Advocate's Handbook

A resource for grassroots action on HIV/ AIDS policy

the National Association of People with AIDS

The Advocate's Handbook is dedicated to the thousands of men and women from all walks of life who have, through their collective energy, intellect, wisdom, outrage, and passion, worked so diligently to improve the lives of people living with HIV and AIDS. The National Association of People with AIDS honors and salutes you.

The National Association of People with AIDS advocates on behalf of all people living with HIV and AIDS in order to end the pandemic and the human suffering caused by HIV/AIDS.

Table of Contents

Introduction
- What is Advocacy..... 4
- Why is Advocacy Important..... 4
- What Can One Person Do..... 5

Part 1: Core Skills
- The Structure of Congress..... 6
- Who Represents Me in Congress..... 7
- How a Bill Becomes Law..... 8
- More About the Committee System..... 10
- The Federal Budget Process..... 12
- Federal Agency Alphabet Soup..... 14
- My State Legislature..... 16
- Who Represents Me in Local Government..... 21
- Glossary of Terms..... 22

Part 2: Action Skills
- Letters and Faxes..... 26
- Phone Calls..... 28
- Personal Visits..... 30
- Public Meetings..... 32
- Public Testimony..... 33
- Bill Analysis..... 36
- Emails, Postcards, and Petitions (Oh my!)..... 38
- Stalemate-Breaking Actions..... 39

Part 3: Organizing Skills
- Conducting Issues Planning..... 40
- Partnerships and Consensus Building..... 42
- Coalition Building..... 43
- Demonstrations and Rallies..... 44

Part 4: Issues Background
- Why Fund HIV/AIDS Programs
- Federal Funding Chart for FY 2002
- HIV Prevention Saves Lives and Dollars
- Ryan White CARE Act: Key to America's Response to AIDS
- The Importance of NIH AIDS Research
- People with AIDS Need Housing
- SAMHSA: HIV & Substance Abuse Prevention and Treatment
- AIDS is a Global Crisis

Introduction

What is Advocacy?

Simply put, advocacy is a conscious action intended to achieve a specific outcome.

Although we often think of advocacy as something learned, the truth is that human beings are natural advocates. We are able to advocate for our own wants and needs from a very early age. A baby cries when it wants to be fed or changed; a toddler begs for ice cream on a hot day; a teen pleads with varying degrees of logic and emotion for a car of her own. At its root, advocacy can be this simple.

ad·vo·ca·cy (Ad"vo*ca*cy) *n.*

The act of pleading or arguing in favor of something, such as a cause, idea, or policy; active support.

But in a larger sense, advocacy is complex. Just as we learned from our early life experiences what works (to get that diaper change, that ice cream, that car), we have also learned what doesn't work -- cry all the time and people stop listening, ask for too much too often and you end up ignored, and all the logic in the world won't add dollars to an empty bank account. We learn that we must put thought into our actions, that we must combine them with knowledge if we are to be successful.

It is this balance of simplicity and complexity that makes advocacy feel like a strange and artificial practice, rather than the natural gift we all began with.

This handbook focuses on a very specific type of advocacy -- policy advocacy, with the intention of using our rights as Americans to improve how government responds to the HIV pandemic. Yes, it is complex, but it is also simple, as you will see.

Think about that ice cream...

Why is Advocacy Important?

"Nothing comes of nothing", goes an old proverb. This could well be said of anything that has to do with policy and the role of government in serving its people. Imagine that you live on a street that has a large pothole. Each time you leave or enter your driveway, your car bounces over the pothole. Every time a neighbor drives by, their car bounces over the pothole. What do you think the chances are of the city coming out to fix the pothole if no one thinks to ask the city to come do it? Probably, not very good. If only one person calls? Chances are still pretty slim. How about if five people call? Chances get better. How about if the whole block organizes and sends letters to the city. Your chances improve a whole lot. But suppose that all the neighbors on the block hold a "Pothole Vigil" -- gather around the pothole, invite the local media, and show all the repair bills they've gotten for the tires, shocks, and wheel alignments their cars have needed because of the pothole?

The next sight you see will be city maintenance workers shoveling asphalt into the offending pothole.

This is why advocacy is important: Because without it, nothing gets done. Or, if it does, it takes much longer than real people can wait for solutions.

HIV and AIDS, and the government funded programs that address them, are much more complicated than potholes; and people really can't afford to wait on important decisions that affect how services are funded or delivered.

AIDS advocacy is important because without it people suffer.

What Can One Person Do?

Even the most important and awe-inspiring movements began with a small, quiet idea that one person had. That idea was shared, gained voice and support, and became greater than its own beginnings. There is no reason why a profound movement of advocacy should not start with you.

In a democratic system of government, like the one we have, a great deal of power rests in the individual -- or, more precisely, the **constituent.** If you have not recently exercised your power as a constituent, you may be surprised at how much you have.

Your Members of Congress (like other elected legislators) make decisions on a daily basis that impact, for better or worse, almost every aspect of your life -- from what kind of medical care your health insurer must give you and when, which prescription drugs you can access through public programs, how much rent subsidy you qualify for, whether or not a community organization can use treatment funding to pay for transportation for clients to and from visits, and a lot more.

If your Members aren't hearing from you, then what are they basing their decisions on? Studies. Reports. Community leaders. Media. Provider associations. Other Members of Congress, and other interest groups.

Congress would very much like to hear directly from you.

This may be hard to believe, but it is true.

5 Great Reasons to Advocate

1. Get government to provide more resources
2. Target specific resources where they are needed most
3. Support beneficial legislation
4. Oppose harmful legislation
5. Shape regulations and administrative actions

Your Members of Congress understand, even if you don't (yet) how important your are in policymaking. There are several specific conversations that your Members of Congress want to have with you:

➡ **What is happening in the district.** Federal lawmakers have access to an extraordinary amount of information, but much of it is combined national data. Oftentimes, constituents know more and can present information directly from the district, a welcome and essential component of decision-making.

➡ **How Federal money is being spent in the district.** Members are interested in how national programs actually benefit their constituents, especially if it can be demonstrated that the money is wisely managed. They feel more comfortable fighting for funding for a program that they know really helps their constituents.

➡ **What specific legislative action would make you happy.** Legislators never like to say "no" to constituents, especially those who are working hard to improve life in the home district — and who are also in a position to influence how other voters perceive lawmakers based on their voting patterns. Your clear request is a meaningful indicator of public sentiment and considered valuable insight by lawmakers.

And the most important thing of all

➡ **Real-life stories of constituents.** Washington is a town run by statistics, but these numbers are meaningless unless they can be understood in a real-life context. Your personal stories help legislators understand your issues and help make your position accessible and compelling. Stories are also easily used in floor speeches and media interviews given by Members.

Part 1: Core Skills

The Structure of Congress

There are two **chambers** in Congress: the **House of Representatives** and the **Senate**. In the House there are 435 **Representatives** from the fifty states and District of Columbia (DC), and one delegate each from the American Territories representing the Virgin Islands, America Samoa, Guam, and Puerto Rico. In the Senate there are 100 ***Senators***, two from each state. Representatives are elected every two years, while Senators serve six year terms.

A new Congress is convened every two years, with each year serving as a single ***session***. For example, in January 2001, the 107th Congress convened opening the first of two one-year sessions.

Leadership

The House of Representatives is led by the **Speaker of the House**. The Speaker is the leader of the party holding the majority of the seats in the House. As of January 1, 1997, Republicans currently hold the majority of the seats in the House. The Senate came under control of the Democrats in mid-2001.

The Speaker controls the activities of the House with assistance from the committee **chairs** and the other two leaders of the party, the **Majority Leader** and the **Majority Whip**. These two leaders work with the Speaker to bring **legislation** up for consideration and develop consensus on major issues facing Congress.

The House minority party also has similar leadership positions: a **Minority Leader** and a **Minority Whip**. These individuals work to form consensus within their party and advance the minority party agenda.

The Senate does not have a position similar to the Speaker of the House. The **President of the Senate** is the Vice President of the United States. This position is largely ceremonial and the Vice President votes only to break a tie.

The Senate **floor** is controlled by the **Senate Majority Leader**. This individual schedules legislation for consideration by the Senate and attempts to form consensus within his/her party. The majority party has significant power in determining which issues and measures Senators will actually get to debate and under what rules. There are Majority and Minority Leaders, as well as Majority and Minority Whips.

The **Whips** organize support for party strategy and assist in floor activities.

Who Are the Leaders of Congress?

It is important to know who the leadership is, since you may need to contact them about issues you care about.

Leadership changes whenever the majority party changes. That is, whenever there is a change in the number of members of any political party in the House or Senate that makes it larger than another one. This can happen because of an election, because a member leaves Congress or changes party affiliations. The party with the most members in a chamber wins control of that chamber.

As of this writing, the following Members make up the House and Senate leadership:

HOUSE

Dennis Hastert (R), Speaker of the House
Dick Armey (R), House Majority Leader
Tom Delay (R), House Majority Whip
Dick Gephardt (D), House Minority Leader
David Bonior (D), House Minority Whip

SENATE

Thomas Daschle (D), Senate Majority Leader
Harry Reid (D), Senate Majority Whip
Trent Lott (R), Senate Minority Leader
Don Nickles (R), Senate Minority Whip

Who Represents Me in Congress?

Knowing who represents you in Congress and how to contact your representatives is a powerful tool for any advocate. Complete this page and keep it handy, so that you can take action quickly when you need to communicate with Congress.

You can find contact information for your Members of Congress by looking in the **Blue Pages** (Government Section) of your local telephone directory, or by calling your County Registrar of Voters. You can also find out on the Internet by typing your home address in a form at http://www.house.gov/writerep/

U.S. House of Representatives

Member's Name:

_____

Congressional District No: _____

Party: _____

Washington Phone: _____

Washington FAX: _____

Bldg/Room No.: _____

Washington, DC 20515

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

U.S. Senate ACTION PAGE!

(1) Senator's Name:

_____

Party: _____

Washington Phone: _____

Washington FAX: _____

Room/Bldg No.: _____

Washington, DC 20510

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

(2) Senator's Name:

_____

Party: _____

Washington Phone: _____

Washington FAX: _____

Room/Bldg No.: _____

Washington, DC 20510

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

Part 1: Core Skills

How A Bill Becomes Law

Introducing Legislation

Legislation originates in different ways. **Members** of Congress and their staff may become alerted to a problem that federal legislation can resolve. Groups with specific concerns work with Members to introduce legislation. More than 8,000 **bills** are introduced in a Congress and generally less than 1,000 become law. The vast majority of bills are nonsubstantive.

The Senator or Representative who introduces legislation is known as the **sponsor**. Sponsors seek other Members to cosponsor their legislation in order to show broad support for the legislation, a crucial first step in advancing a bill through the legislative process.

Example

The Ryan White CARE Act of 1990 was introduced (sponsored) by

Senators Orrin Hatch (R-UT) and Senator Edward M. Kennedy (D-MA).

This would be termed a **"bi-partisan"** sponsored bill, because co-sponsors are from different political parties.

Working Through the Committees

Once introduced, a bill is referred to the committee with relevant **jurisdiction**, those that have the responsibility for issues and policy areas related to the bill. The bill can be referred to several committees that have jurisdiction over the areas the bill affects.

Generally, the full committee refers the bill to the relevant **subcommittee**. The subcommittee chair consults with the bill's sponsor to assess support for the legislation. In many instances, the bill never passes out of its first subcommittee due to lack of support. In some instances, a bill, or portions of it, may be incorporated into other legislation that stands a better chance of passage. Pieces of bill's added to other legislation are called a **"rider".**

Hearings are frequently held on bills to allow individuals and organizations to **testify** on the merits of a bill before the subcommittee. Hearings are used to educate Members of Congress on the importance of the issue. In general, hearings are at the discretion of the committees and are not mandatory. Testimony generally supports the need for legislation, but opponents of the bill can also testify. The sponsor of the legislation may testify in support of his/her own bill before the subcommittee only if he/she is not a member of that subcommittee.

Once hearings are completed and their is sufficient support for the legislation, the subcommittee completes work on the bill by **"marking it up".** This is political-speak for giving the members of the subcommittee an opportunity to amend the bill. Amendments can be offered with the design purpose of weakening the legislation, to create compromise legislation that would gain wider support, or to make technical changes. Although the **mark-up** period for a bill goes largely unnoticed by the general public, significant improvements or damage can be done to a bill at this time when it is most vulnerable to the Members' pens. **Lobbyists and informed advocates can play a powerful role in the final version of a bill by exerting pressure on subcommittee members at this time.**

After amendments have been offered, accepted or rejected, the subcommittee votes on the entire bill as amended. Once passed by the majority of the subcommittee, the bill is given for consideration to the full committee, where the mark-up process is often repeated.

Example

In June 1993, the House Appropriations Committee marked-up the Labor/HHS/Education Fiscal Year 1994 spending bill, which allocated record levels of funding for AIDS research, the Ryan White CARE Act, and women's cancer and prevention programs.

When the committee has voted and passed the bill, it is considered **"reported out".**

The Legislation Goes to the Floor

Once reported out of committee, a House bill goes to the **House Rules Committee**. This committee determines the number of amendments that can be offered on the floor, as well as how much debate

time can be set aside prior to a bill coming up to the floor for a vote. A "good" **rule** might prevent unrelated negative amendments from being offered from the floor or it might limit debate to previously agreed upon topics. Similarly, a "bad" rule could allow negative amendments to be introduced and discussed. Thus, lobbying Members on the rule becomes a major strategic step on the way to final passage of legislation. A majority of the House must vote in favor of the rule before it is finally accepted.

In the Senate the rules are determined in advance by the Majority and Minority Leaders whenever possible. Senate rules require, at the very least, the support of three-fifths of Senate Members. This gives each Senator more power to offer amendments, tie up debate, and demand concessions. The Senate is the domain of the infamous "filibuster" ¾ the act of individual Senators or groups of Senators debating endlessly against a bill, often with the single objective of preventing any action on the bill under consideration.

The Conference Committee

When the House and Senate disagree on parts of the legislation passed, they create a **conference committee** where representatives from both chambers meet to attempt to work out the differences. The representatives to this conference, or **conferees**, are drawn from the relevant committees.

After the House and Senate appoint conferees, each chamber can pass a non-binding instruction indicating a desired outcome of the conference. Only one such **motion to instruct** can be adopted in each chamber.

Once a compromise agreement is reached by the conference committee, the bill is returned to both chambers for a vote. If it again passes both chambers, it is given to the President to sign into law. If it fails to acquire the majority vote in either chamber, the bill must return to conference.

Final adoption of the legislation allows the opposition one last attempt to change the legislation. The opposition can offer a motion to recommit the legislation to the conference. This motion would send the bill back to the conference with instructions to make the changes necessary for the bill to pass. Bills that fail to incorporate necessary amendments will simply remain stuck in conference forever, until Congress adjourns and they die outright.

The Bill Becomes Law

The President can either sign the bill, veto it, or do nothing. If the President signs the bill it becomes law. If the President does nothing, the bill automatically becomes law without the President's signature 10 days after its submission for signature, excepting Sundays **if** Congress is currently in session. If Congress should adjourn at any time during those 10 days, the bill is null and void and does not become law. This is known as a **"pocket veto".** The President can also veto the legislation by returning it to Congress without signing it. If so, Congress may override the veto by passing the legislation with a two-thirds vote in each chamber. In this event, the bill becomes law despite the President's veto.

After the Bill Becomes Law

The provisions of the law take effect immediately unless the law itself provides for another date of effect. The law will also specify which executive departments or agencies are empowered to carry it out or enforce it.

The actual written document is sent to the National Archives and Records Administration, and independent agency of the government, where it is given a number and published in individual form as a "slip law". At the end of each session of Congress, there are consolidated in a bound volume called U.S. Statutes at Large. In addition, all permanent, general laws currently in force are included in the Code of Laws of the United States of America, commonly called the U.S. Code. The Office of Law revision Counsel, part of the institutional structure of the House of Representatives, is responsible for preparing and issuing annual supplements to keep the Code up to date.

Part 1: Core Skills

More About the Committee System

Congressional Standing Committees

Standing committees are permanent panels made up of Members of a chamber. Each panel has jurisdiction over measures and laws in certain areas of public policy, such as health, education, energy, the environment, labor, foreign affairs, and agriculture.

Each chamber has its own standing committees, to allow it to consider many issues at the same time. Each committee selects from the tens or hundreds of measures it receives each Congress a relatively small number (approximately 10%) that merit consideration by the committee, its subcommittees, and finally the full chamber.

Quorums of Standing Committees

Each House and Senate committee is authorized to establish its own quorum requirement for the transaction of business -- that is, how many members must be present in the meeting in order to conduct business. House rules specify that House committees shall have at least 2 members present to take testimony or receive evidence, and at least 1/3 of its membership present for taking any other action except reporting out a bill to the floor. Senate rules also require at least
1/3 of the committee membership to be present to conduct most business, but permit committees to lower that quorum requirement for the purpose of taking testimony. In both chambers a physical majority of committee members must be present to report a bill to the floor.

Joint Committees

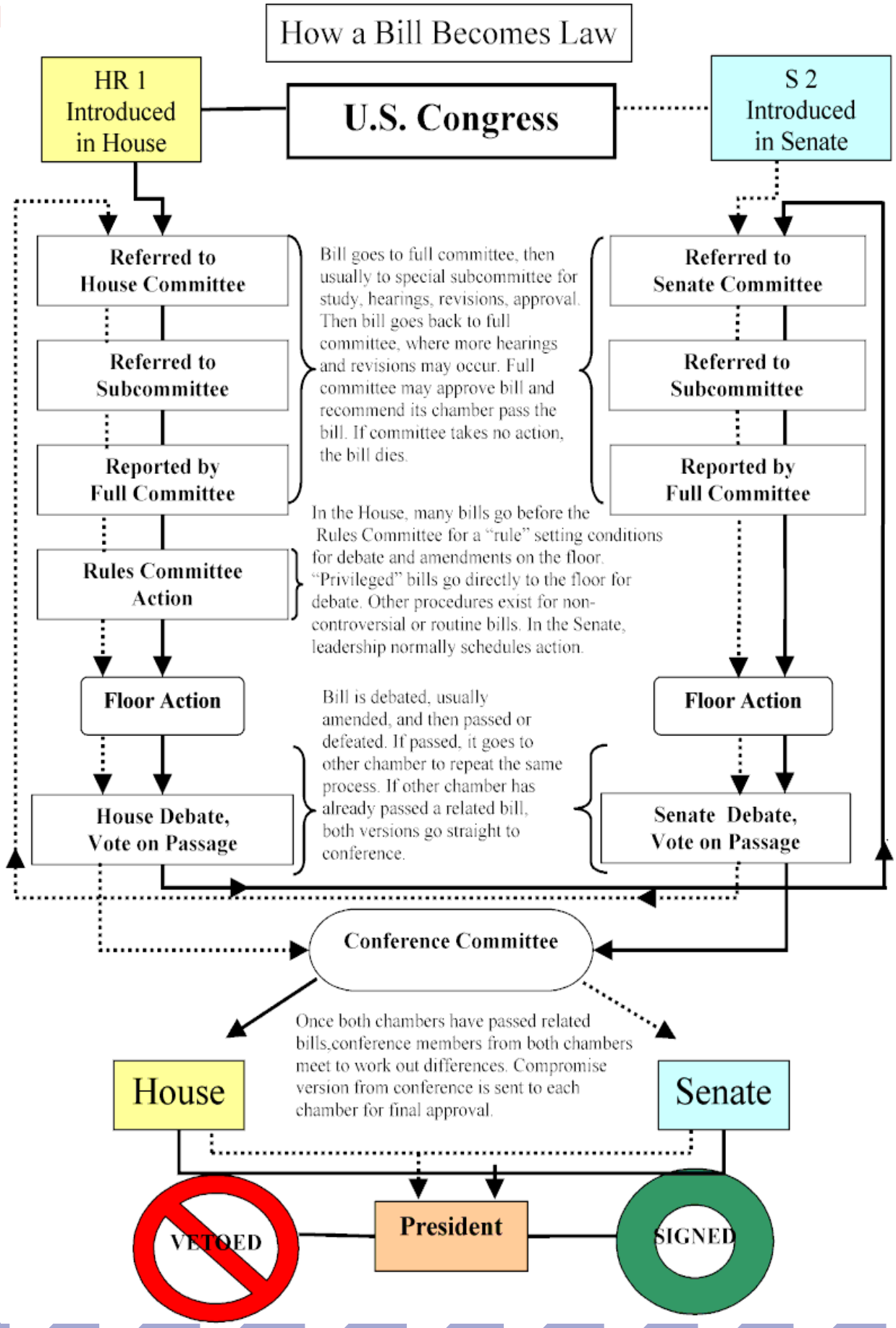
Joint committees are those which have Members from both the House and Senate, generally with the chair rotating between the most senior majority party Senator and Representative. In general, they do not consider or report legislation to the floor.

Committee Control of Legislation

Ordinarily, if a bill is not reported out of committee, it dies. This is because the chambers usually accept the decision of the committee in determining a bill's fate.

But there are always exceptions. Both the House and Senate have procedures for allowing measures stuck in committee to be considered by the full chamber. The House uses a **discharge petition**, usually on controversial measures. It is rarely used and rarely successful, because it is cumbersome and Members feel uncomfortable going against a committee's decision. The process requires a majority of Representatives (218) to sign a petition to discharge the committee of any bill held there for more than 30 days. Then the bill is placed on a special calendar and may be called up be any Member who signed the petition on the 2nd or 4th Monday of any month. If the House agrees by majority vote to consider the bill, it is debated under its general rules.

It is also possible to discharge a Senate committee by motion, but the procedure is rarely used. Instead, because the Senate does not generally require amendments to bills to be **germane** (related to the subject of the bill), a Senator may offer the text of any bill stalled in a committee as an amendment to any bill being debated on the floor. This practice is not allowed in the House under general rules, where amendments must be germane to the measures they seek to amend.


How a Bill Becomes Law
HR 1 Introduced in House
U.S. Congress
S 2 Introduced in Senate
Referred to House Committee
Referred to Subcommittee
Reported by Full Committee
Bill goes to full committee, then usually to special subcommittee for study, hearings, revisions, approval. Then bill goes back to full committee, where more hearings and revisions may occur. Full committee may approve bill and recommend its chamber pass the bill. If committee takes no action, the bill dies.
Referred to Senate Committee
Referred to Subcommittee
Reported by Full Committee
Rules Committee Action
In the House, many bills go before the Rules Committee for a "rule" setting conditions for debate and amendments on the floor. "Privileged" bills go directly to the floor for debate. Other procedures exist for non-controversial or routine bills. In the Senate, leadership normally schedules action.
Floor Action
Floor Action
House Debate, Vote on Passage
Bill is debated, usually amended, and then passed or defeated. If passed, it goes to other chamber to repeat the same process. If other chamber has already passed a related bill, both versions go straight to conference.
Senate Debate, Vote on Passage
Conference Committee
Once both chambers have passed related bills,conference members from both chambers meet to work out differences. Compromise version from conference is sent to each chamber for final approval.
House
Senate
VETOED
President
SIGNED

Part 1: Core Skills

The Federal Budget Process

The federal fiscal year (FY) starts on October 1 and runs through September 30 of the next calendar year. The process of approval and monitoring of the federal budget continues throughout the fiscal year.

Entitlement programs, such as Medicare, Medicaid, and Social Security are found in the **mandatory** portion of the budget. The funding for these programs is set each year using complex financial formulas. Most of the revenue comes from trust accounts and special revenue streams.

All of the federal AIDS-specific programs, such as the Ryan White CARE Act, Housing Opportunities for People With AIDS (HOPWA), the Centers for Disease Control and Prevention (CDC) HIV prevention programs, and the National Institutes of Health (NIH) AIDS research, and funding for global AIDS programs through the USAID, are found in the **discretionary** portion of the federal budget and receive annual funding through the appropriations process.

The official start of the budget process occurs early in February of each year when the President submits his budget recommendations to Congress. (The Office of Management and Budget (OMB) assist the President in developing his budget. The OMB is an office of the White House and is led by someone appointed by the President.) The Congressional Budget Office (CBO) provides an independent report on the economic and budget outlook to the House and Senate Budget Committees within a few weeks after the President's budget is unveiled. During the 6 weeks following the President's budget recommendations, individual committees submit reports and estimates of need on budget items to the budget committees.

A Budget Resolution

By April, Congress acts on legislation called the **"budget resolution"**, which coordinates all of the revenue and spending decisions submitted by the various committees. The deadline for approval of the budget resolution is April 15 (known to the rest of us as Tax Day). It is not unusual for Congress to miss the deadline by weeks or months, and in some years Congress has failed to complete a budget resolution at all.

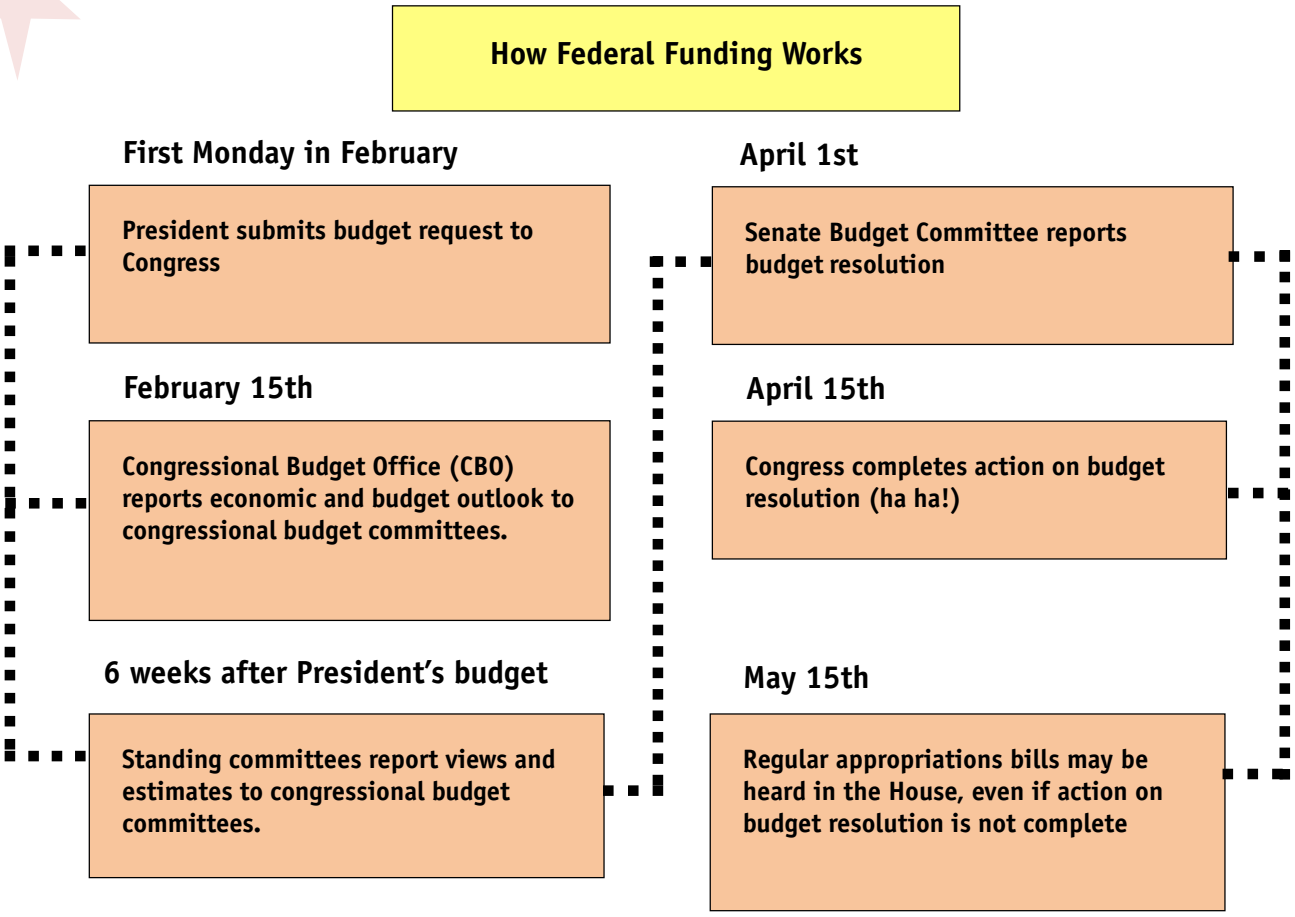
Appropriations

After the approval of the budget resolution, Congress begins considering **appropriations** bills to determine the actual levels of funding for budget items. Congress considers 13 regular appropriations bills each year, in addition to "emergency" spending. All appropriations legislation begins in the House and is processed by the appropriations committees of the House and Senate.

Reconciliation

During this process Congress may also direct a committee to make changes in existing laws or legislation to bring a program in line with the completed budget resolution. This process is called **reconciliation**. Reconciliation legislation must be voted on an approved by Congress.

The entire budget process must be completed before September 30th, the close of the fiscal year. Often, not all of the appropriations bills have been passed by that date and Congress must provide interim funding for programs until the appropriations bills for those programs have been approved. This interim funding is called a **continuing resolution**. Continuing resolutions almost never provide a funding increase to programs. If the appropriations process drags on too long and anticipated increases do not become available in a timely manner, programs can experience such financial strains that services may be cut back or waiting lists created. Sometimes funding comes to a halt altogether. This happened in 1995, when the federal government shut down three times during stalled budget negotiations and when Congress could not agree on passing continuing resolutions to continue funding programs, including the basic operations of government. Eventually, a budget was agreed to in late February that year.



Budget Process, cont'd

Authorization

Bills that establish or renew the mandate, define the mission and authorize funding for agencies and programs are called **authorization bills.** For example, the Ryan White CARE Act was reauthorized in 2000 by a bill titled "The Ryan White CARE Act Amendments of 2000". Authorization bills generally authorize programs for a period of several years at a time -- but funding must still take place on an annual basis. The CARE Act's reauthorization interval is 5 years. Congress often fails to appropriate as much money as it has authorized for a program. It is important to have authorization legislation approved before the appropriations process begins, as it is difficult to maintain or increase funding for an unauthorized program.

Amendments

Throughout both the appropriation and authorization processes, committees or individual Members of Congress may attach amendments (changes) to legislation that place conditions on the use of funds that are being authorized or appropriated. An amendment may be filed to enhance or expand the scope of a program. More often, amendments are offered that place restrictive limitations on the planned use of funds. These may have the effect of weakening or severely compromising the program.

Federal Agency Alphabet Soup

Federal Agencies: What They Do, How to Reach Them

Ah the world of policy-speak! Filled with so many acronyms that it's a wonder those of us engaged in these discussions don't need a cheat sheet just to know what each other are saying. But wait, maybe we do...

ACF – Administration for Children and Families. An agency of HHS that administers over 60 programs to low-income and poverty-level children and families, including Head Start and the Temporary Assistance to Need Families (TANF) program.

Administration for Children and Families
370 L'Enfant Promenade S.W.
Washington, DC 20447
http://www.acf.dhhs.gov/

CDC – Centers for Disease Control and Prevention. Located in Atlanta, GA. An agency under the U.S. Department of Health and Human Services. Among other duties, the CDC is responsible for monitoring the HIV epidemic through AIDS case and HIV surveillance, maintaining national health statistics, supports HIV prevention research and programming.
1-800-311-3435
http://www.cdc.gov/

CMS – Centers for Medicare & Medicaid. (Formerly the Health Care Financing Administration.) The federal agency of HHS that administers Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). Medicaid is the single largest payor of health services to people living with AIDS. Located in Baltimore, MD.
202- 690-6726
http://www.hcfa.gov/regions/

FDA – Food and Drug Administration. The federal agency of HHS that is supposed to assure the safety of foods and cosmetics, and the safety and efficacy of pharmaceuticals, biological products and medical devices. The FDA consists of 9 centers and offices located in and around the Washington, DC Metropolitan area. In 1992, Congress passed the Prescription Drug User Fee Act (PDUFA). PDUFA authorized FDA to collect fees from companies that produce certain human drug and biological products. Any time a company wants the FDA to approve a new drug or biologic prior to marketing, it must submit an application along with a fee to support the review process. In addition, companies pay annual fees for each manufacturing establishment and for each prescription drug product marketed. The FDA has a process for accelerated approval (to move new drugs or old drugs used for a new purpose) more quickly onto the open market. Manufacturers pay an extra fee to use the accelerated approval process.
301- 443-1544
5600 Fishers Ln
Rockville, MD 20857
http://www.fda.gov/

HHS – Department of Health and Human Services. Located in Washington, DC. A federal department that has authority over all things releated to public health and benefit programs, with the exception of Social Security. The department administers a wide variety of programs through its various agencies.
1-877-696-6775
200 Independence Ave, SW
Washington, DC 20201
http://www.hhs.gov/

HRSA – Health Resources and Services Administration. Located in Rockville, MD. An agency under the U.S. Department of Health and Human Services. HRSA administers the Ryan White CARE Act programs through it's HIV/AIDS Bureau (HAB).

301-443-3376
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857
http://www.hrsa.gov

HUD – Department of Housing and Urban Development. A federal department that has authority over all things related to public housing, housing subsidies like Section 8 and HOPWA, and programs that provide housing and housing supports to low-income and poverty-level persons, elderly people, and persons with disabilities.
202-708-0417
451 7th St, SW
Washington, DC 20410
http://www.hud.gov/

IHS – Indian Health Services. An agency of HHS that supports a network of 37 hospitals, 60 health centers, 3 school health centers, 46 health stations and 34 urban Indian health centers to provide services to

nearly 1.5 million American Indians and Alaska Natives of 557 federally recognized tribes. The IHS supports an HIV Center for Excellence and collaborates with AIDS Education and Training Centers (AETCs) on developing training programs to health professionals to educate them on issues of concern to the Native American and Alaskan Native communities.

602- 263–1599
The HIV Center of Excellence (HIVCOE)
Phoenix Indian Medical Center
4212 North 16th Street
Phoenix, Arizona 85016
http://www.ihs.gov/MedicalPrograms/AIDS/index.asp

NIH - National Institutes of Health. An agency of HHS, the NIH is composed of 27 separate Institutes and Centers supporting some 35,000 research projects nationwide in diseases like cancer, Alzheimer's, diabetes, arthritis, heart ailments and AIDS. The majority of AIDS research is conducted through the National Institute of Allergy and Infectious Diseases (NIAID). The Office of AIDS Research (OAR) is located within the Office of the Director of NIH and is responsible for the scientific, budgetary, legislative, and policy elements of the NIH AIDS research program.
301-496-4461
9000 Rockville Pike
Bethesda, MD 20892
http://www.nih.gov/

SAMHSA - Substance Abuse and Mental Health Services Administration. An agency of HHS, SAMHSA is charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. The Substance Abuse Treatment and Prevention Block, which provides funding to link HIV testing/counseling services with drug treatment services, is administered by SAMHSA.

301-443-5700
5600 Fishers Lane
Rockville, Maryland 20857
http://www.samhsa.gov/

SSA - Social Security Administration. Formerly under HHS, SSA became an independent agency in March 1995. SSA manages and administers the nation's public retirement program (Social Security), the public disability benefits program (Social Security Disability Insurance), and a federal income supplement program (Supplementary Security Income) for blind and/or disabled people who have little or no income. SSA also oversees a program of employment supports for persons with disabilities, including the Ticket to Work and other work incentives programs.
1-800-772-1213
6401 Security Blvd
Baltimore, MD 21235
http://www.ssa.gov/

VA - Department of Veteran's Affairs. The federal department that supports American military veterans with health care, home financing, vocational rehabilitation, and other military benefits. The VA's HIV/AIDS program delivers medical, dental, and mental health services through VA hospitals.
202-273-4800
810 Vermont Ave, NW
Washington, DC 20420
http://www.va.gov/

Part 1: Core Skills

My State Legislature

The Basics

Wherever you live in the United States, you will have a Governor and a Lieutenant Governor. If you compare this to federal government, the Governor is like the President, and the Lieutenant Governor is like the Vice President. Both are elected by voting eligible citizens that live in that state.

With the exception of Nebraska, all state's have a **bicameral** state legislature -- a structure of government with two chambers (or houses) that have equal, if not the same, power. (Nebraska uses a **unicameral** system. The single chamber is the Senate and state legislators are elected to serve as Senators in the single chamber.) Your state's two chambers may be called the House and the Senate or the Assembly and the Senate or something a little different. Usually, one chamber is referred to as the Upper House (this corresponds to the Senate, which has fewer legislators and whose members each represent a larger number of people), and the Lower House (corresponding to the House or Assembly, with more legislators who represents smaller numbers of people). The designation Upper or Lower House does not indicate that one is subservient to the other, but it can be a good indication of where the lawmaking power in single votes is.

States are divided into voting districts by population density: the more people living in a district, the smaller the land area will be. Each chamber may have its own voting districts. For example, you may live in a state where you reside in both a House and a Senate voting district. If so, these districts may be nested (think of those little Russian dolls, where one fits into another one that is slightly larger.) California has a nested legislature. Two Assembly districts are fitted within one Senate district, and depending on where you live, you vote for one Assemblymember and one Senator. Or, your state may have chosen to designate legislative districts, that is a single district from which both your Upper and Lower House members will be elected by citizens who live there. You may vote for one or more Lower House legislators and one or more Upper House legislators.

Apportionment and Re-Districting

Every ten years America goes through a massive headcount known as the Census. The Census tries to determine how many people are actually living in the U.S. The data (and there's a lot of it) is used for many purposes. One of them -- apportionment -- is the process of dividing the 435 seats in the U.S. House of Representatives among the 50 states.

The most recent Census was conducted in 2000. From the data gathered, some states will gain new congressional districts (seats) and some will lose. States picking up seats include: Arizona +2, Georgia +2, Florida +2, Texas +2, California +1, North Carolina +1, Nevada +1 and Colorado +1. The states losing seats are: New York -2, Pennsylvania -2, Illinois -1, Indiana -1, Michigan -1, Ohio -1, Mississippi -1, Oklahoma -1, Wisconsin -1 and Connecticut -1.

Old district boundaries are redrawn and new districts are created based on population. As you might guess, the same thing happens to state legislative voting districts if there are significant changes in a state's population from one Census to another. Whichever political party holds the majority in the state legislature has the upper hand in determining how district boundaries will be drawn, with the goal -- of course -- of creating as many district as possible that are likely to contain the most voters who will re-elect that party to office. When redistricting is happening, you may go to bed in one district and wake up in another one!

Confused? It's easy to be. What happens on the federal level impacts states. Plus, each state has the power to make decisions and structure its legislature in the way best suited to the needs of its people. The power to shape its legislature is contained in each state's constitution.

State Constitution

Yes, your state has one. Most people don't know this; they believe that the U.S. Constitution guides their state and local government -- and to some degree it does. For example, a state legislature cannot make a law or take an action that violates the U.S. Constitution. But each state must have its own constitution in order to run its state government.

Who Represents Me in State Government?

ACTION PAGE!

Many of the issues you care about will be decided at the state level, not by federal government. If you are to be able to participate in policymaking, you need to know who represents you and how to contact them.

You can find out who represents you in state government by calling your local Registrar of Voters, or by using the Library of Congress website links at

http://lcweb.loc.gov/global/state/stategov.html

Governor's Name:

_____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

Length of Term in Office (How often is the Governor elected?):

_____

Other Information/Notes:

Lt. Governor's Name:

_____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

Length of Term in Office (How often is the Lt. Governor elected?):

_____

Other Information/Notes:

Part 1: Core Skills

ACTION PAGE!

How is your State Legislature Organized?
It's easy enough to find out. Either visit your state legislature's website (See address on previous page) or call the local office of one of your state legislators. (See next page to find out how to identify them.) Every legislator's office have publications available to help their constituents understand their state government. Ask for them. They're free. While you're at it, ask for a copy of your state's constitution. If it isn't available, you should be able to find it at your local library.

The Upper House is called the:

_____

The Lower House is called the:

_____

My State Legislature is organized using:

Separate voting districts for each chamber

- ☐ Separate, but nested voting districts for each chamber
- ☐ A single legislative district
- ☐ Some other structure
- ☐ My State Legislature will be redistricting in (what year?):

_____

State Budget Cycle
Just like the federal government, your state government is responsible for creating and monitoring a budget to pay for public programs funded and administered by the state.

Some states have an annual budget cycle, where they draft a new budget each year. Others use a biennial budget cycle -- the state legislature develops and authorizes a budget for a two-year cycle, and makes corrections each year to adjust for more or less revenue or expenses than projected.

The fiscal year (FY) for a state budget is most likely to be different than a calendar year (Jan-Dec) and a federal FY (Oct-Sept). Many states use July - June as their fiscal year, but your state may be different.

If you are going to advocate for state funding of HIV/AIDS programs, it is important to know what your state's budget cycle is. You can find out by reading your state's constitution, or by calling your Governor's office or the office of one of your state legislator's and simply asking.

My State's Budget is drafted:

- ☐ Once every year for a single year
- ☐ Once a year for a period of two years

My State's Fiscal Year (FY) is:

_____

My State currently contributes state dollars to:

- ☐ Anonymous HIV testing/counseling
- ☐ The AIDS Drug Assistance Program
- ☐ HIV prevention/education

Notes:

How Long is A Legislative Session, and When does it Begin?

A state legislature can only do business when it is "in session"; that is, during a specific time frame set out in your state's constitution when legislators must assemble in the State Capital and consider the people's business. The constitution also states when a session must conclude and provides a process for keeping a session open (or calling a "special session") to ensure that important matters, like the budget, are not left unfinished.

A session can be as long as an entire calendar year or as brief as three months. It depends on the state constitution. And some state legislatures do not have a regular session each year. Instead, they have a regular session once every two years, and only meet for a few weeks during the "off" year to look at committee and budget reports.

Very large states may have a year-round legislature, and elected state officials may be paid well and expected to carry out their duties on a year round basis, whether the legislature is in session or not. Smaller states may have a part-time legislature where elected officials are paid a small stipend only during the time that the legislature is in session.

My State Legislative Session is held:

☐ Once each year

☐ Once every other year

A regular session begins on _____

and ends on _____

My State Legislature is:

☐ Full Time

☐ Part Time

Use the following pages to write down contact information about your state legislators.

ACTION PAGE!

(1) State Legislator's Name:

_____

Chamber: _____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

(2) State Legislator's Name:

_____

Chamber: _____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

Part 1: Core Skills

ACTION PAGE!

(3) State Legislator's Name:

_____

Chamber: _____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

(4) State Legislator's Name:

_____

Chamber: _____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

(5) State Legislator's Name:

_____

Chamber: _____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

(6) State Legislator's Name:

_____

Chamber: _____

Party: _____

Capital Phone: _____

Capital FAX: _____

Mailing Address: _____

_____

Local Phone: _____

Local FAX: _____

Local Address: _____

_____

Who Represents Me in Local Government?

How is Your Local Government Organized?

If you have cable TV, you may have run across a broadcast of your County or City Government in action. What were all those people jabbering about, anyway? Most likely, it had to do with your tax dollars and services you receive as a resident, so it might be a good idea to find out.

County government may be called County Council or County Board, or some other name depending on where you live, but it's very likely that you have one. (There are exceptions, such as combined County/City government.) This level of government is made up of representatives elected by their fellow citizens in the county where they live. They deal with everything from libraries to sewage and trash to road maintenance -- and, county health services and HIV. Some counties even provide funding to help expand or extend HIV and AIDS services provided within the county. Does yours?

If you live in an incorporated town or city, you also have a city government, usually called the Town or City Council. That city road with the whopping big pothole that we talked about earlier is the property of the city and the interest of the City Council. So are the flickering street lamps, the uncollected trash within city limits, and the available city-owned space that advocates want to rent to set up a needle exchange program. Although the funding and the opportunities may be less with your town or city government, it is just as important to know who represents you, what that level of government currently does to support HIV/AIDS programs, and what policies you may be able to affect through advocacy.

County governments are overseen by a Chief Executive Officer (CEO), whose title will be different depending on the county. Think of this individual as a "Super Mayor", and town and city governments are overseen by a mayor. These elected officers may be political (candidates may be able to run as a member of a political party), or not, depending on your county and town/city charter (like a constitution, only thinner.)

ACTION PAGE!

My County Government

I live in _____ county

My county's CEO is:

_____

My county representative is:

_____

County Govt. Phone: _____

County Govt. FAX: _____

County Govt. Address: _____

_____

My City Government

My Mayor is:

_____

Mayor's Office Phone: _____

Mayor's Office FAX: _____

Mayor's Address: _____

_____

My City Councilmember is:

_____

Councilmember Phone: _____

Councilmember FAX:_____

City Hall Address: _____

_____

Part 1: Core Skills

Glossary of Terms

Act: Legislation that has passed both chambers of Congress, been approved by the President or passed over his veto, thus becoming law.

Adjournment: Action taken by either chamber to end a legislative day, which can last for more than 24 hours. (See also sine die.)

Amendment: A proposal be a Member (in committee or floor session of the respective chamber) to alter the language or provisions of a bill or act. It is voted on in the same manner as a bill.

Appropriation: A formal approval to draw funds from the Treasury for specific purposes. This may occur through an appropriations act, an urgent or supplemental appropriations act, a continuing resolution, or on a permanent basis.

Authorization: A law creating or sustaining a program, delegating power to implement it, and outlining its funding. Following authorization, an appropriation actually draws funds from the Treasury.

Bill: Formally introduced legislation. Most legislative proposals are in the form of bills and are designated as H.R. (House of Representatives) or S. (Senate) depending on the chamber in which they are introduced during each Congress. Bills are numbered in order of introduction (e.g., H.R.1, H.R.2, H.R.3, etc.)

Bipartisanship: Cooperation between Members of both major political parties in either or both chambers, or between the President and Members of Congress representing the other party in addressing issues or proposals. Bipartisan action usually results when party leaders agree than an issue is of sufficient national importance as to preclude normal considerations of partisan advantage.

Budget: The President's annual proposal to Congress, submitted in February, outlining executive branch plans for federal expenditures and revenue for the coming fiscal year (FY). The Budget is subject to substantial revision and amendment as part of its consideration by Congress.

Budget Resolution: House and Senate guidelines, and later caps, on budget authority and outlays. Bills that would exceed budget caps are subject to a point of order, although waivers have been granted regularly by both chambers.

Calendar: A list of bills, resolutions, or other matters to be considered before committees or on the floor of either chamber.

Caucus: Two types of Congressional organizations are called caucuses: (1) a meeting of Democratic party Members in the House, which elects party leaders and makes decisions on legislative business. (Congressional Republicans in both House and Senate organize as conferences); (2) an informal grouping of Members organized to focus attention on, advocate action, or represent mutual interests on policy proposals or geographic areas. Caucuses in this case may be organized by Members of either or both chambers and political parties.

Chair: Chairperson. Used for the majority party leader of a committee. This is an extremely powerful position, because chairs control much of the legislation that is actually brought to the floor for a vote.

Chamber: (1) Meeting place for the total membership of either House or Senate; also known as the "floor". (2) a generic term for either the House or the Senate.

Clean bill: A piece of legislation that has gone through a committee or through the full chamber without amendments, or a bill that has been written to incorporate a previous bill that has undergone a number of significant changes.

Cloture: A parliamentary device used in the Senate (Rule 22) by which debate on a particular measure can be limited. The Senate otherwise has a tradition of unlimited debate. The action of 16 Senators is necessary to initiate a petition for cloture, and a vote of at least 60 Senators is needed to invoke it.

Committee: Subsidiary organizations of both chambers established for the purpose of considering legislation, conducting investigations, or carrying out other assignments, as instructed by the parent chamber. Committee memberships are determined by party leadership in each chamber, with the seniority of a Member (time in service) being generally a prominent factor in committee assignments. Congressional committees generally fall into one of four categories: **(1) Standing committees -** permanent bodies within each chamber specializing in consideration of bills falling in particular subject areas. Most of these panels create subcommittees or other subunits to handle some of the work and hold hearings. Membership generally reflects party strength in each chamber; the senior Member of the majority party gets the Chairmanship and holds the most seats on a committee, and the minority party gets fewer seats; **(2) Joint committees -** Committees including membership from both chambers. Joint committees are usually established with narrow jurisdiction and normally lack authority to report legislation to the floor of either chamber; **(3) Select or special committees -** Usually established for a limited time period to perform a specific function and without authority to report legislation to the floor of its chamber; **(4) Confer-**

ence committees - Ad hoc committees composed of Members of both chambers who are appointed with the specific task of working out the differences between similar bills which have passed both chambers in different form.

Committee of the Whole: (Committee of the Whole House of the State of the Union) A practice widely used by the House of Representatives to expedite consideration of legislation. Advantages include lower quorum requirements (100 members instead of 218) and streamlined procedures, including limitations on debate. All decisions taken in the Committee of the Whole require approval of the full House.

Conference: Republican Members' organization in the House and Senate, and Democratic Members' organization in the Senate. (See also Caucus)

Confirmation: Action by the Senate approving Presidential nominees for the Executive Branch, regulatory commissions, and certain other positions.

Continuing Resolution: A joint appropriations measure providing interim funding for agencies whose regular appropriations bill has not been passed.

Constituent: Resident of a Member's district or state. A person who is represented be an elected official or organization.

Executive Branch: The branch of the federal government which includes the President, Cabinet members and federal agencies. One of the 3 branches of federal government.

Filibuster: Rules of the Senate only. An action typically characterized by individual Senators or groups of Senators speaking at extended length against a pending measure, often with the objective of frustrating action on the pending legislative proposal.

Fiscal Year (FY): The 12 month period used for financial purposes, usually a different period than a calendar year. The federal government's FY begins October 1 and runs through September 30 of the following calendar year. If Congress has not passed a new fiscal year appropriation by September 30, it can halt government operations and programs that depend on government funding.

Five Minute Rule: Under House Rules, a measure considered in the Committee of the Whole is governed by the 5-minute Rule. A Member offering an amendment is recognized to speak in favor of it for 5 minutes; another Member can claim 5 minutes to speak against it.

Germaneness: A House Rules requirement that amendments to a bill must relate to the subject matter under consideration.

Gerrymandering: Drawing of a congressional (or other voting) district lines to maximize the electoral advantage of a political party or faction. The term was first used in 1812, when Elbridge Gerry was Governor of Massachusetts, to characterize the State redistricting plan.

Hearing: A meeting or session of a committee of a governmental body, usually open to the public, to obtain information and opinions on proposed legislation, to conduct an investigation, or to oversee a program.

House of Origin: The chamber where a bill or proposal originated from.

Joint Meeting: A meeting of both chambers of Congress, in which each chamber recesses to meet for an occasion or ceremony, usually in the House chamber. The Members of both chambers agree by unanimous consent agreements to meet, but without formally adjourning the legislative session for the day. Foreign dignitaries visiting the Capitol frequently address joint meetings of the Congress.

Joint Session: A meeting of both Houses of Congress, customarily held in the House chamber. Joint Sessions are held for necessary administrative and official purposes (e.g., the purpose of counting electoral votes, attending inaugurations, and to hear presidential State of the Union messages.)

Lame Duck Session: A session of Congress meeting after the elections have been held but before the newly elected Congress has convened.

Law: An act of Congress, state or local legislative body that has been signed by the President or other executive officer, or has been passed by the legislative body over a veto.

Legislative Day: A formal meeting of a chamber of Congress which begins with the call to order and ends with adjournment. A legislative day may cover a period of several calendar days, with the chamber recessing at the end of each calendar day rather than adjourning.

Legislative veto: The House or Senate can review proposed regulations and actins from the executive branch and modify or block the measures.

Lobbyist: A person or group seeking to influence the passage, defeat or amendment of legislation, generally by personal interview and persuasion.

Majority and Minority Leaders: Floor leaders, respectively, for parties in and out of power. The chief strategists and spokespersons for their parties. Elected by other members of their party, leaders are in both chambers.

Majority and Minority Whips: The assistants to their respective leaders in both chambers. Their job is to marshal support for legislation and strategies, and to "keep the ranks in order" within their respective parties.

Markup: The process by which congressional committees and subcommittees amend and rewrite proposed legislation in order to prepare it for consideration on the floor.

Member: Term referring to elected Representatives and Senators.

Memorial: A petition from Congress from State Legislatures, usually requesting some sort of legislation, or expressing the sense of the State Legislature on a particular issue or question.

Motion: Request by a Member for parliamentary and procedural actions. Motions are governed by the rules of the chamber.

Nomination: Two distinct uses of this term are: **(1)** the process by which candidates for elected offices gain political party approval and status as a party nominee on the general election ballot; **(2)** appointments to the office by the President that are subject to Senate approval.

One-Hour Rule: The rule stipulating debate limits in the House of Representatives. Measures brought up for consideration are debated for 1 hour, with the majority supporters of the bill customarily yielding half of the debate time to the opposition.

One-Minute Speech: By custom (not by rule of the House) Members may be recognized at the beginning of a daily session, after the Chaplain's Prayer, the Pledge of Allegiance, and the approval of the Journal from the previous day's session. Members address the House on subjects of their choice for not more than 1 minute each.

Other Body: The practices of the House and Senate prohibit direct reference in floor debate to actions taken in the other chamber. Members typically refer to actions taken in "the other body", rather than to name the House or Senate expressly.

Override a Veto: Congress may pass a bill vetoed by the President by a two-thirds majority vote in each chamber.

Petition: A request or plea sent to one or both chambers from an organization or private citizens' group asking for support of specific legislation or favorable consideration of a matter. Petitions are referred to appropriate committees for action.

Pocket Veto: When Congress is in session, a bill becomes law without the signature of the President 10 days after it was delivered to him/her, excluding Sundays. If Congress adjourns at any time within those 10 days, the bill dies without the President's formal veto.

Point of Order: An objection by a Member that a pending matter or proceeding is in violation of the rules.

Political Action Committee (PAC): A group organized to promote its members' views on selected issues, usually through raising money that is contributed to the campaign funds of candidates who support the group's positions.

President of the Senate: Presiding officer of the Senate chamber. In the U.S. Constitution, this is the designated role of the Vice President of the United States. In the absence of the Vice President, a President Pro Tempore presides.

President Pro Tempore: The officer who presides over the Senate when the Vice President is absent. Tradition vests this office in the Senior Senator of the majority party.

Previous Question: A motion in the House to cut off debate and force a vote on a pending measure.

Quorum: The minimum number of Members in each chamber necessary to conduct business (218 in the House, 51 in the Senate).

Ratification: Two uses of this term are: **(1)** the act of approval of a proposed constitutional amendment by the legislatures of the States; **(2)** the Senate process of advice and consent to treaties negotiated by the President.

Reapportionment: The process by which seats in the House of Representatives are reassigned among the States to reflect population changes following the decennial Census. The next reapportionment follows the 2000 Census.

Recess: An interruption in the session of House or Senate (or State Legislature) of a less formal nature than an adjournment.

Redistricting: The process within the States of redrawing legislative district boundaries to reflect population changes following the decennial Census. Redistricting will follow the 2000 Census.

Report: The printed record of a committee's actions, including its votes, recommendations, and views on a bill or a questions of public policy, or its findings and conclusions based on oversight inquiry, investigation, or other study.

Report out: Pass a bill out of committee.

Resolution: A proposal approved by either or both chambers which, except for joint resolutions signed by the President, does not have the force of law.

Rider: An unrelated amendment attached to a pending bill in order to improve the bill's chance for passage.

Rule: This term has two specific legislative meanings: **(1)** the standard order for conducting business in the House or Senate. Rules cover duties of officers, orders of business, voting procedures, etc.; **(2)** the rule on a bill, made by the House Rules Committee and specific to House procedures, which is assigned to the bill before it can go to the floor for a vote. These rules are specific to the bill being considered and can limit debate time, amendments, etc.

Session: The period of time during which Congress assembles and carries on its regular business. Each Congress generally has two regular sessions, based on the Constitutional mandate that Congress assembles at least once each year. In addition, the President is empowered to call Congress into special session.

Sine Die: The final adjournment used to conclude a session of Congress.

Speaker of the House: The presiding officer in the House of Representatives, elected by House Members. The Speaker greatly influences the course of legislation in the House, and is designated in the Constitution.

Subcommittee: A subunit of a committee which focuses on very specific legislation, and reports recommendations after markup to the full committee.

Suspension of the Rules: A House procedure which expedites consideration of legislation by limiting debate on a bill and prohibiting amendments, but which also requires a two-thirds majority vote. If successful, a "rules wavier" is said to be granted.

Tabling Motion: A motion to stop action on a pending proposal and to put it aside indefinitely. When the Senate of the House agrees to a tabling motion, the measure which has been tabled is effectively defeated.

Testify: The act of speaking either in support or opposition of a bill before committee or subcommittee, or at any public hearing of a governmental body.

Veto: The constitutional procedure by which the President refuses to approve a bill or joint resolution and thus prevents its enactment into law. A regular veto occurs when the President returns the legislation to its House of Origin without approval.

Notes:

Part 2: Action Skills

Letters and Faxes

Writing and mailing or faxing a personal letter to your elected officials is an easy and effective way to register your opinions on a given issue. It is best if the letter conveys your own experiences in your own words, so avoid copying sample letters verbatim. Generally speaking, an effective letter is no more than one page in length, two at most, and contains a few brief, focused arguments backing up your position. Remember, the best argument is personal experience.

It is a good idea to state your position or the position you wish your legislator to take in both the first and last sentences of the letter.

A letter has an advantage over a phone call, because the legislative office will often keep a hard copy of your letter, so your arguments have a chance of being reread and reviewed.

The most effective letters are targeted to specific issues, conclude with reasonable and specific requests, and arrive in the legislator's office in a timely manner so that he/she can actually do something about the issue.

If you are writing on a bill or budget issue, it is important to know where that proposal is in the legislative life-cycle, so that your letter doesn't come too early or too late. For example, if you heard a frightening rumor about some proposed legislation that actually hasn't been written yet, a letter from you won't be much help to your legislator, since they can only act on bills and budget items that have been written and brought before the committee or floor for action. Conversely, if that scary bill has already made it through every committee and passed the floor, your only recourse is to write to the Governor or the President (depending on whether the legislation is state or federal). Your elected official has already voted on the bill one way or another and really cannot do much but send you a nice return letter thanking you for your concern.

Your letters are an inexpensive yet powerful contribution to the democratic process of self-government. Becoming familiar with the policy-making process and being strategic and timely in your communications and follow up with your elected officials, will absolutely allow you to have a meaningful impact on the decisions that affect all of us.

> Essentially, the only difference between a letter and a fax is how it is delivered: one costs 34 cents and takes a few days to get there, the other costs the same as a phone call and gets there right away. Choose what works best for you.

When developing your letter, keep the following DOs and DON'Ts in mind:

DO

✔ Find out what stage of the legislative process the bill or budget item is at.
✔ Refer to the legislation or budget bill by the correct bill number and title.
✔ State your position in the first and last sentences of your letter, e.g. "I am writing to ask that you support a $300 million increase for the Ryan White CARE Act for next fiscal year".
✔ Use the proper form of address for the person you are writing to.
✔ Write legibly. If the legislator cannot read your letter, he/she cannot act on it.
✔ Be brief, courteous, and reasonable.
✔ Express support for your legislator and the expectation that he/she wants to and will help you.
✔ Make your letter personal! You, not the legislator, are the expert and your real life experience is the ultimate qualification.
✔ Follow up your letter with a phone call after your issue is voted on.

DON'T

✘ Copy sample letters word for word.
✘ Be rude or threatening.
✘ Be vague in either your position or your request.
✘ Send your letter after the vote has been taken.
✘ Include every single argument you can think of, just the strongest points.
✘ Include statistics or stories that you cannot verify later.
✘ Include volumes of extra materials.

Sample: Well Written Letter

June 30, 2001

The Honorable Barbara Boxer
United States Senate
Washington, DC 20510

Proper address

State the request in the first sentence

Dear Senator Boxer:

I am writing to urge you to support the highest level of funding possible for the Ryan White Care Act in fiscal year 2002.

I am a California native, a single mother raising two active teenagers. I learned I was HIV-positive six years ago, and received an AIDS diagnosis only two years later. Although it has been very difficult living with this disease, I count myself luckier than many others. My employer does not offer health insurance, and I cannot afford private insurance, but I was able to access the new class of anti-HIV drugs almost immediately because of the excellent AIDS Drug Assistance Program (ADAP) we have here in California. ADAP is funded under Title II of the Ryan White CARE Act and provides live-saving medicines to people living with AIDS like me, who have no health insurance and do not qualify for Medicaid.

AIDS is personal! Tell your story.

I have been able to continue working and remain an active citizen of my community and a supportive mother to my children, and I credit the high quality of medical services I receive through the CARE Act with much of my success.

Offer a fact or two.

There are an estimated 40,000 new HIV infections every year in America, and advances in health care are allowing many HIV-positive people to live much longer, healthier lives. We need the critical services provided by the Ryan White CARE Act more than ever before. But people like me will lose services if the currently recommended funding level is not increased by $577 million for FY 2002.

Repeat the request

Thank you very much for all your hard work in the Senate to continue funding federal HIV/AIDS programs. I know that you will fight hard for funding increases this year too.

Recognize good work in the past and offer your positive expectations.

I would be happy to speak with you or any member of your staff who wants to hear directly about the benefits to our community of funding the Ryan White CARE Act. I appreciate your attention to this important matter.

Sincerely,

Anita Ramirez
1111 1st Avenue West
Las Palmas, CA 92114

Offer yourself as a resource. And remember to give your address so your Member can write back.

Part 2: Action Skills

Phone Calls

If you've ever had to call a mechanic to fix your car, find a new dentist, or make an appointment with your Primary Care Provider, you already have all the skills you need to call your Members of Congress.

Phone calls are a fast and easy way to make a connection with your Member's office, register your opinion and make a request. You may even be able to find out important information that you can use later, or that you can share with other advocates.

Sometimes, you will be making phone calls in response to an "Action Alert" (see next page), information sent out by an organization that is advocating a position on a certain policy or funding issue. Action Alerts should contain all the information you need to take action, including: who to call; the number to call; the bill number and/or title; the specific request to make. Whether you're responding to an Action Alert or calling on your own, please remember that the most important part of your call is the **personal story** you share.

Sometimes it's helpful to have a little script. You may get one with an Action Alert, but if not you can always jot one down for yourself. The sample script below was originally attached with the sample Action Alert on the next page.

> "I am calling to urge Representative / Senator _____ to cosponsor H.R. 2063 (for Representatives) / S. 987 (for Senators), known as *The Early Treatment For HIV Act*. This bill would give states the option to extend Medicaid to uninsured low-income people living with HIV. It is a humane and cost-effective bill and I urge Representative / Senator_____'s strong support for its passage."

This simple script, along with a brief statement personalizing the issue -- such as "My brother is HIV-positive, doesn't have health insurance and currently cannot qualify for Medicaid. This program would help him get the quality medical care and medicines he needs to remain healthy." -- is a profound combination not easily ignored by elected officials.

Who to Ask For: Your chances of getting your Member on the phone are very slim. But that isn't who you want to talk to, anyway. You want the person who advises the Member on AIDS issues. When you call, ask for the staff person in charge of HIV/AIDS issues. If that person isn't available, as for the Chief of Staff or the Administrative Assistant. If all else fails, leave a voicemail message with the staff in charge of your issue and ask for a call back.

> Call your Members of Congress at:
> (202) 224-3121
> or
> (800) 648-3516

On the Phone: Once you get the person you want, simply and briefly state your request. Be prepared to have a conversation. The staffer may want to ask questions, but don't feel that you have to have the answers to everything, especially the stock question: "Where is the money (for that program) going to come from?" Stock answer - "I don't know, I just know that budget's are flexible and the money can be found if Representative/Senator makes this a priority." Please be patient with ignorance and take the opportunity to educate. These calls are another opportunity to make an ally, one who will advise your Member on how to vote. Make it work for you.

Other Conversations You can Have

- **"Have you gotten many other calls about this issue?"** If an issue is especially controversial or gets a lot of media attention, an office may get many calls and letters from constituents, as well as interest groups. While you've got the staffer on the phone, why not do a little intelligence-gathering? If the office should be getting a lot of contacts and doesn't report that it is, this should start the alarm bells ringing throughout your immediate circle of family and friends, and your community. Your mission is to get that Member's phone to ring!

- **"Have you gotten many letters about this issue?"** Same idea as above. If they haven't, it's time to invite some friends and neighbors over and have a letter writing party.

Sample: Action Alert

Opportunity to Expand Medicaid Coverage To Include People Living With HIV

Urge Your Members of Congress To Co-sponsor *The Early Treatment For HIV Act*

On June 5, 2001 Representatives Nancy Pelosi (D-CA) and Richard Gephardt (D-MO) introduced The Early Treatment For HIV Act (H.R. 2063). A Senate version, S. 987, was introduced by Senators Robert Torricelli (D-NJ) and John Kerry (D-MA).

These bills would give states the option to extend Medicaid to uninsured low-income people living with HIV. Under current rules, most people living with HIV are ineligible for Medicaid until they reach the Social Security definition of disability. If states wish to cover people living with HIV under their Medicaid programs, they have to apply for a Medicaid waiver. This can be a lengthy and burdensome process.

H.R. 2063 and S. 987 eliminate the need for this waiver and allow states to include people living with HIV in their Medicaid program by adding HIV as an eligible category for coverage. Those applying for Medicaid would still have to meet the income requirements of their state Medicaid program.

New HIV/AIDS treatments, such as highly active antiretroviral therapy (HAART), coupled with access to comprehensive HIV medical care, are successfully delaying the progression from HIV infection to AIDS. Quality HIV care and carefully monitored treatment options are improving health and quality of life for many people living with HIV. However, these advances are out of reach for low-income people who cannot afford healthcare and treatment. Expanding Medicaid services to low-income people with HIV can delay progression to disability and prolong health.

In addition, expanding access to Medicaid for low-income people with HIV will help reduce the burden on Ryan White CARE Act programs, including the AIDS Drug Assistance Program (ADAP). These programs are already underfunded and many are reporting difficulties providing adequate services. In addition, CARE Act programs are “discretionary”, which means funding is reviewed every year during the appropriations process. Medicaid is an “entitlement” program, meaning the funding stream is much more stable and those receiving Medicaid services are guaranteed coverage.

The Early Treatment for HIV Act is a humane and cost-effective bill. It allows people to access treatment and healthcare before becoming sick, increasing quality of life and time spent in asymptomatic stages. By providing early access to treatment, it would also help reduce the cost of emergency care, hospitalization, and treating opportunistic infections.

Advocates are mounting a campaign to encourage Members of Congress to cosponsor this bill. A long list of cosponsors will demonstrate strong support for this legislation and help make sure that it is considered for a vote this year. You can make a difference by asking your Representative and Senators to be a co-sponsor!

Action Needed for this Alert:
Write or call your U.S. Representative and two U.S. Senators. Ask them to cosponsor the Early Treatment for HIV Act. Remember that there are two different versions of the bill: Representatives should cosponsor H.R. 2063 and Senators should cosponsor S. 987. Ask them to do everything in their power to make sure the bills are considered for a vote this year. You can use the enclosed sample letter and phone messages to help craft your message.

Courtesy of Treatment Action Network, Project Inform, 205-13th Street #2001, San Francisco, CA 94103
Abridged from its original form

Part 2: Action Skills

Personal Visits

Few people ever take the time to meet with their legislators to discuss issues that are important to them; so few, in fact, that this is one of the most powerful tools you can use as an advocate to influence the government.

The personal visit carries with it distinct advantages that other methods of advocacy lack. Visits with your elected officials not only identify your issues with real, live constituents, they are also forums where dialogue can happen, information can be shared, and minds and hearts can be changed. Once you are in the legislator's office, HIV/AIDS policy and funding issues suddenly become very real and tangible for the legislator — perhaps for the first time in his or her life. Your visit helps the legislator make a personal connection to the issue through you, the constituent. You put a face on the HIV epidemic for your elected officials and bring them something that professional lobbyists cannot always provide — the personal story of what HIV has done to you, your family, your loved ones. These are difficult facts for any legislator to remain distanced from.

The number of direct lobbying opportunities available to you are limited only by your schedule and that of the legislator's office. For a visit to be effective, it is not always necessary to meet with the elected official. A trusted staffer whose primary role is to focus on HIV and other health matters, and to educate the elected official, can be your most valuable ally. The staffer is probably available more often for meetings and phone calls than the legislator. So, never be discouraged to meet with a staffer, and work hard to cultivate a direct relationship that will ensure you access whenever you need it.

State and federal governments go on "recess" during different times of the year. You can find out when your elected officials will be in their local offices by calling the scheduler. Usually, it is also the scheduler who makes all the appointments. This is a person you need to have a good relationship with; if they feel unappreciated or treated poorly by you, they may not be able to find time in the legislator's schedule for your visit. Remember, it isn't the scheduler's or the staffer's fault if your legislator did not vote or act the way you wanted, so reserve your displeasure and your comments until you can meet. Or, write a letter.

Your elected officials maintain very active and tight schedules, so a brief meeting (usually no more than 15 minutes) is all you are likely to get. Make it work for you!

How To Schedule a Visit:

(1) Call your Member's local district office and speak to the scheduler or the person in charge of appointments.

(2) Be sure to tell the appointment person that you are a constituent. Request an appointment to come and visit with the Representative/Senator AND the staff person in charge of HIV/AIDS issues.

(3) The appointment person will probably ask you to fax or mail your request. If this happens, don't feel put off. It's actually to your advantage. You get a chance to clarify in writing what you want to talk about and who you are. Get the mailing address or FAX number and then go do your homework.

(4) Be sure to include the following information in your written appointment request: Your name and the address and phone where you live; the specific issue you want to discuss (HIV/AIDS funding, a bill that will be voted on, etc.); your occupation if it relates directly to the issue you want to talk about; suggested dates/times for the meeting; and the names and zipcodes of any other people who will attend the meeting with you.

(5) Allow a reasonable amount of time to pass after you send your request, then call the appointment person and check to see if your request has been received and what the status is. Be prepared to keep calling. Members have a limited amount of time and you are competing with many other people for some of it. You will need to be persistent.

(6) Once you get an appointment verified, take some time to rehearse what you want to cover. Write an agenda or a "cheat sheet" if you think it will help.

(7) Be sure to call the day before and, if possible, the morning of your scheduled appointment. Sometimes appointments get rescheduled or a member will be running late. The appointment person will be able to tell you this. If your appointment needs to be rescheduled, don't get discouraged. Take the new date and be ready to dazzle them when you get there.

Everything in life comes with its own rules attached. The lobby visit is no exception. Here are a few simple but essential guidelines to follow to keep you from wasting the valuable time you have in meetings with legislators.

Don't go off message. You or your group's power stems from being able to deliver a unified message that does not change from one legislator's office to the next. Sending a different message from those in the rest of the group is counterproductive and unfair to your fellow advocates.

Don't be late or blow off a meeting. Punctuality conveys professionalism, confidence, and urgency. Disrespect never helped secure a vote in Congress.

Don't dress down. Yes, your legislators work for you, but Congress is a formal institutions. Dressing conservatively creates an instant bond with both staff and legislators and invites them to focus on your issue.

Don't let them make you too comfortable. Remember, time is at a premium, and you do not want to waste it searching for chairs or getting coffee.

Don't engage in excessive praise or scorn. You are on Capitol Hill as a credible source of information from the district. Don't distract legislators from that role by being overly complimentary or verbally abusive.

Don't critique your legislator's value system. Sometimes legislators will agree with your position for reasons different than your own. Don't attempt to alter their value system in a brief meeting; graciously accept their support.

Don't treat the meeting as a one-time thing. You are not just having a meeting, you are developing a relationship with your legislators. Remember, this visit will not be your last. Don't lie, don't treat them disrespectfully, and keep any promises you make.

Don't discuss numerous bills or address unrelated issues. Addressing a variety of bills makes it difficult for your legislator to guess your priorities. Discussing other issues diminishes the importance of what brought you there. Keep the agenda focused.

Don't forget to follow up. Your meeting never happened if you leave the office and they never hear from you again. Immediately send a thank you letter, and stay informed on the issue. Contact the office if they vote the right way, and request an explanation if they do not deliver on their promises.

Part 2: Action Skills

Public Meetings

From time to time, Members host public meetings -- sometimes called Town Hall Meetings -- in order to promote their proposals to constituents and hear directly back from constituents what they think about the issues. Some Members also host Open Houses or coffees or breakfasts at their offices. All of these are great opportunities for the savvy advocate to develop a working relationship with the Member's office and to get the message of HIV/AIDS prevention, research, care and treatment, housing and social supports out to Members.

Where's the Meeting?

The easiest way to find out about public meetings and events that your Members host is to call their local offices and ask to be put on the mailing list. You can expect to receive perhaps four mailings a year, sometimes in the form of a newsletter, but most often a flyer or a postcard announcing an upcoming event or series of events.

Town Hall meetings will have a focused agenda developed by the Member, usually in consultation with his/her political party. The purpose of the meeting will be clearly stated on the announcement ("to discuss Social Security reform, to discuss handguns and safe schools, etc). Every public meeting is a good opportunity to an AIDS advocate willing to attend and use the time wisely.

What Can You Do There?

Other than filling up on cookies and fruit punch, you can use the open comment time to raise your issue. It may not actually get addressed in the meeting -- and there's no reason to be obstinate if it isn't. There is a time for that, but not yet -- but you have accomplished several things simply by bringing up AIDS as an issue in the district. (1) You've identified yourself as an advocate and a potential resource for information; (2) if the Member wasn't personally aware that HIV/AIDS was an issue in his/her district, s/he is now; (3) other constituents who are active in the community know that HIV/AIDS is an issue where they live, and if any of them share your concerns you can forge new links in your network; (4) you're on record, so to speak, on the issue, and this can be helpful later in working with the office to place HIV/AIDS on a future Town Hall agenda or to take some other community-oriented action.

What Happens at a Town Hall Meeting?

There may or may not be refreshments and a "social time" at the front of the meeting. The meeting is usually held in a public building -- a school, a library, a public services building -- and may be co-hosted by an official who works for the service agency -- principle, librarian, public works director, etc. The co-host will praise and introduce the Member, who will speak about the purpose of the meeting, may introduce additional expert speakers, and then either continue the open forum him/herself or turn it over to a staffer. Lots of notes are taken, the press normally shows up just to see if something out of the ordinary will happen, snaps a photo and interviews a constituent and leaves. Staff may hand out surveys or pass out invitations to constituents for other more intimate events. And then it's over.

As a Savvy Advocate, You:

- Deliver a clear message of concern on your issue and then graciously sit down when asked to do so.

- Sit near the front of the room, so that you can get through the crowd at the end of the meeting and make a connection to staff. Exchange cards and smalltalk.

- Say "thank you" to Members and/or staff for holding the meeting, and ask when it might be possible to have a meeting that includes HIV/AIDS issues -- and then follow up until it happens.

- Happily take any survey or poll handed out, fill it out, and send it back in promptly with a little thank you note reminding staff who you are and how excited you are about talking to them about HIV/AIDS issues in the district.

- Get many friends, family members, neighbors, and fellow advocates to the Town Hall meeting where you have managed to get HIV/AIDS included on the agenda, to ensure a successful and meaningful dialog. If your Member does his/her part, you must do yours.

Public Testimony

All legislative bodies -- town/city councils, county boards, state legislatures, and Congress -- have the power to make laws, and they know that engaging the public in the process through open hearings is, at the very least, a smart way to find out how easy or difficult the policymaking process around an issue will be. In many cases, public hearings are required by law.

Whenever a bill is considered by one of these bodies, time is set aside for public comment. Many times it is the paid professional lobbyist that fulfills this role, but occasionally a constituent will have personal experiences or expertise that makes him/her an expert on a given issue. For example, a teen may be asked to testify about AIDS education in public high schools. In these cases, public testimony is very important because it gives you a chance to make your statement in front of an entire panel or committee of key officials who will make the decision on the issue.

Testifying in Committee

- Show up to the committee hearing on time; be prepared to wait.

- When you testify, introduce yourself with your full name and any affiliations. Personalize your credentials if you desire (e.g.: I'm a person living with HIV; I've lost a lover to AIDS, etc.)

- Be polite. Address the committee chair as Mr. Chair(man) or Madame Chair(woman). Address all other members by their correct public titles (Councilmember, Supervisor, Representative, Senator, etc.)

- Don't interrupt any committee member when s/he is speaking.

- Don't argue, even if it looks like someone wants to pick a fight.

- Don't be surprised if committee members state common or ignorant attitudes about HIV/AIDS. They are a reflection of the general public.

- Be patient with AIDSphobia or ignorance. You are there to educate them with your experiences, knowledge and perspective. Avoid anger, and know that passion can be very persuasive.

- Personalize your testimony with true-life stories. Bringing an issue down to real people and real experiences works.

- Know who your opponents are. Know their arguments. Be prepared to rebut them.

- Don't be intimidated by "insider" attitudes among lobbyists, staff and legislators. Legislative bodies can be very closed environments, but don't let this insider attitude convince you that they know more than you do about AIDS. **You** are the expert.

- Don't be surprised if you don't get to testify. On major bills, the committee chair will often limit testimony, by either the number of witnesses or by how long a witness can speak.

- If you are with a group, decide beforehand who will speak if not everyone can. Choose carefully.

- Choose how you dress carefully. Legislators will form judgments based on your dress, rightly or wrongly. You don't have to agree with it, but know that it happens, and make your choice accordingly.

- **Have fun!**

Testimony of Nikeeta Williams

Mr. Chair, members of the Committee, my name is Nikeeta Williams, and I live here in the District of Columbia.

Until two years ago, I was unemployed, homeless, and living with nothing more than AIDS and my addiction. I am proud to stand here before you today, a strong, employed, and spiritual woman free from drug addiction for the first time in nine years.

I found treatment and the road away from addiction through the first people who I actually believed cared about me, even though I hardly cared about myself. They were the people operating the clean needle exchange program in the District. It was through these people and this program that I also found treatment for AIDS, referrals to job training and housing, and help with learning all the things I didn't know that I needed to manage my life.

This committee is about to decide on legislation that would make it impossible for nonprofit groups in Washington, DC who receive any federal funding to operate a clean needle exchange program. If that happens, then hundreds -- maybe thousands -- of women and men like me will never get a chance to move into recovery and reclaim their lives.

I urge you, as someone who has benefitted so greatly from this program, please vote against the needle exchange ban contained in H.R. 4942 and give people living in the District with HIV and addiction hope for a better future.

I submit my complete statement, provided in writing, to be entered into the committee record.

Thank you very much for the opportunity to speak to you today.

Write Your Own Testimony!
Use this tool to help you write your own testimony, something generic that you can modify and use for almost any occasion when you are called upon to speak.

ACTION PAGE!

The key components of any solid testimony are:

(1) Your Name

(2) Your relationship to the body you are testifying before. For example, if this is a city council, do you **live** or **work** in the city? **Own a business** in the city? **Receive vital services** in the city?

(3) Your relationship to the issue under consideration by the committee. For example, will their decision impact **services you receive or deliver**? Will it impact **a family member or a friend?** And what will the impact be -- **positive or negative**?

(4) Your relationship to others in the community who will be impacted by the committee's decision. For example, are you a **civic or community leader**?

(5) The action you want the committee to take. **Oppose, support, or amend**?

(6) Appreciation and respect, regardless of how you privately feel about the issue or the committee.

Part 2: Action Skills

Bill Analysis

Most federal and state legislation is introduced in the form of bills. Bills can be public (those that make, change, or overturn a law that affects all people), or they can be private (called "personal relief", seeking an exception from a law or regulation on some unusual and special grounds, like accessing an unapproved drug because you have a terminal condition and the drug may help you.) The text of a bill provides a lot of information on many aspects of proposed legislation. By reviewing key information such as the bill type, the author, the introduction date, the section codes, the digest, and the actual proposed law, you can map the course a bill will most likely take through the legislative process. This overview will focus on federal legislation; however, the components of a state and federal bill are nearly identical. The key information contained in a federal bill is:

Bill Type: (House of Origin) Congress introduces most legislation as House of Representatives bills (H.R.) and Senate bills (S.) This type of legislation requires a majority vote in each chamber (bills that enact taxes or change a budget require a higher number of votes), and the President's signature in order to become law. After a bill has been introduced by its author in its House of Origin, it is given a bill number and referred to a committee.

Author: Only Members of Congress are permitted to introduce bills. Sometimes, Members sponsor a bill on behalf of an interest group or organization. By considering the background of the author, his/her political party, and who (in the public) is sponsoring the bill, you can develop an effective strategy to support or oppose a given measure.

Introduction Date: The introduction date allows you estimate when action will begin on a bill. The path a bill follows in the House is a little different than in the Senate (See, How a Bill Becomes Law), but the first action step after introduction is committee assignment. Committee member need time to review the bill and decide where it should fit into their hearing schedule. There is no hard and fast rule, but the earlier a bill is introduced, the earlier it can begin moving through committees. Savvy advocates use this time between introduction and committee scheduling to assess bills and their potential impact, and determine a strategy if necessary.

Section Codes: The Section Codes (42 U.S.C. 1396a, for example) refer to the U.S. Code, the large body of public laws made at the federal level. By looking up these sections in the U.S. Code, you can find out how a new proposal might change existing law.

The Congressional Record: This is the official "diary" of the daily proceedings of Congress. It is divided into two sections, one for the House and one for the Senate, and a summary -- The Daily Digest -- accompanies each day's record. Actions and statements taken on every bill and item of debate are recorded in the Congressional Record. You can find out a lot about what Members think about a bill and what there intentions are by reading the remarks of Members in the Congressional record.

Cosponsors: A higher number may indicate the bill's popularity and a better chance at passage.

Actual Text: The first section of text will contain the "Short Title", usually a catchy name the author has given it to make it sound good. For example, H.R. 1142, known as the Medi-Access Act of 2001. The Short Title may bear no relation to the Official Title, which is more of a description of what the bill does (e.g., To amend Title XIX of the Social Security Act to allow families...) The rest of the text contains the actual wording of the intended law. Pay attention to words like "shall" and "must", they have a different meaning that "should" and "may". The first two create mandates and the last two are mere suggestions that don't necessarily have to be followed. When these words are used in language creating a program, they can be the difference between a program being funded and implemented, or simply written into law and never acted on. Bills can be amended as they move from a subcommittee, to a committee, to the floor, and then onto the other chamber, where they repeat the cycle. Each time a bill completes a stage in the cycle, a new bill will be printed to incorporate any changes. But during the time it is in process, you may have to read the amendments separately and refer back to the bill to see what they changed.

How to get copies of a bill: You can get them on the Internet at http://thomas.loc.gov by typing the bill number into the search box. Or, you can call your Member's local office and ask the office to get a copy for you.

Bill Analysis Worksheet

ACTION PAGE!

House of Origin: _____

Bill Number: _____

Author: _____

Number of Cosponsors: _____ Party Ratio of Cosponsors: ____ D ____ R ____ I

(1) What is the existing law?

(2) What are the objectives of the bill?

(3) How does the bill propose to achieve these objectives?

(4) If this bill were to pass, what would be the effect on people living with HIV/AIDS?

(5) What are the public health considerations of this bill?

(6) Who are the likely supporters and opponents of this bill?

(7) Are there any alternatives to the bill?

(8) Are there any needed amendments to improve this bill or correct any problems?

(9) Do you support or oppose this bill?

(10) How likely is this bill to make it through the legislative process?

(11) Are there competing measures moving through the legislative process?

Part 2: Action Skills

Of Email, Postcards, and Petitions

Email

There is a growing movement among Internet-capable advocates to make email the centerpiece of every grassroots action targeted at government. In the past few years, we've seen modest email groups grow into huge networks, the birth of online petitions, and the growing sophistication of Net-ready advocates in organizing mass campaigns by email and discussion groups.

But the sad truth is, elected officials, especially Congress, are more Net-weary than Net-ready.

The average congressional office receives between 1,500 and 2,000 emails a day. Short of reading each one of them and verifying street addresses (if the sender bothered to include one), there is no way for a staffer to know which of those emails come from actual constituents and which come from advocates-on-a-mission to E-Zap the office. Some Members try to restrict email by not having a published email address, only a webform that filters out senders using an address restriction; and an equal number of us have learned just what to do to get around the restriction and send mail anyway -- because we are that good.

The problem is that we have become so very good at doing something that is very much ignored. Yes, the staffer greeted by the 2,000 emails that take 30 minutes of his morning to download off the House or Senate server does just what your or I do with all that spam we get.

Point
Click
Delete

That moving, passionate, ingenious email you spent two hours crafting? Zip! gone in a flash. That soulfull rant... Ding! into the Great Recycling Bin in the Sky.

If you want your action to count, somebody has to see it. Fax it, put a stamp on it, or run it by your local district office and slid it under the door.

And, by the way, neither Congress nor the Post Office is trying to put a charge or tax on email. There is no bill 602P. It's an old hoax that you can ignore.

Postcards

You've seen them. They're in the local newspaper and the community rags, in newsletters you get from service organizations, in your mail, in office waiting rooms... your favorite bar....They're... **postcards!**

Yes, the dreaded "check-off" postcards. (Check here and mail this to Congress TODAY if you oppose bill 602P!)

Okay, they're not totally useless, and if it's a choice of doing a postcard or doing nothing, by all means do the postcard. But know how postcards are viewed by legislators and how they are treated. The same thing that makes postcards attractive to people who rarely voice an opinion is the thing that dims their significance to legislators: they're so easy. How long did it take you to make that check mark? Sign your name? Slid it into a mail slot? Was it postage paid? Um hmm.

An intern may get the job of counting the postcards when they come in, put them all in a folder and send them with a sticky note to the staffer in charge of the issue. If there's a counter action running (competing postcards), the postcards may get weighed if a lot come in. (Postcards for = 20 ounces, postcards against = 17 ounces. The opposition wins the postcard war.) This may sound silly, but think about it. What else is there to do with them? No personal story or person behind them, just a standard message, a check-off box and a signature. Weighing them may make the best sense after all.

You can't put out a house fire with an eyedropper. If the issue on the postcard speaks to you, find out enough about to make a phone call or write a letter. It only costs a little bit more and has a far greater impact than a hundred postcards.

Petitions

With the exception of legal petitions that are used to gather the required signatures to place a referendum on a ballot, most petitioning does little to move a policy decision. The one thing they are very good for is for gathering the names and contact information of other people in your community who share similar positions on the issues.

They can be helpful in growing a network of advocates. But don't expect more from them than that.

There's a reason why these two actions are at the end of this section: You want to use them only after other options have been tried and failed, and then only very carefully because they can sour relationships with Member offices. Use only as a last resort.

The FAX Zap (or the Phone Zap)
You can't do this action alone. You need people, and a lot of them. Or, at the very least, the appearance of a lot of them. The idea of the FAX/Phone Zap is simplicity itself: it is an attempt to bring the operations at a Member's office to a screeching halt until they give into your demands. (Hint: if you can make the staffer cry or beg you to stop the action, you win this one.)

The basic resources you need are (1) a targeted office; (2) the FAX number of the office; (3) a large group of people, say twenty-five or more, who have access to a FAX machine (one not paid for by their employer, unless their employer supports the action); (4) a whole day, or two or three, with nothing else to do but send endless faxes to the Member's office.

Scenario: Let's say you've been trying to get a meeting with a certain key Member for a prolonged period of time, and the office never comes through with an appointment. You've tried everything, including just showing up and taking your chances, but no one is ever available to meet with you. You feel you have no other choice but to force the issue.

This is FAX Zap territory. Your mission is to make that FAX hum and buzz all... day.. long... to the point where nothing gets done in the office. Keep faxing the same demand over and over and over, from different people. Give them a response time. Your FAX may say something like "If your office cannot confirm a meeting date by noon tomorrow, we will issue a press release stating that Representative _____ and his staff refuse to meet with people living with HIV and AIDS in his district." Add about a dozen phone calls (from different people) every hour, and you should have them frantic in no time. Few offices have the confidence to just shut off their FAX machine or stop answering the phones.

Note: Never, ever use threatening language! State a reasonable demand that falls within your rights as a constituent. You do have a right to access your elected officials.

The Make-Busy Zap
This is another action that you cannot do alone. You need at least two dozen people who have a lot of free time on their hands and reliable transportation, and another twenty or so that can make a few well-timed phone calls.

Scenario: You've been trying to get a key Member to focus on a crucial issue for months, let's say Medicaid expansion. There is a bill coming up for a vote in a few weeks. You want the Member to support it, or at the very least not to oppose it, but the Member's's office doesn't seem interested and says they're just not hearing from the community about the issue.

They're about to in a big way.

The action day starts with a phone call to the Members local office. The first caller says, "I just found out about (bill number), the Medicaid expansion bill. I can't seem to get a copy and I want to know more about it. Can you get a copy for me?" The staffer should say yes, they can do that. The caller's goal here is to find out how soon s/he can pick it up. "I'll be in the neighborhood after lunch today. Can I drop by and pick it up then?" If the answer is yes, your action is off and running. If the staffer needs a day, postpone the rest of the action to later the same day.

By the afternoon of the same day, you want to have at least ten people call and say basically the same thing as the first one, except they should just ASK when they can pick it up. The answer should be the same as given to the first person. Now things are cooking. Hopefully it's a large enough bill to make it slightly annoying to copy, but not large enough to make it impossible to get enough copies made for all the people who are suddenly calling for it. It will get more annoying as the number of required copies start going up.

When copies become available, your "pick up crew" should start arriving at the office. Try to schedule them to arrive in a pattern that guarantees constant disruption, and if possible, schedule two of them to arrive "by accident" at the same time, so they can stand and chat in the staffer's office about the bill, the weather, why the Member hasn't spoken in public about the bill.. Now, get more people to call and ask for the bill at the same time that people are standing around in the office discussing it. Repeat. The importance of this bill just went way up. Call the Member.

Part 3: Organizing Skills

Conducting Issues Planning

If you are going to be successful in your advocacy efforts, you need a plan for each issue or set of issues or policies you address. Without a plan you are at the mercy of other groups and actions you have no control over.

There is an outline on the following page that can be used as a tool for planning. It is a guided exercise and you will not find instructions in this handbook on how to do it. More importantly, you will find some general guidelines on planning and action here.

1. Fight the Issue Where it Lives: There are two parts to this concept. First, identify what level or part of government has authority to correct the problem or create the program, then target your actions there. Second, don't worry about the last action that failed or the last plan that fell apart. Deal with the issue where it and you both are now.

2. Know What is Behind You: No policy or proposal for a policy simply fell out of the sky and dropped on a Member's head. Everything began somewhere, usually as something else. What you're working on or against now has a history. Learn it. Know who else played a role in its making or kept it from being made. Are they still players now, even if behind the scenes? Know the anatomy of the beast and you won't be surprised by any of the shapes it may take on.

3. Know What is Ahead of You: Where is this proposal going, where do you want it to go, and what does your opposition want to happen? How long will your resources, including your own energy, last? When will you need additional resources and who can you turn to for them? Define an end point, including the "break point", the place beyond which you cannot go.

4. Decide How Much of You You Are Willing to Give: We all like to say we'll give 100 percent, but can we really? What are you willing to lose and what must you gain in order to lose that? Have an intentional conversation with yourself, and any group you are working with, about integrity, ethos, and personal needs. There are compromises, and then there are compromising situations. Know the difference. Make an agreement, and stick to it.

5. "Because it Doesn't Work That Way", or "We Don't Have the Money" is Never an Acceptable Response from Government: There are legitimate barriers to resolving most policy issues. If there weren't, we'd all live in a splendid Utopia where no one ever went hungry or homeless or without medical care, or any of the other problems human beings face. But the majority of barriers are created not by mandate or law; they are created by people who have lost their creativity, energy, or will to improve the world they live in. Do not accept blathering excuses about the complexity of public policy or the partisanship in politics or the lack of money, or any of that nonsense. Congress makes new laws every year, and they manage to find ways around the barriers, including financial barriers, because they want to. Make them want to create your vision. Work with them. Push them. Lead them if you have to. Accept nothing that lacks a dignified and comprehensive response to the issues faced by people living with HIV and AIDS.

6. Teach Yourself to Be Fearless: Don't waste a minute worrying that you're not a lawyer, that you didn't go to college and learn everything about public policy or that you barely remember high school Civics. It doesn't matter. Don't worry about embarrassing yourself. You will someday -- we all do. You'll learn something new and then you'll get over it. Don't dwell in terror on the thought that some staffer or some Member is going to ask you a question that you don't know the answer to. Say, "I don't know," and then make it your business to find out. If you do, you can report the answer next time. Besides, you could ask them some questions that I guarantee they don't know the answers to.

7. Life is Big and Its Nature is Change: Have a big life and advocate for the changes you know will make a difference, for you and for others. Leave the small stuff to change on its own.

Issue Planning

ACTION PAGE!

Use this worksheet to create a basic plan to address any policy issue.

What is the issue?

What is our goal?

What are the arguments in favor of this policy?

What are the arguments against this policy?

Who will support us?

Who will oppose us?

What are our resources?

What additional resources do we need?

What level of government can affect this policy?

What is the current status of this policy?

What is our timeline?

What actions can we take within our resources and timeline to achieve the outcome we desire?

Who is responsible for carrying out these actions?

Part 3: Organizing Skills

Partnerships and Consensus Building

The more advocacy you do, the more often you will find yourself partnering with other advocates, organizations, and even Members, and needing to build consensus.

This can be a very tricky thing. Generally, when we think of partners in the abstract, we seem to dream up these people who believe exactly as we do and agree with us on every issue. Realistically, that is hardly ever the case.

The other fallacy that we, as eager advocates, are susceptible to is the idea that our partners will want to commit the same level of resources to our partnership as we do, and that this is somehow only to expect. Again, this usually isn't what happens, or even what should.

People and organizations have a wide variety of reasons and incentives for developing short- or long-term partnerships with others, and they may not be the same as our reasons or incentives for partnering with them. Part of consensus building (which is not the same as total agreement) is recognizing these differences, and how even those that may not immediately seem beneficial can enhance our advocacy efforts.

Consider the following types of relationships and the ways to deal with them:

BEDFELLOWS: High Agreement/Low Trust
They are aligned with us, but when we have contact with them, don't give us the whole story. When we meet, we are strategic and careful about how much information we share.

- √ Reaffirm agreement
- √ Acknowledge that caution exists
- √ Talk about difficulties in the relationship, not difficulty in the other person
- √ Be clear in what you want in working together. Ask him/her to: take action; give us more than lip service; keep us informed.

FENCE SITTERS: Unknown Agreement/Low Trust
They will not take a stand for or against us. They epitomize order in the midst of chaos.

- √ State your position
- √ Ask where they stand
- √ Apply gentle pressure
- √ Encourage them to think about the issue and let you know what it would take for them to give you support

ADVERSARIES: Low Agreement/Low Trust
They resist attempts to pressure and convert them / Past attempts at negotiating agreement and trust have failed.

- √ State your position or vision for the project (what and why)
- √ State in a neutral way your understanding of the adversary's position
- √ Identify your contribution to the relationship problem
- √ End with your plans and no demands

ALLIES: High Agreement/High Trust
They can intervene for us.

- √ Affirm agreement on the project or vision
- √ Reaffirm the quality of the relationship
- √ Acknowledge doubts and vulnerabilities
- √ Ask for advice and support

OPPONENTS: Low Agreement/High Trust
They bring out the best in us by challenging us.

- √ Reaffirm the quality of the relationship and the fact that it is built on trust
- √ State your position
- √ State in a neutral way what you think their position is
- √ Engage in some kind of problem solving

Although this matrix of thought may seem to apply best to dealing with Members or groups that we think of as "not us", it is actually a very helpful, rational, and dignified way of assessing the strengths of our traditional partners, too, and where some of our earlier efforts together went off course because of misunderstandings about relationships and expectations.

COALITION BUILDING

ACTION PAGE!

I. OUTREACH TO COMMUNITY

A. Organizations

-other AIDS service providers
-other health care providers
-churches

B. Individuals

-PLWHA's
-Mothers
-Concerned community members

II. USEFULNESS OF COALITIONS

A. Strength in Numbers for Advocacy Efforts

-demonstrations
-letter writing campaigns
-lobby days

B. Panel of Experts

-testimony before legislative bodies
-press conferences
-need for diversity and broad base

C. Identify Supporters and Opponents

-build strength for your side
-neutralize or convert the opposition

Above is a narrow outline of coalition building.

What other groups would you or have you out-reached to?

What other reasons or benefits can you think of for forming a coalition?

Use the right hand side of this page to explore how you feel about and think about coalition work.

Part 3: Organizing Skills

Demonstrations & Rallies

The biggest difference between a demonstration and a rally is, demonstration usually has more of an oppositional feel and a rally has more of a supportive feel. You demonstrate against a proposal; your rally in support of one. Essentially, they are the same.

Both demonstrations and rallies rely on the masses as their primary vehicle for getting across a specific message. Condensed simply, the broad message of any public action is "Can all these people be wrong?!" Large gatherings can be impressive in their own right, but it is much better if the action -- and the actors -- have something substantial to say.

The basic elements needed for a demonstration or a rally are:

- Issue
- People
- Place
- Permit
- Signs
- Sound system (a bull horn will do)
- Speakers
- Press

These actions are not usually difficult to arrange, but they are time consuming. It takes concerted effort by a dedicated corps of people in order to ensure that all logistics are covered and that people attending the event will be able to use it appropriately.

Events like these are best planned using a committee structure with clear assignments and deadlines for individual tasks. Otherwise, you end up with a large milling crowd (or worse, a very small wandering crowd) in the day of the action.

Some recurring barriers to organizers of demos and rallies seem to be:

- Difficulty getting a permit in a timely manner
- Becoming a target for a counter action that holds every possibility of being larger and more aggressive than yours
- Difficulty reaching all the communities you want to participate in the action
- Difficulty getting clear estimates of attendance
- Difficulty confirming speakers and agreeing on a message

The other and separate issue to consider is civil disobedience.

Civil disobedience is serious, must be planned in advance, and can be dangerous to the health of people and the credibility of your advocacy effort if not managed correctly.

Never encourage people to get arrested at a demonstration or rally you are responsible for unless you have first taken them -- and yourself -- through a training on how to do civil disobedience.

THE PERFECT DEMONSTRATION

HOW TO DO A DEMO

WHAT IS THE ISSUE?

WHO AND WHERE IS THE APPROPRIATE TARGET

- Legislator
- Specific Entity
- CDC, FDA, Congress, White House, pharmaceutical industry, school board, Board of Supervisors, etc.

HOW

- Legal Demo
- Civil Disobedience: sit in, die in, blocking traffic, interrupting a speech, crossing a police line, chaining oneself to a fence or entrance to a building.
- Legal Demo & Civil Disobedience: phone zap, fax zap, wheat-pasting

PROPS

- Banners, signs, whistles, bull horns, chalk, etc.
- Is street theater part of the action? : make-up, costumes, sets

LEGAL CONCERNS

- Is a lawyer available to help out at site and afterward?
- Bail fund, legal observers, C.D. training
- Long term concerns

PRESS

- Press Release: who, what, when, where and why (about a week in advance)
- Media Advisory: concise version of press release faxed out the day before, early in the morning
- Press Conference: day of event
- Media Team : media coordinator, press runners, spokespeople, press packets

FOLLOW UP

- What do you have to do to keep things cooking?

Part 4: Issue Background

The following pages contain very basic information on some, but certainly not all, of the federal programs of interest to people living with HIV and AIDS.

More information is available and we encourage you to contact us if we can assist you in finding what you need to be successful in all of your advocacy efforts.

THE HIV/AIDS EPIDEMIC
WHY FUND HIV/AIDS PROGRAMS?

The HIV/AIDS Epidemic is a Public Health Emergency

AIDS is an infectious, incurable and usually fatal disease that strikes people in the prime of life and was unknown until 1981. Less than two decades after its first appearance in the U.S., AIDS has killed over 400,000 Americans and is the leading cause of death among African-Americans and the second leading cause of death among Latinos between the ages of 25-44. Overall, AIDS is the fifth leading cause of death among all Americans in this age group. It is estimated that one in 250 Americans is infected with HIV. HIV/AIDS is one of the most devastating epidemics to face our country in recent history, and is different from other life-threatening diseases in a number of ways:

- **HIV/AIDS is a new and complex disease.** Unlike other life-threatening conditions, which have been studied and treated for decades, HIV/AIDS was unknown just seventeen years ago. Research into AIDS prevention, treatment, and care has struggled to keep up with the inroads the epidemic has made into our society. It took five years for researchers to identify the cause of the disease and to establish a diagnostic test for it. It took fifteen years for researchers to develop potent new drugs, known as protease inhibitors, to treat HIV/AIDS. The complexity of the human immune-deficiency virus (HIV) continues to challenge researchers as they search for a cure. The epidemic has placed heavy demands on our society to build up a new infrastructure for complex new care services and prevention programs.

- **HIV/AIDS disproportionately affects younger Americans.** AIDS is a disease that predominately kills Americans in the prime of their life. Half of the 40,000 new infections each year occur in individuals below the age of 25. In 1998 alone, close to one million years of potential life was lost due to the fact so many young people lost their lives. While other diseases may cause more deaths, AIDS often kills some of the youngest, most productive members of our society. It is estimated that the median age at time of infection is now 25 years, and that one out of every four HIV positive Americans became infected when they were 21 years old or younger.

- **People with HIV/AIDS experience discrimination.** Seventeen years after the beginning of the epidemic, people living with HIV/AIDS continue to face discrimination from employers, landlords, health care providers and others. HIV/AIDS-specific programs and services have arisen to meet the needs of people who have lost their jobs, their health insurance and their homes. Housing Opportunities for People With AIDS (HOPWA) and other programs arose, in part, because of the inability of people with HIV/AIDS to access other housing, social service and health care programs. Underlying some of the arguments against increased HIV/AIDS funding is often a moral judgment about who gets the infection and how it is transmitted. Virtually every major cause of death in the nation has some behavioral basis. For example, we conduct research into lung cancer, even though its primary cause is behavior-based, through smoking, while also urging people to change the behaviors that place them at risk. Few other medical conditions have been subjected to the same degree of prejudice and discrimination as HIV/AIDS.

continued

Federal AIDS Funding is Not Higher Than That of Other Diseases

The perception that the federal government spends more money on AIDS than any other disease is false. Because HIV/AIDS is an epidemic, a greater effort has been made to track AIDS care expenditures. For example, overall federal spending for heart disease and cancer in the two major federal health insurance programs – Medicaid and Medicare – is not tracked in the same fashion as AIDS. Therefore, it is misleading to include entitlement spending for AIDS to calculate aggregate disease spending, without including comparable figures for other diseases under entitlement programs. Federal AIDS programs are important because:

- **The initial federal response to the epidemic was inadequate and slow.** Funding for care and housing programs for people living with HIV/AIDS was not appropriated until the 1990s, over ten years after the epidemic began. Community based prevention programs were not put in place until several years ago. Governmental censorship of effective prevention messages further delayed the provision of life-saving information to Americans. We have a lot of catching up to do in order to effectively counter the further spread of the epidemic, care for those who continue to fall ill, and investigate possible treatments and a cure for this dreaded disease. The AIDS epidemic continues to require a concerted federal response and this cannot be accomplished without enhanced funding levels.

- **Volunteers have led the response to the epidemic.** In contrast to the initial lack of leadership from the government, the volunteer response to the AIDS epidemic was remarkable. Thousands of community and volunteer based organizations sprang up to care for those who were ill and teach those who were not how to avoid becoming infected. The volunteer sector continues to work cooperatively with the federal government in a private-public partnership to support innovative and cost effective programs. Volunteers continue to be a vital component in the fight against the AIDS epidemic.

- **Federal Spending on AIDS Programs is Cost-Effective and Makes Beneficial Contributions to Society**
  Putting targeted dollars into care, prevention and research not only saves lives and alleviates suffering; it saves our country from incurring much greater costs down the road. Every case of AIDS prevented through life-saving HIV/AIDS ***prevention and education services*** not only preserves productive human lives, it saves our society over one hundred thousand dollars in care services needed for a single case of HIV infection. Targeted, appropriate ***care and housing*** for men, women and children with AIDS keeps them out of expensive emergency rooms and hospital beds and healthier longer. ***Research*** has already led us towards treatments that keep people healthier and productive longer and will eventually bring us a cure and a vaccine for AIDS.

- **AIDS research benefits other diseases.** All biomedical research is related; AIDS research has become a gateway to the diagnosis and treatment of many diseases. For example, it has led to a new drug for hepatitis B, the leading cause of liver cancer worldwide, and for hepatitis C, a rapidly emerging additional cause of chronic liver disease. The New York Times recently reported that scientists are close to entering clinical trials for genetic treatments for diseases such as cancer and hemophilia using what they know about HIV. The success of the protease inhibitors in prolonging life and enhancing the quality of life of many people living with HIV/AIDS may also hold promise for the treatment of other conditions. Several drug companies are developing protease inhibitors for use in treating bone loss, or osteoporosis; and in limiting the heart muscle damage that results from a heart attack. Twenty-five percent of AIDS research funding is targeted

to basic biomedical research. Treatment and prevention medications which have been developed to combat the opportunistic infections which frequently attack people living with AIDS are now being utilized to fight these same conditions in individuals with advanced breast cancer as well as people who are immune-suppressed because of organ transplants, genetic disorders and severe autoimmune diseases.

- **Targeted care services protect our health care system from collapse.** The addition of hundreds of thousands of seriously ill Americans has strained our already overburdened health care and social services systems. Targeted care services like those provided by the Ryan White CARE Act help ease this burden by providing appropriate early intervention and outpatient care. The availability of these services ensures that hospitals and community health centers can continue to address the other health care needs in their communities while people with HIV/AIDS receive services they need from providers with HIV expertise. For many people living with HIV/AIDS, the CARE Act is their only source of health care and social services.

- **HIV/AIDS programs have become innovative models.** Programs such as the Centers for Disease Control and Prevention's (CDC) recently instituted community planning process for HIV/AIDS prevention and the Ryan White CARE Act are cost-effective, locally-controlled public-private partnerships that target services to those most in need based on priorities determined by local communities.

February 2000

AIDS Action
www.aidsaction.org

Surplus Plunges In New Forecast

Budget Has Little Room for More Spending

By Glenn Kessler
Washington Post Staff Writer
Thursday, August 23, 2001; Page A01

The White House yesterday released an extraordinarily tight budget forecast for the rest of President Bush's term, suggesting there is little room for additional spending on defense, a prescription drug benefit, Social Security reform and other high-profile initiatives without cutting into other programs.

For the fiscal year that ends Sept. 30, the administration projected a budget surplus of $158 billion, but only $1 billion remained after the surplus generated by Social Security payroll taxes is excluded. The administration estimated another slim $1 billion non-Social Security surplus in 2002, $2 billion in 2003 and $6 billion in 2004.

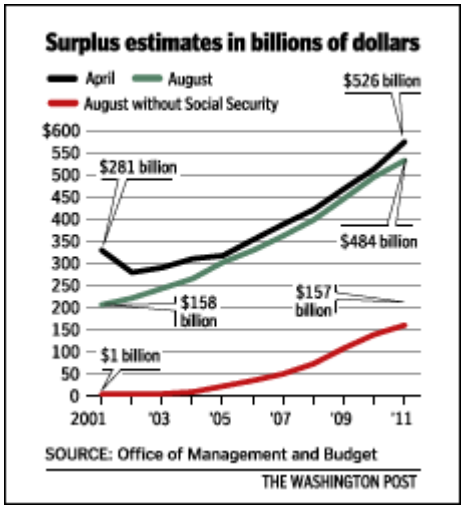
Those numbers stand in sharp contrast to huge surplus projections that have dominated the political landscape in recent years, and Democrats yesterday were quick to pounce on the new forecast. "This is fiscal mismanagement big time," said Senate Budget Committee Chairman Kent Conrad (D-N.D.).

The sharp plunge in the non-Social Security part of the forecast — largely the result of Bush's tax cut and the slowing economy — will loom as a major obstacle to important goals of lawmakers in both parties. Bush, and leading Democrats and Republicans, have sworn not to use surpluses generated by Social Security payroll taxes for other government programs, though that had been common practice until the recent surpluses.

Administration officials emphasized the overall surplus numbers, noting that this year's surplus will be the second-largest in history. "The nation is awash in money, and it's going to be," said budget director Mitchell E. Daniels Jr. Over the next decade, he said, the Social Security surpluses will help reduce the national debt held by the public, now $3.3 trillion, to the smallest share of the economy since 1917.

Although Democrats said Bush's tax plan is to blame for the new fiscal situation, the administration and its GOP allies said runaway spending poses the greatest threat to the surplus. White House spokesman Ari Fleischer said the new forecast was "a warning signal because there are still people in Congress who want to spend more money and bust the budget."

To a large extent, politics rather than traditional economics is responsible for the new blame game in Washington. It is all but impossible for the government to place Social Security or Medicare taxes in a bank, because that would harm financial markets. So in effect, the government borrows the money from the old-age programs and uses it elsewhere.



Under government accounting, spending Social Security or Medicare taxes does not reduce the amount of Treasury bonds credited to the trust funds of the two programs; it also does not affect benefit payments. When surpluses emerged several years ago, politicians agreed to wall off the money and use it for debt reduction. If the money is used for spending, it reduces national saving and could lead to higher long-term interest rates.

The new projections will make it all but impossible to complete work on the 13 annual spending bills — none of which have been enacted — before the new fiscal year starts Oct. 1, lawmakers and aides said. The two biggest bills — defense, and education, health and labor — have not even been considered at the subcommittee level, even though together they make up two-thirds of the discretionary budget.

In its revised budget forecast, the administration accounted for only the cost of the first installment of its much-touted defense buildup. It allocated $190 billion over the next 10 years for a prescription drug benefit, less than what many Democrats say is prudent. No money is set aside for funding Social Security investment accounts, a key goal of the president. And the budget document notes that funds are so tight that cuts in other areas will be necessary to fund the $70 billion restructuring of farm programs and possible emergency spending to aid areas hit by earthquakes, hurricanes and other natural disasters.

But Daniels said aggressive efforts to clamp down on

spending should free up funds. “There will be ample room, particularly if we at last become proficient in Washington at redeploying funds from obsolete, nonperforming and duplicative programs to more important uses,” he said.

A more immediate problem for the administration is that the congressional budget blueprint will not permit additional defense spending in the fiscal 2002 budget if it appears that Congress needs to spend excess Medicare payroll taxes to fund other government programs, something yesterday’s projection said will be required. Bush requested an additional $18 billion for defense over the summer, which Conrad said he would oppose.

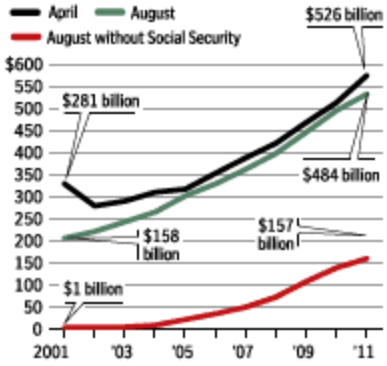
Conrad said he was troubled that at the same time the administration estimated economic growth that is higher than the consensus private forecast, it also projected such a small surplus, excluding Social Security, for 2002. The administration estimates 3.2 percent growth in 2002, compared with the consensus of 2.8 percent.

“I think it is most unwise [to spend Medicare taxes] when the president is forecasting strong economic growth,” Conrad said, noting it will require 60 votes in the Senate to override the blueprint.

Smaller Surpluses

The White House released official budget estimates yesterday showing that the surplus has shrunk enough to eliminate the portion being set aside for Medicare.

Surplus estimates in billions of dollars



Q: What is a budget surplus?

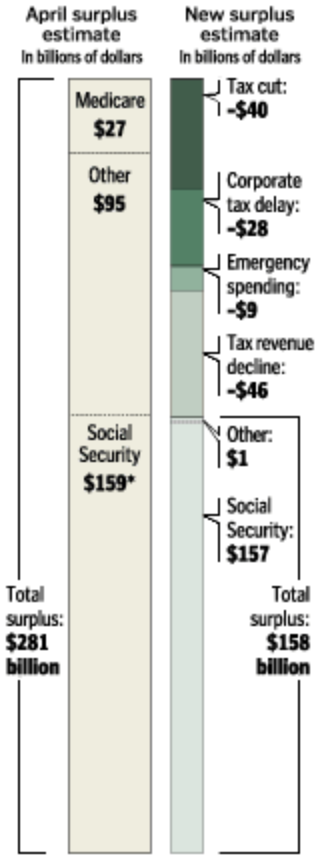
A: The government has a surplus when it takes in more revenue than it spends in a given year. Government revenue is mostly taxes, such as income taxes and Social Security and Medicare taxes that are withheld from paychecks. Although some of the money is kept in different accounts, such as Social Security, from an economic standpoint, the government’s fiscal standing is best deter-mined by the overall surplus.

Q: What are the Social Security and Medicare surpluses?

A: As the surpluses have grown, politicians have resolved not to use the surplus being generated by the Social Security payroll tax for regular government operations. That walls off a big chunk of the surplus from tax cuts or new spending. Democrats and Republicans last year also promised not to touch the surplus for Medicare hospital expenses.

SOURCE: Office of Management and Budget

What ate the surplus:



*The White House revised its Social Security surplus figures to reflect new accounting methods.

THE WASHINGTON POST

Democrats, while relishing the political dilemma facing the administration, also must live with the new budget constraints, although they can blame Bush for them. Many Democrats assert that surpluses generated by Social Security and Medicare payroll taxes should be off-limits to spending. The new budget forecast shows the 10-year surplus, excluding Social Security and Medicare, has shrunk from $2.5 trillion in April to $38 billion today.

Although administration officials tried yesterday to keep the focus on the overall surplus, they were clearly sensitive to the political risk if it appeared that the administration had crossed the politically important line into the Social Security surplus.

In yesterday’s projections for 2001, the administration changed the accounting for Social Security, freeing up $4 billion, and also assumed corporations would pay $5 billion in taxes earlier than expected under the new tax law. Otherwise, the forecast would have shown the administration $8 billion in the hole.

For the 2002 forecast, which also showed a $1 billion surplus excluding Social Security, the administration omitted the $1.4 billion cost of extending some expiring tax credits in 2002, even as the budget document says it wants to work with Congress to extend them.

The Congressional Budget Office next week will release its forecast, and many on Capitol Hill expect it to show that the administration will have to spend Social Security payroll taxes.

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THE DISAPPEARING 2001 SURPLUS: TAX CUTS, BUDGET INCREASES, AND THE ECONOMY

by Richard Kogan and Robert Greenstein

When the Bush Administration issued its budget on April 9, 2001, it predicted a budget surplus outside Social Security of $125 billion for fiscal year 2001, which at that time was six months complete.1 Now, four months later, the predicted $125 billion surplus has practically disappeared. How did this happen? The quick answer is that the recently enacted tax-cut reduced revenues by $74 billion in 2001 and the economy slowed significantly, so that revenue collections fell below predicted levels. (See Table 1.)

Some members of the Administration have attempted to blame the *previous* Congress and administration for the reduction in the 2001 surplus, pointing out that last fall, Congress increased funding for appropriated (or "discretionary") programs.2 While true, this is not relevant; the Bush Administration's April prediction of a $125 billion surplus already accounted for all the funding and tax decisions made last fall by the previous Congress. Clearly, the level of spending enacted last fall does not explain why predictions made *this April* were off base. Nevertheless, to put the issue of program increases and tax cuts into context, this analysis also examines how the surplus projection for 2001 made by the Congressional Budget Office in July 2000 has changed over the course of the last 13 months. In so doing, the analysis compares the budgetary effects of last fall's appropriations bills with the effects of this spring's tax cuts.

- Thirteen months ago, CBO projected a surplus of $125 billion outside Social Security. (It is coincidental that last July's baseline projection of the 2001 surplus by CBO and this April's estimate of the 2001 surplus by OMB, under the Bush Administration's budget proposals, were both $125 billion.)

- Media reports suggest that when CBO issues its new budget projections on August 28, it may show that the projected 2001 surplus outside Social Security has turned into a small deficit. Some $95 billion of the $125 billion deterioration in the size of the projected surplus is due to legislation enacted last fall or this spring.

- *Only 15 percent* of that $95 billion was enacted by the previous Congress and previous administration. Some *85 percent* was enacted by this Congress and this Administration.

1 *The Budget of the United States Government, Fiscal Year 2002*, Office of Management and Budget, Summary Table 3, p 225, April 9, 2001. OMB predicted a total surplus of $281 billion, of which $156 billion was "off budget" (the off-budget surplus is accounted for almost entirely by the Social Security Trust Fund), leaving a predicted $125 billion on-budget surplus. For simplicity, this analysis will refer to the on-budget surplus, which excludes Social Security, as "the surplus." If the $29 billion surplus in the Medicare Hospital Insurance Trust Fund predicted by OMB *also* were excluded, as Congress evidently believes it should be, the predicted surplus for 2001 would have been $96 billion. (The OMB estimate of a $29 billion surplus in the Medicare HI trust fund appears in Table 15-4 of the OMB's *Analytical Perspectives*, also issued April 9.)

2 Lawrence Lindsey, the President's economic advisor, speaking on CNN's *Inside Politics* of August 6, 2001, said "[T]he previous Congress last year, to get out of town, spent $30 billion more than what they had agreed they were going to spend."

This analysis also examines the historical record of federal spending to ascertain whether program spending surged in 2001 as a consequence of decisions made last fall.3 The data do not show such a surge.

- In 2001, federal spending dropped to its lowest level as a share of the economy since 1966.
- In 2001, federal spending grew by 0.5 percent after adjusting for inflation, well below the historical average of 2.8 percent (over the 1962-2001 period) and even further below the 3.9 percent growth rate in spending that the Bush Administration has proposed for 2002.
- Looking only at appropriated programs, expenditures grew by 2.8 percent in 2001 after adjusting for inflation. The Bush Administration has proposed a 5.8 percent increase for 2002; the size of the increase the Administration has proposed is primarily driven by the large increases the Administration is seeking in defense spending.

Changes in the 2001 Surplus from April to August

As Table 1 shows, OMB's April projection of a $125 billion surplus for 2001 (excluding Social Security) has disappeared, largely because of the tax cut but also because of the economic slowdown.

What does the economic slowdown signify for the budget in the future? Where will we be after the economic slowdown is over and the economy once again is operating at full capacity? Will the economy resume the torrid pace of the second half of the 1990s, or will the promise of a "new economy" prove to have been too optimistic? The answers to these questions, which are not known at this time, will affect the nation's long-term fiscal condition. (They will not materially affect the immediate budget situation.)

Table 1
Changes in the 2001 Surplus Since April 2001
(Estimates in billions. On-budget amounts only, which exclude Social Security)

2001 surplus predicted by the Administration on April 9, 2001, based on enactment of its proposed budget policies	**125**
Enacted tax rebates and immediate rate cuts (beyond those proposed by the Administration)	-41
Enacted shift of two weeks of corporate income tax receipts from 2001 to 2002 (included in the tax cut bill)	-33
Enacted new spending vs. proposed new spending, since April	-4
Economic and technical reestimates since April (largely caused by the economic slowdown)	-50
Changes in accounting procedures	+4
Current OMB estimate of the 2001 surplus	**1**

Source: Joint Committee on Taxation and Congressional Budget Office estimates of the cost of enacted legislation (these estimates differ slightly from OMB's); OMB April and August estimates of surplus.

In previous analyses, we have suggested that the long-term revenue losses the tax cut will generate are too large — that over the long term, the tax cut will not leave enough resources to prepare the nation and the Social Security and Medicare trust funds for the retirement of the baby boomers, while also meeting other needs.4 If the current economic slowdown proves to be a harbinger of generally slower growth during the coming decade, the budgetary problems over the course of the decade may be hundreds of billions (or even trillions) of dollars larger than previously thought.

3 Because this aspect of the analysis examines spending in 2001 *resulting from legislation enacted last fall*, it does not include the 2001 expenditures that will result from this spring's defense supplemental appropriations bill and this summer's increase in farm price supports. Inclusion of those two pieces of legislation would make little difference in the figures.

4 See *How Much of the Surplus Remains After the Tax Cut?* Center on Budget and Policy Priorities, revised June 27, 2001.

Changes in the Projected Surplus from July 2000 to August 2001

Some advocates of the recent tax cut speak of the budget increases enacted by the previous Congress as though they far outweigh the tax cut this Congress approved. An examination of the data shows the opposite is the case.

Costs in 2001

This examination starts with the surplus of $125 billion that CBO projected for 2001 in July 2000, thirteen months ago. It then compares the legislation enacted last fall with the legislation enacted this year, to see which contributed more to the deterioration of the 2001 surplus. It can be seen that the revenue losses from this year's tax cut far exceed the cost of increases in appropriations or entitlement programs enacted last year.

Table 2

Changes in the 2001 Surplus Since July 2000.

Preliminary estimates in billions. On-budget amounts only, which exclude Social Security

2001 surplus projected by CBO, July 2000, assuming there would be no tax changes and that appropriations for 2001 would grow only with inflation	**125**
Legislation enacted last fall:	
2001 appropriations	-8
entitlement changes	-4
tax cuts	-2
Legislation enacted so far this year:	
tax rebates and immediate rate cuts	-41
shift of two weeks of corporate income tax receipts from 2001 to 2002	-33
2001 supplemental appropriations	-1
increase in farm price supports	-6
Possible economic and technical reestimates since July 2000 (estimated)	-30 *
2001 surplus likely to be projected by CBO this August (based on press reports)	**0** *

Source: CBO/JCT and press reports

* These two figures are approximations of what the CBO report to be issued August 28 is expected to show.

Table 3

The $95 Billion Deterioration Since A Year Ago July Due to Enacted Legislation

dollars in billions

Enacted last fall	$14	15%
Enacted this session	$81	85%
TOTAL	$95	100%

A more complete analysis of the figures in Table 2 is shown in Table 3, on the next page.

Some $95 billion of the deterioration in the 2001 surplus from last July to this August is due to legislation enacted last fall or so far this year. Of that $95 billion, the vast bulk — 85 percent — is the result of laws passed by this Congress and signed by President Bush. (See Tables 2 and 3.) These data suggest that, even using last year rather than this year as the reference point, it is difficult to blame the deterioration of the 2001 surplus primarily on the prior Congress or the prior administration.

Long-term Costs

We also compare the *ten-year* cost of the legislation enacted last fall with the ten-year cost of the tax cut. As Table 4 (on the next page) indicates, the cost of the tax cuts enacted this year far exceeds the cost of last year's budget increases. Over a ten-year period, the tax cut is nearly four times as costly as the budget increases. The tax cut will be more than five times as costly when it is fully in effect.5

Administration Finds Some of Last Year's Spending Increases Inadequate

It also should be noted that although the Bush Administration apparently finds it useful to castigate the program increases enacted last fall, it is far from clear that the Administration really objects to those increases. The Administration had the opportunity this spring to request the rescission of some amounts enacted last fall. It chose not to do so. Furthermore, of the $434 billion in ten-year expenditure increases enacted last fall, about 60 percent occurred in three areas of the budget: health research and training, defense, and education. In this year's budget, the Administration requested *further funding increases* for 2002 in all three of these areas — an 8 percent funding increase for health research and training, a 7 percent funding increase for defense, and a 4 percent increase for education, compared with the levels needed to cover inflation. In these areas, the Bush Administration appears to believe the previous Congress did not raise spending sufficiently and further increases are needed.

Table 4
The Ten-Year Cost of Recent Legislation

	Ten-year cost in billions	Tenth-year cost as a share of GDP
Discretionary and mandatory program increases enacted last fall	$434	0.33%
Tax cuts enacted last fall	$37	0.03%
Tax cuts enacted this June (assuming all provisions are made permanent)	$1,660	1.75%

Source: CBO/JCT. The ten-year cost of legislation enacted last session covers the period 2001-2010. The ten-year cost of the recently enacted tax cut covers the period 2002-2011, and therefore excludes the $74 billion cost of that tax cut in 2001. Costs would be higher if they also included the resulting increase in federal interest payments.

5 For a discussion of the costs of the recently enacted tax cut, see "New Tax-cut Law Ultimately Costs as Much as Bush Plan: Gimmicks Used to Camouflage $4.1 Trillion Cost in Second Decade," Center on Budget and Policy Priorities, revised June 27, 2001. The data are from JCT estimates of the enacted tax bill and JCT estimates provided to Rep. Charles Rangel of the cost of making the provisions of the tax cut permanent, including adjusting the Alternative Minimum Tax thresholds so that the number of people subject to the AMT does not rise any faster than it would have under prior tax law.

What Spending Explosion? Putting 2001 Spending Increases in Context

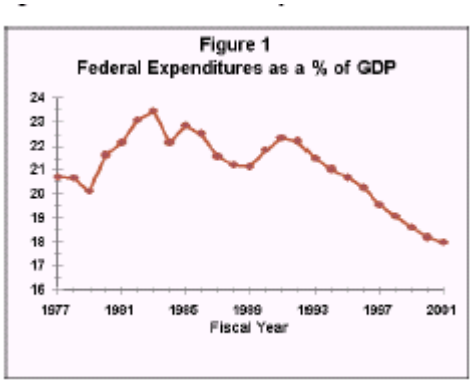
Some policymakers have termed the program increases enacted last fall a "spending explosion."[6] In fact:

- Even with last year's program increases, federal spending continued to fall in 2001 as a share of the economy. OMB's newest figures suggest that federal expenditures will equal about 18 percent of the gross domestic product (GDP) in 2001, which is the lowest level since 1966.
- The rate of growth in federal expenditures between 2000 and 2001 was *below* the historical average.
- The rate of growth in federal expenditures called for in the Bush budget for 2002 is *higher* than the rate that occurred in 2001.

In short, the rhetoric about "last year's spending explosion" is not justified by the data.

Expenditures as a Share of the Economy

As a share of the economy, federal spending has fallen for the last ten years. At about 18 percent of GDP in 2001, it is at its lowest level since 1966.[7] (See Figure 1.) Federal expenditures rise as a share of the economy when the economy is a recession (because even a flat level of expenditures will constitute a larger share of a smaller economy). Although the current year is characterized by a weak economy, federal expenditures will constitute a smaller share of GDP this year than in all years of recent decades, including years in which the economy was robust.



Rates of Growth in Federal Spending

OMB now projects that federal expenditures will grow by 3.1 percent in 2001. This is significantly lower than the historical average (for the period 1962-2001), which is 7.5 percent. OMB also projects that under the Bush Administration budget, federal spending will increase at a faster rate — 6.4 percent — in 2002. These figures are shown in Table 5.

Table 5
Annual Growth Rates in Federal Expenditures

	Nominal increase	Real increase (i.e., adjusted for inflation)
Historical average, 1962 — 2001	7.5%	2.8%
In 2001	3.1%	0.5%
In 2002	6.4%	3.9%

Source: figures for 1962-2000, *Historical Tables*, OMB, April 2001; figures for 2001 and 2002, *Midsession Review*, OMB, August 22, 2001. The 2001 costs of the spring supplemental appropriations bill and the recent farm bill are omitted since they were not enacted by the previous Congress. Had they been included, the figures would be only slightly different. The adjustments for inflation used the OMB deflators published in April 2001.

6 Because this aspect of the analysis examines spending in 2001 *resulting from legislation enacted last fall*, it does not include the 2001 expenditures that will result from this spring's defense supplemental appropriations bill and this summer's increase in farm price supports. Inclusion of those two pieces of legislation would make little difference to the figures.

7 OMB now projects that federal spending will equal about 18 percent of GDP in 2001. In issuing its most recent estimate back in April 2001, the Congressional Budget Office projected that the figure for 2001 would be 17.8 percent of GDP. This CBO projection will be revised upward on August 28 when CBO issues its revised estimates. The upward revision will occur not because Congress has enacted more spending for 2001, but because GDP will now be projected to be smaller in 2001 than previously thought, as a result of the economic slowdown. CBO's new estimate for 2001 may or may not slightly exceed the figure of 18.2 percent recorded for 2000.

These figures just cited do not adjust for inflation; they simply show the year-over-year growth of federal expenditures. Because inflation was noticeably higher in some years in the 1970s and 1980s, the previously mentioned historical average rate of expenditure growth appears larger than it really is. A better comparison, also provided in Table 5, shows the *real* rate of growth, in which the effects of inflation are removed. In real terms, federal spending grew by 0.5 percent in 2001, well below the historical average of 2.8 percent per year and also well below the 3.9 percent that the Bush Administration has proposed for 2002.

Table 6
Annual Growth Rates, Expenditures for Appropriated Programs

	Nominal increase	Real increase (i.e., adjusted for inflation)
Historical average, 1962 — 2001	5.7%	0.9%
In 2001	5.2%	2.8%
Proposed for 2002	8.2%	5.8%

Source: figures for 1962-2000, *Historical Tables*, OMB, April 2001; figures for 2001 and 2002, *Midsession Review*, OMB, August 22, 2001

Some in the Bush Administration have sought to focus the debate about rates of growth on appropriated (or "discretionary") programs, which represent about one-third of the federal budget. A more complete analysis that covers all federal spending is preferable to an analysis only of discretionary programs. However, even if the analysis is limited to appropriated programs, it is hard to make the case that the Bush Administration is trying to reverse a "spending explosion." Table 6, above, makes the same comparisons as Table 5, but only for the one-third of the budget that is annually appropriated. As the table shows, the increases in discretionary spending that occurred in 2001 are smaller — not larger — than those the Administration has proposed for 2002.

The magnitude of the discretionary spending increases the Bush Administration has proposed for 2002 primarily reflects the large defense increases the Administration is seeking. Under the Bush budget, expenditures for defense in 2002 would rise at almost twice the rate, after adjusting for inflation, as expenditures for domestic appropriated programs.

Adjusting for Population Growth

Some argue that calculations of rates of growth in government expenditures should adjust not only for inflation, but also for increases in the population. When he was Governor of Texas, for example, President Bush said that "an 'honest comparison' of spending growth should take inflation and the state's increasing population into account."* Many analysts agree that such an adjustment makes sense; with such an adjustment, analysts can measure the change in the real, per-person level of goods, services, and benefits that a government provides. If such an adjustment is made, the average rate of growth in federal spending from 1962 through 2001 is 1.8 percent per year, federal spending shrank by 0.4 percent in 2001, and the increase the Administration's budget proposes for the coming year (2002) is 2.9 percent.

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* Dallas Morning News, October 28, 1999.

Funding versus Spending

This analysis has focused exclusively on program *expenditures* for the budget as a whole and for the one-third of the budget covering appropriated programs. It has focused on expenditures because of the attention being paid to the surplus; the difference between revenues and expenditures determines whether the budget is in surplus or deficit.

The Administration, in discussing a "spending explosion," has instead focused on funding levels, not expenditures, and sometimes limits its analysis to domestic appropriations, which represent just one-sixth of the budget. Such an approach ignores the $32 billion increase in defense funding the Administration has proposed for 2002. Counting defense, and using data published by OMB in April and August, it can be seen that total funding for appropriated programs was increased in nominal terms by 8.6 percent in 2001 by the previous Congress and Administration, and that this Administration is proposing a further nominal increase of 7.1 percent. In nominal dollar terms, last year's funding increase for appropriated programs was $50 billion and this year's proposed increase is $45 billion. From this perspective, the primary difference between funding increases for 2002 and 2001 is not so much their total size as the fact that last year's increase occurred mostly in domestic programs such as education and health research while this year's increase occurs mostly in defense.

(A better analysis of funding increases would make a variety of adjustments to these data to correct for anomalies and distortions. See *How Realistic Are the Discretionary Funding Levels in the President's Budget and the Congressional Budget Resolution?* Center on Budget and Policy Priorities, August 3, 2001.)

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ADMINISTRATION MID-SESSION ESTIMATES EXCLUDE LIKELY COSTS, INFLATE TEN-YEAR SURPLUS ESTIMATES BY $800 BILLION OR MORE

by Joel Friedman

The Administration's Mid-Session Review excludes a variety of costs that are virtually certain to be incurred over the next decade and thereby overstates the projected surplus outside the Social Security trust fund through 2011. In particular, the Administration's new figures ignore the cost of extending dozens of tax provisions that are scheduled to expire over the next ten years. Those provisions include several popular tax credits that expire in 2001 — and for which the Administration supports a one-year extension — as well as the temporary relief from the Alternative Minimum Tax that was provided in the recently enacted package of tax cuts (P.L. 107-16). Similarly, the Mid-Session Review's projections of federal spending — from the cost of a prescription drug benefit for seniors, to the Administration's plans for a missile-defense system, to appropriations for non-defense programs, such as education, veterans health, transportation, and law enforcement — are well below levels called for by Congress or implied by the Administration's own policies.

The Administration projects that the surplus outside the Social Security trust fund amounts to $575 billion between 2002 and 2011. Of this total, $537 billion represents the surplus in the Medicare Hospital Insurance trust fund, according to Administration estimates. On a ten-year basis, therefore, there is little remaining surplus outside the Social Security and Medicare trust funds. But the outlook would appear even more constrained if the Administration had included anticipated costs that are nearly certain to occur.

- A more accurate accounting of these costs (see Table 1) would result in a surplus that could be between $800 billion and $1.25 trillion smaller over the next ten years, overwhelming the $575 billion that the Administration estimates as the non-Social Security surplus in the Mid-Session Review.

- The non-Social Security surplus, as shown in the Administration's documents, would be concentrated in the latter part of the ten-year period, with 70 percent of it occurring in the last three years of the decade. However, the unaccounted-for costs follow a similar pattern, so when even the low-end estimates are combined with the Administration's figures the resulting projections would show that the Social Security surpluses would be used to fund other government expenditures in each year of the decade.

In its Mid-Session Review, the Administration had the opportunity to present a set of policies that accurately project the nation's fiscal position over the next decade, by updating its budget request and adjusting for the gimmicks that artificially reduce the cost of the recently enacted tax cuts.1 Unfortunately, the estimates in the Mid-Session Review reflect the Administration's continued willingness to rely on unrealistic assumptions and gimmicks to understate anticipated costs in order to portray the centerpiece of its fiscal policy — a very large tax cut that disproportionately benefits high-income families — in a more favorable light. The following is a summary of some of the costs that the Administration has excluded from its projections.

1 For a discussion of the gimmicks in the enacted tax-cut package, see Joel Friedman, Richard Kogan, and Robert Greenstein, "New Tax-Cut Law Ultimately Costs as Much as Bush Plan: Gimmicks Used to Camouflage $4.1 Trillion Cost in Second Decade," *Center on Budget and Policy Priorities*, revised June 27, 2001.

Table 1

Potential Costs That Have Not Been Accounted For in Mid-Session Review
in millions of dollars

	Ten-year total 2002-2011
AMT relief*	250-350
Extend other expiring tax provisions**	70
Missile-defense system and other defense increases	100-200
Non-defense appropriations	70-250
Medicare prescription drug benefit	110
Agriculture	70
Interest on all of the above	130-210
Total, potential costs not accounted for	800-1,250

Note: Totals exclude any funds to address the solvency of the Social Security and Medicare trust funds.

*Low estimate reflects the cost of reducing the number of taxpayers affected by the AMT to the levels projected before enactment of the Bush tax cut (i.e., to about 21 million taxpayers in 2011 rather than to over 35 million); the high estimate reflects a rough approximation of the additional funding needed to reduce the number AMT taxpayers to a more acceptable level than 21 million. See Joint Tax Committee analysis for Rep. Rangel, June 14, 2001.

**See Joint Tax Committee, JCX-66-01, August 3, 2001.

Alternative Minimum Tax — The Mid-Session Review proposes to extend permanently all of the recently enacted tax-cut provisions that artificially expire in *2010*. The projections, however, leave out the extension of those enacted provisions that expire *before* 2010 — including the substantial cost of extending the AMT relief that was part of the tax-cut package but ends after 2004. As a result, the Mid-Session Review revenue estimates are based on the unrealistic assumption that the number of taxpayers subject to the AMT will jump from about 1 million today to more than 35 million by the end of the decade. Such dramatic growth in the reach of the AMT would be unprecedented, and it would transform the AMT from a narrow tax aimed at preventing high-income taxpayers from avoiding income taxes through excessive use of tax shelters to a burdensome tax that affects a broad cross-section of taxpayers. Congress will surely act to prevent this outcome and the higher taxes that it would force upon millions of middle-class taxpayers. But rather than reflecting the cost of a proposal to solve this problem in its Mid-Session estimates, the Administration artificially relies on these extra AMT revenues to bolster its surplus projections over the next ten years.

The Joint Committee on Taxation estimates it would cost about $124 billion over the decade just to extend the levels of the AMT exemption set in the tax-cut legislation. It would cost a further $123 billion — for a total of $247 billion — to hold the number of taxpayers affected by the AMT to 20.5 million in 2011, essentially the level projected before enactment of the Bush tax-cut package.2 Even having 20.5 million taxpayers subject to the AMT would likely be unacceptable; Congress will face significant pressure to reduce the growth in the number of AMT taxpayers to more moderate levels, at a potential cost of another $100 billion or so.

2 The recently enacted package of tax cuts increased the AMT exemption by $2,000 for singles and $4,000 for couples, but this increase expires at the end of 2004. Similarly, current authority that allows non-refundable tax credits, such as the HOPE and Lifetime Learning credits, to reduce AMT liability expires at the end of 2001. The Joint Tax Committee estimated that gradually raising the exemption amounts, reaching a total increase of $4,500 for singles and $9,000 for couples by 2009, as well as allowing non-refundable credits to offset AMT liability, would reduce the number of taxpayers subject to the AMT to a little less than 21 million by the end of the decade, compared to the more than 35 million that would be hit by the AMT without these changes. In an analysis for House Ways and Means Committee Ranking Member, Rep. Rangel, the Joint Tax Committee estimates that these changes would cost $247 billion between 2002 and 2011.

Other expiring tax provisions — The Joint Committee on Taxation has identified more than three dozen tax provisions that will expire at some point over the next decade. In the Mid-Session Review, the Administration proposes to extend only a few of the popular tax credits that have regularly been renewed in previous years, such as the research and experimentation tax credit, which expires in 2004. A host of other provisions are simply assumed to expire, including those that are scheduled to expire in 2001. In its April budget submission, the Administration had proposed a one-year extension of the credits that expire in 2001. In the Mid-Session Review, however, the Administration excluded even these one-year extensions from its revenue proposals, while stating that it still supports these extensions. (See box on page 4.) As past experience demonstrates, most of these tax provisions are certain to be extended on a bipartisan basis. Assuming the extension of all expiring credits throughout the ten-year period would cost an additional $70 billion over the next ten years.

Defense — The Mid-Session Review estimates for defense spending include the additional $18 billion in 2002 that the Administration requested beyond the levels in its initial budget and an equivalent amount each year, adjusted for inflation, throughout the rest of the decade, for a total of $209 billion over ten years. But the budget acknowledges that this is only a *portion* of the defense spending increases the Administration will seek. The Mid-Session Review states: "This is the first installment, totaling $209 billion, of investment in restoring our national defense capabilities..." The Administration plans to request additional amounts for its defense program, including the funds for an accelerated missile-defense system and its force modernization program. While we do not know the ultimate size of the additional defense increases the Administration will advocate, it could reach $100 billion to $200 billion over ten years beyond the figures in the Mid-Session Review.

Funding Dropped from Budget for Must-pass Tax Item
Administration Says It Still Supports

The budget figures in the Administration's Mid-Session Review provide a rosy and unrealistic picture of the budget — and of projected budget surpluses — over the next ten years, primarily because the Administration has omitted an array of virtually inevitable costs. One omission stands out — the removal of the funds included in the Bush budget presented to Congress earlier this year to extend an array of the tax credits scheduled to expire at the end of 2001.

It is a foregone conclusion that these tax credits will be extended. They enjoy strong bipartisan support, are always extended for a few years at a time and always are renewed when their current term expires.

The original Bush budget included funds to extend these credits for one year. The treatment of these tax credits in the original Bush budget was problematic itself, as the budget pretended these credits will be extended for only one year (in order to avoid showing the cost of extending them throughout the decade). But the Mid-Session Review goes one step farther. It omits even the cost of extending for one year the credits that will expire this year.

The omission does not mean that these credits will not be extended — they surely will be — or that the Administration does not support their expansion. The Mid-Session Review states: "The Administration supports the extension of these provisions in a fiscally responsible manner and looks forward to working with Congress to achieve that goal."

The reason for their omission from the mid-session budget numbers may be that extension of these provisions would cost $1.4 billion in fiscal year 2002. The Mid-Session Review shows a surplus of only $1 billion in 2002 outside the Social Security trust fund. Inclusion of this cost apparently would cross the line and require use of a small amount of Social Security trust fund revenue.

Non-defense Appropriations — The Mid-Session Review mirrors the Administration's original budget request for non-defense programs funded through the appropriations process (i.e., for "non-defense discretionary" programs). Expenditures for these non-defense programs wouldbe cut below the levels necessary to keep pace with inflation by about $70 billion over ten years.[3] History suggests such cuts are not likely to occur, especially if both education and health research are increased, as the President and a solid, bipartisan majority of Congress wish. A more prudent and realistic assumption is that non-defense appropriations will grow at least with inflation and more likely with inflation and the increase in the size of the U.S. population — that is, that the real, per-capita level of funding will remain constant. Holding the real per-capita level of funding constant for non-defense appropriations would add about $250 billion to the ten-year costs reflected in the Mid-Session Review and could itself prove to be a conservative assumption, as it would result in spending on these programs that, as a share of GDP, would fall to 3.0 percent by 2011, the lowest level on record. It also is worth noting that for 12 of the last 14 years, the real, per-capita funding for these programs has increased, even though most of that period was one of substantial deficits.

Entitlement spending — The Mid-Session Review includes $190 billion for a Medicare prescription drug benefit, a modest increase above the Administration's budget proposal. Congress, however, has set aside $300 billion for a Medicare drug benefit in its budget resolution. Some analysts question whether even this higher amount will be sufficient to provide a benefit that seniors would find adequate. By setting its request well below the Congressional level, the Administration understates the eventual costs associated with providing a prescription drug benefit.

The Congressional budget resolution also includes about $70 billion over ten years for farm price supports. The House Agriculture Committees has already reported legislation, with floor consideration anticipated for September. The Senate Agriculture Committee is planning to take up its version of the legislation this fall, with floor consideration thereafter. Even if no multi-year authorization is enacted, past experience has shown that Congress will act on an annual, ad hoc basis to provide farmers with price support payments. The Administration acknowledges the eventual costs of the farm bill moving through Congress, but includes no funds for it in its Mid-Session request. Rather, the Administration contends that the costs "will have to be offset where necessary to maintain on-budget surplus," although the Administration has proposed no such offsets. It would appear optimistic, given all the other pressures on the budget that are not accounted for in the Administration's proposals, to assume that offsets of this magnitude could easily be found. These expenditures are virtually certain to be incurred whether or not offsets are found.

Finally, the Administration allocates no funds in the Mid-Session Review to address the solvency of the Social Security or Medicare HI trust funds. Nearly all recent proposals to restore or significantly enhance Social Security solvency — by Republicans and Democrats alike — have relied in part on resources from the general fund to help mitigate the severity of the problem; without such resources, the magnitude of the benefit cuts or payroll tax increases needed to restore long-term solvency is likely to be too great for any solvency plan to survive. (In the past, we have suggested that $500 billion might be devoted to these purposes and noted that such an amount would go only 30 percent of the way to bringing 75-year solvency to Social Security and Medicare.)

Conclusion

The Administration's Mid-Session Review relies on a variety of tactics to portray the fiscal outlook over the next ten years as being substantially rosier than it actually is. A lastminute accounting change in adjustments to Social Security receipts in 2001 and aboveconsensus economic projections for 2002 helped the Administration to project a $1 billion surplus outside the Social Security trust fund in each of those two years. The margins remain narrow through 2005 as well. Moreover, in most years, the budget would use all or nearly all of the Medicare Hospital Insurance trust fund surpluses for other purposes. These other purposes include substantial additional tax cuts the Mid-Session Review proposes (mostly tax cuts included in the original Bush budget but not yet enacted).

To fit within these tighter budget constraints, the Administration adjusted some of its policy proposals. For instance, it delayed until 2004 a number of its remaining tax-cut proposals and deleted from the budget the funding it earlier proposed to extend an array of tax credits expiring this year (while stating that it still supports their extension). It also has relied heavily on unrealistic assumptions to make the numbers add up, leaving out costs virtually certain to occur over the decade. In its Mid-Session Review, the Administration acknowledges some of these costs — such as further defense increases, the farm bill reauthorization, and the extension of popular tax credits expiring in 2001 — but excludes them nonetheless from its projections. In other cases, future costs are not even mentioned, notably those that will have to be incurred to address the explosive growth in the Alternative Minimum Tax. Had these various costs been accounted for, the Administration's projections of the surplus would have shrunk by between $800 billion and $1.25 trillion over the next ten years — overwhelming the $575 billion non- Social Security surplus that it estimates in the Mid-Session Review.

3 Note that the Administration's request for non-defense appropriations is below the levels in the Congressional budget resolution, which itself was $45 billion below the amount needed to keep pace with inflation over the decade.

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FEDERAL AIDS PROGRAMS: FUNDING NEEDS FOR FY 2002

FEDERAL PROGRAM	FY 2001 APPROPRIATION	FY 2002 PRESIDENT'S REQUEST	FY 2002 NEED
HIV Prevention - Centers for Disease Control and Prevention (CDC):	$767.0 m 1*	$778.0 m	$1,300.0 m (+ $533.0 m)
Ryan White CARE Act - Health Research and Services Administration (HRSA): **- TOTAL**	$1,808.0 m 1*	$1,808.0 m	$2,085.0 m (+ $277.0 m)
Title I	$604.2 m	$604.2 m	$634.2 m (+ $30.0 m)
Title II - Care services	$322.0 m	$322.0 m	$402.0 m (+ $80.0 m)
Title II - AIDS Drug Assistance Program **(ADAP)**	$589.0 m	$589.0 m	$713.0 m (+ $124.0 m)
Title III	$185.9 m	$186.0 m	$195.9 m (+ $10.0 m)
Title IV	$65.0 m	$65.0 m	$83.0 m (+ $18.0 m)
Part F: AIDS Education & Training Centers **(AETCs)**	$31.6 m	$31.6 m	$41.6 m (+ $10.0 m)
Part F: HIV/AIDS Dental Reimbursement	$10.0 m	$10.0 m	$ 15.0 m (+ $5.0 m)
HIV/AIDS Research National Institutes of Health	$2,243.0 m	$2,501.0 m	$2,614.0 m (+ $371.0 m)
HOPWA (HUD)	$258.0 m	$277.0 m	$300.0 m (+ $42.0 m)
Substance Abuse Prevention & Treatment Block Grant - Substance Abuse and Mental Health Services Administration (SAMHSA):	$1,665.0 m	$1,725.0 m	$2,000.0 m (+ $335.0 m)
CBC/Minority AIDS Initiative	($ 350.0 m) 2*	4*	$540.0 m (+ $190.0 m)
Global HIV/AIDS Programs (CDC, DoD, Labor, and USAID only)	$ 439.0 m 3*	$446.0 m 5*	$1,000.0 m + $561.0 m)

1 - The figures in FY2001 include funding for the CBC/Minority AIDS Initiative. The FY2002 request is listed separately.
2 - FY2001 appropriations are combined within programs. (See footnote above).
3 - The figures shown for FY2001 include funding only through CDC, DoD, Labor and USAID for HIV/AIDS-specific programs.
4 - Specific funding for the CBC/Minority AIDS Initiative is not broken out in the President's budget.
5 - The President's budget does not specify the funding request for global HIV/AIDS programs through DoD or Labor.

HIV PREVENTION SAVES LIVES & DOLLARS

In FY 2002, more than 40,000 individuals in the United States will become infected with HIV. AIDS remains the leading cause of death for African Americans and the fourth leading cause of death for Hispanics/Latinos between the ages of 25-44. It is the fifth leading cause of death among all Americans aged 25-44. Increased funds for prevention are needed to ensure that effective, scientifically based prevention programs targeting populations at risk can be implemented. By reducing the number of new HIV infections, we can reduce the expensive demand for care services in the future. Absent a vaccine or cure, prevention is the only intervention for stopping HIV transmission.

COMMUNITY INVOLVEMENT LEADS TO BETTER PREVENTION

Several studies of federal AIDS prevention programs have concluded that effective behavior change/risk-reduction activities targeted to populations at greatest risk have been severely under funded. The Centers for Disease Control and Prevention (CDC) instituted HIV Prevention Community Planning as a means of increasing community participation and better targeting of prevention programs in order to better allocate limited resources.

HIV Prevention Community Planning is an ongoing, dynamic collaboration in which state and local health departments, social service agencies, non-governmental agencies, representatives of communities impacted or affected by HIV, and other representatives of communities/groups at risk for HIV infection work in partnership to plan and prioritize an appropriate mix of HIV prevention programs that are responsive to community-identified needs within target populations.

As a result, science-based prevention programs are prioritized by communities to meet their specific needs. The goal of HIV Prevention Community Planning is to ensure that limited prevention funds target populations most at risk for HIV/AIDS. FY 2002 funding increases are needed to help fund unmet prevention needs identified by communities across the United States.

HIV PREVENTION WORKS!

Numerous studies show that HIV prevention interventions can change behaviors in a broad range of populations, including injection drug users in treatment, gay men at risk, and homeless/runaway youth.

Simple informational materials and programs are not enough. To be effective, prevention programs must:

- reach people in a variety of settings (schools, churches, the workplace, clinics, and neighborhoods);
- be culturally sensitive and specific;
- be intensive and long-term;
- provide populations at risk with information, support, and skills to change high-risk behavior;
- involve peers and trusted members of the target community.

FEDERAL APPROPRIATIONS

Preventing AIDS will not only eliminate needless suffering and death but will also reduce expensive health care and other economic costs. The lifetime medical cost of treating a person with HIV from the time that he or she becomes infected until death is estimated at more than $120,000. People with AIDS who stop working can no longer generate income and pay taxes and are often forced to draw upon entitlement programs. There continue to be urgent, under funded priorities in HIV prevention as the virus continues to infect communities of color, women, gay and bisexual men, and adolescents. Cuts in HIV prevention programs will reduce federal spending in the short term, but will lead to increased costs in the future. **Advocates seek $1.3 billion in total funding for the CDC in FY 2002 to support these programs.**

BARRIERS TO EFFECTIVE PREVENTION

● *Restrictions on Content of Prevention Programs*

Communities are best equipped to set priorities, develop and implement effective programs. Programs must not be restricted from using federal, state or local funds for prevention activities that they deem appropriate and consistent with public health. The federal government must not place restrictions or mandates on the content of HIV prevention programs.

● *Federal Funding Ban on Needle Exchange*

The current federal ban on the use of federal funds for needle exchange must be lifted and initiatives that would prohibit nonprofit organizations from receiving federal funding if they operated needle exchange programs with private dollars must not be passed. Numerous government reports and scientific studies, including a 2000 Institute of Medicine Report, have cited the overwhelming evidence supporting the effectiveness of exchange programs in reducing the rate of new HIV infections among IV drug users, their sex partners and children, without increasing drug use. Needle exchange, as part of comprehensive prevention efforts including health information services and access to substance abuse treatment, must be an option for communities, which have identified a need for these services.

ADOLESCENTS AND AIDS

Finally, all attempts to deprive our nation's youth of comprehensive, appropriate and life-saving health education programs must be fought. Congress should fund comprehensive health and sex education instead of increasing spending on scientifically unproven "abstinence only programs". Like needle exchange, there is overwhelming evidence that providing youth with sex education does not lead to an increase in or initiation of sexual activity. Rather, such education provides youth with vital life saving information about prevention of HIV and other STDs.

HIV SURVEILLANCE

AIDS and HIV surveillance activities provide data that are critical to target and deliver prevention and treatment programs and ensures that scarce resources are effectively utilized. Additional funding in FY 2002 is imperative to allow jurisdictions to meet newly released CDC HIV surveillance guidelines, and to strengthen other related and ongoing surveillance and epidemiology programs and activities.

INSTITUTE OF MEDICINE REPORT

In early 2000, the Institute of Medicine (IOM) convened a panel of experts to review current HIV prevention efforts to develop a framework for a national HIV prevention strategy that could significantly reduce new infection. The IOM Report, "No Time to Lose: Getting More from HIV Prevention," recommendations include:

- The nation can and should do more to prevent HIV infection. It will require directing interventions to those who are HIV-infected and those - the women, youth and racial and ethnic minorities - who are increasingly affected by the epidemic. And it will require removing obstacles that impede the implementation of those interventions that are known to be effective.
- Prevention works and prevention resources should be allocated to prevent as many new infections as possible.
- Increasing drug abuse treatment funding to levels that are sufficient to provide drug treatment to all those requesting it.
- Removing legal and policy barriers that limit access to sterile drug injection equipment.
- Eliminating congressional, federal, state, and local requirements that public funds be used for abstinence-only education, and that states and local school districts implement and continue to support age-appropriate comprehensive sex education and condom availability programs in schools.
- Removing policy barriers that hinder the implementation of effective prevention efforts in correctional settings.
- The Centers for Disease Control and Prevention should create a surveillance system that can provide national population-based estimates of HIV incidence.
- The National Institutes of Health should place high priority on the development of anti-HIV microbicides and vaccines and appropriate funding resources should accompany this.
- The Food and Drug Administration should accelerate its efforts to approve prevention technologies that show promise in clinical trials (e.g. new antiretroviral therapies, new microbicidal and vaccine candidates) or are already being successfully utilized elsewhere in the world (e.g. rapid tests).

RYAN WHITE CARE ACT: KEY TO AMERICA'S RESPONSE TO AIDS

Next to the Medicaid and Medicare programs, the Ryan White CARE Act represents the single largest federal investment in the care and treatment of people living with HIV/AIDS in the United States. The CARE Act supports a wide range of community-based services, including primary and home health care, case management, substance abuse treatment, and mental health, dental, nutritional and transportation services. The CARE Act also supports the AIDS Drug Assistance Program in each state, which provides HIV prescription drugs to individuals who would otherwise have limited access to basic HIV treatment. Overwhelming bipartisan majorities in congress reaffirmed the critical role of the CARE Act last year by reauthorizing it until 2005. The new CARE Act law maintains the program's structure and adds components to promote quality services, expand access to early interventions, reach individuals not currently in the system of care, and foster collaborations with Medicaid and other publicly financed health programs.

FUNDING MUST KEEP UP WITH GROWTH IN EPIDEMIC

In FY 2001, the current federal fiscal year, the CARE Act provides $1.8 billion in care and treatment services through five distinct titles

Title I: HIV Emergency Relief Grants to Cities	$604.2 million
Title II: HIV Care Grants to States	$322.0 million
State AIDS Drug Assistance Programs	$589.0 million
Title III: AIDS Health Care Service Grants to Clinics	$185.9 million
Title IV: Services for Children, Youth, Women and Families	$ 65.0 million
Part F: AIDS Education and Training Centers Program	$ 31.6 million
HIV/AIDS Dental Reimbursement Program	$ 10.0 million
Special Projects of National Significance	(3% of other Titles, up to $25 million)

In FY 2002, **AIDS advocates are requesting a $277 million increase** in overall funding for the CARE Act in order to keep up with the growth in the HIV epidemic and the increasing costs of new HIV therapies and diagnostic testing.

QUALITY CARE AND LOCAL CONTROL ARE KEY

The CARE Act provides critically important direct service funding to communities across the country to address to an increasingly complex and growing HIV/AIDS epidemic. The demographics of the AIDS epidemic differ dramatically from one area to another. For this reason, the local planning Consortia and Planning Councils are key to ensuring that the funds allocated to a specific area are used to effectively respond to the local needs of each community. CARE planning has served as the model for the Department of Health and Human Services to ensure community participation, inclusive of the diverse communities affected by HIV/AIDS and the active involvement of service recipients and others from the community who are living with HIV/AIDS. Through the consumer feedback the local planning bodies receive, they are able to respond to the needs of those in care and receive accurate assessments of the quality of the care provided.

COST EFFECTIVE

The CARE Act promotes cost- effective systems of care for people with HIV/AIDS. In many cases, people with AIDS can avoid costly acute care by gaining early access to healthcare, anti-HIV medications and support services. Use of case management services and community-based alternatives ensures that limited federal government resources are used effectively.

Health care services provided through theCARE Act allow monitoring of health status on a regular basis and ensures early, preventative care, rather than waiting until an acute episode requires costly hospitalization. A recent federal study proved the cost savings of CARE Act services. According to the Agency for Healthcare Research and Quality, overall U.S. treatment costs for HIV/AIDS declined 16% between 1996-98 as a result of broad access to anti-HIV medications.

LOCAL CONTROL ALLOWS TARGETED LOCAL RESPONSE

The CARE Act provides maximum flexibility to cities and states, allowing them to develop local systems of care based on the specific service needs of people living with HIV/AIDS in their area. Title I of the CARE Act requires that each local HIV services planning council—comprised of local public health, community-based service providers and people living with HIV/AIDS—assess local needs and make recommendations as to which services are needed. Similarly, through Title II, each state is given maximum flexibility to work with local communities to craft a service mix that is responsive to the specific service needs in that state. The CARE Act rejects a one-size-fits-all approach to AIDS care, recognizing that the AIDS epidemic nationally is the combination of many local epidemics.

The CARE Act Titles: Targeted Solutions

Title I provides emergency financial assistance to 51 eligible metropolitan areas (EMAs), which are home to more than 74% of people living with AIDS. Title I funds support comprehensive HIV health care and essential treatment services for a growing number of low-income uninsured and underinsured persons and families living with HIV disease. During FY 2002, an estimated 200,000 people with HIV will be served by CARE Act Title I programs. About 71% of Title I clients are people of color, with an increasing percentage of women with HIV. In 2002, EMAs will be increasing their efforts to target communities of color and to bring a significant number of people diagnosed with HIV but not in care into the system.

Title II provides support to every state, the District of Columbia, Puerto Rico and the U.S. Territories to improve the quality, availability and organization of HIV medical care and related services. These programs are a primary access point for medications, health insurance and other basic services for people living with HIV who lack private health insurance and who are not poor or sick enough to qualify for Medicaid. The **AIDS Drug Assistance Program** under Title II provides medications for eligible, low-income individuals allowing tens of thousands to access new multi-drug therapies. Both Title II core and ADAP programs are critically important to coordinate and deliver the range of quality care services needed to keep people with HIV alive, healthy, and working.

Title III provides direct grants to 259 community-based clinics and public health providers in 40 states, the District of Columbia, and Puerto Rico. These grants provide support to develop and deliver early and on-going comprehensive outpatient HIV health care services to more than 115,000 persons with HIV/AIDS. Title III grantees provide primary medical care to historically under-served individuals and families with HIV in rural and urban areas. Half of all Title III sites are the only source of quality HIV care available in a given area.

Title IV provides support for comprehensive HIV services and coordinated access to clinical research programs for children, youth, women and families affected by HIV/AIDS. Title IV funds 66 grantees in 33 states, the District of Columbia and Puerto Rico. Over 45,000 children, youth, women and families receive services from Title IV programs, which continue to serve and ever-growing caseload. HIV testing and prenatal care programs have helped to dramatically reduce the rate of mother-to-child HIV transmission among those served.

Part F encompasses three critical AIDS training and service programs: the **AIDS Education and Training Centers (AETCs),** the **HIV/AIDS Dental Reimbursement Program, and Special Projects for National Significance (SPNS).** The AETCs and HIV/AIDS Dental Reimbursement Program receive separate line item funding within **Part F**, while the SPNS program receives three-percent from each of the other four Titles, up to a maximum of $25 million. The AETC Program is the only national program focused on ensuring that health care and social service providers, particularly in rural areas, have access to training and updated information on HIV/AIDS care. The network of 14 training centers includes 70 performance sites serving all 50 states. The Dental Reimbursement Program is a partnership between the federal government, dental schools, dental hygiene programs, and community-based dentists that facilitates the delivery of quality oral health to people with HIV/AIDS, while training new professionals in the delivery of specialized oral health care. The SPNS funds nonprofit organizations to support demonstrations and evaluations of innovative models of delivering health and support services that can then be replicated by other CARE Act-funded programs. The SPNS program has reached its maximum funding cap as prescribed by law, causing some projects and under-served populations to experience loss of funding and access to vital services.

THE IMPORTANCE OF NIH AIDS RESEARCH

AIDS research at the National Institutes of Health (NIH) has led to major advances in the understanding and treatment of HIV and related opportunistic infections. NIH-funded researchers are now at the forefront of the global effort to build upon these findings and develop new, more effective treatment regimens and prevention interventions. Success against AIDS and other diseases will only be possible with a comprehensive national research effort. Therefore, we must support AIDS research and we must support NIH research overall.

AIDS RESEARCH AT THE NIH

The FY 2001 NIH AIDS research budget is $2.2 billion, an increase of approximately 12% over the previous year. This includes funding in the following areas: epidemiology and natural history of the disease, basic biomedical research, behavioral and social science research, and the development of AIDS treatments and vaccines. **For FY 2002, AIDS advocates are seeking a 16.5% increase for NIH overall and a commensurate increase for AIDS research.**

THE LEVINE REPORT

In March 1996, NIH released the Report of the NIH AIDS Research Program Evaluation Working Group of the Office of AIDS Research Advisory Council. The report, developed by an independent cross disciplinary panel and chaired by Dr. Arnold Levine of Princeton University, is the first comprehensive review of AIDS research at the NIH and represents a real opportunity to expedite the search for a vaccine and a cure for HIV/AIDS. There are 14 major points to the blueprint including increased support for investigator-initiated research, more emphasis on vaccine development, and the need to preserve a strong OAR.

FINDING EFFECTIVE TREATMENTS

AIDS research at the NIH has advanced the knowledge and treatment of HIV/AIDS, improving and lengthening the lives of people with AIDS. AIDS research has:

✔ Doubled the survival time of a person with AIDS and improved quality of life.

✔ Developed the fifteen FDA-approved drugs for the treatment of HIV infection, including life-extending AZT, ddI, ddC, d4T, 3TC, nevirapine, indinavir, saquinavir, ritonavir, delavardine, nelfinavir, efavirenz, abacavir, amprenavir, and lopinavir/ritonavir.

OFFICE OF AIDS RESEARCH (OAR)

The NIH Revitalization Act of 1993 strengthened the authority of the Office of AIDS Research to develop an annual research plan and a consolidated bypass budget for all NIH AIDS research conducted at the 25 Institutes, Centers and Divisions at NIH.

The FY 2001 Omnibus Appropriations Act includes compromise language for the consolidated AIDS research budget, allowing the OAR to retain central authority to distribute, administer, and coordinate AIDS research funding. Budget authority for the OAR is of vital importance for effective leadership of our nation's AIDS research effort.

As Congress considers reauthorizing the NIH, it is important that the OAR's strategic planning and budgetary authority be renewed and maintained.

✔ Led to tremendous advances in the treatment and prevention of AIDS-related opportunistic infections including CMV retinitis, *Pneumocystis carinii* pneumonia, and toxoplasmosis.

✔ Demonstrated that AZT or nevirapine may dramatically reduce HIV transmission from mother to fetus.

✔ Demonstrated that combinations of protease inhibitors and other anti-HIV drugs can reduce the amount of virus in patients to undetectable levels. These new regimens are the most powerful weapons to date against HIV and have dramatically changed the medical management of HIV infection.

BROAD BENEFITS OF AIDS RESEARCH

• AIDS research enhances and stimulates research in other fields, with broad implications for other diseases such as cancer, heart disease, and Alzheimer's disease.

• Approximately one-third of NIH AIDS research funding is used for basic science research with broad implications across scientific disciplines.

• AIDS research has accelerated study of the human immune system. NIH AIDS research is the main source of funds for immunological research.

• Several drugs that first received approval for the treatment of AIDS-related conditions, including fluconazole, clarithromycin, and EPO, have important uses for cancer and organ transplant patients.

• NIH AIDS research has accelerated investigation into viruses, particularly retroviruses. NIH AIDS research has enhanced scientific understanding of all retroviruses, some of which may have important roles in other human diseases.

• NIH AIDS research has been a driving force in the emerging biotechnology industry, one of the most important U.S. scientific and commercial endeavors of the last decade.

• NIH AIDS research involving the blood/brain barrier has valuable implications for research on Alzheimer's disease, dementia, multiple sclerosis, encephalitis and meningitis.

In addition to research on HIV treatments, NIH funding also supports essential epidemiological, prevention, and social research on HIV/AIDS.

FUNDING COMPARISONS ARE COUNTERPRODUCTIVE

Comparisons of funding for different diseases are counterproductive and misleading. The health of the nation is dependent upon a strong national commitment to biomedical research across disciplines and diseases that benefits all Americans. Because the existing knowledge base, economic and human costs, and scientific opportunities of every disease are important it is inappropriate and unwise to pit research funding for one disease against another. When discussing AIDS research appropriations, consider these facts:

• AIDS is an epidemic infectious disease, which did not exist twenty years ago and continues to spread throughout our nation.

• AIDS is almost 100 percent fatal when left untreated. Well over 750,000 Americans have been diagnosed with AIDS and more than 430,000 have died of the disease.

• New HIV infections continue to occur at a rate of about 40,000 per year in the United States.

• AIDS is a worldwide pandemic, threatening the lives of millions and the economic and political stability of countries and continents. Research conducted here has worldwide importance.

• AIDS disproportionately afflicts people of color, women, and youth. Approximately half of all new HIV infections occur in people under the age of 25.

• AIDS is the leading cause of death among African Americans between the ages of 25 and 44, the fourth leading cause of death among Latinos of the same age group, and the fifth leading cause of death among all Americans aged 25 to 44 years.

• Scientific priority-setting should consider many factors. One of the most important factors is scientific opportunity. Scientists believe that the scientific opportunities presented by AIDS are enormous, similar to the opportunities that existed in cancer research during the 1970's, which eventually opened new avenues of research and are generally credited with providing the foundation for the molecular biological revolution of the late 1970's and 1980's.

PEOPLE WITH AIDS NEED HOUSING

AIDS is having a devastating impact on families with marginal incomes, severely increasing the risks of homelessness. People with HIV/AIDS face a staggering array of barriers to obtaining and maintaining affordable, stable housing. Despite Federal and State anti-discrimination laws, many people with HIV/AIDS still face illegal eviction from their homes and other acts of prejudice when it is discovered they have HIV/AIDS. Others lose their housing when, because of illness and lost wages, they are unable to pay their rent or mortgage. A growing number of people with HIV/AIDS in poverty are already homeless when they become ill and are shuffled between acute care hospitals, medically unsafe shelter facilities, and the streets at an enormous cost to their health. Without stable housing, people with HIV/AIDS cannot access care or the promising new therapies that can greatly improve the quality and duration of their lives. The Housing Opportunities for People With AIDS (HOPWA) program was established in 1990 to respond to these critical needs.

HOPWA Works!

HOPWA is the only federal housing program that provides comprehensive, community-based HIV-specific housing programs. HUD distributes 90% of HOPWA funding directly to cities and states with high AIDS caseloads through a formula grant. The remaining 10% is awarded on a competitive basis to projects of national significance.

HOMELESSNESS AND AIDS

- 60% of people with HIV/AIDS will require housing assistance at some point during their illness.
- One-third to one-half of all people with AIDS are either homeless or in imminent danger of losing their homes.
- 91% of all HOPWA clients are persons or families with monthly incomes of less than $1,000.
- The Centers for Disease Control and Prevention found an HIV infection rate of up to 21.4% in selected U.S. homeless populations.

● LOCALLY CONTROLLED

HOPWA gives local communities hardest-hit by the AIDS epidemic desperately needed resources and local control over the use of those resources to meet the local housing needs of people with AIDS. State and local governments plan the use of funds and rely on nonprofit organizations, including faith-based providers, to deliver care and assistance to beneficiaries.

● FLEXIBLE

HOPWA gives local communities the capability to devise the most appropriate and effective housing strategies for community members with HIV/AIDS and their families through the coordination of other resources in the community. Communities may use HOPWA funds to develop any of a broad range of housing and support services including short-term supported housing, rental assistance for low-income persons with HIV/AIDS, community residences, or coordinated home care services. HOPWA services complement but do not duplicate other efforts.

● COST EFFECTIVE

Cities and states control the use and administration of HOPWA funds and are required to use funds under HUD's consolidated plan process. To ensure funds are used for housing activities, administrative costs are capped by law at 3% for formula grantees who administer the funds and 7% for the community-based "project sponsors" who actually provide the housing assistance. Every federal dollar of HOPWA funds is combined with at least one dollar of other leveraged resources. HOPWA regulations allow funds to be spent out over a three-year period, and projects often spend other funds in advance of actually drawing on their HUD accounts, due to planning, lengthy development processes, reservation of funds for periodic rental assistance, etc. Despite this, HUD has stated that HOPWA's spend out rates are better than most housing programs.

● HOPWA SPENDING REDUCES PUBLIC HEALTH EXPENSES

At any given time, approximately 30% of people with HIV disease in acute-care hospitals are there only because there is no other community-based residential alternative, at an average cost of over $1,085 per person, per day. The cost of providing housing and services at a HOPWA-funded residential facility is between one-tenth and one-twentieth of that amount. HOPWA reduces the use of emergency health care services by an estimated $47,000 per person, per year.

Increased Funding for HOPWA is Desperately Needed!

States and localities across the nation face severe funding shortfalls in their ability to address the growing housing needs of their citizens with HIV/AIDS. As the number of deaths due to AIDS complications decreases, and more people live longer with HIV disease, the need for affordable and safe housing continues to increase. When surveyed, HOPWA grantees across the nation reported needs that far outweighed their resources, as evidenced by extensive waiting lists for persons living with HIV/AIDS. One New England program for example, reported denials of 84% of more than 1,000 requests for housing in the first nine months of 2000. It is estimated that an additional 4 to 8 jurisdictions across the nation will become eligible for HOPWA funds in FY 2002. If HOPWA funding remains static, jurisdictions actually experience cuts in funding despite increasing need because newly eligible jurisdictions must be accommodated. **AIDS advocates are seeking $300 million for HOPWA in FY 2002.**

Other Programs Cannot Replace HOPWA

Congress created HOPWA in 1990 because other programs were unable to respond quickly to the sudden overwhelming demand for housing from people living with AIDS. Waiting lists in many urban centers became so long that it was not unusual for a person with AIDS to die before housing services could be provided. HOPWA provides resources and flexibility, through formula grants based on need, that cities and states use to address the local housing crisis arising from the AIDS epidemic.

Funding for HOPWA must grow at the same pace as emerging needs. Inadequate funding will only reduce resources to cities and states and increase local competition for existing resources, while undermining years of local planning and development.

Other Housing Programs are Vital to People Living with HIV/AIDS

Not all communities in need qualify for HOPWA funding. For these communities and the many people who are unable to earn enough to afford decent housing, other HUD programs, such as **Section 8** and **McKinney Homeless Assistance Grants (HAG)** program, provide the only safety net. The **Section 8 Certificate and Voucher** program provides housing subsidies to qualifying individuals, enabling them to rent privately owned housing from contract-approved property owners. Funds are distributed and administered through local and state public housing authorities. Thousands of non-profit homeless assistance providers, municipal and state agencies around the country, provide safe housing funded under the **McKinney/HAG** program**,** including specialized homeless intervention services through **Shelter Plus Care**. These programs use federal money to leverage other funds to build and staff temporary housing as well as permanent housing for homeless people with disabilities, and programs that provide outreach, employment assistance, mental health care, substance abuse treatment, case management and other services that have proven effective in moving people out of homelessness. The federal government must increase support for all HUD programs designed to interrupt the cycle of homelessness and provide the wide array of services needed by our nation's homeless men, women, and children.

SAMHSA: HIV & SUBSTANCE ABUSE PREVENTION AND TREATMENT

The intersection between drug and alcohol problems and the HIV epidemic is demonstrated by the rising numbers of new HIV cases that involve some form of drug and alcohol use. At least one-third of AIDS cases are directly or indirectly related to injection drug use. In order to reverse this trend, funding for effective drug and alcohol treatment and HIV prevention services is essential.

SUBSTANCE ABUSE TREATMENT & PREVENTION WORKS!

Drug and alcohol treatment and education are clearly effective. The 1996 National Treatment Improvement Evaluation Study (NTIES) found that among 5,700 individuals, one year after treatment, heroin use decreased by 46.5 percent and crack use by 50.7 percent. It also found that the percentage of individuals who had sex with an injection drug user or exchanged sex for money dropped by over 50 percent.

UNMET NEED CONTINUES TO GROW

While clearly necessary and effective, the availability of drug and alcohol treatment does not meet the current need for services. The 1999 National Household Survey on Drug Abuse reported a staggering treatment gap -- only 24% of the 11.8 million individuals assessed as drug or alcohol dependent received treatment in the survey year. The largest gap was found among adolescents and young adults. While youth aged 12 -25 represent the largest segment of the population assessed with drug and alcohol dependency, only 3.3% received treatment. Waiting lists for treatment are 6 months long in some regions. With the proliferation of successful programs, such as drug courts and other criminal justice initiatives that place non-violent offenders into treatment programs, treatment capacity has become even more over loaded than before. It is imperative that the federal government take significant steps to close the treatment gap. A recent SAMHSA report shows that the private sector share of substance abuse treatment spending has decreased since 1987. This places a greater burden on federal and state governments to meet the growing need for services.

SUBSTANCE ABUSE AND HIV

- Since the beginning of the epidemic, 36% of the over 753,000 cumulative AIDS cases reported to the CDC were directly or indirectly attributed to injection drug use.
- Of the 46,400 new cases of AIDS reported to the CDC in 1999, 13,833 (30%) were associated with injection drug use.
- Of those diagnosed with AIDS, drug use is linked to more than 35% of adult cases, 57% of cases among women, and 52% of cases among children.
- In 1999, 11.8 million people in the U.S. were dependent on alcohol or illegal drugs, but only 24% received some form of treatment.
- Researchers at the National Center on Addiction and Substance Abuse (CASA) estimate that there are 3 million severe addicts who need substance abuse treatment, but only 1.3 million treatment slots are available.

YOUTH AND IMPOVERISHED FAMILIES AT HIGH RISK

Drug and alcohol prevention services still do not reach all youth and other high risk populations across the nation. This presents a serious problem as the United States is facing a 21% growth in the adolescent population in the next 15 years. The use of non-injection drugs (such as "crack" cocaine) indirectly contributes to the spread of HIV when users trade sex for drugs or money, or when they engage in high-risk sexual behaviors that they might not engage in when sober. A CDC study of more than 2,000 young adults in three inner-city neighborhoods demonstrated that crack smokers were three times more likely to be infected with HIV than non-smokers were. In order to reverse these trends, effective drug and alcohol treatment and prevention services are essential. These services reduce HIV transmission, enhance the lives of infected drug and alcohol dependent individuals and reduce health care costs associated with HIV disease.

TRENDS IN SERVICE REDUCTION THREATEN HIV PREVENTION EFFORTS

Entitlement reforms have shrunk existing alcohol and drug treatment and prevention services significantly at a time when more services are desperately needed. On January 1, 1997, an estimated 200,000 individuals with drug and alcohol disabilities lost their Supplemental Security Income (SSI) and Medicaid coverage. Less than 60,000 of these individuals have re-qualified for SSI and Medicaid under another disability. Some of the individuals who have not re-qualified are HIV positive but not sick enough to meet other SSI eligibility criteria.

IMPACT OF WELFARE REFORM ON SUBSTANCE ABUSE SERVICES

Welfare reform requires states to move individuals from welfare to work within a given time period, or a state's federal welfare funding will be decreased. Several national studies have concluded that between 16% to 20% of welfare recipients have alcohol and drug problems. This could translate into an additional 400,000 to 1,000,000 adult welfare recipients needing treatment to move into recovery, off welfare, and into jobs.

Welfare reform also has reduced treatment availability by making individuals convicted of drug felonies after August 22, 1996, ineligible for cash assistance or food stamps in many states. Residential treatment programs serving individuals living with HIV/AIDS, particularly women with children have relied on these funds to help support the room and board costs of care. Without these funds, treatment availability will decrease.

To respond to the enormous unmet need for drug and alcohol treatment and prevention services, AIDS advocates recommend that funding for the Substance Abuse Prevention and Treatment Block Grant (SAPT) – the primary federal funding source for substance abuse treatment – be increased to $2 billion in FY 2002.

AIDS is a Global Crisis

AIDS is the youngest and yet potentially the most devastating infectious disease facing the world today. Since AIDS was first recognized twenty years ago, more than 50 million people have been infected with HIV, and at current rates of spread, the total will exceed 100 million by 2007. While deadly, the disease's effects are delayed rather than immediate, and 36 million people around the world live today with HIV. For every person who dies more than two are newly infected. More than 5 million people were infected in the past year.

Global Overview

The pandemic has already claimed the lives of nearly 22 million people. Each year, more than 5 million new HIV infections occur, including 600,000 children under 15, and three million people die prematurely because of HIV/AIDS. Sub-Saharan Africa has been the hardest hit, with twenty-four million of the region's people HIV-positive – two thirds of the world's infected population. With over 10 percent of its 45 million people infected with the virus, South Africa has the world's largest population of HIV-positive people. Under current circumstances virtually all are expected to die because of HIV/AIDS.

The infection is also spreading rapidly in other regions of the world; Asia will soon have more new HIV infections than any other region and Russia is a new "hot spot" for the disease. More Russians are expected to be diagnosed with HIV/AIDS by the end of the year than all cases from previous years combined.

GLOBAL AIDS FACTS

- More than 95 percent of new HIV infections occur in developing countries, where treatment for AIDS is almost unheard of.
- One in four women of childbearing age in South Africa is HIV positive, and the epidemic is spreading at an alarming rate.
- This year, over six hundred thousand children will be born HIV-positive or become infected by breast-feeding. Few will survive childhood.
- By the year 2010, over 44 million children worldwide will have been orphaned due to HIV/AIDS.

Children at Risk Today

With tens of millions of women infected and with few receiving the treatment that could stop mother-to-child transmission, children are especially vulnerable to infection and death. Equally devastating, the disease also threatens the health and well being of uninfected children by killing their parents. South Africa alone is home to over 500,000 orphaned children, two-thirds of whom have lost their parents to AIDS. The figures are similar for Malawi, Mozambique, Zambia, and Zimbabwe.

Global AIDS Funding

Congress has again increased funding for global AIDS programs. However, it is still short of what is needed to combat this pandemic. While advocates are eager to see an increase in funding for AIDS programs, they do not wish to receive this funding at the expense of other health and development programs. An increased response to global HIV/AIDS should not affect or be pitted against domestic spending on U.S. programs. Global AIDS activities are funded through the Department of Health and Human Services, Centers for Disease Control and Prevention, Department of Defense, Department of Labor, and the U.S. Agency for International Development (USAID), which is the largest single mechanism for carrying out international HIV/AIDS efforts.

In FY 2002, AIDS advocates are seeking approximately $1 billion for global AIDS programs, in addition to significant new support for global health and development programs.

A Winning Strategy Requires Adequate Funding

For over a decade the U.S. has led the world's response to the HIV/AIDS pandemic by funding the largest bilateral program and leading in the creation of several multilateral efforts, such as UNAIDS. But even more is required if the battle against the HIV pandemic is to be won. Of utmost importance in addressing the global HIV/AIDS epidemic is the inclusion of community-based organizations, networks, and people living with HIV and AIDS in program development, implementation and evaluation. Community input, in accordance with the Greater Involvement of People Living with HIV and AIDS (GIPA) principles, is crucial to ensure the long-term success of HIV/AIDS programs. Hundreds of NGOs and CBOs are dedicated to HIV/AIDS prevention, care and support efforts, but need support and capacity building to enhance their impact. Congress can demonstrate greater leadership in addressing the AIDS epidemic worldwide by increasing funding based on need for global health programs including HIV/AIDS in FY 2002.

- **$630 million for USAID funding for global HIV/AIDS**
  This portion of U.S. Government spending on global HIV/AIDS programs comes from the Child Survival and Disease Fund at USAID. USAID programs support prevention, treatment, care, research -- including microbicide research and development -- and infrastructure development to address the global pandemic. Advocates recommend a total funding of $2 billion for the Child Survival and Diseases Fund, with $630 million dedicated to global HIV/AIDS.

- **$208 million for CDC to address the global pandemic**
  Advocates support the doubling of FY 2001 expenditures in the coming year so that care, prevention, and surveillance activities can be expanded. NORA also believes the CDC must work in partnership with USAID, HRSA and other relevant agencies in developing and implementing model global prevention and surveillance technical assistance programs. This coordination should be done in a formal way through the Office of National AIDS Policy so that efforts are not duplicated.

- **Increased funding for the World Bank HIV/AIDS Trust Fund**
  Last year, Congress authorized the World Bank HIV/AIDS Trust Fund and approved $20 million to support prevention, treatment and care programs from other countries and other sources. AIDS advocates recommend that Congress provide as much additional funding as possible to this new funding source.

The toll of war in the 20th century: 33 million
The toll of HIV/AIDS in the last 20 years of the 20th century: 22 million

WARS		HIV/AIDS	
World War I deaths:	9.2 million	Children HIV infected since 1980:	5.7 million
World War II deaths:	20.0 million	Women living with HIV/AIDS:	16 million
Korean War deaths:	1.5 million	Children infected with HIV 1998-2000:	2.4 million
Vietnam War deaths:	2.1 million	AIDS deaths in 2000:	2.5 million

The Minority HIV/AIDS Initiative: Empowering Minority Communities In the Fight Against AIDS

*Disparities in HIV and AIDS health outcomes among ethnic and racial minorities and subpopulations persist. While ethnic and racial minority groups make up 24% of the U.S. population, they represent 57% of the cumulative and 68% of **new** AIDS cases. Ethnic and racial minorities make up 62% of the estimated number of persons living with AIDS and account for 74% of the estimated new HIV infections annually.*

The Minority HIV/AIDS Initiative was established in FY 1999 through the advocacy of the **Congressional Black Caucus** to address the "State of Emergency" of HIV/AIDS among African Americans. The Initiative was expanded in FY 2000 with the strong support of the **Congressional Hispanic and Congressional Asian Pacific American Caucuses** to address the growing impact of the epidemic on other ethnic and racial minorities in the U.S. This Initiative addresses the HIV/AIDS related health disparities experienced by ethnic and racial minority communities by providing targeted funding to:

CREATE & IMPROVE HIV SERVICE CAPACITY IN MINORITY COMMUNITIES

The Initiative is intended to create and improve the existing infrastructure and service capacity of minority community-based organizations (CBOs) to provide quality HIV prevention interventions, health care, treatment and supportive services. This targeted Initiative provides minority CBOs access to capacity building assistance and the health care resources necessary to mount an effective response to the epidemic within their own communities.

EXPAND SERVICES IN HISTORICALLY UNDERSERVED MINORITY COMMUNITIES & ENSURE SUSTAINABILITY

The Minority AIDS Initiative seeks to put into place HIV/AIDS services in communities that have been historically underserved and to complement existing HIV prevention and health care services. These resources are intended to provide a bridge that will enable minority community-based organizations to ultimately compete and successfully access broader federal HIV/AIDS funding for sustainable HIV/AIDS services.

REDUCE PERSISTENT HEALTH DISPARITIES

The introduction of new drug therapies in the mid-1990's led to significant improvements in the quality of life and health for people living with HIV/AIDS and decreases in AIDS deaths. Despite these improvements, ethnic and racial minorities continue to experience poorer HIV/AIDS-related health outcomes. Data from the *Adult/Adolescent Spectrum of HIV Disease project* shows that from 1996 to 1999 an increasing proportion of eligible patients were prescribed highly active antiretroviral therapy (HAART). In 1999, African Americans were still less likely than whites to be prescribed HAART. The Minority AIDS Initiative is intended to address and close these health disparities by enabling minority community based organizations and providers to deliver culturally competent and linguistically appropriate HIV, substance abuse and mental health, prevention, health care and treatment services, and supportive services.

HIV/AIDS Among Minorities

African Americans are most severely impacted. While they make up 12% of the U.S. population, they account for 38% of the new AIDS cases reported through June 2000. About 54% of the estimated new HIV infections reported annually are among African Americans.

Latinos make up 13% of the U.S. population, but account for 18% of the cumulative AIDS cases and 19% of new AIDS cases reported through June 2000. Approximately 19% of the estimated new HIV infections annually are among Latinos.

Asians and Pacific Islanders are among the fastest growing populations in the U.S. Over three-fourths of this population are concentrated in ten states, of which four have HIV-reporting. HIV/AIDS continues to grow among APIs. As of June 2000 just under 1% of the reported AIDS cases were among APIs. However, from 1993 to 1999 the estimated number of living AIDS cases among APIs grew by 50%.

Native Americans continue to experience increases in HIV and AIDS cases. Although they accounted for less than 1% of the new AIDS cases as of June 2000, from 1993 to 1999 the estimated living AIDS cases among Native Americans grew by 48%. Two-thirds of this population are concentrated in ten states, of which seven have HIV-reporting in place.

HIV/AIDS continues to grow in Latino, Asian and Pacific Islander and Native American communities. However, national data mask the full impact of the epidemic on these populations because of the lack of consistent reporting across all states, misclassification, and under-reporting.

THE MINORITY AIDS INITIATIVE WORKS

Now in its third year of implementation, the Minority AIDS Initiative has worked to expand and strengthen the capacity of minority community based organizations to deliver high quality HIV health care and supportive services, and to enhance and better target HIV prevention programs to historically underserved populations and sub-populations.

Through supplemental Minority AIDS Initiative funding for Title I of the Ryan White CARE Act, highly impacted urban areas have been able to expand HIV health care and supportive services for vulnerable minority populations. For example Los Angeles County has expanded health care and supportive services for Black/African Americans not in care with a special focus on women, injection drug users, persons with other chemical dependencies, individuals newly released from prison, the homeless, persons with severe mental illness, and men who have sex with men. In the first 9 months of the program, a sample of the clients served showed increases in their CD4 levels. In other programs services were also expanded for Asian and Pacific Islanders and Hispanics, not in care. In the first nine months, data from a sample of the clients served showed notable increases in client CD4 levels from base line.

In Detroit services targeting Black/African Americans were expanded, with a special focus on women, the homeless, IDU, other chemical dependency, severe mental illness, and those newly released from prison . In the first 9 months, 92% of the clients served had a decrease in viral load and an increase in CD4 counts. All patients were screened for eligibility in clinical trials.

Through the resources provided by the Minority AIDS Initiative, the Centers for Disease Control and Prevention (CDC) was able to increase the number of grant awards to minority community based organizations from 93 to 233 (an increase of 150%). These organizations provide a wide range of HIV prevention interventions to high-risk minority populations. The impact of this service expansion has been to increase access and linkages to HIV prevention, counseling and testing, care and treatment, substance abuse and mental health, STD prevention and other services. This service expansion in highly impacted racial and ethnic minority communities will contribute significantly to the overall efforts to reduce new HIV infections in the coming years.

Through Minority AIDS Initiative funding the CDC was able to increase the number of grants to national, regional and local minority organizations by 50% to deliver technical assistance and capacity building assistance to strengthen the infrastructure and HIV prevention efforts of minority community based organizations and communities. These services will increase the likelihood of community awareness and support for HIV prevention issues, the sustainability of minority organizations, the effective implementation of HIV prevention interventions, greater involvement of minority communities in HIV prevention community planning and increased access to HIV prevention including counseling and testing, and care and treatment.

INCREASED FUNDING FOR THE MINORITY AIDS INITIATIVE IS NEEDED NOW MORE THAN EVER.

In light of the severe and growing burden of the HIV/AIDS epidemic among ethnic and racial minorities and the persistence of health disparities, the Minority AIDS Initiative is needed now more than ever. In FY 2001 this Initiative was funded at $350 million. In ***FY 2002 $540 million*** *is needed in order to sustain current efforts and dramatically expand the initiative to address the growing unmet service, infrastructure and capacity needs in minority communities. This funding level is essential to accomplish the goal of eliminating HIV-related health disparities in ethnic and racial minority communities. The Administration provided no increase in its FY 2002 budget request to Congress for the Minority HIV/AIDS Initiative. Congress must once again show leadership and appropriate the funding needed to empower ethnic and racial minority populations to make significant inroads against the epidemic.*