

CAEAR Coalition Town Hall
Health Care Reform & Ryan White: What Must Be Done To Ensure They Fit

Speaker BIOS

Jon Bouker

Jon S. Bouker is a partner and co-manager of the Government Relations Department at Arent Fox. He has extensive experience in the United States Congress that he puts to work serving clients both in the firm's general business and government relations practices. In the U.S. House of Representatives, Jon served as chief counsel and legislative director to Congresswoman Eleanor Holmes Norton (D-DC) while at the same time serving as minority counsel to Congressman Henry Waxman (D-CA), then ranking member of the House Government Reform Committee. Jon currently represents the CAEAR Coalition, a national coalition of Ryan White CARE Act providers and advocates. Jon also advises numerous health care clients, including hospitals, medical schools, community clinics, international health organizations, health care nonprofits and trade associations. Jon is an adjunct professor of law at American University's Washington College of Law, where he taught the legislation course from 1999 to 2008. He sits on the boards of DC Appleseed, the University of the District of Columbia David A. Clark School of Law, and the Center for Health and Gender Equity (CHANGE); in addition, he is a past chair of the District of Columbia Affairs Section of the DC Bar. Jon is a member of the District of Columbia Federal Law Enforcement Nominating Commission that recommends candidates for the US District Court, US Attorney and other federal agencies, and he is a member of the District of Columbia Access to Justice Commission. The *Washington Business Journal* has recognized Jon as a Top Washington Lawyer in the categories of "Young Guns" and "State and Local Lobbying." Jon and Arent Fox are the prior recipients of DC Appleseed's Community Service Award for contributions to DC Voting rights and the CAEAR Coalition's Partnership Award for work on behalf of those living with HIV/AIDS. Jon received his JD from Georgetown University Law Center in 1995, and his BA (summa cum laude; Phi Beta Kappa) from Georgetown University in 1992.

Amy Demske

Amy Demske is a Senior Government Relations Director at Arent Fox, representing hospitals and health systems, nonprofits, patient groups, device and pharmaceutical manufacturers and other health care organizations before Congress and federal agencies. Amy advises clients about Medicare and Medicaid reimbursement and coverage, electronic health records issues, and healthcare reform implementation. Amy served on the legislative and budget team at the Centers for Medicare and Medicaid Services (CMS) during the passage of the Balanced Budget Act of 1997. She contributed her expertise to the formulation of legislation and policy on federal Medicaid disproportionate share hospital (DSH) program, provider donations and taxes, intergovernmental transfers, the 340(b) drug rebate program, 1115 waivers, the creation of the State Children's Health Insurance Program, and general budget issues. Amy served as leadership aide to the Florida House Majority Leader, and provided state legislators with strategic advice on healthcare issues. She worked closely with members to develop legislation, and managed floor operations during key votes. Amy joined Florida's Executive Branch as legislative director for the Florida Agency for Health Care Administration, serving as Governor Lawton Chiles lobbyist on Medicaid programmatic issues, universal healthcare, fraud and abuse, and provider regulation.

Laura Hanen, MPP

Laura Hanen has been the Director of Government Relations for the National Alliance of State and Territorial AIDS Directors (NASTAD) for the last ten years. NASTAD represents the chief HIV/AIDS program administrators who are responsible for managing federally and state-funded HIV/AIDS prevention, care and treatment services in every state and territory. Ms. Hanen's primary responsibility is to oversee the

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policy development and federal lobbying on appropriations and legislation related to HIV/AIDS and viral hepatitis prevention, care and treatment issues. Ms. Hanen has leadership roles in a number of national coalitions including the Federal AIDS Policy Partnership, the HIV Health Care Access Working Group, the ADAP Working Group, and the Hepatitis Appropriations Partnership. Ms. Hanen joined NASTAD in May 2000. Prior to coming to NASTAD, Ms Hanen was the Senior Lobbyist for the American College of Obstetricians and Gynecologists for 3 years. Ms. Hanen was a legislative assistant for Congressman Rick Boucher of the Ninth District of Virginia. Ms Hanen was also a legislative assistant in the Government Relations Department of the Biotechnology Industry Organization. Ms. Hanen received her Bachelor's degree from Earlham College in Richmond, Indiana and a Master's degree in Public Policy from Georgetown

Ernest Hopkins

Ernest Hopkins is the Legislative Director for the San Francisco AIDS Foundation and Chair of the CAEAR Coalition Board of Directors. Ernest has been involved with CAEAR Coalition since 1994 when he was appointed Chair of the Metropolitan Washington, DC, Regional HIV Health Services Planning Council. He is an appointed member of the Centers for Disease Control and Prevention/ Health Resources and Services Administration (CDC/HRSA) Advisory Committee on HIV and STD Prevention and Treatment and a founding member and Vice Chair of the National Black Gay Men's Advocacy Coalition. He also serves on the board of the National AIDS Housing Coalition and Convening Group of the Federal AIDS Policy Partnership.

Carole Treston, RN, MPH

Carole is the Executive Director of AIDS Alliance for Children, Youth and Families, an organization that provides training and technical assistance to programs serving women, youth, children, and families affected by HIV and AIDS in the US and advocates for public policies that benefit them. She is an RN who in 1988 developed one of the first comprehensive, family-centered HIV/AIDS programs in the country, leading the way for Ryan White Part D programs and a precursor to the "medical home" model of care. She received her MPH from Columbia University, focusing on health policy and management. She served as ED of the Children's Hope Foundation in NYC— an organization that partnered with 120 agencies to improve the quality of life for children, youth and families affected by HIV/AIDS. She also served as the Director of Operations for the Pediatric AIDS Clinical Trials Group. There, she was recognized as an advocate for the Community Constituency Group.

Andrea Weddle, MSW

Andrea Weddle has been the executive director of the HIV Medicine Association (HIVMA), an organization representing frontline HIV medical providers and researchers, since September 2008. Previously she served as the associate director of the association for six years. She devotes much of her time to advancing HIVMA's public policy and advocacy priorities, which include improving access to health care for people with HIV/AIDS; addressing HIV medical workforce issues and promoting public policies grounded in science. Prior to joining HIVMA, she conducted policy research on Medicaid managed care programs as a research associate for the Center for HIV Quality Care and served as the staff director for the Pediatric Infectious Diseases Society. Ms. Weddle has worked in the health policy field for more than decade and has a Master's in Social Welfare from the University of California, Berkeley.



Ryan White Program Appropriations: FY2011 Request

Program	CAEAR Coalition FY 2010 Request	President's FY 2010 Budget Request	FY 2010 Conference Report	CAEAR Coalition FY 2011 Request	President's FY 2011 Budget Request	House Approp. Subcom. FY 2011 Bill	Senate Approp. Full Com. FY 2011 Mark-up
Part A	\$766.1m (+\$103m)	\$671.1m (+\$8m)	\$679.1m (+\$16m)	\$905m (+225.9m)	\$679.1m (+\$0m)	\$694.0m (+\$15m)	\$679.1m (+\$0)
Part B Base	\$514.2m (+\$105.4m)	\$418.8m (+\$10m)	\$418.8m (+\$10m)	\$474.7m (+55.9m)	\$428.8m (+\$10m)	\$428.8 (+\$10m)	\$418.8m (+\$0)
Part B ADAP	\$1,083.6m (+\$268.6m)	\$835.0m (+\$20m)	\$835.0m (+\$20m)	\$1205.1m (+370.1m)	\$855.0m (+\$20m)	\$885.0m (+\$50m)	\$885.0m (+\$50m)
Part C	\$268.3m (+\$66.4m)	\$211.9m (+\$10m)	\$206.8m (+\$4.9m)	\$337.8m (+131m)	\$211.9m (+\$5.1m)	\$211.9m (+\$5m)	\$206.4m (-\$0.5m)*
Part D	\$134.6m (+\$57.8m)	+\$76.8m (+0)	\$77.8m (+\$0.9m)	\$84.8m (+7m)	\$77.8m (+\$0)	\$77.8m (+\$0)	\$77.8m (+\$0m)
Part F AETC	\$50.0m (+\$15.6m)	\$38.4m (+\$4m)	\$34.8m (+\$0.4m)	\$50m (+15.2m)	\$37.4m (+\$2.6m)	\$37.4m (+\$2.6)	\$34.7m (+0)
Part F Dental Reimb.	\$19.0m (+\$5.6M)	\$15.4m (+\$2m)	\$13.6m (+0.2m)	\$19m (+5.4m)	\$15.4m (+1.8m)	\$15.4m (+\$1.8m)	\$13.6m (+\$0)

*Committee indicates that it has maintained funding at FY2010 levels. We are working to clarify the discrepancy.

[EXCERPT]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION,
AND RELATED AGENCIES APPROPRIATION BILL, 2011

R E P O R T
of the
COMMITTEE ON APPROPRIATIONS
U.S. SENATE
on
S. 3686

HIV/AIDS BUREAU

ACQUIRED IMMUNE DEFICIENCY SYNDROME

RYAN WHITE AIDS PROGRAMS

“The Committee is aware that many of the benefits currently provided through Ryan White Care Act programs will become available to people living with HIV/AIDS over the next few years through State high-risk pools, health exchanges and other newly authorized programs. The Committee expects HRSA to offer a plan for how to transition Ryan White benefits into a larger system of care so that Ryan White resources may be targeted to the areas of most need. The plan should include a year-by-year list of actions needed by the administration, the Congress and the States in order to ensure the smoothest possible transition for beneficiaries. The Committee expects the plan no later than 8 months after enactment of this Act.”

A United Voice for the Ryan White Program

Mission

CAEAR Coalition is a national membership organization which advocates for federal appropriations, legislation, policy and regulations to meet the care, treatment, support service and prevention needs of people living with HIV/AIDS and the organizations that serve them. CAEAR Coalition's proactive national leadership is focused on the Ryan White legislation as a central part of the nation's response to HIV/AIDS.

Members

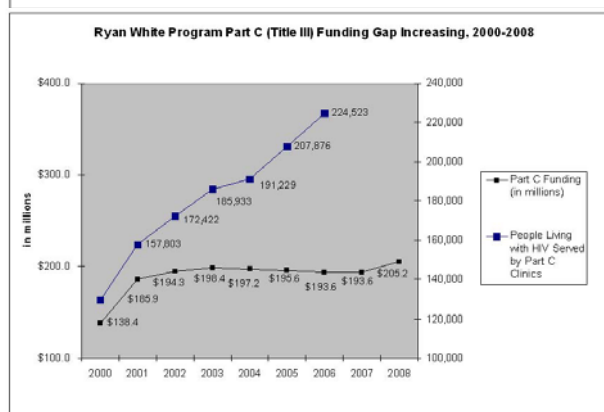
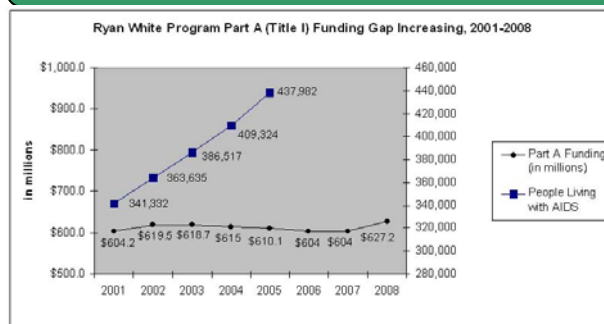
CAEAR Coalition members include:

- Part A grantees
- Part A planning councils
- Part A & Part B subgrantees
- Part C grantees
- National partners
- Recipients of Ryan White services

A Leader in Ryan White Reauthorization

- Membership-driven development of policy recommendations
- Comprehensive analysis of Ryan White funding
- Convening of national partners to form the Ryan White Legislative Group to build a unified voice on the Hill
- Development of bill language based on Legislative Group's policy recommendations
- Engagement of key Hill staff
- Detailed response to draft legislation
- Constituent visits to key members of Congress
- Advocacy to ensure provisions are enacted fairly and with a minimum disruption to care

Fighting for Increased Appropriations in the Face of Rising Caseloads



Member Benefits

- Professional government affairs representation in Washington
- A seat at the table when priorities for Ryan White Program advocacy are set
- Participation in quarterly Capitol Hill advocacy visits with members of Congress
- Meetings with Administration officials at the White House, Department of Health & Human Services (HHS), and Health Resources and Services Administration (HRSA)
- Up-to-date Ryan White Program information through action alerts, updates, and newsletters
- Representation of Ryan White Program interests in other HIV/AIDS coalitions such as the Federal AIDS Policy Partnership
- Access to members-only section of the CAEAR Coalition web site
- The opportunity to network and receive peer TA from counterparts across the country

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MEMBERS

California

- Alameda County Office of AIDS
- Black Coalition on AIDS, San Francisco
- Desert AIDS Project, Palm Springs
- HIV/AIDS Provider Network, San Francisco
- Los Angeles Gay & Lesbian Center
- San Francisco AIDS Foundation
- San Francisco Department of Public Health
- San Francisco Part A Planning Council

Connecticut

- Connecticut AIDS Resource Coalition, Hartford
- Family Centers Inc., Stamford CARES Program

Florida

- Care Resource, Miami
- Miami Beach Community Health Center

Georgia

- AID Gwinnett, Duluth
- Atlanta Part A Planning Council
- Grady Infectious Disease Program, Atlanta

Illinois

- Chicago Department of Public Health, Division of STD/HIV/AIDS
- Chicago Part A Planning Council
- Heartland Health Outreach, Chicago
- The CORE Center, Chicago

Maryland

- Chase Brexton Health Services, Baltimore
- InterGroup Services, Inc., Baltimore

Massachusetts

- Boston Public Health Commission, HIV/AIDS Services Division
- Fenway Community Health Center, Boston

Minnesota

- Hennepin County Human Services and Public Health Department

New Jersey

- Bergen/Passaic Part A Planning Council
- Newark Department of Health and Human Services

New York

- AIDS Service Center NYC, New York
- Brooklyn AIDS Task Force
- Harlem United Community AIDS Center
- NYC Department of Health & Mental Hygiene
- Village Care of New York

Pennsylvania

- Action AIDS, Philadelphia
- Mazzoni Center, Philadelphia
- Philadelphia Department of Public Health

National

- National Association of AETCs
- National Association of People with AIDS
- Ryan White Foundation

Affiliate

- Bristol-Myers Squibb
- OraSure Technologies, Inc.
- Tibotec Therapeutics

Timeline for Health Reform Implementation: Overview

Reform will unfold incrementally. Although some major elements of reform begin in 2010, others will be implemented over the course of several years.

In 2014, the most substantial changes—including shared responsibility for coverage, expansion of Medicaid, insurance exchanges, and creation of an essential benefits package—will take effect.

Early retirees: A temporary reinsurance program will help offset the costs of expensive premiums for employers providing retiree health benefits.

Coverage for young adults: Parents will be able to keep their children on their health policies until they turn 26.

Access to care: Funding will be increased by \$11 billion over five years for community health centers and the National Health Services Corps to serve more low-income and uninsured people.

Small-business tax credits: Small businesses (25 or fewer employees and average wages under \$50,000) that offer health care benefits will be eligible for tax credits of up to 35 percent of their premium costs for two years.

“Doughnut hole” rebates: Medicare will provide \$250 rebates to beneficiaries who hit the Part D prescription drug coverage gap known as the “doughnut hole.”

Benefit disclosure: Employers will be required to disclose the value of benefits provided for each employee’s health insurance coverage on the employee’s W-2 forms.

New payment and delivery approaches: A new Center for Medicare and Medicaid Innovation will test reforms that reward providers for quality of care rather than volume of services. Medicare will increase payment for primary care physicians by 10 percent for primary care services.

CLASS Act: A national, voluntary insurance program for purchasing community living assistance services and support (CLASS) will be established. All working adults will be automatically enrolled—unless they opt out—through payroll deductions that, after five years, will qualify them for monthly payments toward services to help them stay at home should they become disabled.

Medicare value-based purchasing: Medicare will reward hospitals that provide higher quality or better patient outcomes.

Administrative simplification: Health insurers must follow administrative simplification standards for electronic exchange of health information to reduce paperwork and administrative costs.

Shared responsibility for coverage: Individuals will be required to carry health insurance, and employers with 50 or more workers will be required to offer health benefits or be subject to a fine of \$2,000 per employee (not counting the first 30 employees) if any worker receives governmental assistance with premiums through the insurance exchanges.

Insurance industry fee: Insurers will pay an annual fee, based on market share, to help pay for reform.

New rules for insurers: Insurers will be banned from restricting coverage or basing premiums on health status. Annual, in addition to lifetime, limits on benefits are banned.

Premium subsidies: Premium and cost-sharing assistance on a sliding scale will make coverage affordable for families with annual incomes between \$30,000 and \$88,000 that buy plans through the exchanges.

Medicare managed care plans: Four- and five-star Medicare private plans will receive 5 percent bonuses as a reward for providing better clinical quality and patient experiences.

High-cost insurance plans: Insurers will face a 40 percent excise tax on policies with premiums over \$10,200 for individuals or \$27,500 for family coverage.

2010

2011

2012

2013

2014

2018

High-risk pool: People with preexisting conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, subsidized high-risk pool. Premiums will be based on the average health status of a standard population. Annual out-of-pocket costs will be capped at \$5,950 for individuals and \$11,900 for families.

Protection for children: Insurers can no longer deny health coverage to children with preexisting conditions or exclude their conditions from coverage.

Preventive care: All new group and individual health plans will be required to provide free preventive care for proven preventive services. In 2011, Medicare also will provide free preventive care.

Annual review of premium increases: Health insurers will be required to submit justification for unreasonable premium increases to the federal and relevant state governments before they take effect, and to report the share of premiums spent on nonmedical costs.

New insurance rules: Insurance companies will be banned from rescinding people’s coverage when they get sick, and from imposing lifetime caps on coverage. Restrictions will be placed on annual limits.

Pharmaceutical manufacturer fee: An annual, nondeductible fee will be imposed on pharmaceuticals and importers’ branded drugs, based on market share.

OTC drug reimbursement restrictions: Over-the-counter drugs not prescribed by a doctor will no longer be reimbursable through flexible spending accounts or health reimbursement arrangements, or on a tax-free basis in health savings accounts.

Physician quality reporting: Medicare will launch a Physician Compare Web site where beneficiaries can compare measures of physician quality and patient experience.

“Doughnut hole” discounts: Medicare beneficiaries in the Part D prescription drug coverage “doughnut hole” will receive 50 percent discounts on all brand-name drugs. By 2020, the “doughnut hole” coverage gap will be closed.

Premium share spending: Health plans in the large-group market that spend less than 85 percent of their premiums on medical care, and plans in the small-group and individual markets that spend less than 80 percent on medical care, will be required to offer rebates to enrollees.

Flexible spending limits: Contributions to flexible spending accounts (FSAs) will be limited to \$2,500 a year, indexed to the Consumer Price Index (CPI).

Insurance exchanges: New state-based marketplaces will offer small businesses and people without employer coverage a choice of affordable health plans that meet new essential benefit standards.

Essential benefits package: The Department of Health and Human Services will establish an essential standard benefits package for policies sold in the exchanges and individual and small-group markets with a choice among tiers of plans (bronze, silver, gold, and platinum) that have different levels of cost-sharing.

Independent payment advisory board. A new independent payment advisory board within the executive branch will work to identify areas of waste and federal budget savings in Medicare. The board’s recommendations must not ration care, raise taxes, or change Medicare benefits, eligibility, or cost-sharing.

Medicaid expansion: Medicaid eligibility will be expanded to all legal residents with incomes up to 133 percent of the federal poverty level. Currently, states have different—and in many cases very low—eligibility thresholds, and most states do not cover adults without children.