THE HENRY J. KAISER FAMILY FOUNDATION

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act:

A Side-by-Side Comparison of Current Law and Reauthorization Proposals

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The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act: A Side-by-Side Comparison of Current Law and Reauthorization Proposals (as of November 1, 2006)

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, the nation's largest HIV specific federal grant program and a critical source of care and treatment for people living with HIV/AIDS in the United States, was due to be reauthorized by the United States Congress for the third time by the end of FY 2005. However, Congress has not yet acted to reauthorize the CARE Act, and the program's authority has been extended under current law while Reauthorization discussions continue. The White House released principles for Reauthorization in July of 2005. A bipartisan Senate bill, *The Ryan White HIV/AIDS Treatment Modernization Act of 2006*, was passed by the Senate HELP Committee in May 2006. In September, the House passed a modified version of the bill, which may be considered by the Senate when Congress reconvenes in November.

The CARE Act is complex and understanding all of its provisions under current law, let alone some of the changes being considered by the Congress, is a challenging task. The following table, prepared by the Kaiser Family Foundation, provides a side-by-side comparison of current law to key provisions in the Administration's reauthorization principles and *The Ryan White HIV/AIDS Treatment Modernization Act of 2006.* An earlier version of this side-by-side is available on the Kaiser Family Foundation website at http://www.kff.org/hivaids/7531.cfm.

Key Documents Used and Other Suggested Resources:

Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. no. 101-381.
Ryan White CARE Act Amendments of 1996, Pub. L. no. 104-146.
Ryan White CARE Act Amendments of 2000, Pub. L. no. 106-345.
United States Department of Health and Human Services, "Ryan White Care Act Reauthorization Principles", Press Release; July 27, 2005: www.hhs.gov/news/press/2005pres/ryanwhite.html.
U.S. Senate. 109th Congress, 2nd Session. *S.2823. Ryan White HIV/AIDS Treatment Modernization Act of 2006*. [introduced 17 May 2006 by Senators Enzi (R-WY), Kennedy (D-MA), Burr (R-NC), DeWine (R-OH), Frist (R-TN), and Hatch (R-UT)].
U.S. House. 109th Congress, 2nd Session. *H.R. 6143. Ryan White HIV/AIDS Treatment Modernization Act of 2006.* [introduced 21 September 2006 by Representatives Bono (R-CA), Barton (R-TX), Buyer (R-IN), Deal (R-GA), Gillmor (R-OH), Myrick (R-NC), Norwood (R-GA), Pitts (R-PA), Radanovich (R-CA), Terry (R-NE), and Upton (R-MI)].
Congressional Research Service, "Side by Side Analysis of The Ryan White HIV/AIDS Treatment Modernization Act of 2006", Memo to Senate HELP Committee From Paulette C. Morgan and Judith A. Johnson; May 23, 2006.
Congressional Research Service "The Ryan White CARE Act: a Side-by-Side Comparison of H.R. 6143 and Current Law", Judith A. Johnson and Paulette C. Morgan; RL33671; September 26, 2006.
Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau website: http://hab.hrsa.gov/.
National Alliance of State and Territorial AIDS Directors, Ryan White Reauthorization Information: www.nastad.org/Programs/HIVCareAndTreatment/RWReauthorizationInfo.aspx.

Key Dates in Ryan White CARE Act Reauthorization

1990, August 18: First passed; first funds awarded in FY 1991
1996, May 20: Reauthorized with Amendments
2000, October 20: Reauthorized with Amendments
2005, July 27: White House releases Principles
2005, September 30: Reauthorization expires
2006, May 17: Senate HELP Committee introduces and passes reauthorization bill
2006, September 21: House introduces reauthorization bill; passes on September 28.

Prepared by researchers at the Kaiser Family Foundation.
Input provided by the National Alliance of State and Territorial AIDS Directors.

	Current Law: The Ryan White CARE Act of 1990 [P.L. 101-381] & Amendments of 1996 [P.L. 104-146] and 2000 [P.L. 106-345]	**Administration's Principles Introduced: July 27, 2005**	**House Bill: H.R.6143 Introduced: September 21, 2006 Passed, September 28, 2006**
Title	Ryan White Comprehensive AIDS Resources Emergency Act of 1990	Ryan White Care Act Reauthorization Principles	Ryan White HIV/AIDS Treatment Modernization Act of 2006
Purpose	"To provide emergency assistance to localities that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make direct financial assistance available to states to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease in urban and rural areas."	"Focus Federal resources on life-extending care; ensuring flexibility by targeting resources to address areas of greatest need; and achieving results."	"…to revise and extend the program for providing life-saving care for those with HIV/AIDS"
Structure	The Care Act is structured around grant streams that provide funding to cities, states, providers, and community organizations (as well as some other entities). There are five titles with subcomponents: Part A (Title I): Emergency Relief to Eligible Metropolitan Areas (EMAs). Planning Councils must be established; Planning Councils set priorities for spending. Part B (Title II): HIV Care Grants to States, including: Title II Base; AIDS Drug Assistance Program (ADAP); ADAP Supplemental Drug Treatment Grant (ADAP Supplemental); Emerging Community Supplemental Grant (EC). Part C (Title III): Early intervention, capacity building, and planning grants to providers and other eligible organizations. Part D (Title IV): Women, Infants, Children & Youth grants to providers Part E: Emergency Response Employees Part F: AIDS Education and Training Centers Part F: Dental Education, Training, Reimbursement Part F: Special Projects of National Significance (SPNS)	Overall Title structure not addressed Title I Planning Councils would no longer be mandatory and no longer required to set priorities for spending. Establishment of Planning Council at discretion of Mayor.	Overall Title structure maintained but further sub-divided and/or other changes to existing sub-components as follows: Title I: Now divided into 2 subparts • Subpart 1 = EMAs (eligibility redefined; see eligibility) • Subpart 2 = TGAs, a new program for "transitional grant areas." Metropolitan areas eligible as TGAs were previously eligible as Title II ECs and "grandfathered" EMAs. • Planning Council not mandatory for TGAs (unless a TGA was an EMA in FY 2006). Title II: • New Title II supplemental grant program for states: first funds "hold harmless" for Title II awards; second, funds states with a precipitous loss in funding; and third funds grants to states based on demonstrated need for supplemental assistance, as determined by the Secretary. Supplemental grant funds to be used for core medical services (see definition below). • Title II EC eligibility narrowed, since subset of previously defined ECs now become eligible under new Title I TGA. Part E: grants for emergency response employees deleted; new provision added to address public health emergencies. Part F: Minority AIDS Initiative codified as permanent part of the CARE Act (HRSA component only; MAI also receives funding from other parts of HHS).

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Eligibility for Funding: Titles I and II	Title I: EMAs defined as areas with 500,000 or more population reporting cumulative total of more than 2,000 AIDS cases for most recent 5 year period. Title II Base: all states, territories, associated jurisdictions. Those with 1% or more of reported AIDS cases during most recent 2-year period must provide non-federal matching funds according to escalated matching rate (based on number of years at or above 1% threshold). Title II ADAP: all states, territories, associated jurisdictions. Title II ADAP Supplemental: for states with "severe need" as determined by the Secretary, and to include consideration of eligibility standards, formulary composition, and the number of individuals at or below 200 percent of the federal poverty level (FPL). States must match $1 in non-federal funds for every $4 in federal funds. States cannot impose eligibility requirements that are more restrictive than those in place as of January 1, 2000. Title II ECs: metropolitan areas not eligible for funding under Title I and with cumulative total of 500-1,999 AIDS cases in most recent 5-year period (In FY 2007 eligibility for ECs switch to HIV cases only).	Not specified	Changes to Titles I and II. Title I: Metropolitan area population size and disease burden eligibility thresholds changed. • Population: lowered to 50,000 or more. • Disease burden specified by subpart: Subpart 1 EMAs: cumulative total of more than 2,000 AIDS cases during most recent 5-year period (same as current law EMA eligibility) Subpart 2 TGAs: cumulative total of 1,000-1,999 AIDS cases during most recent 5-year period (previously eligible under Title II EC grant). Title II: EC and ADAP Supplemental eligibility changes. • ADAP Supplemental: adds requirement that states cannot have more than 2 percent in unobligated funds; changes part of severe need criteria from "number of individuals at or below 200% FPL" to "unanticipated increase in individuals eligible for ADAP"; no longer ties to January 2000 criteria; State matching requirement can be waived under certain circumstances. • ECs: disease burden eligibility changed to cumulative total of 500-999 AIDS cases during most recent 5-year period (areas previously eligible as ECs because they had 1,000-1,999 cases now eligible under Title I TGAs). States would have to agree that grant would be used to provide funds to ECs separately from other Title II funds provided to ECs.
Funding Distribution for Titles I and II	Funding distributed by formula, supplemental (competitive) grant awards, and set-asides depending on Title and subcomponent. Title I: 50% by formula, 50% supplemental. Formula = EMA's share of total number of estimated living AIDS cases (ELCs*) in all EMAs. Supplemental based on "severe need" Title II Base: 100% formula. Formula = [(80%) x (state's share of all ELCs)] + [(20%) x (state's share of all ELCs outside of EMAs)] Title II ADAP: 100% formula. Same formula as Title II Base Title II ADAP Supplemental: 3% of ADAP earmark set-aside for Supplemental and distributed to eligible states who apply for funding. Title II EC: Set-aside of Title II Base and distributed by 100% formula. Formula = EC's share of total number of reported AIDS cases in all ECs in most recent 5 year period. *ELCs are determined by applying defined survival weights by year to the cumulative number of AIDS cases reported over the preceding 10 year period.	Calls for changes to Title II Base Formula to eliminate "double counting" of HIV/AIDS cases between metropolitan areas and states. Calls for Secretary of HHS to develop "severity of need" for core services index (SNCSI) to be used to determine formula allocations to states and EMAs.	Calls for changes in Title I and II formula weights and funding distribution must be based on use of living HIV/AIDS cases from names-based reporting states only unless exemption is received (see next section). Title I: More weight given to formula as follows: 2/3 formula, 1/3 supplemental, applies to EMAs and TGAs. • Formula = EMA's (or TGA's) share of living HIV/AIDS cases in all EMAs (or TGAs). • Supplemental: first funds hold harmless for EMA awards; second, funds EMAs with a precipitous loss in funding; and third, funds grants to EMAs based on "demonstrated need" as measured on "objective and quantified basis" to be determined by the Secretary of HHS. • Supplemental distributed to EMAs and TGAs through one mechanism; Secretary has discretion on allocating supplemental between them. Title II Base: More weight given to areas outside of EMAs/TGAs and to states with no EMAs/TGAs. Changes 80/20 formula to 75/20/5 • Formula = [(75%) x (state's share of nation's HIV/AIDS cases)] + [(20%) x (state's share of HIV/AIDS cases outside of EMAs and TGAs)] + [(5%) x (state's share of HIV/AIDS cases from states without any EMAs or TGAs)] • Severity of Need Index could replace formula as early as FY 2011; required to be used by FY 2013. Title II ADAP Supplemental: set-aside increased from 3% to 5% of ADAP earmark. Title II EC: Set-side authorized at $5 million of base. Formula = EC's living HIV/AIDS cases as share of all living HIV/AIDS cases in ECs nationwide.

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Use of HIV cases in Funding Formulas for Titles I and II	Uses estimated living AIDS cases. Care Act Amendments of 2000 required Secretary of HHS to determine no later than July 1, 2004 whether data on cases of HIV disease from all eligible areas were sufficiently accurate and reliable for use in funding distribution formulae (to replace use of AIDS cases). If not by then, must go into effect by FY 2007 (note: it was determined that HIV cases were not sufficiently accurate and reliable by July 2004, so the latter deadline of FY 2007 is in effect).	Affirms current law (switch to HIV cases by FY 2007).	Affirms current law (switch to HIV cases by FY 2007). Specifies that formula will use living HIV/AIDS cases from names-based reporting states only, after being reported to and confirmed by the Centers for Disease Control and Prevention (CDC). A second "track" of states and EMAs/TGAs that do not have certified names-based HIV cases with the CDC, but use code-based systems, will have their code-based HIV cases used for funding distribution purposes after an adjustment (described below). Transition Plan: specifies 4-year transition plan through FY 2010, for states without established HIV names-based surveillance systems if they submit transition plan by October 1, 2006 (NOTE: All states have submitted a transition plan to CDC). For states (and jurisdictions within) with exemptions that have code-based HIV reporting, their HIV counts provided to HRSA for purposes of funding distribution will be reduced by 5%.
Grandfathering and Hold Harmless Provisions Grandfathering: protection from loss of eligibility from year to year Hold harmless: protection from loss of funds due to changes in formula funding distribution amounts from year to year	Grandfathering: Title I EMAs that were eligible in FY 1996 remain eligible in subsequent years. Hold harmless: Title I EMAs are protected from funding losses for 5 years using percentages of 98, 95, 92, 89, 85 of base year grant. Base year is the year previous to the loss in funding. Title II Base and ADAP protected from funding losses for 5 years using percentages of 99, 98, 97, 96, 95 of base year grant. FY 2000 was base year for most recent reauthorization.	Grandfathering: Not specified. Hold harmless: Calls for eliminating "hold harmless" for Title 1	Grandfathering: Title I: • Subpart I: eligibility maintained in FY 2007 even if EMA does not meet Subpart I or Subpart 2 eligibility and will be considered TGA. Eligibility would end if EMA fails to have cumulative total of 2,000 or more living AIDS cases in most recent 5-year period *and* a cumulative total of 3,000 or more living AIDS cases in most recent year. • Subpart 2: eligibility for TGAs maintained until fails to have at least 1,000-1,999 cases of AIDS during most recent 5-year period *and* 1,500 or more living cases of AIDS as of most recent year. Hold Harmless: Title I: Subpart 1: for EMAs that were held harmless in FY 2006, extended for 3 years at 95% of the previous year's award each year (after taking into account new formula weights). Subpart 2: No hold harmless provision. Title II: FY 2007-2009, 95% hold harmless; hold harmless eliminated after FY 2009
Core Medical Services	No core set of medical services specified or tied to funding.	Yes. At least 75% of funds for Titles I-IV must be spent on core medical services (services not specified)	Yes. At least 75% of funds for Titles I-III must be spent on core medical services (including for co-occurring conditions) defined as including: outpatient and ambulatory health services; medications; pharmaceutical assistance; oral health care; early intervention services; health insurance premium and cost sharing assistance for low-income individuals; home health care; medical nutrition therapy; hospice services; home and community based health services; mental health services; substance abuse outpatient care; and medical case management, including treatment adherence services. Requirement can be waived if there is no ADAP waiting list and core medical services are otherwise available to all eligible.
Support Services	Defined as outpatient and ambulatory support services (including case management), that facilitate, enhance, support, or sustain the delivery, continuity, or benefits of health services for individuals and families with HIV disease.		Defines support services as services needed by individuals with HIV/AIDS to achieve medical outcomes (e.g., respite care; outreach; medical transportation; linguistic services, referrals for health care and support services). Medical outcomes defined as those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS.

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Minimum Formulary for ADAP	No formulary specified. CARE Act states that the purpose of ADAPs is to: "…provide therapeutics to treat HIV disease or prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections."	Yes. Requires Secretary of HHS to develop a list of core ADAP drugs to be prioritizing for funding. List based on Public Health Service guidelines and to include antiretrovirals and drugs needed for the treatment and prophylaxis of opportunistic diseases.	Yes. Requires Secretary of HHS to develop a list of core antiretroviral drugs, as specified by Clinical Practice Guidelines for Use of HIV/AIDS Drugs, and drugs needed to manage symptoms associated with HIV. ADAPs are required to provide all antiretrovirals.
Unspent Funds	Formula grant fund amounts may be adjusted by Secretary of HHS to reflect unspent or canceled amounts from preceding year. Expiring funds return to the Treasury.	Allows Secretary of HHS to redistribute unspent funds from Titles I and II to ADAPs with the greatest need.	If EMA does not obligate all of formula or supplemental funds within a year of award, funds must be returned. Waivers of cancellation of formula grant balances may be requested. Formula grant would be reduced in subsequent year by amount of unobligated/canceled balance. Unspent funds will also be returned to the respective supplemental pot beginning with FY 2007 money. Expiring funds from years previous to FY 2007 will return to the Treasury.
Other	SPNS – eligible entities are public and private entities. HIV Testing: any HIV testing conducted by a Title III grantee must be carried out in accordance with specified provisions concerning confidentiality, informed consent, counseling and testing, regardless of whether funds used for testing are funds appropriated under the CARE Act, including the requirement that individuals have pre-test counseling and sign statement declaring that counseling occurred and testing was voluntary. Specifies type of counseling to be offered if individuals test negative and positive, respectively. Hepatitis: Not specified.	HIV Testing: Requires states to implement routine voluntary HIV testing in public facilities and work with private providers to achieve that same end. Hepatitis: Not specified.	SPNS: eligible entities are those eligible for funding under Parts A-D only; new criteria for awards added. Funds will be used to develop a client-level data collection system. HIV Testing: Pre-test counseling no longer mandated under Title III. Title III grantees can test individuals after individual confirms test was voluntary. Adds requirement that individuals testing negative or positive must also receive counseling information about Hepatitis A, B, and C transmission and prevention and Hepatitis A and B vaccines. Deletes requirement that these provisions apply regardless of whether funds used for testing are appropriated under the CARE Act. Hepatitis: See above

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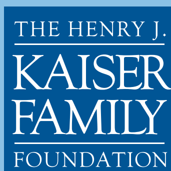
Authorization of Appropriations	"…such sums as may be necessary..." SPNS: Authorized to be funded through a set-aside of no more than $25 million across the Titles. Appropriations bills have directed that SPNS funded should come from PHS evaluation set-asides.	Not specified.	Title I: $604,000,000 for FY 2007, $626,300,000 for FY 2008, $649,500,000 for FY 2009, $673,600,000 for FY 2010, and $698,500,000 for FY 2011; of which: • For FY 2007, $458,310,000 reserved for EMAs and $145,690,000 reserved for TGAs. Secretary determines amount in subsequent years. Title II: $1,195,500,000 for FY 2007, $1,239,500,000 for FY 2008, $1,285,200,000 for FY 2009, $1,332,600,000 for FY 2010, and $1,381,700,000 for FY 2011; of which: • Title II ECs: $5 million reserved each FY • Title II Supplemental: 1/3 of new money reserved each FY • $10 million for partner notification each FY if appropriated Title III: $218,600,000 for FY 2007, $226,700,000 for FY 2008, $235,100,000 for FY 2009, $243,800,000 for FY 2010, and $252,800,000 for FY 2011. Title IV: $71,800,000 for each FY 2007-2011 Part F: AETCs: $34,700,000 for each FY 2007-2011 Part F: Dental: $13,000,000 for each FY 2007-2011 SPNS: Of amount appropriated under parts A-D, the greater of $20,000,000 or amount equal to 3 percent of such amount appropriated under each such part, but not to exceed $25,000,000 MAI: $131,200,000 for FY 2007, $135,100,000 for FY 2008, $139,100,000 for FY 2009, $143,200,000 for FY 2010, $147,500,000 for FY 2011. Other: $30 million of funds appropriated to CDC would be made available each FY for early diagnosis grants to states until the funds are spent. $20 million is for grants to states that have voluntary opt-out testing of all pregnant women *and* mandatory testing of newborns; $10 million is for grants to states that have voluntary opt-out testing of clients at STD clinics *and* voluntary opt-out testing of clients at substance abuse treatment centers



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