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**World Bank AIDS Prevention Trust Fund Act (Introduced in the Senate)**

S 2033 IS

106th CONGRESS

2d Session

**S. 2033**

To provide for negotiations for the creation of a trust fund to be administered by the International Bank for Reconstruction and Development or the International Development Association to combat the **AIDS** epidemic.

**IN THE SENATE OF THE UNITED STATES**

**February 3, 2000**

Mr. KERRY (for himself and Mr. DURBIN) introduced the following bill; which was referred to the Committee on Foreign Relations

**A BILL**

To provide for negotiations for the creation of a trust fund to be administered by the International Bank for Reconstruction and Development or the International Development Association to combat the **AIDS** epidemic.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. SHORT TITLE.

This Act may be cited as the `World Bank **AIDS** Prevention Trust Fund Act'.

## SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS- The Congress finds the following:

(1) According to statistics of the International Bank for Reconstruction and Development (hereafter referred to as the `World Bank'), more than 90 percent of all adults and children with human immunodeficiency virus/acquired immune deficiency syndrome (referred to as **HIV /AIDS** ) live in the developing world--62 percent in Sub-Saharan Africa, 24 percent in Asia, and 6.9 percent in Latin America and the Caribbean.

(2) In Africa, the death toll from **AIDS** has reached 13,000,000, while 23,000,000 others live with the disease, and more than 10,000,000 children have been infected or orphaned by it.

(3) The World Bank, declaring **AIDS** not just a public health problem but the `foremost and fastest-growing threat to development' in Africa, has launched a new strategy for **HIV /AIDS** in Africa, declaring it a top priority for the World Bank on that continent.

(4) The World Bank estimates that for Africa alone, $1,000,000,000 to $2,300,000,000 annually is needed for prevention in the region in contrast to the modest $160,000,000 a year in official assistance currently available for **HIV /AIDS** in Africa.

(5) **AIDS** , like all diseases, knows no boundaries, and there is no certitude that the scale of the problem in one continent can be contained within that region.

(6) Accordingly, United States financial support for medical research, education, and disease containment as a global strategy has beneficial ramifications for millions of Americans and their families who are affected by this disease, and the entire population which is potentially susceptible.

(b) PURPOSES- The purposes of this Act are to prevent human suffering and to ensure the viability of economic development, stability, and national security in the developing world by advancing research to understand the causes associated with **HIV /AIDS** in developing countries and to assist in the development of an **AIDS** vaccine.

## SEC. 3. NEGOTIATIONS FOR THE CREATION OF A WORLD BANK TRUST FUND TO ASSIST IN AIDS PREVENTION AND ERADICATION.

The Secretary of the Treasury should enter into negotiations with the World Bank or the International Development Association (hereafter referred to as the `Association'), with the member nations of such institutions, and with other interested parties for the creation of a trust fund, to be administered by the Bank or the Association, as appropriate, which would--

(1) accept contributions from governments, the private sector, and nongovernmental entities of all kinds; and

(2) use such contributions to address the **AIDS** epidemic in countries eligible to borrow from the Association.

## SEC. 4. LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.

In addition to any other funds authorized to be appropriated for multilateral or bilateral programs related to **AIDS** , there is authorized to be appropriated to the Secretary of the Treasury $100,000,000 for each of fiscal years 2001 through 2005 for payment to the trust fund established as a result of the negotiations entered into pursuant to section 3.

## SEC. 5. REPORT TO THE CONGRESS.

Not later than 3 years after the date of enactment of this Act, the Secretary of the Treasury shall submit to the Committees on Banking and Financial Services and on International Relations of the House of Representatives and the Committees on Banking, Housing, and Urban Affairs and on Foreign Relations of the Senate a written report on the trust fund established pursuant to section 3, the goals of the trust fund, the programs, projects, and activities, including any vaccination approaches, supported by the trust fund, and the effectiveness of such programs, projects, and activities in reducing the worldwide spread of **AIDS** .

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**Mother-to-Child HIV Prevention Act of 2000 (Introduced in the Senate)**

S 2032 IS

106th CONGRESS

2d Session

**S. 2032**

To amend the Foreign Assistance Act of 1961 to address the issue of mother-to-child transmission of human immunodeficiency virus (HIV) in Africa, Asia, and Latin America.

**IN THE SENATE OF THE UNITED STATES**

**February 3, 2000**

*Mr. MOYNIHAN (for himself and Mr. FEINGOLD) introduced the following bill; which was read twice and referred to the Committee on Foreign Relations*

**A BILL**

To amend the Foreign Assistance Act of 1961 to address the issue of mother-to-child transmission of human immunodeficiency virus (HIV) in Africa, Asia, and Latin America.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. SHORT TITLE.

This Act may be cited as the `Mother-to-Child HIV Prevention Act of 2000'.

## SEC. 2. FINDINGS.

Congress makes the following findings:

(1) According to UNAIDS, nearly 4,500,000 children under 15 years of age have been infected with the human immunodeficiency virus (HIV) since the AIDS epidemic began. More than 3,000,000 have already died of AIDS. Children are becoming infected at about the rate of 1 child every minute, and the overwhelming majority of these children acquire the infection from their mothers.

(2) The gap between rich and poor countries in terms of transmission of HIV from mother to child has been increasing. Moreover, AIDS threatens to reverse years of steady progress of child survival in developing countries. UNAIDS believes that by the year 2010, AIDS may have increased mortality of children under 5 years of age by more than 100 percent in regions most affected by the virus.

(3) The discovery of a relatively simple and cheap means of interrupting the transmission of HIV from an infected mother to the unborn child--namely with nevirapine (NVP), which costs US$4 a tablet--has created a great opportunity for an unprecedented partnership between the United States Government and the governments of Asian, African and Latin American countries to combat mother-to-child transmission (also known as `vertical transmission') of HIV.

(4) According to UNAIDS, this strategy will decrease the proportion of orphans that are HIV-infected and decrease infant and child mortality rates in these developing regions.

(5) USAID, UNAIDS, and UNICEF are engaged in 11 pilot projects around the world. These studies will be completed within the year, and the technical and ethical questions associated with antiretroviral prevention strategies will be mastered well enough in order for a significant increase in scale to be undertaken.

(6) Primary prevention strategies should remain the top priority in the fight against AIDS and no funds should be diverted away from it. Therefore, new funding for vertical transmission should only be additive in nature. Once appropriated, this funding will facilitate widespread delivery of antiretroviral strategies to address the vertical transmission problem.

(7) New antiretroviral drug strategy can be a force for social change, providing the opportunity and impetus needed to tackle often long-standing problems of inadequate services and the profound stigma associated with HIV-infection and the AIDS disease. Strengthening the health infrastructure to improve mother-and-child health, antenatal, delivery and postnatal services, and couples counseling generates enormous spillover effects toward combating the AIDS epidemic in developing regions.

## SEC. 3. ASSISTANCE FOR PREVENTION OF VERTICAL TRANSMISSION.

Section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) is amended by adding at the end the following new paragraph:

`(4)(A) Congress recognizes the growing international dilemma of children with the human immunodeficiency virus (HIV) and the merits of intervention programs aimed at this problem. Congress further recognizes that mother-to-child transmission prevention strategies can serve as a major force for change in developing regions, and it is, therefore, a major objective of the foreign assistance program to control the AIDS epidemic. The agency primarily responsible for

administering this part shall--

`(i) coordinate with UNAIDS, UNICEF, WHO, local governments, and other organizations to develop and implement effective strategies to prevent vertical transmission of HIV; and

`(ii) coordinate with those organizations to increase in scale intervention programs and introduce voluntary counseling and testing, antiretroviral drugs, replacement feeding, and other strategies more widely in due course.

`(B) In addition to amounts otherwise available for such purpose, there are authorized to be appropriated to the President, $25,000,000 for each of the fiscal years 2001 through 2005 to be used to carry out this paragraph. Funds appropriated under this paragraph are authorized to remain available until expended.'.

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**AIDS Orphans Relief Act of 2000 (Introduced in the Senate)**

S 2030 IS

106th CONGRESS

2d Session

**S. 2030**

To authorize microfinance and food assistance for communities affected by the Acquired Immune Deficiency Syndrome (AIDS), and for other purposes.

**IN THE SENATE OF THE UNITED STATES**

**February 3, 2000**

Mr. DURBIN introduced the following bill; which was read twice and referred to the Committee on Foreign Relations

**A BILL**

To authorize microfinance and food assistance for communities affected by the Acquired Immune Deficiency Syndrome (AIDS), and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. SHORT TITLE.

This Act may be cited as the `AIDS Orphans Relief Act of 2000'.

## SEC. 2. FINDINGS.

Congress makes the following findings:

(1) By the end of 2000, 10,400,000 children in Sub-Saharan Africa will have lost their mother, or both parents, to Acquired Immune Deficiency Syndrome (AIDS).

(2) In the next decade, 40,000,000 children will become orphans as a result of the AIDS pandemic, most of them located in Sub-Saharan Africa.

(3) Over the next 20 years, AIDS threatens to reduce substantially economic progress in the nations of Sub-Saharan Africa.

(4) Success or failure in fighting the AIDS pandemic will effect the spread of the disease to India, Asia, and the states of the former Soviet Union.

(5) By 2005, more than 100,000,000 people worldwide will have been infected with Human Immunodeficiency Virus (HIV), the precursor to AIDS.

(6) Effective assistance for children orphaned by AIDS, and for those caring for such children, must strengthen the surviving families.

(7) The development and expansion of sustainable microfinance institutions that provide access to credit, savings, and other financial services to the very poor, especially women, are critical components in a global strategy to address the devastating economic and social effects of AIDS.

(8) Microfinance programs are particularly effective in helping those left to care for AIDS orphans by providing the caregivers the means of pursuing a livelihood.

(9) Microfinance programs have been shown to be particularly effective in permitting individuals with AIDS to have access to services and credit not otherwise available to such individuals, including health insurance, life insurance, counseling, and group support.

(10) Food aid can be a critical component in mitigating the impact of AIDS on communities by addressing the nutritional needs of individuals with AIDS and assisting households left destitute by AIDS, and as a part of a larger, comprehensive effort to strengthen and restore sustainable livelihood strategies for households and communities affected by AIDS.

## SEC. 3. PURPOSES.

The purposes of this Act are--

(1) to make microfinance programs an important component of United States policy in fighting the effects of the Acquired Immune Deficiency Syndrome (AIDS) pandemic worldwide; and

(2) to encourage targeted use of food and food-related assistance for humanitarian purposes and for sustainable development in communities affected by AIDS.

## SEC. 4. MICROCREDIT PROGRAMS.

Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended by adding at the end the following new section:

## `SEC. 131. ASSISTANCE FOR MICROCREDIT PROGRAMS FOR COMMUNITIES AFFECTED BY AIDS.

`(a) IN GENERAL- In addition to any other funds authorized to be appropriated by this chapter for micro-enterprise activities or activities relating to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), there is authorized to be appropriated each fiscal year, $50,000,000 for purposes of assisting microcredit programs that serve the very poor, especially women, in communities heavily affected by AIDS.

`(b) PROGRAM ELEMENTS- (1) The maximum amount of credit provided an individual under a microcredit program under subsection (a) may not exceed $600 and (b) the average loan size for a program receiving resources under this section may not exceed $300.

`(2) To the maximum extent practicable, amounts shall be provided under subsection (a) for programs that--

`(A) provide HIV prevention or AIDS care and support, whether directly or through linkages with other programs;

`(B) employ best practices for assisting the very poor; and

`(C) operate in a sustainable manner.'.

## SEC. 5. FOOD ASSISTANCE PROGRAMS.

Title IV of the Agricultural Trade and Development Assistance Act of 1954 (7 U.S.C. 1731 et seq.) is amended by adding at the end the following new section:

## `SEC. 416. ASSISTANCE FOR COMMUNITIES AFFECTED BY AIDS.

`(a) IN GENERAL- The President may provide food assistance under this Act to developing countries in order to assist such countries in mitigating the effects of Acquired Immune Deficiency Syndrome (AIDS) on communities in such countries, including--

`(1) assistance to address the nutritional needs of individuals in such communities who have AIDS;

`(2) assistance for households affected by AIDS; and

`(3) assistance as part of other aid or assistance designed to create or restore sustainable livelihood strategies in communities affected by AIDS.

`(b) AUTHORIZATION OF APPROPRIATIONS-

`(1) AUTHORIZATION- There is authorized to appropriated each fiscal year, $50,000,000 for purposes of providing assistance under this section.

`(2) RELATIONSHIP TO OTHER AUTHORIZATIONS- Amounts authorized to be appropriated for a fiscal year by paragraph (1) are in addition to any other amounts authorized

to be appropriated by this Act for such fiscal year.'.

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**Bill 1 of 8**

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| GPO's PDF version of this bill | References to this bill in the Congressional Record | Link to the Bill Summary & Status file. | *Full Display* - 4,140 bytes.[Help] |

**Global AIDS Prevention Act of 2000 (Introduced in the Senate)**

S 2026 IS

106th CONGRESS

2d Session

**S. 2026**

To amend the Foreign Assistance Act of 1961 to authorize appropriations for **HIV /AIDS** efforts.

**IN THE SENATE OF THE UNITED STATES**

**February 2, 2000**

Mrs. BOXER (for herself, Mr. SMITH of Oregon, and Mr. KENNEDY) introduced the following bill; which was read twice and referred to the Committee on Foreign Relations

**A BILL**

To amend the Foreign Assistance Act of 1961 to authorize appropriations for **HIV /AIDS** efforts.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. SHORT TITLE.

This Act may be cited as the `Global **AIDS** Prevention Act of 2000'.

## SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Since the beginning of the **HIV /AIDS** epidemic 2 decades ago, more than 16,300,000 people worldwide have died of the disease.

(2) More than 33,600,000 people in the world are living with **HIV /AIDS** ; more than 3,000,000 of them are children.

(3) Sub-Saharan Africa has been particularly hard hit by the disease, as the region has accounted for--

(A) 84 percent of the worldwide deaths from **HIV /AIDS** ;

(B) two-thirds of the new infections in 1999; and

(C) 69 percent of those living with the disease.

(4) In sub-Saharan Africa, 55 percent of the infected adults are women and, as a result, more than 10,000,000 children have been orphaned in sub-Saharan Africa because of **HIV /AIDS** --a figure that could double or triple in the next decade.

(5) According to the United Nations, **HIV /AIDS** in sub-Saharan Africa is the `worst infectious disease catastrophe since the bubonic plague'.

(6) The **HIV /AIDS** problem in Southeast Asia is growing dramatically. In 1999, 20 percent of the new infections in the world were in Southeast Asia.

(7) New investments and treatments hold out promise of making progress against the **HIV /AIDS** epidemic. For example, a recent study in Uganda demonstrated that a new drug could prevent almost one-half of the **HIV** transmissions from mothers to infants, at a fraction of the cost of other treatments.

(8) Making progress against **HIV /AIDS** requires a global commitment, with a leadership role from the United States.

## SEC. 3. AMENDMENT OF THE FOREIGN ASSISTANCE ACT OF 1961.

Section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) is amended by adding at the end the following new paragraph:

`(4)(A) Congress expects the agency primarily responsible for administering this part to make **HIV /AIDS** a priority in the foreign assistance program and to undertake a comprehensive, coordinated effort to combat **HIV /AIDS** . This effort shall include providing--

`(i) primary prevention and education;

`(ii) voluntary testing and counseling;

`(iii) medications to prevent the transmission of **HIV /AIDS** from mother to child; and

`(iv) care for those living with **HIV /AIDS** .

`(B)(i) In addition to amounts otherwise available for such purpose, there are authorized to be appropriated to the President to carry out this paragraph $300,000,000 for fiscal year 2001, $350,000,000 for fiscal year 2002, $400,000,000 for fiscal year 2003, $450,000,000 for fiscal year 2004, and $500,000,000 for fiscal year 2005.

`(ii) Not less than 50 percent of funds made available each fiscal year under clause (i) shall be used to combat the **HIV /AIDS** epidemic in sub-Saharan Africa.

`(iii) Funds appropriated under this subparagraph are authorized to remain available until expended.'.

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# Congress of the United States
## House of Representatives
### Washington, D.C. 20515

**COSPONSOR H.R. 3519 - WORLD BANK AIDS PREVENTION TRUST FUND**

Dear Colleague:

We are inviting you to cosponsor H.R.3519, the World Bank AIDS Prevention Trust Fund Act.

In Africa, a human tragedy is unfolding on a scale terrifyingly reminiscent of the plagues that swept through Europe during the Middle Ages. Roughly 70 percent of the people who have contracted the human immunodeficiency virus (HIV) are in Sub-Saharan Africa which has less than 10 percent of the world's population. An estimated 13 million Africans have died from acquired immune deficiency syndrome (AIDS) and many of the 23 million Africans now living with the disease will die in the next decade. Already, the disease has orphaned some 10 million African children.

Globally, an estimated 34 million people have contracted HIV and over 16 million people have died of AIDS. Approximately 2.6 million people died from AIDS in 1999 alone. Each day about 8,500 people, including 1,000 children, become newly infected. About 90 percent of these infections occur in developing countries--in Africa, Asia, and the Caribbean--where the spread of AIDS is undermining economic development by striking down working adults in the prime of their lives.

The legislation we have introduced - H.R.3519 - directs the U.S. government to seek the establishment of a new AIDS Prevention Trust Fund at the World Bank. The bill authorizes U.S. contributions of $100 million a year for five years, in hopes of leveraging that contribution to obtain contributions from other governments as well as private sector companies to reach $1 billion a year. The proceeds of the trust fund would support AIDS education, prevention, treatment, and vaccine development efforts in the world's poorest countries, particularly in Sub-Saharan Africa.

World Bank President Jim Wolfensohn cited in a recent speech before the U.N. Security Council an African farmer: "Today, we are spending more time turning the bodies of the sick than we are turning the soil." Preventing and eventually eradicating the spread of the HIV/AIDS epidemic is clearly the foremost medical, humanitarian, and economic challenge of our time.

The United States is uniquely positioned to lead the world in the prevention and eradication of HIV/AIDS. To abdicate that role would be a mistake of historic dimensions. We hope you will join us by cosponsoring the World Bank Aids Prevention Trust Fund Act. In addition, we urge your cosponsorship of H.R. 2765, the AIDS Marshall Plan Fund for Africa Act, of which Barbara Lee is the principal author.

These two bills represent a joint approach to the AIDS issue. Please contact Amanda Kueter in the Leach office at x56576 or Michael Riggs in the Lee office at x52661 if you would like to do so.

Sincerely,

James A. Leach
Member of Congress

Barbara Lee
Member of Congress

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE**
**INTERNATIONAL SECURITY AFFAIRS**
**AFRICAN AFFAIRS**

OFFICE: (703) 697-9753/8824 FAX: (703) 695-4620

**TO:** Cheryl Bauncle
**FROM:** David Hamon
**FAX NO:** 456-2438
**SUBJECT:**

Attached – I was given some bad information – the African research is in Malaria. But the pt. remains that this is a potential platform for some sort of education

Pls replace this paper & do away w/ the other – it is not correct

Regards,
David

MEMORANDUM FOR CHERYL BAUERLE

SUBJECT: AIDS Emergency Working Group

1. Currently the Defense Department sponsors overseas laboratory research in Africa mostly in the areas of tropical medicine. This may be a platform to provide education.

2. As part of a series of on-going Joint Exercises, we have recommended the military services look into using visiting medical teams and medical exercises (such as MEDFLAGS) to maximize resources while promoting strategies on preventing the spread of AIDS. There may be 5-10 MEDFLAG exercises throughout the world. These exercises are funded and allow military medical personnel to work closely with local medical professionals to address local and regional health problems.

3. In addition, it may be possible to visit Africa locales by US Hospital ships such as MERCY. Such a visit could be used for an interagency coordinated awareness campaign. In so much that these port calls are already funded, additional expense should be minimal.

4. Point of contact in Africa Region (DOD, International Security Affairs) for these ideas is Mr. David Hamon at (703) 697-8824.

*Proposed Balance of Funding Among Component Activities*: The proportional investment in prevention, treatment and surveillance will be in part dependent upon the host country infrastructure. Our overall rough estimate for funding these activities in HHS' integrated proposal would be prevention 50% (inclusive of surveillance and behavioral data gathering that guides prevention efforts), and treatment 50% .

***Objectives / Implementation Goals*** - Instead of expenditure data hooked to categorical activities, we would propose that a more accurate reflection of the appropriate use of funds lies in defined implementation outcomes within the categories of prevention, treatment and surveillance. For example:

Surveillance

(1) Define seroprevalence of HIV, TB and STD within given populations through screening
(2) Rapid definition of modes of HIV transmission through ethnographic/behavioral data collection defining movement of HIV through defined local population
(3) Mortality trend data (impact of OI and TB treatment should drop mortality rapidly)

Prevention

(1) high risk populations identified in a given geographic area
(2) # targeted and brought into an educational intervention (i.e. pregnant women, high risk behavior groups)
(3) # persons screened for HIV, STD and TB
(4) access to condoms/# condoms distribution
(5) # pregnant women on AZT (country-dependent)
(6) # women who seek family planning services who get HIV counseling and testing
(7) # immunization programs that also provide HIV testing for children and counseling for parents

Treatment*

(1) number of persons diagnosed with HIV
(2) number persons diagnosed and treated for TB
(3) number persons diagnosed and treated for STD
(4) number persons treated for simple OIs and appropriate prophylaxis for TB, OIs, malaria
(5) establishment of a coordinated palliative care/hospice capability in coordination with host country - (#'s served)

*Basic Drug Formulary for Treatment under consideration: TB, OI, STD, antimalarial drugs. This very rough first cut would be further refined through a discussion with other health partners. This proposal is limited to treatments for conditions we propose to screen for -- with the exception of not introducing antiretroviral therapies (at this time) beyond AZT indicated for perinatal transmission.

| Cost per Day+ | Prophylaxis | Treatment |
|---|---|---|
| AZT for perinatal transmission (decided on site/in country) | | |

| | | |
|---|---|---|
| Dapsone ($0.19/tablet) | $0.19 | 0 |
| INH ( $0.02/ tablet) | $0.02 | $0.02 |
| Bactrim/Septra ($0.07/tab generic) | $0.07 | $0.28 |
| Doxycycline ($0.11/tab) | $0.11 | $0.22 |
| Azithromycin ($ 6.00/ tab) | 0 | $12.00 |
| Keconazole ($2.80/tab) | $2.80 | $4.60 |
| Flagyl ($0.03/tab) | 0 | $0.09 |
| Nystatin vaginal tabs ($0.11/each) | $0.22 | $0.44 |
| Acyclovir ( $1.08/200 mg tab) | $4.00 | $16.00 |
| Ceftriaxone | 0 | |
| Benzethine Penicillin | 0 | |
| Pen V K (oral penicillin) | 0 | |
| Dicloxacillin | 0 | |
| Keflex | 0 | |
| Erithromycin | 0 | |
| +/- rifampin ($0.61/tab) | $1.22 | $1.22 |
| ) | | |

choroquine (quinine sulfate), mefloquine, quinidine, proguanil for chloroquine resistant Sub-Saharan areas

+/- parasitic diseases - many covered by Flagyl above,
mebendazole for hookworm/roundworm/VLM,
albendazole for cutaneous larvae migrans,
praziquantel for schistosomiasis)

+ Cost per day based on average US pharmacy retail cost -- no assumptions made on price reductions for bulk purchase

*Basic Drug Formulary for Treatment under consideration: TB, OI, STD, antimalarial drugs

| Cost per Day+ | Prophylaxis | Treatment |
|---|---|---|
| Dapsone ($0.19/tablet) | $0.19 | 0 |
| INH ( $0.02/ tablet) | $0.02 | $0.02 |
| Bactrim/Septra ($0.07/tab generic) | $0.07 | $0.28 |
| Doxycycline ($0.11/tab) | $0.11 | $0.22 |
| Azithromycin ($ 6.00/ tab) | 0 | $12.00 |
| Keconazole ($2.80/tab) | $2.80 | $4.60 |
| Flagyl ($0.03/tab) | 0 | $0.09 |
| Nystatin vaginal tabs ($0.11/each) | $0.22 | $0.44 |
| Acyclovir ( $1.08/200 mg tab) | $4.00 | $16.00 |
| Ceftriaxone | 0 | |
| Benzethine Penicillin | 0 | |
| Pen V K (oral penicillin) | 0 | |
| Dicloxacillin | 0 | |
| Keflex | 0 | |
| Erithromycin | 0 | |
| +/- rifampin ($0.61/tab) | $1.22 | $1.22 |
| choroquine (quinine sulfate), mefloquine, quinidine, proguanil for chloroquine resistant Sub-Saharan areas | | |
| AZT for perinatal transmission (decide on site in country) | | |
| +/- parasitic diseases - many covered by Flagyl above, mebendazole for hookworm/roundworm/VLM, albendazole for cutaneous larvae migrans, praziquantel for schistosomiasis) | | |

+ Cost per day based on average US pharmacy retail cost

Final draft 26/Jan 8.00 pm

January 27, 2000

**President Clinton Unveils Millennium Initiative to Promote Delivery of Existing Vaccines in Developing Countries and Accelerate Development of New Vaccines**

In his State of the Union address, President Clinton will call for concerted international action to combat infectious diseases in developing countries. These diseases cause almost half of all deaths worldwide of people under age 45, killing over eight million children each year and orphaning millions more.

The President committed the United States to addressing this terrible problem in his September speech to the United Nations General Assembly. Now the President is asking for foundations, pharmaceutical companies, international agencies, and other governments to join us in this task, and he is announcing these specific elements of his Millennium Initiative:

- **A new financial commitment to purchase and deliver existing vaccines in poor countries.** As Vice President Gore told the U. N. Security Council earlier this month, the Administration's FY 2001 budget will include a **proposed $50 million contribution to the vaccine purchase fund of the Global Alliance for Vaccines and Immunization (GAVI).**

- **Increased investments in health in developing countries. The President is calling on the World Bank and other multilateral development banks to dedicate an additional $400 million to $900 million annually of their low-interest-rate loans to expand immunization, prevent and treat infectious diseases, and build effective delivery systems for other basic health services.** These investments are as central to economic progress as investments in education and physical infrastructure, and they would build on the new focus on basic health services that we have supported as part of the Highly Indebted Poor Countries (HIPC) debt initiative. This proposed shift in existing resources does not require additional U.S. budget expenditures.

- **A significant increase in basic research on diseases that affect developing nations.** The Administration's FY 2001 budget for the National Institutes of Health includes **a sharp step-up in research critical to the development of vaccines for malaria, tuberculosis, and HIV/AIDS.**

- **A new tax credit for sales of vaccines for malaria, tuberculosis, and HIV/AIDS to accelerate the invention and production of these vaccines.** Because developing countries often cannot afford to buy vaccines, the market provides little incentive for pharmaceutical companies to develop vaccines for diseases that disproportionately affect those countries. This tax credit would provide such an incentive, because every **dollar paid by a qualifying organization to buy a qualifying vaccine would be matched by a dollar of tax credits – representing up to $1 billion of additional funding for future vaccine purchases.** The President is calling on other governments to make similar purchase commitments, so that we can ensure a future market for these critically needed vaccines.

## POLICY RATIONALE AND ADDITIONAL EXPLANATION

**Infectious Diseases Pose a Mounting Social and Economic Burden on Developing Countries – And a Threat to Our Health As Well.**

- More than eight million children die each year of centuries-old diseases like malaria, tuberculosis, and respiratory and diarrheal diseases. Deaths from the modern scourge of AIDS are climbing rapidly. Altogether, as many children die of infectious diseases each year as the total number of combatants who perished in World War I.

- In an interconnected and highly mobile world, health crises in other countries are a threat to everyone. We have seen this with HIV/AIDS, with the resurfacing of tuberculosis, and with the outbreak last year of West Nile encephalitis in New York. According to the Global Health Council, during the past 50 years, at least five times as many Americans have died from communicable diseases that have come from the developing world than have died in military conflicts.

**Vaccines Are One of the Most Cost-Effective Ways to Improve the Well-Being and Productivity of the Poorest Countries - And Medicines and Other Basic Health Services Are a Necessary Complement.**

- It costs about $17 to immunize a child, but millions of children die each year of diseases that could be prevented by existing vaccines. Indeed, children in developing nations are 10 times more likely to die of a vaccine-preventable disease than children in developed nations. And these tragedies occur in spite of the enormous efforts of UNICEF and others to vaccinate children, which save 3 million lives each year.

- Highly effective vaccines do not yet exist for malaria, TB and AIDS, which take over 5 million lives each year. But developed nations have the scientific and technological capacity to make new vaccines possible. For example, recent work on genetic sequencing, including the human genome, will open vast possibilities.

- Another health investment with very high returns is simple preventive and curative services. Providing this basic health care together with vaccines would save millions of lives each year.

**A $50 Million Contribution to GAVI to Buy Vaccines For Children – Which Will Save Lives Now and Create Confidence that a Market for New Vaccines Will Exist in the Future.**

- GAVI, the Global Alliance for Vaccines and Immunization, was formed as a collaborative effort of UNICEF, the World Health Organization (WHO), the World Bank, private foundations, bilateral aid agencies (including the U.S. Agency for International Development), industry representatives, and developing countries. GAVI established the "Global Fund for Children's Vaccines" with an initial grant of $750 million over 5

years from the Bill and Melinda Gates Foundation. The formal launch of GAVI, and the official announcement of the Gates gift, will occur shortly in Davos, Switzerland.

- A U.S. contribution will help to purchase vaccines for Hepatitis B, Haemophilus Influenzae B (Hib), and Yellow Fever, along with related safe delivery equipment such as auto-destruct syringes. To ensure that GAVI's vaccine purchases complement, rather than replace, existing vaccination efforts, they will be conditional on a country achieving 50 percent coverage of the DTP (diptheria-tetanus-pertussis) vaccine, which is included along with measles and polio in the existing EPI (Expanded Program for Immunization).

- A U.S. contribution will hopefully catalyze significant contributions from other countries and foundations. It will also add crucial credibility to the international community's commitment to provide a market for new vaccines when they are developed.

**We Must Shift Existing International Resources Toward Building Health Infrastructure in Poor Countries That Can Deliver Vaccines and Medicines and Provide Essential Basic Health Services.**

- The World Bank and other multilateral development banks (MDBs, such as the African Development Fund) lend money on highly favorable terms to the world's poorest countries. Today, roughly $1 billion to $1-1/2 billion of this so-called "concessional funding" is devoted to health care each year. The Administration proposes to increase that amount by $400 million to $900 million per year, with a focus on:
  - immunization;
  - prevention of diseases using basic measures such as information and condoms for AIDS, treated bed nets for malaria, and stronger systems for containing TB;
  - treatment of diseases, including common respiratory and diarrheal infections; and
  - more effective provision of basic health care.

- The Administration is exploring ways to use the HIPC debt reform to support this part of the Millennium Initiative. One possibility is to make an increase in vaccination rates one of the performance targets monitored in the HIPC progress reports. This could be accompanied by debtor countries' agreements to include specific improvements in vaccine delivery systems as priority uses of debt relief proceeds. We also expect that all Poverty Reduction Strategy Papers that are prepared for HIPC candidates will discuss the adequacy of budget resources and suggested policy reforms devoted to basic health care.

- This re-direction of resources supports the Administration's overall strategy for global development, which emphasizes poverty reduction and gives a central role to "global public goods" – like health or the environment – in which positive actions taken in one country benefit other countries as well. To meet this objective, these funds should not come from spending on other basic social programs, such as education and health care.

- This aspect of the Millennium Initiative does not require a new budgetary commitment by the United States (or other donor countries). However, the U.S. ability to influence the direction of MDB lending and the use of HIPC proceeds depends crucially on meeting our existing commitments to these aid programs. We will work with other G-8 finance and development ministries to refine this proposal.

- A conservative estimate suggests that if basic health care including immunization were made broadly available, up to 2 million children's lives could be saved each year.

**Higher Funding for Basic Scientific Research Through the National Institutes of Health (NIH) and Elsewhere Will Hasten the Development of Vaccines for Malaria, TB, and AIDS.**

- The Administration's FY 2001 budget for NIH includes a significant increase in research critical to creating vaccines for these diseases. For malaria and TB, this increase will build on recent advances in the genetic sequencing of these diseases, which have set the stage for major breakthroughs in vaccine development.

- Funding for NIH malaria vaccine research will increase by 20 percent over the FY 2000 level. Future research will range from pre-clinical studies aimed at improving our understanding of the malaria parasite, through the development of vaccine candidates, to clinical trials judging vaccine efficacy and safety. NIH will also expand its collaboration with scientists in malaria-endemic regions, especially in Africa, to strengthen those regions' capacity for conducting clinical trials of malaria vaccines in the future.

- NIH research on a tuberculosis vaccine will receive 50 percent more funding than in FY 2000 and nearly double the FY 1999 level. NIH will focus on studying the body's defense mechanisms against TB, and developing and studying TB vaccine candidates. Through its Tuberculosis Research Unit, NIH supports an international multi-disciplinary team to translate advances in basic research into new tools for fighting TB.

- NIH funding for AIDS vaccine research will increase substantially in FY 2001 and will have more than doubled since FY 1997. These additional resources will allow NIH to accelerate basic research on developing vaccine candidates and to significantly expand testing of potential vaccine candidates in both developing and developed countries. The new Vaccine Research Center on the NIH campus, which will be occupied this summer, will receive a sizeable increase in funding for the development and pre-clinical testing of HIV vaccine candidates.

- The Administration is providing strong support for the path-breaking research on infectious diseases being conducted by U.S. military scientists, including the opening (in October 1999) of the Walter Reed Army Institute of Research/Naval Medical Research Center. Working in close collaboration with scientists worldwide, military scientists have developed and tested successful vaccines against Japanese encephalitis and hepatitis A –

and they are working to create vaccines and medicines to protect service people, travelers, and millions of others from malaria, HIV/AIDS, and other infectious diseases.

**A New Tax Credit Would Effectively Provide Up to $1 Billion for Future Vaccine Purchases, Speeding the Invention and Production of New Vaccines**

- Current tax law provides substantial incentives for pharmaceutical research and development, including the research and experimentation (R&E) tax credit, the orphan drug tax credit, and an enhanced deduction for charitable contributions of certain products. Nonetheless, pharmaceutical companies may be reluctant to invest in developing vaccines for diseases that primarily afflict people in poor countries, because little or no paying market exists in those countries.

- Under the proposal, the seller of a qualified vaccine could claim a tax credit equal to 100 percent of the amount paid by a qualifying organization that received a "credit allocation" by the U.S. Agency for International Development (AID). The tax credit would match the qualified organizations' expenditures dollar-for-dollar, thereby doubling their purchasing power. A qualifying vaccine would be a new vaccine that received FDA approval for use against malaria, tuberculosis, HIV/AIDS, or any infectious disease that causes over 1 million deaths annually worldwide.

- For 2002 through 2010, AID could designate up to $1 billion of vaccine sales as eligible for the credit. This tax credit would be limited to new vaccines developed to fight these terrible diseases. The credit would provide a specific and credible commitment to purchase future vaccines at reasonable prices. Together with similar commitments from foundations and other governments, it would provide a critical and powerful incentive to accelerate vaccine research and development.

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***Memorandum*** January 18, 2000

TO : Senate Health, Education, Labor and Pensions Committee
Attention: Scott Boule

FROM : Paulette Como
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT : **Ryan White CARE Act**

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You requested a comparison of how different methods of estimating the number of people living with acquired immune deficiency syndrome (AIDS) would affect the monies distributed to eligible metropolitan areas (EMA) under Title I of the Ryan White CARE Act in FY99. Attached, please find two tables containing the information that you requested. A comparable comparison for Title II of the CARE Act will follow in a separate memorandum.

This memorandum is divided into three sections. The first section is a brief explanation of the three methods used to estimate the number of people living with AIDS, including assumptions and limitations of the data. The second section is a description of the set-asides that affect the amount of money distributed using the formula and a description of the formula for distributing Title I funds currently in the law. The third section is a brief analysis of the data and discussion of the policy implications of the data.

## Three Methods of Calculating AIDS Prevalence

### Method 1: Current Law

Current law stipulates that the estimate of prevalence, or the number of people living with AIDS, is to be calculated using data (number of new cases of AIDS) reported to the Centers for Disease Control and Prevention (CDC) for each eligible metropolitan area (EMA) over the most recent 120-month period for which data is available. The data is aggregated into 10 12-month periods. Each 12 month period is weighted by the probability that an individual diagnosed with AIDS is still alive given the year that he or she was diagnosed. Thus, someone diagnosed 10 years ago would have a smaller probability of being alive compared to someone who was diagnosed 1 year ago. The same weights are used for all eligible areas. The weighted values of reported cases are then summed to give the

estimate of living AIDS cases in each area. The weights used in these calculations are updated biennially.

One limitation of the current method of calculating AIDS prevalence is that it assumes there is no regional variability in survival, which is unlikely to be true. Another limitation is that it assumes all EMAs report *complete* data of incidence and AIDS related deaths for each particular 12 month time period. This is also unlikely to be true. EMAs (or States reporting for EMA and non-EMA areas) depend on thousands of doctors and care providers to report the data to them. The doctors and care providers do not always report promptly. Several years may pass before some doctors report their data to the State or EMA. Thus the data that the EMAs report to the CDC may not reflect the number of AIDs cases and AIDS related deaths for a particular 12 month reporting period. Delayed reporting is the term used to describe cases that are not reported within the 12 month period in which they are diagnosed.[1]

**Method 2: Cases Reported to be Living.**

One alternative method of estimating AIDS prevalence is to calculate the difference between the number of cases of AIDS reported to the CDC and the number of reported deaths of AIDS cases reported to the CDC. This method was used to calculate AIDS prevalence in EMAs and published by the CDC.[2] This data was used for method 2 of this analysis.

One benefit of method 2 is that it does account for regional differences such as differences in survival and access to care. But, this method does not account for delayed reporting of AIDS cases and deaths.

**Method 3: Adjusted Reported AIDS cases.**

This estimate of AIDS prevalence adjusts for reporting delays using a maximum likelihood statistical procedure. This adjustment takes into account geographic area, race/ethnicity, age, sex, vital status, and exposure category of reported cases. The adjustment is done to both the reports of AIDS cases, as well as the reports of AIDS deaths. The estimate of prevalence is the difference between the adjusted estimate of cases and the adjusted estimate of deaths. The CDC used this method to calculate AIDS prevalence and published the findings.[3] This data was used for method 3 of this analysis.

This statistically adjusted estimate is limited in that it assumes trends in reporting delays by geographic area, race/ethnicity, age, sex, vital status and exposure category are constant within these categories. Another limitation of method 3 is that it is slow to respond

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[1] Delayed reporting is sometimes mistaken for incomplete reporting. Incomplete reporting is when a case is never reported. None of the methods of estimating prevalence in this paper adjust for incomplete reporting.

[2] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Supplemental Report. 1999;5(No.2): 8p.

[3] Ibid.

to changes in reporting patterns. This method is based on historical trends in data reporting patterns. If an area dramatically changes its reporting habits (either to report more promptly or more delayed), the calculation may not reflect this recent change. If the change is sustained, the estimate of prevalence will slowly adjust to this change in reporting behavior.

As with method 2, this method has the benefit of accounting for regional differences in survival. But, according to CDC statisticians, because of the adjustment for reporting delays, method 3 provides a more accurate estimate of the number of AIDS cases in the EMAs.[4]

Set-Asides and the Distribution of Funds Under Current Law

This analysis does *not* assume changes in the underlying formula in the current law. It examines how different data (or estimates of prevalence) used in the same basic formula, result in different distributions of money.

The current law dictates that half of Title I funds are to be distributed using the formula written in the law, and half are to be distributed through supplemental grants. Several set-asides are taken out of the appropriation before it is divided between the formula and supplemental grants. These include Special Projects of National Significance (FY1999 = 1.8% of total Title I appropriated funds), Broad Technical Assistance (FY1999 = 1% of total Title I appropriated funds) and Evaluation (FY99 = 1% of total Title I appropriated funds). For FY1999, after set-asides, $485,966,900 was available for Title I. Half of this amount, or $242,983,450 was divided among the eligible metropolitan areas(EMA) under the formula portion of Title I.

The money is divided among the EMAs according to their proportions of estimated AIDS cases. For example, for FY1999, New York city contained approximately 21% of all of the estimated AIDS cases living in EMAs. Therefore, New York city was portioned approximately 21% of the available funds.

Two adjustments take place to the distributed funds. First, new EMAs are offered $75,000 planning grants.[5] That amount is then deducted from their formula award. For FY99, two new EMAs received $75,000 planning grants: Las Vegas, NV-AZ, and Norfolk-Virginia Beach-Newport News, VA-NC. The planning grant is only offered for the EMAs first year of existence. Therefore, the total amount of money distributed under the formula portion of Title I is smaller by $150,000, but only the two new EMAs are effected by the lower total amount of money. The second adjustment is a hold harmless provision. In the current law, for FY1999, EMAs can not receive less than 3.5% less than what they received in 1995. For FY1999, only one EMA was affected by the hold harmless provision: San Francisco. Under the formula portion of Title I, San Francisco would have received $9,400,823. Under the hold harmless provision, San Francisco should receive $18,457,245. Therefore, the *difference between these two amounts is taken from the supplemental grant*

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[4] Phone conversation with CDC statistician.

[5] Section 2606 (42 U.S.C. 300ff-16)

*portion of Title I and added to the formula portion of Title I.* Thus, the formula portion of Title I is larger by that difference, and only San Francisco receives that money.

*Why is there a hold harmless provision?* The hold harmless provision was added during the re-authorization in 1996, when changes to the Title I formulas were feared to have a large and negative impact on the amount of money some EMAs received.

*Why was San Francisco the only EMA to be effected by the hold harmless in FY1999?* This may be a reflection of an historical trend. Prior to the re-authorization in 1996, money for Title I was distributed based on the number of AIDS cases that had ever been reported in an area. San Francisco was one of the first metropolitan areas to be impacted by the AIDS epidemic. But, most individuals diagnosed with AIDS at the beginning of the epidemic are very unlikely to be alive today. This may be one reason why San Francisco's formula amount ($9,400,823), which reflects the estimated number of people living with AIDS today, is so much less than the hold harmless amount it ultimately receives ($18,457,245), which reflects a portion of how many people were living with AIDS in San Francisco earlier in the epidemic.

*Are new EMAs subject to the hold harmless provision?* New EMAs are not subject to the hold harmless provision. EMAs that came into existence since 1995 could not be adversely affected by changes in formulas that took place in 1996, because they were not eligible, and did not receive money under the prior formula.

For this examination of methods 2 and 3 (for estimating AIDS prevalence), a different hold harmless level was used. As requested, the hold harmless level for methods 2 and 3 in the attached tables was set at 98% of an EMAs 1995 amount[6]. Therefore, in FY1999, using methods 2 and 3 for estimating AIDS prevalence, an EMA could not receive less than 98% of what it received in 1995. Two EMAs received additional money because of the hold harmless provision under method 2 (New York and San Francisco), and one EMA received a more money under method 3 (San Francisco).

## Analysis and Policy Implications of the Data

**Table 1** attached compares the amount of money distributed to each EMA using the formula portion of Title I when AIDS prevalence is estimated under the current method (method 1) and under method 2 – both with and without a 2% hold harmless provision. Recall that method 2 is the difference between the reported cases of AIDS, and the reported cases of AIDS deaths. These estimates were made using AIDS prevalence data for FY1999, the only data made available by the CDC. These examinations are not projections of AIDS cases or grant amounts.

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[6] Under current law for FY1999, EMAs can not receive less than 96.5% of what they received in 1995 for the formula portion of Title 1.

Thirty three EMAs would receive more money under method 2 hold harmless[7] and eighteen would receive less money. The percentage change in money received by EMAs when the hold harmless provision is employed range from a decrease of 15.5% in Norfolk-Virginia Beach-Newport News VA-NC, to an increase of 31.1% in Kansas City, MO-KS. The percentage change between method 1 and method 2 may reflect a variety of things, including, but not limited to such things as regional differences in survival, access to care, and different strains of the virus that may or may not be more likely to respond to currently available drugs.

The hold harmless provision for Method 2 only affected two EMAs – New York, NY and San Francisco, CA. Some EMAs had very large decreases in their money, but were either not subject to the hold harmless because they did not exist in 1995 (e.g., Norfolk-Virginia Beach-Newport News VA-NC, -15.5%), or their decrease was large, but not so large that it was affected by the hold harmless (Chicago, IL, -10.8%[8]). Other EMAs received substantially more under method 2, such as Jacksonville, FL (+24.6%) and Orange County, CA (+24.9%). The committee may wish to consider setting a different criteria for the hold harmless to limit the impact of this data change on some of the EMAs.

Estimated grants are the same under method 2 both with and without the hold harmless provision, *except for New York and San Francisco*. All other EMAs receive the same grant amounts whether the hold harmless in place or not. Without the hold harmless, New York would receive 8.1% less under method 2, relative to current law, and San Francisco would receive 48.1% less under method 2, relative to current law.

Method 2 has at least one major disadvantage in that it provides EMAs with an incentive to delay the reporting of AIDS deaths, if AIDS prevalence was tied to their funding. Such an incentive may jeopardize the reliability of AIDS data received by the CDC in the future.

**Table 2** compares the amount of money distributed when the current method (method 1) and method 3 are used to estimate the AIDS prevalence, both with and without a 2% hold harmless provision. Recall that method 3 uses prevalence estimates adjusted for reporting delays.

Thirty-six EMAs received more money under method 3 compared to method 1 while fifteen EMAs received less money. The percentage change in money received by EMAs with a hold harmless provision ranged from a decrease of 16.7% in Caguas, PR to an increase of 23.5% in Kansas City, MO-KS. The percentage change between method 1 and method 3 may reflect a variety of things. Like method 2, method 3 will reflect regional

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[7] The 2% hold harmless provision used for method 2 and method 3 was relative to the funds an EMA received in 1995.

[8] In FY1995, Chicago received approximately $4,925,000 from the formula portion of Title I. Under a 2% hold harmless provision, Chicago can not receive less than $4,829,500 for FY1999. Using method 2 to estimate AIDS prevalence, Chicago would receive $8,049,000, which is much higher than its hold harmless amount, but yet, 10.8% less than what it would receive under current law for FY1999.

differences. Unlike method 2, method 3 adjusts for reporting delays. Under the current law (method 1) EMAs that are slower to report their data to the CDC are at a relative disadvantage. Under method 3, those delayed reporters are brought to parity. Because there is a set amount of money to distribute among the EMAs, the EMAs that historically were very prompt to report their data to the CDC were somewhat adversely affected by method 3. For example, according to the CDC, EMAs in Puerto Rico, which promptly reported their data to the CDC relative to other EMAs, were adversely affected by the adjustment for other EMA's reporting delays.

As with method 2, there were several EMAs that would receive substantial drops in their funding under method 3 with the current hold harmless provision. The committee may wish to consider a different hold harmless provision to mitigate the decreases in some EMAs funding.

Under method 3, only San Francisco is affected by the hold harmless provision. All EMAs other than San Francisco receive the same grant amounts under method 3 regardless of whether the hold harmless provision is in place. Without the hold harmless provision San Francisco would receive 45.8% less under method 3 relative to current law.

Data used in method 3, unlike method 2 or 1, take longer for the CDC to calculate. Estimates of AIDS prevalence current through July of 1999 may not be available until February or March of the following year. This lag has to do with the deadlines that EMAs have to report their data to the CDC and the amount of time it takes to generate accurate estimates.

Overall, the data comparing method 3 to method 1 are very similar to the data comparing method 2 to method 1. Slightly more EMAs had an increased percent change under method 3. The range of the percentage changes was very similar between current law and each alternative method. But, different EMA are negatively and positively impacted under each alternative method.

I hope this information is useful. If you have any further questions, please call me. A comparable analysis of Title II of the Ryan White CARE Act will follow.

Paulette Como
202-707-7317

FEB.-07'00(MON) 16:31 US SENATE HELP CMTE TEL:202 224 5128 P.008

## Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 2 Hold Harmless (in thousands) | Percent Change from current law | Method 2 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Atlanta, GA MSA | $6,915 | $7,532 | 8.9% | $7,532 | 8.9% |
| Austin-San Marcos, TX MSA | $1,658 | $1,720 | 3.7% | $1,720 | 3.7% |
| Baltimore, MD PMSA | $6,956 | $6,402 | -8.0% | $6,402 | -8.0% |
| Bergen-Passaic, NJ PMSA | $2,401 | $2,135 | -11.1% | $2,135 | -11.1% |
| Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH NECMA | $5,293 | $5,203 | -1.7% | $5,203 | -1.7% |
| Caguas, PR PMSA | $859 | $748 | -12.9% | $748 | -12.9% |
| Chicago, IL PMSA | $9,025 | $8,049 | -10.8% | $8,049 | -10.8% |
| Cleveland-Lorain-Elyria, OH PMSA | $1,505 | $1,561 | 3.8% | $1,561 | 3.8% |
| Dallas, TX PMSA | $5,095 | $5,762 | 13.1% | $5,762 | 13.1% |
| Denver, CO PMSA | $2,130 | $2,520 | 18.3% | $2,520 | 18.3% |
| Detroit, MI PMSA | $3,324 | $3,303 | -0.6% | $3,303 | -0.6% |
| Dutchess County, NY PMSA | $608 | $589 | -3.1% | $589 | -3.1% |
| Fort Lauderdale, FL PMSA | $5,544 | $5,704 | 2.9% | $5,704 | 2.9% |
| Fort Worth-Arlington, TX PMSA | $1,503 | $1,632 | 8.6% | $1,632 | 8.6% |
| Hartford, CT NECMA | $2,027 | $2,259 | 11.4% | $2,259 | 11.4% |
| Houston, TX PMSA | $8,282 | $8,657 | 4.5% | $8,657 | 4.5% |
| Jacksonville, FL MSA | $1,887 | $2,351 | 24.6% | $2,351 | 24.6% |
| Jersey City, NJ PMSA | $2,931 | $2,584 | -11.9% | $2,584 | -11.9% |
| Kansas City, MO-KS MSA | $1,476 | $1,938 | 31.3% | $1,938 | 31.3% |
| Las Vegas, NV-AZ MSA | $1,775 | $1,917 | 8.0% | $1,917 | 8.0% |
| Los Angeles-Long Beach, CA PMSA | $16,905 | $16,783 | -0.7% | $16,783 | -0.7% |
| Miami, FL-PMSA | $10,492 | $11,031 | 5.1% | $11,031 | 5.1% |
| Middlesex-Somerset-Hunterdon, NJ PMSA | $1,406 | $1,338 | -4.8% | $1,338 | -4.8% |
| Minneapolis-St. Paul, MN-WI MSA | $1,288 | $1,484 | 15.2% | $1,484 | 15.2% |
| Nassau-Suffolk, NY PMSA | $2,879 | $2,738 | -4.9% | $2,738 | -4.9% |
| New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT NECMA | $3,115 | $3,631 | 16.6% | $3,631 | 16.6% |
| New Orleans, LA MSA | $3,060 | $3,141 | 2.7% | $3,141 | 2.7% |
| New York, NY PMSA | $51,212 | $47,663 | -6.9% | $47,063 | -8.1% |
| Newark, NJ PMSA | $7,212 | $6,419 | -11.0% | $6,419 | -11.0% |
| Norfolk-Virginia Beach-Newport News, VA-NC MSA | $1,898 | $1,604 | -15.5% | $1,604 | -15.5% |
| Oakland, CA PMSA | $3,147 | $3,282 | 4.3% | $3,282 | 4.3% |
| Orange County, CA PMSA | $2,173 | $2,713 | 24.9% | $2,713 | 24.9% |

1/18/2000

## Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 2 Hold Harmless (In thousands) | Percent Change from current law | Method 2 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Orlando, FL MSA | $2,759 | $2,931 | 6.2% | $2,931 | 6.2% |
| Philadelphia, PA-NJ PMSA | $8,281 | $8,402 | 1.5% | $8,402 | 1.5% |
| Phoenix-Mesa, AZ MSA | $2,015 | $1,880 | -6.7% | $1,880 | -6.7% |
| Ponce, PR MSA | $1,233 | $1,266 | 2.7% | $1,266 | 2.7% |
| Portland-Vancouver, OR-WA PMSA | $1,558 | $1,758 | 12.8% | $1,758 | 12.8% |
| Riverside-San Bernardino, CA PMSA | $3,232 | $3,493 | 8.1% | $3,493 | 8.1% |
| Sacramento, CA PMSA | $1,338 | $1,308 | -2.2% | $1,308 | -2.2% |
| St. Louis, MO-IL MSA | $1,975 | $2,168 | 9.8% | $2,168 | 9.8% |
| San Antonio, TX MSA | $1,858 | $2,012 | 8.3% | $2,012 | 8.3% |
| San Diego, CA MSA | $4,502 | $4,764 | 5.8% | $4,764 | 5.8% |
| San Francisco, CA PMSA | $18,457 * | $18,744 | 1.6% * | $9,574 | -48.1% |
| San Jose, CA PMSA | $1,268 | $1,421 | 12.1% | $1,421 | 12.1% |
| San Juan-Bayamon, PR PMSA | $6,925 | $6,042 | -12.8% | $6,042 | -12.8% |
| Santa Rosa, CA PMSA | $604 | $715 | 18.4% | $715 | 18.4% |
| Seattle-Bellevue-Everett, WA PMSA | $2,654 | $3,004 | 13.2% | $3,004 | 13.2% |
| Tampa-St. Petersburg-Clearwater, FL MSA | $3,597 | $3,947 | 9.7% | $3,947 | 9.7% |
| Vineland-Millville-Bridgeton, NJ PMSA | $341 | $333 | -2.3% | $333 | -2.3% |
| Washington, DC-MD-VA-WV PMSA | $9,877 | $10,415 | 5.5% | $10,415 | 5.5% |
| West Palm Beach-Boca Raton, FL MSA | $3,434 | $3,604 | 4.9% | $3,604 | 4.9% |
| **Total** | **$251,890** [1] | **$252,603** [2] | | **$242,833** [3] | |

**Source:** Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law, the hold harmless is a value 3.5% below the EMA's 1995 grant. Per request, the method 2 hold harmless is 2% below the EMA's 1995 grant.

**Note:** The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The total for the current formula [1] reflects the money distributed under the formula portion of Title I ($242,983,000), adjusted by the amount to hold SanFrancisco harmless at 3.5% of its 1995 amount (+$9,056,000) which is transferred from the supplemental grants portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title 1 (-$150,000). The method 2 hold harmless total[2] reflects the formula portion of Title I ($242,983,000), adjusted by the amount to hold San Francisco and New York harmless at 2% of their 1995 amount (+$9,770,00), adjusted for the new EMA start-up grants (-$150,000). The method 2 *not* held harmless[3] reflects the money distributed under the formula portion of Title I ($242,983,000) adjusted for the new EMA planning grants (-$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

**Note:** Method 2 is the difference between the number of AIDS cases and AIDS deaths reported to the CDC. See attached memorandum.

1/18/2000

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## Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 3 Hold Harmless (in thousands) | Percent Change from current law | Method 3 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Atlanta, GA MSA | $6,915 | $7,363 | 6.5% | $7,363 | 6.5% |
| Austin-San Marcos, TX MSA | $1,658 | $1,709 | 3.1% | $1,709 | 3.1% |
| Baltimore, MD PMSA | $6,956 | $6,909 | -0.7% | $6,909 | -0.7% |
| Bergen-Passaic, NJ PMSA | $2,401 | $2,126 | -11.4% | $2,126 | -11.4% |
| Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH NECMA | $5,293 | $5,582 | 5.5% | $5,582 | 5.5% |
| Caguas, PR PMSA | $859 | $715 | -16.7% | $715 | -16.7% |
| Chicago, IL PMSA | $9,025 | $7,979 | -11.6% | $7,979 | -11.6% |
| Cleveland-Lorain-Elyria, OH PMSA | $1,505 | $1,537 | 2.1% | $1,537 | 2.1% |
| Dallas, TX PMSA | $5,095 | $5,684 | 11.6% | $5,684 | 11.6% |
| Denver, CO PMSA | $2,130 | $2,261 | 6.2% | $2,261 | 6.2% |
| Detroit, MI PMSA | $3,324 | $3,327 | 0.1% | $3,327 | 0.1% |
| Dutchess County, NY PMSA | $608 | $585 | -3.8% | $585 | -3.8% |
| Fort Lauderdale, FL PMSA | $5,544 | $5,569 | 0.4% | $5,569 | 0.4% |
| Fort Worth-Arlington, TX PMSA | $1,503 | $1,613 | 7.3% | $1,613 | 7.3% |
| Hartford, CT NECMA | $2,027 | $2,265 | 11.7% | $2,265 | 11.7% |
| Houston, TX PMSA | $8,282 | $8,768 | 5.9% | $8,768 | 5.9% |
| Jacksonville, FL MSA | $1,887 | $2,211 | 17.2% | $2,211 | 17.2% |
| Jersey City, NJ PMSA | $2,931 | $2,514 | -14.2% | $2,514 | -14.2% |
| Kansas City, MO-KS MSA | $1,476 | $1,823 | 23.5% | $1,823 | 23.5% |
| Las Vegas, NV-AZ MSA | $1,775 | $1,833 | 3.3% | $1,833 | 3.3% |
| Los Angeles-Long Beach, CA PMSA | $16,905 | $16,951 | 0.3% | $16,951 | 0.3% |
| Miami, FL PMSA | $10,492 | $10,703 | 2.0% | $10,703 | 2.0% |
| Middlesex-Somerset-Hunterdon, NJ PMSA | $1,406 | $1,281 | -8.9% | $1,281 | -8.9% |
| Minneapolis-St. Paul, MN-WI MSA | $1,288 | $1,427 | 10.8% | $1,427 | 10.8% |
| Nassau-Suffolk, NY PMSA | $2,879 | $2,923 | 1.5% | $2,923 | 1.5% |
| New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT NECMA | $3,115 | $3,636 | 16.7% | $3,636 | 16.7% |
| New Orleans, LA MSA | $3,060 | $2,941 | -3.9% | $2,941 | -3.9% |
| New York, NY PMSA | $51,212 | $47,974 | -6.3% | $47,974 | -6.3% |
| Newark, NJ PMSA | $7,212 | $6,389 | -11.4% | $6,389 | -11.4% |
| Norfolk-Virginia Beach-Newport News, VA-NC MSA | $1,898 | $1,747 | -8.0% | $1,747 | -8.0% |
| Oakland, CA PMSA | $3,147 | $3,262 | 3.6% | $3,262 | 3.6% |
| Orange County, CA PMSA | $2,173 | $2,617 | 20.4% | $2,617 | 20.4% |

## Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 3 Hold Harmless (in thousands) | Percent Change from current law | Method 3 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Orlando, FL MSA | $2,759 | $2,844 | 3.1% | $2,844 | 3.1% |
| Philadelphia, PA-NJ PMSA | $8,281 | $8,389 | 1.3% | $8,389 | 1.3% |
| Phoenix-Mesa, AZ MSA | $2,015 | $2,138 | 6.1% | $2,138 | 6.1% |
| Ponce, PR MSA | $1,233 | $1,224 | -0.8% | $1,224 | -0.8% |
| Portland-Vancouver, OR-WA PMSA | $1,558 | $1,693 | 8.6% | $1,693 | 8.6% |
| Riverside-San Bernardino, CA PMSA | $3,232 | $3,413 | 5.6% | $3,413 | 5.6% |
| Sacramento, CA PMSA | $1,338 | $1,303 | -2.6% | $1,303 | -2.6% |
| St. Louis, MO-IL MSA | $1,975 | $2,069 | 4.8% | $2,069 | 4.8% |
| San Antonio, TX MSA | $1,858 | $1,981 | 6.6% | $1,981 | 6.6% |
| San Diego, CA MSA | $4,502 | $4,662 | 3.6% | $4,662 | 3.6% |
| San Francisco, CA PMSA | $18,457 * | $18,744 | 1.6% * | $9,997 | -45.8% |
| San Jose, CA PMSA | $1,268 | $1,361 | 7.3% | $1,361 | 7.3% |
| San Juan-Bayamon, PR PMSA | $6,925 | $6,019 | -13.1% | $6,019 | -13.1% |
| Santa Rosa, CA PMSA | $604 | $681 | 12.7% | $681 | 12.7% |
| Seattle-Bellevue-Everett, WA PMSA | $2,654 | $2,933 | 10.5% | $2,933 | 10.5% |
| Tampa-St. Petersburg-Clearwater, FL MSA | $3,597 | $3,817 | 6.1% | $3,817 | 6.1% |
| Vineland-Millville-Bridgeton, NJ PMSA | $341 | $308 | -9.5% | $308 | -9.5% |
| Washington, DC-MD-VA-WV PMSA | $9,877 | $10,300 | 4.3% | $10,300 | 4.3% |
| West Palm Beach-Boca Raton, FL MSA | $3,434 | $3,478 | 1.3% | $3,478 | 1.3% |
| **Total** | **$251,890** [1] | **$251,581** [2] | | **$242,833** [3] | |

**Source:** Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law the hold harmless is a value 3.5% below the EMA's 1995 grant. Under method 2, the hold harmless is a value of 2% below the EMA's 1995 grant.

**Note:** The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The current formula total[1] reflects the money distributed under the formula portion of Title I ($242,983,000), adjusted by the amount to hold SanFrancisco harmless at 3.5% of its 1995 amount (+$9,056,000) which is transferred from the supplemental grant portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title 1 (-$150,000.) The method 3 hold harmless total[2] reflects the the formula portion of Title I ($242,983,000), adjusted by the amount to hold San Francisco harmless at 2% of its 1995 amount ($8,747,000), adjusted for the new EMA planning grants (-$150,000). The method 3 *not* held harmless[3] reflects the money distributed under the formula portion of Title I ($242,983,000), adjusted for the new EMA planning grants (-$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

**Note:** Method 3 adjusts the reported cases of AIDS and AIDS deaths for late reporting. The estimate of prevalence is the difference in the adjusted reported cases and adjusted reported deaths. See attached memo for greater detail.

1/18/2000

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***Memorandum*** January 19, 2000

TO : Senate Health, Education, Labor and Pensions Committee
Attention: Scott Boule

FROM : Paulette Como
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT : **Ryan White CARE Act, Follow-up**

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In response to my memorandum dated January 18, 2000 regarding Title I of the Ryan White CARE Act, you requested that I report an additional comparison of grant amounts to eligible metropolitan areas (EMAs) using 1998 as the reference year for the hold harmless provision. Following, please find two tables containing the information you requested.

This memorandum contains a brief analysis of the data. For a review of the three Methods of estimating AIDS prevalence, and a discussion of the Method of distributing funds under current law, please see my previous memorandum.

## Analysis and Policy Implications of the Data

More EMAs receive larger grants under the formula portion of Title I when FY1998 is used as the reference year for the hold harmless provision, rather than FY1995. This is true for both alternative Methods of calculating AIDS prevalence.

**Table 1** attached compares the grants distributed under the formula portion of Title I when AIDS prevalence is estimated under the current Method (Method 1) and under Method 2 – both with and without a 2% hold harmless provision. Method 2 is the difference between reported AIDS cases and reported AIDS deaths. These estimates were made using data for FY1999. These are not projections. The hold harmless provision for Method 2 references grants EMAs received in 1998. The hold harmless provision prohibits EMAs from receiving less than 98% of the amount of money they received in FY1998.

Thirty two EMAs would receive more money under Method 2 hold harmless[1] and 19 would receive less money. The percentage change in money received by EMAs with a hold harmless provision range from a decrease of 15.5% (relative to what the EMA would have received under current law) in Norfolk-Virginia Beach-Newport News VA-NC, to an increase of 31.1% in Kansas City, MO-KS. The percentage change between Method 1 and Method 2 may reflect a variety of factors such as regional differences in survival and access to care. The range in the percentage change in this analysis (-15.5% to +31.1%) is identical to the range when 1995 is used as a reference year for the hold harmless provision. The reason is that Norfolk-Virginia Beach-Newport News (Norfolk) VA-NC (-15.5%) is a new EMA as of FY1999. Norfolk did not receive a grant in 1995 or in 1998. Thus, the hold harmless provision does not apply to Norfolk. Las Vegas NV-AZ was the only other EMA to be added in FY1999, and since it would receive an *increase* in funds using Method 2 instead of the Method 1, the hold harmless provision did not effect the grant amount for Las Vegas.

The hold harmless provision referenced to 1998 for Method 2 effected five EMAs – Bergen-Passaic NJ (-6.4%), Chicago IL (-10.6%), Jersey City NJ (-6.8%), Newark NJ (-7.1%), and San Francisco CA (-0.05%). Some EMAs had very large decreases in their money, but were either not subject to the hold harmless because they did not exist in 1995 (e.g., Norfolk-Virginia Beach-Newport News VA-NC, -15.5%), or their decrease was large, but not so large that it was affected by the hold harmless (Caguas PR, -12.9% and San Juan-Bayamon PR, -12.8%). Other EMAs received substantially more under Method 2, such as Jacksonville, FL (+24.6%) and Orange County, CA (+24.9%).

One major disadvantage of Method 2 is that it gives EMAs an incentive to delay the reporting of AIDS deaths. Such an incentive may jeopardize the reliability of AIDS data. Differences in the hold harmless provision would not alter this incentive.

**Table 2** compares grants distributed when the current Method (Method 1) and Method 3 are used to estimate the AIDS prevalence, both with and without a 2% hold harmless provision. The hold harmless provision used for Method 3 references 1998. Two EMAs (Las Vegas NV-AZ and Norfolk-Virginia Beach-Newport News VA-NC) are new as of FY1999 and are not held harmless when FY1998 data is used. Recall that Method 3 estimates prevalence with data adjusted for reporting delays.

Thirty-five EMAs received more money under Method 3 compared to Method 1 while 16 EMAs received less money. The percentage change in money received by EMAs with a hold harmless provision ranged from a decrease of 13.2%[2] in Caguas PR, to an increase of 23.5% in Kansas City, MO-KS. The percentage change between Method 1 and Method 3 may reflect a variety of factors. Like Method 2, Method 3 will reflect regional differences. Unlike Method 2, Method 3 is adjusted for reporting delays. Under the current

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[1] The 2% hold harmless provision used for Method 2 and Method 3 was relative to the funds an EMA received in 1998. EMAs can not receive a grant in FY1999 that is smaller than 2% less than the grant they received in FY1998.

[2] This amount is held harmless. In the absence of the hold harmless provision, Caguas PR would have received a grant under Method 3 that was 16.7% lower than it would have received under current law.

law (Method 1) EMAs that are slower to report their data to the CDC are at a relative disadvantage. Under Method 3, those delayed reporters are brought to parity. Because there is a set amount of money to distribute among the EMAs, the EMAs that historically were very prompt to report their data to the CDC were somewhat adversely affected by Method 3. For example, according to the CDC, EMAs in Puerto Rico, which promptly reported their data relative to other EMAs, were adversely affected by the adjustment for other EMA's reporting delays. Norfolk-Virginia Beach-Newport News VA-NC, which had the greatest negative percent change from current law under Method 2 has a much smaller negative percent change under Method 3 (-8.0%). This would suggest that Norfolk had been a relatively slow reporter and would see greater grants under Method 3, even *without the hold harmless*.

Nine EMAs receive the hold harmless amount under Method 3 when FY1998 grants are used as the reference: Bergen-Passaic NJ (-6.4%), Caguas PR (-13.2%), Chicago IL (-10.6%), Jersey City NJ (-6.8%), Middlesex-Somerset-Hunterdon NJ (-6.2%), Newark NJ (-7.1%), San Francisco CA (-0.05%), San Juan-Bayamon PR (-13.1%), and Vineland-Millville-Bridgeton NJ (5.6%). Seven EMAs received negative percent changes between Method 3 and Method 1 but were not affected by the hold harmless provision either because they did not exist in FY1998 (Norfolk-Virginia Beach-Newport News VA-NC, -8.0%) or their decrease in grants under Method 3 was not large enough to be affected by the hold harmless (New York NY, -6.3% and Dutchess County NY, -3.8%).

The data used in Method 3, unlike Method 2 or 1, take longer for the CDC to calculate. Estimates of AIDS prevalence current through July of 1999 may not be available until February or March of the following year. This lag has to do with the deadlines that EMAs have to report their data to the CDC and the amount of time it takes to generate accurate estimates. The committee may wish to consider this constraint when formulating legislation.

More EMAs are held harmless when FY1998 grants are used as the reference, rather than FY1995 grants. This is true for both alternative Methods of calculating AIDS prevalence.

I hope this information is useful. If you have any further questions, please call me at 202-707-7317.

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## Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 2 Hold Harmless (in thousands) | Percent Change from current law | Method 2 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Atlanta, GA MSA | $6,915 | $7,532 | 8.9% | $7,532 | 8.9% |
| Austin-San Marcos, TX MSA | $1,658 | $1,720 | 3.7% | $1,720 | 3.7% |
| Baltimore, MD PMSA | $6,956 | $6,402 | -8.0% | $6,402 | -8.0% |
| Bergen-Passaic, NJ PMSA | $2,401 | $2,247 | -6.4% * | $2,135 | -11.1% |
| Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH NECMA | $5,293 | $5,203 | -1.7% | $5,203 | -1.7% |
| Caguas, PR PMSA | $859 | $748 | -12.9% | $748 | -12.9% |
| Chicago, IL PMSA | $9,025 | $8,066 | -10.6% * | $8,049 | -10.8% |
| Cleveland-Lorain-Elyria, OH PMSA | $1,505 | $1,561 | 3.8% | $1,561 | 3.8% |
| Dallas, TX PMSA | $5,095 | $5,762 | 13.1% | $5,762 | 13.1% |
| Denver, CO PMSA | $2,130 | $2,520 | 18.3% | $2,520 | 18.3% |
| Detroit, MI PMSA | $3,324 | $3,303 | -0.6% | $3,303 | -0.6% |
| Dutchess County, NY PMSA | $608 | $589 | -3.1% | $589 | -3.1% |
| Fort Lauderdale, FL PMSA | $5,544 | $5,704 | 2.9% | $5,704 | 2.9% |
| Fort Worth-Arlington, TX PMSA | $1,503 | $1,632 | 8.6% | $1,632 | 8.6% |
| Hartford, CT NECMA | $2,027 | $2,259 | 11.4% | $2,259 | 11.4% |
| Houston, TX PMSA | $8,282 | $8,657 | 4.5% | $8,657 | 4.5% |
| Jacksonville, FL MSA | $1,887 | $2,351 | 24.6% | $2,351 | 24.6% |
| Jersey City, NJ PMSA | $2,931 | $2,732 | -6.8% * | $2,584 | -11.9% |
| Kansas City, MO-KS MSA | $1,476 | $1,938 | 31.3% | $1,938 | 31.3% |
| Las Vegas, NV-AZ MSA | $1,775 | $1,917 | 8.0% | $1,917 | 8.0% |
| Los Angeles-Long Beach, CA PMSA | $16,905 | $16,783 | -0.7% | $16,783 | -0.7% |
| Miami, FL PMSA | $10,492 | $11,031 | 5.1% | $11,031 | 5.1% |
| Middlesex-Somerset-Hunterdon, NJ PMSA | $1,406 | $1,338 | -4.8% | $1,338 | -4.8% |
| Minneapolis-St. Paul, MN-WI MSA | $1,288 | $1,484 | 15.2% | $1,484 | 15.2% |
| Nassau-Suffolk, NY PMSA | $2,879 | $2,738 | -4.9% | $2,738 | -4.9% |
| New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT NECMA | $3,115 | $3,631 | 16.6% | $3,631 | 16.6% |
| New Orleans, LA MSA | $3,060 | $3,141 | 2.7% | $3,141 | 2.7% |
| New York, NY PMSA | $51,212 | $47,063 | -8.1% | $47,063 | -8.1% |
| Newark, NJ PMSA | $7,212 | $6,703 | -7.1% * | $6,419 | -11.0% |
| Norfolk-Virginia Beach-Newport News, VA-NC MSA | $1,898 | $1,604 | -15.5% | $1,604 | -15.5% |
| Oakland, CA PMSA | $3,147 | $3,282 | 4.3% | $3,282 | 4.3% |
| Orange County, CA PMSA | $2,173 | $2,713 | 24.9% | $2,713 | 24.9% |

1/24/2000

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## Table 1. Estimates of the Ryan White CARE Act Title I Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 2 Hold Harmless (in thousands) | Percent Change from current law | Method 2 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Orlando, FL MSA | $2,759 | $2,931 | 6.2% | $2,931 | 6.2% |
| Philadelphia, PA-NJ PMSA | $8,281 | $8,402 | 1.5% | $8,402 | 1.5% |
| Phoenix-Mesa, AZ MSA | $2,015 | $1,880 | -6.7% | $1,880 | -6.7% |
| Ponce, PR MSA | $1,233 | $1,266 | 2.7% | $1,266 | 2.7% |
| Portland-Vancouver, OR-WA PMSA | $1,558 | $1,758 | 12.8% | $1,758 | 12.8% |
| Riverside-San Bernardino, CA PMSA | $3,232 | $3,493 | 8.1% | $3,493 | 8.1% |
| Sacramento, CA PMSA | $1,338 | $1,308 | -2.2% | $1,308 | -2.2% |
| St. Louis, MO-IL MSA | $1,975 | $2,168 | 9.8% | $2,168 | 9.8% |
| San Antonio, TX MSA | $1,858 | $2,012 | 8.3% | $2,012 | 8.3% |
| San Diego, CA MSA | $4,502 | $4,764 | 5.8% | $4,764 | 5.8% |
| San Francisco, CA PMSA | $18,457 * | $18,369 | -0.5% * | $9,574 | -48.1% |
| San Jose, CA PMSA | $1,268 | $1,421 | 12.1% | $1,421 | 12.1% |
| San Juan-Bayamon, PR PMSA | $6,925 | $6,042 | -12.8% | $6,042 | -12.8% |
| Santa Rosa, CA PMSA | $604 | $715 | 18.4% | $715 | 18.4% |
| Seattle-Bellevue-Everett, WA PMSA | $2,654 | $3,004 | 13.2% | $3,004 | 13.2% |
| Tampa-St. Petersburg-Clearwater, FL MSA | $3,597 | $3,947 | 9.7% | $3,947 | 9.7% |
| Vineland-Millville-Bridgeton, NJ PMSA | $341 | $333 | -2.3% | $333 | -2.3% |
| Washington, DC-MD-VA-WV PMSA | $9,877 | $10,415 | 5.5% | $10,415 | 5.5% |
| West Palm Beach-Boca Raton, FL MSA | $3,434 | $3,604 | 4.9% | $3,604 | 4.9% |
| **Total** | **$251,890** [1] | **$252,190** | 0.1% [2] | **$242,833** | -3.6% [3] |

**Source:** Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law, the hold harmless is a value 3.5% below the EMA's 1995 grant. Per request, the method 2 hold harmless is 2% below the EMA's 1998 grant.

**Note:** The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The total for the current formula [1] reflects the money distributed under the formula portion of Title I ($242,983,000), adjusted by the amount to hold SanFrancisco harmless at 3.5% of its 1995 amount (+$9,056,000) which is transferred from the supplemental grants portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title 1 (-$150,000). The method 2 hold harmless total[2] reflects the formula portion of Title I ($242,983,000), adjusted by the amount to hold 5 MSAs harmless at 2% of their 1998 amount (+$9,356,000), adjusted for the new EMA start-up grants (-$150,000). The method 2 *not* held harmless[3] reflects the money distributed under the formula portion of Title I ($242,983,000) adjusted for the new EMA planning grants (-$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

**Note:** Method 2 is the difference between the number of AIDS cases and AIDS deaths reported to the CDC. See attached memorandum.

1/24/2000

## Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 3 Hold Harmless (in thousands) | Percent Change from current law | Method 3 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Atlanta, GA MSA | $6,915 | $7,363 | 6.5% | $7,363 | 6.5% |
| Austin-San Marcos, TX MSA | $1,658 | $1,709 | 3.1% | $1,709 | 3.1% |
| Baltimore, MD PMSA | $6,956 | $6,909 | -0.7% | $6,909 | -0.7% |
| Bergen-Passaic, NJ PMSA | $2,401 | $2,247 | -6.4% * | $2,126 | -11.4% |
| Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH NECMA | $5,293 | $5,582 | 5.5% | $5,582 | 5.5% |
| Caguas, PR PMSA | $859 | $746 | -13.2% * | $715 | -16.7% |
| Chicago, IL PMSA | $9,025 | $8,066 | -10.6% * | $7,979 | -11.6% |
| Cleveland-Lorain-Elyria, OH PMSA | $1,505 | $1,537 | 2.1% | $1,537 | 2.1% |
| Dallas, TX PMSA | $5,095 | $5,684 | 11.6% | $5,684 | 11.6% |
| Denver, CO PMSA | $2,130 | $2,261 | 6.2% | $2,261 | 6.2% |
| Detroit, MI PMSA | $3,324 | $3,327 | 0.1% | $3,327 | 0.1% |
| Dutchess County, NY PMSA | $608 | $585 | -3.8% | $585 | -3.8% |
| Fort Lauderdale, FL PMSA | $5,544 | $5,569 | 0.4% | $5,569 | 0.4% |
| Fort Worth-Arlington, TX PMSA | $1,503 | $1,613 | 7.3% | $1,613 | 7.3% |
| Hartford, CT NECMA | $2,027 | $2,265 | 11.7% | $2,265 | 11.7% |
| Houston, TX PMSA | $8,282 | $8,768 | 5.9% | $8,768 | 5.9% |
| Jacksonville, FL MSA | $1,887 | $2,211 | 17.2% | $2,211 | 17.2% |
| Jersey City, NJ PMSA | $2,931 | $2,732 | -6.8% * | $2,514 | -14.2% |
| Kansas City, MO-KS MSA | $1,476 | $1,823 | 23.5% | $1,823 | 23.5% |
| Las Vegas, NV-AZ MSA | $1,775 | $1,833 | 3.3% | $1,833 | 3.3% |
| Los Angeles-Long Beach, CA PMSA | $16,905 | $16,951 | 0.3% | $16,951 | 0.3% |
| Miami, FL PMSA | $10,492 | $10,703 | 2.0% | $10,703 | 2.0% |
| Middlesex-Somerset-Hunterdon, NJ PMSA | $1,406 | $1,318 | -6.2% * | $1,281 | -8.9% |
| Minneapolis-St. Paul, MN-WI MSA | $1,288 | $1,427 | 10.8% | $1,427 | 10.8% |
| Nassau-Suffolk, NY PMSA | $2,879 | $2,923 | 1.5% | $2,923 | 1.5% |
| New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT NECMA | $3,115 | $3,636 | 16.7% | $3,636 | 16.7% |
| New Orleans, LA MSA | $3,060 | $2,941 | -3.9% | $2,941 | -3.9% |
| New York, NY PMSA | $51,212 | $47,974 | -6.3% | $47,974 | -6.3% |
| Newark, NJ PMSA | $7,212 | $6,703 | -7.1% * | $6,389 | -11.4% |
| Norfolk-Virginia Beach-Newport News, VA-NC MSA | $1,898 | $1,747 | -8.0% | $1,747 | -8.0% |
| Oakland, CA PMSA | $3,147 | $3,262 | 3.6% | $3,262 | 3.6% |
| Orange County, CA PMSA | $2,173 | $2,617 | 20.4% | $2,617 | 20.4% |

1/24/2000

## Table 2. Estimates of Ryan White CARE Act Title 1 Outlays (in thousands of dollars)
## A comparison of the current law (Method 1) versus the *adjusted AIDS cases* (Method 3)

| Eligible Metropolitan Areas | Current Formula (in thousands) | Method 3 Hold Harmless (in thousands) | Percent Change from current law | Method 3 No Hold Harmless (in thousands) | Percent Change from current law |
|---|---|---|---|---|---|
| Orlando, FL MSA | $2,759 | $2,844 | 3.1% | $2,844 | 3.1% |
| Philadelphia, PA-NJ PMSA | $8,281 | $8,389 | 1.3% | $8,389 | 1.3% |
| Phoenix-Mesa, AZ MSA | $2,015 | $2,138 | 6.1% | $2,138 | 6.1% |
| Ponce, PR MSA | $1,233 | $1,224 | -0.8% | $1,224 | -0.8% |
| Portland-Vancouver, OR-WA PMSA | $1,558 | $1,693 | 8.6% | $1,693 | 8.6% |
| Riverside-San Bernardino, CA PMSA | $3,232 | $3,413 | 5.6% | $3,413 | 5.6% |
| Sacramento, CA PMSA | $1,338 | $1,303 | -2.6% | $1,303 | -2.6% |
| St. Louis, MO-IL MSA | $1,975 | $2,069 | 4.8% | $2,069 | 4.8% |
| San Antonio, TX MSA | $1,858 | $1,981 | 6.6% | $1,981 | 6.6% |
| San Diego, CA MSA | $4,502 | $4,662 | 3.6% | $4,662 | 3.6% |
| San Francisco, CA PMSA | $18,457 * | $18,369 | -0.5% * | $9,997 | -45.8% |
| San Jose, CA PMSA | $1,268 | $1,361 | 7.3% | $1,361 | 7.3% |
| San Juan-Bayamon, PR PMSA | $6,925 | $6,021 | -13.1% * | $6,019 | -13.1% |
| Santa Rosa, CA PMSA | $604 | $681 | 12.7% | $681 | 12.7% |
| Seattle-Bellevue-Everett, WA PMSA | $2,654 | $2,933 | 10.5% | $2,933 | 10.5% |
| Tampa-St. Petersburg-Clearwater, FL MSA | $3,597 | $3,817 | 6.1% | $3,817 | 6.1% |
| Vineland-Millville-Bridgeton, NJ PMSA | $341 | $322 | -5.6% * | $308 | -9.5% |
| Washington, DC-MD-VA-WV PMSA | $9,877 | $10,300 | 4.3% | $10,300 | 4.3% |
| West Palm Beach-Boca Raton, FL MSA | $3,434 | $3,478 | 1.3% | $3,478 | 1.3% |
| **Total** | **$251,890** [1] | **$252,029** | 0.1% [2] | **$242,833** | -3.6% [3] |

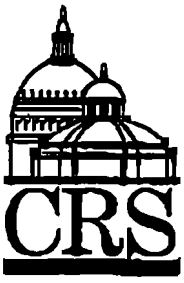
**Source:** Table prepared by CRS based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the hold harmless provision. Under current law the hold harmless is a value 3.5% below the EMA's 1995 grant. Under method 2, the hold harmless is a value of 2% below the EMA's 1998 grant.

**Note:** The totals differ due to differences in the hold harmless and new EMA planning grant adjustments. The current formula total[1] reflects the money distributed under the formula portion of Title I ($242,983,000), adjusted by the amount to hold SanFrancisco harmless at 3.5% of its 1995 amount (+$9,056,000) which is transferred from the supplemental grant portion of Title I to fulfill the hold harmless provision. New EMA planning grants are funded through a technical assistance grant and a corresponding amount of money is subtracted from the money each EMA receives under the formula portion of Title 1 (-$150,000.) The method 3 hold harmless total[2] reflects the the formula portion of Title I ($242,983,000), adjusted by the amount to hold 9 EMAs harmless at 2% of their 1998 amount ($9,196,000), adjusted for the new EMA planning grants (-$150,000). The method 3 *not* held harmless[3] reflects the money distributed under the formula portion of Title I ($242,983,000), adjusted for the new EMA planning grants (-$150,000). All amounts in Table 1 are rounded to the nearest thousand dollars and presented in thousands of dollars.

**Note:** Method 3 adjusts the reported cases of AIDS and AIDS deaths for late reporting. The estimate of prevalence is the difference in the adjusted reported cases and adjusted reported deaths. See attached memo for greater detail.

1/24/2000



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***Memorandum*** January 28, 2000

TO : Senate Health, Education, Labor and Pensions Committee
Attention: Scott Boule

FROM : Paulette Como
Analyst in Social Legislation
Domestic Social Policy Division

SUBJECT : **Ryan White CARE Act, Title II**

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You requested a comparison of how different methods of estimating the number of people living with acquired immune deficiency syndrome (AIDS) would affect the funds distributed to states and territories under Title II of the Ryan White CARE Act in FY1999. Attached, please find the tables containing the information you requested. This memorandum is the complement to the analysis of Title I which I did for your office on January 18, 2000.

This memorandum is divided into two parts. The first part is an explanation of the set-asides that affect the amount of money distributed and a description of the formula for distributing funds under current law. The second part is a brief analysis of the data. For a more detailed explanation of the different methods of calculating AIDS prevalence, please see my memorandum to your office dated January 18, 2000.

## Set-Asides and Distribution of Funds Under Current Law

This analysis does not assume changes in the underlying formula in the current law. It examines how different data (or estimates of prevalence[1]) used in the same basic formula result in different distributions of money. The estimates presented in the tables are for FY1999 – they are not projections. They may differ from those presented by other analyses due to rounding error.

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[1] Method 1 of calculating AIDS prevalence is the method used under current law. It is described on page 2 of this memorandum. Alternative Method 2 of calculating AIDS prevalence is the difference between reported cases of AIDS and reported AIDS deaths. Alternative Method 3 of calculating prevalence is the difference between reported cases of AIDS adjusted for reporting delays and reported AIDS deaths adjusted for reporting delays.

Title II provides funds to all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.[2] Current law states that, unlike Title I, Title II grants are distributed entirely through the formula specified in the law. Several set-asides are taken out of the appropriation before it is divided among the states and territories. These set-asides include Special Projects of National Significance (FY1999 = 1.807% of total Title II appropriated funds), Broad Technical Assistance (FY1999 =1% of total Title II appropriated funds), and Evaluation (FY1999 = 1% of Title II appropriated funds.) A portion of Title II funds are earmarked for the AIDS Drug Assistance Program (ADAP). For FY1999, $461,000,000 of the Title II appropriation was earmarked for ADAP. For FY1999, the remaining portion of the Title II appropriation, $248,904,300 was divided among states and eligible territories using the formula described below.

All of the Title II appropriation (after set-asides and earmarked funds) is divided among states and eligible territories. Under Title II, when a state receives a hold harmless or minimum grant amount, all other states receive less money than they would have otherwise received. The burden of holding some states at the hold harmless level is divided proportionally among all states that are above their hold harmless levels. The discussion that follows will start by describing the formula used to distribute funds, and will then talk about the adjustments that are made when some states receive more money because of the hold harmless provisions.

The estimate of AIDS prevalence for states is calculated the same way for Title II as it is for Title I. The reported cases of AIDS over the previous 120-month period are aggregated into 10 separate 12-month periods. Those 12-month periods are weighted by a factor that represents the probability that individuals who were diagnosed with AIDS are still alive, given the year in which they were diagnosed. Those 10 weighted survival estimates are summed and represent the estimated living cases of AIDS in each state or territory. For Title II, this procedure is done twice. First it is done for all estimated living cases of AIDS in each state, and second for those estimated living cases of AIDS *who do not live within an EMA* in each state.

Non-ADAP Title II appropriations are allocated with a distribution factor which gives greater weight to non-EMA cases. To calculate this distribution factor, each state or territory's total proportion of cases is weighted by 80% and added to each state or territory's proportion of *non-EMA cases*, which is weighted by 20%.

There are two separate provisions in Title II that increase a state's or territory's grant amount above what it would have received through the formula alone. The first provision

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[2] Under current law, several "territories of the United States" are eligible to receive Ryan White grants under Title II, but those territories do not report enough cases to receive funds, and they are not subject the hold harmless provision based on the number of AIDS cases. Those territories include American Samoa, the Commonwealth of the Northern Marianas, and the Republic of the Marshall Islands. There are currently two estimated living cases of AIDS in these three territories combined.

establishes a minimum payment for states[3] based on the estimated number of living cases in the state. States with fewer than 90 living AIDS cases can not receive less than $100,000. States with 90 or more living AIDS cases can not receive less than $250,000. In FY99, five states received one of these two floor amounts. Those states were Montana ($250,000), North Dakota ($100,000), South Dakota ($100,000), Vermont ($250,000) and Wyoming ($100,000).

The second provision is a hold harmless provision. Under current law for FY1999, no state shall receive less than 96.5% of what it received in FY1995. Though all states and territories were eligible for this provision, none received it. All states and territories received FY1999 grants that were larger than 96.5% of what they received in FY1995.

As stated previously, when one or more states or territories receive more money because of a minimum grant or hold harmless provision under Title II, the grants to other states and territories are decreased to fulfill the minimum grant or hold harmless provision. Therefore, after Montana, North Dakota, South Dakota, Vermont and Wyoming receive the minimum grant amount (which is larger than the grant amount they would have received through the distribution formula alone), all state and territory grants are reduced by a "reduction factor." The reduction factor is equal to the difference between the total amount of money to be distributed and the amount of money reserved to increase state and territory grant amounts under the minimum grant and hold harmless provisions, divided by the total amount of money. This reduction factor is multiplied by each state and territory grant and subtracted from the original grant. The result is again tested against both provisions: the hold harmless provision to ensure that no state receives less than 96.5% of its FY1995 amount and the minimum grant provision to ensure that no state receives less than $100,000 or $250,000 depending on the estimated number of AIDS cases in the state. This process is called a ratable reduction.

For the examination of the alternative methods of estimating AIDS prevalence (Method 2 and Method 3) in this memorandum, a different hold harmless level was used. The level of the minimum grant provision remains the same as under current law. But, the hold harmless level for Methods 2 and 3 in the following tables was set at 98% of a state or territory's FY1998 grant, as requested. Therefore, in FY1999, using Method 2 and 3 for estimating AIDS prevalence, a state or territory could not receive less than 98% of what it received in FY1999.

## Analysis and Policy Implications of the Data

**Table 1** compares the amount of money distributed to each state or territory using the formula in Title II of the CARE Act when AIDS prevalence is estimated under current law (Method 1) and under Method 2, with both the minimum grant provision and the hold harmless provision and without either provision. These estimates do *not* include the funds distributed for the AIDS Drug Assistance Program (ADAP). Method 2 of estimating AIDS prevalence is the difference between reported cases of AIDS and reported AIDS deaths. The

[3] This provision is applied to all 50 states, the District of Columbia, and Puerto Rico. Guam and the Virgin Islands are not eligible for this hold harmless provision.

grant estimates in this analysis were calculated using AIDS prevalence data for FY1999, the only data made available by the Centers for Disease Control and Prevention (CDC). These estimations are not projections.

Most of the data used for the analysis of Method 2 and Method 3 in this memorandum were published by the CDC.[4] One part of the calculation requires AIDS prevalence estimates for eligible metropolitan areas (EMAs) for each state. Where an EMA spanned more than one state (such as Boston, which includes parts of Massachusetts and New Hampshire) the CDC did not report the estimated number of living AIDS cases in each state within the EMA for Methods 2 and 3. It did publish those estimates for Method 1, current law. For the analysis of Methods 2 and 3 in this memorandum, I assumed that the estimated number of AIDS cases living in each state within an EMA that crossed state boundaries would be proportional to estimated number of AIDS cases living in each state in the same EMA under Method 1.

Twenty eight states and territories would receive more money under Method 2 with the minimum grant and hold harmless provisions and twenty one would receive less money.[5] The grants for five states would not change. Under current law, three states (North Dakota, South Dakota and Wyoming) would receive the minimum grant award for a state with fewer than 90 estimated living cases of AIDS. Two states (Montana and Vermont) would receive the minimum grant award for a state with 90 or more estimated living cases of AIDS. These states receive the same grant amount under Method 2 with the minimum grant provision as under current law (Method 1). The percentage change in money received by states or territories when the minimum grant and hold harmless provisions are employed range from a decrease of 9.9% in West Virginia to an increase of 42.5% in New Hampshire. The percentage change between Method 1 and Method 2 may reflect a variety of things, including but not limited to regional differences in survival, and access to care.

Ten states and territories received grant amounts determined by the hold harmless provision.[6] Because of this provision (as well as the minimum grant provision mentioned in the previous paragraph), all states that do not receive a grant amount resulting from the minimum grant provision or the hold harmless provision receive less money under Method 2 with both of these provisions than under Method 2 without either provision. The grant amounts for two states, Illinois and Maryland decreased to the point where they too became eligible for the hold harmless provision under Method 2 when they were not previously eligible for it. This is because of the ratable reduction. Under Method 2 with the minimum grant and hold harmless provisions, if a state qualifies for either provision and it would increase the amount of grant money it received, then the state would receive this higher grant amount. Because there is a finite amount of money to be allocated between the states and

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[4] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Supplemental Report. 1999;5(No. 2): [1-8].

[5] Under current law, states and territories can not receive less than 96.5% of the grant amount they received in FY1995. The hold harmless provisions used for analysis of Methods 2 and 3 was 98% of the FY1998 grant amount. Both current law and the Method 2 analysis also include a minimum grant amount provision based on the number of cases of AIDS in the state.

[6] No state shall receive less than 98% of the grant amount it received in FY1998.

territories, if a state or territory is given more money because of the minimum grant provision or the hold harmless provision, all other states receive proportionally less money. For Method 2 without either provision, states and territories receive the grant amounts they would receive due to the formula alone. Illinois would have received 8.2% less money under Method 2 (without the minimum grant or hold harmless provisions) than Method 1. But, with the minimum grant and hold harmless provisions in place, Illinois will get even less money (a decrease of 8.4%) because it will be contributing part of its grant to other states and territories to meet their minimum grant or hold harmless levels, until the point at which it qualifies for the minimum grant or hold harmless provision itself. Once Illinois became eligible for a hold harmless provision, its grant amount stopped decreasing while other state and territory grant amounts might have continued to decrease proportionally to fulfill other state and territory minimum grant and hold harmless provisions. The same is true for Maryland.

New York and West Virginia receive an approximately 9.9% decreases under Method 2 with the minimum grant and hold harmless provisions relative to current law. Though their decrease would be large, it is not so large that it would be affected by either provision.

Nevada and Virginia would receive substantially higher grant amounts – 35.5% and 9.9%, respectively – because of the hold harmless provision. Under current law for FY1999, Nevada would receive approximately $1,569,000, which is less than it received in FY1998, approximately $2,170,000. One possible explanation for this is that the estimated number of people living with AIDS in Nevada as a percent of the national total has decreased relative to other states between FY1998 and FY1999. Under Method 2 without the minimum grant and hold harmless provisions, Nevada would receive a larger grant than it would under current law ($1,665,000.) But with the hold harmless provision, which stipulates a maximum 2% reduction relative to the FY1998 grant, Nevada would receive a much larger grant. Virginia would similarly have received a smaller grant under current law in FY1999 relative to FY1998. Under Method 2 without the minimum grant and hold harmless provisions, Virginia would receive an even smaller grant than it would have received in FY1999 under current law, but with the hold harmless provision, Virginia would receive 9.9% *more* under Method 2 with the minimum grant and hold harmless provisions than it would relative to current law.

**Table 2** compares the amount of money distributed when the current method (Method 1) and Method 3 are used to estimate AIDS prevalence, with both the minimum grant and the hold harmless provisions and without either provision. Method 3 is an estimate of AIDS prevalence which has been adjusted for reporting delays.

Thirty two states and territories would receive more money under Method 3 with the minimum grant and hold harmless provisions and 17 would receive less money under Method 3 with both provisions relative to Method 1. States that receive a minimum grant amount of $100,000 or $250,000 under current law would receive the same amount under Method 3 with the hold harmless. Six states receive minimum grant amounts under Method 3. The percentage change in money received by states or territories when the minimum grant and hold harmless provisions are employed range from a decrease of 12.4% in West Virginia and a decrease of 11.5% in Mississippi, to an increase of 35.5% in Nevada. The percentage change between Method 1 and Method 3 may reflect a variety of things. Like Method 2,

Method 3 reflects regional differences in survival. Unlike Method 2, Method 3 also adjusts for reporting delays. Under current law, states that are slower to report their data to the CDC are at a relative disadvantage. Under Method 3, those delayed reporters are brought to parity. States that had historically reported their data promptly to the CDC will be relatively disadvantaged by this method of estimating AIDS prevalence. According to CDC statisticians, Method 3 is a more accurate method of estimating AIDS prevalence than Method 1.[7]

The minimum grant and hold harmless provisions for Method 3, like Method 2, affect fifteen states and territories. However, some of the states affected under each method are different. Under Method 3, one more state receives the minimum grant allowed to a state with 90 or more cases of AIDS than under Method 2: Idaho would receive a $250,000 grant under Method 3 with the minimum grant provision, a 5.4% decrease compared to current law. Nine states and territories receive a Method 3 hold harmless grant amount that is 98% of their FY1998 grant.

As with Method 2, there are several states that would receive a more substantial decrease in funds under Method 3 with the minimum grant and hold harmless provisions than without provisions. Louisiana, for example, would receive an 8.0% decrease under Method 3 with the minimum grant and hold harmless provisions relative to current law. Louisiana would receive only a 6.9% decrease under Method 3 without either provision. Again, the ratable reduction is the cause. As some states and territories receive more money because of the minimum grant and hold harmless provisions than they would have received by the distribution factor alone, the grants for other states and territories are proportionally reduced to compensate for those higher grant amounts. The ratable reduction process continues until all states and territories are either at a the minimum grant level, the hold harmless level, or above their hold harmless level and the correct total amount of money is distributed.

Method 3 is also similar to Method 2 in that some states receive substantially more money because of the hold harmless provision. Nevada, for example, would have received less money under the formula portion of Title II in FY1999 using Method 1 to calculate AIDS prevalence than it did in FY1998. Because of the hold harmless provision used to analyze Method 3, Nevada would receive a much larger grant amount under Method 3 hold harmless than it would under current law (+35.5%).

Overall, the same number of states and territories receive grants designated by the minimum grant and hold harmless provisions under Methods 2 and 3. Under both methods, the hold harmless provision causes some states and territories to receive more money than they would have without the provision, while some states and territories receive less money than they would have received without the hold harmless provision. The ratable reduction is the cause for this dichotomous result.

I hope this information is useful. If you have any further questions, please call me at 202-707-7317.

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[7] Telephone conversation with CDC, January 2000.

## Table 1. Estimates of Ryan White CARE Act Title II Grants

### A Comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

(in thousands)

| State | Current Formula | Method 2 hold harmless and minimum amount | Percent change from current law | Method 2 no hold harmless or minimum amount | Percent change from current law |
|---|---|---|---|---|---|
| Alabama | $3,315 | $3,496 | 5.5% | $3,541 | 6.8% |
| Alaska | $270 | $311 | 15.4% | $315 | 16.9% |
| Arizona | $2,224 | $2,054 | -7.7% | $2,081 | -6.5% |
| Arkansas | $1,505 | $1,829 | 21.5% | $1,853 | 23.1% |
| California | $30,670 | $31,301 | 2.1% | $31,704 | 3.4% |
| Colorado | $1,968 | $2,278 | 15.7% | $2,307 | 17.2% |
| Connecticut | $3,630 | $4,075 | 12.3% | $4,128 | 13.7% |
| Delaware | $1,393 | $1,376 | -1.2% | $1,393 | 0.0% |
| District of Columbia | $3,319 | $3,781 | 13.9% | $3,830 | 15.4% |
| Florida | $24,977 | $26,191 | 4.9% | $26,529 | 6.2% |
| Georgia | $7,658 | $8,106 | 5.8% | $8,210 | 7.2% |
| Hawaii | $1,102 | $1,120 | 1.6% | $1,134 | 2.9% |
| Idaho | $264 | $260 | -1.5% | $264 | -0.3% |
| Illinios | $6,968 | $6,386 | -8.4% ** | $6,395 | -8.2% |
| Indiana | $3,254 | $3,407 | 4.7% | $3,451 | 6.1% |
| Iowa | $659 | $723 | 9.7% | $732 | 11.1% |
| Kansas | $982 | $940 | -4.2% ** | $889 | -9.5% |
| Kentucky | $1,852 | $1,719 | -7.2% | $1,741 | -6.0% |
| Louisiana | $5,011 | $4,840 | -3.4% | $4,902 | -2.2% |
| Maine | $441 | $539 | 22.3% | $546 | 23.9% |
| Maryland | $6,497 | $5,967 | -8.2% ** | $6,039 | -7.0% |
| Massachusetts | $4,214 | $4,133 | -1.9% ** | $3,953 | -6.2% |
| Michigan | $3,738 | $3,654 | -2.3% | $3,701 | -1.0% |
| Minnesota | $970 | $1,114 | 14.8% | $1,129 | 16.3% |
| Mississippi | $2,270 | $2,101 | -7.4% | $2,128 | -6.2% |
| Missouria | $2,682 | $3,299 | 23.0% | $3,342 | 24.6% |
| Montana | $250 * | $250 | 0.0% * | $203 | -18.7% |
| Nebraska | $548 | $547 | -0.3% | $554 | 1.0% |
| Nevada | $1,569 | $2,127 | 35.5% ** | $1,665 | 6.1% |
| New Hampshire | $310 | $442 | 42.5% | $448 | 44.4% |
| New Jersey | $12,427 | $11,877 | -4.4% ** | $11,345 | -8.7% |
| New Mexico | $1,125 | $1,107 | -1.6% | $1,121 | -0.4% |



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## Table 1. Estimates of Ryan White CARE Act Title II Grants

### A Comparison of the current law (Method 1) versus the number of AIDS cases reported to be living (Method 2)

(in thousands)

| State | Current Formula | Method 2 hold harmless and minimum amount | Percent change from current law | Method 2 no hold harmless or minimum amount | Percent change from current law |
|---|---|---|---|---|---|
| New York | $41,146 | $37,108 | -9.8% | $37,587 | -8.6% |
| North Carolina | $5,301 | $4,962 | -6.4% | $5,026 | -5.2% |
| North Dakota | $100 * | $100 | 0.0% * | $57 | -42.6% |
| Ohio | $4,921 | $4,555 | -7.4% ** | $4,349 | -11.6% |
| Oklahoma | $1,773 | $1,941 | 9.5% | $1,966 | 10.9% |
| Oregon | $1,543 | $1,638 | 6.1% | $1,659 | 7.5% |
| Pennsylvania | $8,590 | $8,297 | -3.4% | $8,404 | -2.2% |
| Rhode Island | $1,070 | $1,121 | 4.8% | $1,136 | 6.2% |
| South Carolina | $4,868 | $5,044 | 1.5% | $5,109 | 2.8% |
| South Dakota | $100 * | $100 | 0.0% * | $82 | -17.5% |
| Tennessee | $4,461 | $4,726 | 5.9% | $4,787 | 7.3% |
| Texas | $17,246 | $17,834 | 3.4% | $18,064 | 4.7% |
| Utah | $946 | $1,053 | 11.2% | $1,066 | 12.7% |
| Vermont | $250 * | $250 | 0.0% * | $224 | -10.5% |
| Virginia | $4,847 | $5,328 | 9.9% ** | $4,538 | -6.4% |
| Washington | $2,934 | $3,209 | 9.4% | $3,251 | 10.8% |
| West Virginia | $625 | $563 | -9.9% | $570 | -8.7% |
| Wisconsin | $1,731 | $1,963 | 13.4% | $1,988 | 14.9% |
| Wyoming | $100 * | $100 | 0.0% * | $85 | -14.6% |
| Guam | $9 | $11 | 21.3% ** | $7 | -17.5% |
| Virgin Islands | $284 | $275 | -3.2% | $278 | -2.0% |
| Puerto Rico | $7,896 | $7,378 | -6.6% ** | $7,095 | -10.1% |
| **Total** | **$248,904,300** | **$248,904,300** | | **$248,904,300** | |

**Source:** Table prepared by the Congressional Research Service based on data from the Centers for Disease Control and Prevention (CDC).

* EMA was affected by the **minimum grant provision** based on the number of cases of AIDS in the state. States with less than 90 living cases of AIDS can not receive less than $100,000. States with 90 or more living AIDS cases can not receive less than $250,000. Guam and the Virgin Islands are not eligible for this provision.

** EMA was affected by the **hold harmless provision** based on a percent of a previous grant amount. Under current law, states and eligible territories shall not receive less than 96.5% of the FY1995 grant amount. For analysis of Method 2, states and eligible territories do not receive less than 98% of the FY1998 grant amount, per request.

**Note:** Method 2 is the difference between the number of AIDS cases and AIDS deaths reported to the CDC by states and EMAs.



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## Table 2. Estimates of Ryan White CARE Act Title II Grants
## A Comparison of the current law (Method 1) versus the adjusted number of AIDS cases reported to be living (Method 3)
(In Thousands)

| State | Current Formula | Method 3 hold harmless and minimum amount | Percent change from current law | Method 2 no hold harmless or minimum amount | Percent change from current law |
|---|---|---|---|---|---|
| Alabama | $3,315 | $3,377 | 1.9% | $3,418 | 3.1% |
| Alaska | $270 | $296 | 9.8% | $300 | 11.2% |
| Arizona | $2,224 | $2,300 | 3.4% | $2,329 | 4.7% |
| Arkansas | $1,505 | $1,770 | 17.6% | $1,792 | 19.0% |
| California | $30,670 | $31,549 | 2.9% | $31,935 | 4.1% |
| Colorado | $1,968 | $2,087 | 6.0% | $2,113 | 7.3% |
| Connecticut | $3,630 | $4,081 | 12.4% | $4,131 | 13.8% |
| Delaware | $1,393 | $1,325 | -4.9% ** | $1,332 | -4.4% |
| District of Columbia | $3,319 | $3,692 | 11.2% | $3,737 | 12.6% |
| Florida | $24,977 | $25,451 | 1.9% | $25,762 | 3.1% |
| Georgia | $7,658 | $7,987 | 4.3% | $8,085 | 5.6% |
| Hawaii | $1,102 | $1,132 | 2.8% | $1,146 | 4.0% |
| Idaho | $264 | $250 | -5.4% * | $246 | -7.1% |
| Illinios | $6,968 | $6,386 | -8.4% ** | $6,390 | -8.3% |
| Indiana | $3,254 | $3,312 | 1.8% | $3,353 | 3.1% |
| Iowa | $659 | $681 | 3.3% | $689 | 4.6% |
| Kansas | $982 | $940 | -4.2% ** | $829 | -15.6% |
| Kentucky | $1,852 | $1,750 | -5.5% | $1,771 | -4.3% |
| Louisiana | $5,011 | $4,609 | -8.0% | $4,666 | -6.9% |
| Maine | $441 | $503 | 13.9% | $509 | 15.3% |
| Maryland | $6,497 | $6,291 | -3.2% | $6,368 | -2.0% |
| Massachusetts | $4,214 | $4,231 | 0.4% | $4,283 | 1.6% |
| Michigan | $3,736 | $3,803 | 1.7% | $3,849 | 3.0% |
| Minnesota | $970 | $1,069 | 10.2% | $1,082 | 11.5% |
| Mississippi | $2,270 | $2,017 | -11.2% | $2,041 | -10.1% |
| Missouria | $2,682 | $3,185 | 18.7% | $3,224 | 20.2% |
| Montana | $250 * | $250 | 0.0% * | $206 | -17.5% |
| Nebraska | $548 | $524 | -4.4% | $530 | -3.3% |
| Nevada | $1,569 | $2,127 | 35.5% ** | $1,591 | 1.4% |
| New Hampshire | $310 | $401 | 29.3% | $406 | 30.9% |
| New Jersey | $12,427 | $11,877 | -4.4% ** | $11,115 | -10.6% |
| New Mexico | $1,125 | $1,162 | 3.3% | $1,176 | 4.5% |



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## Table 2. Estimates of Ryan White CARE Act Title II Grants
## A Comparison of the current law (Method 1) versus the adjusted number of AIDS cases reported to be living (Method 3)

(In Thousands)

| State | Current Formula | Method 3 hold harmless and minimum amount | Percent change from current law | Method 2 no hold harmless or minimum amount | Percent change from current law |
|---|---|---|---|---|---|
| New York | $41,146 | $38,160 | -7.3% | $38,627 | -6.1% |
| North Carolina | $5,301 | $5,037 | -5.0% | $5,099 | -3.8% |
| North Dakota | $100 * | $100 | 0.0% * | $56 | -44.4% |
| Ohio | $4,921 | $4,555 | -7.4% ** | $4,388 | -10.8% |
| Oklahoma | $1,773 | $1,948 | 9.9% | $1,972 | 11.2% |
| Oregon | $1,543 | $1,577 | 2.2% | $1,596 | 3.4% |
| Pennsylvania | $8,590 | $8,508 | -1.0% | $8,612 | 0.2% |
| Rhode Island | $1,070 | $1,089 | 1.8% | $1,103 | 3.1% |
| South Carolina | $4,968 | $4,784 | -3.7% | $4,842 | -2.5% |
| South Dakota | $100 * | $100 | 0.0% * | $81 | -18.6% |
| Tennessee | $4,461 | $4,622 | 3.6% | $4,678 | 4.9% |
| Texas | $17,246 | $18,025 | 4.5% | $18,246 | 5.8% |
| Utah | $946 | $1,033 | 9.2% | $1,046 | 10.5% |
| Vermont | $250 * | $250 | 0.0% * | $221 | -11.6% |
| Virginia | $4,847 | $5,328 | 9.9% ** | $4,869 | 0.4% |
| Washington | $2,934 | $3,190 | 8.7% | $3,229 | 10.1% |
| West Virginia | $625 | $549 | -12.1% | $556 | -11.1% |
| Wisconsin | $1,731 | $1,861 | 7.6% | $1,884 | 8.9% |
| Wyoming | $100 * | $100 | 0.0% * | $73 | -26.8% |
| Guam | $9 | $11 | 21.3% ** | $7 | -24.0% |
| Virgin Islands | $284 | $284 | 0.0% | $288 | 1.3% |
| Puerto Rico | $7,696 | $7,378 | -6.6% ** | $7,027 | -11.0% |
| **Total** | **$248,904,300** | **$248,904,300** | | **$248,904,300** | |

**Source:** Table prepared by the Congressional Research Service based on data from the Centers for Disease Control and Prevention.

* EMA was affected by the **minimum grant provision** based on the number of cases of AIDS in the state. States with less than 90 living cases of AIDS can not receive less than $100,000. States with 90 or more living AIDS cases can not receive less than $250,000. Guam and the Virgin Islands are not eligible for this provision.

** EMA was affected by the **hold harmless provision** based on a percent of a previous grant amount. Under current law, states and eligible territories shall not receive less than 96.5% of the FY1995 grant amount. For analysis of Method 2, states and eligible territories do not receive less than 98% of the FY1998 grant amount, per request.

**Note:** Method 3 is the difference between the number of AIDS cases adjusted for reporting delays and AIDS deaths adjusted for reporting delays.



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