A Legislative Initiative: The Ryan White Comprehensive AIDS Resources Emergency Act of 1990

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INTRODUCTION

Ten years after AIDS¹ was officially recognized in the United States,² there has been an evolution of response to the disease: First, the disease has shifted from a generally affluent population of young Caucasian homosexual males, living in four or five urban areas, to an increasingly inner-city population of poorer black and Hispanic heterosexual men, women, and children sharing contaminated needles and engaging in random sexual intercourse.³ Second, the disease is increasingly associated with IV-drug abuse; it is also

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1. Even though the current reference to the disease is Human Immunodeficiency Virus (HIV), the use of the AIDS designation will continue because of its reference in legislation and in the minds of the public. Nonetheless: “The term ‘AIDS’ is obsolete. ‘HIV infection’ more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than on the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic.” REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC XVII (1988) [hereinafter PRESIDENTIAL COMMISSION].

2. Although the disease that would eventually be called AIDS, and then HIV, was present in America and other countries prior to the 1980’s, official recognition is often associated with the June 5, 1981, publishing of cases of pneumocystis in the Centers for Disease Control’s Morbidity and Mortality Weekly Report. The Centers for Disease Control reported the first case of Karposi’s Sarcoma one month later on July 3, 1981. See Centers for Disease Control, Karposi’s Sarcoma and Pneumocystis Pneumonia Among Homosexual Men—New York City and California, 30 MORBIDITY & MORTALITY WEEKLY REP. 305 (1981). See generally R. SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC 1-112 (1987) [hereinafter SHILTS].

3. See Centers for Disease Control, AIDS and the Human Immunodeficiency Virus Infection in the United States: 1988 Update, 38 MORBIDITY & MORTALITY WEEKLY REP. 1, 11 (4 Supp. 1989) (even when white IV-drug users are compared to black IV-drug users, there is a disproportionate HIV antibody prevalence among blacks); Centers for Disease Control, Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge, 36 MORBIDITY & MORTALITY WEEKLY REP. 1, 2-4 (6 Supp. 1987) (reports sharp drop in the incidence of HIV infection among homosexual men); Okie, AIDS Shifts to Drug-Plagued Inner Cities, Wash. Post, Aug. 27, 1989, at A3, col. 1 (estimating that 1.2 million persons carry the virus and half are black or Hispanic).
increasingly associated with syphilis, tuberculosis, and measles. These last three scourges exploded during the 1980's, with the highest incidence occurring within those areas most affected by AIDS—inner-city ghettos comprised mainly of black and Hispanic men, women, and children. Third, a "Medicaidization" of AIDS occurred among white as well as black and Hispanic persons with AIDS in specific American cities. That is, a study "found that in the three cities where AIDS is most prevalent, Medicaid finances a much larger proportion of inpatient care for AIDS than other illnesses, and that during the epidemic years, Medicaid's share increased while that of private insurance declined." Thus, because of the way that Medicaid provides payments, Medicaidization "represents an increasing financial burden on inner-city public health care systems." Indeed, in spring 1991, public hospitals "asked for up to two billion dollars annually in federal funds to avoid severe erosion or even collapse."

Significant numbers of persons with AIDS, now living within geographically defined areas, are also burdened with sexually transmitted diseases.


6. Id. at 1261. "Medicaid pays for 11% of total health care costs in the United States. By contrast, the Health Care Financing Administration estimates that Medicaid funds 25% of AIDS care." Id. (footnotes omitted).

7. Rich, AIDS, Uninsured Swamp Nation's Public Hospitals, Wash. Post, Jan. 30, 1991, at A3, col. 3 (The president of the National Association of Public Hospitals stated that the cause of the deficit was the "general increase in health care costs, the failure of Medicaid and Medicare . . . to reimburse hospitals fully for the costs of patient care and the fact that more than 30 million people who have no insurance come to public hospitals for free care.").

8. There is increasing geographic diffusion of the virus from a bicoastal epidemic to a national one. See Gardner, Brundage, Burke, McNeil, Visintze & Miller, Evidence for Spread of the Human Immunodeficiency Virus Epidemic into Low-Prevalence Areas of the United States, 2 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 521, 521 (1989) (significant increases for the past 24 months are reported in California, Florida, Illinois, Ohio, and Texas). But because black and Hispanic men and women continue to be overrepresented in every AIDS risk category, primarily due to proximity to IV-drug use, inner-city areas of poverty and drug consumption are crucial target areas for Government action. AIDS: THE SECOND DECADE 4-6 (H. Miller, C. Turner & L. Moses eds. 1990) [hereinafter THE SECOND DECADE]. For shifts in HIV-infected populations, see generally Centers for Disease Control, Pilot Study of Household Survey to Determine HIV Seroprevalence, 40 MORBIDITY & MORTALITY WEEKLY REP. 1, 1-5 (1991); Centers for Disease Control, Reports on Selected Racial/Ethnic Groups, 39 MORBIDITY & MORTALITY WEEKLY REP. 1, 40-41 (3 Supp. 1990); Centers for Disease Control, Mortality Patterns—United States: 1987, 39 MORBIDITY & MORTALITY
(STD’s), such as syphilis, and heretofore declining maladies, such as tuberculosis and measles. Also, the lack of private health insurance9 and progressive reliance upon public health coverage continue an already evident trend towards a “two-tiered system of care”10 and medical protection,11 especially within inner-city areas of America. Inner-city hospitals accepting public

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9. The lack of private health insurance is particularly onerous among persons of color; black Americans are much less likely to have health coverage than whites. “In 1984, an estimated 22 percent of blacks and 14 percent of whites under age 65 were not covered by either public or private health insurance . . . and those figures have been rising since then.” A Common Destiny: Blacks and American Society 430 (D. Jaynes & R. Williams eds. 1989); see also Davis, Little-Blanton, Lyons, Mullan, Powe & Rowland, Health Care for Black Americans: The Public Sector Role, in CURRENTS OF HEALTH POLICY: IMPACTS ON BLACK AMERICANS 213 (D. Willis ed. 1987); Farley, Who Are the Underinsured?, 63 MILBANK MEMORIAL FUND Q./HEALTH & SOC’TY 476 (1985).


care patients are facing devastating economic consequences, and the lack of funds available to other inner-city providers is equally desperate. Any effort to address these specific evolutions within the AIDS epidemic is therapeutic; after ten years, it is more than appropriate to find out what helps and what hinders.

Among the many recommendations in the Report of The Presidential Commission on the Human Immunodeficiency Virus Epidemic, issued in 1988, was that the “Community Health Center Program should be increased in high incidence areas to allow for the provision of additional services to persons infected with HIV.” Indeed, the Commission recommended greater participation by community physicians in protocol development and implementation, a direct grant program to assist community-based trials, and a training program at the National Institutes of Health (NIH) to teach community practice physicians the latest HIV research information and clinical trial management skills. Speakers from the community testified before the Commission that community programs were not injurious to health. On the contrary, community-based physicians and programs making treatment available to minorities and women were the only medical providers concerned with treating opportunistic infections, like Pneumocystis and

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12. A survey by the National Public Health and Hospital Institute examined 623 acute-care hospitals; 322 responded. Two hundred and seventy-six hospitals reported treating persons with AIDS for an average length of stay of 16.8 days. Cost per patient per day was $681, and revenues for each of these patients was $545. Estimated total cost for AIDS inpatient care during 1987 was $486 million, with Medicaid the primary payer. Andrulis, Weslowski & Gage, The 1987 U.S. Hospital AIDS Survey, 262 J. A.M.A. 784, 789 (1989) [hereinafter Andrulis]; see also Hay, Osmond & Jacobson, Projecting the Medical Costs of AIDS and ARC in the United States, 1 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 466, 479 (1988); Hellinger, Updated Forecasts of the Costs of Medical Care for Persons With AIDS: 1989-93, 105 PUB. HEALTH REP. 1, 1 (1990); Scitovsky, Studying the Cost of HIV-related Illnesses: Reflections on the Moving Target, 67 MILBANK Q. 318, 319 (1989).


14. PRESIDENTIAL COMMISSION, supra note 1, at 19.

15. Id. at 58-59. The Commission specifically suggested that the “Community Research Initiative (CRI) offers the possibility to combine the technical expertise of the research community with the outreach potential of community health clinics and physicians in community practice.” Id. at 56. The CRI was the product of New York City community physicians and researchers, first meeting in apartments and townhouses on Manhattan’s East Side. It had four priorities: (1) the testing of drugs that might prevent specific opportunistic infections, (2) testing of drugs that would enhance the body’s immune system, (3) testing of underground drugs used in the community, and (4) designing trials without using placebos. B. NUSSBAUM, GOOD INTENTIONS: HOW BIG BUSINESS AND THE MEDICAL ESTABLISHMENT ARE CORRUPTING THE FIGHT AGAINST AIDS 227-35 (1990) [hereinafter GOOD INTENTIONS]. A group similar to CRI was the San Francisco County Consortium.
Karposi's Sarcoma, and were the only groups willing to allow persons with AIDS to exert authority over decisionmaking.

Ten years into the HIV epidemic, any critical review of the progress made to develop treatments or assess services would raise specific questions: Besides AZT, why are there no additional drugs? Why have so few women and minorities been invited or allowed into government-funded trials? Why must persons with AIDS—a terminal illness—wait extended periods of time for the release of government-tested drugs when self-selecting community-based physicians have been using the same drugs for lengthy periods with documented results? Why is there continued reluctance to approve drugs like ddI (Dideoxyinosine) and ddC (Dideoxycytidine) when AIDS activists and the Bush Administration's Committee to Review Current Procedures for Approval of New Drugs for Cancer and AIDS both advocate approval of drugs on "substantial," even if disputed, evidence of effectiveness? And finally, who will be accountable for the billions of dollars appropriated by Congress for research where the results have been so meager?

There are no complete answers to any of these questions; it is the nature of a democratic society that debate, new developments, and dialogue forestall precise answers. But the one fact upon which all will agree is that, throughout the decade of AIDS, community programs in specific urban areas have

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16. GOOD INTENTIONS, supra note 15, at 266-67. The "National Institute of Allergy and Infectious Diseases had for the most part neglected OIs (opportunistic infections) that did the actual killing of people with AIDS." Id. at 267.

17. See generally AIDs Drugs: Where Are They?, H.R. REP. NO. 1092, 100th Cong., 2d Sess. (1988). It took the FDA a little over two years to go from development to final approval of AZT; usually it takes from 7 to 10 years. But the FDA expended eight human years of effort at a cost of $600,000. Squires, Opening the Channel for New AIDS Drugs, Wash. Post, Mar. 1, 1988, Health, at 6, col. 1.


19. Drugs such as AL 721 and aerosol pentamidine were widely used in local infected communities before government acceptance. Also, community physicians knew that reduced doses of certain drugs—like AZT—were the most effective in the case of AIDS. Years later, NAID and the FDA would agree. GOOD INTENTIONS, supra note 15, at 256; Goldsmith, AIDs Drug Development, Availability Intensify, 262 J. A.M.A. 452, 452 (1989) (Dr. Fauci announced a “parallel-track” system that would provide access to possibly useful drugs as soon as Phase I trials for safety end); Marx, supra note 11, at 916 (five years ago there were virtually no promising drugs; now the system is rapidly becoming overloaded).

made significant contributions to treatment and research. Indeed, the community-based programs have carried the battle. Thus, federal legislation that supports and fosters these endeavors merits review.

THE CARE LEGISLATION

The Ryan White Comprehensive AIDS Resources Emergency Act of 199021 (CARE) is unique because it directs AIDS relief to specific areas—urban areas to date—most affected by AIDS. Specifically, the purposes of the Act are to provide:

emergency assistance to localities that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease.22

While this is unique legislation, it is also absolutely essential to meet the rising costs associated with the counseling and treatment of persons with HIV.

Lifetime medical treatment costs of individuals with AIDS average $40,000 to $75,00023 and the lengthening postdiagnosis survival rate, combined with the inevitable loss of employment and health insurance, increase the probability that an AIDS victim may impoverish him or herself, thereby becoming a Medicaid recipient.24 Of course, many of the persons infected and needing treatment within inner-city areas never had private health insurance. Also, in the case of public insurance programs such as Medicaid,
there are complex categorical exclusions and enormous variations in the financial standards imposed by many of the states. For instance, a family of three in California could receive Medicaid in 1990 with a monthly income of up to $934, about 106% of poverty. “The same family could get Medicaid in Alabama in 1990 only if its income was $118 a month or less. The cutoff is just 13 percent of poverty.” Many states fail to adjust their financial standards adequately to reflect inflation, making real standards more restrictive over time. Actually, “the median state AFDC payment level, which determines family Medicaid eligibility limits in many states, dropped 30 percent in real or inflation-adjusted dollars between 1970 and 1988.” Thus, while the states are seeking to limit payments to Medicaid, there is a concomitant surge in needed care by poor, inner-city persons impacted specifically by the HIV epidemic. This leaves the poor on the disadvantaged side of a two-tiered system of care.

Beyond the billions of dollars spent on research to find a successful vaccine against HIV, the cost of counseling and treatment is the focus of the CARE legislation, especially as this cost is absorbed by specific localities. These localities reflect the dilemma of a recent editorial written by the Executive Vice President of the American Medical Association: “Clearly, the volume of uncompensated care that is provided has reached the breaking point and everyone must be assured access to needed care.” Medicaid reaches only a fraction of the low-income population, although, as disabled persons, persons with AIDS at least meet the minimum protected population. Yet, the large numbers of persons receiving care from medical facilities in urban areas on an uncompensated basis testifies to a system that is not

26. Id. (emphasis in original).
27. See Royers, Federal Spending on AIDS—How Much is Enough?, 320 NEW ENG. J. MED. 1623, 1623 (1989) (In the seven years from 1982 through 1988, federal spending for AIDS was $5.4 billion; in 1989, more than $2.1 billion will be spent.); Winkenwerder, Kessler & Stolec, Federal Spending for Illness Caused by the Human Immunodeficiency Virus, 320 NEW ENG. J. MED. 1598, 1599-1600 (1989). The National Institute of Allergy and Infectious Diseases [NIAID] received $297,000 in AIDS funding in 1982, $63 million in 1986, $146 million in 1987, and close to half a billion dollars in 1990. GOOD INTENTIONS, supra note 15, at 130.
28. Todd, Editorials: Problems With Incentives, 264 J. A.M.A. 1294, 1294 (1990). This editorial hints at the underlying social issue within AIDS treatment: If private insurance provides better and more comprehensive treatment for HIV than does Medicaid, does America have a two or more tiered system of health care? The American Medical Association is advancing a 16-point prioritization program called Health Access America which, if implemented, “would erase the economic incentives or at least make them so neutral that physicians could give needed care as determined by practice parameters, and patients could seek care secure in the knowledge that their treatment would not depend on economics.” Id.
providing adequate care and is about to reach a breaking point.\textsuperscript{29}

The plight of inner-city hospitals and patients, persons with AIDS, and anyone seeking care from a nearly bankrupt system is demonstrated in a September 1989 \textit{Washington Post} story: Juella, 35, a life-long resident of New Jersey, is someone who thinks that AIDS runs in her family.

Her 42 year-old husband died of the disease. So did her 27 year-old brother and her aunt. Several weeks ago, her terminally ill younger sister was released from New York's Bellevue Hospital after months of treatment for AIDS. . . . [Juella] apparently contracted the AIDS virus through sex with her husband. Several weeks ago, she developed a throat infection and now she is a patient on the same floor of the same hospital where her husband died on July 6. She spends most of her time thinking about how her death will affect their three healthy children, who range in age from 10 to 19.\textsuperscript{30}

Juella is part of a scandal of particularity. She is an Hispanic woman in a vector of the inner-city cordoned by syphilis, tuberculosis, measles, poverty, and drugs. She lives in Newark where more than 75\% of the 1,409 HIV cases are drug-related, and 90\% of the cases are among black and Hispanic persons;\textsuperscript{31} New Jersey has the largest number of AIDS cases among women and ranks second in the number of pediatric cases; one third of the population in Newark lives below the poverty line; the infant mortality rate is double the national average; the wait for drug treatment ranges from three to

\textsuperscript{29} Significant recommendations are now being made to address the problem of health care in the United States. See, e.g., American College of Physicians, \textit{ Financing the Care of Patients with Acquired Immunodeficiency Syndrome (AIDS)}, \textit{108 Annals Internal Med.} 460 (1988).


\textsuperscript{31} The impact of AIDS among minority women cannot be overstated. Both AIDS cases and neonatal seroprevalence rates reflect the catastrophic differential risk of AIDS among minority women. For instance, black women account for 54\% of all AIDS cases diagnosed among women, and Hispanic women account for an additional 16\% of the cases. Centers for Disease Control, \textit{AIDS and Immunodeficiency Virus Infection in the United States: 1988 Update}, \textit{38 Morbidity \\& Mortality Weekly Rep.} 18 (4 Supp. 1988). Within New York City alone, 2.17\% of black babies and 1.46\% of Hispanic babies were seropositive, but only 0.39\% of white newborns were found to have antibodies to HIV. Novick, Berns, Stricol, Stevens, Pass \\& Wethers, \textit{HIV Seroprevalence Among Newborns in New York State}, 261 J. A.M.A. 1745, 1748 (1989).
nine months; and the percentage of homeless people is three times that of New York City.  

**Title I: HIV Emergency Relief Grant Program**

Newark, New York City, Miami, Houston, Los Angeles, San Francisco: this list, continually expanding, is the reason for the CARE legislation. Title I of the Act provides an emergency relief grant program with HIV health care services for metropolitan areas where a cumulative total of more than 2,000 cases of AIDS have been reported to, and confirmed by, the Director of the Centers for Disease Control, or where the per capita incidence of cumulative cases is not less than 0.0025. The chief elected official of the city or urban county administers the grants in conjunction with an HIV Health Services Planning Council, which establishes priorities, develops a comprehensive plan for organization and delivery of health services, and “assesses the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within eligible areas.”

Grants under CARE are based on the number of cumulative cases and also on the per capita incidence of cumulative cases in an eligible area. Sup-

34. The HIV Health Services Planning Council “shall include representatives of—(A) health care providers; (B) community based and AIDS service organizations; (C) social service providers; (D) mental health care providers; (E) local public health agencies; (F) hospital planning agencies or health care planning agencies; (G) affected communities, including individuals with HIV disease; (H) non-elected community leaders; (I) State government;” (J) grantees that are public entities and nonprofit private entities; and “(K) the lead agency of any Health Resources and Services Administration adult and pediatric HIV-related care demonstration project operating in the area to be served.” 42 U.S.C. § 300ff-12 (1982), *as amended by* Pub. L. No. 101-381, 104 Stat. 576, 577-78 (1990) (adding § 2602(b) to Title XXVI of the Public Health Service Act).
plemental grants then may be made by the Secretary of Health and Human Services (Secretary) not later than 150 days after the initial awarding of grants to (i) provide emergency relief funds, (ii) address cases of severe need, (iii) support demonstrated commitment of local resources within an area, (iv) complement the ability of the area to utilize such supplemental financial resources in a manner that is immediately responsive and cost effective, and (v) recognize area commitments to infants, children, women, and families with HIV.36

Once the grant has been received, the funds will be used to provide direct financial assistance to "outpatient and ambulatory health and support services, including case management and comprehensive treatment services, for individuals and families with HIV" and "inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate."37 Priority is given to entities that are currently participating in Health Resources and Services Administration HIV health care demonstration projects, but the clear sense of the legislation is to support both public and private nonprofit entities in their efforts to facilitate discharge from hospitals, support housing opportunities and transitional care facilities, and relieve bottlenecks in the system of delivering care and treatment to individuals with HIV that are created by an absence (or shortage) of appropriately qualified health or support services personnel.

As long as a designated area hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, or homeless health center—to name a few of the possible grant recipients—facilitates discharge; limits expenditures for personnel needs,38 administration and planning, and construction; and is a qualified Medicaid provider,39 application for grants will be accepted. Obviously, area deficien-

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[T]he Secretary may not make a grant . . . for the provision of health services in a State unless, in the case of any such service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State, the political subdivision involved will provide the health service directly and has entered into a participation agreement with the State plan and are qualified to receive payments under such plan.
cies in services, lack of outpatient facilities, and resulting stress within inpatient facilities (not to mention the lack of any services in the area at all) will facilitate the application process.

In applying for a grant, an area recipient should show that the funds received will "supplement not supplant" state funds. That is, the legislation seeks to foster new programs to reduce strain within impacted areas. To ensure this, CARE requires the political subdivisions within the eligible area to maintain the level of expenditures by such political subdivisions for HIV-related services for individuals with HIV disease at a level that is equal to the level of expenditures by such political subdivisions for the one-year period preceding the first fiscal year for which a grant is received. CARE funds cannot be used to make payments at any time if payment can be made from any state compensation program, insurance policy, additional government health benefit program, or by an entity that provides health services on a prepaid basis. The emphasis is clearly upon supplementing or increasing services to impacted areas.

Recognizing the discrimination and poverty associated with HIV, CARE specifically requires the provision of HIV health care and support services without regard to the ability of the individual to pay for such services or to the current (or past) health condition of the individual to be served. Furthermore, services shall be provided in an accessible setting for low-income persons; an outreach program of education will be provided to these same low-income individuals with HIV to inform them of services.

Title II: HIV CARE Grants

Inasmuch as AIDS continues to devastate metropolitan areas, Title I entitlement under the CARE legislation serves an immediate identifiable need. Title II HIV CARE Grants "enable . . . States to improve the quality, avail-


41. 42 U.S.C. § 300ff-15 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 583 (1990) (adding § 2605(a)(1)(B) to Title XXVI of the Public Health Service Act). Obviously, the political subdivision may not use CARE grant funds to maintain this level of funding.

42. For guidelines in imposing charges for services, see 42 U.S.C. § 300ff-15 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 584 (1990) (adding § 2605(d) to Title XXVI of the Public Health Service Act). The Conference Report cautions, however, that any schedule of charges was not meant as a "system of bureaucratic mechanisms and means testing related requirements to be imposed on any individual or agency receiving services." H.R. Conf. Rep. No. 652, supra note 33, at 69, reprinted in 1990 U.S. Code Cong. & Admin. News 862, 906 ("A simple application that includes the annual gross salary of the individual should suffice as the baseline by which the caps on fees will be established.").
bility and organization of health care and support services for individuals and families with HIV disease in smaller cities and rural areas. The states must use the grants for similar purposes as those of the metropolitan areas, but there is an added goal of improving coordination of health and support services on a national level. For example, funds are set aside for projects of national significance, allowing for targeted demonstration projects to address the special needs of a variety of populations, including minorities, the homeless, and those in prison. States may also use funds to provide needed drugs, treatments, and assistance for those persons who are eligible to purchase private health insurance. Also, children and families affected by HIV are targeted for support and treatment throughout the course of the disease. Each feature of these grants to states is unique in its approach to


44. While a discussion of HIV within prisons is beyond the scope of this article, CARE does make funds available to “deliver HIV health care and support services to individuals with HIV disease who are incarcerated.” 42 U.S.C. § 300ff-28 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 595 (1990) (adding § 2618(a)(2)(H) to Title XXVI of the Public Health Act). The delicate issue of mandatory testing for HIV within prisons is addressed in 42 U.S.C. § 300ff-67 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 614-15 (1990) (adding § 2667 to Title XXVI of the Public Health Service Act), which does provide for mandatory testing under certain conditions as a prerequisite to the receipt of funding.

45. 42 U.S.C. § 300ff-22 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 586 (1990) (adding § 2612(b) to Title XXVI of the Public Health Service Act) (“Infants and Women, Etc.—A state shall use not less than 15 percent of funds allocated under [the CARE grant program] to provide health and support services to infants, children, women, and families with HIV disease.”). Note that in defining family-centered care, the Act bases its definition on a partnership among parents, professionals, and the community designed to ensure an integrated, coordinated, culturally sensitive, and community-based continuum of care for children, women, and families with HIV disease. 42 U.S.C. § 300ff-23 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 586 (1990) (adding § 2613(d) to Title XXVI of the Public Health Service Act). The definition of family is a sensitive issue and one not completely resolved within the present confines of the Act.

46. These proposals were part of a comprehensive package proposed by Senator Kennedy, the sponsor of the CARE legislation in 1989. The package included the following recommendations:

1. Expand anti-discrimination safeguards for HIV-infected individuals as part of the Americans With Disabilities Act (ADA);
2. Authorize a 3-year Low Income Treatment Assistance Program (LITAP) for FDA approved life-prolonging AIDS drugs;
3. Expand and accelerate access to the most promising experimental AIDS drugs for patients with acute disease;
4. Enable community-based physicians and organizations to fully and actively participate in AIDS drug clinical trials;
5. Obtain full funding for the AIDS Health Care Services Provisions of the H.O.P.E. law;
6. Create community AIDS care consortia to deliver the full range of services to individuals and families affected by the disease;
treatment availability.

HIV care consortia have long been identified with gay and lesbian clinics—that is, health care and support organizations, usually funded in large measure by private donations or fundraising activities, and providing services that may include case management, medical, nursing, dental and hygiene care; diagnostics, monitoring and medical follow-up; mental health care and rehabilitation services; and home health and hospice care. The CARE legislation offers funding for these same services; and essential support services such as transportation, homemaker services, day or respite care; benefits advocacy, advocacy services provided through public and non-profit private entities; and services that are incidental to the provision of health care services for individuals with HIV disease—including nutrition services, housing referral services, child welfare and family services, and foster care and adoption. All of the consortia services recognized by the HIV CARE Grants to the states, territories, and the District of Columbia have been performed during the decade of the eighties by various gay and lesbian clinics in major cities. Nonetheless, the legislation, which addresses these responsibilities through funded government grants, will have a significant impact for black and Hispanic communities, which are not generally as politically organized or

(7) Create transitional and supported-housing for homeless people with AIDS;
(8) Provide assistance to low-income individuals to enable them to pay for health insurance premiums under COBRA;
(9) Institute case management and referral services for IV-drug users wait-listed for drug treatment programs;
(10) Target emergency federal financial aid to localities and institutions hardest hit by the epidemic.


47. For a summary of how these services have assisted families, see generally O'Brien, AIDS: Perspective on the American Family, 34 VILL. L. REV. 209 (1989). For inclusion of these activities in the CARE legislation, see 42 U.S.C. § 300ff-23 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 587 (1990) (adding § 2613(a)(1)(A) to Title XXVI of the Public Health Service Act).

48. The use of the term "legal services" was deleted from earlier versions of the legislation, but the Act clearly implies that legal advocacy is within the parameters of the present legislative definition of advocacy. See H.R. Conf. Rep. No. 652, supra note 33, at 70, reprinted in 1990 U.S. CODE CONG. & ADMIN. NEWS 862, 907. Sensitivity concerning the issue of legal representation provided at government expense may be a reason for the deletion of the express reference. See generally Dickens, Legal Rights and Duties in the AIDS Epidemic, 239 SCI. 580 (1988); Eisenberg, The Genesis of Fear: AIDS and the Public's Response to Science, 14 LAW MED. & HEALTH CARE 243 (1986); Osborn, AIDS: Politics and Science, 318 NEW ENG. J. MED. 444 (1988).

49. For a history, see KRAMER, supra note 11 (critical account of the Government's lack of response to the disease and the gay and lesbian community's efforts to provide assistance); SHILTS, supra note 2 (a comprehensive coverage of the disease throughout the eighties).
wealthy as the homosexual community. If the rate of infection among white homosexual men continues to decline, private sources of funding and, thus, the numbers and services provided by these clinics, may decrease. CARE grants will offer additional funding sources. Also, in areas where there were no clinics, the models provided by the gay and lesbian centers will assist in establishing consortia. The Conference Report recognizes the contribution of existing clinics where, "particularly in high incidence urban areas, considerable planning has taken place and what is desperately needed are the resources to implement essential programs." Because the HIV consortia may provide treatments "that have been determined to prolong life or prevent the serious deterioration of health," the Secretary's determination of what treatments are included within the program is essential. For instance, the AIDS/HIV TREATMENT DIRECTORY lists over 200 treatments, some of which are being considered in clinical tri-

50. The proportion of all AIDS cases attributed to male homosexual and bisexual contact has dropped from 64.9% in 1981 to 55.3% in 1989. Nonetheless, decreasing proportions do not indicate that there is a decrease in the number of cases; it only recognizes that there is a large increase in the number of cases attributed to heterosexual contact among IV-drug abusers. THE SECOND DECADE, supra note 8, at 45; see also Centers for Disease Control, Update: Acquired Immunodeficiency Syndrome—United States 1981-1988, 38 MORBIDITY & MORTALITY WEEKLY REP. 230 (1989) (Even with the changing surveillance definition, the proportion of men solely with histories of homosexual/bisexual activity diagnosed with AIDS is decreasing.); Centers for Disease Control, AIDS and the Human Immunodeficiency Virus Infection in the United States: 1988 Update, 38 MORBIDITY & MORTALITY WEEKLY REP. 1, 12 (4 Supp. 1989); Altman, Who's Stricken and How: AIDS Pattern is Shifting, N.Y. Times, Feb. 5, 1989, at 1, col. 1.


53. AMERICAN FOUNDATION FOR AIDS RESEARCH, 4 AIDS/HIV TREATMENT DIRECTORY (Sept. 1990). This presents the most up-to-date information on experimental treatments, released in book form to subscribers every ninety days. It is also available through an on-line computer network. See also Cotton, Wider Access Provided to AIDS Drugs With Actions Against HIV, CMV Infections, 264 J. A.M.A. 1926 (1990).
als.\textsuperscript{54} Funding of treatment programs to those likely to lack private insurance (and thus the benefits of medical technology)\textsuperscript{55} addresses the ethical issue raised by the two-tiered system of medical care—one for those on Medicaid and one for those on private insurance. This funding also seeks to address the ethical lapse by which women, racial minorities, and children were almost always omitted from past clinical trials. Because the CARE legislation seeks to include these groups through affirmative action,\textsuperscript{56} past discrimination is addressed. Nonetheless, at least one important ethical dilemma remains: providing treatment to prolong life with knowledge that the person enjoying that added health and vitality continues to infect others with HIV. Perhaps this dilemma is addressed in Title III of the legislation, Early Intervention Services.

Because the HIV CARE grants are designed to create a national program, the federal legislation requires a state match according to a progressive formula that increases the state contribution for five consecutive years. The state may obtain the match through public or private funds, or in kind, to include physical plant, equipment, or services.\textsuperscript{57} Disregarding the issue of

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\textsuperscript{54} The National Institute of Allergy and Infectious Diseases (NIAID) publishes an educational pamphlet designed for those considering participation in a clinical trial: AIDS CLINICAL TRIALS: TALKING IT OVER (NIH Publication No. 89-3025) (available at NIAID, Office of Communications, National Institutes of Health, Building 31-A, Room 7A32, Bethesda, Maryland 20892 (1-800-TRIALS)).
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\textsuperscript{55} To be eligible for treatment under the program, an individual must be diagnosed with HIV and be a low-income individual, as defined by the state. 42 U.S.C. § 300ff-26 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 590 (1990) (adding § 2616(b)(1) & (2) to Title XXVI of the Public Health Service Act).
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\textsuperscript{56} Consistent throughout the legislation are directions for the Secretary to give preference to increasing numbers of cases with AIDS or HIV, or to allocate a minimum percentage of funds to services for infants, children, and women. 42 U.S.C. § 300ff-22 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 586 (1990) (adding § 2612(a)(4) to Title XXVI of the Public Health Service Act). For evidence of the importance of this, see Centers for Disease Control, Reports on Selected Racial/Ethnic Groups. Special Focus: Maternal and Child Health, 39 MORTALITY & MORBIDITY WEEKLY REP. 23 (3 Supp. 1990) (emphasizing the severe impact HIV is having on minority children).
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In requiring a state match, it is the intent of the managers to build a partnership between the federal government and the states in the delivery of essential health care and support services to individuals and families with HIV disease. However, in recognition of the efforts made by the states in the battle against AIDS, the managers expected that each state will apply all non-Federal HIV-related expenditures within a state toward its match requirement. This would include but not be limited to HIV related: health care and support services, prevention and education, testing and counseling, diagnostics and therapeutics, research, and all related administrative costs. H.R. CONF. REP. NO. 652, supra note 33, at 76-77, reprinted in 1990 U.S. CODE CONG. & ADMIN. NEWS 862, 913-14.
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the desirability of the match, the terms established by the federal legislation are generous.

Inasmuch as the grants to the states provide an incentive to develop consortia programs, such as those already established in large urban areas to assist the gay and lesbian population, the CARE legislation provides a unique and needed source of funds. The shifting of the disease into non-homosexual populations, most of whom lack medical insurance and an established program of care, demands new initiatives; the funds will provide support for those states and territories perspicacious enough to use them.

**Title III: Early Intervention Services**

In 1990 the Committee on AIDS Research and the Behavioral, Social, and Statistical Sciences published a report in which it made a series of recommendations to the Public Health Service. Among those recommendations was one which stated that AIDS prevention programs "must identify, contact, and help at-risk individuals to assess their level of risk and access appropriate services." Two objectives would be served by such a program of early intervention: First, there is scientific evidence that early detection and treatment of HIV prolongs life and enhances the quality of life; second, the earlier a person is aware of infection, the sooner he or she will have increased motivation to modify behavior that would endanger others. Nonetheless, these two benefits must be realized in a context defined by job, housing, and supportive-relationship discrimination resulting from a breach in the confidentiality of a positive test result. There are also higher rates of suicide associated with an uncounseled positive test result.

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59. THE SECOND DECADE, supra note 8, at 9.

60. See, e.g., Collier, supra note 10, at 1015 ("Zidovudine prolongs survival in persons with advanced human immunodeficiency virus [HIV] disease and delays the progression of HIV infection"); Fischl, supra note 10, at 1010 (same); Mitsuya, Yarchoan & Broder, Molecular Targets for AIDS Therapy, 249 Sci. 1533 (1990) (discussing development of antiretroviral therapy).


62. Suicide rates are higher in persons with chronic and life-threatening diseases than in the general population. The rate for men aged 20-59 with AIDS was 36 times as high as those without AIDS and 66 times that of the general population. The rate of suicide is higher in New York City. See Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu & Mann, Increased Risk
While decreasing the risk of breach of confidentiality and lack of counseling, Title III of the CARE legislation is an effort to address the two positive goals of early testing by creating two types of grants: An allotment program for grants to the states, and a program for categorical grants to public and non-profit private groups. All of the grants seek to bring about the desired goals, and they all must include pretest and post-test counseling. Testing procedures must provide for confirmation of initial positive results, as well as tests needed both to diagnose the extent of immune deficiency and to provide information on appropriate preventive and therapeutic measures.

To foster the goal of providing early intervention, the state or public or non-profit private entity receiving the grant must itself provide all preventative services or agree to provide these services through other entities. Therefore, grants will not be given to provide massive testing facilities to states or other entities so that information may be gathered on segments of the population. Rather, once the grant sanctions testing, the grant must also be used for appropriate outreach activities, case management in the provision of coordinated health care services, and assistance in obtaining other health, mental, and social support services. It is likely that the entity receiving the grant will already be offering preventive services. For instance, eligible grantees mentioned for the categorical grants include sexually transmitted disease clinics, tuberculosis clinics, community and migrant health centers, homeless health care programs, family planning clinics, drug abuse clinics, and comprehensive hemophilia diagnostic and treatment centers.


64. 42 U.S.C. § 300ff-52 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 607 (1990) (adding § 2652(a) to Title XXVI of the Public Health Service Act). For a more com-
Significantly, the entities deemed eligible for categorical grants serve lower economic groups: These persons would not only be likely victims of discrimination associated with breaches of confidentiality; these persons would also benefit the most from awareness of seroconversion and from the government-subsidized treatment programs available to delay opportunistic infections.

In addition, the CARE legislation’s acknowledgment of the association of poverty, sexually transmitted diseases, and tuberculosis\(^{65}\) with HIV is a significant development and should not be ignored.\(^{66}\) The “marked increase among inner-city, heterosexual minority groups suggests that high-risk sexual activity is increasing in these groups despite the risk of HIV infection, which is already elevated because of the high prevalence of intravenous drug abuse.”\(^{67}\) This association warrants further investigation and study. For a comprehensive list of entities, see H.R. CONF. REP. NO. 652, supra note 33, at 79, reprinted in 1990 U.S. CODE CONG. & ADMIN. NEWS 862, 916.

65. See Centers for Disease Control, Update: Tuberculosis Elimination—United States, 39 MORBIDITY \& MORTALITY WEEKLY REP. 153, 153 (1990) (“In all age groups, reported cases increased among non-Hispanic blacks and Hispanics but decreased among non-Hispanic whites.”); Centers for Disease Control, Screening for Tuberculosis and Tuberculosis Infection in High-Risk Populations and The Use of Preventive Therapy for Tuberculosis Infection in the United States, 39 MORBIDITY \& MORTALITY WEEKLY REP. 1, 2 (1990) (persons at high-risk are generally those associated with poverty groups); Centers for Disease Control, Outbreak of Multidrug-Resistant Tuberculosis—Texas, California, and Pennsylvania, 39 MORBIDITY \& MORTALITY WEEKLY REP. 369 (1990). A prominent feature of this outbreak is its public health and economic burden; the cost of hospitalization for ten patients infected was $950,433. Id. at 370.


67. Centers for Disease Control, Continuing Increase in Infectious Syphilis—United States, 37 MORBIDITY \& MORTALITY WEEKLY REP. 35, 38 (1988). While the cases do not indicate if the infected person is a minor or an adult, for purposes of targeting education, it is important to note that “[r]ates of sexual experience (e.g., percentage having had intercourse) are higher for black teenagers than for white teenagers at every age and for both sexes.” Centers for Disease Control, Guidelines for Effective School Health Education to Prevent the Spread of AIDS, 37 MORBIDITY \& MORTALITY WEEKLY REP. 1, 11 (Jan. Supp. 1988). “Approximately 2.5 million teenagers are affected with a sexually transmitted disease each year.” Id.; see also Centers for Disease Control, HIV-Related Knowledge and Behaviors Among High School Students—Selected U.S. Sites, 1989, 39 MORBIDITY \& MORTALITY WEEKLY REP. 385 (1990). Among adults, “Black and Hispanic women with AIDS were more likely than white women to have had histories of IV-drug use or histories of sex with IVDUs.” Centers for Disease Control, Update, Acquired Immunodeficiency Syndrome—United States, 1981-1988, 38 MORBIDITY \& MORTALITY WEEKLY REP. 229, 232 (1989). But see Centers for Disease
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thermore, recent outbreaks of measles suggest that this malady be added to the others currently associated with HIV.\(^6\)

Tuberculosis, measles, sexually transmitted diseases, and, of course, factors surrounding HIV, can be explained, and treatment can be sought for outpatients.\(^6\) The CARE provisions also make these services available to “certain public and nonprofit private hospitals for the purpose of offering, encouraging the use of, and providing preventive health services to inpatients.”\(^7\) Hospitals eligible to receive support are those that have, in the previous year for which data is available, admitted 250 persons with AIDS or, alternatively, a number equal to at least twenty percent of its patients. This inpatient service may encourage a debate: Whether there should be special hospitals established only for patients with HIV infection.\(^7\) One article rejects the idea and concludes it would be better to integrate the treatment of persons with HIV into the mainstream of health care facilities.\(^7\) This mainstream would include outpatient and inpatient counseling and testing services under Title II.

With regard to the goal of providing confidentiality of persons tested, the legislation, like the practices of the medical and the legal communities, "defends the policy of keeping the identity of HIV carriers confidential, except in circumstances where public health or the health of third parties could

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\(^7\) During 1987, 47.5% of the patients had been vaccinated on or after the first birthday; 47.9% were unvaccinated. Id. at 528. Because persons vaccinated at 12-14 months of age have been demonstrated to be at slightly higher risk for measles than persons vaccinated at 15 months of age or more, the Immunization Practices Advisory Committee recommends that persons previously vaccinated at 12-14 months of age be revaccinated. Id. at 528-31. The Centers for Disease Control recommends vaccinating children who are HIV infected. See Centers for Disease Control, Immunization of Children Infected with Human Immunodeficiency Virus—Supplementary ACIP Statement, 37 Morbidity & Mortality Weekly Rep. 181, 181 (1988).


\(^7\) Rothman & Tynan, Special Report: Advantages and Disadvantages of Special Hospitals for Patients With HIV Infection, 323 NEW ENG. J. MED. 764 (1990).

\(^7\) Id. at 768.
unwittingly be damaged by transmission of the virus.\textsuperscript{73} Thus, the legislation requires notification of certain individuals receiving blood transfusions between January 1, 1978, and April 1, 1985, so that they may receive intervention services.\textsuperscript{74} This is not to say that persons receiving transfusions during that time are HIV infected, but the legislation recognizes that effective testing procedures were not in place until March 1985.

The legislation also provides for partner notification as a limited breach of confidentiality. In order to obtain a grant, the state must assure that the public health officer will, "to the extent appropriate in the determination of the officer, carry out a program of partner notification regarding cases of HIV disease."\textsuperscript{75} Because the provision permits the state to monitor this activity, there is some leeway in enforcement and, at least in South Carolina, partner notification has met with acceptance in a small sampling of persons.\textsuperscript{76}

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\item 74. For an excellent summary of the concern over the nation's blood supply, see \textit{THE SECOND DECADE, supra} note 8, at 289-358. The authors recommend that the "Public Health Service sponsor research to monitor trends in transfusion practices nationally to permit evaluation of the appropriateness of blood and blood component utilization and to identify targets for change." \textit{Id.} at 27.
\item 76. See Jones, Wykoff, Hollis, Longshore, Gamble & Gunn, \textit{Partner Acceptance of Health Department Notification of HIV Exposure, South Carolina}, 264 J. A.M.A. 1284, 1284 (1990). Of the 202 partners notified, 132 (65\%) were located and completed the survey satisfactorily. Only 12 (9\%) thought they may have been exposed to HIV before the Health Department's notification. When the 132 partners were asked if they thought the health department did the right thing in notifying them, 87\% said yes; when asked if the health department should continue to notify people, 92\% said yes. \textit{Id.}
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Public policy is quite adamant in its condemnation of intentional transmission of HIV. Intentional transmission could occur through the donation of blood, semen, or breast milk and could thus involve sexual activity or injection with a hypodermic needle. Knowledge on the part of the donor is an essential ingredient. While a person who intentionally infects another with HIV may be liable for damages in a civil context, he or she may also be liable in a criminal context. This is the intent of the CARE legislation and it follows a public policy impetus that began in the states.

In a Florida case, a prostitute was charged with attempted manslaughter because she had engaged in sexual intercourse without telling her client that she was seropositive. The court affirmed dismissal of the charge, but noted that it would have entertained a charge of attempted second-degree murder had it been offered. In 1988 South Carolina enacted one of the first AIDS-specific criminal statutes which makes the knowing transmission of the HIV virus, without first informing the person to whom it might be spread, a felony punishable by a $5,000 fine or ten years in jail.

Thus, in addition to breaching confidentiality with notification in blood transfusions and with partner notification, the CARE legislation requires states to enforce admission of HIV-positive status by knowledgeable persons within certain situations. At present, all of these disclosures are within the jurisprudence of the AIDS epidemic. Furthermore, the legislation relies upon the good intentions of the state and the state's desire to meet the needs of a burgeoning group of men, women, and children with AIDS.

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77. 42 U.S.C. 300ff-47 (1982), as amended by Pub. L. No. 101-381, 104 Stat. 576, 603 (1990) (adding § 2647(a) & (b) to Title XXVI of the Public Health Service Act) (criminal sanction encompassed by the section need not apply if the "individual who is subjected to the behavior involved knows that the other individual is infected and provides prior informed consent to the activity"). The legislation's criminal sanction also would be inapplicable to transmission from mother to child, thus avoiding concern over child abuse in gestation or during breast feeding. H.R. CONF. REP. NO. 652, supra note 33, at 83, reprinted in 1990 U.S. CODE CONG. & ADMIN. NEWS 862, 920.


CONCLUSION

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 is an innovative and resourceful response to the shift in the HIV epidemic during the 1980's. Promised by Senator Edward Kennedy in a 1989 speech at the Whitman-Walker AIDS Clinic in Washington, D.C., the Act is a federal incentive to states and private non-profit and public agencies to continue developing approaches to testing, counseling, treatment, and human services. Undoubtedly, the model and the impetus for these incentives derive in part from the urban clinics established to support the gay and lesbian population throughout the 1980's. But the true inspiration of CARE is that it recognizes the epidemic's shift from the somewhat affluent white male person with AIDS, to men, women, and children of color—living in a two-tiered system of medical care fabricated through "Medicaidization"—unable to afford treatments proven to prolong life.

Certain specifics of the response are significant. First, the legislation accepts the current thinking that the disease must be addressed through education and treatment. Through early intervention in the form of testing and counseling, persons will know of the disease's presence, modify behavior, and begin immediate programs of treatment. Furthermore, since the Act directs these testing and counseling efforts toward poorer communities and populations, the population most affected by the shift in the pattern of HIV will benefit the most. Because the testing and counseling is accomplished within constitutional parameters, the states have an incentive to continue to safeguard the privacy of its citizens while offering essential services.

The Act also recognizes that the disease is shifting to more rural areas of the country where existing clinics do not provide services and, perhaps, the level of expertise available in harder hit cities. In that Title II is directed towards such areas, CARE provides needed impetus to establish programs.

Yet, some ambiguity persists in CARE. For instance, the definition of "treatment" will continue to haunt this legislation as it has the halls of NIH and the National Institute of Allergy and Infectious Diseases (NIAID). The process of the Food and Drug Administration and the agendas of medical research and congressional appropriations will continue to separate the dying from those with private insurance, or alternate means of "treatment." The Secretary of Health and Human Services must work purposefully to recognize this shortcoming in the legislation. Also, definitions of "family," "partnership," and "charges for treatment" will continue to underscore the

debate over these issues within the legal and social community. The presently weak national economy will only exacerbate this debate. The condition of the American economy will affect the funding of this legislation. This is a problem. Indeed, a recent editorial in *The Washington Post* acknowledged that, last year, Congress authorized emergency relief to the cities hardest hit by the epidemic with $875 million in grants. So far only $221 million has been appropriated. But the American recession will also spark state and public and private initiatives designed to obtain grants. This federal-state partnership is a major objective of the legislation. Since the federal government offers generous proposals in its state matching requirement, the burden of initiating these programs may well be manageable and especially needed.

Finally, CARE is not a cure or a vaccine. The objective is to continue to work for a cure and there are glimmers of hope on the horizon. Also, the Act does not overcome the documented evidence which supports the conclusion that delay and ignorance have caused thousands to suffer and die. The apocalyptic question of Larry Kramer remains: “All you ‘doctors’ have continuously told the world that All Is Being Done That Can Be Done. Now you admit that isn’t so. WHY DID YOU KEEP QUIET FOR SO LONG!” This legislation, assuming it is funded and assuming it is used properly, cannot answer this question, especially as it reflects on the minority population of gay men and women. But since CARE, during this second decade of the epidemic, is directed towards the second group of minorities most affected, poorer persons of color, it does say something. It says something good.

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85. See Supplee, *Scientists Map Protein Used by AIDS Virus to Take Over Cells*, Wash. Post, Nov. 29, 1990, at A3, col. 1. “[S]cientists have made the first precise three-dimensional map of a tiny strand of protein that the AIDS virus uses as its entry point to attack the body’s immune system.” This development is hopeful because it may provide a way of tricking HIV into binding with synthetic molecules and thus saving the immune system. *Id.*

86. See, e.g., *PRESIDENTIAL COMMISSION*, supra note 1, at XVIII.

87. *KRAMER*, supra note 11, at 197.