provision that created a Commission to once again study the long-term care needs in the United States. The bipartisan commission released a disappointing and lackluster report, which you thought fell short of the Commission's assignment. After the initial release, several members of the Commission, including Judy Feder, issued an alternative report which outlined a path forward in greater detail. You wholeheartedly endorsed this plan. • You authored the Health Care Coverage for Displaced Workers Act which would have amended the Internal Revenue Code, with respect to the tax credit for the health insurance coverage costs of certain taxpayers, pension and trade adjustment assistance recipients and their dependents.
2014	• You authored the Medicaid and CHIP and Continuous Quality Act which would amend Medicaid to require a state Medicaid plan to

	provide a 12 month continuous enrollment for an eligible individual, regardless of age. • You assisted West Virginians and sought answers from federal and state agencies about the long term public health effects from West Virginia Chemical spill.

MEMO OVERVIEW

The pages that follow tell the story your service to West Virginia in the United States Senate over the past nearly thirty years, and how your work has not only fundamentally changed the lives of both residents of the state, but the lives of all Americans. This memo will discuss both your successes and failures as we attempt to paint an accurate picture of your impact on health policy over the past three decades.

In an effort to recap the most accurate version of your legislative accomplishments, we interviewed many of your former staffers. In addition to their memories, the stories in this memo are taken from archived memos, letters and newspaper articles.

INTRODUCTION

Ever since you came to West Virginia as a VISTA volunteer, one of your central concerns has been the health and well-being of the residents of West Virginia. Without question, you are regarded as a leader in community health and health reform. Your reputation and incredible legacy is well-deserved- you have authored legislation ranging from mine safety to creating a children's health insurance program that has served to decrease the rate of uninsured children exponentially. Your involvement in the health reform debate dating back to the late 1980's has fundamentally shaped the discourse and outcomes of America's health care system.

Your early experiences in Emmons, witnessing the limited access to quality health care compounded by poverty and rural spaces has placed expanding access to health care at the heart of your public service career. You have successfully fought for access to health care for the nation's poorest citizens, children, seniors, families, the disabled, and – through your extensive involvement in health care reform – all Americans.

When you first arrived in the United States Senate with the Class of 1984, you spent your first years in office learning "the system", establishing relationships, and doing committee work. Unlike many of your peers from 1984, such as Senators Gore or Harkin, who immediately sought out high visibility, you invested your time in learning the issues and identifying the ways in which you could

forge a path forward.

Your effort paid off, and by the time you reached your first re-election cycle you were well respected by Senate Leadership and were appointed Chairman of the Senate Finance Subcommittee on Medicare and Long-term Care (now known as the Subcommittee on Health), and the Pepper Commission. Both of those Chairmanships would allow you to tackle some of the most complex health care issues facing our nation and secure your legacy as one of the more effective health care leaders in our nation's history.

Your hard work and diligence was not the singular factor in your success in affecting change in health policy; many leaders have worked hard in order to have their vision of change come to fruition. What has set you apart in your time in Congress is your commitment to pursue legislation that, while not glamorous or often high profile, focused on the people of this country and, more importantly to you, the people of West Virginia whose well-being was often discounted or disregarded. You did not just fight for reform; you fought for dignity and for creating a healthier future. Your genuine commitment to low-income Americans has, and will be your lasting legacy.

BATTLE FOR LONG-TERM CARE

Since you first came to the Senate, you have worked tirelessly to address long-term care. While these services will be needed by just about every family—whether for family members with physical or mental disabilities or even just the infirmities associated with age— they are financially out-of-reach for most families and Medicaid has been forced to serve as the long-term care program by default.

To my colleagues in Congress – we can no longer skirt our responsibility when it comes to addressing the problems of our long-term care system. The fact remains that we've got an aging population and millions of others who rely on long-term care, but a system that is inaccessible and unaffordable. We have a moral obligation to make sure that all people who need access to good, quality health care and supports can obtain the services they need that are both affordable and sustainable.

– September 13, 2013

You understood that the vast majority of Americans had life-threatening gaps in their health insurance coverage, and even more citizens lacked coverage for end of life care entirely. It was only the most privileged in America who had access to the type of health insurance necessary to support an individual or family during a medical crisis; and even fewer who could afford the costs associated with hospice, skilled nursing facilities and long-term hospital stays. As you famously said at one meeting, "You shouldn't have to be a Rockefeller to get these services."

With the impending retirement of the baby-boom generation poses, the long-term care challenge only looms larger.

By the year 2030, there will be 72 million people aged 65 years or older in America - more than twice the number today - with those aged 85 years and older becoming the fastest growing segment of the population. Most of these individuals will lack the retirement and income security necessary to meet their long-term care needs and could face impoverishment instead of the dignity and peace of mind they have worked for their entire lives.

Medicare Catastrophic Loss Prevention Act :

Your first major foray into long-term care legislation in the Senate was when you joined with Senator Bentsen and cosponsored catastrophic care legislation in 1987. In the 1980's and to this day, many Medicare beneficiaries had to rely on Medi-gap policies to cover specific services, which created a piece-meal policy for elderly health coverage. Additionally, the Medicare program did not, and still does not, offer long-term care coverage; placing seniors in a precarious financial and emotional position. The public had become increasingly aware of the various costs associated with long-term and acute care. Due in part to growing public awareness and increasing costs to the federal government; long-term care reform emerged as a hot-button issue. The Secretary of Health and Human Services, Otis Bowen publically proposed the expansion of Medicare to cover long-term and acute illness through public and private sector collaboration. Congress reacted to the proposal coming from the Reagan Administration and a series of long-term care bills were authored, including

Senator Bentsen's proposal. There was initial hesitation as to whether or not you should sign-on to this legislation. You and your staff were hesitant to support Senator Bentsen because there was a sense that senior citizens would feel that the onus of long-term care expenses were unfairly placed on their shoulders and the improvements in this bill were very complicated and made it seem that once again, action on catastrophic care was being deferred. Secondly, Medi-gap policies already covered many of the areas addressed in the Bentsen bill, and it did not augment long-term care insurance to avoid the "spending down" phenomenon experienced by seniors in order to qualify for Medicaid. Finally, one of the major concerns-which was ultimately valid- was rooted in the financing scheme. Given that the financing system was new, there was limited feedback from seniors about the pay-for. Although progressive, it presented new costs for seniors on Medicare.

The Finance Committee scheduled a hearing regarding Bentsen's bill and Bowen's catastrophic care coverage in the spring of 1987. The hearing examined the several options facing the options for addressing the immense financial burden on the Medicare population.

Ultimately you decided that Senator Bentsen's bill offered improvements to Medicare coverage and was a starting point for protecting the elderly from immense health costs incurred by serious health issues. In particular, the legislation aimed to limit the financial burden on Medicare beneficiaries who:

- were in the hospital for an extended period of time;

- needed care in a skilled nursing facility for more than 100 days; or

- needed more than 210 days of hospice or 21 days of home health care.

The legislation also created a study to examine ways Medicare might cover prescription drugs as well as mandatory annual benefit notification to make sure beneficiaries understood what the program covered and what it did not. Under the legislation, beneficiaries would pay a small additional premium and have some cost-sharing obligations for the new services.

The version of The Medicare Catastrophic Loss Prevention Act introduced by Senator Bentsen was permanently postponed by Unanimous Consent in October of 1987. However, in May of 1988, Representative Stark introduced the *Medicare Catastrophic Coverage Act of 1988* in May of 1987. The bill greatly expanded Medicare benefits, specifically in terms of prescription drug benefits. However, it did little in the catastrophic long-term care arena; much like efforts before it. In addition, similar to both Bentsen's bill and Secretary Bowen's, the cost of the new benefits was placed solely on Medicare Beneficiaries.

Representative Stark's legislation was signed in to law, and was applauded by both Democrats and Republicans. However, there was a very serious backlash by seniors and Medicare beneficiaries. At the time, Jimmy Roosevelt's group, the *National Committee to Preserve Social Security and Medicare*, was a brand new organization and trying to make a name for itself. As a

means to gain much needed political clout, the Jimmy Roosevelt decided to orchestrate the attack against the Medicare Catastrophic Coverage Act. He catalyzed a postcard campaign targeted at instilling a sense of fear in seniors based on false accusations they would be paying more and have detrimental changes to their health care.

In order to counter the misunderstanding of the law, you and senior AARP officials made several trips to West Virginia in an effort to educate seniors about the realities of the law. The famous image from this period of time was enraged senior citizens blocking Ways and Means Chairman Don Rostenkowski's car. Fortunately, backlash against the catastrophic coverage legislation was considerably less in West Virginia than elsewhere given the low-income protections included in the law.

Congress and the Administration repealed the act in 1989 based on controversy over funding and widespread concern about who would bear the onus of the cost for catastrophic coverage. You were upset by the willingness of a greater number of your colleagues to repeal sections of the law, you cautioned that: "If we repeal benefits, we are ... looking at a backlash of incredible proportion from older Americans who need the coverage". However, during the process of repealing the law, sections were maintained, specifically the section calling for the creation of a commission on long-term care. In many ways, these questions then formed the basis of the discussion by the bipartisan Pepper Commission and highlighted the need to carefully consider how to finance of long-term care.

The Pepper Commission[1]

The U.S. Bipartisan Commission on Comprehensive Health Care, also known as the Pepper Commission, emerged from the failed efforts of Congress to create legislation for catastrophic insurance coverage under Medicare. Although the legislation that created the Commission, the *Medicare Catastrophic Coverage Act of 1988*, was repealed, the Commission was created through one of the provisions of the law that Congress chose not to repeal. The Commission's charge was to develop legislation that would provide Americans with comprehensive health and long-term care coverage. While the commission was initially led by Representative Claude Pepper (FL), you assumed the Chairmanship when Congressman Pepper passed away in March, only a few months after the Commission's creation.

Your colleagues in the Senate were dismayed and concerned with Senator Pepper's death. Senator Pepper's death left the Commission's Chairmanship open, and at the time, nobody wanted to assume the highly controversial position of leading a commission on health reform. In fact, Tamara thought it was too risky and controversial for you as a new senator, and advised you against taking on the role. Tamara's concerns were realized when Senator Mitchell approached you to take on the role. Technically, Senator Mitchell was the next in line in terms of leadership on the Commission. However, he wanted to give you his seat for several reasons: he had just assumed the position of Senate Majority Leader, he felt that as a Junior Senator you did not have the "baggage" that the other members on the

[1] Judy Feder reviewed and contributed greatly to this section.

Commission had, and you could serve as an open-minded, objective chairman.

When Senator Mitchell first offered you the Chairmanship, you asked for time to consider your answer- much of your hesitation was based on the controversy surrounding the position. As a member of the Finance Committee, you had already begun to tackle health care issues, beginning with Medicare Physician Payment Reform. But coverage had long been a contentious political issue, and many members were reluctant to bear its potential political risks. Ultimately, you decided chairing the Commission would build on your already significant accomplishments and that deliberately taking on the challenges of our health care system would help not only the nation in general, but West Virginians in particular. You saw an enormous need for access to health care and for long-term care in West Virginia. Your choice to take this powerful first step in to health reform policy was not an accident, but driven by your desire to improve the lives of West Virginians. When you formally accepted the Chairmanship you were quoted by PR Newswire:

> "I am honored that I have been chosen to chair this vital commission," said Rockefeller. "Health care has long been one of my priorities, and this position will enable me to continue my fight for quality health care. "There is no one who can actually fill Claude Pepper's shoes," the senator added. "All I or anyone else can hope to do is to make some fraction of the contribution he made to our society and to responding to the health care needs of all Americans."
>
> \- June 15, 1989

As Chair of the Commission you set the tone early-on in order to guide the conversation for the next several months. Your critical message was commitment to action- even if it was not one's personal first choice; the second option should not be inaction. The Press and your colleagues took notice of your awareness and commitment to health reform. In fact, Washington Dateline noted:

> "… many members of Congress seem to have no inkling that there is a crisis in obtaining health insurance and that it is growing. An exception is Sen. John D. Rockefeller, D-W.Va., chairman of a congressional panel on health insurance named for the late Rep. Claude Pepper of Florida. Last week he told a senior citizens' group that he will do whatever it takes to see that every American has access to good, affordable health care.
>
> 'It will not be easy to succeed,' he said. 'We have a president to convince that these problems ... can't go on. We have to persuade him and countless others that it's time to own up to the fact the solutions will cost something.' "
>
> - October 6, 1989

You knew that the zero-sum game mentality had limited past attempts at reform, and you wanted to avoid a total stalemate. You also vocalized the need for the Commission to create a comprehensive, rather than piecemeal set of recommendations. Millions of Americans were in desperate need of health insurance, or better coverage.

There were several options, and a diverse set of opinions from

the Commissioners: Senators Edward Kennedy, Max Baucus, David Durenberger, David Pryor, and John Heinz: Representatives Pete Stark, Henry Waxman, Louis Stokes, Mary Rose Oakar, Bill Gradison and Tom Tauke; and three Presidential appointees, Jim Balog, John Cogan and Jim Davis. However, the partisan and inhospitable political climate limited the bounds under which the Commission could operate. You tried your best to craft a report and set of recommendations that would be acceptable to everyone; Republicans at the time were simply immovable on the issue of health reform. Ultimately, you felt that given our preexisting employer-based system, it was best to build upon it to achieve universal health insurance coverage—requiring employers either to offer coverage or contribute toward the cost of coverage in a public plan (then-called "pay or play"). And you sought a limited social insurance approach for long-term care, focusing heavily on care at home.

In the early days of the Commission the goal was focused on fact-finding. It was important to you that the Commission find the areas in which there was collective agreement, where you needed more information and the best way to gather the necessary information. As the Chair, it was critical that you formulated your own position on the action you wanted the Commission to take and where a consensus position might lie.

In order to more fully understand the needs of Americans and gain grassroots support for the eventual recommendations of the Commission, you and your fellow commissioners organized meetings, hearings and "field trips". The hearings resembled the private seminars and allowed experts to present their views on

the problems, but had two additional components: presentations by people and institutions who were struggling with access issues and presentations by interest groups. These hearings allowed the Commission to listen to a variety of stakeholders from geographically diverse states and build support for the Commission. In addition to these events, Commission staff helped you and your fellow commissioners prepare extensive analyses of the problems in health care and long-term care, consulted outside experts and contacted related agencies to get their input.

Although you avoided addressing revenue creation through taxation, as that was a sure-fire way to anger Republicans, there were still differences in opinion within the Commission. Specifically, determining the appropriate state-federal relationship caused divisions within your Commission. Congressman Stark was pursuing his own social insurance legislation, and wanted the Pepper Commission to recommend a more progressive, comprehensive set of recommendations. Senator Heinz was creating uproar around state's role in Medicaid- he was threatening to withhold support for an employer-based plan if the federal government took over Medicaid. You and your staff negotiated with him up until nearly the day the report was issued. In addition to Senator Heinz, you and the staff tried very hard to get Senator Durenberger on board as well; sadly, you could not move them from the Republican Party platform which rejected health reform.

Although there were on-going partisan disagreements, meetings with Liberty Mutual proved to be informative. According to Robert

Leszewski of Liberty Mutual, some of the major insurance companies were willing to consider the recommendations of the Pepper Commission. Many of the representatives communicated that they felt the health care and insurance system in the United States was broken. Not only that, but there was agreement that their companies could, and should be held accountable. In fact, at the time, many of the insurance companies felt that if the system was not fixed within the next seven to ten years, the public and Congress would call for a national health insurance program. A single-payer system was something they wanted to avoid, as it would put them out of business. This was an important show of support; however, not all insurers shared this view. In specific, Travelers and Aetna remained in the conservative camp. They strongly believed that the American public will continue to pay for health care without limits, and most were extremely happy with the type of care they were receiving. This divide in the insurance community was indicative of the general disagreement on whether managing care or medical underwriting was the path forward.

In addition to some insurance companies, many larger, Fortune 500 companies were vocalizing support of "national health care". News reports from the late 1980's reported that,

> "…Auto executives aren't the only ones who are frustrated over paying hospital bills that are padded by 25 to 30 percent to cover the cost of the uninsured.
>
> 'Today, companies like ours pay for health care twice - once for our own employees and then again, via taxes and inflated

> health insurance premiums, for the employees of those businesses who don't provide benefits for their own people,' Robert L. Crandall, chairman of American Airlines, told a congressional committee.
>
> The Washington Business Group on Health, which represents 175 members of the Fortune 500, is considering whether to endorse some form of national health insurance, said vice president Carol Cronin. Even the conservative National Association of Manufacturers reports that its members are willing to move toward a Canadian-style health insurance plan if costs can't be controlled."
>
> - July 25, 1989

Overall, the biggest contention within the group was how the pay or play model would affect small employers. Senator David Pryor really struggled with the choice between the two. At the time, Senator Pryor led the Small Business Caucus; this made things complicated given many small businesses were opposed to the Employer Mandate recommendation. Ultimately, Senator Pryor decided to support the mandate. In an act of consensus building, Mr. Pryor paid a visit to Senator Baucus, who was also undecided. In a silent and coded plea, Senator Pryor gave Senator Baucus a copy of *Profiles in Courage* in hopes that it would move him to make the right choice, and support the employer mandate recommendation. Unfortunately, Senator Baucus was not inspired by Pryor's efforts and opposed that recommendation.

Despite the disagreements within the Commission and outside

forces, by late February of 1990, the Commission was voting on the body of revenue, long-term care and universal coverage proposals and fleshing out the recommendations so that Congress and various advocacy groups could use the final report as guidance and research tool.

In September 1990, the Commission released its report. In the moments before the Commission was to hold its press conference regarding the release of the report, Senator Durenberger called his own press conference. Senator Durenberger voted against the recommendations made by the Pepper Commission; however, he used the press conference to highlight the provisions he liked and validate the underlying message of the Commission: America's health care system was broken. It was an effort to support his fellow commissioners and uphold the ideals of health reform while providing rationale for his overall "Nay" vote. Today, such a press conference or act of solidarity would likely not be seen from an opposing party member.

The Commission's report called for reform in long-term care as well as the improvement and expansion of the American health care system in general. The panel's report made the following recommendations:

- employers with more than 100 employees would be required to provide coverage to their workers and their non-working dependents or to contribute to the public plan on their behalf;

- employers with fewer than 100 employees would be encouraged to provide coverage through tax incentives and

subsidies;

- Prohibiting insurance companies from denying coverage for pre-existing conditions.

The report also called for in the long-term care arena:

- Federal coverage of up to three months of care in a nursing home, with a twenty percent copayment for those with incomes above two-hundred percent of the poverty line;

- Federal coverage of home and community based services for disabled Americans of all ages, with a twenty percent co-payment for individuals above two-hundred percent of the poverty line;

- Research aimed at reducing the need for long-term care; and

- Better financial protection for people who require more than three months of nursing home care so they would not have to deplete all their resources in order to receive care.

Eleven of the fifteen Commission members, including you, supported the recommendations and the proposal to add long-term care coverage to the American health insurance system. This was unsurprising as long-term care reform was adored by Republicans, simply because it was understood to be an impossibility and unlikely to actually come to fruition in the near future. Given that health reform was gaining political traction, Republican's were increasingly uncomfortable supporting

measures that resembled health reform policy. Based largely on the political tensions surrounding health reform, only eight of the fifteen Commission members—a bare majority supported the recommendations for extending health insurance coverage through a pay-or-play arrangement. You were able to get eight votes because two of the Republican appointees from the Administration supported the recommendations, while you lost Democratic members, including Senator Baucus.

The loss of Senator Baucus's support on the day of the final vote, created an explosive conflict between Congressman Stark and Senator Baucus. Hours before the vote, Senator Baucus had been on board with the health reform recommendations, however, when everyone arrived at the "Hall of Battles"- which was a large conference space at the Hyatt in Washington, D.C. - he changed his mind. When he issued his vote, Pete Stark exploded and began screaming at Senator Baucus. The fight continued for so long that the hotel kicked the Commission out of that room, and had to move the meeting to the Bunker Hill room, which did not have a conflicting reservation. When the Commission was moving rooms, the Press arrived and tried to interview some of the Commissioners. You asked your colleagues to not speak to the Press until after the completion of the votes. Congressman Stark was so incensed, he ignored your request and told members of the press that his colleagues were all cowards. Congressman Stark then stormed in to the Bunker Hill room to join the rest of the Commissioners in finishing the votes. Needless to say, his outburst put a significant damper on the event, and you quickly wrapped up the remaining votes.
The published report from the Pepper Commission only outlined

how to pay for the enhanced coverage: the revenue creation needed to be progressive, come from a wide range of beneficiaries (not just elderly) and be a stable, growing source of revenue. You wanted to be more specific in how and where to get the revenue to fund the new proposals, however, addressing the issue of funding was too great of a political hurdle, so the specifics were dropped. However, in public, you defended your decision to not provide greater detail. You felt that establishing an approach and committing to raising the revenues to pay for it was a breakthrough in and of itself- it was up to Congress, the Administration and the people of the United States to establish how and when the funds would be created. Despite fiscal concerns and ongoing partisan debate, you felt that "it is absolutely inevitable…before the end of this century, well before, the Pepper Commission or a plan similar to that will be the health care system of this country."

You strongly supported the findings of the Commission and its promise of more comprehensive health insurance and long-term care. In many ways, the Pepper Commission Report not only served as the blueprint for your later work on long-term care, it also influenced your interest in access to health care for another group-children- which you would later successfully champion. Moreover, it laid the groundwork for President Clinton's health reform legislation. Unfortunately, little headway has been made in long-term care reform since the time of the Pepper Commission. Typically, the barrier to progress in this area has been an opposition to any "new" government entitlement and budgetary concerns.

NEW ENGLAND JOURNAL OF MEDICINE ARTICLE ON THE PEPPER COMMISSION

In the months after the publication of the final report on the Pepper Commission's findings, you wrote a powerful and moving article for the *New England Journal of Medicine*. In the article, which is included below, you depicted a vision of hope for health reform in the United States. Moreover, you provided a clear explanation of why the Pepper Commission and its recommendations mattered for our nation. Finally, you warned that the health care system would eventually fail the American people if Congress and the citizenry failed to heed the Pepper Commission's call to action.

Text of the article:

"Just over two years ago, Congress created the U.S. Bipartisan Commission on Comprehensive Health Care to recommend legislative action to ensure all Americans coverage for health and long-term care. That commission — renamed the Pepper Commission in honor of its creator and first chair, Representative Claude Pepper (D-Fla.) — fulfills its charge with its just-released final report to Congress.

Some may greet the report as a nonevent — just another set of recommendations to sit on the shelf, as the problems of Americans in getting and paying for health care continue to grow. For some, it has become far easier to bemoan our inability to act than to tackle the problems we all face.

But I see the commission's work in a different light and intend to use it accordingly. I believe the commission's efforts provide an opportunity at long last to come to grips with a rapidly growing health care crisis. The President and the Congress have a choice. We can continue to duck our heads and hope this issue will not bring the nation to its knees, or we can use the commission's recommendations as the rallying point for building the political consensus that can make universal coverage for health and long-term care a reality. I opt for the latter course — not just because it can work, but because it is the only responsible means to take action we know is imperative.

A look at the outcome of the commission's deliberations gives a good indication of what, in fact, it takes to build political consensus. The commission basically faced two separate tasks — reform of the nation's existing system for insuring medical or health care, and creation of a system for insuring assistance in the tasks of daily living that we call long-term care. The commission voted overwhelmingly (11 to 4) in favor of a major government initiative in long-term care. First, this initiative would establish government or social insurance to keep resources intact for severely disabled people at home or with the potential to return home after a short nursing home stay, and second, it would establish a floor of protection against impoverishment for all nursing home users, no matter how long they stay. It is estimated that this long-term care program, although limited relative to the full social insurance some have proposed, would cost $43 billion if implemented in 1990 — almost two thirds of the $70 billion cost of the commission's full set of recommendations.

By contrast, the commission's vote on health care reforms — universal coverage for people under the age of 65 (at a cost of $24 billion) and measures to promote the efficient delivery of quality health care — passed by the slim margin of eight to seven.

Why the difference? The answer lies not in the commission members' perceptions of the need for action. The members consider action to reform the health care system as urgent as — if not more urgent than — action to build a system of long-term care. Rather, I believe at least part of the answer lies in the members' perceptions of the political benefits and risks they face if they put themselves on the line for a specific proposal.

On long-term care, the political gains in taking a stand are substantial and the costs are relatively small. Most Americans — rich and poor, old and young — see themselves at risk of impoverishment if they or their family members need long-term care. They support government action to ensure their protection. At the same time, no entrenched system of private insurance is threatened by government expansion, and providers stand to gain considerably from broader public support. Finally, the elderly and their families are politically organized and active in demanding government help. These factors do not mean it will be easy in the current fiscal environment to enact a program costing more than $40 billion a year. But broad-based support and limited opposition will promote consensus on action as we begin to get the nation's fiscal house in order.

By contrast, members of Congress take substantial political risks when they take a public position on health care reform. Rather

than the clear field we face in long-term care, in health care we face a minefield of vested, powerful, and politically active interests. Small business, big business, labor, insurance companies, doctors, and hospitals all have a strong stake in any action we take, and one group's gain is often another's loss. When it comes to support for reform from the general public, it is neither well organized nor pointed in a single direction. The American public has repeatedly indicated its dissatisfaction with the health care system, particularly its cost. But health care is a smoldering, not a burning issue for most Americans. Because most Americans now have insurance protection, many see lack of insurance or inability to get care as somebody else's problem or the problem of the poor alone. While Americans are dissatisfied with the system overall, they are concerned that particular approaches to reform could leave them in an even worse position. Thus, they are politically watchful.

The difference between the commission's votes on long-term care and health care, then, reflects the many and pointed political pressures that will work against consensus on health care reform, not for it. My own experience with the commission as a political microcosm suggests some of the obstacles we must overcome to make consensus on health care reform possible. We were in fact able to overcome these obstacles to reach a decision, albeit narrowly. Still, the lessons of our process and the outcome are telling.

First and most obvious, the vast majority of commission members faced reelection campaigns this fall, a political fact of life that will continue to shape Congressional consideration of health care

reform. Balancing the many and varied interests of powerful pressure groups will always be a major challenge.

Second and related, in the wake of the traumatic repeal of Medicare catastrophic coverage, members will remain acutely sensitive to potential voter reaction to any particular reform proposal.

Third, in health care there are many entrenched political interests. Politicians and interest groups with established points of view will be inclined to protect their own traditional approaches to issues, not to mention their jurisdictions (the ways and means, finance, energy and commerce, labor, and human resources committees). Moving from those traditions to a common approach is a difficult process, although necessary, as the commission members found.

Fourth, with a complex issue such as this, consensus on the whole requires many, many concessions on individual provisions. In terms of political scorekeeping, the "gives" may not appear to balance the "takes." Politicians may be tempted to throw up their hands with a "my way or none at all" attitude. I believe that overcoming this outlook in particular is needed to break paralysis and achieve meaningful reform. Finally, outright partisan politics will undermine consensus on health care reform, as the commission found in the days preceding the vote, when the White House placed intense pressure on some members to resist any consensus before the November elections.

Overall, on this issue and in this political context, politicians see more to lose than to gain in taking a stand. But taking political

risks to achieve broad social goals is precisely what political leadership is all about. There will never be a day when the answers become easy or cheap. There will never be a day when all of us can have our first choice or ideal solution. There will never be a day when we shall not have to go to the American people, educating them about the costs that have to be incurred and the benefits we all can reap from building universal coverage for health and long-term care in an efficient and effective system.

As a nation, we have everything to gain from beginning that effort. And the report of the Pepper Commission provides us the blueprint to begin right away. Specifically, it can tell the American public that unless we act, we are all at risk of inadequate protection or access to care. It can show them that action is possible — that there are ways to maneuver through the minefield and compromise with the vested interests to achieve a workable strategy for real health care reform.

In a nutshell, here is what the report says. The commission unanimously concludes that federal action is urgent, not only because the current system of job-based and public coverage excludes more than 31 million Americans, but also because the whole health care system itself is in great jeopardy. As health care costs continue to rise, more and more dollars go to services of uncertain value while millions of Americans go without coverage and care. Job-based coverage, on which most Americans depend, is under siege. For workers in small businesses, private insurance is essentially coming apart. Insurers are engaged in intense competition for "good risks." They charge exorbitant premiums or deny coverage to those who have

been sick or are perceived as likely to become sick. Increasingly, people cannot change jobs without taking the chance that they will leave their health care protection behind. Workers in large firms see their benefits threatened each time they go to the bargaining table. As they struggle to control their ever-rising health care spending, employers are cutting benefits and shifting costs to employees. Seven out of eight labor disputes in the past two years have focused on health care coverage, and that struggle has just begun.

And growing numbers of uninsured people threaten even workers whose coverage is intact. It is the premiums and provider payments of the insured that finance the charity care the uninsured receive. And it is the trauma centers and emergency rooms used by the insured that close when the demands for charity care become too great.

Can we address these problems? The commission's answer is an emphatic yes — by building on and strengthening our current combination of job-based and public coverage. In choosing to retain the current system, the commission rejected two commonly proposed alternatives. Replacing the current system with a full government system of national health insurance — at a new federal cost of well over $200 billion — is simply not practical. Shifting the responsibility for so many dollars from private employers to the taxpayer is just unrealistic in the current fiscal environment. More important, shifting so many people from private to public coverage would entail enormous controversy and disruption, forcing the pluralistic system that Americans prefer into a "one size fits all" mold. Such a change is too dramatic to be

achievable in anything like the near future, and we do not need it to make coverage universal and effective. At the same time, simply patching the current safety net by extending Medicaid or providing vouchers to people with low incomes cannot achieve universal coverage. That strategy would cost taxpayers 50 percent more than the commission's recommendations (since government covers low-income workers whom employers fail to protect). More important, even extensive subsidies would leave insurance too expensive for about half the currently uninsured.

Fixing the system we now have is not a simple task, but the commission has laid out all the elements that will make it work: guaranteed coverage for workers through the workplace; private health insurance reforms and substantial incentives to help small employers fulfill this charge; subsidized access to a public program to guarantee all employers, big or small, access to affordable coverage; a decent public plan for non-workers and employers who prefer it; and cost containment and quality assurance for the entire health care system.

More specifically, the commission recommends first that all workers be entitled to health coverage in their jobs, just as they are entitled to a decent minimum wage or participation in social security. Three fourths of all workers and their families have job-based insurance today, and three fourths of the uninsured are workers or their dependents. Once we can say that every American who works is covered, we shall be well on our way to universal coverage. Second, in building job-based coverage, we have to pay special attention to the needs of small employers. Those with fewer than 25 workers employ about half the working

uninsured, and those with fewer than 100 employ two thirds of the total. Rather than require small businesses to provide coverage, as they do big businesses, the recommendations aim to help small businesses obtain the coverage they now lack. To overcome the barriers small businesses face, the commission would preempt the long list of state-mandated benefits with a new federal minimal standard to ensure access to coverage for preventive, primary, and catastrophic care. In addition, the commission would provide small employers with extensive tax subsidies over a period of years to reduce the price of insurance coverage. Only if these reforms and incentives prove inadequate to ensure coverage would small businesses, like big businesses, become subject to requirements.

Third, the commission recommends insurance reform that would ensure predictable rates and prevent discrimination in pricing or enrollment based on health status. Specifically, the commission calls for the prohibition of preexisting-condition exclusions and the denial of coverage for any persons within a group. We require guaranteed acceptance of all groups wishing to purchase insurance. In addition, the commission recommends that insurers set rates on the same terms for all groups in specified areas; rates could not be increased selectively for any group enrolled in a plan.

Fourth, any business subject to the requirements is simultaneously ensured access to affordable coverage. The commission does not believe it acceptable to require businesses to purchase private coverage whatever the cost. Instead, we give employers a choice of purchasing private coverage or coverage

from a public plan. The "price" of public coverage is set as a specified percentage of payroll, putting a cap on the employers' obligations. In setting that percentage, the commission explicitly aims to preserve private insurance for employers who now purchase it and to establish a fair balance of responsibility for additional coverage between the public and private sectors. Fifth, in sharing responsibility for coverage between business and government, the commission recognizes that government must do its share. We recommend a new federal program — not welfare-based — to serve as a safety net for the poor and unemployed, as well as an option for employers who find it more affordable. National standards for eligibility, coverage, and payment would guarantee all Americans, no matter what their income or where they live, access to quality, affordable care.

Finally, the commission recommends a mix of public and private strategies to promote quality care and efficient service. A national system to collect data on health care procedures, performance, and outcomes will enable all payers, public and private, to act as informed purchasers of health care services. Private health insurance reform that prohibits insurers from competing for good risks will promote competition among private insurers to manage care and costs effectively. A federal program for workers and non-workers that relies on Medicare's payment principles will extend these principles and encourage their use by private payers.

None of these measures is without controversy, and some will say they are impossible. But I believe they offer the only means to take charge of the health care crisis before it overwhelms us. We cannot stand by as health care costs rise from more than $600

billion today to close to $2 trillion in the course of the decade and as further millions of Americans lose their insurance protection.

It behooves us as responsible public officials to show the American people what we can accomplish, rather than wait until they force us to act. As elected officials, we can best serve our constituents with leadership and constructive action that over time will benefit and earn the appreciation of all Americans.

But how can we get moving? I believe we can demonstrate that consensus is possible by taking a first step. I myself propose to pursue legislative action not only on the commission's full set of recommendations but also on a "down payment" — to expand public health coverage immediately for children and pregnant women, consistent with the principles the commission put forward. This legislation would guarantee public insurance coverage through Medicaid for every American child living in poverty; begin to strengthen the Medicaid system of provider payment, establishing a national payment standard to promote access to mainstream, cost-effective health care; require the development of measures of clinical practice for services related to high-risk pregnancies; and offset the cost of these improvements by doubling the current federal excise tax on cigarettes.

This down payment starts us on the path toward universal coverage for health care, cost containment, and improved quality of care, and it does so in a fiscally responsible manner. Along with this bill, I am pursuing a similar down payment in long-term care

— expanding the public support that is now so outrageously lacking for care at home.

These two legislative proposals are not intended as a substitute for comprehensive action; rather, I intend them as a catalyst. If we can begin to work together — Democrats and Republicans, Congress and the White House — we can convince ourselves along with our constituents that consensus is possible and that we can indeed act. The report of the Pepper Commission gives us the tools. Now it is up to us to put them to work.

If we do not act promptly, I believe our health care system may well implode by the end of this century. The need for action is starkly clear."

The Medicaid Home and Community Care Options Act

During creation of the Pepper Commission report, you proposed legislation focused on long-term care. In 1989, you introduced the Medicaid Home and Community Care Options Act (S. 785), also known as The Frail Elderly Bill, which was an important first step in creating long-term care infrastructure in the United States. Representative Wyden helped to lead this effort on in the House. This legislation addressed the reality that many regions of the country do not have long-term care services in place, which would impact the ability of states and the federal government to enact any potential comprehensive long-term care legislation. Moreover, it gave states the option to provide community based care without a waiver.

The Medicaid Home and Community Care Options Act specifically aimed to build home and community based services for very low income seniors. Moreover, it directed Medicaid funding for long-term care services to make certain that quality services can begin to be put in place across the country.

At the time, much like today, Congress was facing financial restraints. Families USA published a timely report that highlighted the need for community based care infrastructure. This report was politically very helpful, but despite the awareness the report raised, you still needed to target the very poor and disabled elderly population as opposed to targeting the larger long-term care population, which was politically unpopular. Unfortunately, this legislation did not include mental illness in its eligibility requirements due to budget constraints. However, you saw this as

a stepping-stone toward a comprehensive program, and you were optimistic about its passage and eventual expansion. You worked very hard on this legislation to make certain it would be included in the reconciliation process.

At the time, you needed Senator Bentsen on board with the bill to guarantee its passage. However, his staffer Marina Wise, lacked enthusiasm for the legislation. You committed yourself to winning her over, and Mary Ella Payne, one of your health staffers at the time, remembers that you charmed her child one weekend during the negotiation process; simultaneously winning the admiration of Marina. Ultimately, the "frail elderly bill" was passed in to law during the reconciliation process.

The Long-term Care Family Security Act

With several other leading Democrats, You introduced the Long-term Care Family Security Act in 1992. This was an effort to legislatively move ahead with some of the key recommendations from the Pepper Commission. It outlined the standards for long-term care and aimed to improve the delivery system. While this legislation received significant attention and was the subject of hearings by the Senate Finance Committee Subcommittee on Medicare and Long-Term Care, it failed to gain traction due to the political drama surrounding the Clinton health reform bill, and did not come to a vote.

Health Care Reform

Both in the efforts during the Clinton Administration and in the

development of the Affordable Care Act, you were a strong voice for long-term care. While the Clinton effort wasn't successful, the Affordable Care Act included a few measures that, while not the wide-scale solution that was needed and long-sought, at least provided some important changes to U.S. long-term care policy.

Key long-term care improvements in the Affordable Care Act:

- Improved access to home and community-based services;
- Improved access to hospice and palliative care (taken from your Advance Planning and Compassionate Care Act);
- Creation of an office to research better ways to deliver services to the "dually eligible" (those eligible for both Medicaid and Medicare); and
- Creation of a voluntary, public long-term care insurance option under the Community Living Assistance Services and Supports Act, also known as the CLASS Act.

In an earlier draft, the ACA also would have reimbursed doctors for having advanced care planning discussions with their patients and establish advance care registries to make sure that the patients' wishes are known and followed. Unfortunately, in a gruesomely misleading political attack, this provision was labeled the "death panel provision" and was not included in the final package.

Medicaid and Long-Term Care

Since Medicare only provides coverage for nursing homes in the case of acute events, like recovering from a broken hip, and does not provide services at home or in the community to assist the aged and people with disabilities who need these services, Medicaid has become the long-term care program by default.

As the unquestioned legislative champion of the Medicaid program, you have safeguarded long-term care through Medicaid, both for people who are getting care in nursing homes and those who receive home and community-based services. However, at every opportunity, you have renewed the call from the Pepper Commission to have a more deliberate, thoughtful and accessible source of long-term care. Over the years you have repeatedly raised concerns with Medicaid serving as the long-term care program by default. In particular, you have said time and again that Americans should not be forced to spend their life's savings in order to access long-term care through Medicaid. You believe both the economic and social impact of this "spend down" approach is problematic.

Medicare and Long-Term Care

For the last several years, you have eyed Medicare as a possibly more appropriate place for long-term care services than in Medicaid. Your creation of the new "Office on Duals" in the Affordable Care Act was done with demonstration projects in mind that would explore this possibility. Unfortunately, the Administration has so far only used this office to experiment with

Medicaid's provision of services and not Medicare's. To see greater detail on your work with Dual Eligible's, please see the Medicaid Section of this memo.

The Future of Long-Term Care

On January 2, 2012, as part of the American Taxpayer Relief Act, the CLASS Act was repealed, eliminating the most significant progress on long-term care since the Pepper Commission's recommendations. You did not believe that the CLASS Act was the best overall option for long-term care, but given your commitment to long-term care you tried to save CLASS before its ultimate repeal in the 2012 budget deal. In the months before its removal from the ACA, there were rumors that Senator Thune and the GOP were planning an attack on the floor to repeal the CLASS Act. As it turned out, Senator Thune planned to go to the floor to ask for Unanimous Consent to repeal the CLASS Act.

When your staff heard that Senator Thune was headed to the floor sooner than expected, Sarah Dash rushed to catch you before you went in to a meeting with the West Virginia delegation of the National Guard. Your staff realized that Thune would be successful as no other supportive Senators were available to offer objection on the floor. You agreed to offer your objection. While Sarah was writing your talking points, you apologized to the National Guard, and quickly took a picture with them. You immediately headed to the floor where you offered an objection to Senator Thune's attempt to repeal the CLASS Act. Your efforts on behalf of the CLASS Act earned you the defacto title of the "CLASS Act Hero" from long-term care advocates.

Unfortunately, you were unable to stop the CLASS Act from being repealed during fiscal-cliff budget negotiations at the end of 2012. However, as the unexpected and somewhat unintended hero of the CLASS Act and long-time advocate for comprehensive long-term care, you made certain that the long-term care conversation did not come to an end. In a last minute move, you added language to the American Taxpayer Relief Act to create a Commission on Long-Term Care. The Commission, beset with budget woes and a Chair and Vice-Chair that were unwilling to discuss financing, did not produce a useful report. However, five of the Commissioners (Judy Feder, Judy Stein, Henry Claypool, LaPhonza Butler and Lynnae Ruttledge) were determined to keep moving ahead and produced an alternative Commission report that thoughtfully addressed not only financing but all of the other thorny long-term care issues, such as workforce concerns, family care giving, the institutional bias (favoring nursing homes over home and community based services) and the unique needs of the disability community.

This year, before the end of your term in Congress, you are working to reframe the debate and make certain that this important discussion continues. While you succeeded in including some hospice and palliative care portions of his Advance Planning and Compassionate Care Act as part of the ACA, there are other end-of-life priorities that remain outstanding. In particular, the heart of that legislation, which would give patients access to advanced care planning and establish advance care registries to make sure that patient's wishes are known and followed, is not yet law.

MEDICARE REFORM &IMPROVEMENT EFFORTS

Medicare was created 34 years ago and it has been a tremendous success, increasing the percentage of senior citizens with health insurance from about 50 percent to 100 percent. With such strides made over the years, we must not now take a dramatic step backward by ending the guarantee of quality, affordable health care for every senior…We must listen to the needs and thoughts of seniors. Without real input from seniors, Medicare cannot be changed for the better…I will continue to fight to protect and improve the promise of Medicare.

-January 1, 1999

After your early leadership role in the Pepper Commission and your work on Medicare Catastrophic coverage, improving the benefits and coverage for low-income Medicare Beneficiaries became one of your priorities. Seniors and Medicare Advocacy groups will continue to be positively impacted by the work you did to increase access to affordable prescription drugs, control premiums and deductibles and protect seniors and at-risk populations from powerful lobbies and overwhelming costs.

Medicare Physician Payment Reform Act of 1989

In 1989, you were still busy working on the Pepper Commission, based on your research and discussions around health care reform, you saw a need for reform in how physicians were currently being reimbursed.

In specific, throughout the 1980's there had been a high level of health care

inflation, and there were many concerted efforts in the mid-1980's to freeze Medicare payments. However, despite these efforts, inflation continued to rise. The widespread belief that the fee schedule was ad-hoc was augmented by the great sense of inequity created by the existing system at the time. Providers and beneficiaries alike were impacted by the payment discrepancies in which a doctor in NY, WV and OH would all get paid differently depending on location for the same service.

In an effort to remedy this problem, you began working on a landmark piece of legislation with your fellow Pepper Commission member, Senator Durenberger (R-MN). The debate at the time was the how the payment would be updated. The issue of reform was complicated by the fact that there were several committees of jurisdiction over Medicare payment reform. You had just taken Senator Mitchell's place as Finance Committee Health Subcommittee Chairman; and you were eager to make a difference in the lives of West Virginians. You and Senator Durenberger introduced legislation called the *Physician Payment Reform Act* on October 31, 1989. In a floor speech regarding its introduction, you described the Act as a means to make physician reimbursement more equitable and workable, protect beneficiaries and control costs of the wide-ranging Medicare programs. In specific, this legislation protected beneficiaries from a phenomenon called "balanced billing". It updated the "Maximum Allowable Charge" and limited doctor's ability to burden seniors with excessive cost sharing. In addition, the bill created what was called a national "Resource Based Relative Value Schedule" (RBRVS) that was meant to replace the existing current system of usual, customary and reasonable charges.

Finally, the *Physician Payment Reform Act of 1989* created a cost control mechanism called "Medicare Volume Performance Standards".

The measures you included in the physician payment legislation addressed the many facets of inequity in the Medicare program. You and Senator Durenberger felt that the existing system, which paid doctors based on the cost of providing care, created an unequal system in which Medicare providers refused to see rural and inner-city beneficiaries. Much like today, beneficiaries in these geographic locations tended to be the most in need to high quality, readily available care; given the disproportionate rates of chronic conditions that burdened these populations. The system you and Senator Durenberger proposed, specifically the Medicare Volume Performance Standards, would be used by Congress to make better-informed decisions about fee updates based on reports from the Physician Payment Review Commission. These performance standards were a compromise position. Initially, the bill had contained a similar mechanism called Expenditure Targets. Although this seemed like an analytical, rational option for cost-control for you and Senator Durenberger, it would prove to be one of the most controversial aspects of the law.

Soon after the legislation was introduced, the American Medical Association (AMA) and other powerful lobbies began their campaign to kill the bill based on the inclusion of expenditure targets. The most effective tactic they used, which unfortunately we still see today, is the use of fear. The AMA and others attempted to label the expenditure targets as an effort to limit and "ration" care to Medicare beneficiaries. Understandably, this

caused you an enormous amount of frustration and angered you deeply. You made a moving floor statement in which you tried to dispel the rumors of rationing and delaying care to the elderly. Specifically, you addressed an ad the AMA had placed in the Washington Post and talking points they had distributed to members of Congress:

> "Congress is not toying with anything. My subcommittee has taken the most painstaking, deliberative approach to physician payment reform. This year alone we've held three hearings with over fifteen hours of testimony…personally, I have gone out of my way to ensure balance and to hear all sides. Rationing is not on the table. Nor is any proposal to deny care or otherwise under-fund the Medicare program."

This testimony on the floor truly highlighted your commitment to beneficiaries and directly indicted the AMA for fear mongering and attempting to disrupt the legislative process and outright lies. The AMA had claimed that President George H.W. Bush opposed the cost-control mechanisms included in the legislation. In fact, the Administration strongly supported your original inclusion of the proposal. Senator Bentsen-who was the Chairman of the Finance Committee at the time- had a different view of the expenditure targets, mostly due to his close relationship with the Texas AMA. Chairman Bentsen argued that many doctors in Texas were going to be negatively impacted by the proposal.

Unfortunately, it was clear that Bentsen was going to have to participate in some way. Senator Bentsen and his staff were powerful; and it appeared as if you were going to have to consult

with Bentsen every step of the way. At the time, it was not clear to you or your staff how it was all going to work out. You, your staff and Senator Durenberger moved quickly and effectively to limit the damage the AMA's media campaign could have on payment reform. You spoke with Dr. Sammons from the AMA to express your displeasure with his organization's efforts around expenditure targets. You and Senator Durenberger made statements for the record and you met with various Senate Finance Committee members who you felt might cave under the pressure of the American Medical Association. Your staff felt that because of your knowledge in the area of health reform and well-deserved respect, personal meetings with relevant Senators (Mitchell, Riegle and Daschle) would be enough to ensure support of your legislation.

Moreover, your staff urged you to focus on your desire to vote on this legislation in Reconciliation which gave you additional room for negotiation, and your firm belief that expenditure targets were not rationing of care. In fact, you wanted language in the legislation that eliminated rationing of care as a means of cost savings. Furthermore, you urgently needed to convince them that the only difference was the prospective nature of growth rates- which were intended to ensure the longevity of the program, not alter it immeasurably. You also reached out to various groups of doctors that were willing to stand up to the American Medical Association. You turned to the American College of Surgeons and Dr. Ebert to seek their support. You and your staff saw them as an important ally, although you had differences of opinion regarding the details of the legislations.
Ultimately, your differences in opinion over fee schedule were

reconcilable through a gradual phase-in of the new fee-schedule. You also urged the family physicians to support expenditure targets in exchange for assurances that they would not be penalized for volume increases that were not their fault. Unfortunately, despite your best efforts, the House Energy and Commerce Committee voted on your legislation without the cost-cutting Expenditure Target. The Ways and Means version lacked a data-based process for their included expenditure target-making it a more budget-driven bill. In a very savvy, and swift move, you and Senator Durenberger essentially altered the semantics of the "Expenditure Targets", renaming the process as what we now know as "Medicare Volume Performance Standards". In essence, the two controls were identical in how they achieved cost-savings but the alteration of name and detailed process won the reticent support of the American Medical Association. In a surprising turn of events, Congress moved to vote on a bare bones version of the *Medicare Physician Payment Reform Act of 1989.*

Luckily, the legislation was moving under the larger Budget Reconciliation legislation which allowed for extensive and very frustrating negotiation process. At the time, there was a simultaneous fight between Democratic leadership and President Bush Sr. and the Republicans who wanted to cut capital gains taxes. Senator Mitchell was trying to fight those cuts with every trick in the book; ultimately, the Byrd Rule was invoked. Therefore, in exchange for passing reconciliation, nothing extraneous could be included. You and your staff were in constant communication with the parliamentarian about what extraneous meant. During conversations with Tom Scully from OMB,

Expenditure Targets and the Resource Based Relative Value Schedule (RBRVS) fluctuated between extraneous and not extraneous- based on the most recent negotiations. This process greatly frustrated you. One day during negotiation, Karen Pollitz remembers that you got really angry and said, "How about if I just pay for it?!" It seemed as if negotiations were at a standstill. Despite the apparent deadlock in negotiations, Karen got an unexpected phone call in the middle of the night from one of Senator Mitchell's staffers asking: "Can you get Senator Rockefeller to the Capitol as soon as possible in the morning?" As it turns out, Leader Mitchell was striking a deal to include your payment reform bill in Reconciliation. When you and Karen arrived, Representatives Dingell, Rostenkowski, Stark and Senator Mitchell were all there- but Senator Bentsen was conveniently missing from the room.

Without Senator Bentsen's opposition, your policy was quickly agreed upon. Due to those painstaking negotiations, the version that passed through Congress and was enacted in 1989 did include the Medicare Volume Performance Standards. In addition, for the first time, physician payments were made through a new Medicare fee schedule based on a resource-based relative scale, which replaced charge-based payments; and
physicians were limited in how much they could bill beneficiaries above the new fee schedule.

Given the series of failed legislation regarding catastrophic coverage and the ongoing frustrations facing the Pepper Commission, the passage of this legislation was a major accomplishment.

Inclusion of Psychologists in Medicare Reimbursement

In the 1980's there was quite a bit of arguing in health circles about who could and could not get reimbursed by Medicare, and there was a flat cap on mental health services. This created a greater shortage of physicians for West Virginian's who were enrolled in Medicare. Given the access issues created by poverty, mountainous terrain and workforce shortages, denial of reimbursement was exacerbating an already serious issue. Specifically, There were a considerable number of licensed health professionals that were not MD's who were not getting reimbursed for important services. These clinicians were forced to bill through a physician who would then give a piece of the reimbursement to the relevant provider. Mental health service providers were bearing the weight of this burden; at the time, only psychiatrists were being reimbursed, while psychologists were struggling to serve Medicare patients in desperate need of care.

In states like West Virginia this was a very serious concern given the preexisting mental health shortages. In an effort to remedy the situation, you fought to have psychologists included in Medicare reimbursement. You decided to take on this battle after a group of psychologists met with you and showed you a map of West Virginia to highlight how few mental health professionals were practicing in the state. You successfully won psychologists inclusion in the Medicare reimbursement schedule, and when you attended their annual conference that year, the entire room rose to give you a standing ovation. The West Virginia psychologists and your advocacy on their behalf set the stage for your ongoing commitment to rural access to care and work advocating for

health professionals to function at the top of their license.

Republican Proposed Medicare Cuts, 1995

In November 1994, Republicans won the national elections, giving them control of both the House and Senate. One of their first orders of business was to attack spending in Entitlement programs.

The Senate considered budget reconciliation legislation that proposed to reduce Medicare spending by $270 billion over the next seven years. You and Senator Daschle wrote a letter to the Congressional Budget Office urging them to consider, and include in any of their estimates, the financial and other consequences of major programmatic changes. You and Senator Daschle were deeply concerned that Congress would fail to recognize the implications of such enormous cuts. Speaker Gingrich's proposal would have increased Medicare premiums for seniors in order to help fund a large tax cut for the wealthy. This is counter to the arguments made by Republican leadership at the time who argued these increases would help stabilize the Medicare Trust Fund.

You made a floor statement for the record in opposition to these proposed cuts, in addition to speaking out against Medicare "restructuring" and strengthening private insurance industry, you also advocated to:

> "Protect Medicare from raids to pay for anything, especially tax cuts, but what its intended for—the promise of health

> care security for the seniors of West Virginia and the country. And while we know Medicare is safe, let us replicate the approach used to save Social Security and really prepare Medicare for the challenges of the next century".

President Clinton vetoed the proposal in late 1995. Clinton said "his veto would end 'extreme Republican efforts to balance the budget through wrongheaded cuts' and clear the way for new negotiations with Congress". Unfortunately, as you know Republican efforts to cut spending through the gutting or total elimination of social programs has only increased in the years since the Clinton Administration.

The Balanced Budget Act of 1997

Within the Balance Budget Act legislation, which established many of the current guidelines for Medicare and related programs, Congress implemented a new system for physician payment. As you know, the Sustainable Growth Rate (SGR) was initially implemented to control spending for doctors' services by setting an overall target- both annually and cumulatively. The payment rates are adjusted annually to reflect the differences in actual versus target spending. Congress has continuously avoided making physician payment cuts and permanently fixing the system through legislating temporary delays. You find the battle over physician payment reform to be exhausting and highly aggravating; especially since you believe most Medicare doctors have little to complain about in terms of salary and reimbursement.

In order to make certain powerful physician lobbies do not control the political debate, you have fought for a fair and equitable SGR system since the enactment of the Balanced Budget Act of 1997, which balances beneficiary protections and indirectly protects from negative impacts on Medicaid Beneficiaries.

Critical Access Hospitals

Within the larger Balanced Budget Act, you advocated for the creation of the Critical Access Hospital designation with the Medicare system. Once again, your interest in creating these clinics was based on your concern for the people of West Virginia. Rural hospitals were closing and residents had to travel enormous distance to access care. You understood that you could not save every hospital, so by permitting facilities to downsize and still be reimbursed West Virginian's could still receive the care they often desperately needed.

You collaborated with Senator Grassley and Senator Baucus- both of whom had vested interested in making certain your collective rural and remote populations had access to hospital care. In specific, you made certain that the following language was included in Medicare reimbursement policy:

> "In order to be classified as a Critical Access Hospital (CAH) the facility must be located more than a 15-mile drive from any hospital or other CAH in an area with mountainous terrain or only secondary roads."

The Critical Access Hospitals started as a CMS Demonstration in

West Virginia, and after the documented success of the program in your state and Montana it spread to the rest of the country. Today, Critical Access Hospitals serve as an important source of care and financial stability for the roughly 72 million Americans who live in rural communities, and may not have the means or ability to travel to a major medical center for treatment.

While critics argue about the necessity of these small hospitals, it is clear that for many Americans keeping the Critical Access Hospitals open through additional Medicare funding, has served to increased their access and utilization of care.

Bipartisan Commission on the Future of Medicare

The Commission on the Future of Medicare was active from 1997 to 1999. You were a member of the Commission, which aimed to chart a course to keep the Medicare program solvent into the 21st century. The 1996 budget agreement extended the solvency of the Medicare Hospital Trust Fund for ten years and created the Commission to tackle the long-term issues. The Balanced Budget legislation also brought Medicare spending growth per beneficiary below projected growth in the private sector.

At the time, you hoped the Commission would focus on questions such as:

- How can we assure future generations that the Medicare program will continue to deliver first-rate, quality health care for a hard-to-insure population?

- Does the Medicare program need to be updated to assure that today's uninsured have access to quality health care?

- How can we inject more competition into Medicare and learn from what has and hasn't worked with managed care?

You hoped to center the focus of the Commission around the broader questions of benefits, eligibility, structure and financing. For example, the Medicare Commission sought to recommend: steps to improve health outcome and protect the elderly/disabled, control costs, coordinate with the Medicaid program and long-term care providers, facilitate responses to changes in technology, demographics, health trends and other changes. The idea behind the Commission reflected your own commitment to long-term, rather than piecemeal solutions. Moreover, access, quality, and balancing the private Medi-gap policies with the traditional Medicare program were central to your involvement with the bipartisan group. You felt that the job of the Commission was to work through the complex, hugely successful Medicare program and update it for the 21st century.

At your core, you understood that the program had great potential to be successful well in to the future. Medicare continues to be one of the most important social insurance programs ever created: when Medicare was created nearly 50 years ago, only half of the nation's elderly had health insurance. Today, 99 percent of seniors have health care coverage. Together with Social Security, Medicare is widely credited for dramatically cutting the poverty rate among senior citizens. In 1966, 29 percent of Americans over the age of 65 were poor. Today, poverty among senior citizens is 11 percent.

The Commission was co-chaired by Senator John Breaux (D-LA) and Bill Thomas (R-CA), and led by Bobby Jindal (Executive Director). It consisted of seventeen members, ten of whom were members of Congress. Initially, you felt that the bipartisan group of members of Congress could make genuine changes to the longevity, accessibility and quality of Medicare. In an opening statement, you said,

> "I look forward to the serious and important work before us — preserving, strengthening and improving the Medicare program for current and future generations. I know we are all eager to get started on that work…the purpose of the Commission is to get people to work together, put ideology aside, and figure out what's needed to ensure that, in the future, the elderly and people with disabilities continue to have access to affordable, high-quality care. I look forward to doing exactly that."

Given your previous experience on decision-making commissions, you felt that it was well worth the Medicare Commission's time to think seriously about and work through the process that guided and shaped your collective efforts over the coming year. You felt that the Medicare debate was often cast as a zero-sum choice between just two alternatives — strengthening the program or starting over from a blank slate. Ultimately, you felt that characterization was misguided, and little was gained by playing one option — or one side — against the other.

You also felt strongly that the bipartisan nature and diversity of opinion on this Commission about how best to address the

challenges facing the Medicare program was critical to its success; although it would make reaching a consensus on the contentious issues much more difficult. You said, "We have to give ourselves the time to wrestle with these issues and to learn to trust each other. The work of the task forces will be important, but the full Commission needs to drive the deliberations of those smaller groups". This reflected your trust in Commission but highlighted some of your underlying concerns regarding how the Medicare Commission was structured.

Despite your immense optimism regarding the ability of commissions to be successful, you expressed great concern over the modeling of the task force. The bipartisan group was split in to several smaller subcommittees, which you felt might create space for miscommunication and slow down deliberations. From your extensive experience, you knew that there was no substitute for frequent meetings, discussion and real debate among Commission members. You also felt that the commissioners were never intended to develop a new financing model- you felt that was the role experts such as members of MedPac and other advocacy or policy groups. It was your strong belief that:

> "We must listen carefully to voices outside of Washington. I have no doubt that during the next 12 months, this commission will hear from many of the foremost experts on Medicare, representing a wide range of views. Nor do I doubt the brainpower we have assembled on this Commission. But we need to get out in the country and listen. The public has to be engaged — directly and regularly."

Your openness to public involvement was likely formed based on your work on past complex reform efforts and most recently the failed Clinton health care reform plan. You also felt that similar to the Pepper Commission, commission staffers should provide the commissioners with a common and constant flow of information, data and analysis in order to make certain the members could make informed decisions and recommendations.

Due to political deadlock and lack of consensus, you became increasingly frustrated with the leadership of the Commission, specifically Bobby Jindal, and the on-going delays. By February 1998, the Commission was more than three months behind schedule. In order to remedy the situation you proposed that the Medicare Commission request an extension, rather than give up without any recommendations. On March 16, 1999 the Bipartisan Commission on the Future of Medicare held its last meeting in Longworth House Office Building and vote on the Breaux-Thomas Proposal.

The crux of the proposal created a premium support system modeled on the Federal Employees Health Benefits Program (FEHBP). Under this system, Medicare beneficiaries would be allowed to select health insurance coverage from a list of private managed care plans or opt for the traditional fee-for-service plan. Managed care organizations would offer a standard plan and a premium plan. The plan created a premium support algorithm that provided for about 88 percent of the standard plan-the cost of which would be determined by the "market". Those beneficiaries able to incur the greater costs could purchase an expanded benefit package instead of the standard plan.

Much of the proposal operated on the idea that competition and prices set by the "marketplace" would create savings. However, the proposal did include prescription drug coverage for low-income beneficiaries and support for improved access to private prescription drug coverage.

The Chairmen's' proposal received only ten Aye votes, and seven Nays. In the end, you voted Nay- in opposition to the proposal. You felt that the proposal was

> "…a dangerous gamble that would put the health and lives of 39 million seniors at risk, particularly the thousands of seniors in West Virginia, and in other rural states. Like many Commission members, I could not support a proposal that abandons the guarantee of quality, affordable medical care for every elderly American. The Breaux-Thomas plan could very well turn Medicare into two separate programs: a high-end program for the wealthy, and a substandard program for middle and lower income seniors."

Philosophical disagreements and political pressures impeded the adoption of a workable plan. Unfortunately, the Bipartisan Commission for the Future of Medicare befell an increasingly common demise: deadlock.

Your staff remembers this time as very stressful for you- a time you once called one of the worst years of your life. In fact, when Bobby Jindal visited your office in the time after the Bipartisan Commission on the Future of Medicare, you told him that he failed

to provide quality leadership and you told him that you hoped he would take further endeavors more seriously.

Medicare Beneficiary Access to Care Act (S. 1678)

In 1999, you held hearings across West Virginia to understand the role home health care providers were playing in the state. Based on the hearings, you felt compelled to protect home health care providers from Medicare reimbursement cuts. This legislation included a $20 billion package to assist hospitals, skilled nursing facilities, home health agencies, hospices and clinics. At its core, this legislation aimed to protect small, rural hospitals from losses that resulted from the then newly implemented SGR formula. You felt that the SGR cuts, which were created to protect the Medicare trust, created an unintended negative effect that harmed senior's access and quality of care. Unfortunately, this legislation did not pass out of Committee.

Omnibus Appropriations Bill, for Fiscal Year 1999, Conference

Within the larger *Omnibus Consolidated and Emergency Supplemental Appropriations Act for 1999*, you introduced and led the passage to protect home health agencies from Medicare cuts. You felt that the initial legislation lacked protections for home health providers. Specifically, you felt that there needed to be a bridge between the old home health payment system and new system that was due to be implemented. Your legislation made certain that high quality, low cost home care agencies in rural areas, like West Virginia did not close their doors with the

implementation of Medicare payment reform.

Prescription Drug Reform (2001)

You continued your efforts to expand Medicare coverage for all beneficiaries with another effort for prescription drug reform. However, George W. Bush had won the 2000 Presidential election on a very conservative, pro-austerity platform; making the expansion of a benefit program even more difficult. Despite the rise of pro-austerity politics, you and Senator Bob Graham introduced the Medicare Reform Act of 2001. This legislation aimed to create a Medicare prescription drug benefit that was voluntary, accessible and affordable for beneficiaries. The benefit was integrated in to the Medicare program that included a cap on expenses and a comprehensive benefit. In an attempt to modernize the program, the legislation also offered new preventative services.

Senators Frist and Breaux also offered a plan at the same time, which overhauled the Medicare program by incorporating competition with the private sector and subsidized prescription drug coverage for low-income senior citizens. The Frist option relied solely on private insurers. This was cause for concern as it would likely not be tenable in West Virginia and there were too great of incentives for the private plans to risk-select. West Virginians and other populations in non-competitive markets were likely to be selected against because they were, and are, older and sicker. The bill offered by you and Senator Graham offered greater premium assistance than the Frist-Breaux option.

As Finance Committee and partisan negotiations began,

Chairman Baucus identified roughly $300 billion for the reform plan from the budget resolution- you hoped most of which could be spent on prescription drug reform. You saw Senator Graham's bill as a stepping-stone toward greater access to prescription drugs, however you did think that the premium on the drug benefit was inaccessible for many beneficiaries. Negotiations in the early 2000's were increasingly difficult and partisan. In an attempt to move policy forward you agreed to consider spending money on a Medicare + Choice Option- which you felt did little for West Virginia as long as money was also spent on improving fee-for-service. However, you urged your colleagues to promise to spend no less than $290 billion on drugs. Senator Graham's bill was scored at a total cost of $318 billion over ten years- and it covered a greater number of seniors than past legislation. Nonetheless, concerns remained about premium levels, the political landscape at the time and funding levels.

As negotiations continued, before the proposed markup at the end of July, you had compromised by indicating willingness to include private insurers, as long as Pharmacy Benefit Managers (PBM) have partial risk in exchange; you agreed to have multiple PBM's rather than just one, and agreed to consider a $300 billion benefit. Meanwhile, you were simultaneously urging Senator Breaux to support a prescription drug plan, and trying to stop Senator Baucus from moving too far to the right on Medicare reform. At the time, Baucus was pushing for PBM's and private insurance participation, as well as providing incentives for private plan participation in this market. Since the early 2000's, "incentives" for private plan inclusion in Medicare Advantage Plans has proven only increase the costs for beneficiaries and

taxpayers. Fortunately, the ACA is slowly phasing out these incentives to lower costs, which reflects your initial stance on this policy.

In President Bush's initial budget he proposed $153 billion be appropriated over ten years for "Medicare modernization"- this included a prescription drug benefit. The president proposed a block grant program to help the states provide drug coverage for Medicare beneficiaries with incomes up to 175 percent of the poverty level and to provide catastrophic coverage to limit annual out-of-pocket spending to $6,000 for beneficiaries at all income levels. Then, in July of 2001, President Bush released his Administration's proposal that offered a discount care program to purchase prescription drugs. You felt this plan did nothing to actually improve or offer any coverage to beneficiaries. Ultimately, Bush's plan was stalled by legal action and political gridlock in Congress. Debate and the political impasse between conservatives and more liberal Members of both the House and Senate continued until 2003.

Medicare Modernization Act (2003)

The Medicare Modernization Act of 2003 was an uphill political battle, which ended with you opposing the final legislation. The Act was signed in to law in December 8, 2003; however, the majority of policies did not come into full effect until 2006.

Unfortunately, the vast majority of conflict over this legislation occurred between you, Finance Committee Chairman Baucus and Ranking Member Grassley. You and your colleagues had

differences of opinion about how the drug benefit should be run and regulated. Yvette Fontenot recalls that you were constantly in and out of member meetings regarding PBM's and who should bear the risk. You felt that PBM's should participate; however, the government should bear the risk. Aside from your ongoing work about risk and the drug benefit, your greatest concern with this legislation was the protection of low-income beneficiaries, beneficiaries with serious health conditions and the Dual Eligible population.

You attempted to counteract some of the problematic aspects of the bill by introducing amendments that protected employer coverage of prescription drugs as the legislation did not count payments made on the beneficiaries' behalf by any other entity towards reaching the "stop loss". Another amendment you introduced attempted to protect low-income Medicare patients by not only making the Part D proposal a universal benefit, but also using the Medicaid program as a wrap-around financial cushion for the poorest Medicare patients- most of whom were, and continue to be, Dual Eligibles. You felt that the system at the time, which was uncoordinated, created worse health outcomes for people on both Medicaid and Medicare. It was your belief at the time, that placing "Duals" in Medicare would facilitate better coordination and uniform services because Medicare was a uniform, federal program. Finally, you and Senator Gordon Smith introduced an amendment that included all cancer drugs in Medicare coverage. At the time, many cancer patients on Medicare struggled to get their oral cancer drugs covered. This amendment greatly expanded access to life-saving drugs that were often less toxic than injectable cancer treatments.

Moreover, the coverage issue was of great concern as it was estimated that most cancer drugs would be oral, and therefore not covered by 2010.

Despite your hard work, and negotiations around beneficiary protections, the Bush Administration failed to strongly support the Dual Eligible population in the ways in which you felt were best. In fact, you thought you had moved the Bush Administration toward stronger protections and the Medicaid wrap-around benefit for Duals, but then President Bush made a public statement that countered his earlier promises. Understandably, you were outraged at his change of heart and had evidence on your side.

Earlier that month you saw a statement of support for the Duals population on the White House website. You and your staff made an appointment to meet with President Bush to discuss your disappointment and anger with his policy decision. According to your staff at the time, the meeting between you and President Bush did not go well. The President denied ever making such statement; his denial only angered you further and you left the White House prepared to call the President's bluff.

When you arrived back at your office, you had your staff scour the website and find the supporting statement. You then printed off the webpage, and sent it to the White House. Shortly thereafter, the website was edited to reflect the President's most current position. Although you did not get the additional protection for the Duals population you were seeking, you effectively stood up to the President and demanded accountability to West Virginians and all Americans who needed an effective and high quality

Medicare Drug Benefit. You felt that, "this bill is more focused on subsidizing insurance companies than on providing all seniors with a consistent benefit under Medicare. We should be using every dollar we can to reduce the cost to seniors, not paying off private insurers to provide a benefit." Your staff attests that this White House meeting was a true testament to your character and willingness to fight for those Americans who needed the greatest level of protection.

In the final days leading up the markup and eventual passage of the *Medicare Modernization Act of 2003*, you regularly came upstairs to check-in on your staff who had been working around the clock to negotiate as many changes to the legislation as possible. Yvette, who was your health staffer at the time, was touched by your thoughtfulness. She also recalls that on the day of the markup you were very ill, and were distraught that your staff had worked so hard, and you could not attend the markup. However, you made up for your absence the day the legislation came to the floor for a vote. You made a moving speech defending your opposition to the legislation, which is included at the end of this section. Moreover, you related your concerns directly back to West Virginians and the negative impact the Medicare Modernization Act's passage would have on the residents of your state. Specifically, you knew the following would occur due to the legislation,

- All West Virginian's would pay a higher deductible for their regular doctors

- 44,000 West Virginian seniors would pay more to sign up for

the benefit that they get back in prescription drugs,

- On average, seniors would still have to pay 75% of their drug costs;

- 45,000 West Virginia seniors on Medicaid would pay twice what they currently do for each prescription.

- Finally, all seniors would pay more as the legislation prohibited the re-importation of cheaper drugs.

While you supported the move of the Duals population to Medicare to receive their prescriptions, the overall legislation did not reflect the work your ongoing work to create a comprehensive, cost-saving drug benefit program. Many of your colleagues were persuaded to shift to the Right on this issue, and failed to find common ground on which quality, appropriate risk-sharing, beneficiary protections and cost savings could be provided to Medicare beneficiaries.

Today, Congress is still struggling to find affordable, comprehensive coverage for *all* Medicare beneficiaries. Moreover, the cost of Medicare Advantage, which included private plans in Medicare coverage, has proven to be most costly than originally expected. Unfortunately, low-income beneficiaries and patients with complex conditions often cannot access the type of treatments they need due to enormous financial barriers. However, your efforts to increase access to prescription drugs, has laid the groundwork for ongoing advocacy to open doors to coverage for millions of beneficiaries.

Your commitment to a comprehensive prescription drug benefit for low-income and medically complex populations is largely driven by the widespread existence of chronic disease in West Virginia. You fought, and continue to advocate for quality benefits and strong medical institutions because despite generations of limited access to health care and seemingly insurmountable economic and social barriers, West Virginians could overcome any obstacle if presented with an opportunity to have a healthy life.

TEXT OF MEDICARE MODERNIZATION SPEECH, 2003

"Mr. President, on July 30, 1965, President Lyndon B. Johnson stood with President Harry Truman and, together, they delivered the Medicare program. They proudly addressed the American people as President Johnson proclaimed, ``No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years.''

Today, those words still move me and yet, if I am to be honest, they also haunt me as we consider the Medicare reform legislation before us. I know that this legislation charts a course that will begin to undo the good works of our former Presidents and of a program that is perhaps the single most effective public initiative in our nation's history. Medicare has literally saved the lives of our seniors, keeping them from poverty and providing the peace of mind that comes with security. For this reason, I have a heavy heart and a sense of near dread about this bill.

My heart is heavy because I know that this bill to reform and ``improve'' Medicare is deeply, fundamentally flawed. This is not what Presidents Johnson and Truman wanted for the millions of our parents and grandparents who made America strong, and it is not what I want, either…I cannot support the Republican Medicare prescription drug bill because it forces seniors to choose between paying more for their own doctor or signing up

with an HMO; leaves seniors to pay thousands in out of pocket costs; eliminates employer drug coverage for 2.7 million retirees; prevents efforts to keep drug costs down; and effectively prohibits seniors from importing cheaper drugs from Canada.

I recognize that this bill commits $400 billion to a Medicare prescription drug benefit and truly helps some low income seniors who are without coverage today, and I am glad that it gives a critical boost to rural hospitals and doctors. But the fine print matters and will have very dangerous consequences for how much seniors have to pay for their Medicare benefit, whether this drug benefit really serves seniors, and whether we are strengthening or weakening Medicare for the future. I have always said that a Medicare prescription drug bill must be voluntary, affordable and accessible to all Medicare beneficiaries; must truly help with the high cost of prescription drugs; and must strengthen the Medicare program for the future. This bill fails on all counts. [M]y goal has always been, and continues to be, improving Medicare and the quality of health care available to all Americans. This bill does not improve this program. This bill harms this program--actually harms Medicare.

This bill is a tool to force seniors to leave the traditional Medicare program they know and trust in order to obtain the drug benefit they need and deserve. Many people have said that this plan is voluntary and, therefore, if a senior chooses to stay in traditional Medicare and get a drug benefit, he or she can do so. This legislation does not guarantee that in any way. Under this legislation, seniors will have two different options for receiving a drug benefit. The first option is to stay in traditional Medicare for

their doctor and hospital services and enroll in a ``drug-only plan'' to receive their drugs. The second option is to give up traditional Medicare and enroll in a HMO or PPO for all of their health care services. You may ask: what is a drug-only plan and how does one work? The answer is that we have no idea because no such entity exists today. It is a completely new concept, which the Administrator of CMS said does not exist in nature and would probably not work in practice. The former head of the Health Insurance Association of America said that drug-only plans are like insuring against haircuts. So, it's completely uncertain whether these plans will emerge, but let's say for a moment that they do. Well, at least seniors should be assured that they can remain in traditional Medicare and get a prescription drug benefit, right? Wrong. There is no limit on what these drug-only plans can charge seniors none at all. These plans could charge seniors $100, $500, or even $1,000 per month. These premiums could be completely prohibitive. West Virginia seniors will certainly not be able to afford premiums that high. If that is the case, seniors will not really have the option to stay in traditional Medicare and get a prescription drug benefit. They will be forced to enroll in an HMO in order to get a drug benefit and that is not what our seniors want.

Again, to be fair, this bill has some provisions, including those affecting physician services and rural hospitals that will be helpful to my home State of West Virginia. I fully recognize that; in fact, I pushed for these because I understand that good care is critical to good health, and that we must adequately reimburse Medicare providers for that good care.

However, despite this, I have grave concerns about the compromise produced by the Conference Committee charged with reconciling differences between the House- and Senate-passed Medicare reform bills. I was on the conference committee. I understand the arguments on both sides. And now, more than ever, I believe that the Congress needs to pass a meaningful prescription drug benefit that gives seniors more for their money, not less. I do not want to privatize Medicare, undermine existing retiree coverage, or force seniors to flip-flop between plans. Unfortunately, this bill would do all of that and more. Today, 339,000 seniors live in West Virginia. Nearly 30,000 West Virginia seniors will lose their employer-sponsored prescription drug coverage simply because of the enactment of this bill. As health savings accounts (HSAs) created by this legislation select and cover healthier, younger seniors, employers will be left to cover sicker, older seniors. Employers will see their health care costs rise and they will be priced out of continuing to provide employees or retirees with coverage, leaving remaining retirees with a benefit that is less desirable than they had before. Meanwhile, 70,000 West Virginia seniors will fall into a $2,800 coverage gap, forcing them to bear the total cost of their drug themselves until they reach the end of that gap. In fact, the available benefit will be so stingy that many seniors will pay more for this drug plan than they will receive in actual drug benefits.

At the same time, private insurance plans will be assured even greater profits through a $12 billion ``slush fund'' created by this legislation. Proponents argue that this ``slush fund'' is necessary to bring HMOs into rural areas. The fact is that this additional funding is necessary because HMOs have overhead costs. They

have to pay their investors, provide a return to their stockholders and they have to pay for good marketing materials because that's the best way to skim off the healthiest seniors. On average, private plans have administrative costs that are about 15 percent of total spending whereas Medicare's administrative costs are 2 to 3 percent of total spending. There is no way that private plans can be as efficient as Medicare. Yet I am not opposed to allowing them to compete fairly with Medicare. However, we should make them compete on a level playing field. We should make them compete by creating efficiencies. We shouldn't take money away from the highly efficient Medicare program and give it to the HMOs to help them instead of seniors. That is not the free-market at work. That is not real competition. And, while a ``premium support'' demonstration, which effectively allows a voucher system instead of a real Medicare prescription drug benefit, will take place in six metropolitan statistical areas (MSAs) initially; I believe we can safely assume that this demonstration is meant to be standard at some point. This demonstration is expected to raise monthly Medicare premiums by 26 percent.

Perhaps most disturbing, 45,000 ``dual eligible'' beneficiaries will pay more for every prescription drug they receive under this legislation. Dual eligibles are seniors who qualify for Medicaid by virtue of their income. They currently receive drug coverage under Medicaid. In my State of West Virginia, these seniors pay between $0.50 and $2.00 per prescription depending on the total cost of the drug. Under this legislation, they could be required to pay twice that much. I want to be clear on this point because I was among those insisting that the dual eligibles be included under the Medicare benefit and not left in Medicaid.

I believe this conference report does the right thing by including these seniors in the Medicare benefit. However, this legislation precludes States from ``wrapping around'' Medicare. In other words, States will not receive any Federal dollars for assisting dual eligible beneficiaries with the costs not covered by Medicare. This is unprecedented. For every other benefit covered by Medicaid but not by Medicare, the states receive a Federal match to provide those benefits to our poorest seniors. For example, Medicaid covers long-term care but Medicare does not. So, for those seniors who are also eligible for Medicaid, the Federal Government provides matching dollars to states to provide long-term care to dual eligibles. This conference report completely twists that concept of protecting our poorest seniors against increased costs in an unprecedented way. This arrangement represents a fundamental change in the relationship between Medicare and Medicaid. Many predict that the individuals affected will choose to forgo the prescription drugs that they need rather than try to pay what they cannot afford.

In my judgment, this bill represents the greatest threat to the Medicare program since its enactment. While numerous opportunities existed to strengthen it, they were wasted. Instead of devoting $12 billion to closing the $2,800 coverage gap, this conference report gives it to HMOs. Instead of protecting the right of our seniors to stay in traditional Medicare and get a prescription drug benefit, this bill protects the rights of the private plans to charge any premium they want. Instead of shoring up retiree coverage for the two to three million beneficiaries across the United States who will lose drug coverage as a result of this bill, this bill includes tax shelters that threaten to undermine the entire

employer-based system. This bill is a give-away to special interests, compiled in the dead of night, under wraps. It is shameful. Public policy, like life, is about choices and this bill makes all the wrong choices for our seniors.

While I have painted a bleak picture, I strongly believe that we can avoid disaster. We can do so by putting this bill aside and coming back to the table with a proposal that helps seniors and protects the long-term viability of what is a truly great program. We can take into account the seniors who won't benefit from the low-income provisions in the bill. We can protect retirees, and we can implement positive reform that is productive, not destructive, confusing, or manipulative. It is not too late. It is not too late. I urge my colleagues to reject this bill and to immediately go back to work for the kind of Medicare drug benefit seniors deserve."

Diabetes Program

Your commitment to a comprehensive prescription drug benefit for low-income and medically complex populations connects closely with your work to end the scourges of chronic disease in West Virginia. West Virginia has one of the highest rates of diabetes in the country. If current trends continue, one in three children born after the year 2000 in West Virginia will develop diabetes.

Given the lasting health impacts of diabetes, you invested time advocating for the continuation of the Special Diabetes Program that reduces health care costs and improves health outcomes for the 26 million Americans with diabetes.

In 2012, you and Senator Franken introduced legislation to allow Medicare to cover the National Diabetes Prevention Program. The program underwent extensive research by the National Institutes of Health (NIH), and was expanded to the community level through the CDC, YMCA and United Health Group (a rare occasion you agreed with the actions of United Health). This legislation was re-introduced in March of 2013 with your support. This year you and Senator Franken, joined by a number of your colleagues, requested the HELP Committee to appropriate enough funding to implement the program nationwide.
Finally, you worked with Senator Grassley on an amendment offered at the physician payment reform (SGR) markup in December 2013, which worked to combat the chronic health impacts of obesity and diabetes. While that version of the SGR legislation never came to the Senate floor for a vote, in the final

legislation, passed on April 1, 2014, the Special Diabetes program was successfully extended for another year.

Saving Camden-Clark Hospital

In 2012, Camden-Clark Hospital in West Virginia was merging with St. Josephs in Parkersberg. You were contacted by Camden-Clark in a panic, saying that CMS had suddenly informed them that their Medicare status was going to be revoked. Revoking their ability to treat Medicare patients would have shut down the hospital, as well as required elderly patients to be transferred from St. Joseph's, the hospital Camden-Clark was in the midst of acquiring. Moreover, the hospital serves the Mid-Ohio Valley, which covers a portion of West Virginia and two counties in Ohio, the loss of this hospital would pose barriers to access for the residents of the area.

This was a serious cause for concern given the number of Medicare beneficiaries in the state and the existing shortage of care. You and your staff reached out to CMS, and did some digging. You discovered that the discrepancies involved in the Camden-Clark case were in fact caused by errors on the part of CMS. After discussing the error with CMS- they continued to drag their feet in reinstating payments to St. Joseph's. This was threatening the stability of the hospital. You and your staff decided to move ahead and do press coverage on the issue; you also met with Mike King, the CEO of Camden-Clark to learn more about the issue.

Finally, to avoid extensive negative press coverage about their

bureaucratic errors, CMS sped up their examination of the issue and reinstated Camden-Clark's/St.Joseph's reimbursements.

Sarah Dash recalled during one phone conversation with CMS in which she informed them that you were going to the press- they reacted immediately with reassurances the issue would be solved. Before you had an opportunity to do significant press, the error was corrected.

Medicare Drug Savings Act (2011-2013)

Over the course of your time in Congress, and work with Dual Eligible population you had come to believe that the Duals should get their prescription drugs through Medicare, as opposed to Medicaid. It was your hope that this move would be less costly than supplying drugs through Medicaid. Ultimately, the cost of prescription drugs for the Duals population was greater under Medicare than you previously believed it would be.

In an effort to provide a "fix" to the increasing costs of drugs and protect the Dual beneficiaries, you introduced the Medicare Drug Savings Act, which returns rebates to Duals and low-income beneficiaries in the Part D program. Your proposal not only supports beneficiaries' access to necessary prescriptions, it would save taxpayers over $120 billion in ten years.

Unsurprisingly, your proposal is unpopular with the pharmaceutical industry, as they claim it would negatively impact their profits so greatly that companies would be forced to cut back on research and development. As you know, this claim is patently

false- a growing percentage of pharmaceutical profit is spent on advertising and marketing, not research and development. However, you and others have considered the Medicare Drug Savings Act a means by which we can pay for critical programs and support deficit reduction.

Initially, you introduced the *Medicare Prescription Drug Coverage Improvement Act* (S. 1634) in 2009. It allowed the Secretary of Health and Human Services to lower the cost of prescriptions by entering into rebate agreements with drug companies for dually eligible beneficiaries. Later in 2009, you and Senator Nelson proposed an amendment in The Finance Committee to eliminate the Medicare donut hole through the mechanism in the Medicare Drug Savings Act. Your proposal was included in the Bowles-Simpson Fiscal Commission's recommendations for deficit reduction and the President's Plan for Economic Growth and Deficit Reduction in 2011. Currently, you are offering it as pay-for in Medicare physician reform, also known as SGR. Although it is politically unlikely that this legislation will be taken up as a pay-for, it is testament to your critical analysis of industry reform and commitment to protecting beneficiaries.

Overall, you primary interest has been in the group of Medicare beneficiaries who are not poor enough to qualify for Medicaid but are not rich enough to afford the out-of-pocket costs associated with the program (also known as Dual Eligibles). People in this group often go without care. You have worked tirelessly to create and protect a variety of programs designed to help this group. In specific, this year your focus is twofold: 1) making sure low-income supports for Medicare beneficiaries move with any SGR

legislation; and 2) recommending ways to streamline and improve enrollment in these programs, building on policy lessons from CHIP related to "express lane eligibility."

CHAMPIONING CHILDREN'S HEALTH CARE

"In 1964, when I first came to West Virginia as a VISTA volunteer in Emmons, I was shocked to learn that many of the school-age children living there had never been to a dentist before. I made raising health care standards one of my first priorities in Emmons, and we ultimately got a bus to bring children to the Tiskelwah grade school in Charleston for dental care… A healthy start in life is a necessary component in preparing our children to lead healthy, happy and productive lives in the future."

-April 25, 2007

Prior to 1997, 23 percent of children were uninsured due to a lack of affordable health insurance options. This was especially true for children in families who had too high of an income to qualify for Medicaid but could not afford private health insurance. Due to your experiences living in Emmons, seeing first hand children who lacked access to pediatric, dental and preventive care, you have always recognized the importance of a healthy start that treatment of children requires care that is specifically designed and targeted for their needs. During your time on the Pepper Commission many of the studies and statistics indicated that children were a critical population that lacked access to coverage. The stories you heard were heart breaking, and reinforced your belief Congress needed to better address the needs of children.

You were instrumental in creating, and then reauthorizing, the *Children's Health Insurance Program* (CHIP). Unlike most other health care programs, CHIP takes the specific needs of children into account in its design. The program, which has

historically had strong bipartisan support, provides health insurance for 8 million lower-income American families- guaranteeing that their children will have access to care that is necessary for healthy development. When combined with the states that include their children in Medicaid, the CHIP/Medicaid program offers coverage for over 30 million children.

Funding for CHIP ends in 2015, and you are working this year to not only extend the program, but to improve the quality of care to make certain children are able to succeed in school and well into adulthood.

The Origins of the Children's Health Insurance Program, 1997

In 1996 President Clinton put only $1 billion aside for children's initiatives. The Clinton Administration's central focus that year was on small business and getting people back to work. At the time, Senator Kennedy and Senator Hatch were working on a general health bill. You decided it was time to address the growing rate of children who lacked access to care.

Initially, CHIP was not going to include a Medicaid expansion option. However, after extensive analysis you and you staff realized that it was cheaper to "expand" Medicaid to include children. You included a higher match rate for coverage, which is now in the Affordable Care Act. At the time, enhanced match rates had never been used before to increase coverage; the political climate required it be an incentive rather than a mandate. However, the higher match rate brought up West Virginia's rate to nearly 90 percent; creating an inclusive, affordable program.

Early in the drafting process, you and Senator Hatch started collaborating and it resulted in you blending in many of the concepts from Senator Hatch's and Senator Kennedy's block grant health legislation. You decided it was best to provide states with the flexibility of choosing to either expand Medicaid or create separate CHIP program. Looking back, this was a very fortuitous decision as it is one of the reasons the program is incredibly popular, even with conservative governors.

Although CHIP is widely accepted as one of the most successful programs of its kind, support was limited at the time of its creation. The White House had called and requested you not introduce the Children's Health Insurance legislation. The Clinton Administration did not want to deflect from the attention on jobs and welfare reform. Miriam Wright Edelman, the Executive Director of Children's Defense Fund, met with you and demanded you do not proceed any further with covering children. Your staff remembers the meeting, and you threw her out your office. Moreover, the Children's Advocates did not love the funding caps. Despite the imperfections, it was still widely supported, the few dissenting groups made little impact on the legislation moving forward.

In addition to your collaboration with Senator Hatch, you worked to author the legislation with Senator Chafee, Laurie Rubner, Representative Dingell, and Bridget Taylor. The effort was entirely bipartisan and bicameral. You chose to let Senator Chafee lead, even though you and your staff were the primary authors of the legislation. In 1996 you introduced the Chafee-Rockefeller Bill with support from Senator Hatch and Jeffords.

Despite your hard work, and the unconscionable reality that millions of America's children lacked health insurance, Chairman Roth had absolutely no intention to address a kid's health insurance bill in the Finance Committee. Regardless of your knowledge of Chairman Roth's intentions, you and Senator Chafee brought the proposal to Finance because you knew you had the votes to pass it through Committee.

The Clinton Administration sent you a letter of support the day the legislation was introduced. Mary Ella remembers you reading the letter and wondering why they had even bothered this late in the process. Additionally, the day the CHIP legislation was due to be marked up in committee, you also got a call from one of your fellow Democrats on Finance, Senator Bryan from Nevada, reneging his support due to pressure from the governor of his state and the National Governor's Association (NGA). The negative response from the NGA was likely due to the presentation Mary Ella and other staffers gave to the NGA the previous day.

According to Mary Ella Payne, who was your staffer working on the CHIP legislation, the day before the vote in the Finance Committee, your staff was asked to brief NGA staff on our compromise proposal. Mary Ella went to the Hall of States with Bridgett Taylor, Congressman Dingell's health advisor at the time, and Laurie Rubiner who was Senator Chafee's health LA. After they gave their briefing, NGA staff and others were aghast at the proposal-even though it did not mandate Medicaid coverage- it gave a very generous increase in the federal match, and it included the compromise block-grant funding that Senator Hatch

wanted. Mary Ella recalled the NGA staff being pretty incredulous and they could not believe that you had the bipartisan votes to get the legislation passed the next day when you planned to offer it as an amendment during the Finance mark-up.
In order to make certain your proposal would not succeed; NGA worked quickly and had the Governor from Nevada call Senator Bryan to oppose the proposal that evening. Mary Ella was sure that other calls were made by Governors that night to members of the Finance Committee. Senator Bryan's staff told Mary Ella just moments before the amendment was being offered that Bryan was going to oppose the amendment.

In an effort to remove some of the pressure from members, Senator Breaux moved to have the Chairman create children's health legislation as opposed to address the preexisting bill you and your bipartisan partners had created. This was also devastating as Senator Breaux was one of the key co-sponsors for your compromise proposal. The Committee agreed to allow for Chairman Roth to write a proposal. The events of that initial markup were upsetting for Mary Ella, Laurie Rubiner and Bridgette Taylor; who had spent the previous weekend working out the details of the proposal with Senator Hatch's staffer, Tricia Smith. Mary Ella remembers that they had requested Senator Breaux's staff be there as well; however, it was his child's birthday that weekend so he could not be a part of the planning meeting. Mary Ella still wonders if he declined in part, because he already knew what his boss was going to do at the markup. Understandably, after the mark-up was over, Laurie, Amy Hall, Bridgett, and Mary Ella retreated to your hideaway and had a good cry. They were devastated.

To make matters worse, initially, Senator Roth's staffer Dennis Smith was in charge of writing the Chairman's version of your original legislation. Mary Ella has few positive memories of Dennis, and was dreading that he may destroy health care for children. Fortunately, Julie James took over writing the legislation and chose to closely replicate your legislation. Despite the prior consensus to have the Chairman create a proposal, the evening of the markup of the Chairman's legislation, tensions were high and it was unclear if the legislation was going to make it through Committee.

Around 1 a.m., Senator Hatch requested all staff leave the Finance Committee room. When the staff had left the room, he stood up and made a passionate speech pleading with the Finance Committee to pass this legislation. For those who were there, and relayed the story to Mary Ella and other members of your staff, Senator Hatch spoke to the needs of children and the gravity of the issue. Not only did his plea get the legislation passed through committee- it also convinced his Republican peers that CHIP should not only receive $20 billion in funding, but also received the revenue from the tobacco tax. It was unbelievable show of support on your behalf. The collective effort on behalf of children spoke to your belief that, “children's health care is a genuine bipartisan issue, a genuine incremental bite that Congress feels it can, must and will do something about. It is real. People here really do care about it."

In another unexpected bipartisan act, Republican Majority Leader Trent Lott actually brought the CHIP legislation to the floor for a vote. While you were creating the legislation it was unclear whether he would bring it to a vote. However, Leader Lott did not

want his party to appear as if they were "anti-kids"; moreover, Lott used the idea of utilizing the savings and budget cuts identified by the failed American Health Security Act for later tax cuts as leverage to move the Republican Caucus to vote for CHIP.

Without you and Senator Chafee children's health insurance legislation would not have happened as soon as it did. It simply was not on America's radar until you spoke up for the nation's children and made your fellow Members of Congress care about the glaring needs of children.
Many people misunderstand CHIP as an initiative that Clinton was continuously supportive, when in fact you rallied bipartisan support and moved Chairman Roth without the support of the Clinton Administration. You saw the Children's Health Insurance Program as a means to achieve increases in access where catastrophic and the Clinton health plans had failed. Since its enactment, you have been pivotal in CHIP's Reauthorizations and improvement efforts.

Keep Children Covered Act of 2006

You introduced this bipartisan legislation to prevent Fiscal Year 2007 federal CHIP funding shortfalls of nearly $800 million that was projected in 17 states. This bill passed as part of the National Institutes for Health (NIH) reauthorization bill, which was signed in to law on January 15, 2007. You then successfully introduced this legislation again to fill the remaining FY2007 federal CHIP funding shortfalls. This was signed in to law on May 25, 2007.

CHIP Reauthorization in 2007

You introduced the *Children's Health Insurance Program* (CHIP) *Reauthorization Act of 2007* with Senators Snowe and Kennedy. This legislation garnered 20 bipartisan cosponsors and became the basis for the Baucus-Grassley-Rockefeller-Hatch agreement to reauthorize the program. This agreement and, later, a more conservative agreement, passed both houses of Congress, and President Bush vetoed both. However, your 2007 legislation was the basis of the CHIP Reauthorization of 2009.

In the midst of bipartisan CHIP reauthorization negotiations, Dennis Smith issued a letter to all state health officials "clarifying" how CMS would apply existing requirements in the review process to extend state eligibility under CHIP to children in families with income levels above 250 FPL. The claim was that crowd-out procedures were not working effectively and due to that; five crowd-out strategies were now mandatory for states that expanded their eligibility above an effective level of 250 percent of Federal Poverty Level.

The proposed crowd-out strategies created under the August 17 CMS Directive included the following new regulations for enrollment: Imposed waiting periods between moving from private coverage and enrollment, cost-sharing in approximation to the cost of private coverage, monitoring of health insurance status at the time of application, verification of family insurance status through databases and preventing employers from changing dependent coverage policies that would favor a shift to public coverage.

The CMS Directive also required:

- Assurance that the state has enrolled at least 95 percent of the children in the state below 200 percent of the FPL who are eligible for CHIP or Medicaid;

- Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period, and;

- Assurance that the state is current with all reporting requirements in CHIP and Medicaid reports relating to crowd-out requirements.

Around this time, many states, including West Virginia, had passed legislation to extend eligibility to 300 percent. With the announcement of the August 17 CMS Directive, states were suddenly faced with additional administrative and bureaucratic hurdles for enrolling newly eligible children. These additional barriers altered the highly effective CHIP program in a way you knew would harm children's access to the program. Therefore, you and your staff worked tirelessly to oppose the CMS Directive. In April 2008, you held a CHIP hearing that centered on the consequences of The Directive. The hearing consisted of witnesses, all of whom were connected to CHIP at the highest levels. Your staff tried very hard to have the Administration testify at the hearing with bipartisan support. These efforts were met obstructionist strategies from Republicans and Senator Baucus- specifically from Grassley and Hatch staffers. In addition, Jocelyn

and Ellen went to extraordinary lengths to sway these offices to co-lead the hearing. Ultimately, you chaired the hearing on a partisan basis and did not publish the controversial witness list. Your opening statement applauded the success of the CHIP program and state officials who were on the ground serving families:

> "A cornerstone of the Children's Health Insurance Program has always been state flexibility. And at the time of growing economic uncertainty, we should be making it easier- not harder- for states to cover those working families who are in need of assistance. This is particularly true since many employers may be reducing private coverage because of increasing economic pressures"

In order to reinforce your displeasure with the CMS Directive, you also introduced legislation nullifying the Directive. The markup of the 2007 CHIP legislation was an intense, partisan experience. The Right to Life community took issue with state coverage of fetuses. However, your staff was able to work out a compromise that gave states the option to cover pregnant women without codifying the fetal regulation. Moreover, due to a budget point of order you and your staff were participating in negotiation with Republicans to cut an additional $800 million from the bill, and CBO estimates did not match with the revenue from the tobacco tax.

On top of the negotiations going on around funding, CHIP Reauthorization was facing criticism from Republicans. In addition to opposition to CHIP on Capitol Hill, The Wall Street Journal

published an op-ed that claimed the current bill would limit, not expand coverage. You addressed this outrageous claim during the CHIP Markup on August 2, 2007:

> "In a July op-ed, the conservative National Center for Policy Analysis claims that if CHIP reauthorization bills being considered in Congress are passed, 'millions of children will have less access to health care than they do today'. This is an outrageous assertion that is contradicted by study after study which shows that CHIP and Medicaid have significantly improved children's access to medical care, including preventative and primary care...Children covered by public insurance also fare well compared to those covered by private insurance…Moreover, CHIP has helped reduce racial and ethnic disparities in children's health care, so that children of all races and ethnicities have better access to health care. We could and should do more to further improve access to and the quality of the health care children get in Medicaid and CHIP, but there should be no doubt that a strong reauthorization of CHIP is an investment that will improve children's access to health care and will improve their health."

You felt that conservative attacks on the program, compounded by the August 17 Directive, were unfounded. In specific, the Lott-McConnell amendment garnered a lot of press attention. Senator McConnell offered the Republican alternative to CHIP, called the *Kids First Act*. Under his proposal, millions of children would have lost coverage and it attached private market health care proposals that were harmful to children and families. McConnell's proposal

provided inadequate funding for child health coverage initiatives that were being developed. Without the new programs, 9 million children would have been left without coverage. In addition, it failed to provide outreach and education funding that remains critical to CHIP's high rate of participation. Finally, it limited CHIP matching rate to gross incomes below 200 percent of the Federal; Poverty Line, it proposed the elimination of SCHIP funding for family-based coverage, made cuts to administrative funding and eliminated health insurance protections.

Other amendments you opposed included Senator Graham's proposal to sunset the tax increase on tobacco productions in 2012 and Senator DeMint's amendment which attempted to create new interstate insurance markets, which you felt was not pertinent to CHIP issues. Despite the compromises made by you and your staff at the time, the legislation was vetoed by President Bush and he upheld the CMS Directive. Understandably, you were outraged. This legislation was not only personally important to you, but made certain that millions of children had access to health care. You made the following statement rebuking the President's veto:

> "Why would a president of the United States faced with over 40 million uninsured people take a chance to take the most vulnerable, about 23 or 24 percent of all uninsured people in the United States of America and say no to them?
>
> "They need to have health. And they need to have education. Before everything, they need to have health. Under our bill, passed by both Houses, potentially with an

> override of the veto coming, they would have that. Without that, they will not. It is an outrageous, outrageous act on the part of the president. I never really believed, although a part of me said it was inevitable, that it would happen. That he would actually veto it. But he has. I searched for his motivation but that's not constructive.
>
> All it does is make me angry, discouraged, and I think it's going to have a wide effect around the country. Not politically so much, it's just a sense of, 'What on Earth are they doing there?'"

The devastation you felt on behalf of America's children was profound, "It breaks my heart that we weren't able to cover more of America's uninsured children this year…but I'm not about to give up on our efforts. I will continue to fight for critical health care services for thousands of additional children in West Virginia who need it." However, while President Bush's veto of the legislation limited the program in very tangible ways, in 2009, a new President who expressed commitment to genuine health reform was sworn in to office, and it seemed as though a version of your vision for children's health care may come to fruition.

CHIP Reauthorization of 2009

You were actively involved in drafting the *CHIP Reauthorization Act of 2009*. On February 4, 2009, President Obama signed the CHIP reauthorization bill into law. President Obama based much of the legislation on your original policy proposal in 2007. On the same day, the President also revoked the Bush Administration's

controversial CHIP directive, which had impeded the efforts of states seeking to cover more uninsured children.

You fought for several key improvements to CHIP in the 2009 Reauthorization. First and foremost, you negotiated for the extension of funding for the CHIP program until 2015. Many members of both parties felt that the CHIP program should and could be eliminated with the expansion of coverage under the Affordable Care Act. You fought hard to counter this argument, which many still make today, stating, "[a]fter such meaningful and hard-fought progress for children, repealing CHIP represents a drastic setback. It is a change that I absolutely will not support."

During the negotiation process, you also won more stable long-term funding for the program. Previously, some states had struggled to cover all of their children with the designated level of funding from the federal government. After facing funding shortfalls, the new laws provided stable funding for West Virginia CHIP through a funding formula that took into account West Virginia's specific, and considerable health care needs. This significant federal investment not only meant that all children who were covered by WV CHIP could keep their coverage; it also meant that many more eligible West Virginia children could be covered by CHIP. Moreover, a federal contingency fund was also created to cover funding shortfalls and increased health care costs; which is something you advocated for legislatively during your time in the Senate.

With the reauthorization of CHIP, and funding continued through 2015, West Virginia was now eligible to receive bonus payments

for enrolling the lowest-income children. Millions of dollars were, and continue to be provided for outreach efforts, so that West Virginia organizations could find and enroll children who were eligible for Medicaid or CHIP, but who remained uninsured. Thanks to the increased level of federal resources channeled in to the program, coupled with the nullification of the CMS directive, West Virginia was able to expand CHIP eligibility to 300% of the federal poverty level, just as the West Virginia Legislature initially intended. The reauthorization law also required West Virginia, and all states, to provide more comprehensive dental benefits for children.

The improvement of dental benefits to CHIP plans was an enormous win. Given that one of your most profound experiences in Emmons was seeing the limited access to oral health care for children, you felt that this benefit was a critical missing piece in the otherwise comprehensive program. Your support of pediatric dental coverage continues to be important, as private health plans do not offer dental insurance, leaving millions of children and adults without access to a critical preventative health service. Finally, due to your commitment to the continuation of a high quality CHIP program, mental health benefits were required to equal the level of comparable medical and surgical benefits offered under CHIP; and states now have the option to cover pregnant women for prenatal and postpartum care. The coverage of pregnant women makes certain that newborns are healthy and have access to health care during one of the most vulnerable times of their lives.

Today, the majority of children are enrolled in CHIP through

Medicaid, rather than a separate plan. The rate of uninsured children has dropped to slightly under ten percent. Unfortunately, the political landscape has shifted since 1996 and1997. Senator Hatch's has not voiced his support for its reauthorization. Even if a bill is not enacted this Congress, introducing legislation with your name on it will set the stage for next year, especially given how quickly the 114th Congress will need to move on CHIP Reauthorization in order to avoid major disruptions to the program.

PROTECTING & ENHANCING MEDCAID

"I ask my colleagues- Why is Medicaid so often treated like it's a second-class program- an unwanted burden on society?"

-Jun 13, 2011

Medicaid is the primary source of health coverage for low-income Americans. Even prior to the Medicaid expansion under the Affordable Care Act, the program covered 62 million people, or 1 in 5 Americans. The program is particularly important in West Virginia, as it is a lower income state, but, in all states, it is a program that not only provides needed care but also is an important economic driver—without which many hospitals would close their doors and non-exportable service jobs would end.

Unfortunately, Medicaid beneficiaries, who often don't vote and certainly don't have the means to make political contributions, have very few champions on Capitol Hill. You have taken up this issue with great pride and dedication. Year after year, you have fought to expand the program, pay Medicaid providers more fairly, prevent cuts to beneficiaries, limit cost-sharing that could result in beneficiaries not seeking needed care, expand Community Health Centers where many Medicaid beneficiaries get their health care services and improve access to mental health.

Medicaid is the leanest of all federal health programs, with significantly lower payments for providers and very efficient administration. The program is very cost-effective, and the common suggestion from Republican colleagues that the program

should be dismantled and beneficiaries given some sort of voucher or "premium assistance" in its place, would result in taxpayers paying more and beneficiaries getting less care, a bad deal all around. Given the existing efficiencies in the program, cuts to Medicaid funding (far less than cuts to Medicare or Tricare) almost inevitably result in direct harm to beneficiaries.

Over the years, you have protected the program from proposed cuts (or minimized those cuts) countless times. Often, the focus has been on cost-sharing for beneficiaries, with Republicans claiming that beneficiaries seek unnecessary health services and must have some "skin in the game" in the form of co-pays or premiums to prevent this behavior. You, relying on study after study that demonstrate that adding cost-sharing only results in Medicaid beneficiaries delaying necessary care, have fought back these efforts, with great success.

Your current efforts in Medicaid are focused on encouraging states to expand their Medicaid programs under the ACA, arguing against worrisome "sweeteners" (like the premium assistance model you have so long fought against) the Administration is offering states to encourage expansion, working to protect in beneficiaries who are being moved in great numbers from traditional Medicaid into Medicaid managed care plans and making certain that demonstration projects for dual eligibles improve rather than reduce services to this vulnerable group.

State Fiscal Relief Battle 2003-4:

Since Medicaid is counter-cyclical (with more people qualifying for

the program when times are hard), states can grow particularly resentful of Medicaid spending in tough economic times. The Bush Administration, marked by a desire to limit services, move federal dollars to the private sector and an economic downturn, was one of the worst times for the Medicaid program. The tax cuts pushed by Senate Republicans and the Bush Administration in 2003 not only lessened federal funds but also hurt states' ability to fund their social insurance programs, including Medicaid.

Many members of Congress, with the enthusiastic support of the Bush Administration, proposed that funding for Medicaid be block-granted to help states who were struggling to pay their share of the Medicaid program. Thankfully, you did have some Republican allies in the fight to block-grant the program. You worked with a bipartisan group of colleagues (including Republican Senators Collins, Hutchinson and Smith) to introduce a bill in January 2003 that more directly increased money to states for their Medicaid programs by adjusting the Federal Medical Assistance Percentages ("FMAP") formula by which the state and federal contributions to the program were calculated.

Unfortunately, it was difficult to hold together the bipartisan alliance opposing efforts to block-grant the program. At one point, Senator Bill Nelson, who had been a part of the opposition to block grants but was overly eager to figure out a way to compromise with Senator Frist on how to deliver the money through Medicaid, started negotiating a compromise move to block grants. When you learned of this, you were livid as you knew that block grants would ultimately mean that people would have to go without care and that, if the program were block-

granted, it might never return to being a mandatory program.

In a final effort to sway you and your allies, Senator Frist and House Majority Leader Delay called Senator Collins to the Senate leaders' office, and verbally abused her in hopes of moving her toward supporting a block grant program and leaving her alliance with you. You and your staff met her immediately following this meeting. According to your staff you said, Senator Collins left the Leader's office "white as a ghost and hadn't given an inch".

Ultimately, the efforts to block-grant the program failed and your bipartisan approach eventually passed as an amendment in the larger Bush Tax Cuts legislation. The success of your proposal was in large part due to the fact that you had worked tirelessly to create a coalition of labor, advocates, states, providers, plans who were all working to get your legislation passed.

Against all odds, your amendment was supported by a large majority. Despite this major victory, you were still frustrated that Senate Republicans capped the relief funding at $20 billion, which was $10 billion less than the original promise to provide *at least* $30 billion to states to ease their financial woes.

The Deficit Reduction Act, 2005-6:

Throughout 2005, in the guise of "balancing the budget", President Bush and Republicans in Congress again threatened Medicaid in a bill called the Deficit Reduction Act. While Republican talking points regarding the proposed changes focused on inappropriate "asset transfers" by which wealthy

Americans were moving their money around so that the federal government would foot the bill for nursing home coverage, the real harm in the proposed Deficit Reduction Act of 2005 was that most of the billions of dollars in proposed cuts to health spending would come from giving states flexibility both to increase cost-sharing for Medicaid beneficiaries AND reduce the benefits provided by the program. *The Deficit Reduction Act of 2005* ultimately passed as the 2006 budget reconciliation bill (S. 1932), going into effect in 2006 with dire consequences for many who relied on the Medicaid program—but far less dire than if you had not fought these cuts.

You are widely credited with making the cuts in the Deficit Reduction Act smaller than they would have otherwise been (from the $15 billion originally proposed to the closer to the less than $10 billion that occurred). For example, in an effort to stop the inclusion of the changes to Medicaid in the larger budget bill, you made a moving floor statement that reminded your fellow Senators that the policy behind the budget numbers impact real people:

> "I want to remind my colleagues that this budget isn't simply about numbers. It's about the policies behind the numbers that affect real people who would not have access to health care in the absence of Medicaid. The $15 billion in Medicaid cuts being proposed by this Administration matter to the 50 million children, pregnant women, seniors, and disabled who rely on Medicaid to meet their health care needs. My colleagues on the other side will have you believe that these cuts will have no impact at all on the number of kids covered

> by Medicaid or the number of people going in to nursing homes. They even argue that these cuts will lead to Medicaid expansions because Governors will have greater flexibility over the use of their dollars.
>
> These statements are simply not true. Fewer dollars do not equal greater flexibility. Fewer dollars mean that states, medical providers, and individual beneficiaries are going to have to shoulder more of the burden of rapidly rising health care costs…[t]he bottom line is that this budget is about choices, and this Administration has chosen to unfairly target low-income families. This budget robs the most vulnerable in our society while simultaneously giving greater tax breaks to the rich. This is unacceptable. The federal government has a responsibility to maintain its commitment to Medicaid in order to protect access to health care for working Americans."

In particular, you knew West Virginia Medicaid beneficiaries would have faced increased barriers to access, benefit reductions and higher copayments under the proposed cuts to the program. Specifically, President Bush proposed the following changes to the Medicaid program:

- cutting and shifting at least $44 billion in Medicaid costs to states,

- forcing reductions in coverage for Americans who could not afford private insurance,

- reducing staffing and quality measures in nursing homes,
- limiting resources to people with disabilities who wished to live in the community even as it claimed to expand options to this community, and
- Increasing pressures on states and local governments to increase income, sales and property taxes.

In 2005, Medicaid paid for 55% of all births in West Virginia and it provided the majority of care for residents living in nursing homes. The detrimental effects of cuts to Medicaid would have exacerbated many of the barriers to access and chronic illness that plagued West Virginia and many states in our nation.

President Bush began 2005 with strong critiques of the Medicaid program and a push for the Deficit Reduction Act to include major changes to the Medicaid program. The Republican led Congress gave him a budget resolution that included reconciliation instructions mandating cuts to health care. As one of Medicaid's strongest advocates, you immediately spoke out against the Administration. In March, 2005, you joined with 32 of your colleagues on a resolution to create a Bipartisan Medicaid Commission to consider and recommend appropriate reforms to the Medicaid program, and to strike Medicaid cuts to protect states and vulnerable populations.

And, in May, 2005, you joined Senators Bingaman, Reid, Snowe, Hutchinson and Jeffords, in introducing the Medicaid Formula Fairness Act, which would have strengthened rather than

weakened the program by giving states additional support.

In June of 2005, you, along with Senators Baucus and Bingaman, met with Governor Mark Warner (D-VA) and the National Governor's Association (NGA) to discuss the politics surrounding Medicaid, the upcoming budget reconciliation process and a planned Senate Finance Committee hearing examining how to make the cuts mandated in the reconciliation instructions. In this meeting, you pushed Governor Warner to be strategic and clear when he testified before the Finance Committee. It was of utmost importance that Governors make it clear that requiring deep cuts to Medicaid was bad for beneficiaries, the program and for states in general. You urged Governor Warner to remind the Finance Committee Members that Governors oppose arbitrary Medicaid cuts and caps, and reform proposals that harm beneficiaries. If possible, you wanted Governor Warner to encourage the Senators on Finance to seek the bulk of the $10 billion in cuts in programs other than Medicaid. Further, you urged the Governor to press the point that Medicare should be on the table for some of these cuts as well; especially given the existence of a $10 billion slush fund for private plans in Medicare that MedPac said should be eliminated.

Finally, you used the meeting with Governor Warner and the NGA's staff to bring up some concerns that you had with the Medicaid proposal they were formulating. You were particularly concerned with two provisions. The first recommended greater cost-sharing in the Medicaid program. You argued that it was untenable to require higher cost-sharing in Medicaid than in CHIP, given that Medicaid families were poorer than CHIP families. You

told Governor Warner that additional cost-sharing should be out of the question, "Your plan targets the poorest, most vulnerable people in the country. Medicaid recipients are already paying, on a proportional basis, three times what people with private insurance pay in out-of-pocket medical expenses. It's absolutely unfair to burden them with higher co-payments. Medicaid is the only safety net they have." The second NGA proposal you objected to would have removed the comprehensive coverage requirement for children in Medicaid know as the Early and Periodic Screening, Diagnostic and Treatment program or "EPSDT." You felt no Democrat could or should support such a change given that Medicaid was the sole safety net for children at that level of poverty and they deserved real health care.

While the NGA never became a real ally in the Medicaid fight, your meeting with them did soften their stance somewhat. In two Finance Committee hearings in June, 2005, you strongly critiqued proposed changes to Medicaid from the Administration and some of your Republican colleagues and objected to the characterization of the Medicaid program as being riddled with fraud and wasteful spending. You suggested that genuine reforms to the program could be useful, especially if they were aimed at supporting, not gutting, the functionality of the program.

When Senator Grassley's mark of the President's Deficit Reduction Act came before the Finance Committee in October 2005, you and other Finance Democrats, particularly Senators Bingaman and Schumer, insisted that Medicaid should not be on the table for cuts, especially given that the country was reeling in the wake of Hurricane Katrina, and Medicaid provided a

significant portion of support for the victims. Rather than cutting Medicaid by billions, you and your Democratic allies argued that Congress should be offering additional funds in order to address Katrina-related health priorities.

Ultimately, Senator Grassley's proposal did not take the full amount of cuts from Medicaid as had been proposed. When the bill passed the Senate, some of the savings were taken from Medicare (so that it didn't all come from Medicaid). Overall, there were $7.5 billion in Medicaid cuts and a $1.9 billion package for Katrina relief.

The day after Grassley introduced his Finance Committee proposal you had a meeting with the Department of Health and Human Services (HHS) Secretary Leavitt and Senator Gordon Smith. The meeting was intended to gain your support not for the bipartisan Medicaid Commission you had recommended earlier in the year but for the creation of a presidentially appointed commission to recommend further cuts and changes to Medicaid. Needless to say, they didn't win you over. You told The Charleston Gazette that "Congressional Democrats are not participating in this commission because the Bush administration refused to assure us that it was about anything other than making billions in Medicaid cuts."

Yet Another Proposal to Block Grant Medicaid, 2011

In 2011, Medicaid was again under attack by the growing Tea Party movement and wide-spread calls for reining in the federal budget. This time, the Obama Administration was facing a

proposal to block grant and cut the Medicaid program. You took up the cause as you had in the past, and led a coalition of Senators in opposition to this proposal.

In a letter sent to President Obama you and twenty-eight other Senators urged the President to consider the ramifications of shifting Medicaid to a block grant program or to implementing arbitrary funding caps. You and your colleagues understood that the program faced challenges, but felt there were better ways to reform and protect Medicaid, as well as cut the federal deficit:

> "We stand ready to work with you on policies that would improve quality and reduce costs of the program…Indeed, Medicaid currently provides Governors with the flexibility necessary to be innovative, and respond to the unique needs of Medicaid beneficiaries in each state…With the number of uninsured growing in the nation due to the economic recession and the growing need for health care services for an aging population, we should take steps to stabilize and improve health coverage rather than undermine it and undo the promise of health reform in this nation. Just as past efforts to undermine Medicaid coverage and health security to millions of Americans have been defeated, we look forward to oppose such efforts in the near future."

Aside from the twenty-eight Senators who co-signed this letter, Families USA and dozens of advocacy organizations also joined the letter, forming a united front against the conservative attacks.

The proposal originated in the Republican-led House as a budget

proposal meant to eliminate some of the federal debt without raising taxes. You felt that the plan would shift much of the cost to counties; which lack adequate funding and infrastructure to take on such an enormous burden. Given the potential detriment to local institutions, you were joined by at a news conference by large numbers of county officials- highlighting the extent of the impact this proposal would have on communities.

In an op-ed defending Medicaid against this round of Republican efforts to "balance the budget" you aptly articulated the need for programs like Medicaid:

> "Medicaid is an extension of a guiding principle of our nation's founding- a shared responsibility for the good of all…After almost 50 years Medicaid has been a lifesaving part of what we do as a government- covering 40 percent of births, 50 percent of long-term care and, along with the Children's Health Insurance Program, 34 percent of kids in our country. Those who favor making Medicaid a block grant want to severely limit federal support that would force cash-strapped states to make deep cuts to services and increase the numbers of uninsured."
>
> -September 28, 2011

By June of 2011, the Senate had formulated a budget proposal that was at the very least tolerable for most Democrats. You played a pivotal role as a well-known Medicaid advocate in eliminating cuts to Medicaid in the Senate proposal a newspaper quoted you, stating: "I worked very hard for that in a meeting. I just kept at it. I think if Republicans put revenues on the table,

then my fear is the administration will say, 'OK, now let's go get Medicaid,' because it's the third-largest program in government." You reported to the Press that you "could accept some cuts to Medicaid, but not a massive across-the-board cut." You said of the Democrats in Congress, "We all need to be steeled; Democrats aren't very good at messaging."

This was a very tenuous time as the debt-ceiling was fast approaching, and negotiations surrounding raising the debt limit were escalating.

Regardless of the intensity of the negotiations you continued to assert that Medicaid could not be "the sacrificial lamb". While you continued to be a strong voice for Medicaid beneficiaries, you felt that "[t]here has been an unsettling silence around Medicaid--even from members of my own party,". In preparation for a potential battle over Medicaid during debt-ceiling negotiations, you lined up 41 Senate Democrats who are willing to filibuster against any Medicaid funding reductions.

Ultimately, President Obama signed *The Budget Control Act* into law in August of 2011, which ended the debt and budget negotiations that threatened Medicaid and America's credit rating.

Dual Eligibles:

Although you have always been an advocate for ALL Medicaid beneficiaries, you have made a particular effort on behalf of people who are eligible for both Medicaid and Medicare, the so-called "Dual Eligibles" or simply "Duals." For someone to qualify

for both programs, they must be not only poor but also a senior or a person of any age with a significant disability. While not all Duals require long-term care, many of them do, so special attention to this population has been an inevitable piece of your efforts to create a better system for long-term care in the U.S. You have long raised concern with the fact that there is no assistance for families with long-term care needs until they have impoverished themselves to the point of qualifying for Medicaid. With this problem unresolved, improving services for Duals is the best, most immediate thing that can be done to address the long-term care crisis in this country.

Dual eligibles are a particularly vulnerable population. Some have severe disabilities, most have multiple, chronic health conditions and none have sufficient resources. While getting the benefits of both the Medicare and the Medicaid programs is generally a good thing, the coordination between the two programs is sometimes lacking and important services can fall through the cracks. Also, as good as the Medicaid program is, it varies quite a bit from state to state. As a result, duals in one state can get very different services from duals in another. Moreover, the Medicaid program has a built in bias toward full-time institution-based care for people who need help every day. While this may have been considered a best practice decades ago, evidence now makes it clear that, except for a small portion of beneficiaries, there can be far better quality of life for beneficiaries as well as lower costs for taxpayers if services are provided in the home or community rather than in an institution.

Throughout your time in public service you have fought to provide

more thoughtful care options to Duals. While you often succeeded in raising the profile of this population and alerting your colleagues to the need for better coordination between the Medicare and Medicaid programs, it was not until the passage of the ACA that real progress was made. In particular, you created through the ACA the Federal Coordinated Health Care Office (now typically referred to simply as the "Duals Office") at CMS to evaluate how care was delivered to duals and then test, through demonstration projects, more innovative ways to improve care.

The Duals Office had its work cut out for it as it turned out that the situation was even worse than you knew, as the Administration could not even say with any certainty how many dual eligibles there were across the country when the office got started. While the office now has a better handle on that sort of basic information, it has otherwise been largely a disappointment. Your goal for the office was to test ways to improve care but the demonstration projects approved so far have focused more on bottom line costs than on the provision of care.

You have long argued that duals might be better served through Medicare—which has no state variation—than through Medicaid, but, thus far, all of the demonstration projects approved by the Duals Office have been Medicaid-based and, even more problematic, have focused almost exclusively on private managed care organizations to deliver services. You communicated your concerns to the Administration through numerous letter and meetings. Overall, you insisted that there be better oversight of the demonstration projects and that the projects focus more on the delivery of care than the bottom line. You specifically

suggested that the Office test Medicare-based care models, and you told the Administration that "instead of building sophisticated networks of coordinated care that improve quality and reduce waste and inefficiency, these plans are likely to limit benefits including access to long-term care and supports, cut provider payment rates, or both- further threatening access to care."

You have had meetings both with CMS Administrator Tavenner and HHS Secretary Sebelius to discuss the issue. In these meetings, you sought their commitment that the demonstration projects coming out of the Duals Office would not continue in their current form. Your concerns were echoed by advocacy groups as well as some provider groups after your efforts were made public.

Then, CMS made a public statement to Politico stating "Given the diversity and significant health care needs of dual eligibles, we recognize how critical it is to have the beneficiary protections in place to achieve the highest quality health care possible…we are taking input from Congress, MedPac and others very seriously moving forward." While the Administration has not yet moved ahead with a Medicare-base demonstration project as you would like, your stated concerns have resulted in improved oversight of the existing projects and slowed the approval of other proposed projects that you found objectionable.

Medicaid and the Affordable Care Act[2]:

You supported the expansion of Medicaid eligibility to all individuals at or below 133 percent of poverty, as outlined in the

[2] Please see your ACA Markup Speech at the end of the Health Reform Section.

Senate Finance Committee's health reform bill. However, you pushed for a further expansion by filing an amendment (C16) to the Finance Committee bill to expand Medicaid eligibility to 150 percent of the federal poverty level, as outlined in the Health, Education, Labor, and Pension Committee's health reform bill. This amendment was not ultimately included in the Finance Committee-passed bill. Unfortunately, the final Senate-passed health reform bill only included an expansion to 133 percent of poverty.[3] However, because you and your staff fought to make certain harmful or inequitable Medicaid provisions were excluded from the Senate Finance legislation, the Medicaid program was successfully expanded without seriously compromising the future of the program.

Medicaid expansion was a critical provision of the Affordable Care Act that was created in hopes of covering Americans that could not afford coverage on the Marketplace. However, the inclusion of a comprehensive Medicaid expansion in the ACA was an incredible political battle that continues as states implement the various provision of the Affordable Care Act.

Chairman Baucus crafted a health reform plan that you publically abhorred and you vocalized your intention to vote against it- if Senator Baucus refused to make any changes to his framework. Of your many concerns, you were troubled by Senator Baucus's significant Medicaid limitations in his framework. The Chairman, much to your dismay, was clear that these limitations were included in order to save money. As you recall, Senator Baucus's

[3] While 133% is typically cited, the ACA actually requires that Medicaid expansions include populations up to 138% of poverty—the 133% plus an additional 5% income disregard.

original plan eliminated CHIP entirely and placed those children who were in the program on the Marketplace. Moreover, the Chairman proposed placing the Medicaid population between 100-133 percent of the poverty line, on the Marketplace as well.

Although Senator Baucus argued that states had the option to choose whether or not to place those beneficiaries on the Marketplace, you were adamant that states would be compelled to do so, in order to increase savings.

To add insult to injury, in an effort to win the support of Senator Grassley, Chairman Baucus included Grassley's Medicaid Benefit "Flexibility". This provision *required* all states to implement the benefit "flexibility" provisions of the Deficit Reduction Act (DRA) for all expansion populations. Under the DRA, states were allowed to alter their benefit packages to mirror commercial plans, through the use of "benchmark plans". This provision of the DRA caused greater barriers to access to care and you felt that the application of "benchmark plans" to the expansion population

> "would create a two-tiered Medicaid program. It will undermine the deferral guarantee of Medicaid benefits for expansion populations that are just as vulnerable- if not more vulnerable- than the populations currently covered by Medicaid."

Also, in order to get Grassley's support the Baucus plan required Medicaid premium assistance, which meant that Medicaid-eligible populations with access to employer-based coverage have to take it- even if it was inadequate. Senator Grassley wanted to add a

similar requirement to CHIP Reauthorization, but you were able to defeat his proposal. This provision was also untenable with your beliefs regarding increasing access to health care for low-income families. You argued that if we did not include the similar suggestion in CHIP legislation, then it should not be on the table for Medicaid policy.

In addition to the obstacles created by Senator Baucus, Senator Cantwell created and fought tirelessly for, the Basic Health Plan (BHP). Senator Cantwell argued that it would help low income people in the long run. You felt that the Basic Health Plan undermined Medicaid by allowing the use of Medicaid dollars for a new health care plan that could be used to create sub-par systems for people in low-income communities. Because you knew that Senator Cantwell would refuse to vote on any Finance legislation that did not include her BHP proposal, you gave the plan your tacit approval. However, during the final days of ACA negotiations, when Senator Cantwell was presenting her plan for the BHP, you made Jocelyn sit at the Member's table and advise you during the process (none of the other staffers were sitting with their bosses).

During her presentation, David Schwartz sent Jocelyn an email stating that the plan was financing Medicaid on the backs of low-income people. You saw the email on Jocelyn's phone and read it out loud to Leadership and members of the Finance Committee who were present at the meeting. Jocelyn remembers Senator Cantwell giving her and David a ferocious and angry look- it was likely she knew that losing what little of your support she had would limit the success of her proposal. Fortunately, you and

other members of the Committee were able to scale back the BHP so that it did not greatly threaten the Medicaid program

Addressing Concerns with Medicaid Managed Care:

Medicaid, while jointly funded by the federal and state governments, has historically been administered directly by the states. While the programs vary from state-to-state, all Medicaid Directors have learned to be careful managers who "do more with less." In order to get federal matching dollars, all programs must provide a core set of mandatory benefits. Needless to say, over the years, some states have quietly tried to pare down these benefits and others have boldly sought federal permission (through a waiver application to CMS) to reduce the benefits required.

Under the Bush Administration, there was a flurry of waiver activity through which states sought to modify their Medicaid programs. One of the more popular models, espoused by the President's brother who was then Governor of Florida, was to hand over the administration of the Medicaid program to a private managed care organization. The plan was to give the managed care organization a capitated amount per beneficiary and let the managed care organization decide which benefits to provide. While the most blatant of these waivers were unsuccessful, there was nonetheless the beginning of a movement, which is only speeding up today, from traditionally administered Medicaid plans to Medicaid plans run by private managed care companies.

Not only did you publicly chastise the Bush Administration for its lack of transparency in the Medicaid waiver application process and stop the worst of the waiver applications, but you have persisted over the years in raising concerns with the move to managed care in the Medicaid context. For example, in January of 2010, you and Henry Waxman asked the GAO to examine the use of private managed care in Medicaid and the capacity of the states to over see Medicaid Managed plans. In particular, you and Congressman Waxman were interested in gathering information on: contracting policies and procedures, enforcement of contract requirements and medical loss ratio requirements.

Over the last two years, numerous Wall Street Analysts have come by to talk with your staff about the "great new profit center in health care," and they were referring to the growth in Medicaid managed care. Since the Medicaid program is so lean and efficient, it is reasonable to assume that no significant profits are possible in this market unless services are reduced. Unfortunately, the states that are moving to managed care for their Medicaid programs do seem laser-focused on the bottom line and, as you and Henry Waxman feared, seem to invest little in oversight to see that beneficiaries are getting what they need.

Given these concerns, you wrote a letter to Secretary Sebelius in 2012 explaining the need to add a Medical Loss Ratio requirement to CHIP and Medicaid. The Administration could have made this move on its own, but, since it failed to do so, you introduced legislation in December of last year, that would require a Medical Loss Ratio of 85/15 for all Medicaid managed care plans. This bill, called the *Medicaid Managed Care Responsibility*

and Equity Act (S. 1787), was highlighted in a report issued by the Commerce Committee in May, 2014.

HEALTH REFORM

The terror of becoming sick in a country that holds itself out as a beacon of hope and fairness, yet denies men, women and children access to the doctors and nurses and tests and medicines that we know will prevent illness or make them well.

A country that allows people – especially low-income people, but not only low-income people – to suffer or watch a beloved family member suffer, alone and outside the system.

All at great cost to our national economy and our national productivity, but even more importantly to our national soul, our moral compass, our conscience.

You believe health care should be a right for all Americans and have participated in every major health reform effort during your time in public life. Of particular note are the health care reform effort under President Clinton and the health care reform effort that ultimately led to the passage of the Affordable Care Act.

President Clinton's Health Reform Legislation: Health Security Act

Many people, yourself included, believed President Clinton was the man who was going to create, and pass landmark health reform legislation. President Clinton campaigned on the bold idea that all Americans should have access to health coverage. President Clinton's message was a powerful one, and you believed that he would be the first President to successfully enact health reform legislation that our country so desperately needed.

Within his first days in office, President

Clinton established a Task Force for Health Reform, and you, as well as other well respected health advocates from the Pepper Commission and policy realms weighed in throughout the process. Both Mary Ella and Ellen Doneski were on the Clinton Task Force. Ellen remembers during the Task Force days she would come to the office at five a.m., and update you as to what "Tollgate" the Task Force was studying that day. Ellen would then head to the Old Executive Office Building until eight or nine at night. Often, in order to make certain that you remained up to date on policy changes or Task Force gossip, Ellen would provide you with a late-night update phone call or memo. Moreover, you opened your home to the Clintons and their staffers for their strategy and planning meetings. When you felt that it was necessary, you gave the young political couple advice regarding the direction of their legislation. You even led a meeting with First Lady Hillary Clinton about health care in Morgantown, West Virginia. In a memo to First Lady Hillary Clinton, you outlined some of your ideas and concerns about their health legislation:

> "I am writing to share my thoughts on what I regard as one the essential pieces of the health reform puzzle—a strategy for building a health care workforce in the United States that meets the needs of our citizens…Therefore, I encourage the Health Care Task Force to give its serious attention to these issues, and to recognize that we also must act to ensure that a much more appropriate supply and distribution of health care providers can and must be pursued to achieve health reforms overarching goals of access and cost control."

The memo continued on to summarize the challenges facing our

nation, and to outlined your ideas on how to overcome some of the obstacles. You felt no health care plan could succeed without addressing at least the two following challenges:

> "While total numbers suggest that we are heading toward an oversupply of physicians, only 1/3rd of all physicians are now in primary care practice, and the proportion of students graduating from medical school expressing interest in primary care has been declining precipitously.
>
> Federal spending on medical education includes not only $5.5 billion from the Medicare program, but also over $600 million from the Public Health Service and from the Departments of Veterans Affairs and Defense…even so, we do not have a coordinated national policy that oversees this spending to make sure that it is keeping with our current and predicted workforce needs."

You continued in the memo to offer this advice: "From what we have learned so far, I strongly believe that several major initiatives to improve our supply of primary care health professionals should be included in comprehensive health reform legislation". These initiatives included:

> "Medicare graduate medical education payments should be used to serve our country's workforce needs. The number of medical specialty residency positions should be reduced, and the money should be re-directed for the tertiary care teaching hospitals to consortia to these hospitals, medical schools. Community clinics and other ambulatory care activities to be

sure that trainees have more exposure to primary care delivery sites, especially those serving the neediest communities. The culture of academic health centers must change of students are to find the role models that will influence them toward primary care. Programs for the retraining of specialists as primary care providers have been discussed as one way to improve our supply of primary care providers quickly…I know Phil Lee has expressed considerable interest in this potential solution.

Advanced practice nurse and physician assistants are an underused and a potentially powerful way to increase primary care services. A number of initiatives could be undertaken to increase support for their training and to remove practice barriers. Efforts to enhance the ethnic and racial diversity of our health care workforce, particularly physicians, have fallen short. We can not only increase the recruitment of minority students to health careers through targeted programs, but we should also strive to recruit students from rural America as they have historically been more likely to return to rural communities to practice.

The National Health Service Corps was originally conceived as a means to encourage physicians and others to locate in rural and urban underserved areas…a renewed call for national service should encourage not only the renaissance of the NHSC program but also the creation of a "National Service Program/Health" to recruit undergraduates to serve in health care programs in needy areas. Finally, we must keep in mind the important resource, the "social good" of our academic

health centers. They are the sites of the biomedical research and education that will support our health care systems As important, these are also the sites of health care not only for cutting edge services, but also often for the inner-city underserved that have been neglected by much of the private health care system. As we move toward reform, these resources deserve our support.
We have an extraordinary opportunity to develop a coordinated effort to provide the nation with the health care workforce it needs. I look forward to working with you in bringing this to pass."

-Memo to First Lady Clinton, March 1993

Based on your concerns and advice regarding necessary provisions in the Clinton health proposal, it is evident that the Pepper Commission served to inform many of the provisions you developed that were included in the final *Health Security Act*. You played a central role in the creation of the following provisions of the Clinton Plan:

- Insurance industry reforms
- Prescription drug reforms
- Workforce provisions (Title I)
- Long-term care & Medicare Drug Benefit
- Agency for Health Care

- Medicaid reforms and expansion; and

- Title VI: Antitrust Provisions (written by both you and Congressman Waxman).

In addition to the specific sections you and your staff authored, you also continued your efforts to increase access to mental health services and mental health parity. Moreover, you fought to have strong provisions supporting home health care and hospice care, malpractice reform and the politically charged employer mandate. In short, your efforts during the creation of the Clinton's *Health Security Act* were defined by your belief that the health system needed to have uniform benefits, regardless of one's income or geographic location. Moreover, at the time, you were quoted saying, "health-care reform is part of welfare reform. You have to complete health-care reform before you can complete welfare reform." You knew that without health care, low-income Americans would never gain economic security or equity in the work place.

As the Task Force moved forward in building its policy, you continued to be optimistic about the passage of Clinton's *Health Security Act*. You openly advocated for the legislation to your peers on the floor, frequently noting the inequity in our health care system and the growing health insecurity in the United States:

> "If you have health insurance in the United States of America but have to change jobs, that is when you better start worrying. You better make sure you do not have something called a preexisting condition on your records, because in

America that means that any insurance company can slam the door in your face--and they do… it is absolutely beyond my wildest imagination that in this country called America, a young woman who is married and becomes pregnant but who does not have health insurance…then goes to try to get health insurance, but cannot get health insurance because she has something called a preexisting condition; to wit, she has become pregnant. Only in America. That is why so many of us feel we have absolutely no choice but to go on and on and to persist and to persist.[4]"

Although President Clinton was wholeheartedly committed to changing the health care paradigm in America, as Clinton and the team continued to push for health reform, several weaknesses became clear. Clinton's early plan was vague and painted his plan for reform in broad brush strokes. The lack of initial clarity left the plan for health reform open to attack and redefinition by opposition on the Left and Right. Although the plan was depicted as confusing by the Press and opponents in Congress, you told CNN that despite the lack of clarity at the time,

"…[W]hen the American people really do come to understand the president's plan - they will understand, and small business will understand best of all, that the great majority of small businesses which do provide health insurance coverage for their employees and which are getting clobbered by the insurance market these days, will save an enormous amount of money from what they have to pay today. They will be paying less a percentage of their

[4] Lis.gov. Floor Speeches: http://www.congress.gov/cgi-lis/query/D?r103:4:./temp/~r103JweZ0E::

payroll for health care costs than they are today. They don't know that yet, but they will because it's in the plan."

However, as opposition mounted, the Clintons were forced to clarify and in many ways, redefine their health reform model. At one point, you expressed some concern to Clinton that shifting his plan from a pay-to-play model to the "managed competition" model late in the campaign could be problematic and risky.

In addition, as a behind-the-scenes advisor to Clinton, you tried to guide President Clinton on the most powerful rhetoric for building support of the proposed legislation. You knew that how Clinton spoke about health reform was critical to gaining widespread support with Americans and advocacy groups. You knew that in addition to centering the conversation on moral responsibility, President Clinton should not brush over American's concern about cost savings. Based on your past efforts in health reform, you knew this was a top concern for most Americans. Moreover, you advised that collaboration with Congress was critical to ensuring its passage- given the demise of catastrophic coverage just a few years before. In an op-ed you wrote for the Washington Post in 1994, you articulated the importance of powerful, targeted communication in gaining political support and debunking myths about health reform:

"The independent Congressional Budget Office has said that the Clinton health reform plan can and will achieve those objectives. But opponents want us to ignore the fact that there is no excuse for failing to guarantee all Americans health coverage that they can count on for the rest of their lives.

Instead they want to focus our attention on whether employer premiums should appear in column A, B or C in federal budget documents.

Most Americans could not care less about which accounting theory is put into practice or how budget details are described. What they care about was made clear in town hall meetings, polls, letters and phone calls: They want health care coverage that can never be taken away, a choice of health insurance that will cover their needs and quality health care that they can afford. These real worries should never take a back seat to bookkeeping theory."

Your depth of understanding of health policy and extensive experience working on reform efforts positioned you to educate the "difficult" provider groups and your colleagues on the other side of the aisle. During your meetings with provider groups or hospital associations, you were always clear that groups must be committed to bettering the health care system for the American people; any attempt to further industry over beneficiaries' well-being was not tolerated. An example of your commitment to beneficiaries was illustrated during an American Society of Internal Medicine (ASIM) conference which you and Ellen attended to discuss the impact of the President Clinton's health plan.

In a memo that Ellen wrote to prepare you for the conference, she informed you that ASIM claimed they were committed to health reform, but had done nothing to actually further the cause. When you arrived at the conference, there were over two thousand

ASIM members in attendance. Rather than read your prepared speech, you announced that you were going to read the memo your staff had prepared for the event. Ellen remembers that in front of all of the organization's members and leadership you took ASIM to task about their behavior regarding health reform. You made it abundantly clear that if, as an organization, they were not on board to help Americans, you as a Senator could not be expected to protect their interests during the Reconciliation process.

In addition to provider groups, you worked tirelessly to push your Senate colleagues to support the Clinton legislation. You would often stand up in caucus and outline why Americans needed this health reform plan, and what each provision meant for stakeholders. As a recent former governor, you were given enormous credence over issues of health reform and how it would impact states. Outside of caucus, you consistently met with Republican Senators Chafee, Hatch, Grassley, Packwood and Dole to gain their support for the legislation and find common ground.

When it became apparent that Congressional support was waning and opposition legislation was emerging in both the House and Senate, you remained optimistic that the Clintons would be successful where so many past presidents had failed. Even in the face of doubt, accusations of "government interference" and Conservative rhetoric spread through the American discourse you continued to support the options offered by the Clinton Plan. In an ABC News interview with David Brinkley you boldly defended the Health Security Act:

> "I'm really-I'm really sick of this whole thing of its nothing but bureaucracy. It's the Republican line. It scares the American people. And frankly, the press has fallen for this, too. I don't mind looking at this with a cold eye, but I don't like looking at it with a cynical eye. This is not bureaucracy. Yes, theses always some bureaucracy in everything, but I'd much rather have a bureaucracy called a health alliance which I paid a premium to, which was fighting for me to negotiate my health care at my cost for the quality that I want, which is then being monitored, watch dogged, policed by the state or by the national [government]. But that bureaucracy I'd much rather have than an insurance company. I can't even read their fine print. I'm being handed my health care, and I have no idea what my health care is."

In many ways, at the time both you and Ellen felt that Chairman Moynihan was at least partially responsible for the failure of Clinton's health reform effort. Chairman Moynihan made a floor speech during debate over the *Health Security Act*, which listed the flaws of the legislation and his opposition to its central provisions. It is likely that if Senator Moynihan had not proposed a "third way" to achieve health reform, you and your staff could have garnered enough Republican support for the Clinton plan. Moreover, the industry roundtable, which was made up of insurance companies also decided not to support the Clinton's Health Security Act. When insurers announced their opposition, you were quoted saying, ""Shame on big business. There's a special place in hell waiting for Bob Winters of the Prudential Life Insurance Co." However, the complexity and perceived secrecy

surrounding the Clinton health plan, and the bipartisan anger over a President legislating, rather than proposing reforms, also likely played a significant role in the failure of First Lady Hillary and President Clinton's reform legislation.

Although the Clinton's health plan failed to pass through Congress, you gained a greater understanding of what it would take to sign health reform in to law. You knew that it would take years to have another opportunity to pass sweeping health reform legislation; moreover, it would take extensive education and anger for the American people to realize why our health care system must be reformed. Your patience and continued efforts over the past twenty years helped to set the stage for the creation and adoption of the Patient Protection and Affordable Care Act. Undoubtedly, your experiences in 1993-1994 enabled you to be a primary author and leader in the creation and successful passage of the *Patient Protection and Affordable Care Act* in 2009.

President Obama's Health Reform Legislation: Patient Protection and Affordable Care Act

In 2008, Senator Barack Obama won his campaign for president. President Obama, like many Presidents before him, promised to implement sweeping changes to the American health care system. You were a key leader in the creation and passage of the Affordable Care Act. While you were thwarted in your efforts to include a "public option," you are proud of the law that passed, particularly of its expansion of the Medicaid program (which has already resulted in coverage for over 100,000 previously uncovered West Virginians), requirements that insurers provide

key benefits (and not waste money unnecessarily on administration), the end of pre-existing condition exclusions, and the continued coverage of children on parents' policies until age 26 (which has provided coverage for 18,000 young adults in West Virginia so far).

You are immensely proud of the law you helped to create, and you fought to make certain the provisions helped as many Americans as possible. Even as a Senator, a step removed from the people of West Virginia, you knew and understood the perils of being un-insured based on the hundreds of letters you received from constituents, many of whom were self-insured. When the President made public the "first" version of his ACA legislation, you and your staff were shocked to see that many of his reforms did not touch the self-insured. You made several efforts to gain the attention of the Administration in order to inform them of this error; however, you were ignored.

Finally, you scheduled a meeting with the President and his staffer, Nancy. When you arrived you immediately confronted the President informing him that his proposal did not cover the nearly fifty percent of Americans who were self-insured. Your staff recalls that the President turned to Nancy, and asked: "Is this true?" She was forced in to an embarrassing situation in which she had to admit to the President that the plan was flawed. Based on this meeting with the President, you were finally able to negotiate the application of some of the reforms to all insurance markets including the elimination of lifetime and annual limits, preexisting conditions and premium rate review.

After addressing your direct concerns with the soon-to-be law, you still had to face pushback from your colleagues in the Senate. There was intense debate within the Finance Committee about what provisions should be included in the legislation. In fact, the day of the markup, there were over five hundred amendments to the proposed bill. Your staff wrote a vote rationale for every single amendment, and included how the amendment would impact West Virginia. When you arrived with your book of vote rationales, Senator Conrad turned to his staffer at the time and told her that he wanted a similar book for the next day of voting. Reflective of your commitment to every aspect of health reform, you had an enormous set of priorities for inclusion in the Affordable Care Act- all of which benefited West Virginians.

In order to make certain your priorities were included, you and Jocelyn navigated the mark and negotiations in a strategic manner. For example, you fought to have CHIP reauthorized through 2019, but only funded through FY2015. Your successful extension and improvement of the CHIP provision prevented millions of children getting rolled in to exchange coverage (which is not yet kid-friendly), and gave states an opportunity to apply political pressure when funding expired. Ultimately, you felt that pressure from state-based stakeholders would be more powerful in guaranteeing an extension of CHIP in FY2015 than anything you could do in Finance Committee negotiations.

In addition to policy strategy, you executed excellent political strategy during the markup. On the final night of markup, many members were weary and ready for the markup to come to an end. Fearing that the markup may end before backroom

negotiations were completed, you launched into a story from you days in West Virginia as a VISTA volunteer, working to enroll residents in Medicaid. At the end of the story, you and the room filled with staff and Senators had broken down in to tears. Through the story you told, you attempted to convey the importance of Medicaid as well as the necessity of humility as policy makers.

While this story was important based on its message alone; it also had another purpose. During your story, one of your staffers at the time, Jorge Castro was negotiating with Committee staff to make certain the Cadillac Tax was included in the legislation. If the markup ended early, the tax would not be included, so you chose to regale your colleagues in order to buy Jorge more time. You achieved remarkable success in gaining inclusion on most of your legislative priorities beyond those listed above.

The following are some additional key pieces of legislation that were included the Patient Protection and Affordable Care Act:

The Annual and Lifetime Health Care Limit Elimination Act (S.1149)

This initiative prohibited all health insurers from imposing limits on annual or lifetime medical spending. The Finance Committee health reform bill only included such a provision in the small group and individual market. During the Finance markup, you filed an amendment to strengthen the language regarding lifetime and annual limits. Chairman Baucus ultimately included language prohibiting insurers in the larger group market from imposing

"unreasonable" lifetime or annual limits on coverage. However, he left the term unreasonable undefined. You continued to advocate for full prohibition of limits on coverage.

Ultimately, the final Senate-passed bill did include a ban on lifetime limits, and after 2014, annual limits were also completely prohibited.

The informed Consumer Choices Health Care Act (S.1050)

This legislation called for federal standards for health insurance forms, fair marketing and out-of-network coverage. You also included accountability and transparency guidelines to monitor all health plans. Components of this bill were included in the Senate health bill, particularly the requirement for uniform definitions of standard insurance terms, description of coverage, cost-sharing transparency, coverage details and the standards for providing information to enrollees and policyholders.

Although every committee version included some variation of the provisions included in this legislation, you filed an amendment during the Finance health reform mark-up to significantly enhance transparency provisions. Although the amendment was not adopted, Leader Reid strengthened the provisions about which you were concerned as part of the merged Senate bill. You also successfully secured language in the Senate-passed bill that requires insurers to report on how they treat their consumers and providers in their network. You felt that this public reporting would allow potential consumers to make the best decision possible about what plan was best for them and their families.

Commerce Subcommittee on Oversight and Investigations

You led several powerful and informative investigations in to the health insurance industry. You examined the deceptive practices of health insurance companies and their use of fraudulent practices to set out of network reimbursements. The subcommittee issued reported on the widespread practices that help insurance companies- specifically for-profit companies like UnitedHealth- profit at the detriment of the enrollee. Your role as a leader in these investigations, helped shed light on harmful practices and usher in greater insurance company regulation.

Rescission of Bush Administration Proposed Medicaid Regulations

On July 1, 2010, the U.S. Department of Health and Human Services rescinded regulations proposed by the Bush White House that would have eliminated long-standing policy regarding reimbursement for school-based services, narrowed Medicaid payment policy for covered case management services and limited Medicaid funding for outpatient hospital services. You fought make certain that these Medicaid regulations were stopped. You introduced the *Economic Recovery in Health Care Act (S.2819)* that delayed the harmful regulations. Had you been unsuccessful in halting the implementation of these Bush-era regulations, there would have been significant gaps in coverage for the children and families who rely on Medicaid.

The Medicare Prescription Drug Coverage Improvement Act (S. 1634)

This bill would have created a Medicare-operated prescription drug plan, make improvements to the Medicare-Medicaid Duals program, and allow the Secretary of Health and Human Services to negotiate with drug companies directly to lower the cost of prescription drugs. During the Finance Committee mark-up you filed an amendment to include a provision on S. 1634 that creates the Federal Coordinated Health Care Office (See more in the Medicaid section). This amendment was adopted and it remained in the Senate-passed version of the ACA. Unfortunately, your effort to get the entirety of S.1634 included in the ACA failed to pass through the Finance mark-up

The Medicaid and CHIP Payment and Access Commission (MACPAC)

You fought to include the creation of this Commission, which similar to MedPac will advise Congress on issues facing Medicaid and CHIP. You also worked with the Finance Committee to include language that properly funds MACPAC- all of which were included in the Senate-passed bill.

Two lesser known (or misunderstood) provisions that you championed during health reform are the use of the minimum Medical Loss Ratios to encourage health plans to provide quality and value to enrollees and the creation of the Independent Payment Advisory Board under which changes to Medicare would require the least harmful approach for beneficiaries.

Medical Loss Ratio: Thoughtful Industry Regulation

Once again, during the passage of the ACA you stood out in your willingness to challenge industry to do better. The Medical Loss Ratio requirement in the ACA is the most recent example of this—it simply requires that insurers spend most of the premiums collected on patient care or return those dollars to consumers.

The inclusion of this component of the law began after you conducted investigations through the Commerce Committee on the accuracy of the reporting of insurance companies' Medical Loss Ratios. You found the actual Loss Ratios to be lower than what insurance companies claimed. On August 5, 2009 you sent a letter asking Cigna about its practices of dropping small businesses with employees that incurred high health costs. Then, on August 21, 2009, you called on the top 15 health insurance companies requesting information regarding how they spent their premium dollars.

You and Senator Franken proceeded to cosponsor legislation that called for a minimum medical loss ratio of 90 percent. You were unsuccessful in the passage of that legislation or its inclusion in the Finance Markup. However, in the final Senate passed version insurers are bound by an 85 percent Medical Loss Ratio, and an 80 MLR in the small group market. Moreover, this also applied to grandfathered plans. Although you faced major opposition from insurance companies and widespread misinformation about medical loss ratio, its inclusion in the law offers a safeguard against the misuse of premium dollars and groundwork for higher

quality care.

Independent Payment Advisory Board (IPAB)[5]

As the Senate considered health care reform legislation in 2009, you and other Senators on the Finance Committee were acutely aware of the need to control the growth in health care spending and improve the quality and safety of care delivered to patients. In June of 2009, under your leadership on the issue, your colleagues began to focus on the idea of expanding the powers of the Medicare Payment Advisory Commission (MedPAC) so that the Government might have a greater prospect of carrying out MedPAC's well-regarded recommendations.

MedPAC is a congressional advisory commission, and thus, to give MedPAC's recommendations a binding effect, Congress would either have to enact those recommendations into law or transform MedPAC into an executive agency.

On June 25, 2009, you introduced S. 1380, the *Medicare Payment Advisory Commission Reform Act of 2009*, which would have transformed MedPAC into an executive branch agency. On July 17, 2009, the Obama Administration submitted a legislative proposal to Congress entitled the Independent Medicare Advisory Council Act. The Obama Administration proposal would have created an independent five-member executive council to make recommendations to the President.

At the same time, from June 17 to September 14, 2009, three

[5] This information was retrieved from Jocelyn Moore's archived files

Democratic and three Republican Senate Finance Committee Senators met for a series of 31 meetings to discuss the development of health care reform legislation. During this period, Senators Max Baucus (D–Montana), Chuck Grassley (R–Iowa), Kent Conrad (D–North Dakota), Olympia Snowe (R–Maine), Jeff Bingaman (D–New Mexico), and Mike Enzi (R–Wyoming), met for more than 60 hours.

In June of 2009, staff for these Senators began discussions of means to enhance the power of MedPAC, informally describing those proposals as ''MedPAC on steroids.'' The group of six Senators discussed these matters on July 20, and again on July 28. Although the group of six Senators did not agree to a bill as a group, Finance Committee Chairman Max Baucus took their discussions as the principles upon which he based his Chairman's Mark for the Finance Committee's consideration of health care reform legislation. And thus the ideas discussed by the group of six became the basis for the health care reform legislation that the Senate passed on Christmas Eve of 2009. And that legislation largely colored what became the new health care reform law, the Patient Protection and Affordable Care Act.

The Patient Protection and Affordable Care Act created a new entity, the Independent Payment Advisory Board (IPAB). The new law charged the Board with developing proposals to ''reduce the per capita rate of growth in Medicare spending.'' The law directs the Secretary of Health and Human Services to implement the Board's proposals automatically unless Congress affirmatively acts to alter the Board's proposals.

Many believe that the IPAB will be among the most important cost-containing tools in the health care law. In November 2009, a group of 23 distinguished economists wrote a letter to President Obama that included IPAB as one of four elements necessary in health reform legislation to ensure effective future cost containment.

On a personal level, the creation and inclusion of the Independent Payment Advisory Board is one of your proudest moments. You saw it as a uniquely sensible way to make health care delivery reforms away from the politics of Congress. Needless to say, this approach is unpopular with many of your Congressional colleagues but, unlike other efforts to reform the health care system, IPAB is structured to always safeguard beneficiaries, meaning it would do no harm to the people who matter most. If anything, in an ideal world, IPAB would be strengthened. In fact, a 2012 study by the Institute of Medicine (IOM) suggests that over $750 billion in additional savings could be achieved if the program were broadened to include the private sector, such as hospitals.

The Public Option

In addition to your provisions protecting beneficiaries and promoting industry accountability, you were one of the only Senators advocating for the inclusion of a "public option" or a government-run health care plan in the Marketplaces. Initially, you were very focused on insurance reforms and their inclusion in the ACA; despite your strong belief in the need for a government-run health plan. When you did begin to discuss the "public

option", you framed it under the umbrella of insurance quality and cost reform. Rather than debate the idea of a government health plan, you saw it as a model plan that private insurers would have to measure up to in terms of quality and accessibility. You explained to the Charleston Gazette that, "In being for the public option**,** I am not trying to punish the health-insurance industry; I am trying to help people. I am tired, angry and frustrated at this complicated system that is not working for people." At the time, there was a single-payer bill in the House, and you created a more robust Senate version because you felt the House bill did not address the issues with Medicare and Medicaid in terms of coverage gaps and affordability. In an effort to build support, you distributed a one-pager to every member discussing why every member of the Senate should support the inclusion of your pubic option legislation in the Senate version of the ACA.

Meanwhile, Senator Conrad was advocating for the inclusion of Co-op health plans, as a less politically divisive replacement of your Public Option. You and Senator Conrad disagreed on the stability of Co-ops; he felt they would work well, despite the reality that the plans had only been used with smaller populations, predominately in the mid-west. This prompted you to request a GAO Report that ultimately substantiated your claim that co-ops were an untested model, and millions of newly insured could not, and should not be placed in potentially unstable plans. Despite the findings of the GAO, Senator Conrad continued to fight for their inclusion; during a member meeting you addressed the findings of the report, and called the Senator's co-op plan "absurd".

Even with your common sense approach, your strong support of a public option early on in the drafting process created tension between you and many of your colleagues in the Senate aside from Senator Conrad. In particular, you and Senator Lieberman disagreed on the necessity of a public plan, and whether it would offer better services. This conflict was in many ways ironic, as Senator Lieberman was a strong supporter of the IPAB measure; which was essentially a means to control costs and regulate the quality of care.

Throughout the creation, debate and markup of the Affordable Care Act, you and Jocelyn remained supportive of a public option. You absolutely refused to back down in the face of opposition, and told press after its failure to pass through the Finance Committee, "I fought for a meaningful public option, both in the Senate Finance Committee and on the Senate floor," Rockefeller said. "Unfortunately, there simply has not been enough support to date to pass a strong public option, despite these efforts." While your public option amendment did not pass through the Finance Committee, your commitment to a government-run plan led to the requirement that every exchange must offer an OPM-run plan. Despite the reality that these plans are not what you envisioned, it serves as testament to your commitment to good policy and vision of what health care should look like in this country.

Ultimately, your involvement in the passage of the Affordable Care Act was significant not only because of the number of your provisions that were included, but due to the harmful provisions you successfully blocked from passing through Finance Committee. It is unquestionable that despite opposition to the

ACA, the tumultuous enrollment period and technical flaws, the Affordable Care Act has changed West Virginia, and America, for the better.

With a stroke of a pen, doors to access were opened to millions of people; many of whom were uninsured or underinsured. Medicaid expansion alone, and West Virginia's decision to participate, will change the lives of so many people and positively affect the overall quality of life and economic growth in the state.

Our health care system has been changed forever- the possibilities for our country's health outcomes are entirely different than prior to the Affordable Care Act. Your involvement in health reform over the last 30 years greatly affected the success of the Affordable Care Act, and your specific contributions to the law reflect your continued dedication to protecting beneficiaries and low-income communities.

MEDICAID SPEECH: ACA MARKUP, DAY SEVEN

As mentioned in the Health Reform and Medicaid sections of this memo, late on the last night of Finance Committee's markup of their health reform legislation, you were asked to delay the completion of the markup in order to assure that important negotiations were completed. Rather than take the opportunity to discuss a topic that was either non-germane or politically popular, you chose to discuss the importance of Medicaid. This was a particularly powerful choice of topics as you had passionately advocated for more sweeping, progressive provisions for low-income Americans in the Affordable Care Act. In many ways, you used the final hours of the markup and the story of Eddie, to remind your colleagues that they needed act with courage and compassion in order to bring about true change in our nation's health care system.

Below is the story you told about the importance of Medicaid:

"People can say what they want about Medicaid, but Social Security was not set up for no reason at all. Medicaid and Medicare which passed at the same time were not set up for no reason at all. So it is important, and that is why I think the Deficit Reduction Act is not good.

I am rereading my statement here, folks. This is tactical.This is at the summit. This is at the summit. Criticality of this moment and the pressure, the psychological ramifications are stunning. So I

am going to read my entire Medicaid statement all over again so that you will not miss a single nuance. That is important to me, that is important to America, and that is important to David Schwartz.

And so here we go. Over the last two weeks – Senator Nelson, do I have your full attention?

I have heard a lot of talk about old people, disabled people, vulnerable populations, pregnant women, the elderly, et cetera. But again you just do not hear people talking, public officials or people, about Medicaid; because it is something they had rather not hear about, something they had rather not have in their communities.

Now my experience was different because I was reborn in a secular sense by becoming a VISTA volunteer when I went to West Virginia, not expecting to stay, and then finding after one year living with people, none of whom had work, none of whom had health insurance, none of whom went to school because there was no school bus. And you have heard this speech before. And I could not leave. And it was because I became so devoted to those people and the unfairness. And I will tell you the story of Eddie.

The story of Eddie is an 18-year-old boy fully capable and prepared to work, terrific physical, mental specimen, great attitude, leader in our youth movement in our VISTA community.

And I lined up a job interview at Union Carbide for him. And I took

him with me in my Land Rover, whatever it was, and we went down to Union Carbide. Well, that meant we had to go to Charleston. He had never been to Charleston, which is only 45 minutes away, and he had never crossed a street, never seen a red light. So he was confused by that, but I was with him. And then we went into the Union Carbide Building. It is a big company, had a lot of elevators.

He had never been in an elevator. A lot of people get claustrophobic. He got claustrophobic in the elevator. But I was with him, and he was steady. So we came out on the third floor and we walked into the interviewer's office.

He was a very nice man, but the room was set up so that Eddie and I, sitting side by side, were facing a big window with sunlight streaming directly into our eyes, which did not bother me but made Eddie understandably nervous. So the plant interviewer who was sensitive to Eddie said, why don't you let the blinds down, son, and the sun will not be in your eyes? Well, it happened that the blinds were Venetian blinds, two ropes that do not meet on one side, and one rope which does on the other.

There are no blinds in that district community. Eddie fiddled with that for awhile, but he was humiliated, embarrassed, and so what he did was he reached up and took the bottom seven or eight slats on the blind and he just hung his full weight on those slats, which did not move. (choking up) I am sorry.

So then he sat down, and we proceeded with the interview. But he could not give his name. He had been stripped of all self-worth.

What I had done to him was substantially damaging to him. And a year later he was gone from Emmons, and I have no idea where he is today. But he had Medicaid. He had me by his side, and it did not work. He had Medicaid by his side, and it did work.
So I like to keep poor people where they have health care benefits. I do not wish to see them handed over to the tender mercies of a private exchange, or whatever. And I think you will understand the spirit in which I tell this story.

It is interesting. I took 500-- remember in those days back in '64 and '65, the big rage was Olivetti typewriters? They were slim, they were modern, they were chic? You could say dude about them, they were cool? And I had one of those, and every night I would sit down and I would write pages and pages and pages of what went on during that day, psychologically, to me when things went well, when things didn't go well, to individual parts of our community. There were only 356 people in this whole community, but it was a huge community in terms of the implications of people.

And I have that in my office at home. And in the 43 years since I have left Emmons, I have never opened that diary to read it. I can't do it. And now I am embarrassed. Have I talked enough, Mr. Chairman? I was trying to cover for you. This is off the request of The Chairman. I just had to talk so he could work some things out. It is a little bit more painful for me, and I hope not for him. But actually I do not care about that because I feel the way I feel, and I am who I am. Thus ends the reading of the evening lecture."

PREVENTION &TREATMENT OF PRESCRIPTION DRUG ABUSE

In the last decade, the United States has experienced a tragic increase in deaths and overdoses from prescription drugs – largely fueled by a rise in consumption of prescription painkillers, or "opioids." This problem is particularly acute in West Virginia, where 9 out of 10 of the drug-related deaths are because of the misuse and abuse of prescription drugs.

> *There are no simple solutions. But we can make progress. I have introduced legislation to improve the tools available to prescribers – including better training on controlled substances*

This problem requires a delicate policy approach to balancing genuine medical needs of patients for whom these painkillers are their only relief and people who suffer from addiction to these substances and abuse them. For people suffering from addiction, you have always felt that the priority had to be on treatment more than on law enforcement. Unfortunately, the shortage of mental health treatment providers and facilities is so acute in West Virginia that many patients seeking rehabilitation are unable to get these services.

Sarah Dash recalled a particularly poignant moment that highlights your commitment to drug addiction and abuse: Sarah received a letter from a constituent, relaying her own family's connection to prescription drug abuse. In her note, the

constituent recounted the drug-related deaths and incarcerations that had destroyed her family over the past several years. Sarah believed this was a letter you needed to see. After reading her letter and plea for action, you took her letter to heart, and wrote an emotional, impromptu and personal response to the young woman. Sarah remembers the visible empathy and concern you had for the young West Virginia woman, and Sarah was brought to tears.

The lack of access to treatment and heartbreaking nature of prescription drug abuse in West Virginia led you to tackle the issue head on. In 2012, you chaired a hearing in the Health Subcommittee entitled *Prescription Drug Abuse: How are Medicare and Medicaid Adapting to the Challenge?* The purpose of the meeting was to get an overview of the policy options available through Medicaid and Medicare to potentially address prescription drug abuse. You framed the issue has a public health and clinical care challenge, rather than a criminal justice issue and emphasized that Medicaid and Medicare offered, and continue to offer, pathways to supporting addiction treatment.

In addition to the hearing you chaired, you have taken the lead on several pieces of legislation to establish treatment infrastructure and reduced opioid misuse dating back to the mid-1980's.

High Intensity Drug Trafficking Area Program (HIDTA)

This program was created by Congress with the Anti-Drug Abuse Act of 1988, and provides assistance to law enforcement agencies operating in areas that are considered high drug-

trafficking regions in the United States. This program has been very successful at eradicating trafficking in West Virginia and due to your urging The White House included Hancock, Brooke, Ohio and Marshall Counties in the HIDTA program in addition to Putnam and Mercer counties prior participation.

Prescription Drug Monitoring Programs

You have been very supportive of prescription drug monitoring programs (PDPMs), but you have consistently approached these programs as a public health tool, rather than a mechanism for law enforcement officials. For this reason, you have been very supportive of the National All Schedules Prescription Electronic Reporting program. The program directly funds states for training and technical assistance through a competitive grant process. In recent years the program has not been reauthorized, so you have supported the weaker grant program called the Hal Rogers Prescription Drug Monitoring Program.

Methadone Treatment and Protection Act/Prescription Abuse Treatment and Help Act

This legislation aimed to address the unsafe use of methadone and opioids through prescriber and consumer education on the proper use of methadone, clinical guidelines, state prescription drug monitoring programs, and reporting on opioid related deaths. The legislation was referred to the Senate Health, Education, Labor and Pensions Committee.

Prescription Drug Abuse Prevention and Treatment Act

You re-introduced this legislation in 2013, which takes a comprehensive approach to addressing this problem by calling for new training requirements for health care professionals, outreach and education for consumers and better dosage standards, among other things.

Your have concentrated your efforts to combat prescription drug abuse on several fronts. While your legislation is of critical importance you were also instrumental in establishing social infrastructure through which legislative efforts could be successful. For example, you played a central role in bringing SAMHSA to West Virginia to provide a continuing education course on opioid prescriptions. Moreover, you have supported the implementation of safe disposal laws which provides outreach in the state and expands the institutions that collected and safely dispose of, controlled substances. You have sent numerous letters to government agencies seeking further study of this issue, more appropriate dosaging guidelines and better treatment options. You have also attended drug court graduations and held multiple roundtables in the state to discuss this very personal and difficult issue.

MULTI-ISSUE EFFORTS

Mental Health

In a related vein to prescription drug abuse, you have also been a strong supporter of mental health parity efforts and the 113th Congress's *Excellence in Mental Health Act*, which will provide more funding for mental health providers, especially in shortage areas like 50 of West Virginia's 55 counties.

Alliance for Health Reform, 1991-Present

As you said at the ten year anniversary of the Alliance for Health Reform,

> "The Alliance rose, one might say, from the ashes of the Pepper Commission. I chaired it, Ed Howard was the counsel. Our bipartisan commission recommended its plan for universal coverage by the narrowest of margins, pretty much along party lines. Many of us were afraid that health care as an issue was going to fade altogether. And I knew, from my conversations with my colleagues, that far too few of them understood this complicated issue well enough to deal with it in legislation. Thus was born the Alliance for Health Reform."

I can tell you that my colleagues in Congress are now immeasurably more up to speed on health care issues than they were when the Alliance began its work. The reporters I talk to are better informed as well. I suspect the same is true for Congressional staff. I guess it's something of an overstatement to attribute all of that to the Alliance, but we have certainly played a major role.

- Sep 20, 2001

After the Pepper Commission published its report, you were talking with Ed Howard and Tamara about how the Commission was a $1.2 million health policy seminar for you and your colleagues. Moreover, you realized that many political leaders in Congress did not understand the complexities of the policy they were creating. Tamara broached the idea that it would be useful to create an organization whose job it was to educate Hill staffers and their bosses. Over the following year, Ed Howard researched and interviewed potential board members. You recruited some of the best and brightest health policy leaders in Washington D.C.

After developing a board of directors and full staff, The Alliance for Health Reform was formed in 1991, a year after the release of the Pepper report. In 1993, The Alliance had its first fundraiser at Park Road. Ed Howard recalled that this fundraiser was the most successful The Alliance has ever hosted, even to this day. After the fundraiser, Ed remembers receiving a bill in the mail from you for over $600.00; you explained that you had to pay your staff overtime in order to host the event, and the bill covered those costs. Ed still has a photocopy of the check he wrote you, fondly recalling the success of the event, The Alliance and how it was the only time he has, or likely ever will, pay a Rockefeller.

In the early years of The Alliance for Health Reform, you regularly chaired the briefings and meetings. Moreover, you quickly established The Alliance as a bipartisan/non-partisan source for reliable health policy information. You personally recruited Jack Danforth as your co-chair, and since then you have always personally identified and asked each new co-chair to participate in The Alliance. Given that in the early days, The Alliance had very

little money, and often held briefings in the smaller rooms in the Capitol building. If there were twenty people in attendance, that was considered a successful briefing. Today, The Alliance has to hold their briefings in the larger rooms in of the Senate office buildings in order to accommodate the large number of attendees.

Although The Alliance did not have the reach or capacity to draw large numbers of Hill staff in its early years, the briefings were always timely and featured bi-partisan, well-respected leaders. More importantly, given its roots in the Pepper Commission, The Alliance always focused on issues of access and coverage and the challenges facing health reform. In fact, Ed recalled one of the first televised briefings that C-SPAN covered was entitled: "*Health and Long-term Care: Winning Issues in 1992*?" Ironically, many pollsters and pundits believed that health care issues were politically important, but would not be the one of the defining issues of the year. As you know, the pollsters could not have been more wrong.

The Alliance, like you, was optimistic that President Clinton's health reform plan would pass in to law, but worried what that would mean for the future of The Alliance. Ed Howard remembers the many meetings you had with other board members about the direction in which The Alliance would take should a reform bill pass in Congress. It was a running joke that The Alliance did not want to become the March of Dimes of health policy.

Unfortunately, as you noted in your speech about The Alliance, "I [was] informed that there was no coverage-for-all bill passed in

1993 or 1994. That greatly disappointed me. But it did underscore the need for the Alliance to continue its educational mission among Congressional staff and members of the media." As the passage of the Affordable Care Act has illustrated, the need for ongoing education and outreach is as great as ever due to the complex and wide reaching nature of health care policy.

While the need for education and outreach to Hill staffers and the media is still necessary, The Alliance recognizes that it must also shift with the ACA as well as your retirement. The Alliance, in many ways, is facing an identity crisis as you leave the Senate. Ed Howard hopes that you will remain involved in the way you feel is best- he feels that your involvement is critical to The Alliance as everything it as an organization has achieved, would not have been possible without you as its de-facto leader. Your involvement in the creation of the organization gave it instant credibility in the halls of Congress and in the offices of health policy officials. In addition, your insistence on bipartisan cooperation set The Alliance for Health Reform apart from most of the Washington D.C. policy community, and has become a trusted source for information on health and health reform.

However, your words from The Alliance's tenth anniversary party still ring true:

> "The Alliance mission is not over. Nor is the work of the policy makers and opinion leaders to whom it targets its work. We have to fix the holes in the American health care system. And we can't do that without reliable, timely information. Let's hope it doesn't take another 10 years, but

let's hope the Alliance is around to help."

Access to Affordable Drugs: Chronic and Rare Diseases

Your efforts to create a more competitive market for expensive drugs called biologics demonstrate a willingness to stand up for what is right, even in the face of widespread industry opposition. These newer drugs (developed in the last thirty years) do amazing things but they are extraordinarily expensive. By just 2015, biologics will account for 47% of all drug spending in the U.S. Charges for biologics typically run thousands of dollars per month for a single prescription, and these drugs are not subject to the same type of generic competition as are traditional drugs. You consider this to be unconscionable and believe, once off patent, these drugs should be subject to the same sort of competition that resulted in lower prices—and greater access—with the traditional drug market.

CONCLUSION

While your time in the Senate is winding down, your legacy and the impact you have had on millions of Americans will last long in to the future.

Over the last nearly thirty years you have introduced or cosponsored well over 2,000 pieces of major health-related legislation, chaired and participated in innumerable Commissions, hearings and committee investigations. You provided leadership and policy for both the Clinton's *American Health Security Act*, and President Obama's *Patient Protection and Affordable Care Act*. Although most of America may not know it, their lives were dramatically changed because of you. Most importantly, there are few Senators such as yourself who have remained as committed to people who are low-income, and who tend not to vote or contribute financially to campaigns. Moreover, there are few who are as unaffected by the ever-growing special interests such as the pharmaceutical lobby. The people of West Virginia are who you answer to, and have fought for over the last three-decades.

In nearly every meeting the health team has had over the past few months, West Virginians and non-West Virginians alike are mourning your departure. Without a doubt, upon your retirement Congress will lose one of its "Lions of the Senate".

INDIVIDUAL WEST VIRGINIA SUCCESS STORIES

Wes Holden and Asley Orr from the state staff provided the following examples of success stories your office has had in helping West Virginia constituents with their health crises.

- **Ivan Lee, II,** was the young man with a really inspirational story that participated in your September 2013 CHIP reauthorization roundtable in Charleston. As you will recall, Ivan was mainly raised by his grandmother who he still calls "Mom." Although Ivan was a healthy child, CHIP allowed his grandmother the peace of mind to let him play sports and just be a normal kid. After high school, Ivan attended High Point University in North Carolina where he was a community organizer for President Obama's campaign. He has since moved back to West Virginia (after the birth of his daughter) and is clerking for a Federal Judge.

- **Judy Kinnard,** lost her job working at a drycleaner's where she and her husband had worked for 17 years when the drycleaners closed in 2007. Neither of them had health insurance. She is 67 and her husband is 69. Her husband found a job washing dishes at a nursing home, and she had back surgery and was unable to work for a year and a half. She now works full-time for AARP. Both Judy and her husband have diabetes and high blood pressure. They have had to share their medications or do without. In the past few years they have hit their doughnut holes in July or August. The price of their medications has continued to

increase. The doughnut hole provisions in the Affordable Care Act have helped her afford her medications.

- **Regina Lorenzen,** and her husband have operated a small business (professional photography studio) in Summersville since 1981. They purchased private health insurance for their family from the start as they raised children in Summersville. After 10 years of regular payments and few claims, Regina was diagnosed with a rare lung disease with no cure and for which a double lung transplant is the only option.

  Despite sometimes using supplemental oxygen 24 hours a day, Regina continued to work and pay her health insurance for the next 10 years while she waited for a double lung transplant. She was then, however, notified that her insurance company was no longer going to do business in WV and that her policy would be terminated. She next applied for Social Security Disability, but faced a 6-month period until she would be eligible for Medicare and because of her pre-existing condition, was not eligible for other private insurance. The WV legislature's catastrophic illness fund helped with her insurance premiums and your office contacted the University of Virginia Medical Center about the transplant; she was able to receive the double lung transplant and went on to be covered by Medicare.

- **Donald Heaton**, of Wellsburg, called your Charleston office and spoke with Wes. He is a Multiple Sclerosis patient who was having difficulty with paying for a medication that aided his ability to walk. On March 20, 2010, he attempted to fill the prescription for Acthar HP Gel 80 units at his local pharmacy. He was told

that he would need to meet a co-pay of $5,000.00 for the five injections that his Medicare Part-D insurance did not cover. Wes contacted the Director of the National Organization for Rare Diseases. He explained the difficulty that Mr. Heaton was experiencing and how his quality of life would be affected if he could not be ambulatory. The organization paid the $5,000.00 for the medication that his insurance did not cover. Mr. Heaton was very impressed with having his problem resolved and sent you a very kind thank you letter.

- **Mark Doak, President and CEO of Davis Health Systems,** called Wes about a problem that Davis Memorial Hospital was having with resolving a Medicare audit that took place twenty years ago. Wes contacted the Centers for Medicare and Medicaid Services in Philadelphia. Medicare reported that the hospital owed #3,249,920.00 plus interest in the amount of $356,001.00 as of March 6, 2010. Wes explained that the hospital was in a very rural area of the State and they could not afford such a payment because it would result in a possible closure of the facility or it could be reduced to a clinic. Wes pushed very hard for a waiver of the debt with several officials at Medicare. Eventually they asked Wes to give them sufficient time to conduct an in depth review. During late November 2010, they granted a waiver and forgave the debt. Mark Doak and his hospital board want you to come to Elkins where they can personally thank you for saving their hospital.

- **West Virginia Dialysis Facilities, Inc., of Charleston** called Wes regarding a 15 year old dialysis patient who needed a sewer system installed at her home. Her parents could not afford paying

the three trips a week to Charleston from McDowell County to Charleston for her dialysis treatments. As with most of her neighbors, her home's septic waste flowed directly into the creek and due to dialysis patients using a chemical that is radioactive, federal law prohibits the waste being dumped into a stream. Wes called several business leaders in the Isaban community to come together to donate their time, and through volunteer efforts, a septic system was donated an installed. You will be interested in knowing that this took place during the winter and it took an extra effort to complete the installation because the ground was frozen.

- **Rosemary Saunders, of Follansbee,** sent a letter to your Charleston Office about her diagnosis of very rare inoperable brain cancer. Medicare denied payment on the $50,000.00 medical treatments that she received and owed to her physician. Wes contacted Medicare and asked for a waiver of the debt. Medicare decided that since her physician was using Avastin, a stomach cancer drug, to treat her brain cancer, they would not allow the physician to bill her for the debt. They made their decision based on the fact that the FDA did not approve the drug to treat brain cancer. After sharing the good news with Ms. Sanders, she told Wes that the drug was successful in reducing her brain tumors and asked if something could be done to continue her treatments. Wes then contacted Dr. Art Levinson, CEO, Genetch, and requested that the drugs Avastin and Irinotecan be provided to the Upper Pittsburgh Medical Center free of charge to treat Mrs. Sanders' brain cancer? Dr. Levinson did agree to the request and Mrs. Sanders' physicians also provided their services free of charge. For the past four years, the treatments have been very successful. Mrs. Sanders calls

Wes every now and then to let him know that she is stll among the living and leading a productive life.

- **Dot Nichols,** During one of Wes' mobile office visits to Ripley, he would drop in at the Star Herald Newspaper office, the conservative Jackson County newspaper. One day Dot told Wes about her son, Rick Simons, who needed a liver transplant. Unfortunately, he did not have insurance and the local donation fund drive was not helping very much. Wes contacted several in and out of State hospitals about performing the transplant and they could not be of assistance. He eventually talked to the transplant coordinator at the University of Virginia Medical Center. They told Wes that they would admit Rick on a presumptive eligibility and it would be up to him to make sure that he is approved for a Medicaid card. Wes then contacted the West Virginia Medical Institute about Rick's need for a transplant. He asked them to contact West Virginia University Medical Center to send Rick's medical records and requested that Rick be approved for out-of-state Medicaid.

  Several weeks later, Rick received a call from the University of Virginia Medical Center letting him know that he met a match for a liver. He was transported by helicopter to the medical center where he was given a new liver. Two weeks before Christmas, Wes received a very kind and thoughtful letter from Dot Nichols. At the end it said, "Because of you, my son lives".

- **Kathleen Lovin, Physician Assistant**, called Wes about being upset that Medicare discriminated between Ohio and West Virginia Physician Assistants in their reimbursement rates.

Medicare paid Ohio Physician Assistants at a high rate than West Virginia Physician Assistants based on the population of the two states. Wes contacted Medicare about the problem. They responded that they sent a letter to the American Academy of Physician Assistants and to the Ohio and West Virginia Physician Assistants, as well as to the Boards of Medicine in each State to help them develop a definite list of services by law. Four months later after the review, Medicare changed their reimbursement schedule for all physician assistants so that they could be paid for the same services. On July 1, 1991, Medicare responded that they were notifying all West Virginia physician assistants of the change and how to be reimbursed for previous charges. Wes shared the information with your D.C. press staff but a news release was never sent out.

As a result of the Kathleen Lovin case, Wes decided that he would contact Medicare on behalf of West Virginia physicians who were also being paid less than their Ohio counterparts. During the mid-1990's, physician Medicare reimbursements were processed by Nationwide Insurance, the Medicare contractor. Their offices were located in Columbus, Ohio. During your first term in office, your staff would receive complaints from West Virginia physicians complaining about this discrepancy. When Wes would ask the Medicare officials about the 10% payment difference, he was told that the State of Ohio had a larger population than West Virginia. Wes called the Medicare Medical Director in Columbus, Ohio, and complained about the unfairness of the fee schedule and used the physician assistants as a reference for making the change. The director agreed and said he felt it was unfair as well. He said that he would look in to the

issue. Several weeks later, he returned Wes' call and said that they would start to reimburse West Virginia physicians at the same rate as Ohio physicians.

- **Fredrick Dierking, State Government Affairs Manager, Upjohn Company.** While Wes was attending a public event, he met Mr. Dierking. During the conversation, Wes asked what Upjohn was doing for senior citizens who were falling through the cracks on the health care system in West Virginia. (This event took place while you were starting the Pepper Commission). A month later Mr. Dierking follow-up with Wes and told him that Upjohn would like to provide their diabetes control drug, free of charge to a targeted group of poor West Virginians. Wes then put Mr. Dierking in touch with Bill Merrill, of the West Virginia Academy of Family physicians and with Dr. Bob Walker, of Marshall University. They implemented a pilot program at the Lincoln Primary Care Center that was used as a model for the rest of the nation to duplicate.

  You will also be interested to know that during the late 80's and early 90's, Wes would be involved with coordinating heart and lung transplants for West Virginians at various out-of-state medical centers for low-income individuals. The primary medical center was the University of Pittsburgh Medical Center. The Pittsburgh facility did not like the reimbursement amount that West Virginia Medicaid paid on the transplants.

  Wes would be a go between with the medical center and the State Medicaid officials to negotiate a payment on how much Medicaid would pay for the transplant. Eventually, the costs of

conducting a transplant at the University of Pittsburgh became too excessive and Wes would have to contact other out-of-state medical centers on behalf of a constituent. He became very good friends with many of the transplant coordinators at the medical center.

PERSONAL STORIES FROM STAFF

Yvette Fontenot:

- She hopes that you continue to be an advocate for the people that Democrats *claim* to fight for. She hopes you continue to advocate for low-income folks in health care because you are a trusted voice and Yvette worries that nobody will be able to fill the void your retirement will create. However, she hopes you can be that voice from the outside.

- Yvette said that you the way you live and act, taught Yvette to focus on those who get left behind. During Fiscal Relief, she remembers she used the term "vulnerable low income" in a memo that she wrote to you. Apparently, you pulled her aside and told her not to use term vulnerable. Yvette said that you told her: "They may be low income, but they are not vulnerable as long as there are people here fighting for them". She greatly admires your conviction and commitment: "He never wavered on standing strong for low income people and the people of West Virginia".

- Finally, Yvette believes that CHIP will be a large piece of your lasting legacy. In a grander scheme, it will be your overarching focus on programs that help low income folks. Low income subsidies, Medicaid funding, and Duals. She believes that your advocacy on behalf of low-income Americans will be inextricably linked to your name.

Karen Pollitz:

- Karen affectionately recalls the day she submitted her two-week notice prior to her last day in your office. She had decided to leave the Hill to care of her newborn son. When she came in to your office to formally announce that she was leaving, you turned you her and said: "Are you sure you don't want to stay? If you stay, I'll adopt you."

- One time, she came to your house to pick you up for a weekend, emergency staff meeting. Rather than order lunch, you said you would make lunch for the staff. She thought you would have your personal chef make lunch; However, when she arrived she followed you to your kitchen where you proceeded to make Peanut Butter & Jelly sandwiches on raisin bread for your whole staff.

- Karen once asked what it was like to be a Rockefeller: You responded, "It is just great. If I was as handsome Robert Redford that would be great too".

- During our conversation, Karen contemplated what made you and your colleagues so effective. She believes that Bentsen, Dingell, Rostenkowski, Waxman and you were, and are, powerful men who had a genuine change based agenda. You were part of a generation of leaders that cared deeply about public policy and public service. The example that came to mind for her is the story of how Sargent Shriver had encouraged you to go to VISTA and influenced your decision to go in to public service. The generation of leaders of which you belong, were shaped by the

Depression, WWII and the 1960's. Karen felt that so much of what you and your peers did was motivated by a combination of a commitment to public service, a sense of duty and idealism.

- Karen said toward the end of our meeting that: we have to believe that things will get better, that a better time will rise again. However, she can't help but wonder what the next act will bring.

- She identifies you as a very special man, and she wants you to know that it was an honor to serve West VA. Karen is incredibly proud of the work she did in your office, and the work done after she left. She never once felt the office compromised its values to get something done.

Rachel Pryor:

- During our discussion about her time in the office, she had several personal memories she wanted me to include. In particular, she fondly remembers the ACA Reconciliation process, in which you turned to her at 2 a.m. and said you were voting no on everything the Republicans had submitted. Then, you asked, Rachel, are you hungry?

- She was also always struck by your kindness, and the extra time you took to show your staff your gratitude. When Rachel moved on from the office, she wrote you a thank you note, to which you replied with your own thank you note (she has your note framed above her desk in the Aging Committee).

- Soon after she and Greg started dating, they attended the

Christmas part at Park Road. They were trying to use professional discretion and did not mention to you that they were now in a relationship. However, Sarah Dash excitedly told you, and Rachel remembers how genuinely happy you were that she and Greg were "keeping it all in the Rockefeller family".

Sarah Dash:

- Sarah fondly remembers waiting to see if the government was going to shutdown in 2011/2012. The office had ordered Chinese food and was sitting in the large conference room eating late-night Chinese take-out. You walked by and sat with them and took bets from each of the staff about whether or not the government was going to shutdown.

- Sarah also says she will always remember the day you read Green Eggs and Ham on West Virginia Reads Day. Sarah's son was in the group, and Gregg Margolis's (RWJ Fellow) son sat on your lap as you read to the group.