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HIV Prevention Act 7/97

Corr-SLT - Outgoing-7/97

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Ryan White Letter-Not Updated

Corr: - SLT- Outgoing - 12/97

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WH Tour Tickets

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Corr: SLT - Outgoing - 6/99

Corr: SLT - Outgoing 7/99

CORR - Goosby - ONAP
Outgoing

Re: HIV Prevention Act - 97

7/97

THE WHITE HOUSE

WASHINGTON

MEMORANDUM FOR MEMBERS OF THE PRESIDENTIAL ADVISORY COUNCIL ON HIV AND AIDS

FROM: Eric P. Goosby, M.D., Office of National AIDS Policy

SUBJECT: HIV Prevention Act of 1997 Introduced by Representative Coburn (R-Oklahoma)

This memo provides a brief overview of the HIV Prevention Act of 1997 introduced by Representative Coburn (R-Oklahoma). The bill has 75 co-sponsors and is endorsed by the American Medical Association.

Coburn Bill

This legislation would amend the Medicaid statute to require States to take the following actions as a condition of receipt of Medicaid funds:

- States must require providers to report all positive HIV tests to the State health department.
  Current Policy: All States require reporting of AIDS cases; 26 require HIV infection reporting among adults and children; and 3 states require reporting for children only. Many states with large HIV caseloads (including New York, California, and Texas) have chosen not to require HIV reporting.

- State public health officers must notify all sexual or drug-using partners of each HIV-positive person.
  Current Policy: States are required to have partner notification programs in place as a condition of CDC funding. The Coburn provision is more prescriptive and would entail significant costs to States.

- States must cooperate with the CDC in carrying out a national program of partner notification, sharing information across state lines.
  Current Policy: States work cooperatively on tracing possible contacts of persons with sexually transmitted diseases. This has not been done routinely across State lines for HIV due to differences in State reporting and partner notification programs for HIV.

- Defendants for whom an indictment or information is presented accusing them of sexual crimes can be tested for HIV if the victim requests it or if the nature of the crime has placed the victim at risk for HIV.

Current Law: The Crime bill of 1994 allows victims of defendants charged with certain sexual offenses to get a court order requiring defendants to be tested for HIV. The Crime bill places more focus on information and counseling for the victim. The Coburn provision places minimal focus on the victim. The optimal public health response would be to provide victims with immediate HIV tests (PCR tests) for themselves in order to benefit from new drug therapies that could prevent the HIV infection from taking hold.

- States must authorize health professionals to require HIV tests of patients prior to medical procedures; providers and patients must be notified of positive HIV test results.
  Current Policy: There is no precedent in medical practice for making receipt of a necessary procedure contingent upon a test for infectious disease. There is no protection here that patients will not be denied a medically necessary or appropriate procedure after their HIV status is known. The CDC has long promoted universal precautions, not testing, as the most effective way to prevent HIV transmission in all settings.

- States must authorize funeral services providers to require HIV tests of bodies. States must also require health care entities (such as hospitals) to notify funeral services providers if a body is HIV-positive.
  Policy Response: Universal precautions, used correctly by health care and funeral services providers, provide the safest, most consistently effective protection against HIV transmission. An HIV test result may be falsely positive, and no additional health benefit is gained.

- States must require that applicants for health insurance who undergo HIV tests as part of their applications have the right to the results of those tests. This does not extend to ERISA with respect to group health plans.
  Policy Context: This provision responds to a court case where an HIV-positive man was denied knowledge of his HIV status by a health insurer. His wife sued and won in court (Deramus v. Insurance Company in Mississippi).

- States are required to ensure that adoption agencies notify prospective adoptive parents of a child's HIV status at the request of the parents.
  Current Policy: States have exercised different approaches in dealing with their adoption programs.

Two additional Sense of Congress provisions are included, stating that HIV-positive health professionals should notify their patients if their duties convey any risk of HIV transmission and that States should have laws in effect making it a felony for an HIV-positive person to knowingly engage in behaviors that place others at risk of HIV. [Since 1990, all States have been required to have laws criminalizing knowing transmission of HIV infection.]

Responses to Legislation

The National Governors Association passed a policy resolution at their Winter meeting opposing Federal restrictions and requirements on funding which interfere with State prevention strategies. They specifically opposed HIV testing mandates and requirements that would divert funding from one public health activity to another. The Association of State and Territorial Health Officers also oppose Federal restrictions on the flexibility of the States to design locally effective responses to the HIV epidemic. The HIV/AIDS advocacy community will vigorously oppose this legislation on public health grounds.

The AMA is supporting this bill while also indicating that it is willing to help improve the bill. Some victims rights groups have supported these provisions in the past. The issue remains to identify the best, most compassionate, and most effective public health response to safeguard the health of victims of sexual assault.

Summary

The Administration has significantly increased its investment in prevention activities to reduce the number of new infections occurring and to help people learn their HIV status at the earliest stages of disease. The effect of these prevention and treatment interventions are now yielding encouraging data, with a 27% reduction in new pediatric AIDS cases and a drop in AIDS-related deaths for the first time. The Administration has always worked in close partnership with State and local health departments, who are on the front lines of fashioning effective public health responses to the characteristics of their local epidemic. These professionals are on the front lines of designing appropriate responses to the HIV epidemic locally, and they are responsible for maximizing the effective use of resources to reduce the toll of HIV in their communities. Local flexibility in designing appropriate responses remains an important tenet of effective action, and the Administration continues to support these health officials in their important roles.

[FULL COMMITTEE PRINT]

NOTICE: This report is given out subject to release when consideration of it has been completed by the full Committee. Please check on such action before release in order to be advised of any changes.

Calendar No.

105TH CONGRESS, 1st Session } HOUSE OF REPRESENTATIVES { REPORT 105–

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATION BILL, 1998

JULY 22, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PORTER, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R.]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for the Departments of Labor, Health and Human Services (except the Food and Drug Administration, Indian Health Service, and the Office of Consumer Affairs), and Education, Armed Forces Retirement Home, Corporation for National and Community Service, Corporation for Public Broadcasting, Federal Mediation and Conciliation Service, Federal Mine Safety and Health Review Commission, National Commission on Libraries and Information Science, National Council on Disability, National Education Goals Panel, National Labor Relations Board, National Mediation Board, Occupational Safety and Health Review Commission, Physician Payment Review Commission, Prospective Payment Assessment Commission, Railroad Retirement Board, the Social Security Administration, and the United States Institute of Peace for the fiscal year ending September 30, 1998, and for other purposes.

Emergency medical services for children

The Committee has provided $13,000,000 for emergency medical services for children, which is $507,000 above the 1997 level and $1,000,000 above the Administration request. The program supports demonstration grants for the delivery of emergency medical services to acutely ill and seriously injured children.

Black lung clinics

The bill provides $5,000,000 for black lung clinics, which is $1,000,000 above the 1997 appropriation and $3,094,000 above the Administration request. This program supports 14 grantees which treat a declining population of coal miners with respiratory and pulmonary impairments. The clinics presently receive more than one-third of their funding from other sources, such as Medicaid and Medicare. Of the 14 grantees, four receive community health center funding as well as black lung grants.

Alzheimer's demonstration grants

The Committee provides $5,999,000 for Alzheimer's demonstration grants, which is the same as the 1997 appropriation. The Administration proposed that this funding be transferred to the Administration on Aging at a level of $8,000,000. The program provides grants to States to help them plan and establish programs to provide health care services to individuals with Alzheimer's disease. Funds are used for respite care and supportive services, clearinghouses, training, and administrative costs for State offices. By law, States are required to match the Federal funding—45 percent of the cost of the program by the third year of the grant.

Payment to Hawaii, treatment of Hansen's Disease

The bill includes $2,045,000 for the treatment of persons with Hansen's Disease in the State of Hawaii, which is the same as the 1997 appropriation. The Administration requested this funding in a consolidated cluster which would reduce funding for the programs included in the cluster by $3,498,000. This program, which provides a partial matching payment to the State of Hawaii, dates to the period of Father Damien's facility for sufferers of Hansen's disease (leprosy). That facility now has 63 residents who live there by choice, and the grounds have been converted to a historical site. Most patients diagnosed with Hansen's disease in Hawaii are now treated in the same manner as new patients on the mainland; their care is handled on an outpatient basis, with the program paying for about 5,300 outpatients visits per year.

Ryan White AIDS programs

The bill includes $1,168,252,000 for Ryan White AIDS programs. This is $132,000,000 above the amount requested in the President's budget and $172,000,000 above the 1997 appropriation. The Committee recognizes the urgency of need for AIDS care and drug purchases and has provided increases for each of Ryan White programs.

The Committee commends the Department for the recent release of draft guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. These recommendations reflect the

significant advances in treatment of people with HIV disease as the result of the substantial investment in AIDS research. For people with HIV disease, these guidelines offer the hope of improved health and enhanced quality of life.

The Committee has attempted in this bill to address some of the immediate needs resulting from these new treatment guidelines. However, the magnitude of the recent advances in treatment will require careful long term planning for the promise of the new treatments to reach as many people as possible. In particular, it will be important to assess the extent of changes in priority setting and resources allocation that are already occurring within each of the components of the Ryan White program. Therefore, the Committee directs the Secretary to undertake a comprehensive review of the implications of the new treatment guidelines on AIDS care programs, with an emphasis on the role of the Ryan White care programs, and to submit a report to the Committee by February 1, 1998 outlining a plan of action and recommendations for implementing the new guidelines for programs under the Department's jurisdiction. If the Department's review results in a recommendation for a different configuration for resources allocation than that provided by Congress in the 1998 appropriations bill, the Committee encourages the Secretary to submit a reprogramming request in a timely manner to take maximum advantage of the new opportunities generated by these important treatment guidelines. In addition, the Committee encourages HRSA to accelerate the award of 1998 program year grants to help address the increased program needs that have been identified in the current program year.

Emergency assistance

The bill includes $471,663,000 for the Title I emergency assistance program, which is $16,720,000 above the Administration request and $21,720,000 above the 1997 appropriation. These funds provide grants to metropolitan areas with very high numbers of AIDS cases for outpatient and ambulatory health and social support services. Half of the amount appropriated is allocated by formula and half is allocated to eligible areas demonstrating additional need through a competitive grant process. No new areas are expected to be eligible for funding under Title I in 1998.

Comprehensive care programs

The Committee provides $560,994,000 for Title II, comprehensive care programs, which is $129,040,000 above the Administration request and $144,040,000 above the 1997 appropriation. The funds provided support formula grants to States for the operation of HIV service delivery consortia in the localities most heavily affected, for the provision of home and community-based care, for continuation of health insurance coverage for infected persons, and for purchase of therapeutic drugs.

The Committee is aware of the great promise of protease inhibitor drugs in the treatment of AIDS, whose purchase is financed under Title II, as well as under the other titles, and has included bill language identifying $299,000,000 specifically for the AIDS Drug Assistance Program (ADAP). The 1997 bill designated

Senate
7/22/97

HIGHLIGHTS
LABOR, HHS AND EDUCATION SUBCOMMITTEE MARK

The recommendation before the Subcommittee totals $79.7 billion. This is an increase of $4.97 billion over 1997 and $424 million below the budget request. The recommendation both keeps faith with the budget agreement and addresses the health and education priorities of this Committee. The "protected programs" in the budget deal account for nearly half of the total increases in the bill, and nearly $3 billion of the increases are for education.

Highlights of the Subcommittee Recommendation include:

- $13.692 billion for the National Institutes of Health to support medical research, an increase of $952 million over 1997 and $615 million above the budget request.
- $29.537 billion for the programs of the Department of Education, an increase of $3.086 billion above 1997. Education programs include:
  - $1.271 billion for education reform programs, including: $541 to assist state and local school districts provide the best in education technology for students; and $530 million for Goals 2000.
  - $7.807 billion for Title I, Compensatory Education for the Disadvantaged.
  - $4.956 billion for special education. This includes $3.942 billion for state grants, an increase of $834 million over 1997.
  - $8.570 billion for student financial assistance, including $6.9 billion for Pell Grants, enough to raise the maximum grant by $300 for a total of $3,000.
  - $525 million for the TRIO program, an increase of $25 million over 1997.
- $1.2 billion in advance funds for the 1998/1999 LIHEAP winter program. In addition, the recommendation includes an additional $300 million in emergency LIHEAP funds.
- $1.077 for the Ryan White CARE Act programs, an increase of $81 million over 1997 and $41 million over the budget request. The recommendation includes a set-aside of $217 million for the Aids Drugs Assistance Program (ADAP). Also included in the recommendation is $646 million for the HIV prevention activities of the CDC, $30 million above the 1997 appropriation.
- $1.307 billion for programs authorized by the Older American's Act, an increase of $24 million over 1997 and $28 million over the request.

- $826 million for Community and Migrant Health Centers, an increase of $24 million over 1997 and $16 million above the request.

- $142 million for the Breast and Cervical Cancer Screening program of the CDC.

- $50 million new programs to assist communities in preventing juvenile crime. Funds include $25 million for youth offender demonstration training grants, $15 million for remedial education grants, and $10 million for at risk youth substance abuse prevention grants.

- $5.2 billion for employment and training programs of the Department of Labor, including:

    - $871 for the Summer Youth Jobs program, $1.2 billion for the Job Corps, and $250 million in advance funds for out of school youth activities, if authorized..

    - $1.350 for the dislocated worker program, and $955 million for adult training.

- $999 million for the workplace safety activities of the Department of Labor, an increase of $37.5 million above 1997.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES ($000) 13:53 7/21/97 PAGE 16

		FY 1997 Comparable	FY 1998 Request	FY 1998 Recommendation	Recommendation vs. FY 1997 Comparable	Recommendation vs. FY 1998 Request		
16250	CENTERS FOR DISEASE CONTROL AND PREVENTION							16250
16300	DISEASE CONTROL, RESEARCH AND TRAINING							16300
16350	Preventive Health Services Block Grant	153,994	143,940	143,940	-10,054	---	D	16350
16360	Rape Prevention and Education (non-add)	35,000	45,000	45,000	+10,000	---	NA	16360
16370	Subtotal, Preventive Health Services Block Grant	188,994	188,940	188,940	-54	---		16370
16375	(non-add)							16375
16400	Prevention centers	8,099	8,099	8,099	---	---	D	16400
16550	Childhood Immunization 1/	467,563	427,312	445,545	-22,018	+18,233	D	16550
16800	Acquired Immune Deficiency Syndrome (AIDS)	616,790	634,266	646,790	+30,000	+12,524	D	16800
16950	Tuberculosis	119,294	119,236	119,236	-58	---	D	16950
17000	Sexually transmitted diseases	106,203	111,171	111,171	+4,968	---	D	17000
17050	Subtotal	225,497	230,407	230,407	+4,910	---		17050
17100	Chronic diseases:							17100
17200	Chronic and environmental disease prevention	166,874	191,039	203,454	+36,580	+12,415	D	17200
17250	Breast and cervical cancer screening	139,659	141,897	141,897	+2,238	---	D	17250
17300	Subtotal, Chronic diseases	306,533	332,936	345,351	+38,818	+12,415		17300
17310	1/ Request includes bill language exempting from the							17310
17320	excise tax vaccine purchased with appropriated							17320
17330	funds; savings are estimated at $25 million.							17330

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES ($000) 13:53 7/21/97 PAGE 16

		FY 1997 Comparable	FY 1998 Request	FY 1998 Recommendation	Recommendation vs. FY 1997 Comparable	Recommendation vs. FY 1998 Request		
14550	Ryan White AIDS Programs:							14550
14600	Education and training centers	16,287	17,287	17,287	+1,000	---	D	14600
14650	AIDS dental services	7,500	7,500	7,500	---	---	D	14650
14700	Emergency assistance	449,943	454,943	457,943	+8,000	+3,000	D	14700
14750	Comprehensive care programs	416,954	431,954	469,954	+53,000	+38,000	D	14750
14800	Early intervention program	69,568	84,568	79,568	+10,000	-5,000	D	14800
14850	Pediatric demonstrations	36,000	40,000	45,000	+9,000	+5,000	D	14850
14900	Subtotal, Ryan White AIDS programs	996,252	1,036,252	1,077,252	+81,000	+41,000		14900
15000	Family planning	198,452	203,452	208,452	+10,000	+5,000	D	15000
15050	Rural health research	8,713	8,713	11,713	+3,000	+3,000	D	15050
15100	Health care facilities	12,902	---	10,000	-2,902	+10,000	D	15100
15150	Buildings and facilities	828	---	---	-828	---	D	15150
15200	National practitioner data bank	6,000	8,000	8,000	+2,000	---	D	15200
15250	User fees	-6,000	-8,000	-8,000	-2,000	---	D	15250
15300	Program management	112,929	110,949	116,429	+1,500	+3,480	D	15300
15400	Total, Health resources and services	3,404,567	3,266,479	3,429,071	+24,504	+162,592		15400

[FULL COMMITTEE PRINT]

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Calendar No.

105TH CONGRESS, 1st Session } HOUSE OF REPRESENTATIVES { REPORT 105-

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATION BILL, 1998

JULY 22, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PORTER, from the Committee on Appropriations, submitted the following

REPORT

[To accompany H.R.]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for the Departments of Labor, Health and Human Services (except the Food and Drug Administration, Indian Health Service, and the Office of Consumer Affairs), and Education, Armed Forces Retirement Home, Corporation for National and Community Service, Corporation for Public Broadcasting, Federal Mediation and Conciliation Service, Federal Mine Safety and Health Review Commission, National Commission on Libraries and Information Science, National Council on Disability, National Education Goals Panel, National Labor Relations Board, National Mediation Board, Occupational Safety and Health Review Commission, Physician Payment Review Commission, Prospective Payment Assessment Commission, Railroad Retirement Board, the Social Security Administration, and the United States Institute of Peace for the fiscal year ending September 30, 1998, and for other purposes.

42-612

Emergency medical services for children

The Committee has provided $13,000,000 for emergency medical services for children, which is $607,000 above the 1997 level and $1,000,000 above the Administration request. The program supports demonstration grants for the delivery of emergency medical services to acutely ill and seriously injured children.

Black lung clinics

The bill provides $5,000,000 for black lung clinics, which is $1,000,000 above the 1997 appropriation and $3,094,000 above the Administration request. This program supports 14 grantees which treat a declining population of coal miners with respiratory and pulmonary impairments. The clinics presently receive more than one-third of their funding from other sources, such as Medicaid and Medicare. Of the 14 grantees, four receive community health center funding as well as black lung grants.

Alzheimer's demonstration grants

The Committee provides $6,999,000 for Alzheimer's demonstration grants, which is the same as the 1997 appropriation. The Administration proposed that this funding be transferred to the Administration on Aging at a level of $8,000,000. The program provides grants to States to help them plan and establish programs to provide health care services to individuals with Alzheimer's disease. Funds are used for respite care and supportive services, clearinghouses, training, and administrative costs for State offices. By law, States are required to match the Federal funding—45 percent of the cost of the program by the third year of the grant.

Payment to Hawaii, treatment of Hansen's Disease

The bill includes $2,045,000 for the treatment of persons with Hansen's Disease in the State of Hawaii, which is the same as the 1997 appropriation. The Administration requested this funding in a consolidated cluster which would reduce funding for the programs included in the cluster by $3,498,000. This program, which provides a partial matching payment to the State of Hawaii, dates to the period of Father Damien's facility for sufferers of Hansen's disease (leprosy). That facility now has 63 residents who live there by choice, and the grounds have been converted to a historical site. Most patients diagnosed with Hansen's disease in Hawaii are now treated in the same manner as new patients on the mainland; their care is handled on an outpatient basis, with the program paying for about 6,300 outpatients visits per year.

Ryan White AIDS programs

The bill includes $1,168,252,000 for Ryan White AIDS programs. This is $132,060,000 above the amount requested in the President's budget and $172,000,000 above the 1997 appropriation. The Committee recognizes the urgency of need for AIDS care and drug purchases and has provided increases for each of Ryan White programs.

The Committee commends the Department for the recent release of draft guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Th recom fations reflect the

significant advances in treatment of people with HIV disease[illegible] result of the substantial investment in AIDS research. For people with HIV disease, these guidelines offer the hope of improved health and enhanced quality of life.

The Committee has attempted in this bill to address some of the immediate needs resulting from these new treatment guidelines. However, the magnitude of the recent advances in treatment will require careful long term planning for the promise of the new treatments to reach as many people as possible. In particular, it will be important to assess the extent of changes in priority setting and resources allocation that are already occurring within each of the components of the Ryan White program. Therefore, the Committee directs the Secretary to undertake a comprehensive review of the implications of the new treatment guidelines on AIDS care programs, with an emphasis on the role of the Ryan White care programs, and to submit a report to the Committee by February 1, 1998 outlining a plan of action and recommendations for implementing the new guidelines for programs under the Department's jurisdiction. If the Department's review results in a recommendation for a different configuration for resources allocation than that provided by Congress in the 1998 appropriations bill, the Committee encourages the Secretary to submit a reprogramming request in a timely manner to take maximum advantage of the new opportunities generated by these important treatment guidelines. In addition, the Committee encourages HRSA to accelerate the award of 1998 program year grants to help address the increased program needs that have been identified in the current program year.

Emergency assistance

The bill includes $471,663,000 for the Title I emergency assistance program, which is $16,720,000 above the Administration request and $21,720,000 above the 1997 appropriation. These funds provide grants to metropolitan areas with very high numbers of AIDS cases for outpatient and ambulatory health and social support services. Half of the amount appropriated is allocated by formula and half is allocated to eligible areas demonstrating additional need through a competitive grant process. No new areas are expected to be eligible for funding under Title I in 1998.

Comprehensive care programs

The Committee provides $560,994,000 for Title II, comprehensive care programs, which is $129,040,000 above the Administration request and $144,040,000 above the 1997 appropriation. The funds provided support formula grants to States for the operation of HIV service delivery consortia in the localities most heavily affected, for the provision of home and community-based care, for continuation of health insurance coverage for infected persons, and for purchase of therapeutic drugs.

The Committee is aware of the great promise of protease inhibitor drugs in the treatment of AIDS, whose purchase is financed under Title II, as well as under the other titles, and has included bill language identifying $299,000,000 specifically for the AIDS Drug Assistance Program (ADAP). The 1997 bill designated

$167,000,000 for this purpose, which is the same amount requested by the Administration for 1998.

Early intervention program

The Committee provides $72,928,000 for Title III-B, the early intervention program, which is $3,360,000 above the 1997 appropriation and $11,640,000 below the Administration request. Funds are used for discretionary grants to migrant and community health centers, health care for the homeless grantees, family planning grantees, hemophilia centers and other private non-profit entities that provide comprehensive primary care services to populations with or at risk for HIV disease. The grantees provide testing, risk reduction counseling, transmission prevention, and clinical care; case management, outreach, and eligibility assistance are optional services. Approximately 87,000 HIV positive persons or persons at high risk for HIV infection are expected to receive primary care services in 1997.

Pediatric demonstrations

The bill includes $37,720,000 for the pediatric AIDS demonstrations authorized under Title IV of the Ryan White C.A.R.E. Act. This is $2,280,000 below the Administration request and $1,720,000 above the 1997 level. The program supports demonstration grants to foster collaboration between clinical research institutions and primary community-based medical and social service providers for the target population of HIV-infected children, pregnant women and their families. The projects are intended to increase access to comprehensive care, as well as to voluntary participation in NIH and other clinical trials.

AIDS dental services

The bill includes $7,860,000 for AIDS dental services, which is $360,000 above both the President's request and the 1997 level. The program assists over 100 dental schools and postdoctoral dental education programs with costs of providing oral health care to over 73,000 patients. Dental students and residents participating in this program receive extensive training in the management of the oral care of people living with HIV/AIDS. The Committee strongly supports the increased collaboration between the participating dental institutions and other Ryan White Title grantees.

Education and training centers

The bill provides $17,067,000 for AIDS education and training centers, which is $600,000 above the 1997 appropriation and $200,000 below the Administration request. The centers train health care personnel who care for AIDS patients and develop model education programs.

Family planning

The bill includes $203,462,000 for the family planning program, which is $5,000,000 above the 1997 appropriation and the same as the Administration request. The program provides grants to public and private non-profit agencies to support projects which provide a range of family planning and reproductive services, as well as screening for ancillary health problems such as hypertension and diabetes. The program also supports training for providers, an information and education program, and a research program which focuses on family planning service delivery improvements. During 1996, 5 million clients were served through a network of over 4,800 clinics funded in part by the family planning program. Almost 60 percent of the clinics are operated by State, county and local health departments.

The Committee bill repeats language from the 1997 appropriations bill making clear that these funds shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that these funds shall not be used to promote public opposition to or support of any legislative proposal or candidate for public office.

Rural health research

The Committee has provided $6,713,000 for rural health research, which is the same as both the 1997 appropriation and the Administration request. The activity supports several rural health research centers, the Office for Rural Health Policy's advisory committee, and a telemedicine grant program.

Health care facilities

The Committee has not included funding for health care facilities. $12,902,000 was provided for this purpose in 1997; no funding was included in the Administration request. This expired authority provides funds to public and private nonprofit entities for construction or modernization of outpatient medical facilities. This activity has not been funded by the Committee on a regular annual basis. The Committee felt that provision of services rather than construction was a higher priority in the current stringent fiscal environment.

Buildings and facilities

$2,500,000 is provided for buildings and facilities for 1997, which is $1,672,000 above the 1997 appropriation. The Administration proposed funding this program in a Hansen's Disease services cluster which would reduce funding for the programs included in the cluster by $3,498,000. These funds are used to finance the repair and upkeep of buildings at the Gillis W. Long Hansen's Disease Center at Carville, Louisiana. The increase is intended to finance one-time renovation costs due to be completed during fiscal year 1998 as part of the agreement to transfer the facility to the State of Louisiana, as described in the Hansen's disease services section of the report.

National practitioner data bank

The Committee does not provide funding for the national practitioner data bank for fiscal year 1998, which is the same as both the 1997 action on appropriations and the Administration request. The Administration request and the Committee recommendation assume that the data bank will be self-supporting, with collections of $8,000,000 in user fees.

The national data bank receives, stores and disseminates information on paid medical [illegible]practice judgments and settlements,

Within the increase provided, sufficient funds are available to conduct a telemedicine project that will strengthen the knowledge base in developing graduate and undergraduate health profession education program curricula that meet the special needs of rural communities. The Committee is aware of the proposal by the State of Vermont to conduct a telemedicine demonstration project that would integrate health professions education with the delivery of health services in rural areas, and urge the agency grant full and fair consideration to this proposal.

Emergency medical care for children

The Committee provides $13,000,000 for emergency medical services for children. This is $507,000 above the 1997 level and $1,000,000 above the administration request. The program supports demonstration grants for the delivery of emergency medical services to acutely ill and seriously injured children. The Committee urges HRSA to focus attention on the shortage of these programs in remote and rural areas of the country, such as those in Alaska and Hawaii.

Black lung clinics

The Committee includes $5,000,000 for black lung clinics. This is $1,000,000 more than the fiscal year 1997 amount and $3,094,000 higher than the administration request. This program funds clinics which treat respiratory and pulmonary diseases of active and retired coal miners. These clinics reduce the incidence of high-cost inpatient treatment for these conditions. The Committee intends the increase to sustain patient services at all current operating centers.

Alzheimer's disease demonstration grants

The Committee recommends $5,999,000 for Alzheimer's demonstration grants, which is the same as the 1997 level. The administration requested transfer of funding and program operations to the Administration on Aging.

The Committee is pleased that this program continues to be an effective catalyst by stimulating over 140 State, local, public, and private agencies to coordinate and strengthen community services for Alzheimer's families. The program focuses on making existing services work better, with special emphasis on hard-to-reach and underserved populations. With relatively modest funding, projects have provided outreach and support to an estimated 4.5 million persons in over 20 ethnic groups. The Committee is pleased with the current success of this program and with the creativity and flexibility with which HRSA has administered it. The Committee sees no compelling reason to transfer this program, as proposed by the administration, and is strongly concerned that a transfer risks disruption of the strong public/private partnerships already in place. The Committee, therefore, rejects the proposed transfer and directs that the program remain at HRSA.

Payment to Hawaii, Hansen's disease treatment

Within the amount provided for Hansen's disease services, the Committee has provided $2,045,000 for the 1998 payment to the State of Hawaii for the medical care and treatment in its hospital

and clinic facilities of persons with Hansen's disease at a per diem rate not greater than the comparable per diem operating cost per patient at the Gillis W. Long National Hansen's Disease Center in Carville, LA. This amount is $295,000 above the administration request and the same as the 1997 level. The administration requested funding in a consolidated program cluster for Hansen's disease.

ACQUIRED IMMUNE DEFICIENCY SYNDROME

RYAN WHITE AIDS PROGRAMS

The Committee provides $1,077,252,000 for Ryan White AIDS programs. This is $41,000,000 above the administration request and $81,000,000 above the 1997 level.

Emergency assistance—title I

The Committee recommends $457,943,000 for emergency assistance grants to eligible metropolitan areas disproportionately affected by the HIV/AIDS epidemic. This amount is $8,000,000 above the fiscal year 1997 amount and $3,000,000 higher than the administration request. These funds are provided to metropolitan areas with a cumulative total of more than 2,000 cases of AIDS or a per capita incidence of 0.0025. One-half of the funds are awarded by formula and one-half are awarded through supplemental competitive grants.

The Committee is concerned about the limited AIDS therapy options for children and pregnant women, and encourages the Secretary, when awarding supplemental title I funds, to give priority as appropriate to EMA's whose applications increase services to women and children with AIDS/HIV infection.

Comprehensive care programs—title II

The Committee has provided $469,954,000 for HIV health care and support services. This amount is $38,000,000 above the administration request and $53,000,000 above the 1997 level. These funds are awarded to States to support HIV service delivery consortia, the provision of home and community-based care services for individuals with HIV disease, continuation of health insurance coverage for low-income persons with HIV disease and support for State AIDS drug assistance programs [ADAP].

The Committee is heartened by the advent of protease inhibitor therapy in combination with other medications for patients with HIV, which has resulted in lower mortality rates for individuals with HIV/AIDS for the first time in the history of the epidemic. The Committee continues to be concerned by the high costs of new medications for AIDS, and, in anticipation of higher demand for these treatments, has approved bill language for $217,000,000 for AIDS medications, compared to $167,000,000 provided for this purpose in fiscal year 1997. The Committee remains concerned about the lack of timely national data available to estimate future demand for AIDS medications funded by the ADAP program, and is further concerned about the wide variation in State Medicaid policies regarding eligibility, benefits, and formularies. The Committee urges the Secretary to establish useful benchmarks in measuring

progress for ADAP activities and to increase data collection and information sharing efforts between the Department, the States, and nongovernmental organizations such as the ADAP Working Group, the AIDS Treatment Data Network, and the National Alliance of State and Territorial AIDS Directors. The Committee reiterates its directive that the program use all means necessary to reduce the purchase price of AIDS drugs.

Early intervention program—title III–B

The Committee recommends $79,568,000 for early intervention grants. This is $10,000,000 above the 1997 level and $5,000,000 less than the administration request. These funds are awarded competitively to primary health care providers to enhance health care services available to people at risk of HIV and AIDS. Funds are used for counseling, testing, diagnostic, and therapeutic services.

To the extent practicable, the Committee encourages HRSA to fairly allocate the increase for title III–B between existing grantees and new providers. The Committee understands that existing grantees have been level-funded throughout the history of the CARE Act. By providing additional funds to current grantees, the Committee intends to undergird the HIV care infrastructure already established in title III–B clinics. The Committee also supports expansion of the number of communities receiving assistance from this title. The Committee understands that HRSA is conducting a grant-review process expected to identify qualified new grantees in underserved rural and urban areas.

Pediatric AIDS demonstrations—title IV

The Committee recommends $45,000,000 for title IV pediatric AIDS, which is $5,000,000 higher than the administration request and $9,000,000 above the 1997 amount. This program supports demonstration grants to develop innovative models that foster collaboration between clinical research institutions and primary/community-based medical and social service providers for underserved children, youth, pregnant women, and their families.

Some 5 percent of the funds appropriated under this section may be used to provide peer-based training and technical assistance through national organizations that collaborate with projects to ensure development of innovative models of family-centered and youth-centered care; advanced provider training for pediatric, adolescent, and family HIV providers; health care financing, outcome measures, and policy analysis; and coordination with research programs.

The Committee is aware that the Ryan White CARE Act Amendments of 1996 requires significant enrollment of title IV patients in NIH research programs. The Committee is further aware that funding for the pediatric AIDS clinical trial group has been reduced by the NIH Office of AIDS Research, and urges HRSA to consider this reduction in funding as well as research protocol requirements when evaluating the ability of title IV projects to enroll significant numbers of patients in research programs.

AIDS dental services

The Committee provides $7,500,000 for AIDS dental services, which is the same as the administration request and the 1997 level. This program provides grants to dental schools and postdoctoral dental education programs to assist with the cost of providing unreimbursed oral health care to patients with HIV disease.

AIDS education and training centers

The Committee recommends $17,287,000 for the AIDS education and training centers [AETC's]. This amount is $1,000,000 above the 1997 level and the same as the administration request. AIDS education and training centers train health care practitioners, faculty, and students who care for AIDS patients outside of the traditional health professions education venues, and support curriculum development on diagnosis and treatment of HIV infection for health professions schools and training organizations. With the issuance of new protease inhibitor treatment guidelines for patients with HIV, the Committee provides a significant increase in this account and expects the participating centers to disseminate and educate health care providers on the proper use of these new medications.

Family planning

The Committee recommends $208,452,000 for the title X family planning program. This is $5,000,000 higher than the administration request and $10,000,000 above the 1997 level. Title X grants support primary health care services at more than 4,000 clinics nationwide. About 85 percent of family planning clients are women at or below 150 percent of poverty level.

Title X of the Public Health Service Act, which established the family planning program, authorizes the use of a broad range of acceptable and effective family planning methods and services. The Committee believes this includes oral, injectable, and other preventive modalities.

The Committee is concerned that programs receiving title X funds ought to have access to these resources as quickly as possible. The Committee, therefore, instructs the Department to distribute to the regional offices all of the funds available for family planning services no later than 60 days following enactment of this bill.

The Committee urges that the Office of Family Planning support national and community-based initiatives to involve males in family planning matters. The Committee is aware of the efforts of the National Organization of Concerned Black Men, Inc., of Philadelphia, PA, and its local affiliates to enhance the involvement of African-American males in all aspects of family planning, including teen pregnancy prevention, parenting skills, fatherhood responsibility, and male mentoring, and applauds such practical solutions and urges the Office to support such endeavors.

Rural health research

The Committee recommends $11,713,000 for the Office of Rural Health Policy. This is $3,000,000 more than the fiscal year 1997 level and the administration request. The funds provide support for

AIDS Action council

AIDS Action Analysis
The Coburn HIV Prevention Act of 1997

The HIV Prevention Act of 1997 (H.R. 1062), introduced by Representative Tom Coburn (R-OK), has little to do with preventing HIV transmission. This bill seeks to federally mandate costly and ineffective testing-related measures that undermine proven community-based prevention strategies already being implemented across the country. Instead of allowing states and communities to effectively respond to the specific demographics of the HIV epidemic in their jurisdiction, this legislation represents one-size fits all solutions from Washington that tie the hands of these communities. In fact, states and local communities already have the flexibility to implement provisions of the Coburn bill as part of their prevention strategies, and have, through state law or regulation, as deemed appropriate.

States would be required to implement all of the bill's provisions as a condition of receiving federal Medicaid funds, thereby jeopardizing the source of health care for more than half of all people living with AIDS. No new funding is provided, despite the fact that the Association of State and Territorial Health Officers (ASTHO) estimates that implementation of this legislation would require at least 265 statutory or regulatory changes nationwide and cost approximately $420 million a year. In fact, among the laws and regulations states would be required to change in order to comply with these new unfunded federal mandates are laws and regulations they enacted to comply with conditions of the federal Ryan White Care Act. At the same time, this legislation does nothing to support community-based prevention efforts that have been proven to be highly effective in changing risk behaviors and significantly reducing the transmission of HIV.

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I. National Partner Notification

The HIV Prevention Act would mandate that states report the identities of all people testing positive for HIV, as well as the identities of their sexual and needle sharing partners, to the federal government. These lists would be used by the CDC to establish a national partner notification system, and a state's list would be shared with other states so that individuals could be tracked down and informed that they may have been exposed to HIV by a current or past partner. Additionally, all states would be required to implement mandatory names reporting systems for their own surveillance purposes, even those states that have already implemented unique identifier systems or that measure the number of cases of HIV infection by collecting anonymous demographic information.

- **No other disease is required to be reported by federal mandate**, and the CDC has not requested that Congress create such an unprecedented mandate for HIV. For all other diseases, appropriate surveillance has been accomplished by consensus in the public health community. For example, all state public health departments reached consensus on the voluntary reporting of AIDS cases to the CDC. No federal mandate was needed.

- **Mandatory names reporting is not the only or even the best way to do surveillance to measure cases of HIV infection**. Other methods, such as using unique identifiers and sentinel studies, provide accurate information about the incidence of HIV infection. State health departments design surveillance programs appropriate to their populations, taking into account that surveillance methods that discourage people from being tested in the first place are counterproductive. States are free to implement mandatory names reporting if they feel it is appropriate, and a number of states have done so. State flexibility is key, however; even some states that have confidential name reporting choose to keep anonymous test sites available as an option as well.

- **A federal mandate requiring states to report the identities of everyone testing positive for HIV would eliminate anonymous testing options, including newly-approved HIV home sample collection kits.** States and local communities have adopted a broad range of testing options to encourage people to come forward to be tested without fear of loss of privacy. A 1996 study of 2000 individuals tested at anonymous test sites in California found that 80% said they would not have consented to be tested if their names were to be "confidentially" reported to the state health department. And when Oregon state switched from "confidential" names reporting to anonymous testing, the number of individuals seeking testing increased significantly. Studies have documented higher rates of testing and higher rates of positive test results at anonymous testing sites.

- **Creating a "national" partner notification program is also an unnecessary waste of resources.** Neither the CDC nor states have called for such as system.

- **States and localities are already required to have partner notification programs as a condition of receiving HIV prevention funds from the Centers for Disease Control and Prevention**. The Ryan White CARE Act Amendments of 1996 also requires states to notify a spouse of a known HIV-infected patient that he or she may have been exposed to the human immunodeficiency virus and should seek testing.

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- **Partner notification programs are only useful as part of an *overall* prevention strategy geared to the specific demographics of the AIDS epidemic in a local community**. The federal mandates in this legislation would constrain local public health officials from adopting programs most suited to their jurisdictions. Because partner notification activities are labor intensive, they are expensive and would be likely to divert resources from more effective means of HIV infection control.

- **States must be given the flexibility to design and implement partner notification programs that reflect the level of infection in given communities**. As the AMA has stated, "We recognize that no single type of contact tracing program can be designed for every state and local health department...reliance on the discretion of the public health officer provides necessary flexibility.... Financial resources, community seroprevalence rates, awareness levels in at-risk populations, differing transmission rates among infected populations and how recently the partners of index patients were exposed to HIV are all factors which must be considered by public health authorities in designing their contact tracing programs".

- **Partner notification has proven to be ineffective in stemming recent surges in diseases such as syphilis and gonorrhea**. The Centers for Disease Control (CDC) reported that since 1989 the rates of primary and secondary syphilis have increased by at least 40 percent and up to 293 percent in urban areas across the United States.

- **Mandatory partner notification programs are a poor use of resources**. Most "at risk" populations already know they are at risk; if not, targeted prevention education to such populations is a far more effective use of resources than partner notification. Identifying those with HIV and sharing this information between states does nothing in terms of preventing transmission of HIV. Moreover, a recent California study of HIV-infected drug users found that 63 percent of those interviewed said they, if asked, would not reveal the correct names and addresses of their partners due to social stigma and rejection or for other reasons. Thus, these programs are ineffective as a means of HIV prevention because their success relies on the voluntary cooperation of the infected person.

- **Mandatory partner notification programs may actually discourage <u>women</u> from seeking testing, and have been shown to trigger incidents of <u>domestic violence</u>**. In a recent study of health care providers in Baltimore who work with women infected with HIV, 24% of the providers had at least one female patient who experienced physical violence following disclosure of her HIV status to a partner.

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II. HIV Testing of Sexual Offenders

The HIV Prevention Act requires that states test accused sexual offenders for HIV within 48 hours of the filing of an information or indictment, whether the victim requests it or not, and that the results be disclosed "as soon thereafter as practicable" to "the victim; the defendant; the attorneys of the victim; the prosecuting attorneys; the judge presiding at the trial, if any; and the principal public health official for the local jurisdiction in which the crime is alleged to have occurred" -- seriously compromising the confidentiality of the victim.

- **The federal Omnibus Crime Act of 1994 already provides for HIV testing of accused sexual offenders at the request of the victim, and protects the victim by limiting disclosure of the results to the victim and the person tested.** In addition, at least 44 states and the District of Columbia have laws explicitly providing for HIV tests in sexual offense cases.

- **Testing of sexual offenders does not necessarily provide accurate information regarding the HIV status of the victim due to the window period in which a person could be infected and not test positive for the disease.** Even if the defendant does test positive, the possibility exists that the virus was not transmitted to the victim. Relying on the HIV-status of the offender could result in a false sense of security for the victim or create unnecessary panic, further victimizing the survivor.

- **Focusing on the perpetrator and <u>further victimizing the survivor</u> by discounting her needs, not allowing her to decide whether or not testing of the offender occurs, and revealing her exposure to HIV to anyone associated with the court proceedings, is hardly good policy.** Instead, the survivor of the crime should be offered counseling, testing, and services to address her needs and above all, protect her confidentiality. Rape crisis counselors believe that the best way to help survivors of sexual assault is to provide necessary health care and counseling services directly to them. Sexual assault survivors need support to regain a sense of control over their lives. Concentrating on the HIV status of their assailant undermines the ability of survivors to reclaim their sense of control over their health and safety. They need proper counseling immediately by trained professionals who can assess and convey the risks of transmission. Only by being tested themselves over a period of time will they know their own status.

- **The test of the defendant, when used in court, may cause problems for the**

survivor. If the defendant tests positive, it could be presumed that the survivor will be positive as well. The survivor may face the same discrimination and problems that HIV infected persons face.

III. HIV Testing of Patients

The HIV Prevention Act allows medical professionals to refuse treatment to a patient unless the patient is tested for HIV.

- **Adherence to universal precautions for infection control is the accepted public health approach** to protecting health care workers from accidental exposure to HIV and other blood-borne infections, such as hepatitis B.

- **Testing does not establish the *current* HIV status of the patient** because of the window period between infection and development of antibodies. The best approach to preventing HIV transmission from patient to health care worker or vice versa is through adherence to universal precautions. The American Hospital Association and the American Nurse's Association both oppose blanket screening because it does not provide meaningful protection for health care workers.

- **States have rejected the idea of testing hospital patients because it is ineffective and prohibitively expensive.** Since the beginning of the epidemic, CDC has documented 46 cases of occupational exposure to HIV. The American Hospital Association estimates that testing hospital patients would cost $1.65 billion a year and would have no real impact on the spread of HIV.

- **Delaying a medical procedure while awaiting test results that may not even provide accurate information on a patient's HIV status, could cost that individual his or her life,** while doing nothing to actually prevent the spread of HIV.

IV. Sense of Congress Provisions

The HIV Prevention Act expresses the sense of the Congress that States should criminalize irresponsible behaviors by those who are infected.

- There is no question that deliberately attempting to infect another person with HIV is a heinous criminal act. However, **every state and the District of Columbia addresses this concern by having laws that allow the criminal prosecution of such an act.** For example, there are some laws that address assault with a

deadly weapon or assault with intent to kill, which could be used to prosecute a person who knowingly attempts to infect another with HIV. Since 1986, 24 states have adopted criminal laws making it a felony, misdemeanor, or both to knowingly expose or transmit HIV to another person.

- **Criminal laws against knowingly exposing or transmitting a disease to another person are hardly new.** Even before the HIV/AIDS epidemic, many states imposed criminal or civil penalties on individuals who knowingly exposed another to a sexually transmitted or communicable disease. While many legal experts consider these laws sufficiently broad to cover cases involving HIV and AIDS, several states have amended these laws to specifically include HIV/AIDS or have enacted separate HIV/AIDS-specific laws.

The HIV Prevention Act expresses the sense of Congress that strict confidentiality "should" be maintained in carrying out the provisions of this Act.

- **A "Sense of Congress" provision is not legally binding, and does nothing to deter or penalize breaches of confidentiality.** People living with HIV/AIDS are subject to discrimination in housing, health care, and employment. For people living with HIV/AIDS, maintaining confidentiality is essential to preventing discrimination. Studies have shown that the very fear of breach of confidentiality may deter people from being tested for HIV, and that people who suspect that they may be HIV-positive delay early detection and treatment to avoid the potential negative consequences which flow from confidentiality breaches. **Strict legal protections accompanied by meaningful, enforceable sanctions are the only way to protect against breaches of confidentiality.**

V. Other Provisions

The HIV Prevention Act of 1997 includes a hodge-podge of other provisions regarding funeral service practitioners, adoption agencies, and health insurers, all of which are as burdensome and ill-conceived as the provisions highlighted above. Enormous strides have been made in addressing the HIV epidemic on the federal and state level. This Act is a collection of counter-productive unfunded federal mandates that will only divert resources from real prevention efforts and further stigmatize and frighten people living with and at risk for HIV. For all these reasons, AIDS Action Council strongly opposes the Coburn HIV Prevention Act of 1997.

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Q & A about the HIV Prevention Act

1.) Will the HIV Prevention Act require states to report the names of HIV-positive individuals to the Centers for Disease Control and Prevention (CDC)?

No. The names of patients are not reported to the CDC, only relevant demographic and personal information such as age, sex, race or ethnic group plus transmission or risk category. Names are never reported to CDC as part of an established program of surveillance of widespread disease such as HIV. Names or surrogate identifiers are reported to the respective state health departments to ensure partner notification and contact follow-up.

2.) Will this bill frighten or discourage individuals from getting tested for HIV?

No. AIDS activists made these same claims in 1989 when name reporting and partner notification went into effect in Virginia, but testing for HIV actually INCREASED. More recently, when anonymous testing was eliminated in North Carolina, HIV testing INCREASED by 45%.

There is no evidence in any of the 28 states with partner notification that reporting or notification discourage people from getting tested for HIV.

3.) Does the bill allow physicians to refuse to treat HIV infected patients?

No. The bill specifically states that health professionals, at their discretion, may request that a patient be tested for HIV before performing an invasive medical procedure.

Testing patients for HIV is primarily aimed at protecting the health of the patient. Doctors do not want to prescribe immunosuppressant drugs if the patient is HIV positive. Protecting health care workers from infection is important, but the real key is that doctors need the ability to fully diagnose a patient. A health care provider needs to know if a patient is HIV positive in order to give the patient the best possible care.

Federal law prohibits providers from refusing care to anyone who has tested positive for HIV. The HIV Prevention Act would not change this.

4.) Does the bill require doctors to be tested for HIV before performing invasive procedures on patients?

No, but it does take the first step in this direction by expressing the Sense of the Congress that HIV infected health professionals should notify their patients of their status.

Many states have already addressed this issue. Some even require health care personnel who perform invasive procedures to be tested for HIV. The French Order of Doctors announced earlier this year that it was the "moral duty" of surgeons infected with HIV to "stop operating" and switch to general medicine or administrative work.

5.) Does this bill contain an unfunded mandate? Will the testing, reporting and partner notification be expensive? Where will the money come from?

This is *not* an unfunded mandate. Because many states are already conducting partner notification for HIV and all states conduct partner notification for other STDs, the cost of the partner notification proposal in the bill would not be terribly costly (possibly $10 to $20 million). CDC receives $140 million for HIV counseling and testing. The additional $10-20 million could come from this existing amount which has already been budgeted.

6.) What provisions will be in place to protect confidentiality?

Every state already has strict confidentiality laws in place for all medical diseases. In addition, many states have enacted special laws to protect HIV-status information. Every state has reported AIDS cases to their state public health department and to the CDC for 16 years without incident. Why would this change with reporting HIV? In fact, all existing reporting systems (for example, blood banks, military, CDC, and state health departments) have been conducted with only a single documented breach of confidentiality. Additionally, this bill expresses the Sense of the Congress that "strict confidentiality" should be maintained in carrying out the provisions of the bill.

7.) AIDS activists say that this bill does not treat HIV-infected persons like those infected with other communicable diseases. What other diseases have these same reporting and partner notification requirements?

CDC currently designates 52 infectious diseases as notifiable at the national level. Although AIDS and pediatric HIV infections are included on this list, adolescent and adult HIV infection are conspicuously absent.

Partner notification programs are already in place for other STDs and federal law requires spousal notification for HIV. This bill would notify anyone who may have been exposed to HIV by a past or present partner.