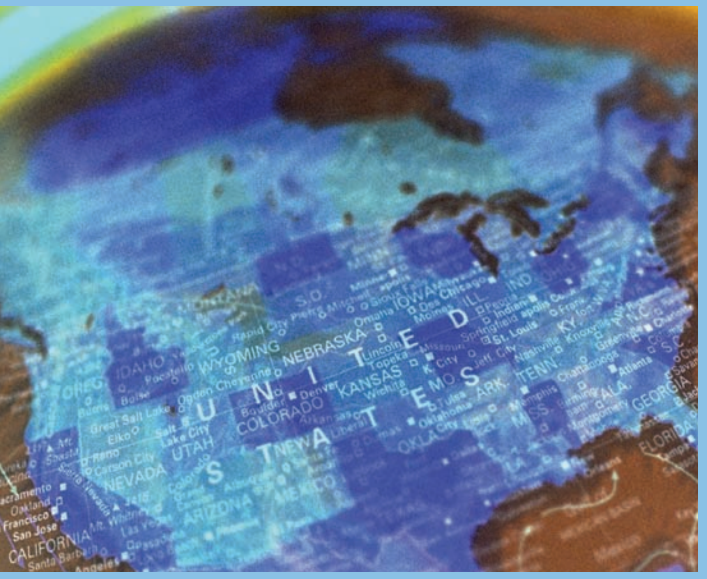

THE HENRY J. KAISER FAMILY FOUNDATION

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 June 20, 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. As of June 2006, two reauthorization bills have been introduced in the Congress, and the White House has released its own principles for reauthorization. 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 each of the two Congressional bills that have been introduced in the current session of Congress.

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.
United States Cong. Senate. 109th Congress, S.2339, Title [introduced by Senator Coburn (R-OK) in the U.S. Senate; February 26 2006].
United States Cong. Senate. 109th Congress, S.2823, Title [introduced by Senators Enzi (R-WY), Kennedy (D-MA), Burr (R-NC), DeWine (R-OH), Frist (R-TN), and Hatch (R-UT); passed by the US Senate Committee on Health, Education, Labor and Pensions; May 17 2006].[1]
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.
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.

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Helpful input provided by: National Alliance of State and Territorial AIDS Directors.

[1] Representatives Barton (R-TX) and Dingell (D-MI) also participated in the drafting of the legislation. A bill has not yet been introduced in the U.S. House of Representatives but markup is expected by The Committee on Energy and Commerce in June 2006.

	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 25, 2005	Senate Bill 2339 Introduced: February 26, 2006	Senate Bill 2823 Introduced: May 17, 2006
Title	Ryan White Comprehensive AIDS Resources Emergency Act of 1990	Ryan White Care Act Reauthorization Principles	Ryan White CARE Act Amendments of 2006	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."	"Eliminate barriers and expand access by increasing ADAP funding, targeting resources to those most in need, and requiring more funding be spent on primary medical care and treatment rather than other less essential services. Prioritize early diagnosis and treatment." (Source: Statement by Senator Tom Coburn, February 26, 2006)	"To provide life saving care to those with HIV/AIDS" (Source: S 2823) "Maintain the current structure of the Ryan White program. Respond to the current changes of the HIV epidemic, without creating drastic reductions in funding which would harm the current HIV care infrastructure" (Source: Committee Outline of Policy Proposal, May 19 2006)
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 F: Special Projects of National Significance (SPNS) Part F: AIDS Education and Training Centers Part F: Dental Reimbursement	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 not addressed Rescinds Title II Emerging Communities	Overall Title structure maintained but further sub-divided and/or other changes to existing sub-components as follows: Title I: now divided into 3 tiers. Old Title I now Tier 1. Two new "transitional tiers": Tier 2 includes current "grandfathered" EMAs who otherwise have fallen below eligibility levels and some current ECs; Tier 3 includes remainder of current ECs. Planning Councils mandatory for Tiers 1 and 2 through 2009; thereafter, they are only mandatory for Tier 1. Planning Councils are voluntary for Tier 3. Title II: Emerging Communities grant mechanism repealed (replaced by new Title I Tiers 2 and 3); New Title II Base supplemental grant pool added that is 1/3 of any new Title II Base funds over prior year level. Part F: Minority AIDS Initiative, which is currently a separate HHS initiative, codified as permanent part of the CARE Act.

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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" defined by meeting at least one of a set of criteria (determined by Secretary of HHS) in place in state in January 2000. States must match $1 in non-federal funds for every $4 in federal funds. 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.	Not specified	Calls for changes to Title I eligibility by allowing up to 60 EMAs, with a population of at least 500,000 and more than 2,500 living HIV cases, to qualify for Title I funding	Calls for changes to Titles I and II. Title I EMA population threshold changed to 50,000 or more population. Eligibility by tier, according to disease burden, as communities previously eligible for Title II EC grants now incorporated into Title I: Tier 1: more than 2,000 AIDS cases for most recent 5 year period Tier 2: 1,000-1,999 AIDS cases for most recent 5 year period Tier 3: 500-999 AIDS cases for most recent 5 year period For Tiers 2 and 3, boundaries used to define metropolitan areas at the time of initial funding to be used in future years. Title II ADAP Supplemental: a state's eligibility based on current "demonstrated need" and no longer tied to criteria that were in place in January 2000; State matching requirements can be waived by Secretary of HHS.
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 in most recent year 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 to Title II Base Formula as of FY 2008 by eliminating "double counting." New formula would be based only on state's share of cases outside of EMAs. ADAP funding increased by $70 million per year through FY 2010 Title II ADAP Supplemental set-aside increased from 3% to 8% of ADAP earmark and ensures that at least $35 million be available to ADAP Supplemental	Calls for changes in Titles I and II formulas, and creates new funding mechanisms. Title I tiers have separate funding authorizations, and their formulas vary by tier. Tier 1: 2/3 formula, 1/3 supplemental. As of FY 2007, Formula = EMA's share of HIV/AIDS cases in all Tier 1 EMAs. Supplemental based on "demonstrated need", which replaces and expands current law definition of "severe need" to be determined by Secretary of HHS. Tier 2: same as Tier 1 except formula based on Tier 2 EMA's share of HIV/AIDS cases in all Tier 2 EMAs. Tier 3: 100% formula. Formula = EMA's share of HIV/AIDS cases in all Tier 3 EMAs. Title II Base: changes 80/20 formula to 75/20/5 as of FY 2007. Formula = [(75%) x (state's share of nation's HIV/AIDS cases)] + [(20%) x (state's share of HIV/AIDS cases outside of Tiers 1 and 2) + [(5%) x (state's share of HIV/AIDS cases from states not receiving any Tier 1 or Tier 2 funds)]. Requires use of Severity of Need Index (SONI) to replace of weighting system by FY 2012. Creates new Title II Supplemental Grant pool with same "demonstrated need" criteria as Title I. Title II ADAP Supplemental: set-aside increased from 3% to 5% of ADAP earmark. New one-time only $40 million "booster" pool created for FY 2007, to be distributed at discretion of Secretary of HHS.

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Use of HIV cases in Funding Formulas for Titles I and II	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) but allows states that established HIV reporting between October 2000 and October 2006 to continue to use HIV prevalence estimates without losing funding until FY 2009, when all states and metropolitan areas must use reported HIV/AIDS cases.	Affirms current law (switch to HIV cases by FY 2007) but specifies that formulae will include combined cases of HIV disease (not AIDS) and AIDS cases. Also specifies 4-year transition plan through FY 2010, allowing for proxy for HIV cases from FY 2007 to FY 2010 in states that do not have established HIV surveillance systems if they submit transition plans and begin reporting actual HIV cases by April 2008. Proxy for HIV cases is equal to the lesser of 90% of living AIDS cases in jurisdiction or 110% of prior year funding level.
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. FY 2000 was base year. Title II Base and ADAP protected from funding losses for 5 years using percentages of 99, 98, 97, 96, 95 of base year grant.	Grandfathering: Not specified. Hold harmless: Calls for eliminating "hold harmless" for Title 1	Grandfathering: Calls for removing "grandfathering" for EMAs if they do not re-qualify for eligibility within the next 2 consecutive fiscal years. Hold harmless: Calls for phasing out Title I "hold harmless" provisions by FY 2009. Protects states from losing more than 5 percent per year (based on FY 2005 funding levels) in their Title II Base awards.	Grandfathering: Calls for changes in grandfathering period for Title I EMAs. Eligibility maintained until grantee falls below eligibility threshold for 3 consecutive fiscal years at which time they would move down to the appropriate Tier if eligible or no longer be eligible. Hold harmless: Title I: hold harmless for Tier 1 only (not Tiers 2 or 3), and applies for 3 years using percentages of 90, 85, and 80 of base year grant. FY 2006 is the base year. Title II Base and ADAP: applies for 3 years using percentages of 90, 85, 80 of base year grant. FY 2006 is base year.
Core Medical Services	No core set of medical services specified or tied to funding percentages.	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-IV must be spent on "primary medical care" defined as including: medications; diagnostic tests; visits with physicians and medically credentialed health care providers; treatment for oral health; treatment for psychiatric conditions; treatment for other health care conditions directly related to HIV/AIDS infection; and health insurance premiums, co-payments, and deductibles. (core services do not include case management for non-medical services or short-term transitional housing)	Yes. At least 75% of funds for Titles I-III must be spent on core medical services defined as including: outpatient and ambulatory health services; medications; oral health care; early intervention services; health insurance premium and cost sharing assistance for low income individuals; home health care; home and community-based health services except homemaker services; hospice services; mental health services; substance abuse outpatient care; and medical case management (including treatment adherence service).

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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 issue guidelines that provide recommendations for medications that shall, at a minimum, be included on ADAP formularies.	Yes. Requires Secretary of HHS to develop a list of core ADAP antiretroviral drugs, as specified by Public Health Service guidelines. States must ensure that these drugs are the minimum used on their ADAP formulary.
Unspent Funds	Grant funds may be adjusted by Secretary of HHS to reflect unspent or canceled amounts from preceding year.	Allows Secretary of HHS to redistribute unspent funds from Titles I and II to ADAPs with the greatest need.	Requires that CARE Act funds left unspent for two years be redistributed through the ADAP Supplemental.	Requires that EMAs and states return unspent funds or apply to use them in succeeding fiscal year. If grantees do not utilize unspent funds in succeeding fiscal year, they are returned to appropriate supplemental pots for possible distribution to other grantees. Funds from FY2007-FY2011 are eligible for redistribution.
Other	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. 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.	HIV Testing: Any state or locality that prohibits or imposes significant barriers to rapid HIV testing, or to partner notification, not eligible for funding; Requires rapid HIV testing at any facility receiving federal funds from HHS; Requires Centers for Disease Control and Prevention to purchase at least 1.5 million rapid HIV tests annually. Hepatitis: Authorizes treatment of hepatitis B and C for people co-infected with HIV/AIDS. SPNS - Requires Secretary of HHS to develop standard electronic client -information data system.	HIV Testing: Clarifies that requirement that HIV testing by Title III grantees adhere to CARE Act confidentiality, informed consent, counseling and testing provisions applies only when using funds appropriated under the CARE Act. Hepatitis: Requires counseling of individuals before HIV testing to include information about hepatitis B and C; Requires Title III grantees to provide information on hepatitis A, B, and C during counseling and to provide information on where hepatitis A and B vaccinations can be obtained. SPNS - Requires development of standard electronic client -information data system to improve ability of grantees to report client-level data.
Authorization of Appropriations	"…such sums as may be necessary..."	Not specified.	Specified as follows: ADAP: annual increase of at least $70 million. ADAP Supplemental: set-aside increased from 3% to 8% of ADAP earmark, and calls for at least an additional $35 million per year.	Specified as follows: Titles I, II, III: 3.7% annual increase over base year of FY 2007. Title I: levels specified by Tier by year. Title II: one-time $70 million increase in FY 2007 (includes $40M ADAP Supplemental "booster"). Title II ADAP Supplemental: set-aside increased from 3% to 5% of ADAP earmark; $40 million booster in FY 2007. Title III: $25 million increase in FY 2007. Title IV, Title V AETC, Title V Dental: each authorized at level amount per year. Title V Minority AIDS Initiative: 3% annual increase.

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