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The Ryan White CARE Act:
A Side-by-Side Comparison of Prior Law
to the Newly Reauthorized CARE Act

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The Ryan White 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. Congress did not act to reauthorize the CARE Act at that time and the program's authority was extended under current law while Reauthorization discussions continued. 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 HR 6143, a modified version of the bill which was sent back to the Senate. On December 6, the Senate passed HR 6143 with further revised language and this final version of the bill was passed by the House on December 9. On December 19, the President signed the bill. Unlike the prior authorizations of the CARE Act, which each spanned a five-year period, the new law reauthorizes the CARE Act for three years and includes a sunset provision which ends the authorization on September 30, 2009.

Ryan White programs are complex and understanding all of provisions under prior authorizations, let alone changes in the new law, is a challenging task. The following table, prepared by the Kaiser Family Foundation, provides a side-by-side comparison of prior law to the newly reauthorized *Ryan White HIV/AIDS Treatment Modernization Act of 2006*. Earlier versions of this side-by-side are 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.

Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. no. 109-415.

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. House. 109th Congress, 2nd Session, House Report 109-695. *Ryan White HIV/AIDS Treatment Modernization Act of 2006*

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 the History of the Ryan White CARE Act

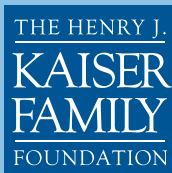
1990, August 18:	First passed; first funds awarded in FY 1991 (P.L. 101-381)
1996, May 20:	Reauthorized with Amendments (P.L. 104-146)
2000, October 20:	Reauthorized with Amendments (P.L. 106-345)
2005, July 27:	White House releases Principles
2005, September 30:	Authorization expires
2006, May 17:	Senate HELP Committee introduces and passes reauthorization bill (S 2823)
2006, September 21:	House introduces reauthorization bill; passes on September 28 (HR 6143)
2006, December 6:	Senate passes compromise bill (HR 6143)
2006, December 9:	House passes Senate version of bill (HR 6143)
2006, December 19:	Bill signed into law (P.L. 109-415)

	The Ryan White CARE Act of 1990 [P.L. 101-381] & Amendments of 1996 [P.L. 104-146] and 2000 [P.L. 106-345]	The Ryan White HIV/AIDS Treatment Modernization Act of 2006 [P.L. 109-415]
Title	Ryan White Comprehensive AIDS Resources Emergency Act of 1990	Ryan White HIV/AIDS Treatment Modernization Act of 2006
Authorization Period	Five-year authorization in 1990, 1996, and 2000	Three-year authorization with sunset on September 30, 2009
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.”	“...to revise and extend the program for providing life-saving care for those with HIV/AIDS” The purpose of the CARE Act is to: “address the unmet care and treatment needs of persons living with HIV/AIDS by funding primary health care and support services that enhance access to and retention in care.” (From House Report 109-695)
Structure	<p>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 several titles with subcomponents:</p> <p>Part A (Title I): Emergency Relief to Eligible Metropolitan Areas (EMAs). Planning Councils must be established; Planning Councils set priorities for spending.</p> <p>Part B (Title II): HIV Care Grants to States</p> <ul style="list-style-type: none"> • Title II Base • AIDS Drug Assistance Program (ADAP); • ADAP Supplemental Drug Treatment Grant (ADAP Supplemental); • Emerging Community Supplemental Grant (EC). <p>Part C (Title III): Early intervention, capacity building, and planning grants to providers and other eligible organizations.</p> <p>Part D (Title IV): Women, Infants, Children & Youth grants to providers</p> <p>Part E: Emergency Response Employees</p> <p>Part F: Demonstration and Training Programs</p> <ul style="list-style-type: none"> • AIDS Education and Training Centers (AETCs) • Dental Education, Training, Reimbursement • Special Projects of National Significance (SPNS) 	<p>Overall Title structure maintained but further sub-divided and/or other changes to existing sub-components as follows:</p> <p>Title I: Now divided into 2 subparts</p> <ul style="list-style-type: none"> • Subpart 1 = EMAs (eligibility redefined; see eligibility). • Subpart 2 = TGAs, a new program for “transitional grant areas.” Includes some metropolitan areas previously eligible as Title I EMAs, “grandfathered” EMAs, and some areas previously eligible as Title II ECs (see eligibility). • Planning Councils not mandatory for TGAs (unless TGA was an EMA in FY 2006). <p>Title II:</p> <ul style="list-style-type: none"> • Title II Base, ADAP, and ADAP Supplemental, and EC remain (with changes) • New Title II supplemental grant program created. <p>Part E: grants for emergency response employees deleted; new provision added to address public health emergencies.</p> <p>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). SPNS program changed.</p>
Eligibility for Funding: Titles I and II	<p>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.</p> <p>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).</p> <p>Title II ADAP: all states, territories, associated jurisdictions.</p> <p>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.</p> <p>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).</p>	<p>Changes to Titles I and II eligibility in at least one subcomponent.</p> <p>Title I: Metropolitan area population size and disease burden eligibility thresholds changed.</p> <ul style="list-style-type: none"> • Population: lowered to 50,000 or more. • Disease burden specified by subpart as follows: <ul style="list-style-type: none"> 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). <p>Title II: ADAP Supplemental and EC eligibility changes.</p> <ul style="list-style-type: none"> • ADAP Supplemental: territories are now eligible for ADAP; severe need criteria changed from “number of individuals at or below 200% FPL” to “unanticipated increase in individuals eligible for ADAP” (other criteria remain the same); no longer ties to January 2000 criteria; State matching requirement may 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 are now eligible under Title I TGAs). States must agree that grant would be used to provide funds to ECs separately from other Title II funds provided to ECs.

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Funding Distribution for Titles I and II	<p>Funding distributed by formula, supplemental (competitive) grant awards, and set-asides depending on Title and subcomponent.</p> <p>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" and is up to 50% of funds appropriated for Title I.</p> <p>Title II Base: 100% formula. Formula = (A) 80% of state's share of all ELCs + (B) 20% of state's share of all ELCs outside of EMAs</p> <p>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.</p> <p>*ELCs are determined by applying defined survival weights by year to the cumulative number of AIDS cases reported over the preceding 10 year period.</p>	<p>Changes Title I and Title II formula weights and funding distribution to be based on living HIV and living AIDS cases from names-based reporting states only, unless exemption is received (see next section).</p> <p>Title I: More weight given to formula as follows: 2/3 formula, 1/3 supplemental, applies to EMAs and TGAs.</p> <ul style="list-style-type: none"> • Formula = EMA's (or TGA's) share of living HIV and AIDS cases from 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. Changed from 50% to 33% of funds appropriated for Title I. <p>Title II Base: Formula changed to give more weight to areas outside of EMAs/TGAs and to states with no EMAs/TGAs; from 80/20 to 75/20/5: (A) 75% of state's share of nation's HIV/AIDS cases + (B) 20% of state's share of HIV/AIDS cases outside of EMAs/TGAs + (C) 5% of state's share of HIV/AIDS cases from states with no EMAs/TGAs</p> <p>Formula to be replaced by Severity of Need Index (SONI). Secretary must develop SONI and notify Congress annually of its status starting in FY 2008. SONI defined as: index of relative needs of individuals within State, as identified by a variety of different factors, multiplied by number of living HIV/AIDS cases in State, providing different weights to cases based on their needs.</p> <p>Title II ADAP Supplemental: set-aside increased from 3% to 5% of ADAP earmark.</p> <p>Title II EC: Set-aside authorized at \$5 million of Title II base. Formula = EC's living HIV/AIDS cases as share of all living HIV/AIDS cases in ECs nationwide.</p>
Use of HIV cases in Funding Formulas for Titles I and II	<p>Uses estimated living AIDS cases.</p> <p>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).</p>	<p>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 mature names-based HIV reporting or 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).</p> <p>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).</p> <p>For states (and jurisdictions within) with exemptions that have "immature" or code-based HIV reporting, their HIV counts provided to HRSA for purposes of funding distribution will be reduced by 5%.</p>

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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	<u>Grandfathering:</u> Title I EMAs that were eligible in FY 1996 remain eligible in subsequent years. <u>Hold harmless:</u> 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 each 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.	<u>Grandfathering:</u> Title I: <ul style="list-style-type: none"> • Subpart 1: eligibility maintained in FY 2007 even if EMA does not meet Subpart 1 or Subpart 2 eligibility and will be considered TGA. Eligibility would end if, for three consecutive years, EMA fails to have cumulative total of 2,000 or more living AIDS cases in most recent 5-year period <i>and</i> a cumulative total of 3,000 or more living AIDS cases in most recent year. • Subpart 2: eligibility would end if, for three consecutive years, TGA fails to have at least 1,000-1,999 cases of AIDS during most recent 5-year period <i>and</i> 1,500 or more living cases of AIDS as of most recent year. <u>Hold Harmless:</u> Title I: Subpart 1: for EMAs that were held harmless in FY 2006, extended for 3 years at 95% of the FY 2006 award (after taking into account new formula weights). Subpart 2: No hold harmless provision. Title II: Eliminates separate hold harmless for Title II base and ADAP. Triggered when sum of Title II base and ADAP < 95% of previous year award. Applies for FY 2007-2009, 95% hold harmless; funded by Title II base supplemental. If exhausted, pro rata reduction will be taken from states remaining after excluding minimum award states and those needing to be held harmless.
Core Medical Services	<u>No</u> core set of medical services specified or tied to funding.	<u>Yes.</u> 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 those identified and 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.
Minimum Formulary for ADAP	<u>No</u> 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."	<u>Yes.</u> Requires Secretary of HHS to develop a list of core antiretroviral drugs, as specified by Clinical Practice Guidelines for Use of HIV/AIDS Drugs, including drugs needed to manage symptoms associated with HIV. ADAPs are required to provide all drugs on the list.
Unspent Funds/ Carryover	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.	Title I: Carryover of unspent funds not permitted unless EMA receives waiver. Title I supplemental carryover not allowable for either tier, and will be canceled at the end of the grant year and redistributed. Both formula and supplemental awards for either tier can be reduced if there are unobligated balances. Title II base and ADAP: Carryover not permitted unless state receives waiver. Title II base supplemental, ADAP supplemental, and ECs: Carryover not allowable and funds will be canceled and redistributed.

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Other	<p>SPNS – eligible entities are public and private entities.</p> <p>HIV Testing: 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 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.</p> <p>Hepatitis: Not specified.</p>	<p>SPNS: eligible entities only those eligible for funding under Parts A-D; new criteria for awards added. Funds used address emerging needs of clients and assist in developing standard electronic client information data system.</p> <p>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.</p> <p>Hepatitis: See above</p> <p>Early Diagnosis Grant Program: portion of funding appropriated to CDC (outside of CARE Act) to be made available to states for early diagnosis services, if state law or regulation calls for: voluntary opt-out testing of all pregnant women <i>and</i> universal testing of newborns; or voluntary opt-out testing of clients at STD clinics <i>and</i> substance abuse treatment centers. Funds can be used for HIV testing (including rapid testing), prevention counseling, treatment of newborns exposed to HIV, treatment of mothers with HIV, and costs associated with linking those diagnosed with HIV/AIDS to care and treatment for HIV/AIDS.</p>
Authorization of Appropriations	<p>“...such sums as may be necessary...”</p> <p>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.</p>	<p>Title I: Annual increase of 3.7 percent for FY 2008 and FY 2009</p> <ul style="list-style-type: none"> • \$604,000,000 for FY 2007, \$626,300,000 for FY 2008, \$649,500,000 for FY 2009 • For FY 2007, \$458,310,000 reserved for EMAs and \$145,690,000 reserved for TGAs. Secretary determines amount in subsequent years. <p>Title II: Annual increase of 3.7 percent for FY 2008 and FY 2009</p> <ul style="list-style-type: none"> • \$1,195,500,000 for FY 2007, \$1,239,500,000 for FY 2008, \$1,285,200,000 for FY 2009 • 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 <p>Title III: Annual increase of 3.7 percent for FY 2008 and FY 2009</p> <ul style="list-style-type: none"> • \$218,600,000 for FY 2007, \$226,700,000 for FY 2008, \$235,100,000 for FY 2009 <p>Title IV: \$71,800,000 for each FY 2007-2009</p> <p>Title VI:</p> <ul style="list-style-type: none"> • AETCs: \$34,700,000 for each FY 2007-2009 • Dental: \$13,000,000 for each FY 2007-2009 • 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. <p>Early Diagnosis Grant Program: \$30 million of funds appropriated to CDC made available each FY for early diagnosis grants to states until the funds are spent. \$20 million for states that have voluntary opt-out testing of all pregnant women <i>and</i> mandatory testing of newborns; \$10 million states that have voluntary opt-out testing of clients at STD clinics <i>and</i> voluntary opt-out testing of clients at substance abuse treatment centers.</p>



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